Research Bulletin

Supportive systems

State-wide implementation of trauma-informed care for young people in healthcare settings

ISSUE 13

Creating service environments that acknowledge the specific needs and sensitivities of young people who have experienced trauma is essential to building trauma-informed healthcare systems. Young people with trauma histories are likely to engage with, and move between, multiple services and systems.[1] This highlights a need for system-wide collaboration on the implementation of trauma-informed approaches. This research bulletin reviews four examples of state-wide implementation of trauma-informed care from the United States. It focuses on the latest evidence on how the principles of trauma-informed care can be operationalised in different settings.

Background

The impact of trauma is widespread, with an estimated two thirds of young people being exposed to trauma by the time they turn 16.[2] The experiences that cause trauma and the way these events affect each individual are highly variable. Many young people affected by trauma do not disclose their experiences or reach out for help. Young people may be unsure about how to disclose their experiences or they may feel fear, shame, guilt, and/or distrust of health professionals when it comes to disclosure. Some young people may not be aware that their symptoms are related to trauma, so without appropriate screening their trauma experiences and symptoms may go unnoticed. Trauma and its effects are often under-assessed, overlooked, or misdiagnosed by health professionals. Financial barriers and/or a lack of appropriate services may also act as barriers to appropriate care.

One way that services can begin to support disclosure and better acknowledge the effects of trauma is through trauma-informed care. This entails support and involvement from all levels of the organisation, to create a safe environment, and a trauma-aware workforce that is equipped to recognise and respond to trauma. This scale of implementation is complex and each service setting will have its own unique way of operationalising the principles of trauma-informed care to suit their organisation. Additionally, there are challenges associated with inter-agency collaboration and ensuring that models are coherent across systems. In order to address these challenges, research teams have implemented innovative programs in a range of contexts that will be described in this research bulletin.

Orygen
The National Centre of Excellence in Youth Mental Health

Services can begin to support disclosure and better acknowledge the effects of trauma through trauma-informed care.

What is trauma-informed care?

Definitions of trauma-informed care vary, with no universally accepted definition in the research literature. Commonly, it is conceptualised as a set of principles that reflect the way in which the organisation, program, or system actively recognises the widespread impact of trauma and its effects, whilst responding therapeutically to this through policies and practice that actively avoid re-traumatisation.[3]

Rather than emphasising a simple definition, this research bulletin is informed by principles of trauma-informed care that are outlined below. Further detail can be found in Orygen's clinical practice point **What is trauma-informed care and how is it implemented in youth healthcare settings**.

What are the core principles of trauma-informed care within youth healthcare settings?

The following have been adapted from Substance Abuse and Mental Health Services Administration's 'Concept of trauma and guidance for a trauma-informed approach in youth settings'[3] and 'Advancing trauma-informed care: Key ingredients for successful trauma-informed care implementation'.[4]

Safety

Throughout the organisation, the staff, and the young people and family/carers they serve, all should feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.

Trustworthiness and transparency

Organisational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among young people, family members/carers, staff, and others involved with the organisation. This involves creating clear expectations with young people about what treatments will involve, who will provide services, and how care will be provided.

Collaboration and mutuality

There is true partnering between staff and young people (to help 'level out' power differences), and staff recognise that healing can happen through relationships and in meaningful sharing of power and decision-making. This involves collaboration between healthcare staff, young people, and families/carers in organisational and treatment planning.

Empowerment

The individual strengths of young people and their families/carers are recognised, built on, and validated. New skills are developed as needed. Young people's strengths are used to empower them in the development of their treatment.

Voice and choice

The organisation aims to strengthen the experience of choice for young people, family members/carers, and staff. It recognises every person's experience is unique and requires an individualised approach.

Culture, historical and gender issues

The organisation incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served, that are gender responsive, and that incorporate a focus on historical trauma. Within Australian settings, it is particularly important to work in a culturally sensitive way with Aboriginal and Torres Strait Islander young people and families/carers.[5]

What does the evidence say?

Kramer TL, Sigel BA, Conners-Burrow N, Worley KB, Church JK, Helpenstill K. **It takes a state: Best practices for children exposed to trauma.** *Best Practices in Mental Health: An International Journal.* 2015 Spr;11(1):14–24.

This study explored the implementation of the Arkansas Building Effective Services for Trauma (AR BEST) project. The AR BEST project was created by trauma research faculty members and clinicians with experience in working with trauma in children. The primary aim of this project was to improve screening and continuity of care for children who have experienced trauma by increasing capacity of mental health professionals to deliver trauma-informed best practice.
A secondary aim of this initiative was to increase trauma-informed approaches in Arkansas' child advocacy centres (CACs), which are child-friendly locations used to provide multidisciplinary investigative interviews, assessments, support, and referral for children who have experienced trauma. The project also aimed to implement changes in child welfare and juvenile justice systems by offering training to directors, supervisors, and frontline staff. At a government level, Arkansas legislature agreed to invest to prioritise the needs of children exposed to trauma.

Training in trauma-focused cognitive behavioural therapy (TF CBT) as an evidence-based treatment was offered to mental health professionals.[6] This involved an online learning component, an in-person training component, and 12 consultation phone calls with a trained trauma expert. Training in trauma-informed care was also delivered to child welfare, juvenile justice workers, and foster families by national experts using resources developed by the National Child Traumatic Stress Network (NCTSN).[7] This training used interactive learning and experiential exercises to cover 12 core concepts in childhood trauma, including content on trauma causes, manifestations, complexities, and implications. Although these trainings were not established as evidence-based, they were endorsed by experts and considered relevant to the youth being supported. Alongside this, case peer review processes and an online mental health screening and referral protocol were created for child advocacy centres.

Over four years of implementation, 1,000 mental health professionals completed web-based training in TF CBT, 674 completed the in-person TF CBT training, and 204 completed the 12 consultation phone calls. Since 2010, more than 100 directors working in child welfare and 800 frontline staff completed the NCTSN training. Evaluation demonstrated increased staff knowledge in trauma-informed practices and improved attitudes towards these practices. Additionally, the intervention was associated with increased registrations in the child advocacy centres, with 78% of children being screened for trauma and 59% of young people who were interviewed in this setting being referred to counselling.

Lessons learnt Dissemination of state-wide trauma-informed practice requires inter-agency collaboration and involvement of stakeholders from all levels of the organisations involved. This program appears to have been successful in creating a network of mental health staff and community partners that is supportive, aware of and trained in trauma-informed practice, and equipped to deliver ongoing training whilst measuring outcomes of implementation. Due to the large scale of this study, it was not feasible to assess whether mental health professionals who received training were implementing trauma-informed practice with fidelity. Future research could explore whether or not implementation of the AR BEST has contributed to any long-lasting trauma-informed organisational changes.

This study also demonstrated the impact of the broader context on trauma-informed practice. The state legislature in Arkansas provided additional funding for the child advocacy centres and this was crucial in supporting the increased activity in training and implementing a trauma-informed care model.

Beidas RS, Adams DR, Kratz HE, Jackson K, Berkowitz S, Zinny A, et al. **Lessons learned while building a trauma-informed public behavioural health system in the City of Philadelphia.** Evaluation & Program Planning. 2016;59:21–32.

This study describes the formation and evaluation of the Philadelphia Alliance for Child Trauma Services (PACTS), which aimed to create a trauma-informed behavioural health system for children and adolescents. To guide this implementation, the exploration, preparation, implementation, and sustainment (EPIS) framework was used.

This is an approach to implementation science that focuses on the impact of contextual factors on the implementation process. Originally named the 'Trauma Initiative', the program offered training in trauma-focused psychotherapies – TF CBT and prolonged exposure (PE) – to clinicians. At a service level, training in the 'Sanctuary Model' – an evidence-based approach to creating trauma-informed organisations – was provided.

Training was provided by PACTS in screening and assessment of trauma. Agencies also partnered with other child-serving organisations to increase capacity for screening and assessment. A significant number of clinicans (n=182) received training in TF CBT. Following implementation, there was a two-fold increase in the number of young people who received TF CBT. 35% percent of these young people had a post-traumatic stress disorder (PTSD) diagnosis. Clinician knowledge of evidence-based practice did not demonstrably increase after training. Clinician openness to TF CBT was highest just after training; however, declined following consultation, at the six-month follow-up.

Lessons learnt This study provides insight into a system-wide implementation of trauma-informed care. The research demonstrates that in the initial phases it is important to engage with leadership and also to provide support for agencies to establish effective screening mechanisms for trauma. Creating a coordinated network of child providers was identified as a core component for success.

The research offers evidence that implementing an ongoing training package can provide a demonstrable increase in the provision of evidence-based trauma treatment. This study also indicates the challenge of building truly sustainable models of trauma-informed care in two ways. First, it showed that staff turnover was approximately 45% over four years. Second, openness to TF CBT increased initially following training and then declined, despite ongoing consultation. One reason for this may be that clinicians were hesitant to use TF CBT given that PTSD was only diagnosed in 35% of young people. This study also highlights that planning and ongoing investment is required to maintain a workforce that is skilled in trauma-informed care.

Wonderlich SA, Simonich HK, Myers TC, LaMontagne W, Hoesel J, Erickson AL, et al. **Evidence-based mental health interventions for traumatised youth: A state-wide dissemination project.** *Behaviour Research and Therapy.* 2011;49(10):579–587.

This study describes the development of the Treatment Collaborative for Traumatised Youth (TCTY) created in 2006 in North Dakota. This initiative aimed to train mental health professionals working with young children and families in TF CBT and structured psychotherapy for adolescents responding to chronic stress (SPARCS). The initiative comprised four phases. In Phase one, 13 clinicians from different services completed training in TF CBT and SPARCS, with twice-weekly supervisory phone calls offered in the six months following each training workshop (i.e. one year of training in total). Phase two focused on creating local trauma training teams which involved a train-the-trainer program to make state-wide dissemination of TF CBT and SPARCS possible. In Phase three of the project, 41 clinicians were trained in TF CBT and SPARCS over the course of one year, using the same training model as described in Phase one. In Phase four, 22 clinicians took part in SPARCS training and 40 in TF CBT, all of whom were recruited from eight state-run human service centres and 30 private agencies. Outcome data indicated that post-traumatic stress symptomatology was significantly reduced in young people seen by clinicians who had received the training.

In 2012, a secondary arm of the TCTY was developed to boost referrals to trauma trained clinicians after a lack of referrals was identified as a major barrier to implementation.[8] This focused on increasing cross-system collaboration between mental health, foster care, child welfare, and education systems in North Dakota on trauma-informed approaches.

Lessons learnt This study demonstrated effective dissemination of evidence-based trauma training, in which community partnerships between child-serving agencies across North Dakota played a crucial role. It was clear that system-wide involvement in trauma-informed practice was integral to identifying, assessing, and referring children affected by trauma. This state-wide training initiative proved complex and required continual evaluation and feedback in order to produce relevant outcomes. Despite the creation of a web-based platform for feedback and data collection, measurement of outcomes was still

limited, which impeded the viability of such long-term dissemination.

Nevertheless, there was some indication that training clinicians resulted in improved outcomes for young people, with reductions in symptoms evident from pre- to post-treatment assessments. Future endeavours should recognise the importance of creating a system-wide trauma-informed culture in which trauma-trained clinicians can practice, and the significance of collaboration for effective provision of treatment and outcome evaluation.

Fraser JG, Griffin JL, Barto BL, Lo C, Wenz-Gross M, Spinazzola J, et al. **Implementation of a workforce initiative to build trauma-informed child welfare practice and services: findings from the Massachusetts Child Trauma Project.** *Children and Youth Services Review.* 2014 Sep;44:233–242.

This study describes the implementation of the Massachusetts Child Trauma Project (MCTP). This initiative aimed to build workforce capacity to care for children with complex trauma in the child welfare system. Training packages were rolled out across four regions of the state. Child trauma training was provided to 1,096 staff members from the Department of Children and Families (DCF) using The Child Welfare Trauma Training Toolkit. This toolkit outlines essential elements of trauma informed care, including:

- maximising safety
- identifying trauma-related needs
- enhancing wellbeing and resilience
- partnering with youth, family, and systems.

The Resource Parent Curriculum was also provided to parents in order to help them better recognise and respond to trauma.

In tandem with these trainings, trauma-informed leadership teams (TILTs) were formed at DCF offices. Their purpose was to monitor and evaluate trauma-informed practice within services. They did so by engaging in self-assessment, team building, supporting, and monitoring innovations in trauma-informed practice.

The final component of the MCTP involved dissemination of training in TF CBT, child–parent psychotherapy (CPP), and attachment, self-regulation, and competency (ARC). Training in these psychotherapies was carried out over the course of one year in parallel with the child trauma trainings and the TILT development.

The basic training toolkit, involving face-to-face and online components, was provided to 1,096 workers. 192 mental health clinicians and clinical supervisors from 20 agencies across the state took part in the trauma psychotherapy trainings. At the end of the first year of implementation, 101 children were enrolled in ARC, 77 enrolled in CPP, and 120 in TF CBT. The early evaluation results suggest that the training process and TILTs led to innovations in trauma-informed care and increased the provision of evidence based therapies.

Lessons learnt This paper demonstrates a wide ranging effort to implement trauma-informed care within the child welfare system. It highlights that identifying leaders in trauma-informed care and empowering them to foster change can be a useful approach to catalysing systemic changes in practice. These leaders can identify local needs, foster innovation, and support staff in implementing evidence-based practices. This study also identified the challenges associated with staff turnover and highlighted the need for multiple rounds of training and building learning communities to ensure the sustainability of changes in practice.

Where to from here?

The research studies that have been reviewed highlight the considerable challenges and opportunities associated with implementing trauma-informed care for young people in health settings.

To achieve meaningful outcomes for young people, considerable investment is required in terms of planning, resourcing, sustainability practices, and evaluation activities at all levels of organisations. Broad systemic changes require extensive consultation, a coherent model, appropriate training, ongoing support – both clinical and managerial – and ongoing collaboration across agencies.

However, the opportunities to provide improved care for young people who have experienced trauma through the implementation of trauma-informed care cannot be ignored. These studies provide evidence to suggest that reforming health systems around principles of trauma-informed care can result in improved access to evidence-based treatment for young people who have experienced trauma.

What does this mean for healthcare systems?

In the interests of 'doing no harm', all health and welfare services should consider the extent to which their service model can be considered trauma informed and take steps to address any deficiencies identified. Together, the papers provide examples to demonstrate that broad systems of care can adopt trauma-informed practices and point to a number of important features and challenges. Adequate funding, leadership, training, and collaboration is required to establish a comprehensive system that is appropriately responsive to trauma in young people. Challenges include maintaining an adequately trained workforce in the face of staff turnover, and momentum for ongoing monitoring, evaluation and service improvement around trauma-informed practices. Trauma-informed care should be embedded in health and welfare agencies. This can be achieved by:

- ensuring that screening and assessment of trauma is part of routine practice so that trauma is being adequately detected.
- ensuring that all staff are trained in trauma-informed care.
- ensuring that young people are being offered evidence-based treatments for trauma.
- having regular ongoing professional development in trauma-informed care.
- ensuring that training systems account for staff turnover.
- developing awareness of and promoting trauma-informed care within the service network.
- focusing on developing partnerships for consistent and effective implementation of trauma-informed care within local networks.
- ensuring that referral pathways are easy to navigate, minimise barriers, and reduce repeated assessments regarding traumatic events.
- ensuring that service users and families are involved in all aspects of planning and evaluating services.
- ensuring that trauma-informed care is recognised as a stated aim of the service and embodied in policy.
- supporting research into trauma-informed care.

Questions for future research

- Does training staff in trauma-informed care lead to increased fidelity to trauma-informed practice models and improved outcomes for young people who have experienced trauma? Building the evidence base in support of trauma-informed care will justify the resources required to implement and support its practice throughout health and welfare service systems.
- How can the practice of trauma-informed care be sustained within services and systems? What level of monitoring and ongoing training is required to embed trauma-informed care within services?
- How can trauma-informed care be monitored within services, what are the key performance indicators to apply?
- Can the cost effectiveness of trauma-informed care be demonstrated?

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Research Bulletin writers

Anna Farrelly-Rosch
Dr Elon Gersh
Dr Shona Francey

Research Bulletin consultants

Dr Sarah Bendall

35 Poplar Road
Parkville VIC 3052
1300 679 436
orygen.org.au

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