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"We're Civil Servants": The Status of Trauma Informed Care in the Community

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Abstract

Trauma-informed care (TIC) in social service organizations means that the organizations operate with the understanding that everyone involved has experienced trauma in their lifetime. This qualitative study examined local service organizations' knowledge and usage of the five main principles of trauma-informed care: safety, trustworthiness, collaboration, empowerment, and choice (as developed by Fallot & Harris, 2006). Ten focus groups (n=69) and six individual interviews (n=6) with social service agency employees from administration through management were interviewed (in focus groups or individually), such that almost all facets of each agency was represented. The participants were asked about their agencies' policies and practices around utilizing the five principles of trauma-informed care (TIC). The results suggest that the vast majority of organizations in this study implemented many of the principles of trauma-informed care with clients, though they had not labeled their practices as "trauma-informed". However, whereas clients were receiving trauma-informed care, some of the principles were neglected as they pertain to staff, such as choice and empowerment. The findings of this study suggest that agencies are unaware of the relevance of trauma-informed care as it relates to staff. It is recommended that future research examine whether the use of TIC in agencies prevents 'burnout', high turnover rates, and vicarious traumatization of staff and direct care workers.

Keywords: trauma-informed care, safety, trustworthiness, collaboration, empowerment, choice, organizational change, secondary traumatization, vicarious traumatization, burnout

Trauma-informed care (TIC) is an organizational change process that is structured around the presumption that everyone in the agency (from clients through agency management) may have been directly or indirectly exposed to trauma within their lifetime. Numerous studies and policy materials demonstrate the positive correlation between early trauma (such as child abuse) and subsequent life struggles (i.e., mental health issues, substance abuse, crime involvement, physical health problems, etc.) (Felitti et al., 1998; Ford, Connor, & Hawke, 2009). To prevent future traumatization and encourage healing from past trauma, researchers, policy organizations, and scholars have sponsored an organizational shift toward trauma-informed systems of care.

Trauma informed environments ask, "What has happened to you?" rather than the customary question, "What's wrong with you?" (Jennings, 2004). However, unlike trauma-specific interventions, which are designed to treat the actual sequelae of PTSD and other trauma-related symptoms, trauma-informed care indicates an organization's commitment to providing services that are "welcoming and appropriate to the special needs of trauma survivors" (Harris & Fallot, 2001, p. 5). Such organizations demonstrate their commitment to trauma-informed care through the development of policies and working environments that subscribe to five basic guiding principles of TIC. These principles are: safety, trustworthiness, collaboration, empowerment, and choice, as experienced by both clients and staff.

Fallot & Harris (2006) discuss the concept of safety in terms of both physical and emotional safety, and examples of such safety would include how/when/where services are offered, open doors/locked doors, physical appearance of the agency, and staff interaction with clients being respectful, engaging, and attentive to signs of client discomfort (p.9). These authors advise that assessing for these types of safety in organizations would involve identifying "formal

and informal activities and settings" where safety (both physical and emotional) could be compromised or insured (p.7). Bloom (2006) advises that a program only achieves true safety for clients when it is also safe for all the employees of the organization. Without such safety, the organization as a whole is at risk for re-traumatizing everyone associated with the organization, from the head of the organization through to the clientele (Bloom, 2006).

Furthermore, Bloom (2006) suggests that trust is a function of safety. This implies that without a sense of physical safety within an organization, staff, clinicians and administrators alike may not have capacity to trust one another or the organization as a whole. In addition, external threats job security such as funding cuts or potential malpractice litigation may further erode a sense of safety. This diminished sense of safety and consequently of trust, may negatively impact interoffice dynamics. For instance, Bloom (2006) speaks of fear, both real and perceived within an organization, as a contagion that can infect all those employed, weakening the resolve of the organization and potentially creating an atmosphere ripe with hostility and contention. Such a volatile and untrustworthy atmosphere is experienced by both those within the organization and the consumers of its services provided by the organization. Creating a physically safe environment for all those employed within an organization is an instrumental component of trauma-informed care.

Fallot and Harris (2006) discuss collaboration, empowerment, and choice as the theme by which organizational policies and procedures should be centered. For instance, an organization that follows a trauma-informed model would naturally have policies and procedures in place that protect both clients' and staff experiences of being able to fully collaborate with each other. This type of organization would not only allow for that, but would expect that. A trauma-informed

organization would maximize the empowerment of both staff and clients, and would also empower all involved to be able to make choices in the issues that affect them.

Trauma-informed care is not only of benefit to clientele in the system. Evidence also suggests that service providers benefit from the approach. Greenwald et al. (2008) found that after receiving trauma intervention training, participants reported decreased stress, increased empathy, and increased comfort and confidence when faced with a challenging case scenario. The researchers concluded that having trauma-related insight about clients likely improves service providers' attitudes and behaviors towards challenging clients (Greenwald et al., 2008).

In order for trauma-informed services to have the desired positive impact on clients, all staff (including direct care staff, janitorial, administrators and management) need to receive training to increase the understanding of how direct or indirect exposure to traumatic events may impact their lives as well as the lives of the clients (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). A trauma informed environment involves an organizational change, from administration to support staff. All staff must understand how violence affects clients being served so that all interactions support recovery and avoid re-traumatization (Elliot et al., 2005).

Working within a therapeutic milieu presents risks to practitioners of secondary traumatic stress. Secondary traumatic stress is defined herein as the occurrences of trauma symptoms in clinicians due to the constant exposure to the experiences and stories of their clients. Secondary traumatic stress is different than burnout in that it specifically applies to those who work with traumatized populations and is precipitated by the repeated exposure to traumatic material (Bride, 2011). Workers experience physical, emotional, and cognitive changes as a result of secondary traumatic stress, and it also impacts their work functioning (Bride, 2011). However, a

true trauma informed workplace that includes supervision and support for direct care workers can reduce the frequency and severity of secondary traumatic stress (Bride, 2011).

There is a small but growing body of research that suggests that trauma-informed care is beneficial for use with several populations, including children who have witnessed violence, adolescents with emotional/behavioral problems, juvenile delinquents who have committed crimes, clients with substance abuse and co-morbidity, those diagnosed with a mental illness, and mothers who are homeless (Howard & Tener, 2008; MacNeil and Mead, 2005; Noether et al., 2007; Rivard, 2004; Rivard, Bloom, McCorkle, Abramovitz, 2005; Savage, Quiros, Dodd, & Bonavota, 2007; Tischler, Edwards, Vostanis, 2009; for a review, see Butler & Wolf, 2009). Additionally, trauma-informed care has been shown to be beneficial to clients and clinicians in reducing the rates of iatrogenic traumatization via seclusion and restraint in mental health facilities. When staff members are trained in trauma-informed care, there are fewer incidences of seclusion and restraint (Busch & Shore, 2000).

Aim of this Study

The aim of this study was to explore whether organizations had policies and practices that operationalized the five principles of TIC put forward by Fallot & Harris (2006): safety, trustworthiness, collaboration, empowerment, and choice, as experienced by both clients and staff. Specifically, the research question was: What are the policies and practices of social service agencies in our county regarding the five principles of trauma-informed care (as put forth by Fallot & Harris, 2006)? In order to research this issue, agency staff members were interviewed on their usage and knowledge of the five main principles of trauma-informed care. The *a priori* hypothesis for this study was that since these principles were naturally aligned with

social work values, the agencies would naturally have policies and programs in place to maintain those principles.

Methods

Procedures

The first step was to gain approval from the Institutional Review Board. After gaining such approval, the next step in this study was to identify a list of social service agencies that would allow either individual interviews or focus groups to be conducted with their staff members. Additional agencies were purposively sampled throughout the study. In total, 32 agencies were contacted. The first contact was made with either the Chief Executive Officer (CEO) or the secretary of the CEO at these agencies. Thirteen agencies requested time to discuss possible involvement in the study within their agency, and other agencies had internal review boards that needed to review the study's materials before agreeing to participate.

Focus Groups

Of the identified 32 agencies, the researchers contacted each organization by phone and e-mail, using a script to ensure consistency. Where feasible, the researchers asked for focus groups with organizations. For organizations where a focus group was not feasible, key informant interviews were requested. For instance, focus groups would not have been feasible with an agency that employed two public school social workers at a public school, because there were only two employees. However, individual key informant interviews would have been feasible with such employees.

When an organization agreed to either individual interviews or focus groups, two interviewers were sent to the organization at the specified date/time. The interviewers consisted of faculty members, doctoral students, and staff from our School of Social Work. The

interviewers were different for each group, though there was a lot of overlap of interviewers. Each set of interviewers were given the same script of questions to ensure consistency of the research methods between the focus groups. Each focus group was audio-recorded and consisted of six to eight agency staff members representing various roles within each agency, such as secretaries, receptionists, direct care workers, social workers, clinicians, supervisors, managers, and CEO's. Focus group meetings lasted approximately 90 minutes. Each focus group member signed a consent form to participate in the research, and also gave verbal and written consent to be audio-recorded. The interviewers followed a specific interview format, and thus the same questions were asked of each focus group. (Please see the actual wording of questions in the Results section.) Ten focus groups were held in total, including a total of 69 respondents. Each focus group occurred with a different agency with a specific specialization. The following types of agencies were sampled: developmental disabilities, substance abuse, emergency crisis services/disaster relief, mental health services, child welfare, residential refugee services, juvenile justice, gerontology, poverty, and child/family welfare. The audio files from the focus groups were transcribed verbatim for analysis. However, of the 10 focus groups, the tape recorder was only functional for seven of them. The other three focus groups were not recorded, and as such, analysis of those focus groups relied on notes from the researchers involved. However, the notes of the researchers in the unrecorded focus groups were strikingly similar to the notes of the researchers in the recorded focus groups.

Key Informant Interviews

Key informants were initially contacted by the researchers of this study via phone and e-mail. The researchers used a script to ensure consistency. Six key informant interviews were held over the course of the study. These key informants included executive administrators, clinicians

and management. Their expertise was in refugee services, human services, public school system,

and mental health services. The researchers utilized the same questions as those used with the

focus groups. Each interview took approximately 60-90 minutes. Written and verbal consent

were obtained from each participant prior to each interview, and the audio recordings were

subsequently transcribed for textual analysis. Following participation, thank you letters were sent

out to all key informants

Results

The questions and results of the agency and key informant interviews are reported in

terms of the five principles of trauma-informed care. The actual questions used in this study are

in **bold font.** *Please note that much of the wording of these questions came from the work of

Fallot and Harris (2006).*

Physical and Emotional Safety of Staff and Clients

QUESTION 1: SAFETY: With respect to safety, here is how we are defining it. SAFETY

can be physical or emotional, and generally involves the protection of self or others. It can

include where services are offered; time of day that services are offered; security personnel

available, open doors or locked and the affect that each has on consumers; the waiting

room appearance.

1) To what extent do your program's activities and settings ensure the safety of

clients?

2) To what extent do your program's activities and settings ensure the safety of

staff?

Physical safety for clients was the most conclusive and consistent finding from the focus

groups and the key informant interviews. All of the agencies and key informants had policies

and procedures around the physical safety of clients. For example, an agency serving clients with developmental disabilities said "*Safety is front and center in terms of what we do*." At that agency, all focus group participants not only agreed with this statement, but also gave examples of their own, such as risk management plans and extensive training regarding the gravity of physical restraints (and why they should be used only as a last resort). However, whereas physical safety was a well-addressed concern, the emotional safety of clients was a more difficult issue for many of the agencies. Sometimes, the physical safety efforts came at the cost of emotional safety. For example, an adolescent residential treatment facility installed cameras everywhere in the organization. They said "*We have cameras all over the place. Even though we have explained to the residents that it is for safety, they were still upset about it*." To this agency's credit, they tried to minimize the emotional damage by addressing those concerns by talking about them with the distressed adolescents.

In that same treatment facility, one clinician reported "*Safety is a core value for us. We even take it to the point of 'words aren't safe,' so like we don't allow the kids to say 'shut up'*." This type of policy is an example of an overall attempt at safety for at-risk populations, and may keep the group at large emotionally safe (as no one in the group would ever have to hear the words 'shut up' directed at them). However, an adolescent who has been removed from his/her home and family might feel emotionally unsafe simply because his/her language has been restricted to such a high degree.

Whereas certain agencies had well-defined policies towards emotional safety of clients, other agencies had difficulty perceiving what emotional safety might look like in their agency. For instance, one agency answered the question by saying "*We're looking at different combinations of colors, and we're trying to make a welcoming environment*." For that agency,

certain color combinations equaled the emotional safety of clients. In contrast, another agency's response to the question was "*I think enabling the individual to develop the skill that he or she needs to self-protect and to self-initiate safe behavior is really the proactive part of what we do.*"

Almost all of the agencies had policies and practices to promote physical safety of staff, such as having two employees on staff at all times, safety assessments before home visits, wearing personal alarms, and having walkie-talkies or after-hours cell phones. However, when asked about agency policies towards the emotional safety of staff, there was generally a prolonged silence and a lot of fidgeting and looking around, as well as facial expressions that conveyed a "huh?" demeanor. One agency answered the question with this statement: "*Nobody yells at you if you make a mistake.*" Among agencies that answered the question positively, regular supervision was the most common answer. One agency also had an entire mental health committee set up specifically for employees of the agency. However, an agency without regular supervision answered the question by saying *"We just learn to use a lot of humor, dark humor, and you just have to learn how to put this aside when you leave. When you leave, you leave, because it can be very draining and you can really take home a lot unless you are able to leave it here. There is no formal training for staff. Once in a while it's overwhelming but then we just go to our friends and family and torture them."*

Trustworthiness for Staff and Clients

<u>Question 2:</u> TRUSTWORTHINESS: With respect to TRUSTWORTHINESS, it can mean transparency and honesty, ensuring consistency and appropriate boundaries, and clear task delivery. It includes providing clear information about what will be done, by whom, when, why and under what circumstances; respectful and professional boundaries

1) To what extent do your program's activities and settings maximize trustworthiness of clients?

2) To what extent do your program's activities and settings maximize trustworthiness of staff?

Focus groups and key informants were questioned about how their programs and policies maximized trustworthiness of staff for both clients and other staff. This question garnered a very similar reaction as the previous emotional/physical safety question, in that there were many examples of ensuring trustworthiness between staff and clients, but not amongst the staff themselves. For example, answers regarding enhancing client trust with respect to staff included having informed consent, clients receiving handbooks on the first day they arrive at a residential substance abuse treatment facility, using language appropriate for each client specifically, and confidentiality policies. A receptionist at a human services agency said *"When we say something to clients and then we do that something, like making sure that someone calls a client back, even when the client doesn't like the answer, I think they appreciate it. There is a customer service side that we work hard on. We try to model behaviors for the clients. Setting a professional boundary shows them that it's alright, and this encourages the trustworthiness of the relationship. If we put a limit on them, they know it's alright to put a limit on someone else. We explain our limits very clearly in the beginning of the relationship with the client."* It was clear from these interviews that maximizing trustworthiness for clients was a value for most agencies, as they put a lot of thought into how they practice their social work with clients.

The agencies that valued ensuring trustworthiness amongst staff did so by holding regularly scheduled meetings and by using open lines of communication throughout. However, no agency had established means of ensuring trustworthiness amongst staff members. As a

matter of fact, when asked this question in a focus group, the head of one agency said "*Who is saying that this is a value? I don't even think this is a value for my organization. I have never heard anyone ever being concerned about this*." In response to this, a clinician at that same agency said "*I don't think you can teach trustworthiness*," to which another clinician responded "*With all organizations, there will always be some dysfunction somewhere*." In that same group, another direct care worker said "*If administrators make themselves more present in the organization, it's easier for staff to trust them. If there's a division, it's hard for the staff in the front lines to have that feeling of trust*."

Choice and Control for Clients and Staff

Question 3: CHOICE: With respect to CHOICE, here is how we are defining it. CHOICE can mean the right to self-determination. It can include how much choice consumers have over the services they receive (such as time of day, gender preferences for service providers, etc.); *are consumers provided a clear and appropriate message about their rights and responsibilities?*

1) To what extent do your program's activities and settings maximize client experiences of choice and control?

2) To what extent do your program's activities and settings maximize staff experiences of choice and control?

The agencies in this study found choice and control to be complicated issues. Every focus group and key informant interviewed in this study spoke about their agencies' values of choice and control for clients. However, when asked to provide concrete examples of client or staff experiences of choice and control, some of the examples showed that clients and staff did not experience either. For instance, if a client wants to switch therapists, this can only happen if

other therapists are available at the times when the client can meet with them, and that can become a challenge in smaller agencies. Another example that came up frequently was court-mandated clients, in that their experiences of choice and control have significant limitations. Court-mandated clients have the right to refuse services, of course, but such refusal comes at a heavy price. One social worker in upper management at a counseling agency said "*Everything's supposed to be consumer choice. I would say it is still to some extent, but a lot of it I would honestly say there is still a lot of lip service paid to that. I don't know that at the end of the day folks really have a whole lot of choice; there's just not always other service options available, so the environment doesn't always foster it.*"

Every agency had policies and practices concerning client experiences of control. The practices generally centered on the client's right to refusal and client choice as to scheduling services. Some agencies tried to maximize staff experiences of choice and control through various means such as choice of hours to work, and allowing the use of different therapeutic techniques with clients. At the same time, some staff members who were interviewed did not conceptualize choice and control as part of their vocation. For example, when asked how the agency's programs, activities, and settings maximize choice for staff, a male respondent said "*Not so much. We're civil servants.*"

Collaboration Between Staff and Clients, and Between Staff and Management

Question 4: COLLABORATION means working together towards a common goal. Collaboration can include giving consumers a significant role in planning and evaluating services; <u>possibly</u> giving them preferences in areas of <u>service planning,</u> *goal setting,* and developing treatment priorities; cultivating an atmosphere of doing "with" rather than

doing "to" or "for"; conveying the message that the consumer is the expert in their own life.

> 1) **To what extent do your program's activities and settings maximize collaboration and sharing of power between staff and clients?**
>
> 2) **To what extent do your program's activities and settings maximize collaboration and sharing of power between staff and management?**

Agencies found it difficult to quantify their experiences of collaboration and sharing of power between themselves and clients, as well as amongst themselves. One agency member answered this question by advising that they have a consumer satisfaction survey, which certainly can be conceptualized as collaboration between the agency and the client. That same agency also had a mentoring system for new staff members. Other agency representatives answered this question by advising that they collaborated with other agencies in an effort to better help clients. Another agency member noted that collaboration "*starts with everyone knowing each other's names*" (i.e., the CEO knowing direct care workers' names).

A medical social worker observed that whereas collaboration between staff and clients is a value in the social work world, it is not a value in the medical world. Others in that same agency explained that they "*collaborate around the clients, but not necessarily with them*," and one social worker remarked that "*we make guesses that we are protecting the client by making decisions for them.*"

Every agency valued communication between agency members themselves, and between agency members and clients. This emphasis on communication was conceptualized as a collaborative effort. As one agency noted "*We have a quarterly review where we'll sit down with the individual and generally their guardian or advocate and the team and discuss how they*

were during the quarter and at that meeting, the individual has the opportunity to speak to their

concerns." Several agencies felt that the process of diagnosing clients was a collaborative

process between clients and staff members. One clinician said "*Doing treatment plans with the*

client, I come up with a diagnosis for you. But then it has to be a collaborative process, in terms

of 'This is how I arrived at the diagnosis; how does that diagnosis fit for you?'... I'm

empowering that person to have some role in their diagnosis."

Client and Staff Empowerment

Question 5: EMPOWERMENT: is the development and enhancement of skill sets. This includes recognizing consumer strengths and skills; <u>building a realistic sense of hope for the client's future;</u> providing an atmosphere that allows consumers to feel validated and affirmed with every contact at the agency.

1) To what extent do your program's activities and settings prioritize clients' empowerment and skill-building?

2) To what extent do your program's activities and settings prioritize staff empowerment and skill-building?

Client-centered planning was a value held by all of the agencies in this study, and their

programs and policies were formed around this value. Some of the ways that agencies spoke of

empowering clients included letting clients choose their own goals, teaching certain skill sets

(such as English as a second language in refugee settings), recognizing accomplishments of

clients, using clients' existing skill sets and building upon them (i.e., using art therapies with

clients who enjoyed such activities), and helping them with concrete needs (such as medical care,

financial concerns, etc.)

Staff empowerment was a more difficult concept for many of the agencies. While some agencies gave their clinicians access to regular trainings, promoted from within, and acknowledged when staff members had accomplishments, other agencies met this question with a blank stare and no concrete answers. One clinician came right out and said "*Clinical staff are not empowered*." Another clinician spoke of a lack of concrete support by saying "*I think you have to be pretty self-sufficient and in a way that's empowering*."

Discussion

The Sanctuary Model (Bloom, 2006) teaches that trauma-informed care requires a trauma-sensitive culture. In order for a culture to be trauma-sensitive, it needs to be sensitive to the potential history of trauma for all people in the culture, including human service workers. Fallot and Harris (2006) state that human service systems are "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" (p.3). While none of the agencies in this study had received specific training for Trauma-Informed care, all of the agencies in this study dealt with traumatized clients. Our results suggest that some of the agencies in this study use trauma-informed care with their clients and staff, some of the agencies use trauma-informed care with only their clients, and some agencies do not use it with either clients or staff.

The principles of trauma-informed care (as they pertain to clients) are consistent with the tenets of social work (i.e., self-determination, empowerment, and social justice). This would imply that clinicians who are abiding by the principles of social work practice are likely engaging in trauma-informed care, perhaps without labeling it as such. With this in mind, it is understandable why some of the agencies in this study are implicitly following most of these principles, even if they have not made an explicit effort to become trauma-informed per se. The

data suggest that most of the agencies are very client-centered, and have given a great deal of thought to using their agency policies and practices for the betterment of their clients.

An interesting finding of this research was that, while the agencies in this study worked very hard to make sure that their programs and policies ensured that trauma-informed care was at the forefront of policy creation for clients, it became clear that these same types of policies are not directed at staff themselves. The five principles of trauma-informed care are not written into the policies or practices that pertain to caring for staff. For instance, in some of the agencies, staff members have no choice of with whom they will or will not work. While there were allusions to a policy of having the option of declining to work with a certain client, the staff members were obviously hesitant to use this option, which suggests that there is some fear of doing so. This lack of a trauma-informed care within the organization, as suggested by Bloom (2006), poses multiple threats to the climate among staff, which may have serious consequences for both staff and clients alike.

There were several limitations in this study. Ideally, the sample for this study would have included all service delivery systems in Western New York. This study obtained 32 contacts and of the 32 contacts, 14 agreed to be a part of the actual sample. It is possible that the agencies that agreed to be a part of our sample were not representative of all of the social service agencies in the area. Obtaining the sample itself was challenging, because many of the social service agencies that were approached to be in the study were already stretched thin in terms of time. Although efforts were made to work within each agency's needs, the number and types of agencies that participated in this study were limited.

The data suggest that the agencies that were interviewed are practicing some of the elements of trauma-informed care with their clients, but they do not know to call it 'trauma-

informed care.' The agencies in this study indicated that many efforts were made to help clients

feel emotionally and physically safe and empowered. The staff and clients worked together

towards making sure that each client has a sense of choice in their own treatment plans, and there

was a sense of collaboration between staff and clients. Trustworthiness between staff and clients

was conveyed by staff doing what they say they were going to do.

The results of this study suggest that while policies and procedures are in place to protect

clients' experiences of choice, safety, empowerment, collaboration, and trustworthiness, they are

far and few between when it comes to staff experiences of same. It is possible that the lack of

these experiences could lead to higher rates of staff 'burnout'. Future research should examine

the relationship between staff experiences in trauma-informed organizations and turnover rates,

vicarious traumatization, and 'burnout'. Future research could also examine the effects of

working within trauma-informed organizations and working in organizations that do not use a

trauma-informed model, and compare rates of secondary stress on its staff members.

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