SAMHSA’s

Concept of Trauma and Guidance for a

Trauma-Informed Approach

*Prepared by*

SAMHSA’s Trauma and Justice Strategic Initiative

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# Introduction

Trauma is a widespread, harmful and costly public supports and intervention, people can overcome health problem. It occurs as a result of violence, traumatic experiences.6,7,8,9 However, most people go abuse, neglect, loss, disaster, war and other without these services and supports. Unaddressed emotionally harmful experiences. Trauma has no trauma significantly increases the risk of mental boundaries with regard to age, gender, socioeconomic and substance use disorders and chronic physical status, race, ethnicity, geography or sexual orientation. diseases.1,10,11

It is an almost universal experience of people with mental and substance use disorders. The need



***With appropriate supports and intervention, people can overcome traumatic experiences.***

to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the***

***impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***



***The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.***

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience

a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.1,2,3,4,5 Research has also indicated that with appropriate

Individuals with experiences of trauma are found

in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.12,13 Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.5,14 Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.15,16,17

In addition, the public institutions and service systems

that are intended to provide services and supports to individuals are often themselves trauma-inducing.

The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems

with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic experienced by these individuals and how to mitigate

events on individuals, families and communities and the re-traumatizing effect of many of our public

the unintended but similarly widespread re-traumatizing institutions and service settings was not an integral of individuals within our public institutions and part of the work of these systems. Now, however, service systems, makes it necessary to rethink there is an increasing focus on the impact of trauma doing “business as usual.” In public institutions and and how service systems may help to resolve or

service systems, there is increasing recognition that exacerbate trauma-related issues. These systems are many of the individuals have extensive histories of beginning to revisit how they conduct their “business” trauma that, left unaddressed, can get in the way of under the framework of a trauma-informed approach. achieving good health and well-being. For example,

a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma



***There is an increasing focus on the impact of trauma***

***and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their***

***business under the framework of a trauma-informed approach.***

# Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

## PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual’s capacity to cope with traumatic experiences. In

fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this

framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems “talk” to each other, to understand better the connections between trauma

and behavioral health issues, and to guide systems to

become trauma-informed.

## APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that



***The key questions addressed in this paper are:***

* **What do we mean by trauma?**
* **What do we mean by a trauma-informed approach?**
* **What are the key principles of a trauma- informed approach?**
* **What is the suggested guidance for implementing a trauma-informed approach?**
* **How do we understand trauma in the context of community?**

this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of

trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents

and 20,000 comments or endorsements of others’ comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

SAMHSA’s approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA’s trauma-focused grants and initiatives, such as SAMHSA’s National Child Traumatic Stress Initiative, SAMHSA’s National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA’s: Jail Diversion Trauma Recovery grant program; Children’s Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

# Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the Simultaneously, an emerging trauma survivors

field of mental health at least four decades ago. movement has provided another perspective on the

Over the last 20 years, SAMHSA has been a leader understanding of traumatic experiences. Trauma in recognizing the need to address trauma as a survivors, that is, people with lived experience fundamental obligation for public mental health and of trauma, have powerfully and systematically substance abuse service delivery and has supported documented their paths to recovery.26 Traumatic the development and promulgation of trauma-informed experiences complicate a child’s or an adult’s systems of care. In 1994, SAMHSA convened the capacity to make sense of their lives and to create

Dare to Vision Conference, an event designed to meaningful consistent relationships in their families

bring trauma to the foreground and the first national and communities. conference in which women trauma survivors talked

about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of



***Trauma survivors have powerfully and systematically documented their paths to recovery.***

physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970’s.18,19,20,21 National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.22,23,24,25 With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.3,25

The convergence of the trauma survivor’s perspective

with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults,

who come to the attention of the behavioral health and other service systems.25,27

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus

on individuals in the military and increasing rates of posttraumatic stress disorders.28,29,30,31

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA’s Women, Co-Occurring Disorders and Violence Study; SAMHSA’s National Child Traumatic Stress Network; and SAMHSA’s National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions

in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA’s National Center for

Trauma-Informed Care has continued to advance this

effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

## FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine’s “Thrive Initiative” incorporates a

trauma-informed care focus in their children’s systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development.

SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming

a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further

its understanding of the impact of trauma and violence on the psychological and physical health of its communities.



***SAMHSA continues its support of grant programs that specifically address trauma.***

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus primary care on how to address trauma issues in on trauma. The Administration on Children Youth health care for women. The Department of Labor is

and Families (ACYF) has focused on the complex examining trauma and the workplace through a federal trauma of children in the child welfare system and interagency workgroup. The Department of Defense is how screening and assessing for severity of trauma honing in on prevention of sexual violence and trauma and linkage with trauma treatments can contribute in the military.

to improved well-being for these youth. In a joint

effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors’ mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma,

its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and

Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women’s Health

has developed a curriculum to train providers in

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with

SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA

to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

# SAMHSA’s Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.



***Individual trauma results from an* event*, series of events, or set of circumstances that is* experienced *by an individual as physically or***

***emotionally harmful or life threatening and that has lasting adverse* effects *on the individual’s functioning and mental, physical, social, emotional,***

***or spiritual well-being.***

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

## THE THREE “E’S” OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

**Events** and circumstances may include the actual or extreme threat of physical or psychological harm

shattering a person’s trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

(i.e. natural disasters, violence, etc.) or severe, How the event is experienced may be linked to a life-threatening neglect for a child that imperils healthy range of factors including the individual’s cultural development. These events and circumstances may beliefs (e.g., the subjugation of women and the occur as a single occurrence or repeatedly over experience of domestic violence), availability of time. This element of SAMHSA’s concept of trauma social supports (e.g., whether isolated or embedded is represented in the fifth version of the Diagnostic in a supportive family or community structure), or to and Statistical Manual of Mental Disorders (DSM-5), the developmental stage of the individual (i.e., an which requires all conditions classified as “trauma and individual may understand and experience events stressor-related disorders” to include exposure to a differently at age five, fifteen, or fifty).1

traumatic or stressful event as a diagnostic criterion.

The long-lasting adverse **effects** of the event are a The individual’s **experience** of these events or critical component of trauma. These adverse effects circumstances helps to determine whether it may occur immediately or may have a delayed onset. is a traumatic event. A particular event may be The duration of the effects can be short to long term. experienced as traumatic for one individual and not In some situations, the individual may not recognize for another (e.g., a child removed from an abusive the connection between the traumatic events and home experiences this differently than their sibling; the effects. Examples of adverse effects include an one refugee may experience fleeing one’s country individual’s inability to cope with the normal stresses differently from another refugee; one military and strains of daily living; to trust and benefit from veteran may experience deployment to a war zone relationships; to manage cognitive processes, such as traumatic while another veteran is not similarly as memory, attention, thinking; to regulate behavior; affected). How the individual labels, assigns meaning or to control the expression of emotions. In addition to, and is disrupted physically and psychologically to these more visible effects, there may be an altering by an event will contribute to whether or not it is of one’s neurobiological make-up and ongoing experienced as traumatic. Traumatic events by their health and well-being. Advances in neuroscience very nature set up a power differential where one and an increased understanding of the interaction entity (whether an individual, an event, or a force of of neurobiological and environmental factors have nature) has power over another. They elicit a profound documented the effects of such threatening events.1,3 question of “why me?” The individual’s experience of Traumatic effects, which may range from hyper- these events or circumstances is shaped in the context vigilance or a constant state of arousal, to numbing

of this powerlessness and questioning. Feelings of or avoidance, can eventually wear a person down,

humiliation, guilt, shame, betrayal, or silencing often physically, mentally, and emotionally. Survivors of shape the experience of the event. When a person trauma have also highlighted the impact of these experiences physical or sexual abuse, it is often events on spiritual beliefs and the capacity to make accompanied by a sense of humiliation, which can meaning of these experiences.

lead the person to feel as though they are bad or

dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal,

# SAMHSA’s Trauma-Informed Approach: Key Assumptions

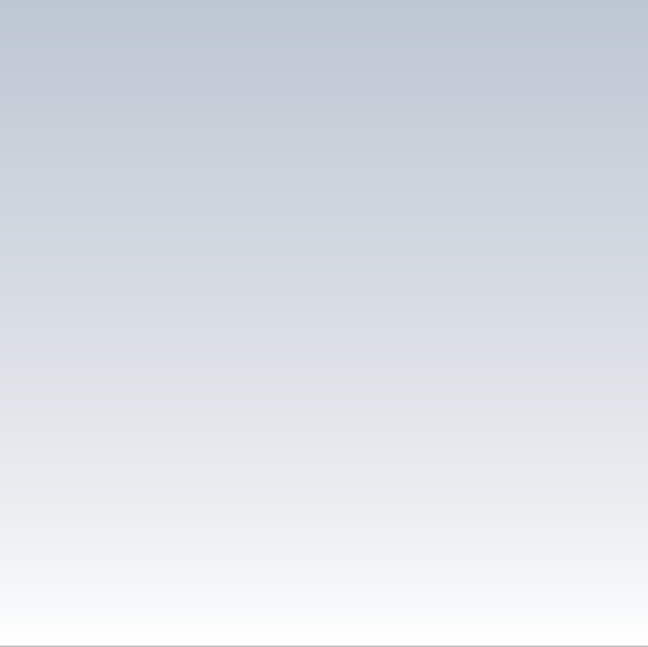
# and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to

influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred

to variably as “trauma-informed care” or “trauma- informed approach” this framework is regarded as essential to the context of care.22,32,33 SAMHSA’s concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.



***A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures,***

***and practices, and seeks to actively***

**resist re-traumatization*.***

A trauma informed approach is distinct from trauma- specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.



***Referred to variably as “trauma- informed care” or “trauma-informed approach” this framework is regarded as essential to the context of care.***

## THE FOUR “R’S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People’s experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to

the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services

in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program,

organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership

that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma

practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote

a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency’s mission may include an intentional statement on

the organization’s commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency’s board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The

organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes

trust, fairness and transparency. The program’s, organization’s, or system’s response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff.

Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.27 Staff who work within a trauma-informed environment are taught

to recognize how organizational practices may

trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

## SIX KEY PRINCIPLES OF A TRAUMA- INFORMED APPROACH

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



***SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH***

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and**

**Gender Issues**

From SAMHSA’s perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA’s definition of recovery,

services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:24,36

1. **Safety:** Throughout the organization, staff and the **5. Empowerment, Voice and Choice:** Throughout people they serve, whether children or adults, feel the organization and among the clients served, physically and psychologically safe; the physical individuals’ strengths and experiences are

setting is safe and interpersonal interactions recognized and built upon. The organization promote a sense of safety. Understanding safety as fosters a belief in the primacy of the people served, defined by those served is a high priority. in resilience, and in the ability of individuals,

organizations, and communities to heal and

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

promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/ or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike.

1. **Peer Support:** Peer support and mutual self-help Organizations understand the importance of power

are key vehicles for establishing safety and hope, differentials and ways in which clients, historically, building trust, enhancing collaboration, and utilizing have been diminished in voice and choice and their stories and lived experience to promote are often recipients of coercive treatment. Clients recovery and healing. The term “Peers” refers to are supported in shared decision-making, choice, individuals with lived experiences of trauma, or in and goal setting to determine the plan of action the case of children this may be family members of they need to heal and move forward. They are children who have experienced traumatic events supported in cultivating self-advocacy skills. Staff and are key caregivers in their recovery. Peers have are facilitators of recovery rather than controllers also been referred to as “trauma survivors.” of recovery.34 Staff are empowered to do their work

as well as possible by adequate organizational

1. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among

support. This is a parallel process as staff need to

feel safe, as much as people receiving services.

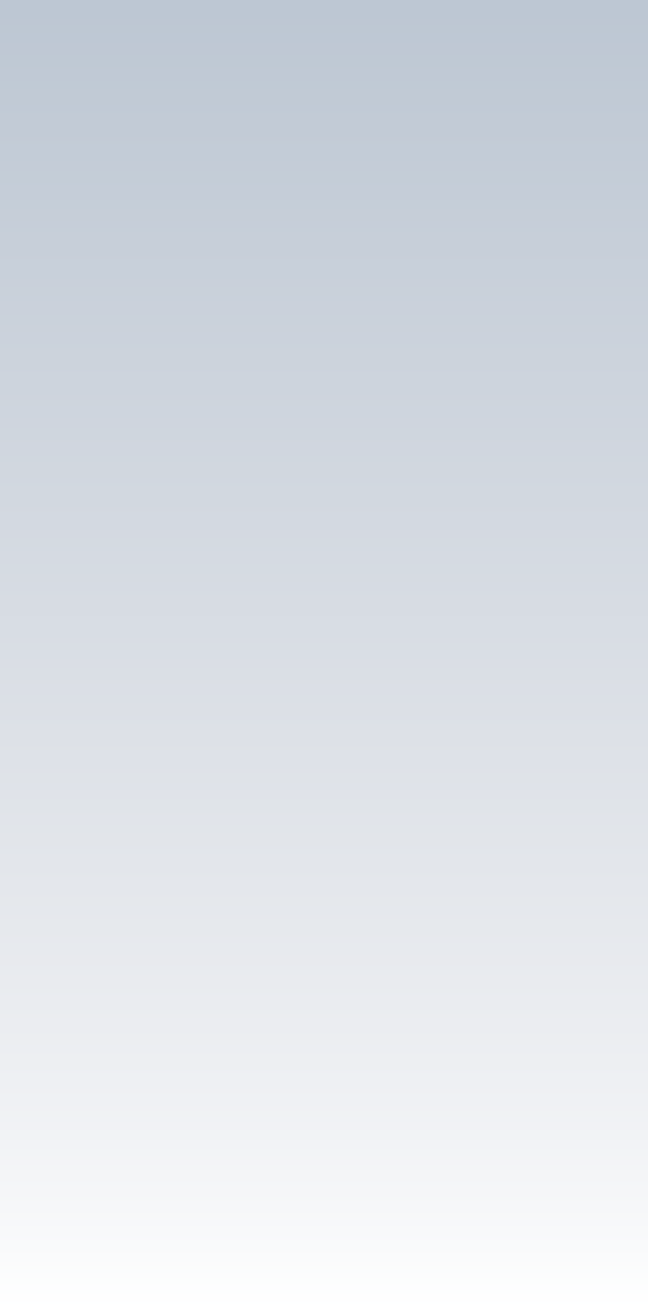
organizational staff from clerical and housekeeping **6. Cultural, Historical, and Gender Issues:** personnel, to professional staff to administrators, The organization actively moves past cultural demonstrating that healing happens in relationships stereotypes and biases (e.g. based on race,

and in the meaningful sharing of power and ethnicity, sexual orientation, age, religion, gender- decision-making. The organization recognizes that identity, geography, etc.); offers, access to gender everyone has a role to play in a trauma-informed responsive services; leverages the healing value approach. As one expert stated: “one does not have of traditional cultural connections; incorporates

to be a therapist to be therapeutic.”12 policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

# Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point



***TEN IMPLEMENTATION DOMAINS***

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce**

**Development**

1. **Progress Monitoring and**

**Quality Assurance**

1. **Financing**
2. **Evaluation**

for developing an organizational trauma-informed approach.20 While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives.

Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct

a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a “checklist” or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing

trauma-informed care.35,36,37,38 What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

**GOVERNANCE AND LEADERSHIP:** The leadership **CROSS SECTOR COLLABORATION:** Collaboration and governance of the organization support and invest across sectors is built on a shared understanding of in implementing and sustaining a trauma-informed trauma and principles of a trauma-informed approach.

approach; there is an identified point of responsibility While a trauma focus may not be the stated mission of within the organization to lead and oversee this work; various service sectors, understanding how awareness and there is inclusion of the peer voice. A champion of trauma can help or hinder achievement of an

of this approach is often needed to initiate a system organization’s mission is a critical aspect of building change process. collaborations. People with significant trauma histories

often present with a complexity of needs, crossing **POLICY:** There are written policies and protocols various service sectors. Even if a mental health establishing a trauma-informed approach as clinician is trauma-informed, a referral to a trauma- an essential part of the organizational mission. insensitive program could then undermine the Organizational procedures and cross agency progress of the individual.

protocols, including working with community-based

agencies, reflect trauma-informed principles. This **SCREENING, ASSESSMENT, AND TREATMENT** approach must be “hard-wired” into practices and **SERVICES:** Practitioners use and are trained in procedures of the organization, not solely relying interventions based on the best available empirical on training workshops or a well-intentioned leader. evidence and science, are culturally appropriate, and

reflect principles of a trauma-informed approach.

**PHYSICAL ENVIRONMENT OF THE** Trauma screening and assessment are an essential **ORGANIZATION:** The organization ensures that the part of the work. Trauma-specific interventions are physical environment promotes a sense of safety acceptable, effective, and available for individuals and collaboration. Staff working in the organization and families seeking services. When trauma-specific and individuals being served must experience the services are not available within the organization, setting as safe, inviting, and not a risk to their physical there is a trusted, effective referral system in place

or psychological safety. The physical setting also that facilitates connecting individuals with appropriate

supports the collaborative aspect of a trauma informed trauma treatment.

approach through openness, transparency, and

shared spaces. **TRAINING AND WORKFORCE DEVELOPMENT:**

On-going training on trauma and peer-support are **ENGAGEMENT AND INVOLVEMENT OF PEOPLE** essential. The organization’s human resource system **IN RECOVERY, TRAUMA SURVIVORS, PEOPLE** incorporates trauma-informed principles in hiring, **RECEIVING SERVICES, AND FAMILY MEMBERS** supervision, staff evaluation; procedures are in place **RECEIVING SERVICES:** These groups have to support staff with trauma histories and/or those significant involvement, voice, and meaningful experiencing significant secondary traumatic stress choice at all levels and in all areas of organizational or vicarious trauma, resulting from exposure to and functioning (e.g., program design, implementation, working with individuals with complex trauma. service delivery, quality assurance, cultural

competence, access to trauma-informed peer **PROGRESS MONITORING AND QUALITY**

support, workforce development, and evaluation.) **ASSURANCE:** There is ongoing assessment,

This is a key value and aspect of a trauma-informed tracking, and monitoring of trauma-informed principles approach that differentiates it from the usual and effective use of evidence-based trauma specific approaches to services and care. screening, assessments and treatment.

**FINANCING:** Financing structures are designed to key principles of a trauma-informed approach. Many support a trauma-informed approach which includes of these questions and concepts were adapted from resources for: staff training on trauma, key principles the work of Fallot and Harris, Henry, Black-Pond,

of a trauma-informed approach; development of Richardson, & Vandervort, Hummer and Dollard, and appropriate and safe facilities; establishment of Penney and Cave.39, 40, 41,42

peer-support; provision of evidence-supported trauma

screening, assessment, treatment, and recovery supports; and development of trauma-informed cross- agency collaborations.

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff,

**EVALUATION:** Measures and evaluation designs used and individuals being served. For example, a

to evaluate service or program implementation and juvenile justice agency may want to ask how it would effectiveness reflect an understanding of trauma and incorporate the principle of safety when examining appropriate trauma-oriented research instruments. its physical environment. A primary care setting may

explore how it can use empowerment, voice, and To further guide implementation, the chart on the next choice when developing policies and procedures to

page provides sample questions in each of the ten provide trauma-informed services (e.g. explaining step domains to stimulate change-focused discussion. by step a potentially invasive procedure to a patient at The questions address examples of the work to be an OBGYN office).

done in any particular domain yet also reflect the six

**SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **KEY PRINCIPLES** | | | | | | |
| **Safety** | **Trustworthiness** | | **Peer Support** | **Collaboration** | **Empowerment,** | **Cultural,** |
|  | **and** | **and Mutuality** | **Voice, and** | **Historical, and** |
|  | **Transparency** |  | **Choice** | **Gender Issues** |
| **10 IMPLEMENTATION DOMAINS** | | | | | | |
| **Governance and Leadership** | * How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? * How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? * How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories? | | | | | |
| **Policy** | • | How do the agency’s written policies and procedures include a focus on trauma and issues of | | | | |
|  |  | safety and confidentiality? | | | | |
|  | • | How do the agency’s written policies and procedures recognize the pervasiveness of trauma | | | | |
|  |  | in the lives of people using services, and express a commitment to reducing re-traumatization | | | | |
|  |  | and promoting well-being and recovery? | | | | |
|  | • | How do the agency’s staffing policies demonstrate a commitment to staff training on providing | | | | |
|  |  | services and supports that are culturally relevant and trauma-informed as part of staff | | | | |
|  |  | orientation and in-service training? | | | | |
|  | • | How do human resources policies attend to the impact of working with people who have | | | | |
|  |  | experienced trauma? | | | | |
|  | • | What policies and procedures are in place for including trauma survivors/people receiving | | | | |
|  |  | services and peer supports in meaningful and significant roles in agency planning, | | | | |
|  |  | governance, policy-making, services, and evaluation? | | | | |

|  |  |  |
| --- | --- | --- |
| **10 IMPLEMENTATION DOMAINS** *continued* | | |
| **Physical**  **Environment** | * How does the physical environment promote a sense of safety, calming, and de-escalation   for clients and staff?   * In what ways do staff members recognize and address aspects of the physical environment   that may be re-traumatizing, and work with people on developing strategies to deal with this?   * How has the agency provided space that both staff and people receiving services can use to practice self-care? * How has the agency developed mechanisms to address gender-related physical and   emotional safety concerns (e.g., gender-specific spaces and activities). | |
| **Engagement** | • | How do people with lived experience have the opportunity to provide feedback to the |
| **and** |  | organization on quality improvement processes for better engagement and services? |
| **Involvement** | • | How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have |
|  |  | a difficulty processing information? |
|  | • | How is transparency and trust among staff and clients promoted? |
|  | • | What strategies are used to reduce the sense of power differentials among staff and clients? |
|  | • | How do staff members help people to identify strategies that contribute to feeling comforted |
|  |  | and empowered? |
| **Cross Sector** | • | Is there a system of communication in place with other partner agencies working with the |
| **Collaboration** |  | individual receiving services for making trauma-informed decisions? |
|  | • | Are collaborative partners trauma-informed? |
|  | • | How does the organization identify community providers and referral agencies that have |
|  |  | experience delivering evidence-based trauma services? |
|  | • | What mechanisms are in place to promote cross-sector training on trauma and trauma- |
|  |  | informed approaches? |
| **Screening,** | • | Is an individual’s own definition of emotional safety included in treatment plans? |
| **Assessment,** | • | Is timely trauma-informed screening and assessment available and accessible to individuals |
| **Treatment** |  | receiving services? |
| **Services** | • | Does the organization have the capacity to provide trauma-specific treatment or refer to |
|  |  | appropriate trauma-specific services? |
|  | • | How are peer supports integrated into the service delivery approach? |
|  | • | How does the agency address gender-based needs in the context of trauma screening, |
|  |  | assessment, and treatment? For instance, are gender-specific trauma services and supports |
|  |  | available for both men and women? |
|  | • | Do staff members talk with people about the range of trauma reactions and work to minimize |
|  |  | feelings of fear or shame and to increase self-understanding? |
|  | • | How are these trauma-specific practices incorporated into the organization’s ongoing |
|  |  | operations? |

|  |  |
| --- | --- |
| **10 IMPLEMENTATION DOMAINS** *continued* | |
| **Training and Workforce Development** | * How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? * How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? * How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? * How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person’s experience of trauma, access to supports and resources, and opportunities for safety? * How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. * What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? * What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization’s workforce? |
| **Progress** | * Is there a system in place that monitors the agency’s progress in being trauma-informed? |
| **Monitoring** | * Does the agency solicit feedback from both staff and individuals receiving services? |
| **and Quality** | * What strategies and processes does the agency use to evaluate whether staff members feel |
| **Assurance** | safe and valued at the agency?   * How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? * What mechanisms are in place for information collected to be incorporated into the agency’s quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports? |
| **Financing** | * How does the agency’s budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? * What funding exists for cross-sector training on trauma and trauma-informed approaches? * What funding exists for peer specialists? * How does the budget support provision of a safe physical environment? |
| **Evaluation** | * How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? * How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? * What processes are in place to solicit feedback from people who use services and ensure   anonymity and confidentiality?   * What measures or indicators are used to assess the organizational progress in becoming trauma-informed? |

# Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a

place of work, learning, or worship. How a community

responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be

re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family,

a community may be subjected to a community- threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or

circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence

in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which

individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma

is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills

to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

# Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent

a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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