

**Creating Cultures of Trauma-Informed Care:  
Program Fidelity Scale Instruction Guide Version 1.1 (1-14)**

1) This document serves as a guide to the use of the Creating Cultures of Trauma-Informed Care (CCTIC) Fidelity Scale. The intent of the Fidelity Scale is to gauge the extent to which a program or agency has developed a culture of trauma-informed care. By trauma-informed, we mean a culture that incorporates knowledge about trauma—its prevalence, impact, and the complex paths to recovery and healing—into every aspect of the program’s contacts, activities, relationships, and physical settings. Safety, trustworthiness, choice, collaboration, and empowerment are the five core values of that culture.

2) A word about language: Though there continues to be controversy about appropriate ways to refer to people receiving services in behavioral health settings, we have decided to use the term “client” to refer to these individuals in this document. “Consumer” has developed, over the years, an increasingly commercial connotation and to repeatedly state that we mean “people receiving services” seems clunky grammatically. Though “client” is a far from perfect solution, it carries with it ease of use and ready recognition. We apologize to those who find this usage offensive in any way. It is in fact an attempt to restore the dignity of being a person who collaborates with another to achieve a certain set of goals.

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

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

6) Please send suggestions for clarification or editing to Roger Fallot at [rfallot@ccdc1.org](mailto:rfallot@ccdc1.org). Thank you for using this scale and instruction guide!

## Overview

The CCTIC Fidelity Scale consists of six domains:

- 1) Program Procedures and Settings;
- 2) Formal Services Policies;
- 3) Trauma Screening, Assessment, and Service Planning; Trauma-Specific Services
- 4) Administrative Support for Program-Wide Trauma-Informed Services;
- 5) Staff Trauma Training and Education; and
- 6) Human Resources Practices.

Within each of these domains is frequently a set of subdomains (e.g., in Program Procedures and Settings, these subdomains correspond to the five core values noted above, adapted for service recipients and agency staff). And within each subdomain is a set of “indicators” that serve as criteria for meeting the intent of that section. If there are no subdomains (as, e.g., in #2, 5, and 6 above), we simply list indicators for that domain. The indicators are set up as “yes” or “no” options; either the indicator is met or it is not. We describe more fully the criteria for meeting each indicator below.

Further, we make suggestions about the sources of information that might be most relevant for getting an accurate reading for each indicator. The possible sources of information are the following:

CEOINT=Chief Executive Officer or Clinical Director Interview (or equivalent)

CLINT= Client or Consumer Interview

STINT=Staff Interview

CRR=Clinical Record Review (or equivalent)

PDR=Policy (or Public) Document Review

IPOBS=In-Person Observation

SURR=Survey Review (Results of a Formal Client or Staff Survey)

## **Domain 1A. Safety for Clients and Staff**

### **1. Physical Setting:**

#### **Indicators:**

**a) The area around the program (sidewalks and parking lots, e.g.) is safe and the program is accessible for both clients and staff.**

*Criteria for this indicator:* Because this is a subjective indicator, it is important for the rater to draw on their own immediate experience (IPOBS) of the area around the program to note any safety-related concerns. For example, poorly lit parking lots, sidewalks that entail “running a gauntlet” of smokers, long walks from public transportation, difficulty parking, are just a few of the sorts of issues that may arise in this indicator. In addition to IPOBS, though, it is important to get the perspectives of both staff and people receiving services (STINT and CLINT). These interviews may be bolstered by formal survey results (SURR).

In order to meet these criteria, those elements of the surrounding setting that are under the control of the program, should meet with 80-90% agreement that the environs are safe. In-person observation is weighed in this equation so that if the fidelity rater does not feel physically safe coming to the building (again, given the constraints of the location of the program), stated evidence of perceived safety must be nearly unanimous.

**b) The program’s entrance area and waiting room is safe and hospitable, offering adequate personal space; exits are clearly marked and accessible.**

*Criteria for this indicator:* In-person observation also plays a significant role in rating this indicator. Hospitable entry spaces have welcoming qualities, including visual images that reflect the culture of the population served. Signs indicating rules and regulations are framed in a positive way (e.g., in terms of positive expectations rather than sanctions for negative behavior). The waiting room should not be overcrowded, should have individual chairs, and adequate space to allow people to be separate from each other. Exit signs should be readily visible and should clearly indicate which way people should go to exit the building.

In order to meet these criteria, not only should the IPOBS but also any interviews with persons receiving services (CLINT) and staff (STINT) (along with any formal surveys) should indicate 85-90% agreement that the entry area is experienced as hospitable and welcoming and that the waiting room is safe and comfortable.

**c) If there are security personnel present, they are trained in customer service as well as in maintaining safety.**

*Criteria for this indicator:* The intent of this indicator is to ensure that, if there are security personnel present, their attitude and demeanor reflect trauma-informed values. Thus, security staff should have received training and/or ongoing supervision that emphasizes the importance of being welcoming and of offering assistance (“May I help you?”) rather than being officious and communicating distant authority (“Here is what you need to do.”). All individuals are treated

with equal respect. CLINT and STINT as well as CEOINT and IPOBS are preferred sources of information. These interviews may be bolstered by formal survey results (SURR).

In order to meet this criterion, the in-person observation must coincide with both client and staff interviews or surveys. If there are not security staff present, this indicator is marked “NA” for not applicable.

**d) The program’s signage is clear and welcoming; it directs people to the most frequently used areas (e.g., rest rooms, intake and reception areas).**

*Criteria for this indicator:* Welcoming signs are prominently placed and have a hospitable content (e.g., “Welcome to Program xxyy.” Or “Enter here and be welcome.”). The program does not use signs that carry commands (e.g., “Payment will be made at each visit.”) or warnings (“Staff are to be treated with respect. Violators will be prosecuted to the full extent of the law.”). Signs clearly direct people to the most commonly used areas (reception, intake, waiting rooms, restrooms, exits). IPOBS, along with the three interviews, are usually the best sources of this information.

**e) The program’s décor includes images and colors that fit well with the recovery goals of the clients; ideally, some of the art work, paint, and flooring should have been created or selected by a team of clients.**

*Criteria for this indicator:* Images of a diverse population representing those served are displayed in the appropriate areas of the program (e.g., waiting and reception areas, hallways, staff offices). Other images of landscapes, nature, and of people involved in various activities also reflect the interests and cultures of clients. Walls are painted with colors that fit the recovery goals of the clients (e.g., soothing colors for adult office spaces; brighter colors for children’s programs). Ideally, the wall colors and some of the images on the walls have been created by, or chosen by, a Client Advisory Group. IPOBS along with the three interviews are again the best sources of information. These interviews may be bolstered by formal survey results (SURR).

**f) The program has designated “quiet spaces” for use by clients and staff who need or want a place of respite.**

*Criteria for this indicator:* At least one “quiet space” or room is available for the use of clients and staff. Ideally, there are separate spaces for clients and staff to go when they are feeling stressed or overwhelmed or simply need a “break” from the day’s routine. The rooms should be clean and comfortable (with individual chairs) and have soothing or engaging activities available (e.g., music, sounds like waterfalls or oceans, tactile objects to manipulate). IPOBS and the three interviews are preferred sources of information. These interviews may be supplemented by formal survey results (SURR).

**g) Staff offices are safe and/or have appropriate safety back-ups like “panic buttons.”**

*Criteria for this indicator:* Based primarily on feedback from staff interviews (STINT), this rating indicates the degree to which staff members feel safe when they are in their offices (all

staff, not only clinical or direct service staff; female and male staff members should both be taken into consideration). “Panic buttons,” emergency call systems, or other backups are available when needed or requested by staff. STINT may be supplemented by CLINT (to ensure that clients also feel safe in staff offices) and by CEOINT as well. These interviews may be supplemented by formal survey results (SURR).

## **2. Interpersonal Contact Indicators**

### **Indicators:**

#### **a) The program’s first contact (by phone or in person) with prospective clients is welcoming and respectful.**

*Criteria for this indicator:* Whether the initial contact is by telephone or in person, the person who answers the phone or greets the prospective client is welcoming and positive about the program and respectful of the client. If an answering service or automated message system is used, these should be responsive to prospective clients, taking into consideration the possible stress the client may be feeling at the time of the call. Therefore, automated messages should be calm and welcoming, with a set of options that is manageable for someone experiencing acute difficulties. CLINT and IOPOBS are the primary sources of information; STINT and CEOINT are secondary. These interviews may be supplemented by formal survey results (SURR).

#### **b) The staff (including the reception staff) are attuned to signs of distress among clients and respond in a gentle, compassionate way.**

*Criteria for this indicator:* All staff (direct service and support staff) are attuned to potential signs of distress among clients. They approach clients in a respectful way and ask whether and how they might be of help (rather than ignoring or disparaging a client who may be acting in an off-putting way). There is an assumption that everyone is doing the best they can at that particular moment to deal with their concerns. IPOBS and CLINT are primary sources of information; STINT and CEOINT are secondary. These interviews may be supplemented by formal survey results (SURR).

#### **c) In making contact with clients, staff take into account whether clients may be involved in potentially dangerous situations (e.g., domestic violence or living in a shelter).**

*Criteria for this indicator:* Whether by phone or in person, staff members understand the importance of the fact that clients may be involved in a situation that is dangerous for them. Domestic violence or living in a shelter are only two possible sources of danger to clients and all staff members take this into account when contacting clients. This may mean, for example, asking whether someone is able to talk freely and being open to nonverbal or less obvious signs that they are not. It means, in ongoing relationships, making arrangements for clients to indicate if they are feeling endangered. And it means making arrangements to talk with a client in a safe space and at a safe time. CLINT is the primary source for this information; STINT, CEOINT, and IPOBS are secondary. These interviews may be supplemented by formal survey results (SURR).

#### **d) Clients are given clear guidelines in advance about what to expect of the program.**

*Criteria for this indicator:* Throughout the intake process, from the first contact until the person is settled into a routine set of services, staff members give the client clear and complete information about what to expect in the next phase of the process. So, in the first telephone contact, the prospective client is informed about the next step [e.g., the intake interview can be described at this point so that the person knows what to expect in terms of content (“The interviewer will be asking you some questions about x, y, and z.), length (“The interviews usually take about an hour.”), goals (“The interviewer will be trying to get a sense of your needs and goals and their match with our program.”) and the following step (“At the end of the interview, the staff person will make some recommendations about how we might be of assistance in helping you meet your goals.”)]. The staff person is also skilled at asking questions of the prospective client. As the intake process proceeds, the staff members describe as fully as possible what the meaning and implications of their recommendations are regarding specific programs for the client. (“I recommend that you consider starting with our intensive outpatient program. Let me tell you why and then we can talk about your thoughts and reactions to this idea.” This statement is followed by a full description of the IOP and what it entails.) CLINT are primary sources for this information; STINT, CEOINT, and IPOBS are secondary sources. These interviews may be supplemented by formal survey results (SURR).

**e) All staff are given clear guidelines in advance about what to expect of the program; supervisors and managers set the tone by offering clear and reassuring messages about the program’s tasks and expectations.**

*Criteria for this indicator:* Prospective and newly hired staff are given a full orientation to their programmatic responsibilities, including the program’s goals, processes for achieving those goals, and expected outcomes. The prospective staff member is provided a full sense of what their day-to-day work will be like, perhaps including the opportunity to “shadow” a current staff member who performs the same job. Program leaders offer new staff members clear guidance about their supervisory relationships and the criteria by which their performance will be evaluated, offering them realistic yet positive messages about the support available to them in their job. STINT are the primary sources for this information; CEOINT and IPOBS are secondary sources. These interviews may be supplemented by formal survey results (SURR).

**f) All staff members (including senior administrators) feel supported when they have challenges in their work; “we are all in this together.”**

*Criteria for this indicator:* The entire program creates a sense of safety via collaboration. There is minimal “us against them” thinking and there is a pervasive sense of fairness about the program. When staff members feel challenged in their work, they feel safe approaching their colleagues, supervisors, or senior administrators with their concerns. Staff feel confident that they will be met with support and encouragement rather than blaming and discouragement. STINT are primary sources for this information; CEOINT and IPOBS are secondary sources. These interviews may be supplemented by formal survey results (SURR).

**g) Staff doing work that takes them into areas away from the office feel safe and supported by the program.**

*Criteria for this indicator:* When staff members' work takes them into areas that might be dangerous, they still feel supported by the program. The program attempts to minimize these possibilities for staff and, when they are unavoidable, offers support in the form of additional staff to accompany them, or ready access to backup, for example. The program promotes the idea that "safety first" applies to staff as well as to clients. STINT are the primary sources for this information; CEOINT and IPOBS are secondary sources. These interviews may be supplemented by formal survey results (SURR).

**Domain 1B. Trustworthiness for Clients and Staff**  
**Indicators:**

**a) The program makes it clear who will do what, when and with what goals in mind; it is clear which actions will be taken and who is responsible for these actions—this is true in all aspects of the program's functioning, for both clients and staff.**

*Criteria for this indicator:* Because trustworthiness begins with following through on what a program offers to accomplish, it is paramount that the program be clear about how its actions will be undertaken: who will make which decisions, what actions will follow from those decisions, when they will be implemented and reviewed, etc. Though this process begins with clients who come for services, it applies equally to the staff who provide these services and the support staff who work for the program. CLINT, STINT, and CEOINT are the best sources of information, followed by survey results (SURR).

**b) The program is transparent in the way it operates; administration and managers share information openly with staff and clients (without violating their own responsibilities regarding confidentiality).**

*Criteria for this indicator:* Because trauma is often cloaked in lies and secrecy, it is essential that programs operate with the maximum degree of transparency. Decisions made about the program, its staff, and individual clients all have to be openly and honestly discussed with the people concerned. This clarity often begins from the top down with the Executive Director or CEO in a position to set an example of transparent leadership that then can carry over to supervisory and middle management, and ultimately to the direct service and support staff. CLINT, STINT, and CEOINT are the best sources of information, followed by survey results (SURR) and by IPOBS.

**c) The program reviews its services with each prospective client, based on clear statements of the goals, risks, and benefits of program participation, and obtains informed consent from each client; new staff go through a parallel process in which expectations are clarified and responsibilities made clear.**

*Criteria for this indicator:* Early in the process of service provision, a member of the staff reviews with each prospective or new client, the goals and expected outcomes that attend participation in the program. Risks and benefits are included in this discussion, which may end with gaining meaningful informed consent from each client. There is a similar process for new staff, in which the program's expectations of the staff person are made clear as are the criteria by

which the person's performance will be evaluated. CLINT, STINT, and CEOINT are the best sources of information, followed by survey results (SURR) and by IPOBS. A review of policy documents (PDR) may help to clarify the program's commitment to this style of leadership and program-wide process.

**d) The program has a clear procedure for the review of any allegations of boundary violations, including sexual harassment and inappropriate social contacts.**

*Criteria for this indicator:* The program's written procedure for following through on any instances of reported boundary violations is consistently implemented. The procedure should include guarantees of appropriate confidentiality and a step-by-step process for people who claim to be victims of such behavior within the program to bring these instances to the attention of appropriate people—either within or outside the program. The importance of clarity, consistency, and follow-through cannot be overstated. In this instance, PDR is supplemented by CLINT, STINT, and CEOINT.

**e) Administrators and supervisors consistently validate the importance of staff support.**

*Criteria for this indicator:* Staff support here includes administrative or organizational support, professional support, and staff self-care. Thus, there are three domains to be considered: 1) formal organizational support for staff (e.g., vacations, flex-time, mental health benefits, resources that equip staff for their job performance); 2) professional support (e.g., supervision that addresses real, day-to-day staff concerns--rather than simply meeting an administrative function; in-service training); and 3) support for staff self-care (e.g., providing lunch time and encouraging staff to take such daily breaks; support for staff wellness programs; providing quiet space for staff to relax in the midst of a difficult time at work). *These examples are not meant to be exhaustive, only illustrative.* In order to meet this criterion, each of the three domains must be met to a reasonable extent as indicated primarily by STINT and SURR. CEOINT, PDR, and IPOBS can supplement these other sources of information.

**Domain 1C. Choice for Clients and Staff**

**1. Routine Practice:**

**Indicators:**

**a) Staff members review the program's service options (e.g., types of services offered, locations, housing possibilities, choices regarding clinicians—including gender) with each client prior to the development of an initial recovery or service plan.**

*Criteria for this indicator:* As a part of the intake and early engagement process, staff members make it a routine part of their practice to ask clients about their preferences for specific services available to them, including the person (and gender) of the staff member with whom they will be working most closely. It is especially important that these conversations occur prior to the development of a written recovery plan, so that the recovery plan may reflect fully the client's choices. CLINT and SURR are the primary sources of information for this indicator; CRR, STINT, and CEOINT are secondary sources.

**b) The program routinely asks clients about how and when they would like to be contacted.**

*Criteria for this indicator:* As part of the intake process, staff members ask clients about their preferences for being contacted by the program. Recognizing that this might involve a discussion of current danger in their living situations, staff are especially sensitive to ask these questions only when the clients are by themselves, without significant others in the room. It is also better to ask these questions in an open-ended fashion: “How would you like me to get in touch with you if that becomes necessary?” rather than “Is it all right if I call you at this number?” Explaining the circumstances under which the program might want to contact the person may be useful in beginning this conversation. CLINT and SURR are the primary sources of information for this indicator; CRR, STINT, and CEOINT are secondary sources.

**c) The program ensures that each service option is as independent of others as possible, so that a client’s choice about one service does not necessarily affect another.**

*Criteria for this indicator:* The program does not unnecessarily tie program choices to each other. If a person wants to participate in only one of the options available to her or him, the program strives to make that choice work, rather than offering a pre-packaged set of activities in which all clients are expected to participate. Living in supportive housing is not contingent on engagement in other services. STINT, CEOINT, and CLINT are primary sources of this information; PDR is a secondary source.

**d) The client’s goals are given the greatest weight in recovery planning.**

*Criteria for this indicator:* The recovery plan should reflect the participant’s choices and preferences even when they may differ from those of the staff or the program as a whole. This should be evident in the process of developing the plan as well as in the final document. Staff members should listen carefully to determine the person’s goals and then should put those into the recovery plan. CLINT, SURR, and CRR are primary sources for this information; STINT and CEOINT are secondary.

**e) Staff members are provided options, when possible, regarding factors that affect their daily work (hours and flex-time; timing of leave; décor of office; trainings offered).**

*Criteria for this indicator:* Because choice is as important for staff as it is for service recipients, administrators and supervisory personnel support the staff in making as many choices as feasible about factors that affect their daily work and routine. For example, staff are given the choice to work unique hours or to have flex-time whenever this is feasible. Similarly, the timing of their vacation, the decorating of their office and the program space; and the kinds and timing of educational offerings all reflect the priorities of the staff. STINT and SURR are primary sources of information; CEOINT and PDR are secondary.

**f) The program offers a balance between autonomy and clear guidelines for staff members’ work responsibilities; it is alert for ways to maximize staff choice regarding how they meet their job requirements.**

*Criteria for this indicator:* The program administrators and supervisors keep alert to opportunities to expand staff members' choices regarding their work style. For example, certain staff may prefer to work with a particular group of clients (e.g., gender, race, age, sexual orientation may be of particular salience for these staff members). The program attempts to honor such requests whenever possible and not contraindicated by other concerns. Staff members who have particular interests in an intervention that is consistent with trauma-informed care (e.g., motivational interviewing) are supported in their pursuit of skills in these areas. STINT and SURR are primary sources of information; CEOINT and PDR are secondary.

## **2. Crisis Preferences:**

### **Indicators:**

**a) The client collaborates in developing a plan (e.g., Wellness Recovery Action Plan and/or a crisis/safety plan) that indicates the client's preferred options, including responses from staff, in crisis situations.**

*Criteria for this indicator:* In anticipating crisis situations, the program makes it clear that client well-being is a paramount consideration. Therefore, the program initiates conversations with program participants to determine the client's preferences in the event they become unable to manage their situations without help. The crisis or safety or Wellness Recovery Action Plan is part of the person's easily accessible record so that crisis teams know not only where the plan may be found but something about what works for different individuals. CLINT and STINT are primary sources, along with CRR, CEOINT, and PR as secondary sources.

**b) The program consistently takes into account these preferences in responding to client crises, including preferences regarding gender of supportive others.**

*Criteria for this indicator:* The program staff try to control whatever aspects of urgent situations that they can. By giving priority to the preferences of the client, staff is less likely to have a situation throw them or the client more out-of-the-ordinary than is built-in to the reality of the moment. Specifying the gender of supportive others is frequently a key but overlooked aspect of dealing with crises. CLINT, STINT and CRR are primary sources; CEOINT is a secondary source.

## **Domain 1D. Collaboration for Clients and Staff**

### **Indicators:**

**a) The program has a routine and effective way of gathering client opinions about the program's direction and operations; weighs clients' opinions in their decision-making; and communicates clearly with clients the process of decision-making. Alternatives include a Client Advisory Board, regularly used focus groups, suggestion boxes, etc.**

*Criteria for this indicator:* Because there many ways to get client feedback about the quality of the services they receive, there are several way to meet this criterion, the point of which is to ensure that there is some regular and built-in method of getting client opinions about the agency

or program. Formal surveys of clients is one way to gather this information as are focus groups, suggestion boxes, and a Client Advisory Board (or an ad hoc Client Advisory Group for special projects). It is also important that the agency's responses to client feedback is given to the clients themselves, whether this comes in the form of survey summaries, or of individual responses to suggestions (sometimes posted on a bulletin board next to a suggestion box). /the best sources of information on this are CLINT and SURRs, supplemented by IPOBS and/or CEOINT.

**b) The program has a routine and effective way of gathering staff opinions about the program's direction and operations; weighs staff opinions in their decision-making; and communicates clearly with staff the process of decision-making. All staff are included in any major change process, including support staff.**

*Criteria for this indicator:* Just as there are several ways to meet the criteria for the first indicator, there are several ways to meet this indicator's criteria. The point is parallel to the previous one: that in order to feel that power is shared and decision-making is mutual, staff members need to feel included in all aspects of major changes at the agency (such as becoming a more trauma-informed program). The best sources of information are STINT and SURRs. These may be supplemented by IPOBS and/or CEOINT.

**c) The program cultivates a model of doing things "with" rather than "to" or "for" clients.**

*Criteria for this indicator:* As noted above, "power over" someone is qualitatively different than "power with" someone. Doing things "to" or "for" clients heightens the power differential that the trauma-informed model is designed to mitigate. Therefore, clients should feel as though they are partners with companions on their recovery journey, not as if they are "cases" to be "managed." CLINT and SURRs are the best sources of information on this point, supplemented by STINT and IPOBS.

**d) The program creates ways to engage clients as partners in plans for the recovery support services they need and want.**

*Criteria for this indicator:* This may be accomplished in any number of ways: by extensive use of collaborative documentation, by employing person-centered planning, by shared decision-making, or by any other means that communicates clearly to clients that their positions and experiences are heard, understood, and incorporated into their recovery plans. The "usual" way of documenting this is often inadequate: a client's signature on a recovery plan. CLINT and SURR, followed by STINT, CEOINT, and CRR are all ways to get a sense of this indicator.

**Domain 1E. Empowerment for Clients and Staff**  
**Indicators:**

**a) The program routine recognizes client strengths and skills in the planning, implementation, and evaluation of its services.**

*Criteria for this indicator:* In clear ways, preferably in the recovery plan itself, the client's strengths are built in to the planning process. For example, strengths may be listed as part of client resources or assets (e.g., high self-esteem or good judgment and decision-making or strong self-protective skills). These strengths may then be taken into account as staff work with the client and as they evaluate client progress. For example, the Trauma Recovery and Empowerment Profile (TREP) lists eleven skill domains for individuals who are healing from trauma and arrays each of these domains on a five-point rating scale. This kind of skills-oriented rating scale may be useful in meeting the criteria for this indicator. CLINT, STINT, and CRR are the primary sources of information for these criteria, with CEOINT a backup source.

**b) The program routine recognizes all staff members' strengths and skills in the planning, implementation, and evaluation of its services.**

*Criteria for this indicator:* Staff members' strengths are considered fully in the planning, implementation, and evaluation of program services. This means that there is a formal way for staff to discuss and employ their strengths, skills, and interests in the service of programmatic goals. For example, staff may include their strengths in a formal evaluation at least annually. Their goals and skills are also a routine part of this evaluation. For example, a staff member with special skills in group therapy may decide to learn more about leading a trauma-specific group model. The goal is then included in the evaluation process and the staff person is rewarded when the goal is met. STINT, SURR, and PDR are the best sources of information, supplemented by CEOINT.

**c) In each formal activity, the program helps to develop or enhance client skills explicitly.**

*Criteria for this indicator:* Clients of the program recognize that the staff are working to develop or enhance their skills because this is openly discussed by the staff member and the client. The goal and intent of this indicator is to have such skill development be a part of each formal contact with each client, so that, after every visit, the client is clear about which skill has been addressed during that day. CLINT and STINT are the best sources of information here with SURR a secondary option, focusing on items that reflect client skill enhancement.

**d) In each contact, the client feels validated and affirmed.**

*Criteria for this indicator:* After each visit, the client is able to say that they feel validated or affirmed by their interaction with the program staff. "Validation" refers to the client's perceptions and feelings being understood (and communicated as understandable) by the staff with whom they work. The goal is similar to c. above, in that it is desired that this be experienced at every contact with the program's staff. CLINT, SURR (focused on those items that refer to client's feeling validated or affirmed by the program staff), and STINT are sources of information for this item.

**e) The program offers training designed to strengthen or develop specific skills needed by staff in order to perform their jobs well.**

*Criteria for this indicator:* Staff members report feeling empowered by having the opportunities to learn or deepen skills needed to perform their jobs to the best of their abilities. Programs can offer formal trainings in order to accomplish this task or can offer high quality supervision in skill development areas of interest to, and needed by, the staff in order to strengthen their confidence in their job performance. SURR and STINT are the best sources of information in this domain, with CEOINT as a secondary source of feedback.

**f) The program emphasizes shared accountability and responsibility throughout its hierarchy (in contrast to blaming the person with the least power).**

*Criteria for this indicator:* Staff at all levels of the organization feel that they are held appropriately accountable, and given appropriate responsibility, for their work. It is clear to all staff members that they should emphasize shared accountability and responsibility, that the team is in this together. Therefore, staff are not to blame others lower in power than they, nor are those in lower power positions to accept blame inappropriately attributed to them. This equality should particularly extend to women and racial minorities, who have traditionally been in one-down positions in many agencies. This process should result in a sense of confidence and empowerment regarding the work of all staff. STINT and SURR are the best sources of information about this indicator.

## **Domain 2. Formal Service Policies**

### **Indicators:**

**a) The program has developed written policies that seek to eliminate involuntary or coercive practices (seclusion and restraint, involuntary hospitalization or medication, outpatient commitment). For those programs whose clients are “mandated” to treatment, efforts are made to maximize the realistic choices enrollees have. These efforts are part of the program’s written policies.**

*Criteria for this indicator:* The program’s written policies should directly address the possibility of involuntary or coercive practices and should seek to minimize, and eventually to eliminate, such practices in day-to-day practice as well as in times of client crises. For “mandated” clients, the program should establish means of maximizing choices available to these persons and should include these means in written policies. PDR is the best source of information for this indicator.

**b) The program has a written de-escalation policy that minimizes possibility of re-traumatization; the policy includes reference to a client’s statement of preference for crisis response, including preferences regarding gender of those involved as supports.**

*Criteria for this indicator:* The program’s written policies should include a formal de-escalation policy that maximizes client choice and control and minimizes the likelihood of re-traumatization. By having client statements of preference detailing how they would like to be treated in the event of an urgent situation. And by making these statements readily available to staff involved in crises, the program has taken important steps. Gender issues sometimes arise in this domain because programs do not ask basic questions such as: “Would you prefer a man or a

woman to sit with you when you are feeling upset? Or do you have no preference?" PDR is the best source of information about this indicator.

**c) The program's policies regarding confidentiality (incl. limits and mandated reporting) and access to information are clearly written, maximize legal protection of privacy, and are communicated to each client.**

*Criteria for this indicator:* Confidentiality policies are written at an appropriate level for the reading skills of clients served by the program. They maximize the legal protection of protected health information for clients and are clearly and regularly communicated to each client. Very importantly, they include the limits of confidentiality; such limits may be particularly different for men and women, in that women may need to know especially about the necessity of reporting childhood abuse (and the fact that it might eventuate in the termination of her parental rights) whereas men may need to know about the need to report threats against other people. Both of these possibilities should be mentioned in the limits of confidentiality section of this document. PDR is the best source of information.

**e) The program has clearly written and easily accessible policies outlining client and staff rights and responsibilities as well as a grievance policy.**

*Criteria for this indicator:* Client and staff rights and responsibilities are clearly spelled out in documents that are written appropriately for the reading level of the two groups and are readily accessible (either posted in a conspicuous place or notice of their availability is so posted). A grievance policy is included in the rights statement for both clients and staff so that it is eminently clear where such concerns (with discrimination or mistreatment, for example) are to be taken. Statements regarding discrimination should include sexual harassment and gender/age/race/sexual orientation discrimination responses. PDR is the best source of information.

**f) The program's policies address issues related to staff safety (e.g., community visits, being alone in an area of the building); incident reviews reduce staff vulnerability.**

*Criteria for this indicator:* The program's written policies should contain guidelines for maximizing staff safety, especially when staff are in vulnerable situations. Incident reviews should be outlined in the written policies (see g) below). PDR is the best source of information.

**g) The program's policies address the need for debriefing after critical incidents, Both staff and clients involved in the incident are also engaged in the debriefing, which has as its goal an understanding and preventive approach (in contrast to a blaming one).**

*Criteria for this indicator:* The procedure to be followed in conducting reviews of critical incidents should be outlined in the written program policies. The policies should include who is to be involved in the debriefing (everyone who witnessed or participated in the event) well as the style and goals for such debriefings. These reviews and their description should emphasize a non-blaming approach to discovering what can be done to minimize the possibility of that kind

of incident being repeated (rather than focusing on who or what is to blame for the incident's occurrence). PDR is the best source of information.

**h) All services are based on trauma-informed values and the curricula and materials used reflect these core values.**

*Criteria for this indicator:* The program's written policies indicate that all services are provided in a trauma-informed way. In particular, the policies state that trauma-informed curricula and other materials are to be used in all curriculum-based groups. PDR is the best source of information.

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

#### **1. Screening, Assessment, and Service Planning**

##### **Indicators:**

**a) Universal Trauma Screening. Within the first month of service participation, every client has been asked about their histories of exposure to trauma.**

*Criteria for this indicator:* Each program will have latitude in the screening procedures for trauma histories. However, it is important that each program have in place a consistent, universal method for getting a sense of each individual client's history of exposure to potentially traumatic events. The screen should include histories of abuse and violence, and the questions (with explanation, rationale, and the option not to answer any question that the client does not wish to answer) should be asked within the first month of engagement with the provider agency. The best source of information is CRR, followed by STINT, CEOINT, CLINT, and PDR.

**b) The trauma screening includes questions about lifetime exposure to sexual, physical, and emotional abuse and violence.**

*Criteria for this indicator:* The program's trauma screening needs to include questions about abuse and violence that may have been experienced over the course of the person's lifetime. Childhood and adulthood questions may be helpfully separated but this is not necessary for the purposes of the screening. CRR is the best source of information, followed by STINT, CEOINT, CLINT, and PDR.

**c) The trauma screening is implemented in ways that minimize client stress; it reflects considerations given to gender of interviewer, timing, setting, relationship to interviewer, client choice about answering, and unnecessary repetition.**

*Criteria for this indicator:* Minimizing client distress and the possibility of re-traumatization is a clear priority of trauma-informed programs. Client choice about the gender (and other personally relevant characteristics) of the interviewer and answering questions should be honored whenever possible. The timing of the interview, the relationship to the interviewer, and the necessity of avoiding repetitive questioning are further concerns to be addressed in the ways

in which screening is conducted. STINT, CEOINT, CRR, CLINT, and PDR are all possible sources of good information about this process.

**d) Unless specifically contraindicated due to client distress, the program conducts a more extensive assessment of trauma history and needs and preferences for trauma-specific services for those clients who report trauma exposure.**

*Criteria for this indicator:* After the question “What happened to you?” the follow-up question is “How did you deal with that?” or “What has the impact of that been in your life?” Assessment of trauma’s role in someone’s life follows from the positive results of a trauma screen. This can be conducted in either more structured ways (by, e.g., using a formal trauma impact scale, including a PTSD symptom checklist) or a less formal way (by simply exploring with the survivor the follow-up questions above). One of the last questions to be asked is, “Given what we have talked about, I wonder: are you interested in getting involved in some kind of service that addresses directly your trauma history and moves toward recovery and healing?” “If so, here are some options we can talk about.” The best sources of information are STINT, CLINT, CEOINT, and CRR.

**e) The program conducts gender-specific assessments for women and men, and for girls and boys, if applicable. These assessments are based on knowledge of gender differences in socialization as well as biology.**

*Criteria for this indicator:* Males and females are given separate assessments tailored to the gender-specific needs and the gender-specific ways in which males and females experience trauma, encode it, and respond to it. Talking with women and men about the messages they received growing up female or male is another way to get into this topic. The important issue here is to have some idea of the potential differences between men and women and to build these in to the assessment process. Best sources of information are STINT, CRR, CLINT, CEOINT and PDR.

**f) Recovery planning is conducted in an individualized, person-centered way that is based on trauma theory and knowledge.**

*Criteria for this indicator:* Trauma theory and knowledge constitutes one of the bedrock underpinnings of trauma-informed approaches to care. Individuals who are in the midst of recovery planning need not only individualized services but trauma-informed ones, those that take into consideration the very broad and diverse impact of trauma, as well as its diverse paths to recovery and healing. The best sources of information are CRR, CLINT, STINT, CEOINT, and PDR.

## **2. Trauma-Specific Services:** **Indicators:**

**a) The program ensures that those individuals who report the need and/or desire for trauma-specific services are either offered them on-site or referred for appropriately matched services.**

*Criteria for this indicator:* It follows from the preceding emphasis on trauma and gender-related screening, assessment, and service planning that offering either trauma-specific services that are usually gender-specific as well [e.g., Helping Women Recover and Helping Men Recover are two substance abuse interventions that emphasize integrating trauma work with substance abuse; TREM and M-TREM (the Trauma Recovery and Empowerment Model groups for women and men) address primarily mental health issues related to trauma in gender-specific group curricula]. These are the kinds of integrative approaches that characterize an increasing number of services offered in the public sector. If a particular program is unable to offer these services themselves, it is essential for all programs to be knowledgeable about their community's options for these trauma-specific interventions. Then the possibility of referrals can be built in to the recovery planning process for women and men, who can choose from among individual and group interventions that feature trauma-specific styles. Best sources of information are CRR, STINT, CLINT, CEOINT, and PDR.

**b) Trauma-specific services are effective; they have an evidence base for the population being served.**

*Criteria for this indicator:* Trauma-specific services should ideally have an clear evidence base establishing their effectiveness for the population being served. Best sources of information are STINT and CEOINT as well as websites such as [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov).

**c) Trauma-specific services are accessible. People can get to them easily and they are offered at times that meet the members' needs.**

*Criteria for this indicator:* Trauma-specific services offered by the program should be available at times that fit with the members' needs and their daily schedules. Further, they are offered at a location that fits with the members' transportation needs. Best sources of information are CLINT, CEOINT, and STINT.

**d) Trauma-specific services are affordable for the members.**

*Criteria for this indicator:* Trauma-specific services offered by the program are priced within the range that members can afford. Best sources of information are CLINT, CEOINT, and STINT.

**e) Trauma-specific services, in style and content, are responsive to the preferences of the program's clients.**

*Criteria for this indicator:* The preferences of the program's clients are given considerable weight in selecting those trauma-specific services that are offered. In style and content, it is important that members feel that the group is responsive to their needs. This is especially true given the frequent preference of individuals for a gender-specific group. Best sources of information are CLINT, CEOINT, and STINT.

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

### **1. Overall Administrative Support:**

#### **Indicators:**

**a) The program has adopted a formal policy or mission statement that refers to the importance of trauma and the need to account for clients' experiences of trauma in all aspects of program operation.**

*Criteria for this indicator:* A written policy or mission statement is a very important way for a program to announce its intention to become more trauma-informed. It should include a statement about the centrality of trauma in the self-understanding of the program and its mission. The best sources of information are PDR and CEOINT.

**b) The program has a clear philosophy, reflected in its day-to-day operations, that takes trauma experiences into account. The philosophy is reflected in written materials as well as in informal practices.**

*Criteria for this indicator:* The program's philosophy is reflected in written documents as well as in daily practice. The written documents detail a way of thinking about the persons served in terms of trauma and take into account the same factors in addressing the needs of the staff. The day-to-day realities of the work also embody the core values of trauma-informed care. The best sources of information are PDR, CEOINT, STINT and CLINT, along with SURR.

**c) The program has named a trauma specialist ("champion") and workgroup(s) to lead agency activities in trauma-related areas and provides needed support for these initiatives.**

*Criteria for this indicator:* There are two interrelated criteria for this indicator. First, the program administrators have identified a trauma specialist or "champion" who is designated as the lead person for the trauma initiative. There may be co-leaders for the effort. Second, the program administration has demonstrated support for this initiative 1) by providing financial support when necessary for trauma-informed changes proposed by the workgroup; and 2) by ensuring that the entire program understands the import of this initiative. The best sources of information are CEOINT, STINT, CLINT, and PDR.

**d) The group reflects the composition of the staff and people in recovery in terms of gender, race, and cultural background. All constituencies in the program are represented on the workgroup.**

*Criteria for this indicator:* The workgroup overseeing the trauma-informed change process needs to reflect the composition of the staff and persons served by the program. This is true in terms of both representing the various constituencies in the program (senior management, clinical supervisors, direct service staff, support staff and people in recovery) and also representing the gender, racial, and cultural characteristics of both the staff and the people served by the program. Best sources of information are CEOINT, STINT, CLINT, and PDR.

**e) Program administrators monitor and participate actively in responding to the recommendations and activities of the trauma leadership team or workgroup.**

*Criteria for this indicator:* The senior program administrators (CEO, ED, COO, Chief Clinical Officer, for example, are not merely passive recipients of reports from the initiative workgroup. Rather, they have an active role, developing high quality collaborations with the workgroup and supporting the workgroup's activities whenever feasible (in addition to the financial support mentioned in c) above). Best sources of information are CEOINT, STINT, CLINT, and PDR (including minutes of the workgroup's meetings).

**2. Services Offered by the Program:**  
**Indicators:**

**a) The program offers simultaneous, integrated services for mental health, substance abuse, and trauma.**

*Criteria for this indicator:* Services are offered in simultaneous (rather than sequential) and integrated (rather than parallel) structures for people in recovery who bring these interrelated sets of concerns. These may be organized in interventions like TREM or Helping Women Recover but may also be done in ways that organize other services into packages that reflect the understanding of the interconnections among trauma, mental health, and substance abuse recovery. Best sources of information are CEOINT, STINT, CLINT, and PDR.

**b) The program uses role models and mentors, who may also be people in recovery.**

*Criteria for this indicator:* People in recovery often say that it is important for programs to have peer support specialists available for those who choose to work more closely with a person who shares their recovery experience. Peers in recovery may be especially valuable in providing this modeling by sharing their experiences of a person with lived experience of recovery from trauma, mental health, or addictive concerns. Best sources of information are CLINT, STINT, CEOINT, and PDR.

**c) The program makes available, on site or by referral, primary care, spiritual, employment, and parenting services.**

*Criteria for this indicator:* So-called wrap-around services need to be trauma-informed. Therefore, primary care, spiritual support, employment activities and parenting services need to be safe, trustworthy, and maximize choice, collaboration, and empowerment. Best sources of information: CLINT, STINT, and CEOINT.

**d) The program offers specific services for pregnant women or makes referrals to such programs.**

*Criteria for this indicator:* Because of the special needs of pregnant women, agencies need to either offer specific programs for these women or make referrals to such programs readily available. Best sources of information are STINT, CLINT, CEOINT, and CRR.

**e) The program offers child care or helps make arrangements for such care for parents who need it**

*Criteria for this indicator:* For parents, either mothers or fathers, who need child care, the program either offers such care on site or helps to make arrangements. Best sources of information: CLINT, STINT, CEOINT.

### **3. Trauma Survivor/Person in Recovery Involvement:** **Indicators:**

**a) Administrators actively solicit the opinions of people in recovery who have had experiences of trauma. By membership on a Client Advisory Board (CAB), by focus groups, by individual interviews, and/or by suggestion boxes, people in recovery can have their voices heard.**

*Criteria for this indicator:* Because of the prevalence of trauma exposure in most populations served by the mental health and addiction systems of care, it is likely that the vast majority of people in recovery will be trauma survivors. It is vital that their voices be heard in a trauma-informed program. In relation to this particular initiative, but in relation to all programming decisions (planning, implementation, and monitoring), people in recovery should have a major say in how those decisions are made. Client or Peer Advisory Boards or Councils may be established by the program on an ongoing basis in order to provide a regular conduit of information from people served to administrators. Focus groups, individual interviews, suggestion boxes, and formal and informal surveys also provide useful ways to have the perspectives of people in recovery weighted in the collaborative process of building a trauma-informed program. Best sources of information: CLINT, STINT, CEOINT, and SURR.

**b) People in recovery who have had lived experiences of trauma are actively involved in all aspects of program planning and oversight.**

*Criteria for this indicator:* . Not only in relation to this particular initiative, but in relation to all programming decisions (planning, implementation, and monitoring), people in recovery should have significant input into how such decisions are made. Full representation should involve gender, race and age (as well as any other particularly relevant variable in the program\'s constituency) for client advisory groups, for focus group and individual interviews, and for formal and informal surveys. Best sources of information: CLINT, CEOINT, STINT, and SURR.

### **4. Program Data-Gathering and Program Evaluation** **Indicators:**

**a) Program gathers data addressing the needs and strengths of clients who are trauma survivors and evaluates the effectiveness of the program and trauma-specific services. Gender, race, and age may be important categories in understanding these data.**

*Criteria for this indicator:* Programs should routinely gather information about participants' needs and strengths, based on baseline assessments, and use this information to evaluate the effectiveness of their services. For trauma survivors, these data should include the effectiveness of trauma-specific, gender-specific services. The gender, race, and age of the respondent may be key grouping factors in looking at the program's outcomes. Best sources of information: PDR, CEOINT, STINT, CLINT.

**b) Administrators include at least five key values of trauma-informed cultures in client satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment. The respondent's gender, race or age may be factors considered in understanding these data.**

*Criteria for this indicator:* Client satisfaction surveys are a key source of information flowing from the program participants to its administrators and staff. The five core values of trauma-informed care are central in any formal survey conducted by a trauma-informed program. And gender, race and age may be used once again as grouping factors in order to determine whether subgroup members see the program differently in these regards. Best sources of information: SURR, CEOINT, CLINT, and STINT.

**c) Administrators include at least five key values of trauma-informed cultures in staff satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment. The respondent's gender, race, and age may be factors considered in understanding these data.**

*Criteria for this indicator:* Staff satisfaction surveys need to include the same five core values as do client surveys. And, just as with the client surveys, staff survey findings need to take into account the respondent's gender, race, and age. Best sources of information: SURR, CEOINT, STINT, and CLINT.

**d) Results of both the client and staff surveys are consistent with a trauma-informed culture. All ten of the key values ratings are at the "agree" or higher level on the rating scale.**

*Criteria for this indicator:* In order for a program to consider itself trauma-informed, it must register solid scores for both clients and staff in the five core areas of trauma-informed care. Both men and women must see the program as safe, trustworthy, and as maximizing choice, collaboration, and empowerment. Though early in the change process, scores may be lower than the "agree" level across the board, they should move toward that benchmark as the process progresses. Best sources of information: SURR, CEOINT, CLINT, and STINT.

**Domain 5. Staff Trauma Training, Education, and Support**  
**Indicators:**

**a) All staff (including administrative and support personnel) have participated in at least 2.5 hours of “basic” trauma education that addresses at least the following: 1) trauma prevalence, impact, and recovery; 2) ensuring safety and avoiding retraumatization; 3) maximizing trustworthiness (clear tasks and boundaries); 4) enhancing client choice; 5) maximizing collaboration; 6) emphasizing empowerment.**

*Criteria for this indicator:* The five core values of trauma-informed care are embedded here in a training that adds trauma prevalence, impact, and recovery. All staff need to participate in this training in order to have the basics of trauma-informed care firmly in their minds. Best sources of information: STINT, CEOINT, and PDR.

**b) All staff have participated in at least 2.5 hours of education addressing the necessity of staff support and care in a trauma-informed context.**

*Criteria for this indicator:* As in Domain 5.a., all staff, including administrative and support staff, need to participate in this staff support and care training, an essential element in a trauma-informed context of care. Best sources of information: STINT, CEOINT, and PDR.

**c) All new staff receive at least one hour of trauma education as part of orientation.**

*Criteria for this indicator:* All new staff, regardless of their position in the program, receive, as part of their orientation to the agency, at least one hour of training that address the core issues of trauma. Best sources of information: STINT, CEOINT, and PDR.

**d) Direct service staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma recovery skills).**

*Criteria for this indicator:* These three hours of trauma education are intended to involve more directly the trauma-informed elements of services. But they are intended to equip direct service staff with the skills they need (e.g., grounding, making connections between current behavior and histories of violent exposure, and safety planning) for working more effectively with trauma survivors. Best sources of information: STINT and CEOINT, as well as PDR.

**e) All staff are provided adequate resources for self-care, including supervision, consultation, and/or peer support that addresses secondary traumatization.**

*Criteria for this indicator:* Staff are able to address needs for support in the face of secondary traumatization in a variety of ways. Supervision that focuses on the relationships between staff and their clients, consultation that addresses vicarious trauma, and/or peer support that offers a supportive context for exploring secondary trauma are all possible ways to meet this indicator’s criteria. Best sources of information: STINT, CEOINT, and PDR.

**Domain 6. Human Resources Practices**  
**Indicators:**

**a) Prospective staff interviews include trauma-related questions. (What do applicants know about trauma, including sexual, physical, and emotional abuse? About its impact? About recovery and healing? Is there a “blaming the victim” bias? Is there potential to be a trauma “champion?”).**

*Criteria for this indicator:* All prospective staff interviews should include questions about trauma. These might include a vignette of someone in distress about a trauma-related event or simply open-ended questions about the applicant’s response to people who have histories of exposure to violence. The goals are simultaneously to identify those candidates least likely to be hired (those who blame the victim, for example) and those most likely to be hired (those whose knowledge of trauma and is extensive and who show interest in making trauma a significant part of their work). Best sources of information: CEOINT, STINT, and PDR.

**b) Staff performance reviews include trauma-informed skills and tasks, including the development of safe, trustworthy, collaborative, and empowering relationships with clients that maximize client choice.**

*Criteria for this indicator:* Regularly scheduled staff performance reviews are done in a collaborative way that maximizes the staff’s choice in doing their jobs effectively. Special attention is paid to those areas that reflect commitment to trauma-related concerns (e.g., staff goals may reflect skill development in the five core values of TIC; they may reflect goals related to the development of trauma-specific group leadership; or they may reflect other trauma-related issues). Best sources of information: CEOINT, STINT, or PDR.

**c) The program routinely assesses staff members’ knowledge of trauma relevant for the program’s goals (see content in Domain 5). This may be done following educational events or as part of performance reviews or in ongoing supervision.**

*Criteria for this indicator:* There are a number of ways to assess staff members’ knowledge of trauma as it fits with the program’s goals. Following educational events, there can be a quiz to compare to a similar one done before the training. Alternatively, this can be assessed at the time of performance reviews when the staff member is invited to discuss their activities focused on trauma. Finally, in ongoing supervision, trauma can be a recurring point of discussion. Best sources of information: STINT or CEOINT.

**d) The program has a consistent way to recognize outstanding performance among staff.**

*Criteria for this indicator:* The program, as part of empowering and collaborating effectively with its staff, has developed at least one means of recognizing publicly the special contributions of its staff to the well-being of other staff and of clients. These can include such practices as having an “employee of the month,” or simply recognizing more spontaneously when a staff member has done something “above and beyond the call of duty.” Staff, supervisors, or clients may make this recognition known and public. Best sources of information: STINT, CEOINT, and PDR.