Section 2: Integrating Trauma-Informed Practices, Policies, and Procedures

On a Foundation of shared knowledge and established team structure, RTIC Teams can move to Section 2 and use this document as a tool for guiding dialogue and actions to support the integration of trauma-informed approaches.

Before RTIC Teams move to planning strategic actions, it is beneficial to consider ***how trauma-informed integration can be aligned with existing organizational initiatives.*** Trauma-informed integration can often come alongside and reinforce activities or initiatives already existing within an organization. By aligning alongside existing initiatives, RTIC Teams can demonstrate connection and prevent redundancy in areas that may overlap.

A. Professional Development

Staff are encouraged to continue advancing knowledge and skills in trauma-informed approaches				
Not at all	Minimally	Moderately	Fully	Not sure
Staff are supported to integrate the six trauma-informed principles into their professional practice				
Not at all	Minimally	Moderately	Fully	Not sure
Professional development opportunities are offered through a variety of formats to engage different learner types				
Not at all	Minimally	Moderately	Fully	Not sure

B. Self-Care of Staff

Staff are supported to practice self-care strategies to enhance well-being				
Not at all	Minimally	Moderately	Fully	Not sure
Staff have learned the signs and symptoms of secondary traumatic stress				
Not at all	Minimally	Moderately	Fully	Not sure
Workforce concerns regarding burnout and secondary traumatic stress are addressed				
Not at all	Minimally	Moderately	Fully	Not sure

C. Leadership

Strategic planning reflects a commitment for integrating trauma-informed approaches and supports				
Not at all	Sometimes	Often	Consistently	Not sure
Leadership invites feedback to improve trauma-informed practices and services				
Not at all	Sometimes	Often	Consistently	Not sure
Trauma-informed approaches are included within supervision practices				
Not at all	Sometimes	Often	Consistently	Not sure

D. Physical Environment

All areas of the physical environment are safe, welcoming and calming				
Not at all	A few areas	Most areas	All areas	Not sure
Staff are encouraged to interact with population served in a welcoming manner				
Not at all	Sometimes	Often	Consistently	Not sure
The physical environment reflects the population served (i.e. visuals, materials, languages)				
Not at all	A few areas	Most areas	All areas	Not sure

E. Practices, Procedures and Policies

Diversity, inclusion, and equity are integrated within practices, procedures and policies				
Not at all	Sometimes	Often	Consistently	Not sure
Practices, procedures and policies are reviewed to support integration of trauma-informed approaches				
Not at all	Sometimes	Often	Consistently	Not sure
Staff know how to respond to youth and adults in crisis (i.e. verbal escalation, aggression, suicidal thinking)				
Not at all	Some	Most	All	Not sure

F. Population-served

Staff are encouraged to promote positive relationships and social connectedness with population-served				
Not at all	Sometimes	Often	Consistently	Not sure
Population-served has opportunity to voice needs, concerns and experiences				
Not at all	Sometimes	Often	Consistently	Not sure
Population-served collaboratively set goals with staff on trauma-informed supports and services				
Not at all	Sometimes	Often	Consistently	Not sure

G. Community Partner Collaboration

There is communication with community partners to develop and sustain common goals				
Not at all	Sometimes	Often	Consistently	Not sure
There are coordinated services and supports implemented with community partners				
Not at all	Sometimes	Often	Consistently	Not sure
Data is collaboratively reviewed with community partners to inform decision making				
Not at all	Sometimes	Often	Consistently	Not sure

Identification of Trauma Experience: Questions and Practices to Consider

Many organizations question whether it is necessary or how to identify the experience of trauma within their population-served (i.e. student, patient, client, consumer etc.).

The decision on whether to identify trauma through screening processes should be a ***team*** **decision supported by leadership and in consultation with a health care or behavioral health provider.**

RTIC Teams are encouraged to have an in-depth dialogue regarding the following questions **before** action is taken to identify trauma experiences.

- What information are we looking for?
- Do we need the information? If yes, why?
- What will we do with the information?
- Who would have access to the information?
- Would knowing the information change our professional practice? How so?
- Is there opportunity for inclusion of strength-based assessments?
- Do we need to use a formal screening tool or can we apply trauma-informed practices by working from the assumption of exposure to trauma experiences?
- What might be the impact on our population-served?
- What interventions and/or resources do we have in place to respond to what we learn?
- What legal or ethical principles or policies need to be taken into consideration before the identification of trauma experiences?

Decisions on whether to screen or inquire about trauma experiences should be made following the in-depth team conversation. Many teams will choose to work from a trauma-informed approach ***without*** formal screening.

For organizations who choose to screen or inquire about trauma experiences, the Center for Health Care Strategies Inc. has shared the following considerations supporting actions regarding the identification and response to trauma[1]:

1. Treatment setting and population-served should guide screening. Upfront, universal screening may be more appropriate in primary care settings. Other providers, such as behavioral health clinicians, may prefer to screen for trauma after having an established relationship.

2. Screening should benefit the population-served. Screening for trauma must have a clear strategy in place for utilizing the information in a way that supports health, including an established referral network.

3. Care coordination should be employed to avoid rescreening. Sharing results across support and treatment settings with appropriate privacy protections may help reduce rescreening and the potential for re-traumatization.

4. Ample training should precede screening. Professionals should be proficient in trauma screening and in conducting participant follow-up in a manner that is sensitive to cultural and ethnic characteristics.

Adapted from Center for Health Care Strategies Inc. (2019) https://www.chcs.org/media/TA-Tool-Screening-for-ACEs-and-Trauma_020619.pdf