TRAUMA-INFORMED CARE: IS CULTURAL COMPETENCE A VIABLE SOLUTION FOR EFFICIENT POLICY STRATEGIES?

Vittoria Ardino

Abstract

Treatment and support needs within the public system require a systemic approach characterized both by trauma-specific diagnostic and treatment services and a “trauma-informed” environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services. The paper provides a critique of what steps are needed to promote a dialogue between evidence-based practices and culture competence in trauma-informed services highlighting the strategic gaps that may maintain a disconnection between treatment and service delivery, and between cultural psychology and the traumatic stress field. The paper concludes with policy recommendations and with a reflection on the challenges ahead, especially in terms of effectiveness and the task of integrating psychotraumatology into the routine of mental health services.

Key words: trauma-informed care, policy, culture, service delivery

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Introduction

Traumatic events interfere with the way one thinks, feels, and acts. Some people have minimal symptoms after trauma exposure or recover quickly, while others may develop more significant and longer-lasting problems. Long-term consequences can also cause multiple costs to victims and their families, and to whole society, such as unemployment, lost work time, and increased health care utilization and costs (Chan et al. 2009, Goldin et al. 1988, Maguen et al. 2012). In responding to adverse outcomes, the trauma field mostly focused on evidence-based treatments resulting in an explosion of randomized controlled trials. However, less research and policy initiatives have been devoted to implement effective models of services to improve the system of care for traumatised individuals (Ko et al. 2008). For example, the prevalence of PTSD in primary care settings is similar to those of depressive disorders and higher than those found for other anxiety disorders (Prins et al. 2003); however, given the high prevalence and lack of attention to identification, it is no surprise that trauma-related disorders are frequently under-recognised and untreated leading to longer term conditions and healthcare utilisation (Grubaugh et al. 2005, Liebschutz et al. 2007).

This effort is even less if we consider the role of culture in providing alternative pathways to healing and integration of extreme stress experiences (Moodley and West 2006).

This paper provides a critique of what steps are needed to promote a dialogue between evidence-based practices and culture competence in trauma-informed services highlighting the strategic gaps that may maintain a disconnection between treatment and service delivery, and between cultural psychology and the traumatic stress field. Furthermore, the paper identifies the fundamental characteristics of a trauma-informed system of care including core service components (assessment and screening, inpatient treatment, residential services, addictions programming and case management). In so doing, this work puts forward the importance of the implementation of a broad spectrum of policies and practices to reflect the needs of the specific target population.

Mental health services have a long history of serving victims of trauma without being aware of or considering the pervasiveness and long-term consequences of traumatic events (Harris and Fallot 2001). However, with the increasing understanding of the clinical features of traumatic stress, the importance of creating a Trauma Informed Care (TIC) approach has been more recognised.

Trauma-informed care

A “trauma-informed” care is based on a specific set of principles (Elliot et al. 2005; see table 1 below) enabling to reconsider service systems in the light of a basic understanding of the role that trauma plays in the lives of people seeking mental health services (Harris and Fallot 2001).

“Trauma-informed” services are not specifically
designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors (Harris and Fallot, ibidem).

TIC systems favour a design of services that accommodates the vulnerabilities of trauma survivors and enables services to be delivered with an attention to potential retraumatization; intervention plans also facilitate consumer participation in treatment (Blanch 2003). Trauma-informed care requires closely knit collaborative relationships with the public sector service system and the local network of private practitioners working with traumatised clients (Harris and Fallot 2001). Treatment programs designed specifically for survivors of trauma are consistent on several points: the need for respect, information, connection, and hope for clients; the importance of recognizing the adaptive function of “symptoms” and the need to work in a collaborative empowering way with survivors of abuse (Saakvitne et al. 2000).

All trauma-specific service models – including those that have been researched and are considered emerging best practice models – should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections (Herman 1992). The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants (Freyd et al. 2007). Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control – precisely the beliefs that were shattered by the original attachment relationships. Saakvitne and colleagues (2000) define a therapeutic relationship as one that offers respect, information, connection, and hope relationship; this type of relationship helps develop safety and trust, the essential building blocks of healing human connections. Safe relationships are consistent, predictable, nonviolent, nonshaming, and nonblaming. Staff must be aware of the inherent power imbalance in the helper-helped relationship and do their best to flatten the hierarchy. Interpersonal violence involves a perpetrator and a victim. The trauma of this “power over” experience for the victim is best healed in a very different type of relationship, one that is collaborative and empowering (Miller and Guidry 2001). Empowering traumatised clients and service users enable them to reduce that pressure to conform and to encourage an active role in their treatment. Too often, programs focus so intently on problems that they miss the many strengths a person brings to the human service setting (Bloom 1997, Brown and Worth 2000). The medical model highlights pathology and inadvertently gives the impression that there is something wrong with a person rather than that something wrong was done to that person. On the other hand, defining a person entirely

### Table 1. Principles of trauma-informed care

<table>
<thead>
<tr>
<th>Principles</th>
<th>Definition</th>
<th>Effective strategies</th>
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<tbody>
<tr>
<td>1</td>
<td>Trauma-Informed Services Recognize the Impact of Violence and Victimization on Development and Coping Strategies and the need of addressing long-term and pervasive impact</td>
<td>✓ recognition of the difficulties survivors face in seeking services &lt;br&gt; ✓ increasing of sense of safety and hope &lt;br&gt; ✓ staff understanding of the effects of traumatic life events on individual development</td>
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<td>2</td>
<td>Trauma-informed Services Identify Recovery from Trauma as a primary goal</td>
<td>✓ offer of specialised services that address past trauma &lt;br&gt; ✓ integration of trauma care into non specialised services</td>
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<td>3</td>
<td>Trauma-informed services empower the client</td>
<td>✓ support the client to take charge of her life and control over her actions &lt;br&gt; ✓ encourage sense of control over important life decisions</td>
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<td>4</td>
<td>Trauma-Informed Services Strive to Maximize client Choices and Control Over Her Recovery</td>
<td>✓ collaboration with the client</td>
</tr>
<tr>
<td>5</td>
<td>Trauma-Informed Services Are Based in a Relational Collaboration</td>
<td>✓ the need of healing in a context in which interpersonal relationship are the opposite of traumatising</td>
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<tr>
<td>6</td>
<td>Trauma-Informed Services Create an Atmosphere That Is Respectful of Survivors’ Need for Safety, Respect, and Acceptance</td>
<td>✓ creation of a place perceived as safe and welcoming for survivors &lt;br&gt; ✓ give clear information, consistent and predictable</td>
</tr>
<tr>
<td>7</td>
<td>Trauma-Informed Services Emphasize Clients’ Strengths, Highlighting Adaptations Over Symptoms and Resilience Over Pathology</td>
<td>✓ focus on resilience rather than highlighting pathology</td>
</tr>
<tr>
<td>8</td>
<td>Trauma-Informed Services Minimize the Possibilities of effective strategies: intervention approaches that avoid to retraumatise clients</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Trauma-Informed Services Strive to Be Culturally Competent and to Understand Each Woman in the Context of Her Life Experiences and Cultural Background</td>
<td>✓ a deep understanding of the client’s cultural context</td>
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<tr>
<td>10</td>
<td>Trauma-Informed Agencies encourage service-user involvement in designing and evaluating services</td>
<td>✓ involvement of service users to design services &lt;br&gt; ✓ involvement of service users as a part of an ongoing evaluation of those services</td>
</tr>
</tbody>
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Adapted from: Elliot et al. 2005
Trauma-informed care

as a victim of a situation brings another problematic identity. Trauma-informed practice recognizes symptoms as originating from adaptations to the traumatic events or context (Allen 1995, Saakvitne et al. 2000). Understanding a symptom as an adaptation reduces the client’s guilt and shame, increases her self-esteem, and provides a guideline for developing new skills and resources to allow new and better adaptations to the current situation.

Another commonly missed strength is the person’s capacity to serve in valued social roles. Someone may have many problems and yet function well as a mother, employee, neighborhood organizer, and so on. Emphasizing the skills associated with her social roles increases the client’s perception of her own resources and feelings of hope.

The effects of trauma can be seen in both problems directly related to trauma and problems that initially appear to be unrelated (Harris and Fallot 2001, Herman, 1992). These may include homelessness, HIV-positive status (Cohen et al. 2000) difficulties with employment, family problems, and they have higher levels. They have higher levels of health problems (Liebshutz et al. 1997).

Trauma symptoms arising from past violence and the absence of a safe environment create obstacles to services, treatment, and recovery for survivors (Cusak et al. 2004, Saakvitne et al. 2000). Strategies that survivors develop for self-protection, combined with the posttraumatic stress symptoms of hyperarousal or avoidance, make a survivor’s entrance into a service setting frightening. Unacknowledged or untreated trauma and related symptoms interfere with seeking help for health, mental health, and substance abuse problems; hamper engagement in treatment; and make relapse more likely.

Many common procedures and practices in service settings retrigger trauma reactions and are experienced as emotionally unsafe and disempowering for survivors of trauma (Harris and Fallot 2001). Service systems that do not subscribe to principles of trauma-informed treatment or understand the pervasive long-term impact of trauma may inadvertently create an invalidating environment. As a result, they may fail to reach many traumatized individuals and experience higher dropout rates than necessary.

In addition some policies while not harmful, serve to undermine effective strategies. For example: policies designed to introduce evidence-based trauma interventions that neglect to provide sufficient initial training, funding to support start-up or continued training, policies and practices that ignore the need to build in resources for collaboration or trauma-related screening policies that do not factor in community-based service capacity (Hoagwood et al. 2000b, Stiffman et al. 2000a).

To address the treatment and support needs of survivors of trauma within the public system requires a systemic approach characterized both by trauma-specific diagnostic and treatment services and a “trauma-informed” environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services. Change to a trauma-informed organizational or service system environment will be experienced by all involved as a profound cultural shift in which clients and their conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently. The new system should be characterized by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history, cultures, and their society; open and genuine collaboration between provider and client at all phases of the service delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual’s identity rather than a single discrete event; and by a focus on what has happened to the person rather than what is wrong with the person (Saakvitne 2000, Harris and Fallot 2001). Without such a shift in the culture of an organization or service system, even the most “evidence-based” treatment approaches may be compromised.

Cultural competence as a core component of trauma-informed care

Treatment providers must be able to understand the client’s cultural context. Cultural competency includes having the knowledge and skills to work within the client’s culture, understanding how one’s own cultural background and the program influence transactions with the client (Fong and Furuto 2001). Understanding the influence of one’s culture is essential to making an effective therapeutic connection and to being part of the recovery process. The meaning one gives to trauma can vary by culture. Healing takes place within an individual’s cultural context and support network, and different cultural groups may have unique resources that support healing. Cultural competence does not require that every service provider have detailed knowledge of every culture, but rather that he or she recognize the importance of the cultural context. It is often helpful to ask question trying to understand client responses through the lens of culture.

Therefore, the implementation of a culture-sensitive and trauma-informed approach requires a series of steps including appropriate screening and assessments, effective interventions and support, culturally and linguistically competent strategies, strong organisational capacity, including outcome monitoring. However, there is considerable confusion about what constitutes cultural competence. For example, it may be narrowly interpreted to mean better knowledge of the cultural beliefs and practices of a specific cultural group, with little attention to how culture modifies illness perceptions, illness behaviour, and acceptability of specific interventions.

Cultural competency is somehow expected to emerge if the racial and ethnic mix of the workforce is representative of the local population. Not surprisingly, working practices following standardised professional trainings remain similar among staff from different ethnic groups because of the common pattern of training. Indeed, a patient and a health professional, ostensibly belonging to the same ethnic group because of shared country of origin, may actually differ in terms of social class, religious practices, languages, and cultural beliefs about illness and recovery. Despite a growing body of health and educational policies that prioritise cultural competency in health care provision, there is surprisingly little agreement on the meaning of cultural competence.

Recent years have seen the development of professional standards for training and quality assurance in cultural competence (Lopez 1997, Sue 1998). In the case of trauma-informed care this specifically includes the clinician’s ability to elicit cultural information during
the clinical encounter, to understand how the different cultural worlds of patients and their families influence the course of the post-traumatic consequences, and to develop a treatment plan that empowers the patient by acknowledging cultural background and resources while allowing appropriate psychiatric interventions. Cultural competence has to do with knowledge and skills pertaining to a single cultural group, which may include history, language, etiquette, styles of child-rearing, emotional expression, and interpersonal interaction, as well as cultural explanations of illness and specific modalities of healing. Often, it is assumed that specific cultural competence is assured when there is an ethnic match between clinician and patient. However, ethnic matching without explicit training in models of culture and intercultural interaction may not be sufficient to ensure that clinicians become aware of their tacit cultural knowledge or biases and apply their cultural skills in a clinically effective manner. In the course of professional training, clinicians may distance themselves from their own culture of origin and become reluctant or unable to use (or understand the impact of) their tacit cultural knowledge in their clinical work. Clinicians from ethnic minority backgrounds may resent being pigeon-holed and expected to work predominately with a specific ethnocultural group. Patients may have complex reactions to meeting a clinician from the same background.

At the level of services, ethnic match is represented in the organization of the clinical service, which should reflect the composition of the community it serves (Kareem and Littlewood 1992). This is not merely a matter of hiring practices but it also involves creating structures that allow a measure of community feedback and control of the service institution. When people feel a sense of ownership in an institution, they will evince a higher level of trust and utilization. It is important, therefore, for clinicians to understand how the institutional setting in which they are working is seen by specific ethnocultural communities.

Increasingly, clinicians work in settings where there is great cultural diversity that precludes reaching a high level of specific competence for any one group. Changes in migration patterns of immigrants and refugees lead to corresponding changes in patient populations. For all these reasons, it is crucial to supplement specific cultural competence with more generic competence that is based on a broad theoretical understanding of culture and ethnicity.

Generic cultural competence abstracts general principles from specific examples of cultural differences. The core of generic competence resides in clinicians’ understanding of their own cultural background and assumptions, some of which are related to ethnicity and religion, and many of which are derived from professional training and the context of practice. Appreciating the wide range of cultural variation in gender roles, family structures, developmental trajectories, explanations of trauma, and responses to adversity allows the clinician to ask appropriate questions about areas that would otherwise be taken for granted. The culturally competent clinician has a keen sense of what he or she does not know, and has a solid respect for difference in trauma processing.

To challenge the notion of cultural competence a further examination of the core questions pertaining to culture and the patterns of posttraumatic adaptation is required. One important challenge is how to culturally translate the evidence provided in the trauma-informed study field. Another challenge is how to conceive and develop trauma-informed, culturally responsive, and client-friendly approaches. Yet another major challenge facing psychology today is how psychological treatments developed in one country and culture can be transferred to another culture and how this can be translated to a trauma-informed service. To address culture, an increasing number of practitioners and scholars in the trauma field have focused on culture specific interventions emphasizing differences among different cultural groups, rather than making profound revisions of the current approaches to the study of trauma. Another challenge is the creation of trauma assessment instruments that address the multiple cultural realities of clients.

The creation of a culture-sensitive trauma-informed care emphasizes the role of organizational culture because it represents the most inclusive and general level of an agency or program’s fundamental approach to its work. Organizational culture reflects what a program considers important and unimportant, what warrants attention, how it understands the people it serves and the people who serve them, and how it puts these understandings into daily practice. In short, culture expresses the basic values of a program. Culture thus extends well beyond the introduction of new services or the training of a particular subset of staff members; it is pervasive, including all aspects of an agency’s functioning.

In order to accomplish this cultural change, two steps are required:

1) Initial Planning: The program considers the importance of, and weighs its commitment to, a trauma-informed change process. The following elements are key to the successful planning of organizational trauma-informed change: a) administrative commitment to and support of the initiative; b) the formation of a trauma initiative workgroup to lead and oversee the change process; c) the full representation of each significant stakeholder group on the workgroup—administrators, supervisors, direct service staff, support staff, and consumers; and d) identification of trauma “champions” to keep the initiative alive and “on the front burner.”

2) A Kickoff Training Event. Usually two days long, the kickoff training is attended by as many of the staff as practical and includes significant consumer representation; it certainly includes all members of the trauma initiative workgroup. During this event, there are at least three presentations. In the first, central ideas of trauma-informed cultures are presented, emphasizing shifts in both understanding and in practice. Second, the importance of staff support and care is emphasized, ensuring that staff members experience the same values in the organizational culture that consumers need to experience. Finally, a third presentation addresses the importance of trauma in the work of the specific agency (e.g., trauma and substance use, trauma and children or youth, trauma and mental health problems). There is also a great deal of time for the workgroup members and other attendees to discuss the planning process in more detail.

Mental health policy, trauma and culturally informed care

Policy-making can be viewed as involving an authoritative allocation of values. Traumatized individuals incur significant costs; they may not be able to work, may incur debts as well as future lost
health of traumatised individuals. It is important to identify professionals who may promote the mental health of individuals experiencing trauma-focused interventions? It is reasonable to assume that costs will be reduced if trauma-related disorders were treated effectively and long-term conditions prevented.

There is mounting scientific evidence to demonstrate the cost effectiveness of mental health prevention and treatment interventions (Keating and Herzman 1999; Durlak 1998). It is reasonable to assume that costs will be reduced if trauma-related disorders were treated effectively and long-term conditions prevented.

This includes information on the human resources available. For example, what is the role of primary care providers, what training have they received and what competencies do they have? Who supports mothers after childbirth? What is the role of traditional healers? How many specialist mental health workers are available in the country, and do they receive training in trauma-focused interventions? It is important to identify professionals who may promote the mental health of traumatised individuals.

It is also important to understand the attitudes of health workers to the current system and possible changes in the system. The quality of trauma-informed services depends on the knowledge and motivation of these workers. The structure and focus of the existing organization of trauma-informed services should be examined so as to allow identification of its various components and enable eventual benchmarking. An assessment of the prevailing situation should involve gaining knowledge of the full range of settings where clients live, are educated and socialize. Such settings include: clinics, community centres, day programmes, homes, inpatient units, foster care, places of worship, prisons, schools, residential settings and the streets.

To make treatment for traumatised individuals more effective, a public health model must be adopted, a model based on the premise that caring for the health of an individual protects the community – and in turn, caring for the health of a community protects the individual, with society at large reaping the overall rewards.

Recognizing the centrality of trauma is key to accomplishing the overall mission of a new policy framework, promoted by the UK Government, “No health without mental health” (HM Government 2011), a transformed mental health system with the goal of recovery. Convergence of evidence from research studies, including neurobiological and epidemiological studies (Jennings 2004), suggests that the effects of childhood trauma lead to an array of often co-morbid problems (health, mental health, substance abuse, and social). This calls for a transformed mental health system (see criteria in Box 1) characterized by an integrated, rather than separate or categorical, perspective on the origins of mental health, health, and social problems throughout the lifespan; and changes of, and modifications to, current mental health practices, organizational environments, policies, procedures, fiscal mechanisms, workforce development, and services which reflect a shift from an illness/symptom-based model to an injury/trauma model – a shift from asking the question, “What is wrong with you?” to “What happened to you?”

Without such a shift in both perspective and practice, the dictum to “Do no harm” is compromised, recipients of mental health services are hurt and retraumatized, recovery and healing are prevented, and the transformation of mental health care will remain a vision with no substance in reality.

There has been significant growth in the number of countries addressing trauma and in the variety and number of trauma-focused activities initiated. However, mental health systems vary markedly in the degree to which they have adopted emerging best practices in trauma-specific services and in the extent to which their service systems are trauma-informed. The initiation and sustainability of trauma-informed service systems based on an injury or trauma model are at present highly dependent on state mental health leadership and the appointment of senior staff with expertise, responsibility, and accountability for addressing trauma throughout the system. Without such leadership and single point of accountability, systems and practices tend to revert back to the traditional illness/symptom-based model.

Effective policy strategies recommend to conduct national educational campaigns that increase the understanding of trauma and its impacts on health, mental health and social well-being; o raise awareness

### Box 1.

**Criteria for Building a Trauma-Informed Mental Health Service System Policies/Guidelines Regarding the System**

1. **Trauma function and focus government strategies for mental health.** A single, high-level, clearly identified point of responsibility should exist within policy-makers charged with implementing trauma-informed service systems and use of evidence-based and emerging best practices in services.

2. **Government position paper.** A written statewide policy or position statement should be adopted and endorsed. This document should include a definition of interpersonal violence and trauma; make a clear statement about the relationship between trauma, mental health, and recovery; and publicly declare trauma to be a priority health and mental health issue.

3. **Workforce orientation, training, support, competencies and job standards related to trauma.** All human resource development activities should reflect understanding of, and sensitivity to, issues of violence, trauma, and coercion; incorporate relevant skill sets and job standards; and address prevalence and impact of traumatic events.

4. **Linkages with higher education to promote education of professionals in trauma.** Formal, ongoing efforts should be made to collaborate with institutions of higher education to create new trauma-based curriculum, revise existing curricula, ensure the teaching of evidence-based and emerging best practices in trauma, include consumer/survivors as trainers, and incorporate trauma and violence as a core part of the training of all future behavioural health care workers in all disciplines.

5. **Patient involvement and trauma-informed rights.** The voice and participation of service users, should be at the core of all systems activities—from policy and financing to training and services.
of the role of internal and external stigma as it affects the disclosure of childhood abuse experiences and as it exacerbates traumatic impacts over the life span. Policy plans should focus on a single, high-level, clearly identified point of responsibility within a state’s administrative structure, charged with implementing trauma-informed service systems and use of emerging best practices in trauma throughout state supported services and develop a written statewide policy or position statement (NASMHPD 1999) signed by leadership, defining interpersonal violence and trauma; clearly stating the relationship between trauma, mental health, and recovery; and publicly declaring trauma to be a priority health and mental health issue for the state’s mental health system.

A crucial turning point would also be to address trauma and cultural competency in the national strategic social care including refugees, racial and ethnic minorities, and rural populations and with concern for gender, age and developmental phase over the life span.

Health and Social Care should also design service settings and develop collaborative arrangements that support the integration of services used by individuals that have an array of health, mental health, and social problems by incorporating screening for past and present experiences of abuse and trauma for all adults and children at the first point of contact when entering the system of care – regardless of which “door” they enter (primary health care, mental health, substance abuse, criminal justice) and by conducting a trauma assessment of all those who report a history of trauma during initial screening as an integral part of the clinical picture, repeated periodically and used as part of all treatment, rehabilitation, and discharge planning. A life-span perspective should be adopted and, whenever possible, assessment and referral should be conducted by a multi-disciplinary team.

Policy-makers should also encourage research, needs assessments, surveys, and data gathering at a national level to explore prevalence and impacts of trauma; to assess the status of services; to support more rapid implementation of evidence-based and emerging best practice trauma treatment models; and to use as part of an ongoing quality improvement and planning process to ultimately prevent the development of complex trauma disorders and major mental illnesses.

Conclusions

The goal of this article was to increase awareness of the importance of providing trauma-informed care and services and the role of culture to facilitate an effective implementation of such services. Perhaps the best first step for an organization is to train all existing staff, from administrators to clerical workers, on the pervasiveness of trauma and the impact the experience of violence can have on women’s lives (Elliott 2003, Fallott and Harris 2002, Fearday et al. 2001). Input from service users should be part of this process (Brown and Worth 2000). Consumers, administrators, and providers can then work collaboratively to amend procedures to make them more trauma-informed.

Working collaboratively, providers and consumers will continue to discover new ways of helping survivors achieve the quality of life to which they are entitled and to make a better allocation of resources.

Such changes in service delivery point to the next steps in developing and systematically evaluating trauma-informed models. First, these initial principles need to be further defined and operationalized in terms of specific activities and competencies. Then, these activities and competencies need operational measurements that permit consistency of program and provider evaluation across sites. Trauma-informed service implementation can then be evaluated in terms of fidelity to a formal model, following the evaluation approach that has been taken with other complex interventions such as assertive community treatment, integrated services for people with co-occurring disorders, and supported employment. Reliable comparisons of the relative effectiveness of trauma-informed services compared to non-trauma-informed services rest on the development of this specificity in definition and measurement.

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