Trauma-Informed Care in Youth Serving Settings: Organizational Self Assessment **

Directions: Please rate the items listed in the various categories. Please write comments about why you rated items in a particular way on the back side of each page.

This list is meant to be comprehensive and the process of implementing trauma-informed care generally takes multiple years. While implementation of these elements is the goal, the list represents an ideal to strive for.

	How much is this value embraced by your organization? **1=Not at all** **2=Slightly** **3=Moderately** **4=Mostly** **5=Very Much**
Trauma-Informed Care Values The following values underlie all the elements of trauma-informed care listed below. These values underlie the relationships between staff and clients, staff and their peers, as well as supervisory staff and their supervisees. Inherent in these values is the belief that all aspects of the organization's functions should be shaped by consumer involvement and input.	
1. **Safety** – physical and emotional safety.	1 2 3 4 5
2. **Trustworthiness** – creation of a feeling of trust and safety via clear and thoughtfully considered frame and boundaries governing all aspects of the organization's work.	1 2 3 4 5
3. **Collaboration** – inviting, whenever possible, the input of those served by the organization and staff of the organization; providing opportunities for decision-making and innovation.	1 2 3 4 5
4. **Empowerment** -- sharing power with, and giving appropriate authority and decision-making power to, those served by the organization and staff of the organization; maximizing choice and control for the organization's consumers and employees; recognizing and highlighting strengths; looking for opportunities to praise and reward positive behavior; viewing mistakes as learning opportunities.	1 2 3 4 5

**** Significant sections of this assessment were adapted from the work of Fallot, R.D. & Harris, M. (2006). *Trauma-informed services: A self-assessment and planning protocol, version 1.4*. Community Connections: Washington, D.C. (202-608-4796).**

	How much is this element present in your organization? **1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very much**
A. Administrative Support for Program-Wide Trauma-Informed Services	
1. Organizational administrators support the integration of knowledge about violence and abuse into all program practices.	1 2 3 4 5
2. The organization has a "trauma-informed care initiative" (e.g., workgroup/task force, trauma specialist) endorsed by and authorized by chief administrator.	1 2 3 4 5
3. A competent person with administrative skills and organizational credibility is designated to lead this task force.	1 2 3 4 5
4. Administration supports the recommendations of the trauma task force and follows through on these plans.	1 2 3 4 5
5. Administration attends at least portion of trauma training themselves (vs. sending designees in their places); they allocate some of their own time to trauma-focused work (e.g., meeting with trauma initiative representatives, keeping abreast of trauma initiatives in similar program areas).	1 2 3 4 5
6. The adminstration release staff from their usual duties so that they may attend trainings and deliver trauma services.	1 2 3 4 5
7. Necessary sources of funding for trauma training and education are found.	1 2 3 4 5
8. The administration is able to tolerate certain level of organizationsl disruption in making the transition, including such things as staff confusion, conflict within treatment team, resistance to change, and property destruction.	1 2 3 4 5
9. The administration values and rewards staff efforts to be flexible and to offer choices to the clients, even when the result is that the client is not immediately brought under control.	1 2 3 4 5
10. The administration develops a policy statement that refers to the importance of trauma and the need to acknowledge consumer experiences of trauma in service delivery.	1 2 3 4 5
11. The administration celebrates successes.	1 2 3 4 5

	How much is this element present in your organization? (1=Not at all 2=Slightly 3=Moderately 4=Mostly 5=Very)
B. Organizational Structure	
1. Clinically-trained staff are in leadership positions of multi-disciplinary treatment teams and are integrated into the daily life of programs.	1 2 3 4 5
2. In congregate care, organization has an organizational and supervisory structure where clinical and residential staff are integrated into treatment teams rather than belong to separate clinical and residential "silos."	1 2 3 4 5
3. Intake and discharge process are planful, recognizing the important meaning of relationhip beginnings and endings for traumatized children.	1 2 3 4 5
4. Staff schedules are structured such that staff have time to meet, think about, and talk about the work rather than only doing the work.	1 2 3 4 5
5. Staff have regular clinically-oriented supervision, ideally individual supervision, where they can discuss client issues including their countertransference and vicarious traumatization.	1 2 3 4 5
6. Forums (ie. supervision, treatment team meetings, periodic retreats) aimed at helping staff to acknowledge, address, and transform their vicarious traumatization.	1 2 3 4 5
7. Organization makes use of outside consultants who have expertise in trauma when necessary.	1 2 3 4 5
C. Trauma Screening and Assessment	
1. The program has a consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with the client.	1 2 3 4 5
2. Trauma screening is relatively brief, not overly complicated, and avoids unnecessary detail that would increase likelihood of triggering traumatic memories.	1 2 3 4 5
3. The screening process avoids unnecessary repetition of same questions at multiple points in the intake or assessment process. It is often important to return to the questions in treatment after some appropriate time interval.	1 2 3 4 5

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D. Milieu Treatment Practices and Behavior Management (for congregate care settings)	
1. Staff and clinicians routinely think first about the meaning and function of behaviors before deciding how to intervene.	1 2 3 4 5
2. Staff display an attitude of the child "doing the best that they can" rather than assuming intentionality.	1 2 3 4 5
3. Staff use active listening to explore the problem rather than immediately speaking to the child about consequences or solving the problem.	1 2 3 4 5
4. Staff refrain from power struggles with children.	1 2 3 4 5
5. Organization uses of relationship-based behavior management system (such as The Restorative Approach™ *) instead of "point and level" system. Phase system can be used.	1 2 3 4 5
6. During behavioral issues, staff recognize primary goal as helping children to calm down and get back in control of their behavior.	1 2 3 4 5
7. Staff are sensitive to the many ways their interactions with children can trigger shame.	1 2 3 4 5
8. Staff refer to children in descriptive ways and refrain from negative labels (e.g. "manipulative," "resistant," "borderline," etc.)	1 2 3 4 5
9. Staff value flexibility and individualized care in managing behavior rather than strict compliance with rules and treating all children equally.	1 2 3 4 5
10. Multidisciplinary team members function well as a team - manage conflict, care for each other, avoid splits such as therapist/child care worker splits.	1 2 3 4 5
11. Program has thoughtful physical touch policy that recognizes the critical importance of touch for healthy child development and is sensitive to issues of child abuse, allegations of abuse, and re-traumatization.	1 2 3 4 5
12. Staff are willing to talk with their peers and supervisors about their strong positive and negative reactions to clients and doing the work.	1 2 3 4 5
13. Staff feel free to ask their peers for help, or take over for a peer, when there is an impasse in managing a behavioral issue.	1 2 3 4 5

*** The Restorative Approach™ is a trauma-informed behavior management system and an alternative to a "point and level system." For information, contact Klingberg Family Centers, 860-832-5507.**

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E. Physical Environment and Layout of Agency	
1. Space, including waiting and reception area, is welcoming and inviting for clients and families.	1 2 3 4 5
2. Living or program space is nurturing (e.g. colors, plants, music) and affirming (e.g. display of child art/work, culturally competent).	1 2 3 4 5
3. Crisis or "calm down" rooms are safe and soothing places for children to get strong feelings under control.	1 2 3 4 5
F. Clinical Treatment Practices	
1. Utilization of crisis prevention plans (also called safety tools or personal safety plans) written in collaboration with child, family, and possibly previous providers.	1 2 3 4 5
2. Before addressing problem behavior, the team, led by the clinician, considers their understanding of the reasons for the behavior and uses this understanding to determine their interventions.	1 2 3 4 5
3. Treatment planning is built from formulation that considers impact of trauma on client's development and current symptoms/behaviors, and includes goals of developing emotion regulation skills/self capacities as well as healthy attachments.	1 2 3 4 5
4. Family therapy addresses family dynamics, builds parenting skills, and reinforces child's growth and changes.	1 2 3 4 5
5. Staff have an awareness of the role of trauma in the history of parents, and family treatment includes a trauma focus.	1 2 3 4 5
6. Discharge is careful, thoughtful, gradual and includes referral to trauma-informed resources.	1 2 3 4 5
7. Program offers trauma-specific treatments such as: Trauma Focused Cognitive Behavior Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization Reprocessing (EMDR), Trauma, Adaptive, Recovery Group Education and Therapy (TARGET), etc.	1 2 3 4 5
8. Treatment utilizes sensory interventions to help children calm down and teach self-soothing.	1 2 3 4 5
9. Psycho-educational groups about trauma are offered to clients and families.	1 2 3 4 5

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G. Restraint and Seclusion Reduction	
1. All levels of staff are aware of propensity for re-traumatization through restraint and seclusion with traumatized clients.	1 2 3 4 5
2. Restraints and seclusion used only when there is threat of imminent danger.	1 2 3 4 5
3. Staff training focuses on de-escalation techniques to avoid restraint and seclusion.	1 2 3 4 5
4. Staff value avoidance of re-traumatization via restraint and seclusion even if it means less adherence to rules, increased property damage, and longer negotiation time.	1 2 3 4 5
5. Each child has an individual plan stating both medical and psychological risks in restraint which includes specific guidelines for staff actions to avoid.	1 2 3 4 5
6. Organization monitors trends in restraint and seclusion. Increased in restraint/seclusion trigger discussions aimed at understanding and addressing the increases.	1 2 3 4 5
H. Workforce Development	
1. Trauma training is required for staff at all levels and of all disciplines (see "Staff Trauma Training" below).	1 2 3 4 5
2. Staff who display mastery of trauma-informed practice are encouraged, celebrated, and promoted.	1 2 3 4 5
3. Organization promotes a culture of performance improvement, one that understands that mistakes will be made but learning will occur.	1 2 3 4 5
4. Trauma-informed values and concepts are integrated into staff orientation.	1 2 3 4 5
5. Hiring practices screen for staff whose values are consonant with a trauma-informed approach.	1 2 3 4 5

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I. Staff Trauma Training	
1. All staff members receive foundational trauma training with a primary goal of sensitization to trauma-related dynamics and the avoidance of re-traumatization.	1 2 3 4 5
2. Staff members receive training in a trauma-informed understanding of unusual or difficult behaviors. Training stresses concept of symptoms as adaptations.	1 2 3 4 5
3. Staff trauma training also includes topics of: frame and boundaries; relationship building with traumatized children; how to use their responses to particular clients (countertransference); impact of, and how to address, secondary trauma such as vicarious traumatization (VT).	1 2 3 4 5
J. Monitoring Trauma-Informed Initiatives	
1. Organization monitors the progress of trauma-informed care initiative in ongoing way.	1 2 3 4 5
2. Data related to implementation of a trauma-informed approach is collected, monitored, and used for quality improvement.	1 2 3 4 5
3. Organization develops a debriefing process to analyze incidents characterized by conflict, violence, and aggression to inform policy, procedures, and practices in order to avoid such incidents in the future.	1 2 3 4 5

Sources:

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