TRAUMA-INFORMED CARE SCREENING AND ASSESSMENT TOOLKIT

for Community Mental Health and Substance Use Care Organizations and Mobile Crisis Units

NATIONAL COUNCIL *for* Mental Wellbeing

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HEALTHY MINDS STRONG COMMUNITIES

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Introduction

As mental health and opioid crises continue to affect communities of all sizes across the nation, it is imperative that organizations embrace new processes for screening and assessment in mental health and substance use care organizations and mobile crisis units. Understanding the prevalence and impact of trauma is a crucial element in improving engagement and mental health and substance use treatment outcomes in every community.

Trauma is universal, but so are healing, growth, resilience and recovery.

Trauma-informed and resilience-oriented (TIRO) screening and assessment measures provide clear guidance for care organizations and mobile crisis units to support not only the individual receiving services but also the staff delivering care – a trauma-informed team is a team who provides better care both to those they serve and to each other. These measures establish service targets and standardize outcome metrics as part of a larger framework, allowing stakeholders to understand the need for care from a TIRO lens.

This toolkit outlines the trauma screening and assessment process for community-based care organizations and mobile crisis units and the impact of TIRO care. This toolkit can be used by care organizations and mobile crisis units across the state of Indiana. The guidance, tools and resources within this toolkit were collected and created to assist your organization with the foundation to support mental health and substance use care.

OVERVIEW AND KEY TERMS TO UNDERSTAND

Trauma

Trauma is "an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being" (Substance Abuse and Mental Health Services Administration [SAMSHA] 2014, 2019). Traumatic events or circumstances can include: physical, sexual and emotional abuse; neglect, interpersonal violence, community violence, serious injury and illness; and bullying, forced displacement, racism, war, historical trauma and others (National Child Traumatic Stress Network, 2018; SAMSHA, 2016). However, trauma is defined by the individual and their specific experience of the event or circumstance.

Trauma can be pervasive and long-lasting and can have community-wide effects. These effects have the potential to pass through generations and result in historical or cumulative trauma (Stevens, Andrade, Korchmaros, & Sharron, 2015). Historical trauma is identified as the compounding of emotional and psychological wounding from one generation to the next resulting from mass violence such as colonization, genocide, forced migration, racism and slavery (Cerdena, Rivera, & Spak, 2021).

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are potentially traumatic experiences, which also include environmental factors that risk safety, stability and bonding (e.g., substance use problems, mental health problems, and parental separation), that occurred during childhood (0-17). The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study investigated possible childhood traumatic events and the health and wellness of the individuals later in life (CDC, 2021). These ACEs have the potential to increase the level of toxic stress and influence the child's developing brain which can affect how the individual responds to stress throughout their life (CDC, 2021).

The pervasiveness of trauma throughout our country is astounding. The CDC (2019; 2021) reports that about 61% of adults (based on those surveyed) experienced at least one ACE and one in six had experienced four or more. A large-scale, diverse study by Merrick, Ford, and Ports (2018) was conducted identifying the prevalence of ACEs among adults in the United States from 2011-2014. The research data from the study reflected the significant exposure to ACEs, with approximately 61% of adults experiencing at least one ACE and nearly 25% experiencing three or more ACEs. The research indicated that trauma is pervasive regardless of identified factors however, there was a significantly higher rate of exposure of ACEs by those who identified as "Black", "Hispanic", or "Multiracial"; those with less than high school education; those with an income level of less than $15,000 per year, unemployed, or unable to work; and those identifying as gay/lesbian or bisexual (Merrick, Ford, & Ports, 2018).

The original CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study identified the prevalence of adverse experiences in childhood but it also identified the positive correlation between ACEs scores and poor health outcomes. These poor health outcomes include increased risk of mental health and substance use struggles in adulthood including higher rates of depression, suicide attempts, hallucinations and substance misuse. ACEs were also identified as a factor for increased risk of chronic health conditions in adulthood including higher rates of smoking, liver disease, heart disease and chronic obstructive pulmonary disease (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998). Further, adverse experiences in childhood have been linked to an increased risk of a negative impact on future life circumstances such as education, job opportunity and potential earning. ACEs, social determinants of health, historical and ongoing traumas and impacts of poverty can also increase toxic stress which can impact brain development as well as affect learning, attention and decision-making (Sacks & Murphy, 2018).

Resilience

In the literature, definitions of resilience are copious. However, many of these definitions are consistent with a broad understanding of the concept. A broad definition of resilience is "resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress" (American Psychological Association, 2018). Further, the American Academy of Pediatrics (2021) defines resilience as "the process by which the child moves through a traumatic event, utilizing various protective factors for support, and returning to "baseline" in terms of emotional and physiologic response to the stressor." Substance Abuse and Mental Health Services Administration (SAMSHA) (2015) describes resilience as "the ability of a person, family, organization, or community to cope with and adapt to challenges and setbacks." Enhancing resilience can be complex and the application of the concept may look different depending on the context of the individual, family, organization, society or culture. Therefore, when considering resilience, it is important to consider a range of disciplines as well as listen carefully to those who are confronted with the trauma (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014).

Individual factors that contribute to the increase in resilience and hope for adults and protective factors for children include having at least one stable supportive caring relationship, self-regulation and problem-solving skills and positive experiences (Harvard University, 2021). Many other possible protective factors exist however, and depending on the specific individual circumstance the type of protective factor needed may be different. Assessing individual and family protective factors can help organizations support the ongoing enhancement and development of resilience.

Trauma-informed Care

A trauma-informed approach to care incorporates: realization of trauma and the significant effects trauma can have on an individual, family, organization and community; recognizes the signs of trauma; responds universally in a trauma-informed way with practices embedded throughout the entire organization or community; and resists retraumatization that at times can be triggered by unintended stressful and toxic environments. Trauma-informed care shifts the perspective from "what is wrong with you?" to "what happened to you?" and further reflections of "what didn't happen?" This perspective supports not only safety, support and connection but also realizes that there is a neurobiological response to trauma.

Trauma-informed, Resilience-oriented Approach

A TIRO approach to programs, organizations and communities provides an opportunity to improve the quality of services that are provided and the quality of work for the workforce. This includes improvement in areas such as engagement, outcome measures and overall staff wellness (Menschner, 2016). Further, research has shown improvements in access to services (Cullen, Mackean, Walker, Coombes, Bennett-Brook, Clapham, Ivers, Hackett, Worner, & Longbottom, 2021) and retention rates, as well as patient satisfaction (Hales, Green, & Bissonette, 2019). If staff are cared for and also provided with an environment that promotes the principles of TIRO care, the experience they have with their work and the environment (interactions with peers, etc.) can improve. Further, staff wellness is likely to improve the quality of care they provide to individuals receiving services as well as their interaction with other individuals such as co-workers, family and community. Increased staff wellness, quality of services and engagement from individual receiving services as well as promotion of healing and recovery also leads to improved clinical and financial outcomes (e.g., decreased hospital days, decreased staff sick days/turnover).

Principles of Trauma-informed and Resilience-oriented Care

The principles of TIRO approaches can be applied to systems, organizations and communities; however, the implementation may look different depending on where it is applied. When an organization, community or system implements TIRO care — and it is ultimately embedded into the culture — the policies, procedures, processes, decisions and interactions are guided by the six key trauma-informed care principles: 1) safety; 2) trustworthiness and transparency; 3) peer support; 4) collaboration and mutuality; 5) empowerment, voice and choice; and 6) cultural, historical and gender issues.

Safety. The principle of safety reflects that the organization, community or system is promoting physical, psychological, social, cultural and moral safety among staff and individuals whether directly or indirectly. The environment and interactions are important when considering safety.

For example:

- Creating waiting areas, clinical offices or exam rooms that are safe and welcoming.
- Respect for privacy.
- Respect for an individualized experience of safety.
- Creating a space where individuals feel they can communicate needs.

Trustworthiness and transparency. The principle of trustworthiness and transparency reflects the organization, system or community's ability to increase trust through ongoing actions and clear communication. Further, organization, system and community operations, decisions and policies are open, clear, accountable and consistent.

For example:

- Provide clear, direct and understandable information about services provided.
- Maintain consistency in operations and providing information on change.
- Ensure appropriate informed consent.
- Share information in an open honest way (e.g., successes and struggles, problem solving strategies, results of surveys, etc.).
- Be open to questions, concerns and feedback.

Peer support and mutual aid. The principle of peer support and mutual aid supports the value that individuals with lived experience can provide encouragement and assistance to promote recovery and healing. Peer organizations provide a unique perspective of lived experience that can be utilized to provide support, mentoring, education and advocacy. For example, peer organizations facilitate education and groups, provide one-on-one support (mentors, coaches and advocates) and help link individuals to services and transition from treatment facilities, hospitals and jail. Further, peer support workers help individuals engage and stay engaged in the recovery process as well as reduce possible relapse (SAMSHA, 2020). Integration of peer organizations into organizations can offer valuable insight into how services are received and how to improve these services. Peer support has been shown to increase self-esteem and confidence, sense of control, hope and inspiration, empathy and acceptance, engagement in wellness and social support and functioning as well as decrease psychotic symptoms, hospital admissions and substance use and depression (SAMSHA, n.d.).

For example:

- Incorporate peer organizations into the initial phases of organizational contact.
- Include peer organizations in organizational meetings, committees and teams, such as trauma-informed care core implementation teams, safety committees and evidence-based practice areas (e.g., dialectical behavior therapy teams).
- Include peer organization roles within the organization.
- Provide groups within the organization led by peer organizations (e.g., wellness recovery action plans [WRAP]).
- Amplify the voice of lived experience.

Collaboration and mutuality. The principle of collaboration and mutuality reflects the importance of the sharing of power between the organization, workforce and individuals who are receiving services, their family and community. It is important to remember that everyone has a role to play in a trauma-informed organization, system or community and that healing happens in relationships and in sharing decision-making and power. In a trauma-informed, resilience-oriented approach, all voices, regardless of position of power, are important and should be heard.

For example:

- Individuals/clients have a primary role in planning of services.
- Instead of advice, giving support is provided to make decisions that are aligned with an individual's values and beliefs.
- Individuals play a role in evaluation of services.
- Those who are influenced by change are asked about the change from service level to organizational level.

Empowerment, voice and choice. The principle of empowerment, voice and choice includes the promotion of strengths, resilience and the ability for individuals, organizations, sectors/systems and communities to heal and recover from trauma. Further, the complexity of individuals and their needs requires an individualized approach to support safety and quality of care. Creating an environment in which an individual's voice is listened to and their choices are supported offers the space for empowerment and self-advocacy. This space may be valuable to individuals who through previous trauma may have experienced diminished voice and choice. To create this space for empowerment staff does not attempt to control the recovery of the individual but provides support in addressing the individualized needs in the recovery process. Staff also receive the individualized support that they need to feel empowered and safe.

For example:

- Individuals are provided with clear and appropriate messages about their rights, responsibilities and service options.
- Individuals participate and are provided information regarding possible treatment options.
- The organization supports questions, concerns or thoughts. Support can come from opportunities, formalized communication plans and ongoing healthy response to feedback, as well as clear and communicated trauma-informed policies and procedures.

Cultural, historical and gender issues. The principle of cultural, historical and gender issues includes an overall embedding of the principles of diversity, equity and engagement. These principles support the acknowledgement and actively resisting of cultural stereotypes and biases based on race, ethnicity, sexual orientation, age, religion, gender identity, geography, etc., while further providing recognition of the current and ongoing profound impact of historical/intergenerational trauma on individuals, families, organizations, communities and systems. For example,

- Reviewing policies, practices and procedures for consistency with a diversity, equity and engagement perspective.
- Supporting racial and gender diversity in the workplace.
- Providing services that represent cultural humility.
- Offering organizational messages in multiple languages.

Trauma-informed and Resilience-oriented Domains

The pervasiveness of trauma, with varying degrees and types, within our communities as well as how important it is for organizations to realize, recognize, respond and resist retraumatization is well established. The principles of trauma-informed care help organizations to reflect on an overarching framework or "lens" through which policies/procedures/processes, behaviors and interactions are filtered. Further, with the "bi-focal lens" of TIRO, resilience is also reflected in the systems and interactions within the organization. The National Council for Mental Wellbeing's seven domains of a TIRO organization helps provide a framework or guidance on how TIRO care presents in an organization. Organizations can utilize the domains to assess their organization's TIRO implementation as well as provide guidance to the organization on setting goals and performance monitoring. The National Council's seven domains of trauma informed care include:

1. **Early Screening and Assessment:** A screening and assessment process is developed and implemented in a way that is appropriate to the services that are provided, routine, culturally relevant and sensitive, and competently rendered.
2. **Client-driven Care and Services:** Services include engaging the voice of lived experience in many ways throughout the organization. This may include voices from individuals or the family of individuals who have received services from the organization or other organizations. The voice of lived experience is included in a meaningful way in the TIRO team, policies/procedures/processes, committees, quality improvement efforts, etc.
3. **TIRO, Educated and Responsive Workforce:** Organizational communication (direct and indirect; internal and external) offers messaging and reinforcement of the organizational commitment to TIRO care. Further, the organization provides varying forms of learning opportunities (e.g., training and development, meeting agenda items, supervision, community engagement) to improve the delivery of services that are effective, efficient, timely, respectful and person-centered. The organization is committed to education and training on trauma, effects of trauma and TIRO organizations, as well as education and training for clinical staff on trauma and resilience specific research-based treatment models.
4. **Provision of TIRO, Evidence-Based and Emerging Best Practices:** The organizational commitment to education and training supports an organization that is able to provide a wide array of trauma and resilience-specific services. These services are provided in a way that supports and encourages engagement of supports, shared decision-making, collaborative processes and coordination of care among organizations.
5. **Safe and Secure Environments:** The organizational culture reflects a desire to increase safety within the environment through policies, procedures and practices as well as everyday interactions and physical spaces. There is a desire and commitment to increase understanding within the workforce on how to create safe, trusting and healing spaces for both individuals receiving services as well as the workforce. Systems are in place within the organization to monitor and improve

safety (e.g., a safety team). Organizations address alternative strategies to avoid seclusion and restraint, adverse incidents, management of conflict and ongoing commitment to a physical space that feels safe, calm and welcoming. These systems can support the decreased likelihood that the organization will unintentionally cause distress or retraumatize individuals receiving services.

6. **Community Outreach and Partnership Building:** The organization understands the importance of a TIRO approach not only within the organization but also with the larger community. There is a desire to support individuals served by supporting the community understanding of trauma and a TIRO approach. This response may include smaller to larger influences such as conversations at community meetings, community training or educational materials/newsletters/social media, referrals to other TIRO organizations and community-wide coalitions.
7. **Ongoing Performance Improvement and Evaluation:** TIRO data are collected and utilized (areas of improvement and successes), as well as presented (clear and easy to understand) to varying audiences. TIRO metrics are included in the organization's continuous quality improvement processes.

PURPOSE:

For this toolkit, the focus is narrowed from the seven domains above and will be specifically emphasizing TIRO screening and assessment. The purpose of this document is to:

1. Describe the importance of a TIRO screening and assessment process.
2. Describe a TIRO screening and assessment process.
3. Identify key components of a TIRO screening and assessment process.
4. Identify how a TIRO screening and assessment process is conducted, including key questions and critical elements.
5. Summarize tools and resources to support implementation of a TIRO screening and assessment process in mental health and substance use treatment and mobile crisis units.

HOW TO USE THIS TOOLKIT

This toolkit will support community mental health and substance use care organizations and mobile crisis units in the state of Indiana in their assessment or implementation of a TIRO screening and assessment process. The TIRO screening and assessment process framework provides a strategy to assess and implement TIRO within an organization. This toolkit should be utilized within a system wide TIRO implementation. Throughout the toolkit you will be provided with tools and guidance on why, what and how to assess or implement your screening and assessment process in a way that is consistent with the principles of trauma-informed care. The framework outlined in this toolkit is broken down into three major components:

1. **The "Why" of a TIRO screening and assessment process** – it is first important for organizations, those within or external to the organization, to understand why an organization is implementing a TIRO screening and assessment process;
2. **The "What" of a TIRO screening and assessment process** - the need for organizations to understand what a TIRO screening and assessment process is and what it looks like; and
3. **The "How" of a TIRO screening and assessment process** - understanding how the TIRO screening and assessment process is conducted or implemented is essential to implementing the process in a way that truly reflects the principles of trauma-informed care.

Trauma-informed and Resilience-oriented Screening and Assessment Process

WHY?

With the pervasiveness of trauma in our communities, there is a relatively high likelihood that an individual entering treatment, regardless of the entry point, has experienced trauma. The TIRO screening process is critical to developing collaborative relationships with individuals receiving services, especially those who have experienced trauma. At the time of screening and assessment, many individuals will not disclose a trauma history, understand what a trauma history is or connect a history of trauma to their response, current experience or the way they interact with the world. The impact of trauma can present as criteria for differing diagnosis which can lead to potential misdiagnosis, inappropriate or invalidating intervention and decreased quality of care. Further, not recognizing or addressing the symptoms of trauma can lead to decreased engagement in treatment, early termination of treatment, increased risk of relapse and reduced benefit or outcomes (SAMSHA, 2014). The TIRO screening and assessment process moves toward conversations about recovery and resilience, leads to offering appropriate services and offers hope of improved mental health and healing.

A progressive TIRO screening and assessment process can provide an experience for individuals receiving services that decreases stress, thereby increasing an individual's ability to benefit from the services provided and decreasing the potential for retraumatization. A TIRO screening and assessment utilizes the principles of a TIRO approach at each step/stage of the process. The process would include the appropriate pathways to care based on the needs of the individual as well as the individual's voice and choice. Additionally, the utilization of peer support workers as core organizations — in tandem with clinical organizations — supports the process toward recovery and wellness.

WHAT?

A TIRO screening and assessment, as steps in the process, support the provision of quality services. Quality services that reflect the change in perspective from what is "wrong" with you to what "happened" to you or "didn't happen." This is a focus and shift from symptoms and disorder, which may only partially explain what the individual is experiencing to truly reflecting on the experience of the individual receiving services currently and historically. TIRO screening and assessment also supports a preventative approach to treatment, identifying individuals that may be at risk for more severe symptoms of traumatic stress. The process helps organizations identify individuals and families' needs early and tailor services to meet those needs. Both screening and assessment play an important role in TIRO care; however, they are uniquely different.

TIRO Screening. A TIRO screening provides an opportunity to understand, in a general, brief way to detect exposure to traumatic events and symptoms. A screening can help determine whether the person needs a professional, clinical, trauma-focused assessment. A professional does not need to have a specific advanced degree or license to conduct or assist an individual receiving services with a screening. At times, a screening can be completed independently of an administrator. Screening includes information including:

- Trauma history, including type, severity and duration.
- Trauma-related, depression or dissociative symptoms.
- Risk for safety, self or others.
- Concerns with sleep or intrusive experiences.
- Behavioral, interpersonal or developmental concerns.
- Historical mental health diagnosis.
- Substance use.
- Protective factors and resources available.
- Physical health concerns.

The screening process is not a prescriptive process. Each individual is unique, and critical judgement is important. Overall, the screening process may indicate or require further assessment based on the information the individual or family reported.

TIRO Assessment. A TIRO assessment is a more in-depth process on an individual's past and present experiences. The assessment requires a more extensively trained professional which may include advanced degrees, specific licensure or certification, and specialized training. An assessment may include many of the topics identified in the screening assessed at a deeper level. It reflects not only the presence of symptoms but also the severity and impact. An assessment may also include additional topics not included in the screening for a thorough, holistic assessment of the individual. This may include the use of:

- A clinical interview.
- Self-assessment tools.
- Review of medical records.
- Psychological assessments.
- Ancillary information from family or supports, medical organizations, other agencies, etc.

Screening

- Brief
- Does not need specialized degree or license
- Universally used in various settings
- Identify possible exposure to traumatic events, general symptoms, substance use, etc.
- Identify need for further assessment or care

Assessment

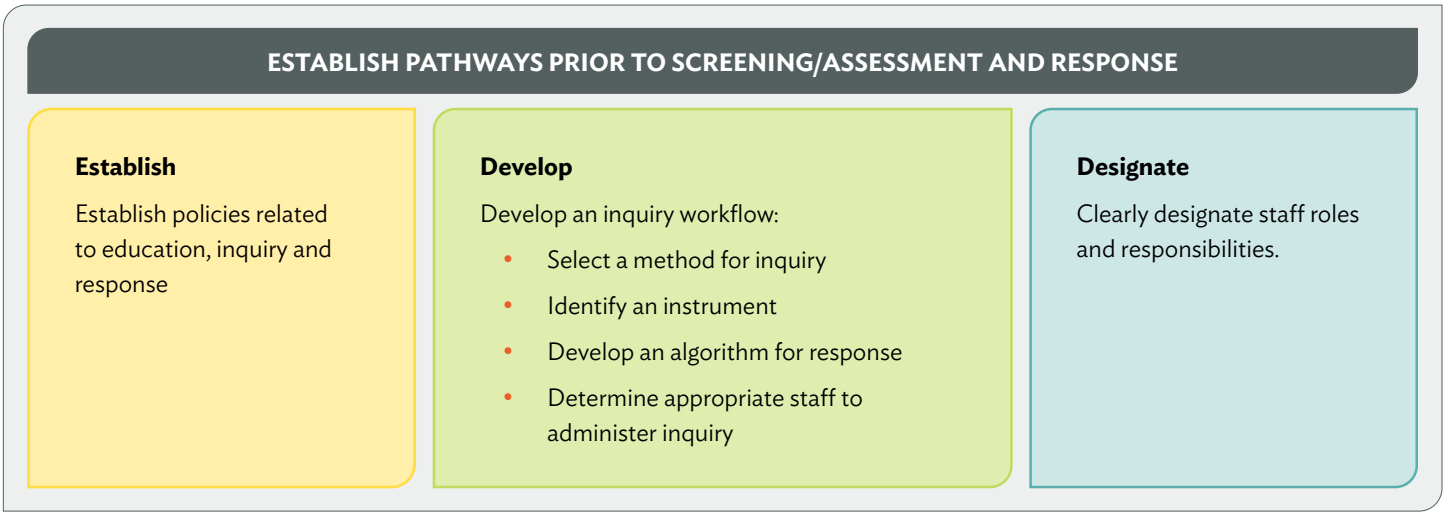
- Comprehensive
- Requires degree/license
- Referred to appropriate organization and setting
- Explore the extent, severity, duration of trauma, symptoms, substance use, etc.
- Identify appropriate pathways to care

A TIRO screening and assessment tool is invaluable to the treatment process; however, it is also important to consider other components of the screening and assessment process. Consider the process starting with TIRO support staff: From the moment an individual or family walks into the building or support staff answer the phone, the process of TIRO screening and assessment begins. The process continues through interaction with access to care staff with risk assessment and screening and then to clinically appropriate ongoing services. These clinically appropriate ongoing services may include a TIRO crisis response, an urgent TIRO assessment, a routine TIRO assessment or a referral out to other TIRO community services/recovery support services. The mental health professional completes a TIRO assessment and makes recommendations for services based on risk, medical

necessity/level of care, as well as need. The individual is assigned to an ongoing TIRO therapist and/or case manager based on recommendations, medical necessity/level of care, need and individual voice and choice. The therapist and/or case manager completes further assessment and a TIRO person-centered plan. A TIRO peer support professional follows the individual or family throughout each step/phase of the screening and assessment process and ensures understanding of the process and provides support when needed. When the individual or family is assigned to the ongoing worker, the TIRO peer support professional begins the process of recovery check-ins as part of the person-centered treatment plan.

HOW?

How organizations complete the TIRO screening and assessment process can influence whether or not individuals benefit from the services provided, continue with services or even return after the first contact. Thinking about a critical organizational change process may include consideration and assessment of organizational processes and accountability measures and what to start doing, stop doing and do more of. Organizations can begin the process of implementation by creating a plan for the screening and assessment process in the organization, establishing policies and procedures, determining the pathways to care, as well as designating and training staff. Establishing clear TIRO pathways to care will support individuals receiving services, as well as the workforce, within and after the screening/assessment process.



Consider these key questions during planning, implementation and evaluation of organizational TIRO screening and assessment process:

1. **Are the policies and procedures related to screening and assessment in place and TIRO?**

   Understanding and developing policies and procedures around the TIRO screening and assessment process — including the workflow, tools, roles of the workforce and training — is vital to implementation. Further, it is important to have ongoing evaluation of the policies and procedures related to the screening and assessment process. This may be based on feedback received from the workforce or individuals or families receiving services or alignment with the TIRO principles. The Principles Assessment Tool can assist in answering this question for your policies and procedures.

2. **Are the tools that I am utilizing TIRO?**

   There are many TIRO screening and assessment tools available. When an organization is considering what screening and assessment tools to utilize, consider the quality of the tool, how well it meets the needs of the target population and how well it fits within the organization's service delivery system.

When determining the quality of the tool that your organization is considering incorporating into the TIRO screening and assessment process, it is important to examine validity, reliability and standardization and norms. Validity is the degree to which the tool, including each of its specific items, accurately accomplishes its purpose (i.e., whether the specific tool measures what it is intended to measure). Reliability is the degree to which the tool is consistent across time and different raters. Standardization of norms includes a process during the development of the tool that allows for comparisons between data from the screening/assessment tool with general populations of the same age group.

It is also important to weigh the following criteria to measure whether the screening and assessment tools make sense for the organization:

- How well do the tools meet the needs of the target population?
- How well do the tools fit within the organization's service delivery system?
- Does your organization serve adults, youth and/or families?
- Are the tools culturally appropriate for the target population?
- Why does your organization have contact with the individual or family, what services will you be providing and in what specific setting(s) will they be located (e.g., community mental health organizations, criminal justice system, educational settings, occupational settings, physician's office, hospital medical and trauma units, emergency rooms, etc.)?
- What method, written or verbal, would be most appropriate?
- Who will conduct the screening or assessment, do they have the appropriate training and is it within their scope of practice?

3. **Are staff sufficiently trained in TIRO approaches?**

Training in TIRO approaches is invaluable at all levels of the organization in each and every role. The screening and assessment process incorporates many individuals within the organization, in person, on the phone and telehealth options, all of which play a role in TIRO. It is important that as an organization, there is an ongoing commitment to TIRO training for the entire workforce. This may also include supporting training for the community.

Further, depending on the services provided within the organization, it may be important for the organization to consider accessibility of clinicians trained in TIRO evidence- based practice.

All staff should be trained in accordance with the TIRO Training Plan to better understand the why, what and how of TIRO screening and assessment.

4. **Are there clearly defined TIRO action steps/pathways based on results of screening and assessment?**

As discussed, understanding and developing policies and procedures around the determined TIRO screening and assessment process including the workflow, tools and roles of the workforce, and training is vital to implementation. Further, it is important to know what are the pathways to care post screening and assessment. What is the plan for response? What is the appropriate level of care/medical necessity? Is it most appropriate to refer to a community organization? Are the community organization networks, trauma-informed? Is a TIRO evidence-based practice most appropriate and is it available? Is the organization incorporating peer support?

5. **Are there accountability measures in place, for continuous quality improvement purposes, to determine if screening and assessment is being done in a trauma-informed manner and if the individual(s) receiving services feel the process is trauma-informed?**

Organizations should consider accountability measures that provide valuable information as to how aligned the process is with the principles of trauma-informed care and if individuals and families receiving services from the organization feel that the process is trauma-informed. This includes determining which measures are monitored, how feedback from individuals and families are received and who within the organization is tracking this information and supporting the continuous quality improvement process?

TIRO Screening and Assessment Critical Elements

Within TIRO screening and assessment, there are many critical elements. These critical elements support trauma-informed principles in the screening and assessment process (safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment voice and choice; and cultural, historical and gender issues)

Receive permission. Receive permission and offer the space for an individual to discuss or disclose trauma while supporting voice and choice in how and if they wish to share this information. Provide a rationale for talking to the individual or family about trauma and why a universal screening and assessment is valuable as well as explain how the information that you gather will be used.

Tempo and pacing. The tempo and pacing of the assessment process is important to consider. As the clinician it may be important to be aware of the tempo of the information sharing process. Reassure the individual or family of the opportunity to participate in the process in the future and the importance of processing in a way that is healthy and therapeutic (which may be with a different ongoing clinician). In addition, the clinician offers space to share and does not encourage avoidance or reinforce that discussing trauma-related material is dangerous. However, moving forward with trauma-related material slowly, safely processing in a grounded way.

Re-engage and reassess. Re-engage and reassess trauma throughout the treatment process for all individuals. Many individuals and families will choose not to share this information in the initial screening and assessment process. Therefore, it is important to reassess.

The use of language. It is important that organizations are aware of the effects of the words used and how this plays a role in an individual's response to treatment, including retraumatization, activation and stress response. Continuously consider up-to-date language in areas such as gender and sexuality, substance use concerns and suicide. Also, consider organizational policy and procedures related to linguistics and differing levels of reading and writing ability. This is especially important when providing independent and/or written screening and assessment tools.

Collaborative approach. It is important that there be a collaborative approach during the assessment process. While the clinician holds a body of knowledge that the individual receiving services does not, the individual has an understanding outside the scope of the practitioner. Both must collaborate and learn from each other for the best outcomes.

Additionally, utilizing a collaborative approach to documentation has been shown to improve patient satisfaction, clinical outcomes and engagement. Further, collaborative documentation strategies have been shown to decrease lengths of treatment episodes, and the process provides immediate patient feedback (Lloyd, 2004; Maniss & Pruit, 2018). The collaborative approach can also improve the accuracy of the record through the immediate feedback. Collaborative documentation allows the opportunity to exhibit transparency and for an individual(s) receiving the service to actively participate in their own record. While this process has been shown to support positive outcomes, it is also important to remember that organizations should use clinical judgement when utilizing collaborative documentation strategies as it may not always be appropriate.

Special Considerations in the TIRO Screening and Assessment Process

The workforce. The workforce response plays an important role in the screening and assessment process. Consider utilizing peer and family support services in this process. The workforce needs to be trained in trauma, response to trauma, cultural competence and humility and how to ask about trauma in a trauma-informed way. Further training and use of motivational interviewing, collaborative documentation and shared decision-making can improve engagement in the assessment process. It is possible that there are many organizations that have experienced ACEs and/or experienced trauma or secondary trauma while in their organization role. Training in managing individual levels of distress may also support organizations' ability to maintain health in their role. Increased learning can ultimately influence the response that organizations have to individuals and to the disclosure of traumatic experiences. It is important that organizations lead with compassion, are aware of verbal and non-verbal responses, as well as offer support and appropriate responses to individuals during the screening and assessment process.

The peer workforce. It is important that organizations are integrating peer-based roles. This includes integrating peers into the screening and assessment process. Utilizing peer recovery specialists, certified peer specialists and peer support specialists provide mutual support to individuals receiving services utilizing a shared understanding of lived experience. While the roles and services provided by peer roles vary across organizations, services provided may include outreach and support, education, recovery planning and coaching, linking to services, etc. There are quite a few national resources available to provide support to organizations planning to incorporate peers into their work.

- SAMHSA's Bringing Recovery Supports to Scales Website
- Meaningful Roles for Peer Providers in Integrated Healthcare
- CCBHC Peer Services Organizational Self-Assessment
- Role Clarity in Peer Recovery Support Services: Navigating the Terms
- Supervision of Peer Practice: The Challenges and Opportunities for Organizations with Peer Recovery Support Services Programs
- Supporting Recovery from Opioid Use: A Peer's Guide to Person-Centered Care (Online Course)
- Cultural Humility Primer: Peer Support Specialist and Recovery Coach Guide
- Peer Support Toolkit - City of Philadelphia, Dept. of Behavioral Health & Intellectual Disability Services
- Hiring Guidelines for Peer Specialists
- Peer Support Specialist Interview Questions
- Certified Community Behavioral Health Clinics, Peer-Delivered Services And Peer-Operated Agencies: Opportunities for Collaboration And Expansion

In addition, The Peer Network Indiana provides resources for the state of Indiana, including a peer certification program. Further, organizations will need to have peers trained through WRAP and supervisors trained in trauma-informed supervision as well as peer supervision. Peer roles can play a significant role in engagement and recovery of individuals receiving services, and organizations need to utilize the resources available to make sure that peer roles are meaningfully employed and supported in the work that they do.

Address cultural and gender issues. When providing services, recognition of the current and ongoing profound impact of historical/intergenerational trauma on individuals, families, organizations, communities and systems is essential. It is important to understand that history and intergenerational trauma influence experience of the services provided and not addressing this or allowing space can influence an individual or families engagement with services.

Cultural competence is often language used when discussing cultural and gender diversity in health care. Cross, Bazron, Dennis, and Isaacs (1989) set a foundation for work in cultural competence, in which, organizations have a clearly defined, congruent set of values and principles and demonstrate behaviors, attitudes, policies, structures and practices that enable them to work effectively

cross-culturally. Since this seminal work, many changes have occurred in the research/work on the concept and practical application of cultural competence. For example, the U.S. Department of Health and Human Services Office of Minority Health, 2013 National Standards for Cultural and Linguistic Competency in Health and Health Care furthered a framework and structure for organizations in exhibiting cultural and linguistic competency. Further, additional research has reflected on the importance of cultural humility.

Cultural humility is another way to understand and develop a process-oriented approach to competency. Cultural humility is different than cultural competency in that it is a process which includes humility to engage in self-reflection and critique – being reflective and an ongoing learner; humility with a desire to fix power imbalances where none ought to exist and patient-focused care and humility in aspiring to develop partnerships with people, groups and communities to advocate for others (Tervalon & Murray-Garcia, 1998). Greene-Morton and Minkler (2019) and Isaacson (2014) reflect that one cannot "achieve or fail" cultural competence, yet it is something that one continues to grow in knowledge in the communities that one works or interacts with. Further, cultural competence and cultural humility together provide professionals with tools to interact with diverse populations. Cultural diversity may include language, religion, race, sexual orientation, gender, age and ethnicity. For example, consider the importance of cultural competency and cultural humility related to gender diversity, including having a basic competency in gender diversity while also remaining humble as an organization, being active in self-reflection and self-critique, leading with genuine curiosity, utilizing a collaborative approach and creating space for autonomy in sharing (Sadusky & Yarhouse, 2020).

HOW TO ASSESS: CULTURALLY SENSITIVE TRAUMA-INFORMED CARE
Questions Providers Should Ask

LISTEN for variations in understanding. Ask:

- What is your understanding of what's happened?
- What is worrying you the most?
- What does your family think about it?

BE OPEN to involving other professionals. Ask:

- Whom do you normally turn to for support?
- Who else should be involved in helping your child?
- Are you open to outside referrals and resources?

RESPECT different communication practices. Ask:

- Who typically makes the decisions about your child?
- What information should be shared with your child?
- Is there anyone else you would like me to talk to?

Virtual Screening and Assessment. In recent years, telehealth and virtual services have increased in frequency, and the COVID-19 pandemic increased this frequency exponentially. While many characteristics of TIRO screening and assessment process in-person are similar to telehealth, there are also many unique characteristics of TIRO screening and assessment process with telehealth. For example, creating a safe and secure environment may look different for telehealth.

Within the TIRO screening and assessment process, creating a safe and secure environment is a primary concept. Creating a safe and secure environment is important for staff and the individuals served (children, adults and families) to feel physically, psychologically, socially, culturally and morally safe. This is an environment where the physical setting is safe and the interpersonal interactions promote a sense of safety. It is also important to create mutually respectful interpersonal climates that foster safety, trust, choice, collaboration and empowerment. To create safe, trusting and healing environments, the policies, procedures and practices that may unintentionally cause distress or retraumatize individuals (workforce or those receiving services) are examined and changed. Areas to consider in your virtual work related to creating safe and secure environments, specifically screening and assessments, include:

ADJUSTMENT AND FLEXIBILITY

- When responding to virtual changes.
- Very important when abrupt changes occur, during transitioning and during screening and assessment process.
- When technological challenges occur.
- When considering the length and frequency of sessions.

LEGAL AND ETHICAL

- Training on legal and ethical obligations when delivering services virtually.
- Federal/State rules (interjurisdictional practice and mandated reporting).
- Utilization of platforms.
- Supporting workforce in ethical considerations and dilemmas.
- HIPPA and secure platforms.
- Informed consent.

TECHNICAL AND CLINICAL COMPETENCE

- Gaps in organization competencies.
- Training for in-person may not necessarily translate to virtual, specialized training.
- Training with the utilization of online tools, whiteboards, share screen, emergency health record tools, evidence-based practice tools and apps.
- Understanding how to connect relationally on a virtual platform.

CONFIDENTIALITY

- Continue to maintain confidentiality in a virtual space.
- Reinforce confidentiality with virtual platforms.

WORKFORCE TRAINING/MEETING

- Virtual connection to maintain continuity of care.
- Continue trainings and supporting staff remotely, including supervision.

STAFFING AND DEBRIEFING

- Debriefing for remote staff.
- Policies and procedures updated to meet current situation.

CLINICAL APPROPRIATENESS

- Crisis and risk.
- When In-person services are needed.

CRISIS PLAN

- Have a crisis plan in place.
- Policy and procedures with remote staff, telehealth and crisis situations:
- What is the procedure if an individual receiving services is in crisis while staff are on telehealth?
- Who supports remote staff to connect with 911 or other crisis contact?
- Crisis connection procedures for non-clinical staff, warm hand off.
- If a crisis occurs, clinicians are trained and provide an immediate assessment for suicidality and homicidality via telehealth.

INDIVIDUAL RECEIVING SERVICES AND CLINICIAN PRIVACY

Individual receiving services

- Have a safe and private location.
- Discussion and communication about privacy.
- Discuss and create a plan for interruptions.

Clinician

- Have a safe and private location.
- Discuss safety, home details, pets, etc.
- Maintain boundaries and therapeutic relationship.
- Maintain individuals receiving services confidentiality.

HOW TO ASSESS: CULTURALLY SENSITIVE TRAUMA-INFORMED CARE

Questions Providers Should Ask

LANGUAGE:	IDENTITY:	DATA:	AVOID:	TERMINOLOGY:
Use language that is respectful of culturally and linguistically diverse communities, first person terminology.	Use specific ethnic group(s) identity term to the extent possible, avoid gendered terms when possible.	When providing demographic and statistical information, share disaggregated data and collection methodologies noting limitations.	Avoid any language that could be misunderstood as blaming or degrading, e.g., "dysfunctional families."	Use terms such as "family member" or "care provider" instead of "mom or dad" to interrupt hetero-normativity and other assumptions about family structures.

VIRTUAL PLATFORM CONSIDERATIONS:

- Video vs. phone.
- Technology requirements.
- Digital equity: access to internet and technology.
- Use guides with visuals.
- Don't assume. Make explicit, even the small stuff.
- Technology can be a struggle for even the most confident. Be ready to navigate frustrations and other feelings in yourself and others.
- Age doesn't apply: Age does not indicate capacity to lead or retain learning via a virtual platform.
- Offer frequent breaks.
- Be mindful of adult learning theory and attention on virtual platforms.
- Utilize virtual "hallways"/"break rooms"/"calming rooms" depending on the topic.

INFUSE TRAUMA-INFORMED APPROACHES INTO YOUR DAILY WORK:

1. Be patient and persistent. People are not necessarily going to open up immediately about their past traumas. Be persistent in being there and listening. It helps to establish safety and security and builds trust.
2. Convey respect. Be respectful in your responses and interactions.
3. Validate and affirm feelings.
4. Read the individual receiving services needs and respond accordingly.
5. Help set realistic expectations and goals.
6. Provide ongoing choices and supports. Remember this is their life and their journey. Choosing what services and supports they receive, who they receive them from and when they receive them.
7. Know your role. You are there to help and guide, not to do things for them. Know the limits of the role.
8. Follow through with what you say you will do. In order to build trust and safety, follow through with what you say you are going to do. If something happens that you were unable to do something, be transparent.
9. Provide consistency and minimize surprises. There is nothing worse than surprises to make a survivor feel unsafe and less secure. Surprises may trigger the human stress response, therefore retraumatizing individuals receiving services.

Clarify expectations -- Remain matter of fact yet supportive -- Respect personal space -- Adjust tone/volume of speech -- Culturally appropriate symbols -- Emphasize personal control -- Choice of organization gender -- Right to refuse any/all questions -- Allow time and space -- Avoid phrases that imply judgement about trauma -- Provide results of tools used

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Appendix

THE NATIONAL COUNCIL FOR MENTAL WELLBEING'S SEVEN DOMAINS OF TRAUMA-INFORMED, RESILIENCE-ORIENTED CARE (TIROC)

The National Council's Seven Domains of Trauma-Informed, Resilience-Oriented Care model is built on the following core values and principles reflected in a trauma-informed, resilience-oriented organization:

- Safe, calm and secure environment with supportive care for all
- System wide understanding of trauma prevalence and impact, resilience, equity and trauma-informed, resilience-oriented care
- Cultural competence, cultural humility, diversity, equity and engagement
- Person-served and staff voice, choice and self-advocacy
- Recovery, person-driven and trauma-specific services and supports
- Healing, hopeful, honest and trusting relationships

DOMAIN 1 – *Early Screening and Comprehensive Assessment:* Develop and implement a respectful screening and assessment process that is routine, competently delivered, culturally relevant and sensitive.

DOMAIN 2 – *Person-Driven Care and Services:* Involve and engage people who are or have been recipients of services to function in numerous roles in organizations and to meaningfully participate in planning, implementing and evaluating improvement efforts.

DOMAIN 3 – *Trauma-Informed, Resilient, Educated and Responsive Workforce:* Increase awareness, knowledge and skills of the entire workforce to deliver services that are effective, efficient, timely, respectful and person-centered. Implement equitable policies, procedures and practices that build and sustain a trauma-informed, resilient and diverse workforce.

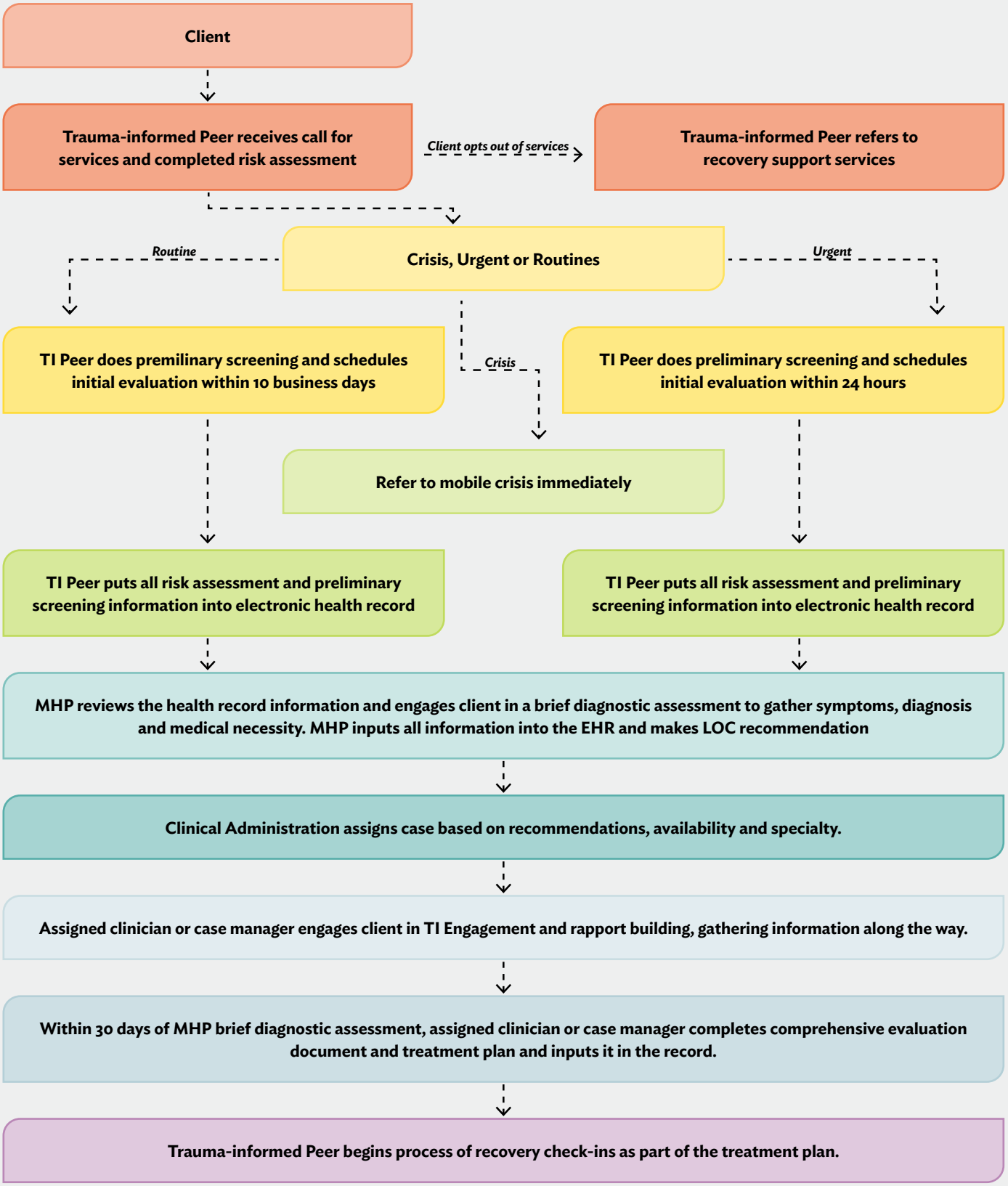
DOMAIN 4 – *Providing of Trauma-Informed, Resilience-Oriented Evidence-Based and Emerging Best Practices:* Increase awareness, knowledge and skills of the clinical and peer workforce to deliver research-informed treatment and supports services that address effects associated with trauma and honor the core principles of trauma-informed, resilience-oriented care.

DOMAIN 5 – *Create Safe and Secure Environments:* Increase the awareness, knowledge and skills of the workforce to create safe, trusting and healing environments. Examine and change policies, procedures, and practices that may unintentionally cause distress and may retraumatize those served and those that serve.

DOMAIN 6 – *Engage in Community Outreach and Partnership Building:* Recognize that the people served are part of and affected by other systems, and thus assume a leadership role in educating and engaging partners in trauma-informed, resilience-oriented care.

DOMAIN 7 – *Ongoing Performance Improvement and Evaluation:* Ensure a system is in place to measure performance in each domain. Track, analyze and utilize data to address challenges and reinforce progress.

TRAUMA-INFORMED, RESILIENCE-ORIENTED PROGRESSIVE SCREENING AND ASSESSMENT PROCESS



TIRO Principles Assessment Tool

Tool Purpose: The TIROC Principles Assessment Tool is designed to assist organizations in examining policies, practices, procedures, and outcomes against the trauma-informed, resilience-oriented care principles.

Tool Completion: The TIRO Principles Assessment Tool should be completed by the team that is responsible for the policy, procedure, practice or outcome that is being examined.

Tool Directions: Examine each policy, practice, procedure or outcomes answering the following questions for each principle:

1. Are there points in the process where this principle is not honored?
2. Where is this process could the principle be operationalized?
3. How could it be operationalized?

SAFETY

This policy, protocol, procedure or document:

- Emphasizes value for psychological, social, cultural, moral and physical safety for everyone, including adapting usual approaches, if needed.
- Reinforces listening to member's histories without judgment.

Are there points in the process where this principle is not honored?	Where in this process could the principle be operationalized?	How could it be operationalized?

TRUST AND TRANSPARENCY

This policy, protocol, procedure or document:

- Recognizes trust is something that is earned over time, so persons served and staff may not disclose information until a relationship is established.
- Recognizes persons served and staff may "test" relationships, because they may have been hurt by people or systems in the past who were supposed to guide or protect them.
- Recognizes persons served and staff may be sensitive to interactions or communications that do not include them.
- Recognizes that persons served may anticipate that staff will not follow through with commitments or agreed upon plans.

Are there points in the process where this principle is not honored?	Where in this process could the principle be operationalized?	How could it be operationalized?

PEER SUPPORT

This policy, protocol, procedure or document:

- Emphasizes leadership development of staff and persons served as leaders in planning, implementation, continuous quality improvement, and evaluation activities for services and organizations that they are involved with
- Recognizes the need for peer support, volunteerism and service provision by individuals that have experienced trauma and/or addictions.
- Recognizes the need for trauma-informed peer supervision and support in addition to clinical supervision for individuals providing services who have experienced trauma and/or addictions

Are there points in the process where this principle is not honored?	Where in this process could the principle be operationalized?	How could it be operationalized?

COLLABORATION AND MUTUALITY

This policy, protocol, procedure or document:

- Recognizes relationships matter and demonstrates interest in peoples' histories and current life circumstances.
- Establishes an expectation staff will work together with persons served to create a plan that embraces strengths and further learning rather than dictating a plan to change behavior.
- Establishes an expectation that staff will work to minimize power differentials when possible.

Are there points in the process where this principle is not honored?	Where in this process could the principle be operationalized?	How could it be operationalized?

EMPOWERMENT, VOICE AND CHOICE

This policy, protocol, procedure or document:

- Redefines persons served "problems" as coping strategies or adaptations.
- Recognizes persons served strengths and anticipates areas where persons served need to build skills.
- Recognizes persons served 1) may often feel like they cannot be successful and 2) require their strengths to receive more emphasis and attention.
- Recognizes persons served are often told what to do and how to do it, so they may have a hard time believing their choices and opinions matter to others.
- Recognizes a "one-size-fits-all" approach can make persons served feel discounted.
- Demonstrates persons served and staff choices are important and valued.
- Recognizes that in the past, some persons served may have been told 1) what they think does not matter and 2) to do things that make them feel uncomfortable or unsafe.

Are there points in the process where this principle is not honored?	Where in this process could the principle be operationalized?	How could it be operationalized?

RESPECT FOR CULTURAL, HISTORICAL AND GENDER DIFFERENCES

This policy, protocol, procedure or document:

- Emphasizes the need to move past cultures stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography.)
- Recognizes the impact of historical trauma on how persons served access and experience services.
- Recognizes the role culture plays in how persons served access and experience services.
- Recognizes the need to offer gender responsive services
- Recognizes the need to ensure diversity, equity and engagement in all processes, procedures, protocols and interactions

Are there points in the process where this principle is not honored?	Where in this process could the principle be operationalized?	How could it be operationalized?

Trauma Screening and Assessment Tools

Trauma Assessment for Adults - Self-report (TAA)

Resnick, Falsetti, Kilpatrick, & Freedy, 1996

Description: The 17-item self-report Trauma Assessment for Adults (TAA) examines different types of stressful life events. It assesses 14 life events such as combat exposure during military service, physical or sexual assault, surviving a serious car accident, and others stressful events using a yes/no format. Each life event endorsed asks about presence of injury ("yes" or "no"), perception of danger ("yes" or "no"), and ages when it happened (first and last time). The TAA is appropriate for clinical or research purposes.

Sample Item:

- Have you served in the military in a war zone, or had military combat experience?

To Obtain Scale

Heidi Resnick, PhD
Department of Psychiatry and Behavioral Sciences
National Crime Victims Research and Treatment Center
171 Ashely Ave.
Charleston, SC 29425-0742

Measure availability: Information on measures is available to everyone. However, the assessment tools themselves can only be distributed to qualified mental health professionals and researchers.

Trauma History Screen (THS)

Carlson, Palmieri, Smith, Kimerling, Ruzek, & Burling, 2009

Description: The Trauma History Screen (THS) is a brief, 13-item self-report measure that examines 11 events and one general event, including military trauma, sexual assault, and natural disasters. For each event, respondents are asked to indicate whether the event occurred ("yes" or "no") and the number of times something like this happened. For each event endorsed, additional dimensions are assessed, including age when it happened, a description of what happened, whether there was actual or a threat of death or injury, feelings of helplessness and feelings of dissociation, a four-point scale for duration of distress ("not at all" to "a month or more") and a five-point scale for distress level ("not at all" to "very much"). The THS is suitable both for clinical and research purposes, and can be administered to a wide population with its low reading level, use of common language, and simple responses.

Sample Item: A really bad car, boat, train, or airplane accident (yes or no). Number of times something like this happened.

To Obtain Scale: This measure was created by staff at the VA National Center for PTSD. To obtain this scale complete the online request form.

Measure availability: Information on measures is available to everyone. However, the assessment tools themselves can only be distributed to qualified mental health professionals and researchers.

Trauma History Questionnaire (THQ)

Green, 1996

Description: The Trauma History Questionnaire (THQ) is a 24-item self-report measure that examines experiences with potentially traumatic events such as crime, general disaster, and sexual and physical assault using a yes/no format. For each event endorsed, respondents are asked to provide the frequency of the event as well as their age at the time of the event. The THQ can be used in both clinical and research settings, and is available in English and Spanish.

Sample Item:

- Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)? ("yes" or "no", number of times, approximate age)
- Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?

To Obtain Scale

Bonnie L. Green, PhD
Department of Psychiatry, Georgetown University
2115 Wisconsin Ave., N.W., Suite 120
Washington, DC 20007
Email: bgreen01@georgetown.edu
Available for download at http://ctc.georgetown.edu/toolkit*

Measure availability: Information on measures is available to everyone. However, the assessment tools themselves can only be distributed to qualified mental health professionals and researchers.

Life Events Checklist for DSM-5 (LEC-5)

Frank W. Weathers, PhD; Dudley D. Blake, PhD; Paula P. Schnurr, PhD; Danny G. Kaloupek, PhD; Brian P. Marx, PhD; & Terence M. Keane, PhD

Description: The Life Events Checklist for DSM-5 (LEC-5) is a self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. The LEC-5 assesses exposure to 16 events known to potentially result in PTSD or distress and includes one additional item assessing any other extraordinarily stressful event not captured in the first 16 items.

Formats: Three formats of the LEC-5 are available:

- Standard self-report: to establish if an event occurred
- Extended self-report: to establish worst event if more than one
- Interview: to establish if Criterion A is met

Administration: For each item, the respondent checks:

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Download the Life Events Checklist for DSM-5:

- Standard self-report (PDF)
- Extended self-report (PDF)
- Interview (PDF)

Measure availability: Information on measures is available to everyone. However, the assessment tools themselves can only be distributed to qualified mental health professionals and researchers.

Traumatic Events Questionnaire (TEQ)

Vrana & Lauterbach, 1994

Description: The 11-item Traumatic Events Questionnaire (TEQ) assesses 9 events such as experiencing a serious accident (industrial, farm, or car), receiving news of serious injury or death of someone, and being a victim of physical or sexual abuse. It also allows for an unspecified traumatic event to be examined.

For each event endorsed, respondents are asked to provide the frequency, age at the time(s) of the event, degree of injury, degree of life threat, degree of how traumatizing the event was at the time, and degree of how traumatizing the event is currently. A 7-point scale (1 = "not at all" to 7 = "extremely") is used for each of the degree questions. The TEQ is suitable for research and clinical purposes.

Sample Item: Have you witnessed someone who was mutilated, seriously inured, or violently killed? (How many times? How old were you at the time? Were you injured? Did you feel your life was threatened? How traumatic was this for you at that time? How traumatic is this for you now?)

Versions: The military version includes three additional items that examines serving in a war zone (e.g., being a Prisoner of War and observing or participating in atrocities).

To Obtain Scale

Scott Vrana, PhD
Dept. of Psychology, Virginia Commonwealth University
Natchitoches, LA 71457
Email: srvrana@saturn.vcu.edu

Measure availability: Information on measures is available to everyone. However, the assessment tools themselves can only be distributed to qualified mental health professionals and researchers.

Primary Care PTSD Screen (PC-PTSD)

Prins, Ouimette, & Kimerling, 2003

Description: The PC-PTSD is a four-item screen that was designed for use in primary care and other medical settings, and is currently used to screen for PTSD in Veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale Instructions: In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to? ☐ Yes ☐ No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ☐ Yes ☐ No
3. Were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No
4. Felt numb or detached from others, activities, or your surroundings? ☐ Yes ☐ No

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

To Obtain Scale: Download the Primary Care PTSD Screen (PDF)

Measure availability: Information on measures is available to everyone. However, the assessment tools themselves can only be distributed to qualified mental health professionals and researchers.

PTSD Checklist for DSM-5 (PCL-5)

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. 2013.

Description: The PCL-5 is a 20-item questionnaire, corresponding to the DSM-5 symptom criteria for PTSD. The wording of PCL-5 items reflects both changes to existing symptoms and the addition of new symptoms in DSM-5.

It has the following purposes:

- Monitoring symptom change during and after treatment
- Screening individuals for PTSD
- Making a provisional PTSD diagnosis

Several important revisions were made to the PCL in updating it for DSM-5:

- PCL for DSM-IV has three versions, PCL-M (military), PCL-C (civilian), and PCL-S (specific), which vary slightly in the instructions and wording of the phrase referring to the index event. PCL-5 is most similar to the PCL-S (specific) version. There are no corresponding PCL-M or PCL-C versions of PCL-5.
- Although there is only one version of the PCL-5 items, there are three formats of the PCL-5 measure, including one without a Criterion A component, one with a Criterion A component, and one with the LEC-5 and extended Criterion A component.
- The self-report rating scale is 0-4 for each symptom, reflecting a change from 1-5 in the DSM-IV version. Rating scale descriptors are the same: "Not at all," "A little bit," Moderately," "Quite a bit," and "Extremely."
- The change in the rating scale, combined with the increase from 17 to 20 items means that PCL-5 scores are not compatible with PCL for DSM-IV scores and cannot be used interchangeably.

The information in this document is taken from PTSD: National Center for PTSD http://www.ptsd.va.gov/index.asp

Trauma-Informed, Resilience-Oriented Staff Training Plan

PURPOSE

This Trauma-Informed, Resilience-Oriented Screening and Assessment Training Plan establishes basic trainings that all staff involved in screening and assessment processes need to complete before engaging in the progressive process. The following objectives have been established for this plan:

- Educate all staff on trauma, its prevalence and impacts
- Provide all staff with tools and strategies for implementing a trauma-informed, resilience-oriented approach to screening and assessment
- Connect trauma, health and addictions for all staff

STRATEGY AND APPROACH

The training developed by the National Council are available for all care providers and mobile crisis units to use with their staff. Trainings can be provided at one time or broken down into different mini-trainings. Information from the trainings can also be provided in a virtual format. If the trainings developed by the National Council are not used, the topics listed below should be covered in the trainings for staff.

TRAINING TOPICS

For training to be effective, all staff should receive general training in the foundations of the following:

SESSION 1: Trauma and Equity 101

Description: To Understand resilience and how to build an equitable practice, one must first understand the impact of trauma and the role of resilience in our lives. This learning session will provide participants with and overview of trauma, how it impacts our functioning, and how we can start healing through a TIRO and equity lens. Participants will be able to:

1. Understand why to address trauma and equity now
2. Describe the principles of trauma-informed, resilience-oriented care

Download Link: Trauma and Equity 101

SESSION 2: Intergenerational Trauma and its Impacts

Description: Research indicates that not just trauma, but intergenerational trauma specifically has an overwhelming impact on individuals, communities and systems, though it is often overlooked in screening, assessment and treatment. This learning session will provide participants with a shared definition and understanding of intergenerational trauma, its impacts and strategies for recognizing and acknowledging it in trauma-informed, resilience-oriented ways. Participants will be able to:

1. Explain how systemic, cultural and intergenerational trauma manifests itself in clients
2. Explain how systemic, cultural and intergenerational trauma manifests itself in staff
3. Describe strategies for addressing manifestations of intergenerational trauma in trauma-informed, resilience-oriented ways.

Download Link: Intergenerational Trauma

SESSION 3: Trauma and its Connection to Health and Addiction

Description: Addressing trauma is now the expectation, not the exception, in community agencies. It is equally vital that we understand and build resilience in conjunction with understanding the impact of trauma. The combination of an individual's experience of trauma and resilience impacts every area of human functioning — physical, mental, behavioral, social and spiritual. Workers and community providers are expected to view the people they serve through the trauma-informed, resilience-oriented lens and to competently intervene in this area. The good news is that trauma is treatable and organizations can become trauma-informed and resilience-oriented in order to best meet the needs of the people they serve. Participants will be able to:

1. Understand the prevalence and impact of trauma, including understanding findings from the ACE study
2. Be aware of the neuro/bio/psycho/social impact of trauma and addictions
3. Explain the connection between behavior and trauma and ways to intervene with those we serve in a trauma-informed, resilience-oriented manner

Download Link: The Connection between Trauma, Health and Addiction

SESSION 4: Combatting Compassion Fatigue

Description: A key component to providing quality services is ensuring we are also providing ourselves and our staff with all the resources to be the most effective workforce. In order to do that, we need to make sure we address compassion fatigue and moral injury through TIRO supervision practices. In this learning session we will explore what is compassion fatigue, the role TIRO Supervision pays in building a resilient workforce and specific tools we can use with ourselves and our staff to provide them resources and tools to address compassion fatigue. Participants will be able to:

1. Define compassion fatigue
2. Explain the role TIRO Supervision plays in addressing compassion fatigue
3. Describe three strategies for combatting compassion fatigue

Download Link: Compassion Fatigue

SESSION 5: Creating Safe Spaces for Trauma-Informed Engagement

Description: Going to the top of the inbox can be difficult to manage during the best of situations, but what happens when you are trying to engage colleagues and external stakeholders during an international pandemic? This workshop will provide a brief overview on how anxiety can impact our general functioning, our functioning in crisis, and different strategies you can use to adapt your engagement style to maximize your time and increase your connection and goal achievement. By the end of this webinar, participants will be able to:

1. Recognize the impact anxiety has on general functioning
2. Identify two engagement strategies you can implement to increase the likelihood of connection
3. Learn how to engage others using a compassionate approach

Download Link: TIRO Engagement

SESSION 6: Trauma-Informed Physical Assessment

Description: Earning trust and building positive relationships with patients are essential pillars of a trauma-informed approach to build a therapeutic relationship. There are several policies and practices providers and organizations can apply that help foster open communication, trust and sense of safety between providers and patients. A trauma-informed physical exam infuses the principles of trauma-informed care throughout the appointment and helps level the power differential between provider and patient, as well as guides providers to conduct physical exams in a manner that will not lead to retraumatization. For patients with histories of trauma, it can be reassuring to know what will happen during the exam and why. Join us to :

1. Understand the components of a trauma-informed physical exam
2. Explore the elements of collaborative documentation
3. Manifest safety through prioritization of conversation and attunement

Download Link: TIRO Physical Assessment

SESSION 7: Addressing Crisis in a Trauma-Informed Manner

Description: General concerns and anxieties can be difficult to manage during the best of situations, but what happens when you are trying to manage them in a crisis state. Understanding trauma, our stress response state and its impact is the first step to beginning to foster resilience through this crisis. Building resilience in the workforce, and regulating yourself and others, is key to adapting to the challenges ahead. When we combine our understanding of the stress response with resilience practices we can change the way we intervene in crisis to produce better outcomes for everyone. Participants will be able to:

1. Understand how to identify someone in a stress state
2. Identify steps to achieve emotional regulation and one's own level of arousal
3. Identify two interventions you can implement to respond to crisis in a Trauma-Informed manner

Download Link: Addressing Crisis in a TIRO Way

SESSION 8: Trauma-Informed Peer Support

Presenter: Elizabeth Burden

Description: Peer support is one of the core principles of a trauma-informed approach; it is also central to recovery-oriented systems of care. This session brings the two concepts together, examining how peer work furthers the aims of trauma-informed organizations and systems, and how trauma-informed principles inform peer practice. Participants will be able to:

1. Define trauma and trauma-informed care
2. Describe the impact of trauma on peer support participants
3. Compare how the core principles of recovery-oriented peer practice align with those of trauma-informed approaches
4. Explain what it means to engage participants in trauma-informed peer recovery support services

Download Link: Trauma-informed Peer Support