Webinar Q&A: Implementing Trauma-Informed Care into Organizational Culture and Practice

Event Date: October 30, 2017

Responses from Ken Epstein, PhD, Director, Child, Youth and Family System of Care, San Francisco Department of Public Health

1. ***Where does spirituality fit in to your work? How do we care for the mind, body, and spirit?***
   Spirituality is one of many resources that aids resilience and recovery. We encourage individuals to explore spiritual and cultural beliefs and practices, and to integrate into their lives those that enhance their well-being, resilience, and recovery. In particular, we have been piloting integrating mindfulness into our organizational structure at the San Francisco Department of Health (SFDPH). We are in the process of adapting generic mindfulness practices to better represent the cultural, spiritual and religious diversity of our organization. This will include incorporating practices that are indigenous to cultural and racial groups within the department. Finally, we have embraced the process of healing circles for staff following local and national traumatic events. These healing circles are facilitated, sometimes involve drumming, and at others a more talk-oriented approach.

2. ***How do you keep leadership engaged? Have you experienced any push-back from leadership and, if so, how have you proceeded?***
   Engaging leadership is the holy grail of being able to sustain and promote a healing organization. In my experience, leaders stay engaged when there is pressure from three places: first, from within the highest levels of the organization; second, from the champion staff members; and finally, from their leadership peers (which can cause a healthy competition).

   Engaging leadership involves an initial engagement, as well as the creation of learning communities within the organization and ongoing practices to ensure engagement. Implementing trauma-informed practices into organizational culture takes time, commitment, and continuous reflection and cultivation of growth. We encourage leadership engagement through our peer support network—the *Trauma-Informed Systems (TIS) Leadership Learning Community*—that connects leaders working to build trauma informed systems with each other. The TIS Leadership Learning Community allows for leaders from across SFDPH to learn from each other, share successes and challenges, and receive support and encouragement. This helps create a structure that fosters growth and maintains momentum. It also offers leaders the opportunity to troubleshoot obstacles within their organization that may impede efforts. We have found the Leadership Learning Community to be instrumental in maintaining engagement and success.

3. ***What is the financial investment needed to initiate and maintain this work?***
   This will be different in each organization. For SFDPH, we started with a simple idea, which is to develop something that would be hard to cut for financial reasons. That would mean that it is inexpensive, and embedded in existing structures. In our organization, the only positions dedicated to this work are a TIS program coordinator, an administrative staff member, and a psychologist who only works part-time. We started by developing a 101 training, and once established, our developers created a "train-the-trainer" program. This involves training existing staff to train their peers or departments. In addition, we have focused on embedding the changes into existing meetings and initiatives. To train and implement at the Department of Public Health (which has 9,000 employees), our budget was around $250,000. Additionally, we accounted for the expense of additional staff time. For smaller nonprofits, the costs are likely much less.

4. ***Once you do the initial training, do you offer any ongoing training? If so, what is the focus of the trainings?***
   TIS 101 follow-up trainings include: (1) train-the-trainer sessions; (2) cultural equity trainings; and (3) a champion and leadership learning collaborative. Organizations might also consider creating specialized trainings based on the needs of individual teams or departments, such as trainings on vicarious trauma or nonviolent communication.

5. ***How has implementation science strengthened your organization's approach to change management?***
   Through implementation science, we learned that knowledge alone would not lead to sustained change. We therefore built a model in which our Trauma 101 training would be preceded and followed by coaching and support to evaluate, initiate, and stabilize change within organizations. These components include Champion and Leadership Learning Collaboratives, which are composed of selected practitioners working to lead change, the TIS self-study, assessment tools to monitor change efforts, and policy and practice development to integrate TIS and healing into the workplace. These efforts have led to policy and practice changes within our organizations that sustain trauma-informed and healing workplaces, and increased confidence in staff that the initiative will not be abandoned. Additionally, since our first training in 2014, the number of organizations that have received TIS trainings has grown exponentially, and an increasing number of organizations are requesting assistance in implementing TIS at their workplaces.

6. ***How do you address staff trauma?***
   Addressing staff trauma is paramount to our model and approach. We believe we cannot effectively provide trauma-informed care if our staff and organizations within SFDPH are experiencing the effects of trauma. We work to: (1) build knowledge about the signs and symptoms of trauma within one's self and others; (2) integrate resources for resilience and recovery into the workplace (such as wellness breaks, creating peaceful spaces, incorporating mindfulness meditation practices into meetings, and providing information on resources for support such as employee assistance programs); and (3) encourage staff to connect to resources outside of work that foster resilience and recovery (such as meditation, yoga, exercise, hanging out with friends, taking vacation, and having a healthy work-life balance).

7. ***How do you engage skeptics for a trauma-informed approach?***
   This is a great question. Skeptics exist everywhere, and skepticism is one of the organizational symptoms that we are addressing. Our work is to constantly be front and center and communicate openly and transparently. For some, data helps to overcome skepticism; and for others, seeing tangible activities and results is helpful; and for still others, it is constant communication. We speak to successes and connect staff who are skeptical with staff and organizations that have experienced the benefit of implementing TIS. One important thing to keep in mind is that people want to feel better, be more productive, and be more engaged. It is the trauma in the system that has become a barrier to this. Engaging skeptics is what this organizational change is all about.

8. ***Can you share the commitment to change document, evaluation tool, and the application for champions?***
   Links to the commitment to change document and application for champions can be found below.

Responses from Rahil D. Briggs, PsyD, Director, Pediatric Behavioral Health Services, Montefiore Medical Group

1. ***How often do you screen adults for ACEs?***
   Our current workflow recommends screening patients aged 18 years and older **only once** with the ACEs questionnaire, as it asks about events that happened prior to age 18. We are in the process of evaluating initial screening data to determine if this is the best workflow.

2. ***Are you willing to share your ACEs screening tool?***
   Please click on the following links to view Montefiore's ACEs screening forms, offered in English and Spanish, for adult patients and parents of infants and children. English | Spanish

3. ***Any advice for those working at organizations that are not able to do warm hand-offs?***
   For organizations that do not have integrated behavioral health clinicians who can do warm hand-offs, we recommend that primary care providers develop working relationships with the local behavioral health practices within their geographic area to which they may refer patients. For example, organizations can invite the leadership of the local behavioral health practices to present on their services to the primary care practice, and identify a person with whom the primary care practice can communicate if patients have difficulty securing appointments at the local behavioral health clinic.

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ADDITIONAL RESOURCES

- ACEs Screening Cover Letter and Questionnaire: These materials from Montefiore Medical Group in the Bronx provide guidance about ACEs screening and an ACEs questionnaire for parents of infants, parents of patients 1-17, and patients 18 and older. English | Spanish
- Commitment 2 Change & Trauma-Informed Systems Principles: These documents from the San Francisco Department of Public Health helps staff think about how to integrate a trauma-informed focus into their everyday work.
- Trauma-Informed Systems Champions Learning Collaborative: This document includes a fact sheet and application for the San Francisco Department of Public Health's 12-month training program to develop trauma-informed champions.