



RESEARCH REPORT

# Early Adopters of Trauma-Informed Care

An Implementation Analysis of the Advancing Trauma-Informed Care Grantees

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# Executive Summary

**This report describes six organizations' efforts to become more trauma-informed, based on 69 interviews with staff and other stakeholders in 2017. These six organizations were selected to participate in a pilot demonstration as part of the Advancing Trauma-Informed Care (ATC) initiative led by the Center for Health Care Strategies and funded by the Robert Wood Johnson Foundation. Through this initiative, these organizations received grant funding and participated in a two-year learning collaborative allowing them to share insights with each other and receive technical assistance from national experts.**

The six ATC organizations were all located in low-income neighborhoods of major cities and served patients deemed by interviewees to have high rates of traumatic experiences. Four organizations provided primary care and behavioral health services on site, one was a local public health department, and another was a partnership of organizations that included a children's hospital and a school with on-site therapists. Most of these organizations had experience delivering health care services in a trauma-informed way and were using their ATC grants to incrementally build on earlier efforts.

The six ATC organizations worked to make organizational cultures more trauma-informed; educated staff about trauma and the impact of exposure to adverse experiences on patient behavior; and encouraged staff to engage in more "self-care" to prevent vicarious trauma and staff turnover. Some organizations also increased their use of patient questionnaires to identify patients with a high number of adverse childhood experiences (ACEs) who could benefit from additional services, and some organizations began offering new trauma-specific services to their patients.

***Changing organizational culture.*** Three grantees tried to change their organizational cultures by encouraging staff to adopt principles from the Sanctuary Model or a customized trauma-informed model developed by the organization. Interviewees recognized that organizational change is a long process that requires being nimble, and all three of these organizations were constantly innovating and learning from past missteps. A barrier to culture change was the hierarchical structure of the organizations. Interviewees also acknowledged that not everyone in the organization was on board with change.

***Training and hiring.*** All six grantees offered periodic training to their staff on how to be more trauma-informed, often with outside consultants helping to develop the curricula and in-house staff

members delivering at least some trainings using a “train-the-trainer” model. Attendees praised interactive components such as clinical vignettes and role-playing exercises aimed at improving patient encounters. Interviewees said that trainings were especially valued by staff with less clinical training, for whom the content was more likely to be novel, and helped staff better understand certain patient behaviors and gave them a common language and skills to help de-escalate patients who are triggered. Trainings offered only to staff with a particular job title were described as tailored to their audience, but trainings offered to all staff were viewed as promoting empathy between different types of staff.

**Promoting staff self-care.** Two grantees focused on promoting self-care to prevent staff burnout, and other grantees touched on this topic in their trainings. Most grantees also surveyed staff to assess their levels of professional burnout. Organizations promoted self-care in two ways: by promoting activities that people could do on their own to reduce stress (e.g., breathing exercises, venting to a colleague, going for a walk), and by making structural changes aimed at promoting staff wellness (e.g., adding a “meditation minute” to the start of staff meetings, offering a quiet room for meditation, offering yoga classes for staff). Many interviewees said they did not adopt new self-care techniques after trainings, but appreciated grantees’ efforts to promote self-care. Interviewees reported that primary care staff were more resistant to self-care than behavioral health staff because of cultural differences between these two professions. A few staff reported that self-care techniques recommended by their organization did not always include all the techniques favored by staff—promoting meditation but not praying, for example.

**Screening for early adversity and trauma.** Two grantees encouraged staff to give patients questionnaires to identify their number of ACEs. Patients who self-reported at least four ACEs were offered the opportunity to meet with an on-site care coordinator or a behavioral health provider during or after their primary care appointment. Other grantees used less systematic approaches to uncover this information, such as building relationships with patients over time. Most grantees also screened at least some of their patients for depression, anxiety, or post-traumatic stress disorder.

**Delivering trauma-responsive services.** Interviewees at several grantee organizations noted that patients prefer to receive talk therapy from therapists located in their primary care practice, as opposed to therapists based in other locations—in one case, even if that meant being put on a waiting list for a few months. Interviewees also noted that sometimes patients “aren’t ready” for talk therapy and prefer creative arts therapies (e.g., dance movement therapy, art therapy) or group therapy focused on practical skills (e.g., regulating emotions, more productive ways of communicating) because these interventions don’t require participants to relive past traumas. Interviewees mentioned some universal

precautions they take with patients, such as using a welcoming, respectful, and gentle tone of voice; creating a calm office environment; and explaining procedures to patients in advance.

***Involving patients.*** Most grantees had standing patient advisory committees, but some interviewees worried that the patients in these committees may not fully represent the patient population's views. One grantee had addressed this concern by shortening the terms for patient advisors to six months, to ensure the committee heard a continuous stream of fresh perspectives. A few grantees collected patient input from a broader set of patients through focus groups or a survey, but grantees rarely collected anonymous patient feedback. Interviewees at several organizations thought they could be doing more to gather meaningful input from patients, but patients we interviewed were effusive in their praise of the ATC grantees.

***Facilitators and barriers.*** Interviewees reported that their efforts were facilitated when organization leadership strongly supported these activities; when middle management was involved in implementation of the activities; when staff were given the freedom to innovate, learn from failures, and revise approaches based on lessons learned; when skilled therapists were available on site to participate in warm handoffs from primary care providers; and when staff were released from clinical duties to participate in new activities such as trainings and meetings. Barriers included staff resistance to change; organizational hierarchies and power dynamics that can inhibit open exchange of ideas; not collecting enough patient input on the services patients actually want to use; lack of accountability when staff fail to make good faith efforts to engage in new trauma-informed efforts; pressure to see many patients a day to meet productivity targets; reliance on grant funding for organizational transformation and lack of stable funding sources for some services (e.g., screenings, social work case management, alternative therapies).

# Introduction

Over the past few decades, the adverse short- and long-term impacts of trauma on individuals, families, the health care system, and society have received increasing attention (Davis and Maul 2015; Felitti et al. 1998; Raja et al. 2015; SAMHSA 2014a; Shonkoff et al. 2012). Trauma is defined by the US Substance Abuse and Mental Health Services Administration (SAMHSA) as an “event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (SAMHSA 2014a). Events that cause trauma include intentional acts, such as sexual assault, intimate partner violence, witnessing or being the victim of acts of violence, and combat, as well as unintentional acts, such as experiencing catastrophic accidents and natural disasters.<sup>1</sup> Exposure to trauma is widespread, affecting people from different backgrounds throughout their lives (Marsac et al. 2016).

Population estimates of the prevalence of exposure to childhood trauma vary based on their definitions of traumatic experiences, but one often-cited study of patients in an HMO found that over half of adults had some type of trauma in childhood and 25 percent were exposed to two or more types of traumatic experiences (Felitti et al. 1998). In a larger, more recent study in five states, 59 percent of adults reported at least one adverse childhood experience (ACE), and 37 percent reported at least two such experiences (CDC 2010). Research on ACEs has also demonstrated the prevalence of trauma among children today. According to a nationally representative survey from 2011, 22 percent of children ages 17 and younger had experienced two or more traumatic experiences (e.g., child abuse, child neglect, household dysfunction, extreme economic adversity; Bethell et al. 2014).

People also experience traumatic events as adults. In a multicountry study that measured a wide array of traumatic events, 79 percent of Americans reported experiencing traumatic events sometime in their lifetime (Scott et al. 2013).<sup>2</sup> Exposure to trauma and to different types of trauma also varies across populations based on race, age, income, educational attainment, veteran status, and other characteristics (SAMHSA 2014b).

People exposed to traumatic experiences respond in different ways depending on individual risk and protective factors, the specific type of trauma, the person’s age when the event occurred, the event’s recurrence, and other factors. Not all exposures to trauma produce a clinical traumatic stress reaction such as post-traumatic stress disorder (PTSD). PTSD is estimated to affect 8 percent of the US adult population, but prevalence varies across population groups; women, people with low incomes,

people with low educational attainment, and veterans report higher rates of PTSD than other groups (APA 2013; SAMHSA 2014a).

Exposure to multiple categories of ACEs is also linked to a number of health risk factors later in life. Specifically, experiencing four or more types of ACEs increases the risk of alcoholism, drug abuse, depression, suicide attempts, smoking, sexually transmitted disease, physical inactivity, and obesity, relative to patients with no ACEs, and increases the likelihood that patients will report being in poor health overall (Felitti et al. 1998). A recent European study found that people with more ACEs may be more likely to die prematurely (Kelly-Irving et al. 2013). Among children, exposure to ACEs is linked to lower rates of school engagement and higher rates of chronic disease in childhood (Bethell et al. 2014). The multicountry study of trauma mentioned above also found that people who had experienced traumatic events over their lifetimes had greater rates of chronic physical medical conditions (Scott et al. 2013).

Researchers are still trying to understand why exposure to ACEs is associated with increased risk of physical and behavioral health problems; so far, they have found correlations (but not causal links) between ACEs and impacts on the brain. Exposure to ACEs or other forms of maltreatment have been found to be associated with underdevelopment of the parts of the brain responsible for interhemispheric communication and executive functioning, which allow people to engage in cognitive tasks including sustained attention; memory; organizing and planning; task initiation and focus; emotion regulation; and sensory, motor, and emotional functions (Child Welfare Information Gateway 2015). Exposure to ACEs has also been found to be associated with the body's ability to appropriately release stress hormones such as cortisol, which can affect cognitive processes and the immune system.<sup>3</sup> Changes to brain structure and chemical activity can affect behavioral, social, and emotional functioning; for example, patients can experience a persistent state of fear and hyperarousal (meaning nonthreatening stimuli are misinterpreted as threatening), develop anxiety or depression, or experience intellectual impairment (Child Welfare Information Gateway 2015).

Children and adults who have been exposed to trauma may also have adverse responses to the health care system, hindering its ability to meet their needs. These responses may occur among people with PTSD and among people with subclinical responses to trauma. Some people may be retraumatized in dealing with the health care system, and past exposure to trauma may make it difficult for patients to keep scheduled appointments and comply with proposed treatment plans. Understanding how trauma has affected patients' lives and their interactions with and perceptions of the health care system is fundamental to structuring a health care system that responds to these patients' needs and promotes better physical and mental health outcomes.

In recent years, there has been growing interest in improving the way care is delivered to patients who have had traumatic experiences, by making organizations more “trauma-informed.” According to SAMHSA, a “trauma-informed” organization “realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.”<sup>4</sup> One group of experts has suggested that the “key ingredients” of a trauma-informed approach to care include both organizational and clinical activities (table 1).

**TABLE 1**

**Key Ingredients for Creating a Trauma-Informed Approach to Care**

Organizational	Clinical
<ul style="list-style-type: none"> <li>▪ Lead and communicate about the transformation process</li> <li>▪ Engage patients in organizational planning</li> <li>▪ Train clinical as well as nonclinical staff members</li> <li>▪ Create a safe environment</li> <li>▪ Prevent secondary traumatic stress in staff</li> <li>▪ Hire a trauma-informed workforce</li> </ul>	<ul style="list-style-type: none"> <li>▪ Involve patients in the treatment process</li> <li>▪ Screen for trauma or its symptoms</li> <li>▪ Train staff in trauma-specific treatment approaches</li> <li>▪ Engage referral sources and partnering organizations</li> </ul>

**Source:** Christopher Menschner and Alexandra Maul, “Key Ingredients for Successful Trauma-Informed Care Implementation” (Hamilton, NJ: Center for Health Care Strategies, 2016), exhibit 1, [http://www.chcs.org/media/ATC\\_whitepaper\\_040616.pdf](http://www.chcs.org/media/ATC_whitepaper_040616.pdf).

The Robert Wood Johnson Foundation’s Advancing Trauma-Informed Care (ATC) initiative is administered by the Center for Health Care Strategies and aims to better understand how to practically implement trauma-informed approaches across the health care sector. The ATC initiative has three components: (1) two-year pilot demonstration grants, which were awarded to six trailblazing organizations to allow them to build on earlier efforts in this area; (2) a learning collaborative for these and other similar organizations, convened quarterly to allow organizations to learn from each other and from national experts; and (3) one-on-one technical assistance provided by national experts such as Sandra L. Bloom and Allison Briscoe-Smith.

This report presents findings from a qualitative analysis of efforts implemented by the six ATC-funded organizations as they worked to become more trauma-informed. These efforts typically involved changing organizational culture to be more trauma-informed, educating staff about how exposure to traumatic experiences can affect patient behavior and how to address this, and encouraging staff to engage in more “self-care” to prevent secondary or vicarious trauma from causing staff burnout or turnover. Some organizations also increased their use of patient questionnaires to identify patients with a high number of ACEs so that additional services could be offered to those

patients. The six ATC organizations were all located in low-income neighborhoods of major cities and served patients perceived by interviewees as having high rates of trauma. These organizations had experience delivering health care services in a trauma-informed way and were using their ATC grants to incrementally build on past efforts (table 2).

**TABLE 2**

**Summaries of Six ATC Organizations' Efforts to Become More Trauma-Informed**

<b>Organization</b>	<b>Activities</b>
Women's HIV Program at University of California, San Francisco	<ul style="list-style-type: none"> <li>▪ Train staff on effects of trauma, strategies for communicating with traumatized patients, and prevention of vicarious trauma among staff who serve such patients</li> <li>▪ Convene all-provider meetings before clinic to review patient needs and support staff</li> <li>▪ Carefully match patients to the psychosocial services likely to be most helpful to them, from an array of services available on and off site</li> <li>▪ Colocate a licensed clinical social worker to offer on-site therapy to patients</li> <li>▪ Offer a new group therapy intervention that emphasizes skill building over disclosure of traumatic experiences for patients who aren't ready for traditional talk therapy</li> <li>▪ Solicit input from staff and patients on practice plans through monthly meetings</li> </ul>
Center for Youth Wellness San Francisco, CA	<ul style="list-style-type: none"> <li>▪ Strengthen integration between this behavioral health services practice and its colocated FQHC by embedding care coordinators in the FQHC to receive warm handoffs of referred patients</li> <li>▪ Train staff on the effects of trauma and vicarious trauma and strategies to prevent staff burnout</li> <li>▪ Establish new protocols for screening patients, planning treatments, and conducting family conferences; cultivating emotional balance; and instilling cultural humility in clinical staff</li> <li>▪ Convene discussions at the executive level about how best to proceed with efforts to make the organization more trauma-informed</li> </ul>
San Francisco Department of Public Health San Francisco, CA	<ul style="list-style-type: none"> <li>▪ Provide three-hour mandatory trainings on building a trauma-informed organizational culture ("Trauma 101") for all 9,000 staff</li> <li>▪ Hold quarterly meetings among agency leaders to develop strategies to align policies and procedures to be trauma-informed</li> <li>▪ Convene "champions" from different divisions to help them identify and implement customized, systematic, trauma-informed changes in their organizations</li> <li>▪ Give champions training on trauma-informed systems; coaching on organizational change, project implementation, evaluation, and participatory decisionmaking; and opportunities to share lessons learned with each other</li> <li>▪ Survey staff about organizational culture to help champions identify areas in need of improvement</li> <li>▪ Provide racially focused cultural humility training (including introductory and train-the-trainer sessions and an annual conference), developed with Ken Hardy</li> </ul>

Organization	Activities
Greater Newark Healthcare Coalition <sup>a</sup> Newark, NJ	<ul style="list-style-type: none"> <li>▪ Train BRICK Avon Academy teachers on student behaviors that may suggest exposure to trauma and how children exposed to trauma learn differently</li> <li>▪ Train pediatric residents at a local hospital on ACEs, the biology of adversity, and ways to improve daily interactions with patients</li> <li>▪ Embed a social worker therapist at Avon to treat students from kindergarten through fourth grade through one-on-one, parent-child, and group therapy</li> <li>▪ Create a therapeutic classroom at Avon for students to attend for weeks at a time</li> <li>▪ Convene a range of Newark organizations to brainstorm approaches to educate the public about the effects of trauma on children, develop the workforce available to treat such children, and develop concrete services and interventions for these children</li> </ul>
Montefiore Medical Group New York, NY	<ul style="list-style-type: none"> <li>▪ Train staff in 22 primary care practices on ACEs screening, the impacts of trauma on patient behavior, strategies for de-escalating interactions with agitated patients, and self-care to prevent staff burnout</li> <li>▪ Assist practices in increasing the share of their patients they screen for ACEs</li> <li>▪ Deploy a newly formed Critical Incident Management Team to counsel practices after they have experienced a traumatic event (e.g., a shooting)</li> <li>▪ Develop waiting room posters to educate patients about the importance of behavioral health treatment for traumatic experiences</li> </ul>
Stephen and Sandra Sheller 11th Street Family Health Services Philadelphia, PA	<ul style="list-style-type: none"> <li>▪ Work to promote organizational healing and a more mindful culture by completing Sanctuary Model certification</li> <li>▪ Convene all-staff meetings to emphasize and institutionalize core Sanctuary principles</li> <li>▪ Form an “Undoing Racism” committee that meets monthly to discuss racism and identify approaches to combat structural racism</li> <li>▪ Encourage self-care among staff through mindfulness classes and seminars</li> <li>▪ Allow staff to spend two hours a month attending any of the above events</li> </ul>

**Notes:** ACE = adverse childhood experience; FQHC = federally qualified health center. See appendix for longer descriptions.

<sup>a</sup> Greater Newark Healthcare Coalition partnered with Rutgers University Behavioral Health Care, BRICK Avon Academy, and the Children’s Hospital of New Jersey at Newark Beth Israel Medical Center. People working at all these organizations were interviewed for this study.

# Study Methods

To identify lessons learned from the organizations awarded ATC grants, we conducted 69 interviews with a range of staff (table 3). The bulk of our interviews were conducted in March 2017, but a sixth grantee had a delayed start and was interviewed in June 2017.

**TABLE 3**  
**Types of Interviewees at Each Organization**

	Women's HIV Program at University of California, San Francisco	Center for Youth Wellness	San Francisco Department of Public Health	Greater Newark Healthcare Coalition <sup>a</sup>	Montefiore Medical Group	Stephen and Sandra Sheller 11th Street Family Health Services
Implementing staff <sup>b</sup>	7	3	6	7	5	4
Affected staff <sup>c</sup>	5	5	5	0	8	6
Patients <sup>d</sup>	3	2	0	0	0	3
<i>Total</i>	<i>15</i>	<i>10</i>	<i>11</i>	<i>7</i>	<i>13</i>	<i>13</i>

<sup>a</sup> Greater Newark Healthcare Coalition partnered with Rutgers University Behavioral Health Care, BRICK Avon Academy, and the Children's Hospital of New Jersey at Newark Beth Israel Medical Center. People working at all these organizations were interviewed for this study.

<sup>b</sup> Implementing staff included staff in management positions who were leading efforts to make their organization more trauma-informed and staff working with them in these efforts.

<sup>c</sup> Affected staff received training and other supports offered as part of organizations' efforts to become more trauma-informed, and were primarily frontline service providers such as primary care physicians, nurse practitioners, nurses, social workers, and office managers. We were not able to interview teachers or hospital residents receiving training through the Greater Newark Healthcare Coalition's efforts, but we obtained candid feedback from other staff who attended these trainings.

<sup>d</sup> Patients (i.e., adult patients and adult parents of child patients) were only interviewed at some organizations. Other ATC organizations said that interviewing their patients/students/clients would not be feasible, or they were primarily implementing workforce interventions aimed at changing organizational culture, which patients were not expected to notice.

To collect consistent data across organizations, we developed semistructured interview guides with similar questions that were worded differently depending on an interviewee's role in an organization's efforts. A separate interview protocol was developed for patients. The questions asked in each interview depended on which aspects of an organization's efforts a given interviewee was involved in and knowledgeable about.

Our interview guide was based on a deep understanding of all six organizations and their trauma-related efforts. We developed this knowledge by reading grant applications describing the organizations' planned activities and by conducting an earlier round of interviews with leaders of each organization when they were six months into their ATC-funded efforts (for most grantees, in July 2016). We also attended the learning collaborative's quarterly webinars led by the Center for Health Care

Strategies throughout our evaluation period (2016–17) and two annual in-person meetings, which all included presentations for and by ATC organizations and discussions among them.

To ensure that our interview guide aligned with the goals of the sponsors of the ATC initiative, we obtained feedback on our proposed interview questions from our consulting clinical psychologist, Cynthia Margolies, who specializes in trauma treatment methods, and from staff at the Center for Health Care Strategies and the Robert Wood Johnson Foundation. To ensure that the human subjects in our study were appropriately protected, our study protocol was reviewed and approved by our organization's Institutional Review Board.

Most of our interviews were conducted one on one and in person in private rooms at interviewees' workplaces; a few interviews were conducted by phone because of scheduling conflicts during our in-person visits. Interviews generally lasted 30 to 90 minutes, depending on the interviewee's involvement in organization efforts to become more trauma-informed. To encourage candor, we assured interviewees that we would not attribute quotes to specific people in our report. Interviews were attended by an interviewer and a notetaker and were audio-recorded.

After our site visits, notetakers used audio recordings to produce transcripts of interviews. One researcher coded all interview notes using NVivo qualitative data analysis software to allow passages of interview notes to be tagged with different key words, which could then be used to search for quotes on a particular topic. The key words (or "codes") used for this study were developed using an inductive (as opposed to deductive) approach, meaning they were identified after interviews were conducted based on the topics and themes that emerged in interviews, rather than established a priori. After running separate NVivo queries for different codes, the authors of this report further subdivided NVivo query output for a given code into different topics or themes and aggregated all quotes on a topic; these findings were then synthesized into the findings summaries that appear in the next section of this report.

To increase the validity of our findings, interviewees were confidentially emailed a copy of this report in draft form and invited to review and comment on it. Some minor corrections were then made in response to comments received from interviewees.

# Interview Findings

Interviewees shared their experiences and insights on adopting a trauma-informed organizational culture, training staff to be more trauma-informed, promoting staff self-care to reduce burnout, screening for trauma, delivering trauma-specific services to patients, and involving patients in trauma-informed efforts. We close this section by noting some overarching facilitators and barriers that emerged from our interviews.

## Adopting a Trauma-Informed Organizational Culture

Implementing trauma-informed care requires changes in both organizational and clinical practices (Menschner and Maul 2016). One respondent paraphrased Sandy Bloom: “Trying to throw trauma treatment into a system that isn’t trauma-informed is like throwing seeds into dry sand.” Unsurprisingly, organizational change is a critical part of each ATC organization’s efforts to become trauma-informed. Their efforts take different forms and vary in the degree to which systemic organizational change is supported, implemented, and considered, and in the principles and strategies used to drive this change.

Each ATC organization provides a comprehensive training for all staff members to ensure that staff have at least a foundational understanding of trauma and its impact and to develop a common language around trauma. (These trainings will be described in detail in a subsequent section of this report.) Three organizations are implementing comprehensive organizational change in their trauma-informed initiatives by developing or using existing frameworks for trauma-informed systems or organizations. One organization is deciding whether to make the whole organization trauma-informed and how best to achieve its goals. The two other organizations are not implementing what would be considered a comprehensive trauma-informed system but are still making important organizational changes to train all staff about individual and societal trauma and to screen and identify people affected by trauma and provide them with appropriate services. Here, we focus on the three organizations working toward systematic organizational change: 11th Street Family Health Services in Philadelphia, the San Francisco Department of Public Health, and the Women’s HIV Program at the University of California, San Francisco.

**11th Street.** 11th Street is going through the multiyear process of being certified in the Sanctuary Model. The Sanctuary Model is a trauma-informed process of organization change that intends to shift culture over time. The Sanctuary Model is built on four pillars: shared knowledge, shared values, shared

language, and shared practice. Shared knowledge includes a comprehensive understanding of the effects of stress and trauma on individuals, organizations, and communities and the path to healing and recovery. Shared values include commitments to nonviolence, emotional intelligence, social learning, open communication, democracy, social responsibility, and growth and change. Shared language includes using the SELF mnemonic (safety, emotions, loss, and future) to understand and address patients' emotions and one's own. Shared practice includes a toolkit to develop and maintain Sanctuary including community meetings, safety plans for staff, red-flag moments, and other tools.

Implementation of the Sanctuary Model at 11th Street was in the hands of steering committee members who attended an initial Sanctuary training over the first few months of the process. Then a core group of staff with representation from across the organization was created to move the initiative forward. Monthly meetings of this core group are now open to all staff, and each department is encouraged to send representatives to the meetings who can report back to a broader group of people. Initially, these meetings were working meetings, but more recently they have shifted to include skill-building exercises, sharing, and programs designed to be fun. This shift was reported to increase participation.

One outgrowth of the Sanctuary work at 11th Street is a focus on addressing racism inside and outside the organization. One respondent said that as the organization began to implement the Sanctuary Model, "all of these things kept coming up, and we had a sheet that was the 'parking lot'—and I thought we had to address them. The same things kept coming up, and they were important things. They were issues dealing with discrimination, power, oppression, stigma, the whole structural components of what you're talking about. I thought these have to be addressed." The organization considered holding cultural competency trainings, but staff wanted to embed the work in the organization. Eventually, they created an "Undoing Racism" group facilitated by people outside the organization who have been trained in the Undoing Racism curriculum.<sup>5</sup> The meetings focus on issues in the organization and in the community at large. These monthly meetings are attended by about a quarter of the center's staff and are an integral part of the Sanctuary work.

11th Street also concluded that mindfulness practices were essential to the success of Sanctuary. One respondent said: "We've been doing Sanctuary for years, but then we realized: how do you really embed it more in your soul? You can have knowledge, you can do things, you can have protocols, but it's all about your presence. It's in Sanctuary, but it's not the same thing as mindfulness." As part of the movement to mindfulness, 11th Street has offered mindfulness-based stress reduction and yoga classes to patients and staff.

**San Francisco Department of Public Health (SFDPH).** The SFDPH identified six core principles it believes are essential to becoming a trauma-informed system and has coupled these principles with a model of organization and systems change. The SFDPH hopes to move the department from, as one interviewee put it, a “trauma-organized system” to a “trauma-informed system” that is healing and relational for staff and clients. This interviewee added: “If you leave bureaucracies alone, they are dehumanizing by their very nature. People don’t intend to dehumanize people, but every day something happens that tells them they are not worth something. So it takes intentional steps, every day, to humanize a system.” Thus, the goal of the initiative is to create a trauma-informed system that takes care of both the workforce and the community.

The six principles underlying the trauma-informed systems work at the SFDPH are (1) understanding trauma, (2) safety and stability, (3) cultural humility and responsiveness, (4) compassion and dependability, (5) collaboration and empowerment, and (6) resilience and recovery. These principles are translated into organizational change through several mechanisms.

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*If you leave bureaucracies alone, they are dehumanizing by their very nature. People don’t intend to dehumanize people, but every day something happens that tells them they are not worth something. So it takes intentional steps, every day, to humanize a system.*  
—SFDPH implementing staff

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At the individual level, all employees receive mandatory foundational training. At the end of the training, everyone is asked to make a “commitment to change” focused on creating a more trauma-informed workplace. Individuals are reminded about their commitment to change one to two weeks later and then surveyed about their commitments two to three months after that. A qualitative analysis found that the most prevalent themes among commitment-to-change goals were improving relationships, focusing on self-care, sharing and using tools and practices learned in the training, and increasing mindfulness of trauma and its impact on others.<sup>6</sup>

At the organizational level, the overarching strategy was to embed trauma-informed experts and leaders within all levels of the organization. The SFDPH initially focused its effort on agencies where executive leadership was on board as an early adopter of trauma-informed system transformation and developed a leadership and champion model of change. *Leaders* are executive staff charged with aligning

the six principles with their agencies' values, policies, and practices. *Leaders* are supported through a learning cooperative that meets quarterly. *Leaders* are responsible for ensuring that resources and infrastructure can support and sustain a trauma-informed system, including identifying and providing staff time for champions to engage in trauma-informed system change.

*Champions* are frontline staff who participate in a monthly learning collaborative where they receive support, tools, and strategies for piloting changes. They are charged with working with other staff to transform their units and agencies into a trauma-informed system, in conjunction with the leaders. In addition, *Champions* are responsible for administering the Tool for a Trauma-Informed Worklife survey in their units. *Champions* have used data from this survey to choose the types of change to focus on first.

One respondent noted that *Champions* “have their own space to develop their skills to be change agents. I think that’s really important in an agency of our size, empowering people to make changes in their more local work-life or program, as opposed to broad changes from the top down.” The strategy’s local nature allows champions to focus on their unit’s unique issues, arising either from responses to the Tool for a Trauma-Informed Worklife survey or through other mechanisms. Many of the skills *Champions* learn are grounded in implementation science including root cause analysis (e.g., the five whys, fishbone, and reverse causality exercises), and champions receive training in participatory decisionmaking.

As the leaders/champions approach played out, it became clear that not all champions had buy-in or support from their middle managers to innovate and implement trauma-informed system change. Agencies where these middle managers were champions saw less of this problem. As a result, the SFDPH is implementing a new *Catalyst* role for middle managers that will give them the power and authority to help create change and allow them to work with champions and leaders. One interviewee explained, “For our organization really to change, the change takes place with the *Leader* setting the path, getting out of the way, and allowing the *Champions* and *Catalysts* to fail and be successful. Our first round was very successful. We learned that one of the things that got in the way was that the champions weren’t always feeling safe to innovate because they weren’t sure if their direct supervisors (middle managers) were in support.”

The trauma-informed initiative works closely with other organization initiatives including SFDPH’s Cultural Humility Working Group and African American Health Initiative. And system changes have added trauma-informed performance measures to performance appraisals and the coordination of workforce surveys.

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*For our organization really to change, the change takes place with the Leader setting the path, getting out of the way, and allowing the Champions and Catalysts to fail and be successful. Our first round was very successful. We learned that one of the things that got in the way was that the champions weren't always feeling safe to innovate because they weren't sure if their direct supervisors (middle managers) were in support.*

*–SFDPH implementing staff*

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Respondents agreed that the broad systemic change envisioned under this initiative will take time. One respondent said that the SFDPH was “where we start making changes, implementing changes, and monitoring them over time. That is the phase we’re in now: actually making practice and organizational changes and looking at the process, trying to understand what works for these large organizations, what doesn’t work, and where is the most beneficial place to jump in.”

***Women’s HIV Program at the University of California, San Francisco (UCSF).*** UCSF, the third organization that implemented comprehensive organizational culture change, relied on a framework for trauma-informed primary care developed with other experts that “defines trauma broadly, addresses both recent and lifelong trauma, and includes an essential focus on provider support and wellbeing” (Machtinger, Cuca, et al. 2015). The framework for trauma-informed primary care includes (1) an environment that is calm, safe, and empowering for both patients and staff; (2) screening that inquires about current and lifelong abuse, PTSD, depression, and substance use; (3) on-site and community-based programs that promote safety and healing; and (4) a foundation of trauma-informed values, robust partnerships, clinic champions, support for providers, and ongoing monitoring and evaluation.

The organization worked toward a more trauma-informed environment by focusing on each aspect of the framework. Initially, the whole organization received training on trauma-informed care, and additional trauma-informed clinical services were added. Across the board, staff noted that a common language with which to talk about trauma and patients’ responses to it was an important outcome of the training. The training also contained a daylong focus on cultural humility, the challenges of talking about race, and the intersection of race and trauma.

Several changes were made to create a safe environment and strengthen the foundation of the clinic. The organization is in the process of renovating its waiting room to be more calming for staff and patients. In the meantime, the organization began providing chair massage and pet therapy during clinic

times, played calming music, and hung art throughout the clinic. The organization has set up a monthly stakeholder meeting including four patients as well as representatives from each department. The group provides feedback and helps design and implement trauma-informed initiatives in the organization.

A director of trauma-informed care, who trained as a clinical social worker, was hired to oversee trauma-informed activities, including the supervision and support of behavioral health staff. The director has weekly meetings with all behavioral health staff to determine clients' support needs. Before each clinic, one social worker runs a staff meeting that includes physicians, nurse practitioners, social workers, and caseworkers. In this meeting, staff discuss patients coming into the clinic that day and raise any concerns across the different disciplines involved in patient care and support. This meeting reduces staff isolation, enhances team cohesion, and provides support to staff working with clients. Respondents on the behavioral health team noted that both their weekly staff meeting and the preclinic meeting made them feel more valued and supported.

## **Cross-Organizational Themes**

Several themes emerged from these three organizations. All three agreed that transformation was a long-term process and that real change would not occur overnight. They embraced a strategy that fostered continuous learning and improvement and strived to make large and small changes, from implementing the *Catalyst* program at the SFDPH to making Sanctuary meetings more focused on skill building and having fun. Staff at these organizations were often trying new approaches, so it was important that staff at all levels had the freedom to innovate and fail.

On the other hand, respondents often noted that the hierarchical structures of medical and governmental organizations made it difficult to become trauma-informed. Respondents from most organizations reported that not all employees felt empowered to make changes or voice their concerns. Respondents also said that leadership was predominantly white, but lower-level staff and patients were people of color. In contrast, one respondent reported that after one training and other changes in the organization, staff had a greater understanding of the challenges facing people with different roles within the organization, communication among staff members had improved, and staff who had felt disempowered now had more of a voice in the organization.

Respondents at most organizations mentioned that not all staff were on board with organizational change. This was true for organizations implementing major organizational change and those that were not. In three organizations, respondents noted that providers who see patients for reimbursement have

a harder time participating in trauma-informed activities. In two organizations, respondents said that people who were initially reluctant had been won over because their concerns were being addressed. Other respondents said that calling the change “trauma-informed” hindered the initiative’s efforts: “When we break it apart and we’re really talking about what does it mean to have a healthy, supportive organization where people have voice and choice as appropriate to the work setting, when you break it down to those tenets, I think everybody buys into it.”

## Training and Hiring a More Trauma-Informed Workforce

Although all the ATC grantees offered workforce training with the goal of making their organizations more trauma-informed, each chose a unique pathway and focus to achieve this goal (table 4). The trainings at most organizations touched on the same broad topics: trauma, ACEs, vicarious trauma, and self-care. But because the organizations had different objectives, their trainings had somewhat different emphases. For example, one organization emphasized convincing staff to increase their use of an ACEs screening questionnaire, but other organizations did not. At most organizations, trainings focused on developing a universal understanding of trauma and language to talk about trauma. Cultural humility was also covered in four grantees’ staff trainings.

All organizations conducted in-person trainings for staff. One organization also offered supplemental online trainings, which had low completion rates among non-nursing staff; one leader thought this might be because the training platform was not accessible from staff’s home computers. A select set of initial trainings was mandatory in all six organizations. Two of the smaller organizations closed their offices to patients for half-days so that large groups of staff could attend initial trainings. Other organizations trained staff in smaller groups to keep practices open. These organizations offered three to four initial trainings for staff, which occurred quarterly or were spaced throughout the year; some also offered longer trainings for a subset of staff. Most organizations followed up their initial trainings with ongoing trainings or booster sessions. Ongoing trainings ranged from stand-alone one-hour trainings to full-day retreats. Staff from a few organizations expressed appreciation for the ongoing training sessions because they kept topics relevant and in the front of people’s minds.

TABLE 4

## Summaries of Six ATC Organizations' Trauma-Informed Workforce Training Efforts

Organization	Main focus of trainings	Main content delivered at trainings	Structure of trainings
Stephen and Sandra Sheller 11th Street Family Health Services	Cultural shift to a more mindful organization through the Sanctuary Model and mind-body efforts	<ul style="list-style-type: none"> <li>■ Sanctuary Model</li> <li>■ Introduction to trauma</li> <li>■ Self-care, with an emphasis on mind-body techniques such as mindfulness</li> </ul>	<ul style="list-style-type: none"> <li>■ Initial all-staff trainings on the Sanctuary Model and trauma</li> <li>■ Ongoing meetings for the Sanctuary Model, Undoing Racism, and mind-body initiative core teams</li> </ul>
Center for Youth Wellness	Understanding trauma and its impact on staff; screening for ACEs	<ul style="list-style-type: none"> <li>■ Introduction to trauma</li> <li>■ Vicarious trauma and self-care, including mindfulness</li> <li>■ Trauma-informed treatment planning, including screening for ACEs</li> <li>■ Cultural humility</li> </ul>	<ul style="list-style-type: none"> <li>■ Initial trainings on trauma and self-care</li> <li>■ Ongoing trainings for teams, optional trainings for individuals, and trainings for leadership led by outside organizations</li> </ul>
Montefiore Medical Group	Screening for ACEs; self-care to reduce vicarious trauma in staff	<ul style="list-style-type: none"> <li>■ Introduction to trauma</li> <li>■ Introduction to ACEs and ACE screening</li> <li>■ Manifestations of trauma</li> <li>■ Self-care</li> </ul>	<ul style="list-style-type: none"> <li>■ Quarterly learning collaboratives for teams from practices</li> <li>■ Role-specific, in-person trainings led by therapists</li> <li>■ Online trainings</li> </ul>
Greater Newark Healthcare Coalition <sup>a</sup>	Understanding and responding to the manifestations of trauma in the classroom and medical setting	<ul style="list-style-type: none"> <li>■ Introduction to trauma and ACEs</li> <li>■ Trauma in the classroom (teachers)</li> <li>■ Self-care (teachers)</li> <li>■ Physical manifestation of trauma (residents)</li> </ul>	<ul style="list-style-type: none"> <li>■ Trainings for teachers on professional development days</li> <li>■ Small group trainings for medical residents</li> </ul>
San Francisco Department of Public Health	Training an entire public health department through trauma foundation training; establishing champions of this initiative	<ul style="list-style-type: none"> <li>■ Understanding stress and trauma</li> <li>■ Cultural humility</li> <li>■ Safety and stability</li> <li>■ Compassion and dependability</li> <li>■ Collaboration and empowerment</li> <li>■ Resilience and recovery</li> <li>■ Commitment to change</li> </ul>	<ul style="list-style-type: none"> <li>■ Half-day course for all staff</li> <li>■ Webinars and in-person trainings for subsets of staff</li> <li>■ Leaders' and champions' learning collaboratives</li> </ul>
Women's HIV Program at University of California, San Francisco	Understanding the manifestation of trauma for HIV+ women; increasing staff communication	<ul style="list-style-type: none"> <li>■ Introduction to trauma, with a focus on HIV and gender</li> <li>■ De-escalation techniques</li> <li>■ Vicarious trauma</li> <li>■ Communication among staff and with patients</li> <li>■ Cultural accountability</li> </ul>	<ul style="list-style-type: none"> <li>■ Three half-day initial trainings, shortened to three 1.5-hour trainings for new hires</li> <li>■ Outside trainer attends staff huddles once a month to discuss trauma</li> </ul>

**Notes:** ACE = adverse childhood experience.

<sup>a</sup> Greater Newark Healthcare Coalition partnered with Rutgers University Behavioral Health Care, BRICK Avon Academy, and the Children's Hospital of New Jersey at Newark Beth Israel Medical Center. People working at all these organizations were interviewed for this study.

In all organizations, staff were taught about and encouraged to practice self-care as part of their trainings to reduce the risk of staff burnout. This topic often resonated strongly with staff. At one organization, trainers did not originally plan to focus on self-care and burnout prevention, but the need to focus on these topics became evident after the first training, according to one trainer. A staff member at another organization said that she wished the trainings had focused more on self-care. The extent to which organizations, and specific practices and departments within these organizations, adopted self-care practices and other organizational changes varied widely: some organizations merely reminded staff of existing resources, but others made structural changes, such as adopting morning team huddles and incorporating mindfulness exercises into staff meetings.

All organizations relied on outside consultants to develop their trainings. Trainings were led primarily by internal staff in most of the six organizations, but several organizations brought in an outside trainer to lead some or all trainings. One organization that initially relied heavily on an outside trainer is now encouraging staff members to lead workshops and trainings on site. The two largest organizations in the ATC initiative conducted “train-the-trainer” efforts to prepare a group of staff members to lead trainings. Some organizations also prepared for trainings by surveying staff to assess their baseline understanding of key concepts and to identify knowledge gaps to target in trainings.

Most trainings featured didactic and interactive components, including role-playing and patient vignettes specific to the practice setting, which audience members were asked to discuss. Some interviewees at one organization said they were glad that trainings allowed time for staff to break out into groups or clinical teams to discuss how they would implement the changes they were learning about. Staff at four organizations said that the interactivity of the trainings resonated with them and helped them learn more from the sessions. Three organizations discussed concrete tools and practical tips for staff to use in their practice settings, and staff at these organizations said that these training elements were valuable. In two organizations, trainers or leaders observed clinicians as they delivered services to patients and offered them feedback on specific patient interactions; staff found this real-time, on-site advice and feedback very useful. A few staff members at one organization wished that their half-day initial trauma trainings, which were purely didactic, had been split into multiple shorter sessions or combined into a full-day retreat to make them more engaging, but they recognized that those options would be more logistically complicated.

Organizations differed in how they broke up groups for training. Four organizations had separate trainings for leadership. These trainings were designed to prepare leadership to teach concepts to the rest of the staff, to pilot a piece of the initiative, or to focus on leadership and management skills specific to the leadership team. Respondents said that separating training groups by staff role was valuable

because it allowed them to tailor the trainings to the specific issues that each staff type would be likely to see in the practice setting. Staff at some organizations found that doctors wanted trainings to focus on the physical manifestation of trauma and to include scientific evidence and statistics, but other types of staff preferred more fun and interactive trainings. One organization conducted trainings with a mix of staff types; some staff at this organization said that this was valuable because it brought many different perspectives into the room and helped break down silos between different staff types. Interviewees at large and small organizations found that involving staff of all levels in trainings was crucial for concept implementation after the trainings.

Interviewees identified several other factors that helped or hindered their workforce training efforts. Staff at nearly all organizations felt that leadership buy-in was one of the most important elements and that when leadership did not believe in the value of a training, neither would staff from that organization. And for trainings to happen, leadership needed to believe that they were worth the money and time away from patient care. At some organizations, only a limited number of staff were excused from clinical duties to attend some trainings, which obviously limited the reach of these trainings. An approach that one interviewee said had helped turn out large numbers of attendees at their organization was to add trauma-informed trainings to meetings that people were already planning to attend, rather than scheduling special one-time meetings about trauma.

The most prevalent challenge to offering trainings was finding time to train staff, given that meant taking them out of clinical practice and reducing access to services and losing billable revenue. Some staff also felt that they didn't have time to attend these trainings and still complete all their work. Leaders at one organization gave every staff member two hours a month to attend a training or meeting, but several staff at the clinic still felt they didn't have time to attend all the trainings they wanted to.

Another barrier was resistance or pushback from subsets of staff (which varied by organization but often spanned many staff levels), both during and after trainings, to changes such as increasing the use of an ACEs screening questionnaire and participating in staff self-care strategies such as meditation and yoga classes. Also, some clinical staff who regularly interacted with patients at a few organizations felt they hadn't learned much from the trainings because they already knew effective approaches for de-escalating interactions with upset patients or managing their own stress. Staff at a few organizations worried that trauma trainings could be triggering for staff who had experienced trauma in their lives.

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*I was surprised by how much anxiety there was about talking about trauma, considering that we all work [in a low-income area] and we all work at a place that really focuses on health care and social justice. It just surprised me that it was still such a frightening topic.*

*—Leader of a trauma-informed effort*

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Most staff members thought the trainings were valuable, and staff with less clinical training were especially likely to say so. The trainings helped reveal staff members' baseline understanding of trauma and comfort talking about trauma. Respondents at most organizations said that this initiative, and trauma-related trainings in particular, shaped and gave meaning to what staff had already been dealing with. It explained behaviors that staff had often seen patients or students exhibit, and gave them a common language to use in communicating with each other and with patients.

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*It's like when you're sick and you don't know what's wrong, when you finally get a diagnosis you feel like you can deal with that. But when we're all working from this unnamed approach, and we all realize this is trauma-informed, it helps us to get it and understand what we're working with.*

*—Case manager*

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## **Shift to Hiring a Trauma-Informed Workforce**

At four organizations, staff felt that the trainings and the general shift to becoming more trauma-informed had affected what type of people the organization now wanted to hire. These organizations now consider whether a new hire would go the extra mile to interact with patients and staff in a trauma-informed way and would be on board with the concepts and activities emphasized by the organization. One organization restructured their entire hiring process to try to eliminate racial bias. It shifted from relying on the personal networks of (mostly white) staff members in leadership positions to using a more structured hiring process with transparent rubrics for how candidates are chosen for interviews, how interviews are structured, and how final decisions are made. Another organization began to think more about hiring staff who look like and have backgrounds similar to those of the patients they serve.

## Promoting Staff Self-Care to Prevent Burnout

All six ATC organizations actively encouraged their staff to engage in more self-care to reduce the impacts of secondary or vicarious trauma and prevent staff burnout. Two organizations made this a central focus of their recent efforts to become more trauma-informed: the Center for Youth Wellness (CYW) offered staff multipart trainings on cultural humility and emotional balance and Google-led trainings on mindfulness, and 11th Street offered classes and workshops where employees could learn and practice techniques to reduce stress (e.g., mindfulness-based stress reduction, meditation, yoga). At Montefiore, the Women's HIV Program at UCSF, the SFDPH, and BRICK Avon Academy, self-care was covered in trauma-informed trainings but was not the central focus.

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*What we've [focused on are] things that you can do for yourself....It's really just trying to offer a whole basket of things that people can do.*

*—Montefiore staff member*

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Interviewees described two types of self-care interventions: ones that anyone could do on their own (e.g., venting to a colleague, exercising after work, doing breathing exercises when confronting a stressful situation) and structural changes that organizations can make to foster staff self-care (e.g., reducing the number of patients that providers are expected to see per hour, releasing clinicians from two hours of clinical work per month so they can attend on-site stress-management workshops, adding a meditation component to the start of staff meetings).

Common techniques reported by interviewees to reduce stress include the following:

- talking to coworkers, supervisors, or on-site behavioral health providers to vent or identify how to better handle a situation in the future (this was the most popular approach by far, used by interviewees in all six organizations);
- deep breathing exercises;
- going on a short walk during lunch;
- exercising before or after work; and
- taking the breaks and lunch hours that staff are already allotted.

One trainer said that because of the fast pace of many primary care practices, all the techniques they recommended to staff “were focused on how quick it can be to relax, how quick it can be to reset.” Several organizations also encouraged staff to be “more trauma-informed toward each other” because it can “feel better,” as one interviewee put it. Some interviewees also said that staff try not to send after-hours emails or talk to other staff about work during their lunch hour.

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*I think we come from a pretty decent place already...but I maybe see a shift in the deliberateness...I see everybody trying even that much harder to be conscious of the language we use, the way we treat each other, being respectful of each other, being respectful of the patients, being more sensitive to all of the things that are going on. We were already at a good level and I think the training helped us want to try to be even better.*

*—UCSF Women’s HIV Program staff member*

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Organizations also made structural changes to foster staff self-care, including incorporating short mindfulness exercises, breathing exercises, or a “meditation minute” into staff meetings or daily team huddles; setting aside a quiet room for meditation or deep breathing; offering yoga classes, Zumba classes, weekly meditation sits, or massages; scheduling all-staff lunches and staff outings to baseball games, escape rooms, or community service activities; and offering one-on-one clinical supervision (common among therapists but also sometimes used by nontherapists to reduce staff burnout). One interviewee at 11th Street described their new supervision protocol as “reflective supervision” and explained that it gives staff “a place to go to say, ‘I sucked in that scenario,’ or ‘I messed up with that client, how can I get better?’” Montefiore offered a relaxation hotline (718-920-CALM) with prerecorded deep breathing exercises and calming classical music that plays for a few minutes, which staff could call between appointments or on a break; interviewees said that staff used the hotline.

At three organizations, subsets of staff could decide what structural changes they would implement to promote self-care in their team. In at least two of these organizations, these teams had to report back to a larger group on what changes they’d made, to ensure that changes were made. Nevertheless, staff at these organizations reported wide variation in the implementation of structural changes.

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*The number of patients that I schedule per hour, per position, is another trauma-informed strategy. I try not to crowd people or push the limits on capacity.*

*—Physician*

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Another structural change adopted by most ATC organizations was surveying staff to assess morale and burnout, using the Professional Quality of Life survey or another customized survey. Organizations differed in how they used the survey results to make structural changes. Two organizations analyzed the results to identify areas to target for improvement, but another organization's leaders reported that they didn't find the Professional Quality of Life survey very useful and were looking into using a different instrument.

Two organizations created in-house teams to counsel staff after a traumatic incident. Several staff at Montefiore reported that their new Critical Incident Management (CIM) Team was "very positively received" by the three practices where this team had been deployed, and that it had made staff feel like their employer cared about them in a way that other self-care efforts had not. The CIM Team was formed after a Montefiore staff member was murdered off site, as a way to help staff process the loss of their coworker. The CIM Team consists of behavioral health providers who work in primary care practices and can be deployed to practices after a traumatic event has occurred to counsel staff. The team was trained by the Police Organization Providing Peer Assistance in a two-day session that introduced them to a model developed by George Everly and Jeffrey Mitchell (1999).

The intervention offered by the CIM Team varies by practice depending on staff needs, but it generally includes an initial daylong visit by three members of the CIM Team within one to two calendar days of an incident. At this visit, CIM Team members introduce themselves during a practice's morning huddle, then station themselves in a staff lounge with some food and speak with staff as they drop in throughout the day between appointments and on breaks. During this first visit, the CIM Team focuses on "defusing"—offering a brief intervention asking questions such as "Where were you?" "How are you impacted?" "What did you think about it?" "How did you hear about it?" A few days after that, a second visit focuses on "debriefing"—asking more in-depth questions such as "What emotional symptoms are you having?" "Has this triggered any previous traumas?" A third visit occurs about a month later, "just as a check-in."

Unlike the successful CIM Team, another organization's staff support groups led by clinician trainees were poorly attended. One interviewee thought staff may not have used this resource because these therapists, who were not employed by the same organization as the staff they sought to counsel, were "outsiders" who were "not from the community" and were "younger," because the staff may not have realized that they needed a support group, or because the name "staff support group" turned some people off.

Several staff reported that they liked that their employer promoted self-care, even if they didn't adopt the techniques or participate in the classes. One behavioral health provider explained that these offerings sent a supportive message to staff, which was appreciated: "Even if you can't engage in [these activities], it creates the sense of a healthier community." But not all staff appreciated the efforts. One interviewee said some staff resisted the addition of "check-ins" to the start of staff meetings, explaining that some people thought "it seemed fluffy" and said things like "I just want to come to work, see my patients, and go home. Now you want me to talk about what makes me nervous, happy, anxious, or stressed? ... Do we have to do this?" An interviewee at another organization also observed that some colleagues reacted to requests that they be more open about their feelings by saying, "I don't want to do that because it's not appropriate for the workplace."

One organization responded to this resistance by expanding its self-care offerings to include one-time talks on living in a more mindful way, such as learning to notice how you are reacting to a situation and becoming aware of unhelpful judgments your mind is making. The goal of these talks was to try to reach a broader audience because, according to one respondent, "not everybody here wants to have a meditation practice" or wants to commit to attending a weekly class.

One primary care physician observed cultural differences between her professional field and the behavioral health care field, which she believed explained why some primary care staff were less interested in some self-care activities. This interviewee felt that primary care staff did not have the luxury of thinking about things like yoga because they already had enough trouble making time to eat lunch, with their hectic work schedules. A behavioral health provider at another organization agreed: "Medical doctors are funny people. There's not a lot of self-care. In the mental health world, we talk about self-care all the time. In the medical world, it seems far less talked about."

## Screening for Trauma and Its Symptoms

Interviewees at all six ATC organizations believed that knowing whether a patient had had adverse childhood experiences was important and useful, but they had different views about the best way to obtain this information. Montefiore's and CYW's feeder health centers<sup>7</sup> asked their general patient populations to complete a questionnaire identifying their number of ACEs<sup>8</sup> as part of physicals and well-child visits (which are longer than sick visits). These organizations collect this information in a "deidentified" way, which in this context means they only collect the *number* of ACEs a patient has and do not ask which ACEs a patient has. Other ATC organizations only give a small subset of their patients an ACEs screening questionnaire (e.g., pregnant women) or let patients volunteer information about traumatic experiences as part of regular patient visits and/or verbally ask patients whether they have had specific adverse experiences. Because ACEs questionnaires only collect information about childhood trauma and not about current symptoms, ATC organizations usually asked patients to complete other screening questionnaires to identify symptoms of depression, anxiety, or PTSD.<sup>9</sup>

ACEs screening questionnaires are usually given to patients upon check-in at their primary care practice and filled out by an adult patient or the parent of a child patient because, as one behavioral health provider noted, "ACEs questions are pretty explicit and could be quite upsetting to a kid. One 16-year-old is not another 16-year-old in terms of how exposed to this stuff they are." Also, children might not know about some ACEs, such as a family member's mental illness. A leader at one organization reported that giving receptionists talking points to use when giving patients the ACEs screener had been helpful. Once a patient completes an ACEs questionnaire, a nurse or a medical assistant usually collects the completed form as they are accompanying a patient to their exam room, and then enters the patient's number of ACEs in the practice's electronic medical record and tells the patient's primary care provider if the patient has four or more; this number of ACEs is associated with a markedly increased risk of health problems (Felitti et al. 1998).

As part of a patient visit, a primary care provider usually references the questionnaire and asks the patient if he or she would be interested in speaking with a behavioral health provider or a care coordinator about available behavioral health services. If the patient is willing, this other staff member joins the provider and patient in the exam room or speaks with the patient one on one in a session held directly after the provider's visit or scheduled for a later date. (Patients can also be connected with behavioral health services through other routes, such as a depression screening questionnaire or comments they make in their appointment with the provider.)

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*You filled out this form, and it looks like there has been a lot of difficult things that you've experienced. How are you doing with that? Is there anything you'd like to talk about? I think it'd be important for you to meet with one member of our behavioral health team to make sure that you're doing OK and that there are not effects on the baby.*

*—A physician's script for talking to patients about their ACEs scores*

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### **Complex Views on Screening for Traumatic Experiences**

Interviewees had rich, nuanced views on the benefits and drawbacks of screening for trauma, which didn't always neatly align with their organizations' official policies. Several interviewees called screening for trauma "controversial," said they were "conflicted" or had "mixed" feelings about it, or said "there are pros and cons."

At one organization that had decided not to formally screen for ACEs, one interviewee said that "almost everyone I see has something, [so] it's not a helpful tool for me in setting treatment goals or even talking to the client." Another behavioral health provider noted the importance of coupling the ACEs screener with other screeners to identify patients' symptoms.

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*The only caveat I would say is that [an ACEs screening questionnaire] doesn't measure current symptoms; it's just saying that you've experienced something, but it's not measuring whether you have PTSD, depression, or anxiety....I think the other thing is that adults also have experienced trauma after the age of 18, so that's something the ACEs [questionnaire] doesn't necessarily capture. Sometimes that can get missed.*

*—Licensed clinical social worker*

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Montefiore recently began recommending that its primary care staff screen for ACEs, and most of its practices now screen at least some patients for ACEs. In some practices, staff resisted the new screening protocol. Several interviewees said that staff did not want to devote precious visit time to issues not directly related to patients' chief medical complaints and cited the lack of evidence that

screening for ACEs leads to improved health outcomes in adults, the risk of rupturing rapport with a patient, and staff's fears of opening "Pandora's box" and then not having enough behavioral health resources to offer patients. At Montefiore, all primary care practices employ behavioral health staff; one interviewee said this was "the only way [ACEs screening] could have even been a possibility." Based on Montefiore's experience working with an array of practices, this interviewee recommended that ACEs screenings only be conducted on days when behavioral health staff are on site and available to talk to a patient who is triggered or expresses a willingness to learn about available behavioral health services.

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*If you don't have your behavioral health staff on site, don't do the screening. That's another big rule of thumb.*

*—Montefiore interviewee*

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Interviewees also said that staff who give patients the ACEs screener or collect it from them should be trained on the importance of screening for ACEs and on the potential uses of this information (e.g., explaining that the patient's number of ACEs will not be reported to a local child protective services agency). One organization met less resistance from patients when staff told them the questionnaire was optional, and saw higher reported numbers of ACEs when staff explained that they were asking these questions because there is a direct link between ACEs and health outcomes. Nevertheless, interviewees at this organization had mixed views about whether patients were reporting their true number of ACEs, with some interviewees convinced that some patients were underreporting.

Interviewees disagreed on whether it was better to use a screener or to have a trusted clinician ask patients about past trauma as part of patient visits. One behavioral health provider favored having patients fill out an ACEs screener because she felt it gave patients more control over what to disclose; she noted that it is relatively easy to not fill out a form, but social norms make it harder to decline to answer a question posed in conversation. Another interviewee from this organization felt that staff would need to undergo a lot of training before asking ACEs questions aloud, to avoid retraumatizing their patients; the questions would need to be read in an "unbiased" and "neutral" tone, without "squirring" or "undertoning" or "lowering the volume" of their voice. But interviewees at another organization said they had found success in beginning conversations about traumatic experiences by telling patients they can decline to answer questions that are "too personal."

At one organization, primary care practice staff supported screening children for ACEs because “you have a chance to prevent that ACE number from going up,” but most did not see the benefit of screening adults. One staff member reported that adult patients sometimes say that a traumatic experience “happened so long ago that they don’t think it is traumatic anymore” or tell their provider that they had “put it away, but by talking about it, it brings it all back again and they feel traumatized by that.” Staff most resisted the screening of elderly patients because they worried it would dredge up memories that patients had already “dealt with, or don’t really want to go back to.” One staff member described a typical reaction to the ACEs questionnaire from elderly patients: “What? Why are you asking me these things? You know what I care about. What I care about is that my wife died last year.”

A leader at another organization said that screening for ACEs was useful because it could help staff understand why a patient might be acting hostilely or refusing to comply with medical recommendations: “Oftentimes, when someone has experienced horrific things earlier, they don’t stop...Traumatic events might still be happening.” A behavioral health provider at another organization felt that screening for ACEs gave practice staff an opportunity to emphasize how resilient a patient was, by noting that the patient had “come through a lot.”

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*Have the conversation, because your patient is refusing to do this because of trauma issues.  
—Behavioral health provider*

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Interviewees also reported disagreement over the inclusion or exclusion of certain experiences in ACEs questionnaires. One interviewee said that patients in their practice’s low-income neighborhood often pushed back on some questions, making comments like the following: “Yes, which mom doesn’t beat up the kids?” “If I hadn’t been beaten up, I wouldn’t be where I am now.” “Are you kidding me? Who is not divorced?” A few interviewees felt that the ACEs questionnaire excluded important adverse experiences, such as those incorporated into the Philadelphia Urban ACE Survey (Cronholm et al. 2015; PHMC 2013). But one physician also found the urban ACEs instrument lacking: “Homelessness, to me, is an adverse childhood experience, but it’s not necessarily one of the questions.”

## Providing Trauma-Specific Services

Most ATC organizations had social workers or psychologists on staff or colocated on site to receive warm handoffs from primary care practitioners, offer patients additional screening for mental health conditions, and provide short-term counseling services to patients (e.g., for up to 12 sessions at one organization). Patients were often referred to external organizations if they were likely to need medication prescribed by a psychiatrist or long-term counseling (except at CYW, which provides in-house counseling typically for 12 to 18 months). Most organizations also had care managers or care coordinators on staff or colocated on site to help patients apply for Medicaid insurance or connect with food pantries, diaper banks, or other social services, and/or to help facilitate communication between physical and mental health providers.

Most interviewees reported that their organizations had access to an adequate supply of Medicaid-accepting mental health providers and social services agencies, but this was not so in Newark. A few interviewees also reported shortages of substance abuse treatment programs (in San Francisco), psychiatrists (in the Bronx), and safe affordable housing (in Philadelphia and the Bronx). One interviewee noted that although Philadelphia has an adequate supply of behavioral health providers, many of these therapists do not “look like people they’re serving.”

Cognitive behavioral therapy was the approach most commonly used by the therapists we interviewed, but one organization serving children had recently shifted from this approach to a dyadic approach called child-parent psychotherapy. Unlike cognitive behavioral therapy, which focuses on teaching patients practical skills they can use right away to modify dysfunctional thinking and behavior, child-parent psychotherapy is aimed at strengthening child-parent bonds to improve a child’s sense of safety, attachment, and appropriate experience of emotions.

Interviewees at several organizations found that patients preferred to see behavioral health counselors who worked in the same office as their primary care provider, even if it meant going on a waiting list of a few months and not beginning treatment right away. As one therapist put it, patients “feel comfortable and safe—there’s less stigma going into here than going into a behavioral health building.” A staff member of another organization felt that having therapists on site reduced no-show rates for behavioral health providers: “If our patients can come to the same place to get a multitude of services, they are more likely to show up because they know the staff and are more engaged with the clinic.” Several other interviewees reiterated these points. The UCSF Women’s HIV Program ended up offering an in-house group intervention (STAIR, discussed below) after finding that the approach used by a specialized, off-site facility that they were referring patients to was not resonating with patients.

## Alternative Therapies

Interviewees at several organizations noted that patients often “aren’t ready” for talk therapy. One behavioral health provider observed that “talk therapy doesn’t work for everyone” because some people “don’t want to relive their trauma through talking about it” and “trauma is sometimes very unspeakable, because some things can happen so early in life—even before you’re verbal.” To reach these patients, some organizations offered alternatives to traditional one-on-one talk therapy. 11th Street had a robust suite of offerings including dance movement therapy, music therapy, art therapy, yoga, and mindfulness-based stress reduction classes. One staff member reported that creative arts therapies were “incredibly popular, especially among people who aren’t comfortable seeing a [traditional] mental health provider,” although sometimes patients receive both talk therapy and creative arts therapies.

Interviewees at two organizations said that both adult and child patients sometimes “have difficulty identifying feelings.” One staff member said this sometimes meant that adult patients could tell “a story around what those feelings are,” but could not come up with the “actual word” to describe how they were feeling. To help with this, some organizations made “feelings lists” and placed them in exam rooms for patients’ reference. One therapist had children play games such as Uno or Jenga with modified rules requiring them to say aloud the card they were playing or the move they were making, to get these children used to talking with her.

The UCSF Women’s HIV Program implemented a hybrid treatment approach called STAIR (Skills Training in Affect and Interpersonal Regulation), which included talking but did not require the amount of personal disclosure common in talk therapy. STAIR was originally developed for veterans with PTSD and includes one-on-one reexperiencing therapy,<sup>10</sup> but UCSF’s clinic dropped that component and modified the intervention to focus only on skill building; one staff member said that the reexperiencing component was “not something that [our patients] could handle at the moment.” In UCSF’s STAIR group, which meets two hours a week for 12 weeks, “you’re not supposed to talk about trauma in detail so that it doesn’t open it back up, but you can talk about how to have a hurdle with the trauma, how to be able to cope with it and how to understand it.” Another staff member explained that STAIR “focus[es] on emotional regulation and relationships, which a lot of people struggle with if they are a survivor of trauma.” Another staff member said that this intervention reduces the social isolation of HIV-positive patients, which can help patients heal and make safer lifestyle choices. Staff consistently reported that STAIR was popular and helpful for the patients who participated, and one interviewee observed that it had particular appeal for patients who “don’t believe in therapy.”

The UCSF clinic also offered a community-based theater program, *Medea*, adapted from a theater program for incarcerated women<sup>11</sup> and described by one interviewee as “expressive therapy.” Patients participating in this group intervention disclose their trauma histories and HIV status to each other, complete writing assignments (e.g., a letter to one’s daughter), and transform their writing into theatrical vignettes that they then perform. One interviewee reported that this intervention helped reduce social isolation and gave patients “a powerful role model who’s a black woman” – Rhodessa Jones, the leader of the intervention. The clinic has studied this intervention and found that patients reported benefits including sisterhood, catharsis, self-acceptance, safer and healthier relationships, and the gaining of a voice (Machtinger, Lavin, et al. 2015).

## **Additional Challenges for Treating Children**

The ATC organizations that mainly serve children face additional challenges in delivering trauma-informed care. Interviewees at three organizations reported that offering mental health treatment to children often involves working with their parents. One behavioral health provider said that “seeing a child that’s dealing with trauma is like seeing three clients in one” because “you can’t create change in a child without the family system involved somehow.” And a child’s care may be more complicated if it involves other health officials or providers, such as a school psychologist, a judge overseeing a child’s progress under court-ordered therapy, and a local department of human services.

Another challenge is that “you don’t have a lot of time with the kids.” One therapist said that “your typical kid with behavioral issues can talk to you for 20 minutes at the most.” Establishing a relationship with a child may be difficult under these time constraints, especially if the child has had experiences where an adult let them down or broke their trust, according to one interviewee. Children may also feel conflicted about answering a therapist’s questions if a parent has told them not to talk about something.

Some interviewees also noted that “children aren’t the best reporters,” as one behavioral health provider put it. Sometimes therapists must clarify whether something a child reports is something that happened, something they saw in a movie, something they heard about, or something they dreamt about. A physician at another organization said that children are sometimes unable to verbalize what is being asked of them, because of how old they are and what cognitive abilities they have developed. A behavioral health provider at a third organization agreed that “the child may not be able to tell the story of what happened in a fact-based way, so if the parent isn’t able to actually tell me what happened, I don’t necessarily know what is going on.” This therapist explained that a child may report that there is a monster in their bedroom that comes out at night, but a parent may clarify that a burglar entered the

child's room one night. Getting to the bottom of what a child may have experienced is especially difficult if a parent is not ready to talk about a traumatic experience. The therapist said, "If parents are too triggered by that, I end up having to do a lot of work to prepare the parent so that I can work with the child." Another therapist said that working with a child is more complicated if a parent is the cause of trauma and has told the child "not to say anything about what happened at home" or "why they have bruises on their arms."

Interviewees noted that when providers work with children, they are required to report current abuse to their local child protective services agency. One behavioral health provider said that this can cause new traumatic experiences for a child if it prompts upsetting interactions with police or other authority figures or the removal of an abusive family member from a child's home, even though such actions may improve the child's safety. One physician noted that asking children questions about abuse can sometimes change their memory of an incident, so non-behavioral health providers shouldn't ask too many questions.

One behavioral health provider felt that working with children is harder in some ways and easier in others: although a counselor must contend with all these difficult issues, "you are working in real time with a child who's young—there is less brain patterning, that isn't as hard to undo. They're more resilient."

But treating children can be more traumatic for staff. One counselor said that "it's harder to witness a child that's been severely neglected or abused. It is not easy case work....It's differently pressured and time sensitive for me." This work can be especially dispiriting when a child "is in the really unhealthy environment, and often there's nothing you can do to change that; you can just help *them* change." Several staff at another organization also said they felt frustrated that "children do not control the environment they're in."

## Universal Precautions

Some interviewees described precautions they take with all patients—whether they have been identified as having traumatic experiences or not—to reduce the anxiety associated with a medical visit.

Staff at CYW said that they try to be "very welcoming, kind, and respectful" when greeting patients so that patients feel they are entering a safe, nurturing space; clinicians also try to "establish relationships up to a point of what is clinically responsible." Interviewees at two organizations said they use a gentle tone of voice when interacting with patients. The FQHC partnering with CYW has tried to

“diminish stress from the minute you walk in the door” because “a more chaotic environment just leads to more chaotic behavior.”

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*Just imagine if it were your loved one that went through that experience. How would you want [medical professionals] to speak or attend to that person?*

*—Nurse*

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Staff at UCSF’s Women’s HIV Program said they are now trying to be “more conscious of how we interact with each other and how we interact with the patients,” and that instincts about the “right way” to respond to heightened situations have now been replaced with “tools and words to be more deliberate in how we care for our patients.” The clinic has also tried to make its waiting room more welcoming by offering service dogs for patients to pet; providing food (e.g., burritos) for patients; and leaving out coloring pages. One interviewee said this last strategy was “really helpful”; sometimes clients will bring the coloring pages into their talk therapy sessions and continue to color. Once, this clinic showed “funny animal videos” on the television in the waiting room to lighten the mood, which delighted the patients. The clinic also offers patients chair sessions with a massage therapist and is now redesigning the waiting room to make it less stressful for both patients and staff.

11th Street Family Health Services’ efforts to adopt the Sanctuary Model are aimed at improving patient care, among other goals. One interviewee said, “Sanctuary is not about checklists; it’s about shifting your internal approach to care.” One interviewee described a medical assistant doing deep breathing exercises with a patient before taking her blood pressure to help the patient relax. A nurse practitioner noticed that a patient was hunched over and called in the dance movement therapist to do some exercises to help the patient relax. Another provider said they take time with patients to “talk them through the procedures.”

Some interviewees talked about the importance of making a practice’s physical space trauma-informed, although this meant different things to different people. One staff member felt that the 11th Street building was trauma-informed because it had natural light in many rooms and was “open” so that patients didn’t feel “trapped in.” But a staff member at Montefiore said that a large open space was not conducive to completing the ACE questionnaire because it gave patients less privacy than an exam room and may make them feel “exposed.” A staff member at the Center for Youth Wellness said that

office colors were chosen intentionally to reduce stress and alleviate anxiety, and the parent of a patient said the space is “welcoming” and “beautiful,” with plenty of toys and books for children, movies playing on a television, and animal artwork on the walls.

## Involving Patients

Organizations varied in how they sought patient feedback on their trauma-informed efforts and their operations overall. Most organizations felt that patient feedback was important during the process of becoming more trauma-informed, but only three organizations brought in the patient voice from the very beginning. In these three organizations, patient feedback informed changes in the way patients are screened for traumatic experiences (including changes to the screening questionnaire itself) and to the protocol used to collect and process this information (including the information given to patients about the questionnaire). Across all organizations, patient input usually did not affect staff trainings, but one organization had patients present during staff trainings, which interviewees reported to be “powerful.” Interviewees at several organizations said they felt their organization could do more to solicit patient input on their operations.

Most organizations had a standing committee of patients who gave feedback on behalf of the patient community, but meeting frequency varied. Only a few organizations collected feedback from a broad group of patients through focus groups or surveys. One organization held monthly stakeholder meetings with a group of staff and a small group of patients that would change every few months to provide more perspectives. Most organizations did not give patients the opportunity to provide anonymous feedback, which some found troubling. One staff member said, “It’s also good for clients or patients to have anonymous ways to provide input...because a lot of times there is already an extreme power differential—whether it is race, class, or formal education level—between a patient or client [and a provider], or at least they are perceiving that there is one.” A staff member from a different organization worried that the patients on their patient committee were often those “who are easiest to have there—and those are not always the folks who need to be there,” but another interviewee noted that the organization was starting to ask other patients to join the meetings.

Staff from two organizations hesitated to attribute too much value to the opinions of a few patients asked to speak for the entire patient population. They cautioned that an organization may not be capturing an accurate representation of the community’s opinions through the committees and risked inflating the opinions of a few by turning to the same people for all issues. At one organization, a few staff members felt that their organization hadn’t asked the broader community if patients were actually

interested in certain new offerings. One staff member suggested that the organization could benefit from consulting with patients to determine the types of interventions most relevant to and desired by the community. Another staff member felt that their organization's efforts might be better directed to integrating their services into local schools and churches.

Based on staff reports of patient input and our own interviews with patients, patients seemed satisfied with the care they received at three organizations. Patients reported that the staff and the physical space made them feel safe, and they commonly described staff as “warm” and “genuinely caring.” Patients appreciated staff efforts to engage with them through the clinical process, from the initial greeting by front desk staff to the handoffs between staff. Most patients felt that providers listened to their opinions and gave them an equal say in decisionmaking processes. Many patients liked and used the nonmedical services offered at practices, such as yoga and cooking classes, and appreciated the therapists and mental health providers integrated into organizations' care settings, even if they chose not to see one. Some patients felt frustrated by high staff turnover rates and by the lack of staff diversity in some practices.

A few organizations did outreach to educate their local communities about trauma and inform them of their services, but this was never the primary focus of trauma-informed care efforts. A few interviewees wished that more outreach was done, although they recognized how busy the organizations were already. One organization was designing large permanent posters to hang inside waiting rooms to inform and educate patients about their emphasis on behavioral health and ACE awareness. Another organization offered classes in local schools and libraries about topics such as healthy cooking and resilience. Two organizations hosted screenings of films nationally recognized for introducing the concept of trauma and resilience to the general public. One organization held classes to teach parents how to become more involved in their activities. Another organization used an outside grant to support a group of students during the summer in learning about the concepts and science of ACEs and developing an interactive way to teach these concepts to their peers.

## Facilitators and Barriers

In this section, we discuss overarching themes that facilitated or hindered the six grantees' efforts to become more trauma-informed.

### **Organization Leadership Must Be Committed to Change**

Respondents in charge of implementing trauma-informed efforts reported almost unanimously that becoming a trauma-informed organization hinged on strong commitment from leadership. Leaders included clinic directors, the director of a public health department, and the senior vice president and chief medical officer of a health system.

### **Be Flexible, Innovate, and Learn from Failure**

In each organization, leaders felt empowered to innovate, fail, and learn from their early failures, and in each organization, this yielded later successes. This approach was consistent with the idea of continuous quality improvement. Innovations included inviting more types of people to participate in trainings and activities aimed at generating organizational change; developing and offering trauma-specific services on site, after patients expressed low interest in receiving off-site therapy; refining the process used to screen for ACEs, substance abuse, and interpersonal violence, in response to early experiences with patients; extending the length of the main behavioral health intervention offered, after patients kept cycling back into this program; and shortening the length of some staff self-care classes to make them more appealing. Each of these changes came about after earlier strategies failed.

### **Not Everyone Will Be on Board with Transformation**

Although each organization had trainings for all staff, respondents in four organizations noted that only some staff members are engaged in trauma-informed activities. In one organization, clinical staff had difficulty making time for monthly meetings that were part of the trauma-informed effort. To address this, all staff were given two hours a month to participate in trauma-informed activities of their choosing. In another organization, not all clinicians were willing to screen patients for ACEs. To convince these providers of the value of screening, this organization had other clinicians give presentations at trainings, because clinicians highly value the experiences of other clinicians. In a third organization, some staff were highly committed to becoming a trauma-informed organization, but others did not see

its value. This organization was beginning a more engaged process, organization-wide, to develop a strategy for how to move forward.

## **Organizational Hierarchy Is a Barrier**

For five of the six grantees, organizational hierarchy was a barrier to becoming trauma-informed. One respondent said, “Hierarchy often pushes against relationship building, so over time we may start to chip away at that. We’ll see in five years if that’s happened.” Hierarchy challenges varied across respondents and organizations and included lack of racial diversity in leadership roles and hiring practices; power dynamics among physicians, therapists, nurses, and medical assistants; inconsistent supervisory support to give voice and innovate around trauma-informed efforts; and insufficient incorporation of patient voices, needs, and requests into the practice. Several organizations were innovating to address different types of hierarchies.

### **RACIAL HIERARCHIES**

In several organizations, staff trainings include segments about structural racism and cultural sensitivity that try to establish a basic understanding and common language around these issues. In one organization, an Undoing Racism working group is ongoing and well attended. Another organization just received funding to receive Undoing Racism training.

### **EXPLICIT ORGANIZATIONAL HIERARCHIES**

Several organizations reported that including staff at all levels and in different roles was important for changing organizational culture or clinical workflows. These grantees explicitly recruited a wide variety of people for their trauma-informed efforts. One organization incorporated middle managers in efforts to support frontline workers as the latter designed and implemented changes to organizational culture, and another organization set up a monthly meeting with representatives from each department and patients to guide its trauma-informed initiative. A third organization trained staff in participatory decisionmaking to help elevate the voices of people outside of leadership roles.

### **MEDICAL HIERARCHIES**

Another organization changed the way it prepared for clinic each day. Under the new system, physicians, nurse practitioners, social workers, and case managers meet before clinic to discuss the physical, emotional, and other needs of the patients coming in that day. They also identify patients they are particularly worried about, whether or not those patients are coming in that day. The meeting is

managed by a social worker on the clinic team. Staff reported that this meeting got everyone on the same page about patients, made staff feel like a critical part of a team (not only supporting the work of the primary care providers), and reduced provider isolation.

### **PATIENT-PROVIDER HIERARCHIES**

Two organizations brought patient voices into their trauma-informed efforts. In one organization, patients participate in a monthly meeting with representatives from the clinic to provide input on clinic functioning, redesign, and policy. Each month they discuss different topics, such as clinic workflow and safety measures. Suggestions from patients have already been implemented through these meetings. At the other organization, the team implementing the trauma-informed effort interviewed people on the patient advisory committee about how care at the organization is traumatizing to them. Through this process, the team learned a lot about the patient experience. According to one staff member, patients on the patient advisory committee spoke in trainings about how “powerful” and “meaningful” it was for them to be screened for past trauma.

### **Few Systems of Accountability Are in Place**

Each organization is tracking its progress by interviewing or surveying staff over time. Data are used to inform future change and to understand where efforts are successful or unsuccessful. One organization had even incorporated trauma-informed goals into performance appraisals.

But, according to respondents, most organizations do not have strong systems for accountability. Lack of accountability sometimes intersects with the challenges of working in hierarchical organizations and emerges when staff do not feel that their voices are heard or that it is not safe to voice opinions. But accountability is also compromised when those leading trauma-informed initiatives cannot engage all staff. One respondent said, “There has to be a system in place to do the work. You can’t just do this stuff ad hoc....If you are not willing to build the infrastructure for the program and hold people accountable to the program...then [it’s not going to work].”

Organizational approaches to accountability varied depending on the perceived problem. In one organization, managers are now responsible for ensuring that their departments are represented in monthly meetings on their trauma-informed efforts. Three organizations have implemented coaching strategies. One organization is implementing reflective supervision, where staff can get feedback on how they could have handled a difficult interaction differently. In a second organization, staff are observed and given constructive feedback on how best to handle challenging situations. And a third

organization is developing a coaching program to assist and train frontline staff on being agents of change. But interviewees typically felt that more could be done to hold staff accountable for adopting trauma-informed principles into their day-to-day work.

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*There has to be a system in place to do the work. You can't just do this stuff ad hoc....If you are not willing to build the infrastructure for the program and hold people accountable to the program...then [it's not going to work].*

*—Respondent in leadership role*

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Sometimes accountability for implementing trauma-informed efforts conflicts with other objectives of the organization. One interviewee said, “Trauma-informed systems is focused on relationships and building or repairing relationships, which takes time and processes. That is part of the work that needs to happen. But at the same time, we all have goals and need to see a certain number of clients, and we all need to process a certain number of contracts, whatever our own department is responsible for.” The tension between work productivity and involvement in trauma-informed efforts had different implications for different organizations and staff. Clinical staff in three organizations said it was difficult to participate in trauma-informed efforts when most of their day was spent seeing patients and the business model of the organization depends on revenues from treating patients.

## **Many Trauma-Informed Efforts Are Funded by Grants**

Grant funding was essential to each organization’s trauma-informed efforts and was used for some combination of training, certification, and services. In many organizations, staff time for development and training is absorbed by the organization. The organizations used different types of grant funding to support their trauma-informed services. One organization used grant funds to hire an initiative director and a social worker to provide trauma-informed services to patients and to direct, train, and provide support to behavioral health staff. Another organization used grant funding to hire a social worker therapist. Another organization’s behavioral health services are fully grant-funded. One organization supports yoga and creative arts therapy with grant money. Two organizations that rely on grant funding for staff and services said that it allows them to be more flexible and innovative, unconstrained by insurance requirements.

Grants are often necessary because not all the services they offer can be funded through reimbursement from public or private health insurance. In two organizations, medical and behavioral health providers can bill for their services, but warm handoffs from medical to behavioral health providers are reimbursed only in certain circumstances. Organizations had trouble billing for screenings, yoga, and services delivered by particular types of clinicians; and for behavioral health treatment, when the organization has an insurance contract to provide medical care to a patient but behavioral health is carved out of its contract. One organization lobbied state officials to allow licensed professional counselors to be reimbursed for their creative arts therapy services; reimbursement is low because licensed professional counselors are not billable providers for FQHCs, but the payments help with the costs of providing these services. One organization noted that, with few exceptions, insurers will not reimburse case management services associated with finding housing or food.

# Conclusion

The six ATC grantees were developing trauma-informed organizations and providing trauma-specific services before receiving their ATC grants and used the grants to further their activities to become more trauma-informed. Each organization worked to develop an organization-wide understanding of trauma and its effects; to encourage staff to engage in self-care; to deliver trauma-responsive services; and to involve patients in the organization—all key elements of trauma-informed organizations and care. The grantees used some similar strategies to become more trauma-informed, but they also pursued unique initiatives targeted to their organizations and patient populations.

Several features were critical to the success of the grantees' efforts. First, at the highest levels of the organization, leadership was invested in the trauma-informed effort. Second, each organization embraced innovation and continuous improvement and was willing to implement, fail, and learn from mistakes. Third, most organizations had already begun the transition to becoming trauma-informed before receiving the ATC grant, so they built on existing strategies and commitments to trauma-informed care. Fourth, all six organizations were providing some type of trauma-informed services on site before the ATC grants. Finally, several organizations implemented a “train-the-trainer” model with embedded champions, which will likely increase the sustainability of the trauma-informed initiatives.

All six organizations faced similar barriers to becoming trauma-informed, including structural hierarchies and resistance from some staff. In addition, most organizations relied on funding from this and other grants to implement and enhance their trauma-informed efforts; these opportunities may not be available to all organizations or providers.

Hopefully, the changes these organizations have made will reduce vicarious trauma, burnout, and turnover among staff and create a more compassionate and healing workplace. Trauma-informed efforts may also improve care for patients who have experienced trauma, cause less retraumatization, and improve physical and mental health outcomes. All six organizations are evaluating the effects of their trauma-informed initiatives on staff, and some are examining changes in the experience and health status of patients. Rigorous evaluations of trauma-informed efforts are needed to understand what elements of trauma-informed organizations and trauma-specific care are effective at improving staff and patient outcomes, and how this varies for different patients and organizations. For example, each organization provided trauma-specific behavioral health services on site or at a colocated site; understanding whether this is an essential ingredient in improved patient outcomes is important before spreading and scaling the practice. Respondents almost universally felt that the transformation from a

trauma-inducing to a trauma-informed organization would take a long time, and that understanding what is effective in the short and long term will be important for the field.

# Appendix. Grantee Profiles

This appendix provides descriptions of the six ATC grantees' efforts to make their organizations more trauma-informed. These efforts built upon earlier work in this area and were expected to be continued or further developed after the grant period.

## Center for Youth Wellness

San Francisco's Center for Youth Wellness provides behavioral health services to children referred from a federally qualified health center in the same building, the Bayview Child Health Center. The organization conducts clinical research to identify the most effective ways to treat children who have experienced trauma. It also engages in "movement building" efforts to increase health care providers' awareness and interest in screening for ACEs and offering trauma-informed care; see, for example, the 2015 TED talk by its founder and CEO, Nadine Burke Harris.<sup>12</sup>

CYW's efforts to become trauma-informed have included training and organizational assessment and enhancements to screening and treatment planning processes. The center has conducted trainings for its staff on trauma and its effects, mindfulness practices to reduce burnout, and cultural humility. An all-staff training introduced the Sanctuary Model for consideration as an organizational approach to becoming trauma-informed. Clinical behavioral health staff and research staff have been trained on cultivating emotional balance. CYW has also conducted the Behavioral Health Trauma-Informed Care Organizational Self-Assessment two years in a row; this assessment is being used to inform discussions on how best to move forward as a trauma-informed organization. CYW expects to engage in more trainings and efforts related to transforming organization culture.

With ATC grant funding, CYW has worked to better integrate its services with its partner FQHC's services. CYW has enhanced its trauma-informed screening and treatment planning process. The organization developed new protocols and training for providers and medical assistants on screening and answering questions families may have. CYW also incorporated new screening questionnaires into the patient intake process (including a new, more comprehensive ACEs questionnaire developed in-house) and updated its electronic health record to accommodate the changes. The organization has trained caseworkers on family conferencing and is implementing this in its clinical practice. Finally, CYW is further improving integration by embedding two new CYW care coordinators in Bayview Child Health Center's office space, where they can receive warm handoffs from pediatricians after a family

has completed an ACEs questionnaire. CYW and Bayview Child Health Center are working on sharing more information with each other through weekly “Multi-Disciplinary Rounds” meetings.

## Greater Newark Healthcare Coalition

Greater Newark Healthcare Coalition is a convening organization with ties to many local organizations in Newark. Using its ATC grant, the coalition assembled partners to pursue a multifaceted effort to address child trauma in Newark. The three prongs of this ATC effort addressed short-term needs (by providing behavioral health services at BRICK Avon Academy), medium-term needs (by training teachers at Avon and pediatric residents at the Children’s Hospital of New Jersey at Newark Beth Israel Medical Center), and long-term needs (by convening a multistakeholder, citywide committee to brainstorm future efforts to address trauma in Newark).

In the short term, grant funds were used to support a full-time licensed social worker employed by Rutgers University Behavioral Health Care who offered behavioral health services to Avon students in kindergarten through fourth grade. The social worker provided one-on-one counseling, small group sessions, and family therapy sessions with parents. Students were referred to this colocated social worker through the school’s Intervention and Referral Service process for identifying children with behavioral problems. A senior Rutgers counselor came to the school once a week to consult on cases and supervise this social worker.

ATC funds also supported a new therapeutic classroom at Avon called “Diver’s Cove,” where a small group of four to six students with behavioral problems learned behavioral skills and received close attention from a teacher and a teacher’s aide as they completed schoolwork assigned by their regular teachers. Students typically remained in Diver’s Cove for only a few weeks at a time and then returned to their regular classroom after demonstrating improved classroom behavior. The school’s ATC-funded social worker led group sessions with the students in Diver’s Cove for one 42-minute period per day and offered one-on-one counseling to these students.

In the medium term, Rutgers staff provided quarterly training to Avon teachers. By the time of our site visit, they had delivered three trainings focused on engaging in self-care to prevent staff burnout and interacting with students who exhibit disruptive behaviors and may have experienced traumatic events. Rutgers staff also presented trainings to pediatric residents at the Children’s Hospital of New Jersey at Newark Beth Israel Medical Center. Trainings for residents were given during two-hour Grand Rounds, small group trainings, and residents’ rounds, which allowed trainers to offer real-time tips and

feedback on exchanges between residents and patients. Trainings focused on filling knowledge gaps identified by the hospital's pediatrics chair.

Avon plans to continue the efforts begun under this grant, including funding two social worker counselors and its Diver's Cove classroom. The school also plans to hire a full-time trainer to offer additional trauma-informed trainings to teachers. Similar efforts are being implemented in a sister school called BRICK Peshine Academy, using another source of philanthropic funds, and the Children's Hospital of New Jersey intends to continue to "evolve" in this area.

Greater Newark Healthcare Coalition's long-term efforts center on the "ACE Impact Team," which brings together a range of Newark organizations. So many organizations were interested in participating that the committee broke into three subcommittees working on the following topics: (1) community education, (2) workforce training and capacity building, and (3) concrete interventions and supports. The committee has already won new grant funds for the ACE Impact Team to undergo Undoing Racism training, and for a small group of high school students to form a "youth healing team" that will learn about the science behind ACEs and develop a communications strategy to educate their peers and their community about ACEs and resiliency. The committee also plans to sponsor a public screening of a movie about the impact of traumatic experiences on children's development.

## Montefiore Medical Group

Montefiore Medical Group in the Bronx used its ATC grant to train staff in 22 primary care practices on the impacts of exposure to traumatic events on patient behavior, strategies for de-escalating interactions with agitated patients, the importance of screening patients for ACEs, and self-care approaches for staff to reduce burnout and secondary trauma. Montefiore's training approach includes the following components:

1. training staff who are already responsible for leading practice transformation through four in-person learning collaborative meetings,
2. offering prerecorded webinars for all staff, and
3. having some practices' behavioral health professionals deliver interactive, role-specific, in-person trainings (after they themselves have been trained on how to deliver these trainings).

Coaches employed by Montefiore are working with practices to help them increase their use of an ACEs screening questionnaire. Montefiore also formed a Critical Incident Management Team, made up of behavioral health providers employed by Montefiore, who are deployed to a practice within a day or

two of a traumatic event (e.g., the murder of a staff member) to counsel staff. At the time of our interviews, Montefiore was developing new posters for practice waiting rooms to educate patients about the effects of traumatic experiences and/or inform patients that Montefiore asks about and tries to address behavioral health concerns.

Montefiore practices are free to decide how to conduct ACEs screening and whether to use the ACEs screener for adult patients (it is already used for patients ages 5 and younger), which age groups to offer the screening to, which types of visits to offer the questionnaire at, how often to collect the questionnaire (e.g., only once, more common at adult practices; or repeatedly, more common at pediatric practices).

Montefiore's recent efforts build on past work, including being an early adopter of the National Committee for Quality Assurance Patient-Centered Medical Home model of care, participating in Medicare's Pioneer Accountable Care Organization model, screening patients for mental health issues, and offering warm handoffs to on-site behavioral health counselors employed by Montefiore.

## San Francisco Department of Public Health

The San Francisco Department of Public Health is working to become a trauma-informed system that fosters “wellness and resilience” for everyone working in or served by the public health system. The model is designed to create a common language and understanding about trauma and to create organizational change at individual, agency, and system levels. The SFDPH is training its 9,000 employees based on the six guiding principles of its initiative: understanding stress and trauma, cultural humility, safety and stability, compassion and dependability, collaboration and empowerment, and resilience and recovery. After each training, attendees are asked to commit to making one small change in their workplace to make it more trauma-informed.

Through its ATC grant, the SFDPH built on these efforts by helping six county agencies identify and implement more systematic trauma-informed changes. These agencies were early and engaged adopters of the department's trauma-informed initiative. This effort is led by two committees: a group of eight agency leaders who convene quarterly, and a group of 17 frontline staff drawn from each of the agencies (known as “champions”) who convene monthly. The latter group receives training in “trauma-informed systems” and coaching on organizational change, project implementation, evaluation, and participatory decisionmaking, and it shares lessons learned through trying different strategies in

different units. A new group of middle managers called “catalysts” will be empowered to support the work of champions.

Champions’ efforts are informed by a staff survey about organizational culture fielded in 2016. This survey asked SFDPH employees to assess the degree to which their agencies understood trauma, were safe and stable, were culturally humble and responsive, were compassionate and dependable, were collaborative and empowering, and were resilient and recovery-focused. The results of this survey were distributed to agency leaders and champions, who are now using these findings to identify areas for improvement.

The SFDPH is sharing what it has learned with community-based organizations and other counties in the Bay Area, including lessons about implementing train-the-trainer models, facilitating champion learning collaboratives, and engaging leadership in trauma-informed systems work.

## Stephen and Sandra Sheller 11th Street Family Health Services

11th Street’s trauma-informed initiative has grown out of the health center’s efforts to become certified in the Sanctuary Model, a curriculum that aims to change an organization’s culture to promote healing and shift the way staff interact with each other and with patients.<sup>13</sup> New hires complete a half-day Sanctuary training, and Sanctuary refresher trainings are offered periodically. A small core team met regularly for several years to work on completing Sanctuary certification requirements. Over time, these meetings moved away from planning work for certification and opened up to all staff, reinforcing core Sanctuary concepts in a more participatory, experiential, and “fun” way. At the time of our site visit in spring 2017, 11th Street had only one remaining requirement for Sanctuary certification: training staff in “reflective supervision,” which would take place in the coming months.

11th Street formed an Undoing Racism committee in response to feedback from staff implementing the Sanctuary Model. The Undoing Racism committee is a group of 15 people of different races and roles in the organization who meet monthly for two hours to talk about racism within the organization, within the surrounding community, and within society at large.

11th Street is also working to improve staff mindfulness and reduce feelings of secondary trauma and burnout through offerings such as mind-body stress reduction classes and one-stop workshops.

Staff are permitted to spend two hours a month at any of these meetings or classes, and are encouraged to participate in as many trainings and meetings as their schedules allow.

In addition to these recent efforts, 11th Street continues to offer its patients an array of behavioral health services, including on-site talk therapy and creative arts therapies (e.g., dance/movement, art, and music). Primary care providers make warm handoffs to in-house social workers and behavioral health consultants who can assist patients with an array of psychosocial needs. To promote more healthy lifestyles, an in-house nutritionist leads cooking classes and consults with patients, and an on-site fitness center is available to patients. Mind-body educators offer traditional and trauma-informed yoga, as well as mindfulness and stress reduction classes.

## Women’s HIV Program at the University of California, San Francisco

The Women’s HIV Program at the University of California, San Francisco, serves low-income women living with HIV/AIDS. Working with other experts, the UCSF clinic developed a framework for trauma-informed primary care that guides their transformation efforts. The framework for trauma-informed primary care includes an environment that is calm, safe, and empowering for both patients and staff; screening that inquires about current and lifelong abuse, PTSD, depression, and substance use; on-site and community-based programs that promote safety and healing; and a foundation of trauma-informed values, robust partnerships, clinic champions, support for providers, and ongoing monitoring and evaluation.

Through the ATC grant, practice staff have received training on trauma’s effects and manifestations, ways in which clinic staff can experience vicarious trauma from working with traumatized patients, recommended strategies for communicating with traumatized patients, and cultural humility. The organization has also trained staff on topics such as providing care to transgender patients and strategies for de-escalating interactions with agitated patients.

The UCSF Women’s HIV Program is a small clinic where providers see patients frequently. Providers ask patients about topics such as intimate partner violence, suicidal thoughts, and immediate safety concerns during visits. If a patient is identified as needing additional services, an on-site social worker asks the patient a more comprehensive set of screening questions, including questions about past traumatic experiences. New patients also receive a psychosocial screening. UCSF has now implemented an interpersonal violence screening that is conducted every six months by a provider, and

the clinic is pilot-testing a PTSD screening for trauma-related symptoms that will be conducted annually. The clinic is also considering how best to screen for substance abuse and chronic pain.

The Women's HIV Program recently began convening weekly meetings of psychosocial staff to discuss patients and "service match" them to the intervention likely to be most beneficial for them. Available services include on-site case management, on-site talk therapy, off-site talk therapy at UCSF's Trauma Recovery Center, on-site STAIR group therapy, a community theater program (Medea) adapted from a theater program for incarcerated women, and a trauma-informed leadership group.

Through its ATC grant, the Women's HIV Program has colocated a licensed clinical social worker therapist from the UCSF's Trauma Recovery Center within its office space. This therapist has led a new group intervention for patients who are not ready to engage in traditional therapy but are interested in learning strategies to better cope with daily stresses. This intervention, called STAIR (Skills Training in Affect and Interpersonal Regulation), was originally developed for veterans with PTSD,<sup>14</sup> but the practice modified it to focus only on skill building, dropping the one-on-one reexperiencing therapy that would normally be included. The STAIR group meets two hours a week for 12 weeks to work on emotional regulation, communication, and relationships, and has reduced patients' feelings of isolation.

Concurrent with its ATC-funded efforts, the practice hired a licensed clinical social worker to manage various trauma-informed efforts, to provide clinical supervision to the practice's social worker case managers, and to facilitate a monthly meeting to solicit input from staff and patients on practice plans. Patients have provided input on approaches the practice could use to expand and formalize screening of patients for risk factors and symptoms such as substance use. The practice also convenes all staff to coordinate the physical and behavioral health care of patients before each clinic; this meeting has reportedly decreased staff isolation in dealing with patients with complex needs. The practice's recent work builds on earlier efforts to be trauma-informed, which include the therapeutic interventions mentioned above, patient massages, free burritos, and service dogs in the waiting room.

# Notes

- <sup>1</sup> Trauma can result from a wide range of emotionally harmful experiences including violence, neglect, loss, disaster, and war. See SAMHSA (2014a).
- <sup>2</sup> As with ACEs, the prevalence of adult exposure to trauma varies depending on how exposure to trauma is measured. Early studies that examined this issue include Kessler (2000) and Pietrzak and colleagues (2011).
- <sup>3</sup> See, for example, Kalmakis and colleagues (2015).
- <sup>4</sup> “Trauma-Informed Approach and Trauma-Specific Interventions,” SAMHSA, last updated August 14, 2015, <https://www.samhsa.gov/nctic/trauma-interventions>.
- <sup>5</sup> “Undoing Racism Community Organizing Workshop,” People’s Institute for Survival and Beyond, accessed December 29, 2017, <http://www.pisab.org/programs#urcow>.
- <sup>6</sup> Briana Loomis, *San Francisco Department of Public Health Trauma Informed System Initiative: First Year Data Report, April 2014–March 2015* (San Francisco: Department of Public Health, n.d.).
- <sup>7</sup> The Center for Youth Wellness provides mental health and wellness interventions to children referred by a federally qualified health center in the same building, the Bayview Child Health Center.
- <sup>8</sup> Multiple versions of ACEs screening questionnaires have been developed. See Emerald Montgomery, “Resource List -- ACE Surveys,” ACN Resources Center Blog, June 14, 2016, <http://www.acesconnection.com/g/resource-center/blog/resource-list-extended-aces-surveys>.
- <sup>9</sup> ATC organizations reported using the following non-ACEs screening questionnaires: Pediatric Symptom Checklist, Child Behavior Check List, Youth Self Report, Stress Index for Parents of Adolescents, Parenting Stress Index, Trauma Symptom Index, PTSD Checklist, and the Patient Health Questionnaire for depression (PHQ-2 and PHQ-9 versions).
- <sup>10</sup> “Continuing Education: Skills Training in Affect and Interpersonal Regulation (STAIR),” US Department of Veterans Affairs, last updated December 14, 2017, [https://www.ptsd.va.gov/professional/continuing\\_ed/STAIR\\_online\\_training.asp](https://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp).
- <sup>11</sup> “About the Medea Project,” Medea Project, accessed December 29, 2017, <http://themedeproject.weebly.com/>.
- <sup>12</sup> Nadine Burke Harris, “How Childhood Trauma Affects Health across a Lifetime,” filmed September 2014 at TEDMED, San Francisco, video, 15:59, [https://www.ted.com/talks/nadine\\_burke\\_harris\\_how\\_childhood\\_trauma\\_affects\\_health\\_across\\_a\\_lifetime](https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime).
- <sup>13</sup> “The Sanctuary Model,” Community Works, accessed December 29, 2017, <http://sanctuaryweb.com/TheSanctuaryModel.aspx>.
- <sup>14</sup> “Continuing Education: Skills Training in Affect and Interpersonal Regulation (STAIR),” [https://www.ptsd.va.gov/professional/continuing\\_ed/STAIR\\_online\\_training.asp](https://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp).

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