WHAT YOU NEED TO KNOW: Every organization that embarks on the journey to implement trauma informed care (TIC) will have its own set of motivators, conditions, and challenges. However, we have also found strikingly common themes across a wide range of agencies, systems, and fields of practice. Several partners around the state have allowed us to document their ongoing process and results in the hope that the information might be useful to others. Below is the first "report" of a TIC demonstration site.

Clackamas County Behavioral Health Centers
Trauma Informed Care Initiative
2012-2016

Introduction

In the fall of 2015, Trauma Informed Oregon (TIO) invited Clackamas Behavioral Health Centers (CBHC) to serve as a demonstration project for the implementation of trauma informed care (TIC). The invitation was based on the commitment and ongoing efforts at CBHC to improve policy and practice to better meet the needs of those most affected by histories of trauma in the workforce and in the population they serve.

Purpose. The purpose of the collaboration between TIO and CBHC was to document the TIC initiative at CBHC, including the background, the process, the challenges, and the results, as well as to assess and report on the impact. Both TIO and CBHC staff also saw this partnership as an opportunity to highlight and acknowledge the commitment and efforts that had been made and are continuing at CBHC.

Methods. TIO staff began meeting with the TIC Workgroup at CBHC in the late fall of 2015 to gather background information about how the initiative started, the organizational climate and context in which it was implemented, and the processes that had been used to identify priorities and plan for improvements. Discussions focused not only on concrete steps that were taken, but also on the factors or circumstances that facilitated the process and those that created barriers or challenges. In addition, CHBC staff that had been involved shared relevant documents (meeting minutes, e-mails, etc.) and created a timeline to illustrate how the initiative rolled out over these first four years. Consumer feedback data from two different data collection points and two staff surveys provided additional important information.

Sharing the findings. This report summarizes the results of this collaborative documentation project. It is intended to support the efforts of other organizations who are entering or engaged in a similar process by illuminating the successes and challenges that are frequently encountered across systems and by describing how one organization has persevered. Staff from the CBHC workgroup or management team are available to share their experience directly with interested partners around the state.

Background and Context

The TIC initiative at CBHC began during a period when both external and internal conditions were challenging to workforce morale and energy. The conditions we learned about at CBHC are so common across our human service systems that they are worth noting, particularly since the initiative persisted in spite of these challenges.

External Factors. CBHC was the sole provider of Medicaid mental health services in Clackamas County in the early 2000s. The centers were understaffed and struggling to meet the need. During the significant economic downturn following 9/11 with across the board budget cuts, especially felt in the behavioral health system, also resulted in the loss of positions at CHBC and the elimination of certain job classifications; newer staff faced potential "bumping" by senior staff; some left to find work elsewhere. There was tension in the agency and a culture of extreme scarcity that persisted beyond the decade.

In 2009, the county initiated a Behavioral Health Redesign to increase options for the community by providing a greater diversity of services and service providers. This meant downsizing county direct services and shifting resources to help establish nonprofits in the area. CBHC fell under a "no growth" mandate. Although well-intentioned, the redesign process felt rushed, created anxiety over more potential job losses, and further demoralized county staff, some of whom felt their work and efforts were not valued.

Finally, health care reform and the efforts to integrate behavioral and physical health care in Oregon resulted in structural changes in the county, increased caseloads, increased paperwork requirements – in short, additional stressors in an already stressed system.

Internal Factors. The challenges from outside the organization contributed to tension and stress inside as well. The impact of potential staff cuts, the potential for bumping, and a history of mistrust of management showed up differently among various teams across the organization (in some cases, there was a strong bond and mutual support within teams, but in others, already challenging dynamics were exacerbated).

CBHC is a unionized shop. This affords important protections to the workforce, but also has particular characteristics that have affected the movement towards trauma informed care. Supervisors are not part of the union, which can contribute to perceived lack of connection with direct service staff and potentially contribute to mistrust. Union procedures require lengthy and progressive discipline strategies when there are personnel issues; transparency is not possible under certain circumstances, at times contributing to anxiety or mistrust in the workforce. Overtime pay is required by contract; this is recognized as fair and just, but may result in sending staff home when their best interests might be better served by greater flexibility to meet their own needs and the needs of their clients. In short, the impact of a union can be both consistent with and contrary to the principles of trauma informed care.

Change Agents and Facilitating Conditions

By 2010, clinical staff at CBHC were aware of the national movement towards trauma informed care and the importance of it to their work, but many had limited understanding of what it meant beyond direct clinical intervention or treatment. Some staff attended a training in 2011 but the systematic agency-wide effort began in 2012, fostered by four key ingredients:

- An MSW field placement student at the clinic that year brought passion for trauma informed care, basic knowledge, and a connection with expertise and technical assistance at the School of Social Work at Portland State University (PSU). Although serving in a student role, her expertise had credibility and brought a neutral voice to the process.
- A new clinic manager listened and responded, endorsed the effort, and provided coaching and supervision to the student through the first difficult year of work, making it possible for her to create and sustain a TIC workgroup.

- Through the student, CBHC formed an ongoing relationship with PSU providing access to technical assistance and training; CBHC set aside funds to pay for this assistance as well as staff time to devote to the effort.
- Training in TIC was provided for all staff, followed by a training in Trauma Stewardship and a focus on staff wellness programming. Regular training for new staff and annual refresher training for all staff have been important investments on the part of management.

These elements (a dedicated and knowledgeable individual to lead the effort, commitment and investment on the part of leadership, access to information and technical assistance, and agency-wide training) contributed greatly to overcoming obstacles and sustaining momentum over time.

Assessment and Planning

CBHC created an infrastructure for planning (the TIC workgroup), gathered information to identify and prioritize opportunities, and despite struggles with the process, came up with concrete changes in policy, procedure, and practice to recommend or initiate.

The Workgroup. Early in 2013 a TIC Workgroup formed. All staff were invited and membership was open to anyone. Through a small contract with PSU, a TIC consultant assisted the group during the initial assessment and planning process. Workgroup membership, leadership, cohesion, and productivity has varied over time, but the group is still in place four years later, meeting monthly. Clients have not served on the workgroup (client input is sought through Lunch and Listen Sessions, described below), but a peer support staff member now participates.

Assessment Strategies. The TIC workgroup at CBHC has employed a number of different strategies to gather information from staff and clients. Each has been useful and each has presented challenges.

- *Staff survey*. The workgroup labored months to produce a staff survey in order to capture the workforce experience of the agency. The survey included questions directly related to TIC, drawn from a nationally recognized agency self-assessment tool, as well as a range of other questions specific to CBHC. The staff survey was administered first in 2013 and again in 2015. Initial results were somewhat helpful, giving voice to staff concerns and a sense of the challenges to morale, but were hard to translate into specific action steps or issues that could be easily remedied.
- *Client survey*. Questions related to TIC were also added to an annual client feedback survey which is administered each fall. Ratings were uniformly high on all items and have continued to be high. This speaks well for the quality of service provided by CBHC but is of limited usefulness in identifying opportunities for improvement.
- *Lunch and Listen*. Once a month, CBHC offers lunch to any clients who want to come and share their thoughts/feedback on clinic practices and policies. This process has yielded some important areas to work on, but is recognized to be skewed to the experiences of the relatively small number of clients who regularly participate (usually 15-20).
- *The principles of TIC as a framework*. Beginning with physical safety, the workgroup identified specific circumstances or conditions at the centers that felt physically unsafe to staff or clients. This proved to be fairly straightforward and has yielded many specific areas to work on (see Selected Action Steps below). The process became more difficult when the group moved on to "emotional safety" and some of the other principles of TIC that are harder to define or operationalize.

- *Output from training sessions*. TIC training at CBHC included a chance for staff to work in small groups, identifying "hot spots", i.e., circumstances, situations, or conditions in the agency that could activate a trauma response in staff or clients. Some workgroup members used individual team meetings to get more information about the concerns that were raised. These "hot spots" continue to provide insight into staff perceptions and experiences and critical opportunities for growth.
- *Workgroup input*. As the workgroup became more knowledgeable and versed in trauma informed care, next steps emerged from discussions and from the clinic manager who has been a strong advocate for TIC.

In summary, assessment for TIC at CBHC has been a patchwork of different approaches but has worked and continues to work because of the commitment and creativity of the leadership and staff involved.

Action Steps

Some of the specific actions that CBHC has implemented over the past several years are listed in the Appendix to this document. They cover a wide range, including modifications to the physical environment; changes in practices/protocols to address safety concerns; resources devoted to staff wellness activities; adoption of trauma policies and modification of existing policies; support for staff wellness activities; creation of more meaningful opportunities for feedback from staff and clients; ongoing training on trauma, vicarious trauma, and trauma informed care; and development of staff skills in providing specialized trauma specific interventions. New concrete action steps are regularly identified and implemented.

Follow Up

We were interested to learn about the rollout of some of the action steps and how the results were experienced by the rest of the CBHC staff, located at multiple clinics across the county. We used the opportunity of a bi-annual all-staff meeting to administer a follow-up survey which reached 77 individuals, representing nearly 90% of the total employees. In the survey, we listed 12 action steps that were intended to affect the whole organization (excluding than those that were program-specific). We asked staff to respond to three question about each action:
1. How important do you think this action is to trauma informed care?
2. To what extent did you see it happen?
3. If it happened, how much of a difference has it made?

On the survey, staff were also encouraged to provide input on what they thought important next steps might be and to respond to nine trauma-related items connecting to their own experience at the agency.

With respect to implementation, the survey results provided important information about which action steps had been widely adopted across the agency and which had not reached their intended audience as well as expected, despite being "institutionalized" at the management level. Turnover and changes in position, combined with other pressures on time and attention, resulted in incomplete rollout of some practices, including for example, self-care plans as part of annual reviews. Some staff remained unaware of the "agency-wide" expectation of this practice.

Moreover, looking at responses to the "How important do you think this action is to trauma informed care" question with respect to specific action steps helped the workgroup understand the perspective of staff who were not directly involved in planning. Hearing what is important (or less

important) to staff is helping the workgroup address priorities that perhaps had not surfaced in the past. It's also a way to know whether more information, education, or agency-wide conversations could be helpful in order to create a shared vision about the meaning and implementation of trauma informed care.

Impact

Based on survey results, the action steps that were viewed as making the most difference were: 1) training for staff on vicarious trauma and "trauma stewardship"; 2) incorporating TIC principles into the annual client feedback survey; 3) protecting the privacy of individuals who are asked to provide urinalysis (UAs) on site; 4) offering coffee as well as water to clients in the waiting room; and 5) posting gender inclusion sign at restrooms. There were also higher levels of agreement on a number of items related to the workforce experience at CBHC,[1] including:

- The leadership team of CBHC values Trauma Informed Care principles (safety, trustworthiness, choice, collaboration, and empowerment).
- Self-care is encouraged and supported with policy and practice at CBHC.
- The clinic site I work at has practices in place to address potentially unsafe situations.

Additional data to address impact. Our work with CBHC to assess impact may also include examining agency-level data over time regarding staff absenteeism and turnover to see if we can detect changes in these that might be linked with the ongoing implementation of TIC-specific policies and practices at CBHC. However, recognizing that there are numerous confounding circumstances and conditions that can affect these outcomes, we also look for qualitative data to help explain how the workforce may have been affected. Many staff members are new, and as one supervisor commented, "Newcomers don't have any idea what it was like in the past," as she recounted her own experience of the changes in the organizational culture over the last few years. She also noted, however, that new staff often comment that CBHC is "so different" from the organization they left.

The client feedback survey, also administered in 2013 and again in 2014, showed such strong positive ratings of the staff and services at CBHC at both data collection points that there is a "ceiling effect," i.e., it is not possible to detect change. Because satisfaction surveys often have a positive response bias, we will be looking for other ways to capture any changes in the experience of clients as well as suggestions for additional improvements that could be made. This may happen through discussion or focus groups or potentially through the Lunch and Listen sessions that occur monthly.

Lessons from the CBHC Experience

The accomplishments and continuing progress at CBHC are especially admirable given that the effort began in a challenging context and has had a fair share of ups and downs over the past four years. Following are the elements that have seemed to matter most:

- *Perseverance*. It was challenging, especially during the first year, to move past the low morale evident across the agency and the tension between program staff and the management, a sense that nothing would make a difference combined with a lack of trust or team spirit. Early

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[1] These findings are in comparison to data collected in 2011. However, we use caution in their interpretation because of differences in sample size (fewer respondents in 2011) and changes in staff composition.

workgroup discussions were frequently derailed by the need to process feelings and experiences. As a result, assessment strategies sometimes met with mixed response and were not always productive. What mattered was not giving up and taking the long view through changes in membership, temporary gaps in the initiative, loss of a designated facilitator on the workgroup, etc.

- *Vision and leadership*. The commitment of the clinic manager and her direct involvement in the workgroup, along with investment of resources in training and consultation and the knowledge and commitment of key staff, made an important contribution. One workgroup member noted that she would likely have left the group had the manager not joined and that the manager's participation signaled real potential for change.
- *Action.* Making things happen – whether large (an agency-wide trauma policy) or small (changing a sign in the lobby) – made a difference. Action steps have been ongoing at the agency level and encouraged at the team level as well.
- *Sustaining momentum*. The workgroup and clinic manager have made conscious efforts to build on success by crediting the workgroup and the TIC initiative with changes that staff noticed and appreciated, by presenting at staff meetings, by reaching out and engaging different teams and programs within the agency, and through other strategies aimed at maintaining and increasing buy-in.
- *Outside support*. Access to outside expertise and guidance made a difference – both indirectly through consultation for the clinic manager and key staff, and directly through all-staff training, or technical assistance to the workgroup when it was struggling to identify next steps.

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CBHC Trauma Informed Care Initiative
Selected Action Steps

Staff Wellness/Wellbeing:
Stretch and breathing class and Yoga
Annual Self Care plans
Flexible schedules
Small group trainings for all staff: Vicarious Trauma/Toxic Stress
Training for all staff: *Trauma Informed Care 101 and 201*
Opportunities to attend *Trauma Stewardship*
De-escalation training
Mindfulness Training
County sponsored wellness activities

Safety:
Agency-Wide Trauma Policy developed (other policies reviewed and amended)
Access to supervision (on-call)
Protocol: Spark – end of day, real time attendance
Protocol: Closing – never having one person alone in the building
Home visits: End at 5:00 p.m.
Support locking front door at 6:00 p.m.
Intercoms added at two clinics
Safety sign posted in clinic lobby
Page added to the client handbook about the nature of the service relationship and boundaries
Sheriff's Office assessment of buildings for safety
Light added to dark hallway

On Boarding:
Within first 30 days of hire: New staff review trauma informed services policy
Within first 60 days of hire: New staff watch video on trauma, video on trauma stewardship, and develop self-care plan
Within first 6 months of hire: *Trauma Informed Care 101*

Hotspots Addressed:
Coffee for clients
Cord for waiting line
Admin time for staff added to schedules
Appreciation and gratitude at the beginning of each meeting
UA signs to close restroom when in use for UA
Gender Inclusion signs
Productivity transitioned to provider dashboards and direct service percent
Trauma Informed supervision

Client Voice:
Lunch & Listen
Feedback from clients put into client satisfaction survey
Client letters re-written to be much friendlier