WHAT YOU NEED TO KNOW: For organizations that are required to demonstrate compliance with the 2015 Trauma Informed Services Policy of the Oregon Health Authority (OHA), we have created a crosswalk between the TIO Standards and the policy provisions. Look for small blue check marks on the Standards that directly align with the OHA Policy. This was done in collaboration with OHA and is intended to be a resource and support for behavioral health providers. We encourage agencies to use the Crosswalk to identify and highlight Standards that you are already addressing and to set priorities for next steps in your efforts to implement trauma informed care.

STANDARDS OF PRACTICE FOR TRAUMA INFORMED CARE

The following Standards of Practice for Trauma Informed Care in Oregon are based on nationally recognized principles of trauma informed care (TIC) and are in alignment with SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.[1] Each section of the Standards references specific elements in the SAMHSA Guidance document. In addition, the Standards reflect what we are learning about implementation from partners around the state and were reviewed by a workgroup from the Trauma Informed Oregon Collaborative that included family members, youth, and individuals with lived experience as well as providers from different fields of practice. The Standards are intended to provide benchmarks for planning and monitoring progress and a means to highlight accomplishments. **We recommend use of this tool by multi-level teams within organizations.**

Please keep the following in mind in using the Standards tool:

1) The Standards of Practice are intended to help agencies communicate to their constituencies (individuals seeking services, community partners, contracting or funding entities, etc.) how and to what extent they are working to build trauma informed care within their program, clinic, agency or system. **This is a voluntary process.** We are not attempting at this time to develop metrics or a system of accountability.

2) Moreover, there is no assumption that the Standards will be equally useful across all organizations or systems. **Culturally specific organizations, for example, may describe how they effectively provide care for trauma survivors in quite different ways** than what appears in the Standards. Health care providers also may need different language, and possibly alternative or added Standards as well.

3) Individual Standards also will be interpreted differently in different contexts. For this reason, **the Standards invite a qualitative (descriptive) response** rather than a yes/no answer.

4) However, in order to assist agencies to assess strengths and weaknesses and to set goals, we have included a simple set of ratings. These are for internal communication and planning purposes only. **The ratings cannot be used to compare one program or agency to another**. Note that although the

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highest rating (4) says "we're stellar in this area," there is always room for improvement, and perspectives may vary depending on who is making the rating.

5) **There is no expectation that an agency or program will be able to respond affirmatively to every item listed.** We hope the Standards will support planning and ongoing quality improvement. Furthermore, **agencies may be doing any number of other things to create trauma informed care** that we have not captured here. Space is provided for this additional information.

6) In using the Standards tool for planning, **it may be helpful to summarize the self-ratings into areas of strength and areas where work is needed** and to consider whether to build on existing strengths (moving ratings from a 2 or 3 to a 4, for example) or to address significant gaps (areas where self-ratings are low). In addition, **we strongly encourage efforts to address issues that affect the workforce as well as those that affect individuals seeking or receiving services** and to look for low cost/high impact opportunities.

7) Finally, **we recognize that the experience of individuals seeking services (and of the workforce as well) often comes down to personal interactions that reflect (or don't) sensitivity, respect, caring, transparency, an understanding of trauma, etc.** We are not able to capture the quality of those individual interactions in a set of agency-level Standards. We hope that procedures for inviting and using feedback, commitment to training, supervision, and the involvement of individuals with lived experience in the service system(s) will help fill in those gaps. And, again, we encourage the use of this tool to stimulate discussion that includes multiple perspectives and experiences.

The Standards of Practice will be reviewed annually, based on feedback from participating programs, agencies and systems.

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STANDARDS OF PRACTICE FOR TRAUMA INFORMED CARE

I. Agency Commitment and Endorsement. Agency leadership acknowledges that an understanding of the impact of trauma is central to effective service delivery and makes operational decisions accordingly [includes **Governance and Leadership, Policy, Financing**, and aspects of **Engagement and Involvement***].

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Ia. Leadership team (including administration and governance) has received information/training on trauma and trauma informed care. *Describe the process.*	1 2 3 4
Ib. Trauma Informed Care appears as a core principle in agency policies, mission statement, written program/service information. *Describe or provide examples*: √	1 2 3 4
Ic. Individuals with lived experience in your service system have leadership roles in the organization. *What roles?* √	1 2 3 4
Id. There is a process in place for regular feedback and suggestions from staff and service recipients related to trauma informed care, e.g., perceived safety, welcoming environment, transparency, shared decision making, helpful/supportive staff, etc. *Describe process. Examples of feedback and change(s) that resulted?* √	1 2 3 4
Ie. Decisions about changes in policy, practices, procedures, and personnel are made in a way that minimizes negative impact on workforce and on individuals/families receiving services. *How do you achieve this? What processes are in place?*	1 2 3 4
If. Agency budget reflects a commitment to trauma informed care (e.g., resources for specialized training, flexible funding for staff wellness, peer specialists, staff time to coordinate or serve on workgroup, etc.). *How is this commitment reflected in the budget?*	1 2 3 4
Ig. Agency-wide workforce wellness program is in place. *Describe the program. How many staff participate?* √	1 2 3 4
Ih. The organization has made a commitment to diversity and equity within the organization and with the population served. *How is this reflected in policy and practice?* √	1 2 3 4

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II. Environment and Safety. There is demonstrated commitment to creating a welcoming environment and minimizing and/or responding to perceived challenges to safety [includes **Physical Environment** and aspects of **Engagement and Involvement***].

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IIa. Physical space (external environment, exits and entrances, waiting room, offices, halls, lighting, restrooms, etc.) has been reviewed (see NOTE below) for actual and perceived safety concerns that may affect staff and individuals receiving services. *What was the process? Who was involved? When did this last occur? What changes were made as a result?* √	1 2 3 4
IIb. Physical environment has been reviewed for "welcoming" quality, e.g., cleanliness, odor, color, furniture (in good repair and arranged for comfort), access to water, etc. *What changes have been implemented?* √	1 2 3 4
IIc. Physical environment has been reviewed for cultural responsiveness. *Describe modifications made.*	1 2 3 4
IId. There is a designated "safe space" (permanent or temporary) for staff to practice self-care. *Describe.*	1 2 3 4
IIe. Physical safety and crisis protocols for staff and for individuals receiving services are in place and are regularly practiced. *What's the protocol? How do you ensure information is available when needed?*	1 2 3 4
IIf. Individuals who have received services from the agency have helped develop and/or have reviewed decisions about physical environment and/or safety protocols. *What was the process?*	1 2 3 4
IIg. There is a process in place to hear and respond to safety concerns that arise. *Describe the process and how it is trauma informed.* .	1 2 3 4

NOTE: The term "reviewed" can mean many things. Please consider, throughout this document, who was involved in the process of reviewing aspects of the physical environment or practices/policies, and what perspectives were represented.

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III. Workforce Development. Human Resource policies and practices reflect a commitment to trauma informed care for staff and the population served [includes **Training and Workforce Development***].

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Training **IIIa.** Employees have received core training in Trauma Informed Care. Check the content that staff has had: A= all staff; M = management/admin; DS= direct service staff. ○ The Adverse Childhood Experiences study ___ ○ The prevalence and impact of trauma on individuals in our agency ___ ○ The neurobiology of trauma___ ○ Issues of power and oppression related to the experience of trauma____ ○ Historical oppression; intergenerational trauma ___ ○ Principles and implementation of Trauma Informed Care___ ○ The role and benefits of peer support services___ ○ Trauma in the workforce; secondary trauma___ *If you provide (or make available) more in-depth training, please describe.* *Other trauma-related training regularly offered/required (including on trauma specific services)?* √	1 2 3 4
IIIb. Core training is offered at least annually. *Which modules? How frequently? How many staff attend? How is annual training delivered, by whom?* √	1 2 3 4
IIIc. Training is provided on supporting, managing, and responding to reactivity (e.g., de-escalation training). *Describe. How often is this training offered and to whom? How many staff have participated?*	1 2 3 4
IIId. Organization is building internal capacity to ensure that ongoing training and education for staff on trauma informed care is available. *How? What is the current status?* √	1 2 3 4
IIIe. Alternative opportunities for staff to learn about TIC (e.g., webinars or videos, community events) are offered regularly. *Examples? How many staff have utilized?* √	1 2 3 4

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Hiring and Onboarding Practices **IIIf.** Screening and interviewing protocols include applicant's understanding and prior experience/training regarding the prevalence and impact of trauma and the nature of trauma informed care. *What questions are asked during the interview process? How do you gauge an applicant's ability to respond in a trauma-sensitive way to the individuals you serve (some organizations are hiring for 'warmth and emotional intelligence')?*	1 2 3 4
IIIg. Individuals with lived experience of our service system participate in the hiring process. *How? How is their feedback utilized?*	1 2 3 4
IIIh. New employee orientation and training includes the core principles of trauma informed care and affirms the agency's commitment to ongoing trauma awareness and education for staff. *Describe.*	1 2 3 4
Supervision and Support **IIIi.** Staff receives regularly scheduled supervision. *Which staff? How often does this process happen?* √	1 2 3 4
IIIj. Peer Support personnel, whether contracted or on staff, also receive regular support and guidance. *What is the process?*	1 2 3 4
IIIk. Supervision includes discussion of staff care and wellness. *Describe or provide example.* √	1 2 3 4
IIIl. Supervision includes learning and application of knowledge about Trauma and TIC. *Example of how this happens?* √	1 2 3 4
IIIm. Supervisors have had training/consultation on supervising for TIC. *When and how does this occur?*	1 2 3 4
IIIn. Performance reviews expect increased awareness, understanding and practice skills related to trauma informed care. *Describe.* √	1 2 3 4
IIIo. Supervisors and staff can explain personnel policies; disciplinary actions reflect principles of transparency, predictability, and inclusiveness insofar as possible, given legal or contractual considerations. *Examples of how this is ensured?*	1 2 3 4

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IV. Services and Service Delivery. Service delivery reflects a commitment to trauma informed practice [includes activities related to **Screening, Assessment, Treatment Services,** aspects of **Engagement and Involvement**, and **Cross Sector Collaboration***].

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IVa. The first point of contact is as welcoming and engaging as possible for individuals seeking support or services. This includes reducing distress related to referral, self-referral, intake, etc. *Describe or provide examples of how this is achieved.*	1 2 3 4
IVb. Intake and all direct service staff are able to talk with individuals seeking services about the prevalence and impact of trauma and how it can affect engagement and involvement. *How is this information delivered in a trauma informed way? Do you have a script or coaching for staff?* √	1 2 3 4
IVc. Direct service staff understand the heightened risk of suicide for trauma survivors and are able to respond appropriately and get appropriate help. *What is the protocol? What ensures that staff are able to implement?* √	1 2 3 4
IVd. Intake forms and processes have been reviewed and modified to reduce unnecessary detail that might be triggering to individuals who are seeking or entering services. *What has been modified to improve the intake process for the consumer?*	1 2 3 4
IVe. Agency has written easy-to-read documentation for staff and service recipients that explain core services, key rules and policies, and process for concerns/complaints. *Describe or provide documentation. How it is available in the agency?* *Note if service recipients have reviewed.*	1 2 3 4
IVf. Policies related to treatment services (cancellations, no-shows, other rules) have been reviewed and modified as needed to reflect an understanding of trauma and its impact. *What was the review process used? What has happened as a result of these changes?*	1 2 3 4

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IVg. Individuals receiving services have the opportunity to provide input/feedback and/or to grieve policies that affect them. *What is the process or structure for this to happen?* *How is the process trauma informed?*	1	2	3	4
IVh. In organizations providing direct service, the importance of the primary relationship is recognized and supported through policy and practice. *How do you work towards continuity of care?*	1	2	3	4
IVi. In organizations providing direct service, trauma specific services are offered, preferably reflecting promising or best practices. *What services are offered?* √	1	2	3	4
IVj. In organizations not providing direct services, staff has up-to-date information about trauma specific services available for referrals. *How do you ensure this information is available and used?* √	1	2	3	4
IVk. Peer support is available and routinely offered to individuals receiving services. *If yes, what services are offered? What is the role of peers in the organization (paid staff, volunteer)?* √	1	2	3	4
IVl. Individuals receiving services are not terminated without notice and direct contact (unless precluded by circumstances). *How do you ensure this? What's the protocol?* √	1	2	3	4
Cross-Sector Collaboration **IVm.** Agency is working with community partners and/or other systems to develop common trauma informed protocols and procedures. *Describe efforts and progress in this area, including any shared or cross-training that occurs.* √	1	2	3	4

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V. Systems Change & Progress Monitoring. There is demonstrated commitment to planning, implementation and continuous improvement [includes **Progress Monitoring and Quality Assurance, Evaluation**, and aspects of **Engagement and Involvement***].

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Va. The agency has a structure/process in place to further develop and sustain trauma informed care (for example, a multi-level/cross program workgroup that meets regularly). *What does this structure/process look like? Who participates?* √	1 2 3 4
Vb. Agency has initiated or completed an agency self-assessment. *What process was/is used? What priorities have been established as a result?* √	1 2 3 4
Vc. The perspective of persons with lived experience was or is being included in the agency self-assessment process. *How?*	1 2 3 4
Vd. Agency policies have been reviewed through a trauma informed lens and modified to meet TIC principles. *Example of policy change that was made? Changes that resulted?* √	1 2 3 4
Ve. There is a regular mechanism for communicating out to staff and stakeholders about emerging TIC practices and the agency's efforts to promote and sustain TIC. *How does this happen? How often?* √	1 2 3 4
Vf. Senior Management receives regular updates on progress and priorities for systems change to ensure trauma informed care. *Describe the process? How often does it occur?*	1 2 3 4
Vg. Senior Management and/or TIC implementation team is using agency data to help establish priorities and measure impact (e.g., staff retention, absenteeism, engagement and retention of service recipients, etc.). *What data?*	1 2 3 4
Vh. The self-assessment or quality assurance process for trauma informed care is ongoing. *Provide examples of objectives met and current priorities.*	1 2 3 4

VI. Please add anything else you would like stakeholders to know about how the organization/program is implementing trauma informed care.

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