Section 3: The Self-Assessment

The first section provided information about Trauma-Responsive Systems, and the second provided information about Trauma-Informed Care.

This section helps you assess where your organization is relative to key characteristics in environments that operate from a trauma-informed perspective.

Areas Assessed

The assessment looks at the five areas described below.

1. ***Leadership and Culture***: Management commitment and buy-in, strategy and focus, communication of why the transformation is important, the culture of caring and response, and similar issues.
2. ***Trauma-Informed Care/Response Structure***: Alignment with TReSIA model, connection to business objectives and strategies, coverage of main contact touchpoints, cooperation between teams and work groups, and other relevant issues.
3. ***Policies and Processes***: Clarity and consistency of policies, processes and systems all reflecting trauma-responsive processes and as appropriate, trauma-informed care.
4. ***Employee Skills***: Employee awareness of and commitment to trauma-responsive efforts, employee knowledge and skills, and similar issues.
5. ***Tools and Resources***: Technology, tools, staff, space and other concerns for achieving the transformation.

There are ten statements to score for each area. The assessment is based on industry-standard assessment concepts and while it has not been tested for reliability or validity, it offers a generally accepted standard process.

How does the TReSIA Assessment Work?

You'll complete TReSIA's self-assessment for your organization, or, complete it as a group or team-based activity. Use the outputs as you create the change / transformation plan in Section #4.

Completing this self-assessment takes about 45 minutes, and consists of the following steps:

Step 1: Self-Assessment

Read each of the statements. Score each statement on a scale of 1 (not like) – 5 (very much like) in terms of how much it is "not like" or "like" your organization. Write the score in the box provided on the far right.

Step 2: Map Your Scores

Turn to the TReSIA assessment's last page. Use this page to map your score to the **same** item on the response sheet—**note** that the item numbers on the response sheet are *not* in numeric order, they're in groups!

Recognize that "persons who receive service" and "service recipients" are customers.

Map them according to the instructions to create a graph of your current state.

Step 3: Review the Recommendations

There are recommendations for each of the statements.

Use your lowest scoring items from Step 2, highlight and then review the recommendations for each.

In this Step, the items are grouped according to standard organizational components in Trauma-Informed Care (Employee Skills and Knowledge, Policies and Processes, Facilities, etc.).

Step 4: Develop Your Action Plan

Based on the graph of your current state in Step 2, and the items you focused on in Step 3, follow the directions in Section 4 to develop your action plan.

Remember to incorporate knowledge of organizational policies and procedures.

Identify the steps you can take to increase the degree to which your organization models Trauma-Informed Care and Trauma Responsive Systems.

Step 1: Self-Assessment

Note—this version is for mental health and social services agencies. A version for other sectors will be released by end of June 2011. Contact us for that version.

Read the following statements. Determine how much "not like" (1) to "very much like" (5) your organization is compared to the statement and circle the number. Please both circle your answer and write it in the box on the far right.

There is no right or wrong.

	Not like				Very much like	
1. Employees are taught to respond when anyone (staff or service recipient) is distressed.	1	2	3	4	5	
2. We have mapped / conveyed the benefits of the transformation to our business objectives and strategies	1	2	3	4	5	
3. We have programs that use points, levels, rewards or other economies for behavioral management.	1	2	3	4	5	
4. All Business Units, Departments, and other work groups have formal learning plans that include competency-based relevant courses.	1	2	3	4	5	
5. We have electronic healthcare/human resources software that reflects trauma-informed and –responsive care.	1	2	3	4	5	
6. Management rewards behaviors that help service recipients increase and maintain functioning.	1	2	3	4	5	
7. We are aware of the issues of most concern to staff and service recipients and have prepared employees for handling them in a trauma-responsive manner.	1	2	3	4	5	
8. We have implemented universal screening for traumatic events beyond asking about abuse in a manner appropriate to our setting.	1	2	3	4	5	
9. Supervisors and managers use formal transfer of training plans to support knowledge and skill adoption.	1	2	3	4	5	
10. Staff and volunteers (if applicable) have an online library of resources for trauma-informed care and trauma-responsive systems.	1	2	3	4	5	

Step 1: Self-Assessment, continued

11. We are committed to the long-term transformation (not a "program of the month") to trauma-informed care and trauma-responsive systems.	Not like 1 2 3 4 5 Very much like	
12. Service recipients are actively involved in defining their programs with specific goals for changes in functioning.	1 2 3 4 5	
13. All employees demonstrate mastery of trauma-informed communication skills, even those who don't interact with service recipients.	1 2 3 4 5	
14. Staff are connected to protocol-specific groups for the purpose of learning (e.g., LinkedIn.com Groups).	Not like 1 2 3 4 5 Very much like	
15. Staffing patterns support employees in optimal effectiveness (e.g., time is built in for charting) and self-care.	1 2 3 4 5	
16. Representatives from our current and past service recipients, the community and other key stakeholders are involved in key projects.	1 2 3 4 5	
17. Part of our early process in beginning services is to find out from the people how we can be of service to them when they are in distress.	1 2 3 4 5	
18. We use data gathered anonymously from multiple sources, including service recipients, in continuous improvement.	1 2 3 4 5	
19. Our organization is adopting TIC/TReS by making major changes in a short period of time.	1 2 3 4 5	
20. Access to coaching, consulting, supervision, and training (instructor led as well as online) in TIC and related concepts is readily available.	1 2 3 4 5	
21. We have sensory integration rooms where people can calm, and self-soothe.	1 2 3 4 5	
22. Our communication efforts to staff and volunteers (if any) recognizes the reality of traumatic events in their histories.	1 2 3 4 5	

Step 1: Self-Assessment, continued

23. Our staff focuses on the symptoms a person displays through the lens of "How might help them?"	1 2 3 4 5	
24. Our training function has a formal training plan in place to train all staff, even those who don't interact with service recipients, about TIC and recovery.	1 2 3 4 5	
25. We have a readily available directory of the groups with whom we interface, with up-to-date names, numbers, roles, and responsibilities	1 2 3 4 5	
26. Our organization focuses on reducing any appearance or action of coercion and retraumatization.	Not like 1 2 3 4 5 Very much like	
27. Our programming has shifted from a "treatment" model to a model based on "recovery" (improved functioning, reduction in symptoms)	1 2 3 4 5	
28. When a problem occurs, the people involved are engaged in how to restore the relationship (staff and service recipients alike).	1 2 3 4 5	
29. We provide training in Trauma Informed Care to others in the continuum of care, maintaining fidelity to the model we have chosen.	1 2 3 4 5	
30. We have access to clinical journals and conference proceedings.	1 2 3 4 5	
31. Staff and employees refer to the people we serve by their diagnostic labels (for example, "she's a schizophrenic").	1 2 3 4 5	
32. We have reconciled the challenge between the strength-based approach of TIC and the requirements of various funding streams.	1 2 3 4 5	
33. We have processes in place to counter the natural tendency to revert to a more traditional model.	1 2 3 4 5	
34. We implement tools and services that reduce the time, trauma, and costs of healing for staff and people we serve.	1 2 3 4 5	

Step 1: Self-Assessment, continued

35. Persons served are involved in determining achievable goals as well as measurement of their success.	1 2 3 4 5	
36. Everyone who works for the organization has knowledge of the workstream (who supplies what to whom, up and downstream).	1 2 3 4 5	
37. We have reviewed each policy against the elements of Trauma-Informed Care and adjusted as needed.	1 2 3 4 5	
38. The management of vicarious traumatization through self-care is an expectation of our staff.	Not like Very much like 1 2 3 4 5	
39. Staff receive training in how to create and maintain strength-based records and self-determining behavioral change records.	1 2 3 4 5	
40. We offer techniques grounded in evidence such as TF-CBT, DBT, PCIT, and CBT-Mindfulness training.	1 2 3 4 5	
41. . We have examined our physical facility with an eye towards what increases and decreases discomfort and safety for people we serve	1 2 3 4 5	
42. We have an ongoing learning process, formal and informal, to reinforce Trauma-Informed Care	1 2 3 4 5	
43. Staff approach clients using an "if..then" statement to manage behavior.	1 2 3 4 5	
44. Peer support groups are fully functional and operating independently.	1 2 3 4 5	
45. The success of our work is evident in the quality of community life.	1 2 3 4 5	
46. Staff model what is expected of and hoped for for service recipients.	1 2 3 4 5	
47. Multiple opportunities exist and are used for consultation with subject matter experts in Trauma-Informed Care.	1 2 3 4 5	

Step 1: Self-Assessment, continued

48. We have an ongoing mechanism for gathering feedback from service recipients to which we respond	1	2	3	4	5	
49. We have incidents where consumers are restrained, or secluded.	1	2	3	4	5	
50. Our marketing effort includes internal and external communications that focus on trauma-informed care, and recovery.	1	2	3	4	5	

Count (but do not multiply) the number of items you circled 1, 2, 3, 4, or 5 and enter that count. **The total should = 50** (items) ***Totals->***	Not like 1	2	3	4	Very much like 5

Step 2: Map Your Scores

Strength of overall direction

This mapping helps you see where you are strong in implementing TIC (the 5s—there is only one reverse scored item among all 50). The more you have that are 3s, 4s, and 5s, the more you are modeling TIC behaviors in these areas. Can you go further? Of course. Would everyone in your organization agree with your assessment? Probably not. Increasing awareness is the first step.

Transfer the count from Step 1 to this chart	**Not like 1**	**2**	**3**	**4**	**Very much like 5**	
The total of all entries on the bottom row should = 50 ***Totals->***						

Specific Item Responses

The grid below tells you which items focus on a particular category assessed. Review your scores. Wherever you find you ranked an item **3 or lower**, mark the corresponding item number below. This will help you identify any thematic areas of aspects of particular concern, based on how many items in the category are marked.

Categories	#	#	#	#	#	#	#	#	#	#
Leadership and Culture	1	6	11	16	34	26	31	35	45	50
Trauma-Informed Care/Response Structures	2	7	12	17	22	27	32	41	43	46
Policies and Processes	3	8	13	18	23	28	33	36	37	38
Employee Skills	4	9	14	19	24	29	39	40	42	44
Tools and Resources	5	10	15	20	21	25	30	47	48	49

Step 3: Recommendations

Item	Recommendations
1. Employees are taught to respond when anyone (staff or service recipient) is distressed.	Ignoring people who are distressed symbolically makes them invisible and sends the message that they are not worthy of care. Early childhood is the stage of life during which children learn how to respond to their own and others distress, and if this learning is missing or impaired, the negative impact of being ignored when in distress is compounded. If you can observe unnoticed, make note of what happens when someone nearby becomes upset. Who is tended to? Told to not feel? Told they are using their feelings "just to get attention" or that they will incur a loss if they continue to act distressed?
2. We have mapped and conveyed the benefits of the transformation to trauma-informed care to our business objectives and strategies	Successful changes can be connected to alignment with stated business goals and needs. If your organization recognizes the costs of secondary trauma to employees in terms of benefits, and if it recognizes the costs of controls such as seclusion, restraint, and physical "take-downs" then mapping known consequences of TIC becomes easier. Additionally, certifying agencies such as CARF, The Joint Commission, and others may have standards to which TIC maps.
3. We have programs that use points, levels, or other economies for behavioral management.	While economies that exchange desirable behavior for rewards are common in caregiving settings, the challenge is that they do not teach or model the behavior of recovery from the impact of trauma. They are also seldom applied in a non-institutional setting. This adds burden to the person who has learned to manage affect and behavior for one set of rewards who must now learn another to function in the changed environment. The remedy is the development of a relationally based milieu in which the focus is on helping people learn to self-soothe, experience connection, and the practice of creating mutual restoration in relationships.

Step 3: Recommendations, continued

Item	Recommendations
4. All Business Units, Departments, and other work groups have formal learning plans that include competency-based TIC courses.	While the experience of TIC is "viral," the assumption of universal exposure requires universal response: everyone needs to be trained, on the same content, adapted to their context, and the learning needs to be managed.
5. We have electronic healthcare software that reflects trauma-informed care.	The changing role of technology can make it more challenging to include the voice of the service recipient in the process of becoming an active participant in their own increasing health. If your EHR application has a configurable forms function in the clinical record, consider either building or adding an recipient-driven action plan that is co-signed by staff and client. Otherwise, scan and attach the action plan. Consider WRAP (Wellness Recovery Action Plan at www.mentalhealthrecovery.com) and the LEAP (Life-Enhancing Action Plan http at www.traumainformedcare.com). Pay attention to language and policy reflected in the documents the EHR requires.
6. We reward behaviors that help service recipients increase and maintain higher levels of functioning.	Remember that each person's (staff and those who receive services) level of emotional development stalls at the point of their first traumatic experience. The three primary concerns are connection, self-regulation, and feeling as if one is worthy of living. Positive feedback, programs that catch people doing something right, developing mechanisms that foster different levels and kinds of connections (such as alumnae programs) are all part of the programming that supports this.
7. We are aware of the issues of most concern to staff and service recipients and have prepared employees for handling them in a TIC manner.	One of the reasons all staff need to be trained is that the most powerful testimony that this is not a "program of the month" is that modeling by all other personnel is powerful in reducing resistance. Training the implementation team equips them to model what others are expected to adopt. Identifying the issues people are concerned about and being proactive in responses that model the desired outcome, consciously, is an effective tool.

Step 3: Recommendations, continued

Item	Recommendations
8. We have implemented universal screening for traumatic events beyond asking about abuse.	In all settings, think about the intrusiveness of the intake process in asking service recipients to share difficult material without a trusting relationship in place. Consider a screening tool that asks first if the person has experienced events that overwhelm them with which they did not know how to cope. If yes, then ask by categories: medical, accidents, in relationships, crime, fire, and so on. This is likely to be less traumatizing and reduces the risk of confounding care. This also sets up for more precise clinical assessment in the mental health setting without suggesting any particular traumatic event.
9. Supervisors and managers use formal transfer of training plans to support knowledge and skill adoption.	"Transfer of training" refers to the actions before and after a training event that others take to support the learner in learning and applying new ideas, content, and skills. It typically includes a pre-training meeting to advise of attendance and ask for learner goals for the event, and a post-event meeting to debrief and plan for follow-on.
10. Staff and volunteers (if applicable) have an online library of resources for TIC.	Having tools that can be readily accessed and used helps people adopt and adapt. Make sure the model you adopt provides access to tools. www.traumainformedcare.com also contains a list of links and a developing set of materials for download.
11. We are committed to the long-term transformation to trauma-informed care (not a "program of the month").	Employees and staff who experience a new initiative that is allowed to fizzle refer to it as a "program of the month." Many know that ignoring the mandate or complying minimally is all that is required, as management will soon abandon the effort. As you plan your change effort, continue it a minimum of 30% longer than you think you need to. Ensure that your effort has ongoing communication about changes, methods of identifying and making public what is going well and transparency about what needs to improve. Consider developing all required standardized communication before launch, and reinforcing efforts with human interest stories. Publicize measurements and make outcomes known.

Step 3: Recommendations, continued

Item	Recommendations
12. Service recipients are actively involved in defining their programs with specific goals for changes in functioning.	Engaging service recipients in learning how to advocate for themselves, how to create and achieve self-directed behavioral change and to pace their learning and practicing of healthier behaviors is critical. Programs, plans and goals for should also point to the elements of recovery as defined in the SAMHSA Consensus Statement on Recovery. Education about the elements of recovery is an integral part of the planning process.
13. All employees demonstrate mastery of trauma-informed communication skills, even those who don't interact with service recipients.	Staff respond to others when they are in distress. Their communication reflects understanding that others' behavior is somehow helpful in a meaningful way. People conscientiously avoid retraumatizing, coercive processes. They ask questions seeking information, and recognize others' input. They also respect the person, and help them have the experience of different modeling. Restoration-focused processes are in place.
14. Staff are connected to protocol-specific groups for the purpose of learning (e.g., LinkedIn.com Groups).	Survey staff for trauma-treatment tools and techniques in which they are trained, and poll for participation in ongoing learning about those tools and techniques. As you choose the trauma-informed model to implement, find out what kind of ongoing learning activities it offers.
15. Staffing patterns support employees in optimal effectiveness (e.g., time is built in for charting) and self-care.	Are case loads, scheduling patterns, and record keeping time requirements balanced to preserve the health of staff? Recognize the impact of exposure to others' material requires self-care, and use the plan in model you adopt to help skilled helpers exercise self-care. Valuing self-care for those who work in your organization is a symbolic representation of the self-care you wish them to help service recipients learn.

Step 3: Recommendations, continued

Item	Recommendations
16. Representatives from our current and past service recipients, the community and other key stakeholders are involved in key projects.	People respond best to what they help create. Every project where there is clear impact on your constituents and your community benefits from having them as team members with full participation. Choose recipients who represent a spectrum of success. Family members should be from families other than those persons selected as service recipients.
17. Part of our early process in beginning services is to find out from the people how we can be of service to them when they are in distress.	When people initially come in for care, they may or may not be able to participate in helping others learn how to help when they are in distress. Trauma-informed care assumes people know something about what is helpful to them, and engages them in developing collaborative crisis management plans. Ask your implementer what tools the model you choose offers.
18. We use data gathered anonymously from multiple sources, including service recipients, in continuous improvement.	Regular "customer-satisfaction" surveys help your organization look at places where opportunity exists for improvement in process, method, policy, facility, relational processes. Remember that anyone who receives a service from someone else (e.g, the business office receives information from clinicians about services provided that is vital to claim processing). Ensure the voices of these people are also heard.
19. Our organization is adopting TIC by making major changes in a short period of time.	If your organization is making major changes instead of incremental changes, remember that the impact will be different for your staff and constituents. Create a change management plan, using a tool such as the TICIA transformation plan, and review it with a skilled change management consultant. Explore candidly where resistance may exist and tend to managing it. Ensure your outcomes measures are appropriate.
20. Access to coaching, consulting, supervision, and training (instructor led as well as online) in TIC and related recovery concepts is readily available.	As you select your model for TIC, ensure a full range of performance supports is available to you. Your provider should offer coaching, consulting, support for supervision, and access in a variety of ways.

Step 3: Recommendations, continued

Item	Recommendations
21. We have sensory integration or other calming rooms where people can reduce their stimulation and self-soothe.	A major challenge for people who have encoded experiences as traumatic is self-soothing. Rooms where people can self-soothe and calm using tools such as "sensory integration" and where they can go to reduce escalations are important. Helping people learn to plan this outside of the service providing environment is also critical.
22. Our communication efforts to staff and volunteers (if any) recognizes the reality of traumatic events in their histories.	Assuming that all participants in the service delivery chain have some experience of trauma is an effective way to begin to reduce the impact of the unspoken and to increase opportunities to deepen TIC. Communication from marketing, programming, and any other source needs to carry and reinforce the messages of your TIC model.
23. Our staff focuses on the symptoms a person displays through the lens of "How might help them?"	TIC teaches that behavior that brings a person to care, or that a person displays when they are distressed is most often what has worked in the past, and has meaning in the present. In a TIC environment, evidence of this exists in how staff relate to people in distress and how staff speak with each other about a person's actions.
24. Our training function has a formal training plan in place to train all staff, even those who don't interact with service recipients, about TIC and recovery.	Does the model you are implementing offer a condensed version for leadership, administration, and others who are not direct care providers? Direct care providers who have the most contact need the most in-depth training. If you have clinical staff, they too need the most in-depth training. Other staff who have contact with the service recipient (front desk, scheduling, claims, OT, AT, etc.) benefit from a lighter version of the training that uses cases to which they can relate.
25. We have a readily available up-to-date directory of the internal and external groups with whom we interface	This directory contains information about the organizational structure and what department or extension to call for what, it also has community agency information (the external groups).

Step 3: Recommendations, continued

Item	Recommendations
26. Our organization focuses on reducing any appearance or action of coercion and retraumatization.	Incorporate the differences in the table in Section 2 of TICIA into your stated ("what we say we do") and operative ("what really happens") processes/ procedures. Note what you see—especially be alert for reward systems, behavioral control techniques, behavior modeling processes, how distress is dealt with. For example, if your organization is residential, and you have seclusion/restraints that occur, think about what it would sound like from the service recipient's point view to hear staff say "We're only doing this for your good" or "Relax, calm down" while being pinned down.
27. Our programming has shifted from a "treatment" model to a model based on "recovery" (improved functioning, reduction in symptoms)	Funding often requires "detect and diagnose" and reimbursement based on a "disease" model that leans towards "biology" and "brain disease." This is the traditional model. The nature of recovery (improved functioning and reduction in symptoms, as opposed to "12-Step") also involves learning and practicing what has been learned in different environments, building on the skills that are present. This is a strengths-based model. This is evident in several ways during the transformation. Staff who "get it" about focusing on improving strengths and skills are likely to complain about the lack of room and formatting to document this. Diagnoses of certain types are likely to decrease (see table, Section 2). Staff will more and more recognize themselves as "helping people learn" and will themselves begin to learn more.
28. When a problem occurs, the people involved are engaged in how to restore the relationship (staff and service recipients alike).	Reconciliation and restoration engage everyone who was involved in the incident. This is inherently relational, and the development of a relational culture precedes the ability to successfully adopt a restorative model. Make sure the TIC model you choose reflects knowledge of the role of relationship as preeminent in the "making right" processes service recipients often struggle with. These processes reflect the dynamics of power, authority, social influence, and the issues of every person involved.

Step 3: Recommendations, continued

Item	Recommendations
29. We provide training in Trauma Informed Care to others in the continuum of care, maintaining fidelity to the model we have chosen.	Because TIC is a relational process, it helps when everyone on your continuum of care shares common language. How do you know what fidelity is in the model you're implementing? The model you adopt should provide clear indications of how to assess fidelity. Ask your vendor for information about public education, marketing support, co-operative training, and other needs.
30. We have access to clinical journals and conference proceedings.	Ensure professionals are "up-to-speed" on the latest information they need. Internet subscriptions as well as "designated reporters" on specific topics help staff keep skills and knowledge "fresh."
31. Staff refer to the people we serve by their diagnostic labels (for example, "she's a schizophrenic").	The degree to which people's behavior is translated to who they "are" correlates with adoption of TIC. The lower the score, the better. For example, people labeled "manipulative" are generally disliked. TIC recognizes that when a person has been punished for asking for something, they learn to ask indirectly (to "manipulate") as a form of self-protection and to reduce the risk of loss or harm. Tend to "asking indirectly as a form of self-protection" instead of "manipulation."
32. We have reconciled the challenge between the strength-based approach of TIC and the requirements of various funding streams.	This task involves addressing the conflict between two often conflicting styles of documenting contact. One, the traditional, is the system required for payment of services and is based on diagnostic labeling and medical codes. It is a symptom of illness focused system. The other, trauma-informed, is the system that demonstrates a strength-based approach.

Step 3: Recommendations, continued

Item	Recommendations
33. We have processes in place to counter the natural tendency to revert to a more traditional model.	Recognize that the reason most change efforts fail is that they stop too soon. Plan and then add 30% more time to continue reinforcing and rewarding the right behavior. As you complete the Transformation Plan in Section 3 of TICIA, you'll identify areas where resistance may exist—and plan for them. Habituate your staff to respond from the TIC frame of reference. Plan to persist in concrete ways.
34. We implement tools and services that reduce the time, trauma, and costs of healing for staff and people we serve.	This means asking of each group, "What makes it easier for you to do this work?" as well as "What makes it harder for you to do this work?" It also means being vigilant for effective tools that help extend your services--for example, there are a number of online sites that offer "brain games" that are helpful to some. Can you bring in a chair masseuse for staff once a month? How about a mindfulness meditation group for staff? Implementing peer support groups? Identifying and strengthening natural supports?
35. Persons served are involved in determining achievable goals as well as measurement of their success.	When people can describe how their lives would be different if they were further along the road in their recovery, they can begin to learn how to achieve the new lives they can envision. Helping people learn self-regulation and self-directed behavior modification in the service of health improvement is a powerful tool. What are the techniques and processes by which service recipients participate in creating and measuring progress towards goals?

Step 3: Recommendations, continued

Item	Recommendations
36. Everyone who works for the organization has knowledge of the workstream (who supplies what to whom, up and downstream).	There's the way things are supposed to happen ("stated"), and the way they really do ("operative"). Create the "big buckets" that each represent a workflow, such as Front Desk, Scheduling, Service Delivery or Billing. Some may have sub-processes, especially Billing. Have the people who do the work create an accurate map of the process as it is—use adhesive notes to identify who passes what to whom and where decisions get made.
37. We have reviewed each policy against the elements of Trauma-Informed Care and adjusted as needed.	Each policy regarding service delivery needs to be reviewed against a standard set of questions—which ones look like more traditional model policies, using the table in Section 2 as guideline. Help reviewers remember their job is only to identify instead of to fix what they find. Create a plan for stating criteria and solicit submissions for revisions. Be sure to identify the actual process so people who submit recognize the context of decision making.
38. The management of vicarious traumatization through self-care is an expectation of our staff.	Staff can only care for others to the extent to which they care for themselves. Exposure to others' trauma is traumatic for those who provide services. Ensure that the model you adopt considers self-care and discusses Vicarious Traumatization (VT) and the impact of mirror neurons. Organizations that embed self-care and tend to VT are likely to have higher morale, better productivity, and better outcomes.
39. Staff receive training in how to create and maintain strength-based records and self-determining behavioral change records.	What is a strength-based record? How do staff help clients mark change and progress? These skills depend on staff knowledge of human development, service recipient input and learning style, and skill in helping people devise meaningful and attainable goals. Ensure staff have support in thinking these issues through in ways that comply with regulatory, payer, and agency needs.

Step 3: Recommendations, continued

Item	Recommendations
40. e offer techniques grounded in evidence (such as the behavioral health techniques TF-CBT, DBT, PCIT, and CBT-Mindfulness training).	Using techniques grounded in evidence has multiple positive effects: people get better more quickly; skills are transferable to outside the setting; it engages the act of learning, which is strength based. Help your professional staff recognize that the focus of others is the best resolution, and that no matter what the technique, the therapeutic nature of relationship is still foremost. Identify and relate metaphors about applying the same technique to all diagnoses or situations ("malpractice" in medicine, for example). Continue to address the resistance, which mimics service recipient reluctance to do things differently.
41. We have examined our physical facility with an eye towards what increases and decreases discomfort and safety for people we serve	Would you be comfortable in the areas your service recipients use? Is it calming? Can you see what is going on around you? Are bathrooms located in well-lit areas away from exits? Is the décor soothing? What about texture and color? This is an important item. It is useful to have a group of service recipients talk about what would increase comfort and safety from their point of view, and to incorporate this feedback in action plans.
42. We have an ongoing learning process, formal and informal, to reinforce Trauma-Informed Care.	How will you know TIC is working? Early in the implementation process, think through how you will know if it's working. What will you measure? What can cause the numbers to change that is independent of TIC? How robust do you need the data to be? How will you use it?

Step 3: Recommendations, continued

Item	Recommendations
43. Staff approach clients using an "if..then" statement to manage behavior.	While this is taught as an effective method of motivating people to comply with behavior it is also coercive and retraumatizing. In many traumatic situations, if you "do/don't do" something, then "something bad happens/will happen." It is better to drill and practice on intentional, trained acts that help reduce the degree of traumatic reactivation when distressed. Remaining calm and engaged rather than getting triggered is key for staff and to help others learn.
44. Peer support groups are fully functional and operating independently.	Because TIC has a "recovery" focus modeled after SAMHSA's Consensus Statement on Recovery" peer support is a service extending model that also develops leadership and collaboration based on strengths. What structure do you have for peer support groups? Does your vendor for the model you are implementing have a program to help train peer support group leaders? How are you managing peer support groups your agency sponsors? Where are the natural supports for adding more?
45. The success of our work is evident in the quality of community life.	What evidence is there that the services provided make a difference in the community? How do you define success? Because of the relational nature of the work of helping people improve or heal, it is helpful to look at their successes, the quality of life changes in those around them, and in the quality of life changes for the people providing services. You will want to identify meaningful ways to look for this as you deepen your transformation to TIC.
46. Staff model what is expected of and hoped for in terms of service recipients.	Service recipients want to be successful. Part of this success is having the acceptance and care of the people they are supposed to see as "healthy." They model staff. Ensure staff understand that "do as I say, not as I do" is unacceptable. They need to be continuous learners, engaged in meaningful relationships, and improving their mental health. They need to actively model what they expect of the people they serve.

Step 3: Recommendations, continued

Item	Recommendations
47. Multiple opportunities exist and are used for consultation with subject matter experts in Trauma-Informed Care.	Just as it is important to have ongoing contact available for implementation of a model, identifying the subject matter experts in TIC for ongoing consultation is important. Check with the provider of your model for a list of potential contacts.
48. We have an ongoing mechanism for gathering feedback from service recipients to which we respond.	Listen to how staff respond to service recipient feedback—is it dismissed because of the diagnosis or label applied to the recipient? Are trends or multiple comments about the same situation collected and considered? The continuous improvement cycle of Plan-Do-Check-Act applies in service delivery for staff, service recipients, others affected by your work. If you have a process in place, see how it is doing. If not, implement one.
49. We have incidents where consumers are restrained, or secluded.	If you are a residential, inpatient or congregate facility, the number of and type of restraints or seclusions that occur is carefully monitored. These incidents are retraumatizing for staff and those in your care. They reflect a need to examine perceptions and practices around safety, how early escalations are recognized, and how staff help agitated people calm and self-soothe. Reducing them through the implementation of robust TIC is possible, and the model you choose should have a strong component addressing how to reduce escalations and manage crises. Careful tracking of events, triggers, and resolution is required. Additionally, information on Self-Inflicted Injury and its relationship to trauma and suicidality may be helpful.
50. Our marketing effort includes internal and external communications that focus on trauma-informed care, and recovery.	Your marketing department's efforts to increase community awareness of TIC and what it means supports increasing services and coordination. Community penetration of TIC and trauma-informed culture increases the connections between the community's need and your programs.