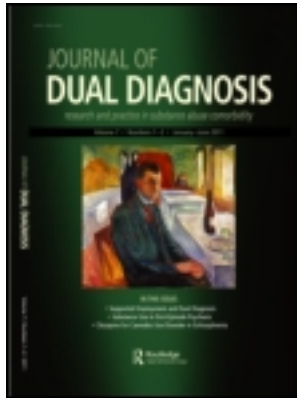


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### Assessing Trauma-Informed Care Readiness in Behavioral Health: An Organizational Case Study

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## Assessing Trauma-Informed Care Readiness in Behavioral Health: An Organizational Case Study

Samantha Anne Farro, PhD,<sup>1</sup> Colleen Clark, PhD,<sup>2</sup> and Cary Hopkins Eyles, MA, CAP<sup>3</sup>

**Objective:** In this organizational case study the authors pilot a new protocol for evaluating and developing trauma-informed care in behavioral health settings. **Methods:** A mixed methods design was used to collect data with three instruments: the Adverse Childhood Experiences, the Consumer Perceptions of Care, and the Community Readiness Model key informant interview. Adults ( $N = 138$ ) in a behavioral health residential treatment program provided a consumer perspective on trauma and integrated services. Providing the staff perspective, key informant interviews of staff ( $N = 7$ ) were conducted and the overall protocol's utility was assessed. **Results:** Results indicate the protocol is an efficient, strength-based, and culturally sensitive assessment approach that provided valuable data about the agency's prevalence of consumer trauma, level of integrated trauma-informed services, and readiness to advance a trauma-informed organizational culture. The piloted protocol also fostered understanding of trauma-informed care principles among staff and improved awareness of how to enhance the level of trauma-informed services at their agency. **Conclusions:** In addition to providing assessment data, the protocol helped agency staff and leadership to fully engage and mobilize toward change. Further application of this tool and future research are discussed. (*Journal of Dual Diagnosis*, 7:228–241, 2011)

**Keywords** *trauma-informed care, mental health, substance abuse, co-occurring disorders, organizational assessment and development*

The prevalence of people with histories of trauma or abuse in mental health and substance abuse treatment settings is high (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005), with 50%–99% of women having experienced trauma in their lives (Domino et al., 2005; Elliot et al., 2005). Women with histories of trauma have higher rates of disability, multiple physical symptoms, and are higher users of medical, mental health, and substance abuse treatment services than those without trauma histories (Domino et al., 2005; Kartha et al., 2005; McNutt, Carlson, Persaud, & Postmus, 2002; Rosenberg et al., 2000; & Weissbecker & Clark, 2007). In general, women are more likely than men to meet the criteria for posttraumatic stress disorders (Tolin & Foa, 2006). However,

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when considering people with substance use disorders, there appears to be more equivalent rates of posttraumatic stress disorder (Stewart, Grant, Ouimette & Brown, 2006). This is perhaps due to increased risks for men associated with their substance use (Stewart et al., 2006).

Adopting a treatment approach that integrates trauma with co-occurring mental health and substance use disorders has demonstrated more sustainable positive outcomes for consumers<sup>1</sup> (Domino et al., 2005; Elliot et al., 2005). Evidence also suggests it is a cost effective approach for agencies (Domino et al., 2005), possibly due to the pervasiveness and overlapping relationship between trauma, mental health, and substance abuse. Neglecting trauma can lead to re-traumatization and poorer treatment outcomes (Barton, Johnson, & Price, 2009; Cocozza et al., 2005) while recognizing its influence affirms and invites the voice of the consumer as a valuable element in treatment (Cimmarusti & Gamero, 2009).

### Trauma-Informed Care

For an organization to be trauma-informed, “all staff . . . from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of people being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization” (Elliott, 2005, p. 462). Building on the work of Harris and Fallot (2001) and the Substance Abuse and Mental Health Services Administration’s Women, Co-Occurring Disorders, and Violence Study (Clark & Power, 2005), Elliott and colleagues (2005) identify 10 principles of trauma-informed care, including:

- (a) Recognizing the impact of violence and victimization on development and coping strategies;
- (b) Identifying recovery from trauma as a primary therapeutic goal;
- (c) Working from an empowerment model;
- (d) Maximizing consumer choices and control;
- (e) Focusing on relational collaboration;
- (f) Creating an atmosphere that is respectful of survivors’ need for safety, respect, and acceptance;
- (g) Emphasizing consumer strengths (i.e., highlighting adaptations over symptoms and resilience over pathology);
- (h) Minimizing the possibilities of retraumatization;
- (i) Striving for cultural competence (i.e., understanding each consumer in the context of her life experiences and cultural background);
- (j) Soliciting consumer input by involving consumers in designing and evaluating services.

Through the work of survivors, scholars, community leaders, and directors, behavioral health care agencies now recognize the importance of trauma-informed practices. However, agencies

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<sup>1</sup>The term consumer used throughout this article refers to a person receiving treatment. Other terms include survivors, clients, and recovering person.

are often at a loss for how to develop a fiscally feasible plan for implementing trauma-informed practices. Becoming fully trauma-informed can be considered an organizational culture shift, similar to the one described by Minkoff and colleagues needed to transform systems traditionally focused on either mental health or substance abuse to provide integrated services for those individuals with co-occurring disorders (Minkoff, 2005; Minkoff & Cline, 2004).

A first step toward this cultural shift is assessing an organization's current level of trauma awareness. Fallot and Harris (2006, 2009; Harris & Fallot, 2001) developed a Trauma-Informed Services Self Assessment Scale and Planning Protocol to assist agencies in developing trauma-informed care practices according to a concretely defined and high standard of trauma-informed care. This tool is built on five values (i.e., safety, trustworthiness, choice, collaboration, and empowerment; Fallot & Harris, 2006, 2009; Harris & Fallot, 2001) and examines 6 organizational domains (i.e., program procedures and settings; formal service policies; trauma screening, assessment, and service planning; administrative support for program-wide trauma-informed services; staff trauma training and education; and human resources practices; Fallot & Harris, 2009). Information is collected via a review of clinical records, a review of administrative records, interviews, surveys, and focus groups. The Fallot and Harris (2006, 2009; Harris & Fallot, 2001) protocol provides a "gold standard" assessment that has defined trauma-informed care and provided one of the first in-depth assessments of trauma-informed practices. While the model provides extensive information, the time and resources required to implement it are not always feasible for community programs.

## Readiness for Change

In this study the authors pilot an alternative model for assessing and adopting trauma-informed care that is more efficient, culturally competent, and incorporates the readiness-to-change dynamic into the assessment itself. The stages-of-change transtheoretical model has helped redefine how change is addressed. Prochaska and colleagues have suggested that organizations, like individuals, more effectively change when interventions are matched to the organizations' readiness to change (Prochaska, Prochaska, & Levesque, 2001). Employee buy-in is enhanced while resistance and stress are minimized when stage-matched interventions are used (Prochaska et al., 2001). Utilizing stage-matched interventions also expedites change and provides staff opportunities to participate in the change process (Prochaska et al., 2001).

### *Community Readiness Model*

The Community Readiness Model (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Thurman, Plested, Edwards, Foley, & Burnside, 2003) applies the stages-of-change concept to organizational- or community-level changes. While other organizational change models exist (Lehman, Greener, & Simpson, 2002), this readiness model is a culturally sensitive and strength-based tool (Jumper-Thurman, Edwards, Plested, & Oetting, 2003) that assesses a community's level of readiness and builds its capacity to successfully implement an initiative regardless of its current starting point. This model has been widely used both nationally and internationally for topics including: drug and alcohol prevention (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997; Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999), cardiovascular

disease (Peercy, Gray, Thurman, & Plested, 2010), intimate partner violence (Brackley et al., 2003; Han, 2003), smoking and tobacco use policy (York & Hahn, 2007), HIV/AIDS (Aboud, Hug, Larson, & Ottisova, 2010; McCoy, Malow, Edwards, Thurland, & Rosenberg, 2007; Plested, Edwards, & Thurman, 2007), breast cancer (Lawsin, Borrayo, Edwards, & Belloso, 2007), and head injury (Stallones, Gibbs-Long, Gabella, & Kakefuda, 2008). The model of community readiness provides a guided assessment and intervention process that leverages a community's strengths (e.g., culture, history, resources, level of problem awareness, readiness for change) to facilitate change (National Center for Community and Organizational Readiness, 2009; Plested, Jumper-Thurman, & Edwards, 2009).

### Research Objectives

In the current evaluation, the authors were guided by two objectives. The first objective was to pilot a new protocol for conducting a multifaceted assessment of trauma-informed care in a behavioral health program. The focus was on assessing the level of trauma-informed services in the program from two perspectives: survivors/consumers and agency staff.

The second objective was to assess the new protocol's utility for advancing trauma-informed services for men and women in a behavioral health program. Taking into account the needs, strengths, and consumer population of the program, the protocol was designed to inform development of interventions individualized to the program's culture and level of readiness.

## METHODS

### Participants

#### *Community Program Partner*

For this study, the researchers partnered with a large, urban-based, behavioral health program provider operating three residential facilities (one for women and two for men). Treatment averages 6 months in length and is based on the modified therapeutic communities model with services, usually in a residential setting, that utilize the peer community to address substance use disorders and related problems in living (DeLeon, 2000). Treatment services are co-occurring, capable, and integrated utilizing the Minkoff Model (Minkoff, 2005). Treatment facilities are not locked. Consumers are employed during the last three months of treatment and continue attending aftercare services following discharge.

#### *Consumers*

Survey participants ( $N = 138$ ) were consumers in one of the three residential treatment facilities (men:  $n = 92$ ; women:  $n = 46$ ). The average participant age was 33 years ( $SD = 12.9$ , range: 18–83) for men and 32 years ( $SD = 12.4$ , range: 19–79) for women. Consumer response rate was 90% overall (46/54 women; 92/100 men).

### *Program Staff*

Key informant interviews ( $N = 7$ ) were conducted with staff from two men's facilities and one women's ( $n = 5$ ,  $n = 2$ , respectively). Interviewees were representative of the program's levels of employment including: support staff supervisor, counselor supervisor, and residential treatment program manager. Two interviewees were male, five were female, and the average length of agency employment was 7 years ( $SD = 5$ , range: 1–14). All invited staff agreed to be interviewed except one person (7/8 staff) who was unavailable due to severe illness.

### Measures

#### *Adverse Childhood Experiences*

Developed in collaboration with the Centers for Disease Control, this is a 10-item survey designed to assess exposure to abuse and household dysfunction during childhood (Felitti et al., 1998). Participants respond "yes" or "no" to descriptive items with "yes" responses summed to yield a cumulative exposure score. The range of adverse experiences covered include: verbal, physical, and sexual abuse; emotional and physical neglect; parental substance abuse, mental illness, and imprisonment; divorce; and domestic violence. Scores have a graded relationship between the number of adverse experiences and the number of adult health risk behaviors and diseases (Felitti et al., 1998). The 10 categories of this scale are also significantly associated with one another (Dong et al., 2004).

#### *Consumer Perceptions of Care*

This measure (Clark et al., 2007) was developed to assess consumers' perceptions of key services integrating trauma, mental health, and substance abuse issues. It is a 26-item measure that uses a 4-point Likert scale ranging from *strongly agree* (1) to *strongly disagree* (4). It is comprised of four factors: services integration, choice in services, trauma-informed assessment, and respect for cultural diversity. It is a reliable and valid instrument and the factors show a high degree of internal consistency (Clark et al., 2007).

#### *Community Readiness Model*

This model (Edwards et al., 2000; Thurman et al., 2003) assesses 6 dimensions: knowledge about the issue, existing efforts related to the issue, knowledge of efforts, leadership (including influential community members), resources (e.g., time, space, volunteers, money), and community climate. Key informant interviews from 6–8 individuals across different sectors provide data on each dimension that acts as a diagnostic tool for determining level of readiness across a continuum of nine levels.

A procedure for developing community change strategies is also incorporated into the model. These guidelines address each dimension's level of readiness but are broad enough to encourage cultural considerations be taken into account. With this model, strategies are developed in

collaboration with community members/leaders such that interventions are specific to the context of a community and optimize the use of local assets and resources. For the current study, the community is defined as the residential treatment program.

## Procedures

This study was conducted in accordance with the Declaration of Helsinki and was reviewed, approved, and supervised by a University of South Florida's Institutional Review Board. Because a waiver of signed consent was granted for this study, a complete discussion of the study and a detailed written consent statement were provided to all participants.

### *Recruitment*

Adult consumers were recruited from a community program comprised of three different residential facilities (2 men's facilities, 1 women's facility). During each site's required weekly house meeting, volunteer participants were provided survey packets (including an introduction letter, a detailed statement of consent, the Adverse Childhood Experiences survey and the Consumer Perceptions of Care survey). Completed surveys were collected anonymously in a sealed box.

Recruitment of program staff as key informants was conducted by collaborating with a program director to obtain a list of seven staff contacts that were representative of the three residential facilities and of the program's levels of employment. Interviews were conducted per the methods of the National Center for Community and Organizational Readiness (NCCOR, 2009), began by reviewing informed consent, and were simultaneously transcribed for scoring purposes. Interviews were conducted in person except one that was done via phone. Lastly, staff were invited to voluntarily attend the Feedback and Strategies Development Workshop.

### *Feedback and Strategies Development Workshop*

During a voluntary, two-hour workshop with the residential treatment staff, study results were presented and voluntary feedback was collected. Oral feedback regarding the utility of the piloted organizational assessment was transcribed throughout the presentation while anonymous written feedback was collected ( $n = 7$ ) at the end. Written feedback was collected using the following questions: Is this assessment/information useful to you? If so, how? If not, why?; Does this assessment help you to understand your community's level of trauma informed care?; Does this assessment help you to understand the next steps for enhancing your community's level of trauma informed care?; What other information would have been useful to include in this study?; and Any other thoughts, comments, ideas, etc., that you have?

### *Timeline*

Implementing the piloted protocol was a seven month process, with care being taken at each step to work in collaboration with leadership/staff and tailor the evaluation to the program's needs. During the first two months, the idea was introduced and accepted by the community program leadership, planning was initiated, and IRB approval was granted. Data collection (including

surveys and staff interviews) was completed in two months, data analysis in one month, and the Feedback and Strategies Development Workshop was completed in one month. Lastly, the final write up incorporating all data and feedback was completed in one month.

## Data Analysis

In this study the researchers used a mixed methods approach. SPSS statistical software was used to conduct descriptive analyses, two-tailed *t*-tests, and Pearson chi square analyses to examine group differences for gender. Interview data were scored by the first two authors and one outside coder using the readiness model's structured rating scale. The first two authors independently scored all seven interviews while the outside coder scored two randomly selected interviews for comparison. On a rating scale of 1–9, the average difference between each of the three coders' overall community readiness scores was 0.45 (*SD* = 0.29, range: 0.12–0.68). Lastly, during a series of meetings the first two coders reviewed and discussed all discrepant scores until a consensus was reached on a final rating score.

## RESULTS

### Prevalence of Childhood Trauma

Eighty-six percent of consumers (82% of men, 96% of women) reported at least one adverse childhood event. This dropped to 80% (75% of men, 91% of women) when divorce was excluded. No differences in prevalence of any type of trauma were found between males and females with the exception of sexual abuse, where more females reported exposure than males ( $\chi^2 = 15.66$ ,  $p < .000$ ; Table 1).

TABLE 1  
Prevalence of Adverse Childhood Experiences

	All Consumers ( <i>N</i> = 134)	Female ( <i>n</i> = 46)	Male ( <i>n</i> = 88)
Verbal abuse	45%	39%	48%
Physical abuse	33%	33%	33%
Sexual abuse*	27%	48%	16%
Emotional neglect	34%	39%	31%
Physical neglect	18%	18%	18%
Divorce/separation	68%	78%	64%
Domestic violence	29%	31%	27%
Substance abusing parent	63%	72%	59%
Parent with mental illness	30%	40%	25%
Parent imprisoned	28%	33%	25%

*Note.* On questions related to physical abuse, physical neglect, divorce/separation, domestic violence, and parent with mental illness experiences the female *n* = 45.

\* $\chi^2 = 15.66$ .  $p < .000$ .



TABLE 2  
Consumer Perceptions of Care (CPC) Scales and Adverse Childhood Experiences (ACE) Results

Scale	Gender	<i>n</i>	Mean	Std. dev.	Sig. (two-tail)
Service integration*	Male	74	2.925	.624	.000
	Female	44	3.432	.741	
Consumer involvement*	Male	79	2.498	.724	.008
	Female	42	2.901	.885	
Cultural sensitivity*	Male	73	2.808	.780	.001
	Female	39	3.321	.674	
Trauma-informed assessment*	Male	78	2.944	.680	.000
	Female	44	3.439	.559	
CPC total*	Male	74	2.820	.570	.001
	Female	41	3.257	.689	
ACE total*	Male	92	3.304	2.647	.046
	Female	46	4.261	2.594	
ACE total (9)	Male	92	2.6957	2.362	.065
	Female	46	3.5000	2.447	

\*Indicates a significant effect; ACE scores range from 0–10; CPC scores range from 1 (*strongly agree*) to 4 (*strongly disagree*); ACE total (9) excludes Divorce.

A two-tailed *t*-test revealed that females reported a significantly higher cumulative number of adverse childhood experiences compared to males ( $p < .05$ ). However, this difference did not persist when divorce was excluded (Table 2). When divorce was excluded, 14% of consumers reported exposure to one type of trauma, 14% reported two types, 17% reported three types, and 35% of consumers reported being exposed to four or more types of childhood trauma.

### Consumer Perceptions of Trauma-Informed Care

Most consumers (82%) reported being provided with services that integrated trauma, mental health, and substance abuse during their treatment. A 51% agreement rate was found for consumer choice/involvement, 85% for cultural sensitivity, and 87% for trauma-informed assessment. Most (78%) consumers felt that services were sensitive to their needs and experiences of trauma. A two-tailed *t*-test indicated female consumers were significantly higher on all Consumer Perceptions of Care scales relative to males (Table 2).

### Readiness for Trauma-Informed Practice

Community Knowledge about Trauma-Informed Care and Resources Related to Trauma dimensions were at the *preparation* (5) level followed by Community Knowledge of Efforts and Leadership dimensions, which were at the *initiation* (6) level. Lastly, the Community Efforts and Community Climate dimensions were at the *stabilization* (7) level (Table 3).

TABLE 3  
Community Readiness Results

Dimensions Assessed	Level of Readiness	Brief Description
A: Existing community efforts	Stabilization (7)	Efforts (programs and activities) have been running for several years.
B: Community knowledge of efforts	Initiation (6)	An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.
C: Leadership	Initiation (6)	Leaders are active and supportive of the implementation of efforts.
D: Community climate	Stabilization (7)	The majority of the community generally supports programs, activities, or policies. "We have taken responsibility."
E: Community knowledge about the issue	Preparation (5)	Some community members have basic knowledge of trauma, trauma-informed care, and the relevance of it with substance abuse treatment. General information on trauma and substance abuse is available.
F: Resources related to the issue	Preparation (5)	Some members of the community are looking into the available resources.

*Note.* Level of readiness ranges from (1) *No awareness*, (2) *Denial/resistance*, (3) *Vague awareness*, (4) *Preplanning*, (5) *Preparation*, (6) *Initiation*, (7) *Stabilization*, (8) *Confirmation/expansion*, to (9) *Professionalism/high level of ownership*.

### Feedback and Strategies Development Workshop

Staff reported that the piloted protocol was valuable, helped them better understand their current level of trauma-informed care, and improved their understanding of how to enhance trauma-informed services. Specifically, staff reported that having local data to "affirm where we are at" and using the model to provide "direction for where we need to go" to enhance trauma-informed care was beneficial.

Staff suggestions for improving the protocol focused on the consumer data and included: broadening the assessment of childhood trauma (e.g., including occurrences of hospitalizations, chronic disease, death of a sibling, death of a parent, poverty, community violence), adding an open-ended trauma question (e.g., "Did anything else happen that was traumatic for you?"), documenting length of time in treatment, and assessing experiences of adult trauma (e.g., military related experiences).

### DISCUSSION

Consistent with prior research, the majority of consumers in this study were survivors of trauma and most had been exposed to multiple types of trauma. Independent of a reported history of trauma, most consumers also felt that they were receiving integrated, trauma-informed, and culturally sensitive services. Similar with other studies of people with substance use disorders (Stewart et al., 2006), both men and women reported high rates of traumatic experiences. However, women reported more favorable ratings of services than males. This may be due to women being more aware of the role of trauma in their existing problems (Sonne, Back, Zuniga, Randall, &

Brady, 2003), or a discrepancy in staff awareness of the importance of trauma for men compared to their awareness of it for women. Relatively fewer consumers of either sex indicated feeling they had a choice in their services. However, this finding may relate to the population surveyed, as many in this study were court mandated to treatment (Clark, Becker, Giard, & Mazelis, 2005).

Corroborating the consumer surveys, the program's capacity for providing trauma-informed services and its awareness of the need for trauma-informed care was relatively advanced, as reported by staff. However, the staff did identify three inter-related areas of growth needed for enhancing the program's trauma-informed organizational culture: agency-specific data/information, training efforts and requirements, and on-going quality improvement efforts.

The community readiness results indicated a dearth of local data specific to the program's consumer population and a lack of information about existing trauma-related programs/trainings in the organization. The gap between the program's trauma-related resources/activities and the staff's awareness of these efforts indicates a need for improved advertisement and communication. While this issue was somewhat addressed in the program simply as a function of participating in this study, a more enduring solution is needed. Examples may include flyers of events, newsletters, bulletin board announcements, or staff listserves to facilitate communication and announcements.

The need for collection of program-specific, trauma prevalence data was more directly addressed as a built-in feature of the piloted protocol. Such data can potentially be used to help educate funding sources and other collaborators on the importance of trauma-informed practices in behavioral health treatment and can possibly help secure trauma-specific resources.

Related to training, a plan for increasing the number and quality of trained professionals would be helpful for getting all staff educated and working "from the same page" regarding trauma. Working with leadership to enact more formal policies related to trauma-informed care training requirements for all staff is one consideration. While identified trauma experts were present within the organization, trauma-informed practice was commonly subsumed under the umbrella of co-occurring disorders practice. Though overlap in the conceptual foundation of these two practices exists, being able to tease them apart and view trauma as a unique consideration demonstrates a sophisticated awareness of the issue. Training, possibly by the program's own "trauma champions," is one way to foster this deeper level of understanding across all staff.

Lastly, initiating quality improvement, such as ongoing and structured evaluations of trauma-related efforts, emerged as one option for improving the program's trauma-informed care culture. Regular evaluation can improve existing efforts via empirically-informed modifications and can foster a more self-reflective organizational environment related to trauma-informed care. The authors addressed this area in the current study partially by providing evaluative information to the program at one point in time. However, the piloted protocol was chosen for this study to explore whether it is feasible for community programs to undertake the evaluation themselves. Thus, the piloted protocol may be considered an option for ongoing quality improvement.

## Future Directions

Preliminary evidence indicating the piloted protocol was effective in evaluating a behavioral health program's prevalence of consumer trauma, level of integrated trauma-informed services,

and level of organizational readiness to advance trauma-informed culture. Evidence also indicated that the evaluation was helpful for guiding community program changes.

Throughout the process, program leadership and staff were supportive of the evaluation. For example, during the workshop, staff were actively engaged in brainstorming optimal ways to use the study's results to advance their services. Presenters facilitated open debate regarding program-specific ideas for enhancing trauma-informed practices and culture (e.g., best practices for asking consumers about trauma, how to facilitate openness about trauma). Additionally, since the completion of this study, the program leadership has reported that changes are being made with the specific intent of advancing on the dimensions of trauma-informed readiness.

Several limitations of the current study are noted. The authors relied on self-report data, collected from one community program that provides one type of treatment (e.g., residential). Additionally, interview fidelity measures (e.g., consistency/accuracy of conducting the interviews), consumer experiences of adult trauma, and length of time in treatment were not included in this protocol. Despite these limitations, this study highlights the relevance of trauma-informed practices in behavioral health and provides preliminary support for an alternative methodology to evaluate trauma-informed care.

Future directions for research include incorporating observation into the protocol and employing the model in diverse settings (e.g., community mental health centers, jails, child welfare, and hospital settings) and types of care (e.g., inpatient, outpatient, and home-based care). It would be helpful to assess a program over time to determine if changes were implemented and, if so, how these changes would be reflected in the protocols' results from the consumer and staff perspective. Further studies may also benefit from mapping the findings onto the results of the more traditional Fallot & Harris (2006, 2009; Harris & Fallot, 2001) protocol. Assessing additional childhood and adult traumatic events would be beneficial in future research. The Traumatic Life Events Questionnaire (Kubany et al., 2000) is one option for measuring adult traumatic experiences. Lastly, because the length of time a consumer has been in treatment may influence perceptions of care, it may be preferable to include it in future studies.

## Conclusions

The current study examines an alternative methodology for evaluating trauma-informed care. Based on a stages-of-change organizational model, this organizational case example demonstrates the use of a new protocol to assess and develop a behavioral health program's capacity for trauma-informed care. This approach may be helpful for assessing trauma-informed practice in a manner that translates into manageable and culturally-relevant next steps and engages organizations in the process of advancing change. Evidence suggests the new protocol may have potential as a model for guiding other behavioral health programs in implementing trauma-informed care practices in an efficient and feasible manner.

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## DISCLOSURES

The authors report no financial relationships with commercial interests.

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