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Envisioning a Trauma-Sensitive Public Health Department: Implications for Practice, Policy, and Research

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Abstract

Historically, the concept of trauma and associated long-term sequelae has rested primarily in the fields of psychology and psychiatry. However, recent attention and research around the health implications of trauma have unmasked this concept as a pervasive public health issue. This has catalyzed a movement to create a paradigm shift that transforms a formerly myopic understanding of trauma towards one that acknowledges the complexity and wide reaching impact of trauma. At the core of this paradigm shift is an understanding of the interconnectedness between trauma and socio-ecological constructs at the individual, family, community, and organizational level. This framework positions local public health departments to be leaders in this change.

This paper will explore the role that early childhood trauma, organizational trauma, and resilience play in the public health field and how these concepts help to inform the need for a coordinated, multi-tiered approach to addressing trauma as a public health issue. Additionally, a three month pilot project, implemented at the City of Berkeley Public Health Department, will be discussed including implications learned from this case study that help inform practical applications, policy, and future research for public health departments.

Keywords: adverse childhood experiences, organizational trauma, public health

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Introduction

The Substance Abuse and Mental Health Services Administration (n.d.) defines trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being". Although trauma has primarily been siloed as a mental health issue, compelling research and a renewed movement is creating a paradigm shift towards addressing a broader definition of trauma. Moreover, data from epidemiological studies clearly present trauma as a public health crisis. In order to fully understand and address trauma one needs to examine the milieu in which trauma occurs or develops.

Public health departments are primed for this socio-ecological approach to addressing population health issues and are well-positioned to be the leading agents in preventing trauma. However, an innovative theory introduced by Sandra Bloom (2010) suggests that organizations, like individuals, experience a parallel process of traumatization. When organizations, such as public health departments, experience trauma they begin to create disjointed systems, reactive environments, feelings of helplessness, and overall ineffectiveness in staff and the organization at-large (Bloom, 2010). When this happens, organizational trauma becomes a barrier to addressing trauma at multi-levels of a system and can further prevent public health departments from truly becoming trauma-sensitive workplaces. This paper will examine trauma as a public health issue, discuss implications of organizational trauma and resilience, and share key findings

from a pilot project conducted at a local health department around creating a trauma-sensitive organization.

Literature Review

Although there are a multitude of definitions for trauma, in approaching this term from a public health perspective, one needs to adopt a broad interpretation rooted in a socio-ecological framework. In other words, it is not just defined as post-traumatic stress disorder (PTSD), but rather a spectrum of experiences such as toxic stress, natural disasters, developmental trauma, complex PTSD, and intergenerational trauma. Another important concept in transforming the approach of addressing trauma is the understanding and acknowledgement that trauma happens in organizations, groups, and people.

Trauma is complex, costly, and ubiquitous. According to the National Comorbidity Survey, over 50% of surveyed adults stated that they have experienced at least one type of traumatic event over the lifecourse (Thompson et al., 2011). The data also suggests that disproportionality can be seen in some populations. For example, higher rates of violence exposure can be found in impoverished urban communities. The U.S. Department of Justice conducted a study that found that over 98% of urban adolescents had some type of exposure to violent crimes, whereas 83% of adolescents in suburban areas reported similar exposure (Overstreet & Matthews, 2011). Moreover, trauma comes with substantial costs. Childhood trauma costs approximately $4379 per incident and over $100 billion per year in the United States (Sansbury, Graves, & Scott, 2015).

Similar to other helping systems, public health departments serve as the safety net for the most vulnerable (Scutchfield & Howard, 2011). This means that public health departments interface with a population that has experienced one or more traumatic events. One way that

public health departments can impact trauma is by fostering an organizational shift toward trauma-sensitive systems of care. A trauma-sensitive department distances itself from the conventional question of "What is wrong with you?" and instead comes from a culture that asks, "What has happened to you?" (Bowie, 2013). At the core of this exchange is the adoption of five trauma-informed guiding principles: safety, trustworthiness, collaboration, empowerment, and choice (Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014). Bloom (2010) argues that in order to create a true trauma-sensitive environment, one that is aware of how trauma affects individuals being served and strives towards delivering care that is trauma-informed, an organization needs to acknowledge and address its own processes of traumatization.

In order to better understand the interconnectedness of trauma, three main concepts will be discussed: adverse childhood experiences, organizational trauma, and resilience.

Adverse Childhood Experiences

In 1998, leading researchers Dr. Vincent Felitti and Dr. Robert Anda published a groundbreaking article linking childhood trauma and lifelong health, now commonly referred to as the Adverse Childhood Experiences (ACE) study. The focus of the study was to determine whether there was a relationship between a set of ten identified childhood adversities and risk behavior and subsequent disease later in life (Felitti et al., 1998). In collaboration with the Center for Disease Control (CDC), Kaiser Permanente in San Diego surveyed over 17,000 of their adult patients using the ACEs survey (Center for Youth Wellness, 2014). Approximately 75% of the study participants were Caucasian, 39% were college graduates, and they all had health coverage through Kaiser Permanente (Felitti et al., 1998). The ten ACEs can be categorized into three types: abuse, neglect, and household dysfunction (Center for Youth Wellness, 2014). Although there is ample research that discusses the impact of a single traumatic

experience on a person's health, the ACE study was particularly interested in the compounding effects from multiple adverse experiences.

In their findings they found that ACEs were substantially common among their study participants. Approximately two-thirds of the participants reported experiencing at least one ACE and one-fourth reported experiencing two or more ACEs (Felitti et al., 1998). Using a logistic regression model, the researchers were able to confirm a statistically significant dose-response relationship between the numbers of adverse childhood experiences a person experienced and multiple disease conditions including cardiac heart disease, cancer, chronic bronchitis, and poor self-rated health (Felitti et al., 1998). In other words, participants that reported four or more ACEs were more likely to experience increased risk for negative health behaviors and serious health conditions compared to participants who had experienced none. For example, a person with four or more ACES was twelve times more likely to attempt suicide, seven times more likely to be an alcoholic, four times more likely to be a smoker, and twice as likely to have cardiac heart disease, stroke, or cancer (Center for Youth Wellness, 2014).

According to the researchers, the critical link between a person's ACE score and health implications lies within the risk behaviors. From a neuroscience perspective, behaviors such as smoking, overeating, and substance use are used as conscious or subconscious coping mechanisms to deal with childhood experiences or chronicity of stress associated with these experiences. Since the initial ACE study was published, significant gains have been made in understanding the developing brain and the impact that adverse experiences and toxic stress have on the body's stress response and brain physiology. For example, research shows that when a developing brain and body is overloaded from a stressful event, the associated hormones that the body releases in response to this stress can change the underlying neural structure of the brain

(Center for Youth Wellness, 2014). This type of stress is often referred to as toxic stress. These changes from toxic stress can alter a person's ability to make decisions, learn, and connect relationally (Overstreet & Mathews, 2011).

Although the number of participants was significant, the ACE study is not without limitations, such as the retrospective and self-reported nature of data collection. Although direct causality cannot be made due to these limitations there have been several studies published since then that reinforce the significant association between childhood experiences and long-term health impacts. For example, utilizing the California Behavioral Risk Factor Surveillance System, the state of California was able to collect and analyze their ACE data. Overall, approximately 60% of adults surveyed experienced at least one ACE, whereas one in six experienced four or more (Center for Youth Wellness, 2014). The latter finding is significantly higher than the original ACE findings. In California, the researchers also found a dose-dependent correlation between poverty, education, and employment and ACEs. For example, a person with four or more ACEs was 21% more likely to be below the Federal Poverty Level, 27% more likely to have less than a college degree, and 39% more likely to be unemployed compared to a person with less than one ACE (Center for Youth Wellness, 2014). This makes sense given the clear connection between traumatic experiences early on in life and associated high-risk behavior that the ACE study highlighted.

It has been fifteen years since the original ACE study was published, and it still serves as a foundational study in understanding the link between early childhood trauma and later in life health implications. Despite many similar findings, trauma has struggled to garner the public health attention that these findings warrant. This leads one to beg the question as to why. As previously mentioned, one plausible barrier that this paper explores is organizational trauma.

Organizational Trauma

Organizations are comprised of people. As previously discussed and seen in large epidemiological studies, many people experience personal trauma, particularly early on in life. This leads to an underlying assumption that statistically, many public health professionals have personally experienced some type of ACE. The majority of research around trauma looks at the impact that it has on clients, not on the "helping" professionals and organizations that serve them (Sansbury, Graves, & Scott, 2015). However, an evolving perspective is looking at trauma experienced by organizations. Organizational trauma posits that organizations, such as a public health department, experience trauma and chronic stress and are vulnerable to the same associated effects as individuals (Bloom & Farragher, 2013). Moreover, when individuals join a group they are susceptible to adopting a group or organization's identity. When one looks at this relationship, "parallel processes" can be observed between traumatized clients, staff, administrators, and organizations (Bloom, 2010). Although these are primarily unconscious processes, they hinder the ability of a system to address the needs of the individual being served. It is important to reiterate that these parallel processes are largely unconscious, meaning that the direct influence of individual trauma and trauma experienced in an organization is rarely acknowledged (Bloom, 2010). From this, one could postulate that public health departments are not effectively addressing the issue of ACEs due to the internal organizational trauma that exists and remains largely invisible.

A prominent theme that emerges in the literature around organizational trauma is the term secondary trauma. Secondary trauma is defined as the manifestation of traumatic symptoms in helping professionals as a direct result from constant exposure to the traumatic experiences from the client population that they are serving (Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014).

Helping professionals, such as public health workers, can absorb another's trauma and this transference directly affects staff by altering cognitive schemas and personal belief systems, heightening defensiveness and creating an emotional contagion of hopelessness (Sansbury, Graves, & Scott, 2014). Similar to the ACE study, the issue of secondary trauma needs to be incorporated into a public health approach to trauma due to these physical, emotional, and cognitive effects (Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014). If these effects are not addressed then they ultimately bleed into the workplace culture and can affect the work of that individual, program, and organization.

In addition to secondary trauma, staff can be exposed to organizational chronic stress. Some examples include increased workload demands, excessive paperwork, ethical conflicts, staff turnover, and inadequate collaboration (Bloom, 2010). In order for public health departments to become more effective in delivering trauma-informed care, they must first become trauma-sensitive to the ways that clients, staff, administrators, and organizations are impacted by personal and collective trauma (Bloom, 2010).

Resilience

Studies have shown that there is great variability in trauma symptomology that is reflective of the complexity and interplay of influential factors such as chronicity, environment, and neurobiological mediators (Harvey, 2007). In other words, not all individuals, groups, or organizations are negatively affected or homogenous. One way to mitigate the effects of trauma is to foster resilience. The literature on trauma and resilience is vast and ever-evolving. An antiquated view of resilience is one where an individual is able to overcome traumatic effects, and in some cases, flourish from these past experiences (Harvey, 2007). However, similar to trauma, resilience is now being considered a multidimensional concept impacted by socio-

ecological factors. Resilience is cultivated when an individual *and* the environment are capable

to interact in a way that successfully combats the deleterious effects of trauma (Ungar, 2013).

This description accurately captures the interconnectedness that resilience has with the

complexity of an individual within the socio-ecological context. In addition to the agency of an

individual, other processes are at play, such as politics, economics, family structure, and cultural

norms (Ungar, 2013). This translates to an understanding of resilience as a mechanism that is not

unidirectional and self-determined, but rather something that has contextual and cultural factors.

This diminishes the blame on an individual and directs it towards the larger systems of influence.

Resilience takes a strength-based approach; it looks at a person, community, or

organization's assets (Allmark, 2014). Some common constructs of resilience identified in the

literature include: social supports, community cohesion, experiences of self-efficacy and

confidence, and cultural adherence (Ungar, 2013). Although there might be desire to want to

promote these constructs universally, Wyman (2003) cautions that not all cultures positively

respond to these constructs. For example, some cultures may view community cohesion as the

essence of their being, whereas other cultures might view individuality and separation as

empowering and vital for growth (Ungar, 2013). Public health departments have a role in

cultivating healing and one way to do this is by incorporating culturally responsive approaches

that are focused on enhancing the resilience of individuals as well as their own organization.

Agency Information

Nestled between two large cities, Richmond and Oakland, lies the City of Berkeley.

Unlike other cities in Alameda County, the City of Berkeley is one of three California cities to

have its own public health department. The Berkeley Public Health Division (BPHD) was

established in the 1880s, primarily for the purpose of controlling the spread of disease (Health

Status Report, 2013). Since then the BPHD has greatly expanded their scope of services to include a community health clinic, home visiting program, place-based programs, and an evaluation unit.

At the macro-level, BPHD is one of five divisions under the Health, Housing, and Community Services Department. The other divisions include Mental Health, Housing & Community Services, and Environmental Health. This organizational structure lends itself to integration and cross-collaboration across other health-related divisions. At the micro-level, BPHD consists of three broad sections: Family Health, Epidemiology and Clinical Services, and Health Promotions and Operations. Approximately 50 public health workers comprise the entire BPHD. There is one BPHD clinic located in West Berkeley, and an additional school-based health center at the local high school.

The fieldwork project focused specifically on the Family Health Section (FHS) and will be described in more detail. Under the direction of the Manager of Family Health, the FHS currently includes nine programs such as the Communicable Disease program, Berkeley Black Infant Health program, Public Health Preparedness & Immunization, and Child Health & Disability Prevention program. Overall, seventeen employees work in the FHS with job classifications including support staff, community health worker, public health nurse, and program manager. Although the majority of the FHS staff resides in one location, at least two programs are located off-site from the main headquarters.

Overall, Berkeley is considered to be a healthy community (Health Status Report, 2013). However, similar to many communities in the United States, significant health inequities continue to persist. For example, African Americans living in South and West Berkeley consistently face poorer pregnancy outcomes and increased rates of childhood asthma

hospitalizations, hypertension, heart disease, and diabetes (Health Status Report, 2013). Along with the ten essential services of public health, BPHD recognizes the urgency that is needed to address these health inequities. Although gains have been made around this work, more work needs to be done in order to achieve the full vision of "Healthy people in healthy communities" (Health Status Report, 2013).

Implementation of the Project

As previously mentioned, trauma can impact a myriad of ecologies. It is important to note that these levels do not exist as silos, but rather, are interconnected in such a way that it makes it difficult to solely focus on one level without incorporating another. The literature around trauma-sensitive work primarily explores the relationship between trauma-informed principles in relation to the particular population that is being served by the organization. In addition to exploring this dyad, the project "Envisioning a Trauma Sensitive Public Health Department", was also interested in exploring another dimension around organizational trauma in relation to a public health workforce.

The three month project only included BPHD staff that were part of the FHS. Although the concept of trauma from a public health lens was not completely novel, the FHS had not previously explored this issue in an intentional way. The primary purpose of this pilot project was to explore and begin to universally introduce the different components that are involved in creating a shift towards a trauma sensitive public health department. This was achieved through two core components: an assessment survey and presentation series, as well as a variety of learning objectives outlined in Appendix A. Some guiding questions for the project were: "What is the current understanding of trauma as a public health issue?", "What is the role of organizational trauma and resilience in the FHS?", and "What are current barriers to creating a trauma-sensitive culture in public health departments?". Overall, this project was a fluid process

that fluctuated between researching the available literature and applying learned concepts to the FHS. The information shared below serves as a precursor to better inform the fidelity of a more formal initiative aimed at establishing trauma-sensitive public health departments.

Assessment Survey

One critical step of the pilot project was an assessment of the FHS regarding trauma-related concepts and organization culture. This was captured through a survey entitled "Addressing Trauma & Toxic Stress: Informational Survey" (Appendix B). While the survey was created specifically for this project, and therefore is not a validated tool, it was informed by other well-utilized and validated surveys. A brief in-person introduction to the survey was given to all seventeen staff members to provide context around the larger project and the intent of the survey. Being mindful of trauma-informed principles around safety and trust, staff was reassured around the anonymity of the survey results. Due to the personal nature of trauma, the survey started with three open-ended questions around personal perspectives regarding the definition of trauma, programmatic impact, and history of associated training. Utilizing 5-point Likert scale, subsequent questions were asked around knowledge; support and self-care; and readiness. Finally, the last set of questions was focused on existing strengths and barriers to implementing trauma-sensitive work.

Presentation Series

In order to have a transformational approach to trauma, there needs to be a shared understanding. A critical step in establishing this is through the development and teaching of a common language. As part of this project, a two-part series was created to introduce key language and concepts to the FHS. The first presentation focused on the ACE study and related findings. In order to understand the symptomatology of trauma, it is helpful to have an

appreciation of how the brain and body react to stress so basic concepts from neurobiology were incorporated. Finally, secondary trauma was highlighted under the auspices of organizational trauma. Due to the dense content covered in the first presentation, the second presentation started with an overview of those salient points. Trauma-informed principles were then introduced in relation to the neurobiology content that was presented in an attempt to further inextricably link the need for safety, trustworthiness, collaboration, empowerment, and choice in public health settings. However, the main focus of the second presentation centered on resilience and the role that individuals, groups, and organizations have around creating and fostering resilience as means for healing from trauma.

It is important to mention that a trauma-sensitive approach was utilized while planning and implementing this series. Awareness around this potentially triggering subject was ever-present, and steps were taken to alleviate perceived or real anxiety and fear. Participation was supported by the manager. However, staff had the final choice on whether to attend. Each presentation started with a mindfulness practice as a means of grounding staff and buffering potential stress responses. Resilience was intentionally incorporated into this project as a way to provide a counter narrative to trauma in the hopes of supporting more collaboration and empowerment.

Findings/Discussion

Quantitative

The survey response rate was 94% (n=17) which is significant and leads one to postulate that participation was an indication of interest in this topic. The survey results can be found in Appendix C, but a few of the key findings will be highlighted here. Over 50% of staff in the FHS had previously received some type of trauma-related training. Respondents were most interested

in learning more about how traumatic stress affects the brain and body and the cultural

differences in how people understand trauma. Overall, 35% of staff strongly agreed or agreed

that the current work environment values the importance of self-care and provides staff with

opportunities to practice this. This means that two-thirds of the FHS do not agree with these

assertions. This is significant and can be indicative of secondary trauma. Approximately 35-40%

of respondents felt neutral around the questions related to vicarious and secondary trauma which

points to the need for more explicit explanation and understanding around these critical topics.

While 88% of the respondents believe that the utilization of trauma-informed principles will

improve work-life, only 47% felt like they had a clear understanding of what this meant in their

professional role. The most cited existing strength to support this work was supportive

colleagues. In terms of resilience, this is an important strength to build upon.

However, the experienced barriers were not as pronounced. Approximately 35% of

respondents felt that lack of buy-in from organizational leadership and lack of time and funding

for training proved to be the biggest barriers to promoting trauma-sensitive practices within

programs. Overall, all but one respondent agreed that trauma is an important public health issue

and that being trauma-informed is important for everyone in the BPHD. This is a foundational

place to start and is an indication around the readiness of the FHS to take on this work.

Qualitative

Trauma is a much more nuanced topic and this is indicative from qualitative responses.

Although there are guiding definitions of trauma, the informational survey provided respondents

with the opportunity to provide their perspective and individual definition. Each response was

unique, yet common themes emerged throughout the individual definitions. For example, several

of respondents described trauma as an overwhelming event or experience that results in a loss of

control, threatens one's sense of safety, and leads to the inability to cope and calm oneself. In response to how trauma impacts the respondent's work or program, the most common theme resonated around the notion that the vast majority of clients that visit the FHS programs for service have experienced trauma. Several respondents also reported feeling helpless and hopeless when they are unable to adequately address the trauma-related needs of the clients. This can lead to feelings of poor self-efficacy and disengagement. A few responses also indicated that public health is viewed as part of "the system" which many clients are triggered by and distrustful of. This makes the work and the relationship with the community challenging.

Finally, there was another dominant theme in the survey results that is relevant to the focus of this paper. Many respondents expressed the impact of organizational trauma experienced within the BPHD. Similar to many other organizations, BPHD experienced the detrimental effects from the financial recession in 2009. Difficult decisions were made, layoffs occurred, and eventually there was an organizational merge that transpired. Anecdotally, the work environment is no longer viewed as the golden years of yesterday, and instead was described as one that has experienced loss, distrust, and anxiety and fear for the uncertainty of tomorrow. One respondent stated that trauma impacted the physical work environment because "my coworkers and I are survivors of mass layoffs…those that were not let go had to deal with the emotional triggers of losing friends and added stress of uncertainty." Although these traumatic events occurred over five years ago, the emotional contagion of organizational trauma was palpable in the responses.

In terms of the presentation series, FHS attendance was 80% and 50% for the first and second presentation, respectively. Some barriers to attendance included high frequency of time-off related to summer, conflicting work-related priorities, and location, especially for program

staff located off-site from the main building. Although not mandated presentations, the variance in attendance suggests that adequate support from administrators and multiple opportunities to attend presentations are needed in order to more universally reach staff needs. Although the impact of the presentation series was not quantitatively evaluated, anecdotal feedback indicated that the series was pertinent and well received. Moreover, it served as a catalyst to thinking about the different mechanisms through which trauma manifests in public health. For some, this was a personal reflection and for others it was related to programmatic implications. Overall, the presentations served as a brief introduction to trauma-sensitive principles for staff that were in attendance. The majority of present staff expressed an interest and desire to continue the conversation and pursue a more formal way of transforming the FHS.

Public Health Significance

The implications of trauma in the literature and from anecdotal findings from the pilot project are significant and warrant a public health undertaking. The social context around trauma needs to be restored so that people, groups, and organizations have a better understanding of the broad implications that trauma has on one's health and the health of an organization. A public health approach is primed to address this issue at the primary, secondary, and tertiary level. This framework is needed in order to rectify the disjointed systems of service that currently exist and truly form a comprehensive and integrated approach that is trauma-sensitive. The question is where to start. A multi-pronged movement is needed that provides direction for practice, policy, and research.

Practice

Public health staff, programs, and departments need to be trauma-sensitive. One of the critical components to address this expansive charge is a multi-pronged initiative that

incorporates universal approaches, such as all-staff training, program-specific trauma-informed interventions, and self-reflection on personal trauma. However, this type of transformational approach that is being described is not without substantive challenges. Existing organizational culture can view this movement as something that will add more work to an already full load, or perhaps, another passive attempt at creating meaningful change. However, because of the prevalence of trauma, universal training across all disciplines and classifications is a first practical step for public health departments to take. An emphasis is put on universal training. In order to see the collective impact that trauma warrants there needs to be a collective approach across an entire organization. This is critical to create a common language to begin to establish a unifying perspective on how trauma is viewed through a public health lens. Past studies have shown a decrease in staff anxiety, and increase in staff's attitudes and empathy towards others when they have received training that increases understanding and awareness on how trauma works in individuals, groups, and organizations (Greenwalk et al., 2008). This training is paramount to creating a trauma-sensitive public health department that shifts from asking "what is wrong" to "what is strong".

Trauma-informed principles are a way to nurture the healing process for clients served by FHS, as well as the ripple effects from 2009 that still need to be honored. The core trauma-informed principles: safety, trustworthiness, choice, collaboration, and empowerment; are foundational blocks that need to be openly discussed in staff meetings, program planning, and direct service environments.

Another practical step is to create an asset map. Public health departments, programs, and professionals may already be performing trauma-informed principles and it's important to map these out so that there is a place to start. Although there are already programs within the FHS

that exemplify a trauma-sensitive culture, they are not identified as such and are frequently done in isolation. A coordinated and intentional adoption of trauma-informed principles across the FHS will strengthen the overall fidelity as well as convey consistent messaging to all clients and staff. Identifying where these approaches and interventions already exist is a considerable first step in conducting an asset mapping of what current work is already aligned with a trauma-sensitive culture and help identify areas of need.

As previously discussed, healing from trauma does not rest solely on the individual ecology but is the result of interconnectedness. Resilience does not only exist in the community that a public health department is serving. Public health departments need to foster the resilience that exists within individual staff as well as the overall system. Supporting cross-collaboration, reflective supervision, and cultivating an environment of gratitude and positive recognition are all ways to enhance resilience and promote healing.

Organizations also have the ability to address secondary trauma. One study found that the more staff viewed the organization as supportive, the less secondary trauma was experienced (Sansbury, Graves, & Scott, 2015). Acknowledging that secondary trauma exists in public health is a step in the right direction, but there needs to be a genuine prioritization of self-care. This is a classic case of practicing what one teaches. Public health departments advocate and fight for an environment that is a healthy and safe place for a community to live, work, learn, and play. In order to more effectively push this agenda forward, public health departments need to assess and reflect on the environment that they are cultivating internally.

Policy

The effects that ACEs have on one's health are indisputable and disturbing. They are a call for action at the local, state, and national level to create policies that prevent and allay the

detrimental effects from ACEs. This means that policies need to be put in place that support a coordinated approach across sectors that promote a holistic approach to trauma. Public health needs to advocate for policies that sponsor universal training and screening around trauma and adverse experiences in the medical field, and other tertiary systems. Organizations, including public health departments, need to recognize the impact that trauma has on the workforce and co-create workplace policies that are created from a place of safety and collaboration. For example, policies and procedures related to safety cannot be written with the sole focus on risk management. There needs to be a preventative tone in these policies that acknowledges the direct and indirect impacts from trauma that help foster emotional safety. Finally, because trauma is so common among all demographics, trauma sensitive principles need to inform and guide these public health policies. All of these proposals require a reprioritization of resources. Money needs to be reallocated from reactive responses to preventive measures and policies.

Research

Trauma is not just a mental health issue, and because of this new and expansive understanding, the depth of research around trauma needs to expand across other disciplines as well. For example, there are not coordinated surveillance systems in place to accurately track the prevalence and incidence of trauma (Bloom & Sreedhar, 2008). This issue was identified at the local level at BPHD, and can be seen at the state and national level as well (Mann, Guice, Cassidy, Wright, & Koury, 2006). On the individual level, although there is a fundamental understanding on the complexity of trauma, there is a significant need for more scientific integration across the relevant fields of study such as epigenetics, immunology, and developmental neurology (Bloom & Sreedhar, 2008).

This project and subsequent findings make it clear that more rigorous analysis and evaluation are needed around distilling the impacts from organizational trauma in the public health setting. The vast majority of research around organizational trauma and related concepts has been conducted in highly structured environments, as opposed to more realistic settings (Overstreet & Matthews, 2011). As previously stated, this pilot project serves as the precursor to a more formal approach of establishing a trauma-sensitive public health department. The next evolution of this work needs to include structured data collection, analysis, and evaluation components. As this transformation begins to take place, quality assessment and program fidelity need to be at the forefront. Research is a critical tool to ensuring that the change is continuously being monitored and evaluated for effectiveness.

Conclusion

Scutchfield and Howard (2011) described the third revolution of public health as "moving from the proximal risk factors for disease and the interventions appropriate to those to the more distal risk factors and interventions". Trauma may be viewed as a distal risk factor to health. However, the research is clear on the direct short-term and long-term insults that traumatic experiences have on individuals, groups, and organizations. Although existing programs have good intentions in addressing trauma; national and local data demonstrate that a new approach and paradigm shift is needed to more fully understand the impact. As with many other health-related issues, public health departments need to engage and collaborate with a diverse group of stakeholders around trauma and serve as the leader of this movement. In order to serve the external community, internal organizational trauma needs to be addressed.

There are multiple points for intervening and different types of intervention. However, if there is not a socio-ecological understanding of trauma then the ripple effects of trauma will

continue to persist. The first step in a collective impact approach is naming the unifying problem. The time is now to start naming and treating trauma as a public health issue that affects individuals, groups, and organizations. Moreover, public health departments need to start acknowledging the role that trauma plays internally so that they are more adequately prepared to help and heal their community. Public health departments need to be the leaders of this next revolution. The good news is that this pilot project demonstrated that there is a willingness and readiness to address trauma in a public health setting. However, in addition to this willingness there must be a lasting commitment to this work. Just as there are parallel processes of traumatization that occur between an individual and organization, there needs to be parallel processes put in place by public health departments that foster a trauma-sensitive culture and lead to improved health and healing.

References

Allmark, P., Bhanbhro, S., & Chrisp, T. (2014). An argument against the focus on community resilience in Public Health. *BMC Public Health*, *14*(1), 62.

Bloom, S. L. (2010). Organizational stress and trauma-informed services. *A Public Health Perspective of Women's Mental Health* (pp. 295-311). Springer New York.

Bloom, S. L., & Farragher, B. (2013). *Restoring sanctuary: A new operating system for trauma informed systems of care*. Oxford University Press.

Bloom, S. L., & Yanosy Sreedhar, S. (2008). The sanctuary model of trauma-informed organizational change. *Reclaiming Children & Youth*,*17* (3), 48-53.

Bowie, V. (2013). Trauma-informed care. *Youth Studies Australia*, *32*(4), 81-83

Center for Youth Wellness. (2013). *A hidden crisis: Findings from adverse childhood experiences in California*. Retrieved May 21, 2015 from
https://app.box.com/s/nf7lw36bjjr5kdfx4ct9

City of Berkeley (2013). *Health status report*. Retrieved August 22, 2015 from
http://www.ci.berkeley.ca.us/Health_Human_Services/Public_Health/2013_Health_Stats_Report.aspx

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258.

Greenwald, R., Maguin, E., Smyth, N. J., Greenwald, H., Johnston, K. G., & Weiss, R. L. (2008). Teaching trauma-related insight improves attitudes and behaviors toward challenging clients. *Traumatology*, *14*(2), 1.

Harvey, M. R. (2007). Towards an ecological understanding of resilience in trauma survivors: Implications for theory, research, and practice. *Journal of Aggression, Maltreatment & Trauma*, *14*(1-2), 9-32.

Mann, N. C., Guice, K., Cassidy, L., Wright, D., & Koury, J. (2006). Are statewide trauma registries comparable? Reaching for a national trauma dataset. *Academic Emergency Medicine*, *13*(9), 946-953.

Overstreet, S., & Mathews, T. (2011). Challenges associated with exposure to chronic trauma: Using a public health framework to foster resilient outcomes among youth. *Psychology in the Schools*, *48*(7), 738-754. doi:10.1002/pits.20584

SAMHSA-HRSA Center for Integrated Health Services (n.d.). Retrieved August 22, 2015, from http://www.integration.samhsa.gov/clinical-practice/trauma

Sansbury, B. S., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma*, *17*(2), 114-122. doi:10.1177/1460408614551978

Scutchfield, F. D., & Howard, A. F. (2011). Moving on upstream: The role of health departments in addressing socioecologic determinants of disease. *American Journal of Preventive Medicine*, *40*(1), S80-S83.

Thompson, R. W., Arnkoff, D. B., & Glass, C. R. (2011). Conceptualizing mindfulness and acceptance as components of psychological resilience to trauma. *Trauma, Violence, & Abuse*, *12*(4), 220-235.

Ungar, M. (2013). Resilience, trauma, context, and culture. *Trauma, Violence, & Abuse*, *14*(3), 255-266.

Wolf, M. R., Green, S. A., Nochajski, T. H., Mendel, W. E., & Kusmaul, N. S. (2014). 'We're

civil servants': The status of trauma-informed care in the community. *Journal of*

Social Service Research, *40*(1), 111-120. doi:10.1080/01488376.2013.845131

Wyman, P. A. (2003). Emerging perspectives on context specificity of children's adaptation and

resilience. *Resilience and Vulnerability: Adaptation in the Context of Childhood*

Adversities, 293-317.

Appendices

Appendix A: Learning Objectives

Student: Victoria Lopez
Agency and Department/Division: City of Berkeley Public Health Division/Family Health Section
Preceptor: JoAnn Evangelista, MPH- Health Planning Education and Promotion Supervisor
Dates of Placement: May 21st- August 25th

Goal 1: Increase knowledge and understanding of trauma as a public health issue			
Objective 1: Conduct an extensive literature on adverse childhood experiences and organizational trauma			
Methods/Activities	Deliverables	Timeline	Anticipated Hours
Research adverse childhood experiences and organization trauma and link to health and wellness later on in life.	List of research and relevant literature	May 21-July 21	50
Objective 2: Attend related trainings, conferences, and webinars			
Methods/Activities	Deliverables	Timeline	Anticipated Hours
Participate in trainings, conferences, meetings, and webinars related to trauma, ACEs, and organizational trauma	List of trainings, conferences, meetings, and webinars that were attended	May 21-August 21	30
Objective 3: Understanding Berkeley specific epidemiology related to trauma			
Methods/Activities	Deliverables	Timeline	Anticipated Hours
Research existing surveillance measures from the literature	List of surveillance systems	July 16-August 1	10
Meet with Epidemiologist to discuss surveillance measures	Notes and action steps	August 4	2
Goal 2: Establish effective working relationships with staff in the Family Health Section			
Objective 1: Attend monthly meetings for the Childhood Cluster Program			
Methods/Activities	Deliverables	Timeline	Anticipated Hours

Participate in month "Childhood Cluster Meetings"	Notes and action steps	May 21-August 25	5
Prep for facilitation of 20 minute discussions at each Childhood Cluster meetings around trauma and Public Health	List of discussion topics and related notes; successful facilitation of discussion	May 21-August 25	10
Objective 2: Establish bi-weekly meetings with preceptor			
Methods/Activities	Deliverables	Timeline	Anticipated Hours
Schedule bi-weekly, in-person meetings with preceptor	Notes	May 21-August 25	15
Establish communication via email and phone as needed with preceptor	Notes and email	May 21-August 25	1
Goal 3: Develop and administer a survey instrument that can be used to assess current knowledge, organizational culture, and readiness around trauma-sensitive work			
Objective 1: Create a survey based off of literature review and existing tools			
Methods/Activities	Deliverables	Timeline	Anticipated Hours
Research existing survey tools re: assessing trauma-informed settings	List of existing surveys	May 21-June 21	10
Create survey tool specific to the Family Health Section	Information gathering survey	May 21-June 21	40
Objective 2: Administer survey to Family Health Section			
Methods/Activities	Deliverables	Timeline	Anticipated Hours
Meet with all staff of FHS to introduce the survey and answer any related questions	Surveys will be administered	July 21-July 24	5
Objective 3: Analyze survey responses and report findings			
Compile all survey results and analyze qualitative and quantitative data	Written data analysis	July 27-July 31	15
Disseminate the results of the survey to the Family Health Section	Dissemination of data report	August 10	1

Goal 4: Introduce a shared language and understanding around trauma			
Objective 1: Conduct a 2-part presentation series on trauma			
Methods/Activities	Deliverables	Timeline	Anticipated Hours
Synthesize information related to: spectrum of trauma, organizational trauma, neurobiology of trauma, stress response and incorporate it into a 1-hour presentation	Powerpoint presentation covering: ACE Study, Secondary trauma, and Neurobiology/Stress-response	June 21-August 9	50
Synthesize information related to: trauma-informed principles, resilience, and self-care	Powerpoint presentation covering: Trauma-informed principles, resilience, and self-care	June 21-August 19	50
Objective 2: Provide a toolkit of information and resources			
Compile a list of pertinent research articles, resource websites, trauma-informed handouts	Electronic toolkit	August 10-August 25	10

Appendix B: Information Gathering Survey

ADDRESSING TRAUMA & TOXIC STRESS: INFORMATIONAL SURVEY

Trauma occurs when an external threat overwhelms a person's ability to cope. Sources of trauma can include childhood emotional, physical, or sexual abuse; abandonment or neglect; sexual assault; domestic violence, community violence; institutional abuse, natural disasters, racism/poverty, and many other circumstances.

To help better assess our Family Health Section and where we are at in becoming trauma-informed programs, **please complete this survey and return it to me by Friday, July 24th**. This survey should take approximately 10-15 minutes. Please note: There are no wrong answers! Don't spend too much time on one question. The most important aspect is capturing your genuine insights and perspectives. The information gathered from this survey will be shared with the entire section and will inform upcoming trainings and recommendations. This survey is anonymous and any identifying information will be confidential. Thank you for taking the time to fill out this survey!

Open Ended Questions	Written Response (Remember, there are no wrong answers!)
How do *you* define trauma?	
How does trauma impact your work? How does trauma impact your program?	
Have you received trauma-related training? If yes, please share any changes in personal knowledge, awareness, and/or program practice that you have seen as a result.	□ Yes □ No
Additional Comments:	

Please rate your level of agreement with the following statements:

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Knowledge **I need more training in the following areas:**					
Understanding what traumatic stress is					
Understanding how traumatic stress affects the brain and body					
Understanding how trauma affects a child's development					
Understanding how trauma affects a child's attachment/relationship to his/her caregiver					
Understanding the cultural differences in how people understand and respond to trauma					
Please write the most pressing topic related to trauma that you would like training in. (This can be one listed above, but does not have to be.)	RESPONSE:				
Support & Self-Care					
My program has regular team meetings					
Topics related to trauma are addressed in team meetings					
I can explain the term "vicarious trauma" (sometimes referred to as compassion fatigue or secondary trauma)					
I can recognize signs and symptoms of vicarious trauma in myself					
My work environment values the importance of self-care					
My work environment provides me with opportunities to practice self-care					

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Supervisors only: Part of my supervision time is used to help staff understand their own stress reactions					
Readiness					
Trauma is an important public health issue.					
Being trauma-informed is important for everyone in Public Health					
It is important for *all* staff in Public Health to have a common language around trauma					
I believe that using trauma-informed principles will improve my worklife					
I have a clear understanding of what trauma informed principles/practices mean in my professional role					
I am willing to adopt trauma-informed interventions that are evidenced based practices.					
It will be easy for me to apply trauma informed principles in my work.					
Additional Comments:					

Please check all that apply:

Question	
What strengths currently exist in our work environment that supports a trauma-informed perspective?	□ Program curriculum or approach □ Support from supervisors to attend related trainings □ Collaboration with other agencies (If so, please state agency: _____) □ Guiding principles □ Supportive colleagues □ <u>Other:</u>
What barriers have you experienced in promoting trauma-informed practices within your program?	□ Lack of buy-in from organizational leadership □ Lack of funding for training □ Lack of time for training □ Difficulty implementing what is learned at the training □ I haven't experienced any barriers □ <u>Other:</u>
What types of information about trauma are you most interested in receiving?	□ Research articles □ List of related websites □ Notification of upcoming trainings □ Web training modules □ <u>Other:</u>

Appendix C: Survey Results

(n=16)

I.   Knowledge

I need more training in the following areas:

Understanding what traumatic stress is:
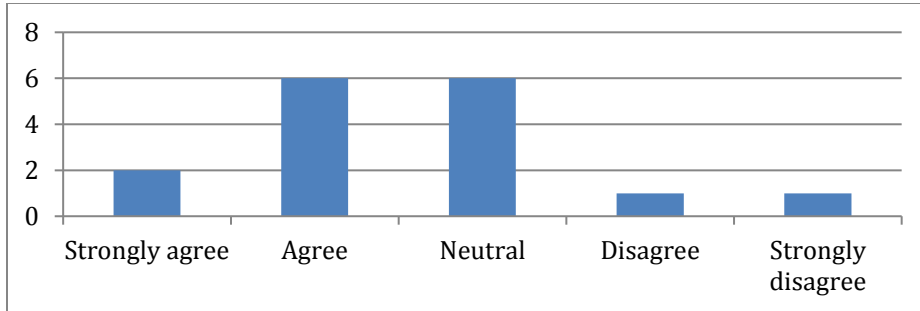
Understanding how traumatic stress affects the brain and body:
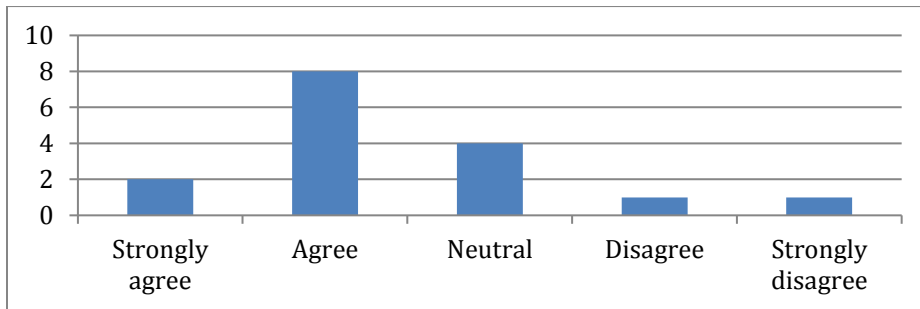
Understanding how trauma affects a child's development:
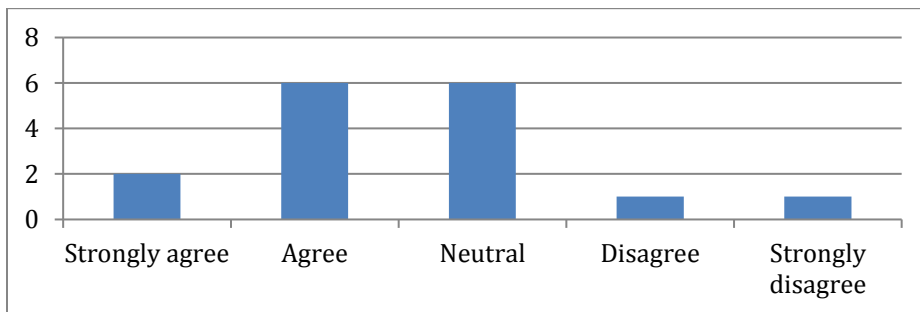
Understanding how trauma affects a child's attachment/relationship to his/her caregiver:
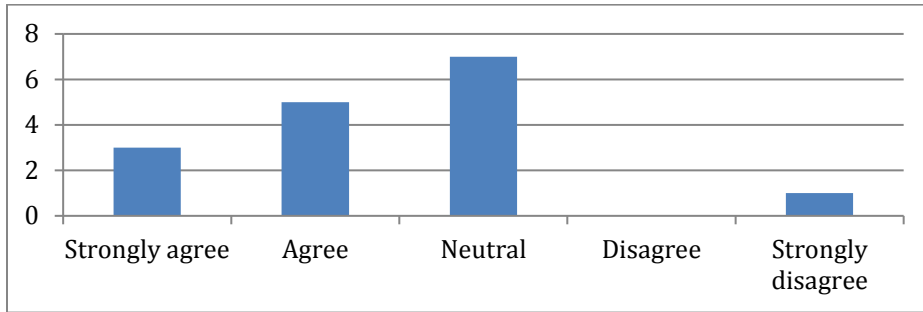
Understanding the cultural differences in how people understand and respond to trauma:
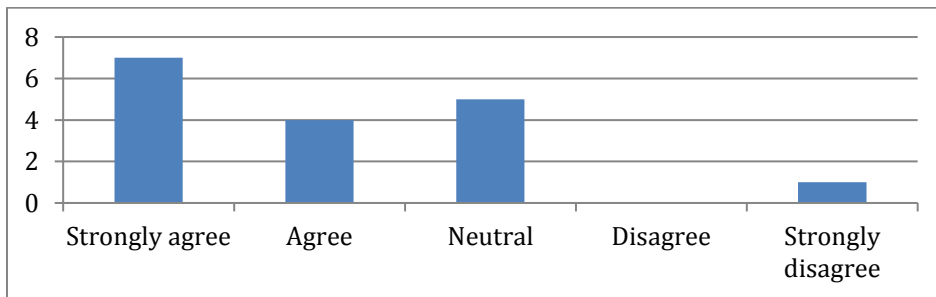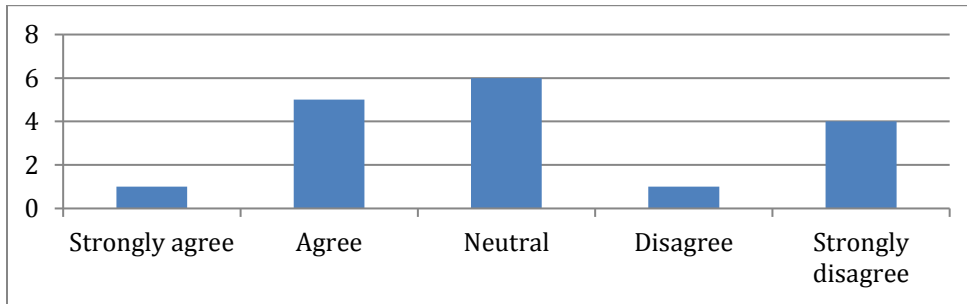

II.   Support and Self Care

My program has regular team meetings:
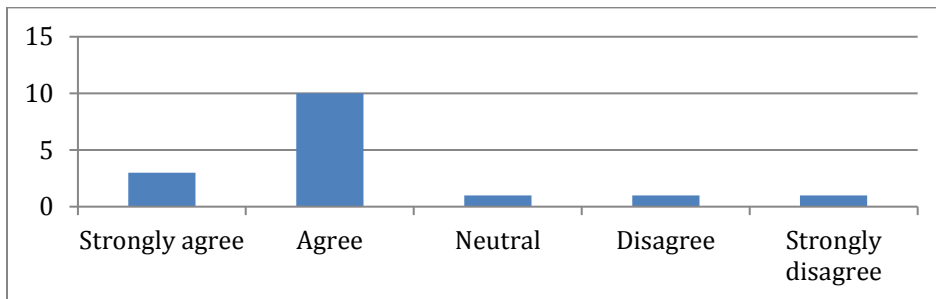
Topics related to trauma are addressed in team meetings:
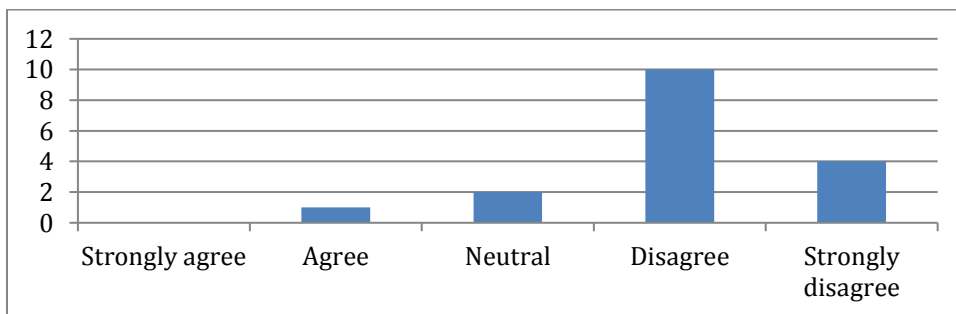
I can explain the term "vicarious trauma" (sometimes referred to as compassion fatigue or

secondary trauma):

I can recognize signs and symptoms of vicarious trauma in myself:
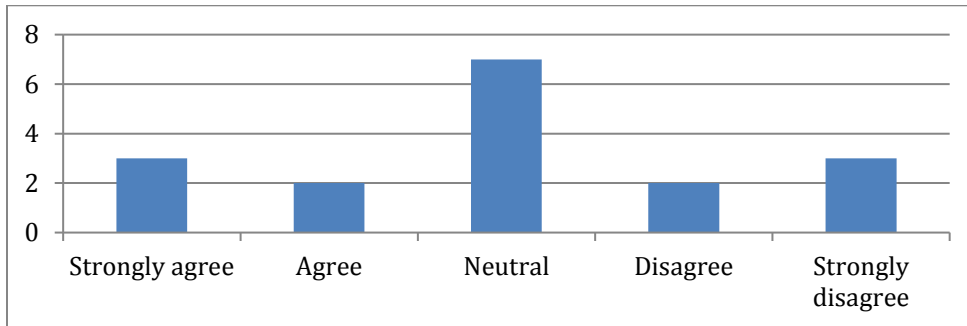
My work environment values the importance of self-care:
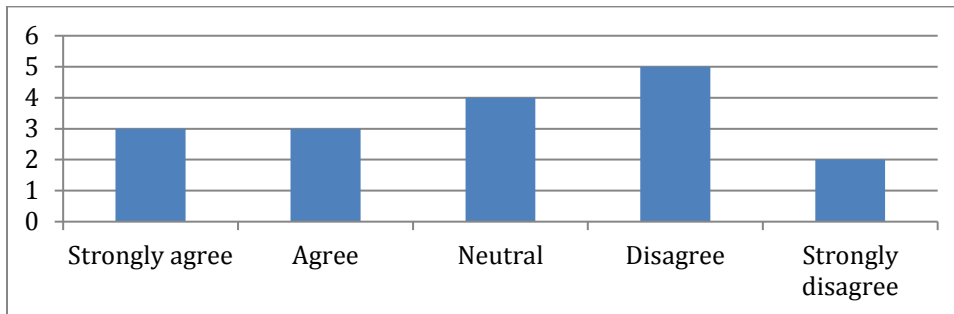
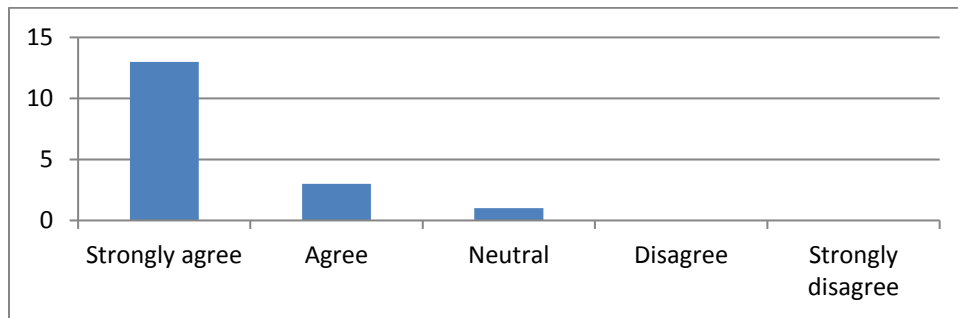My work environment provides me with the opportunities to practice self-care:
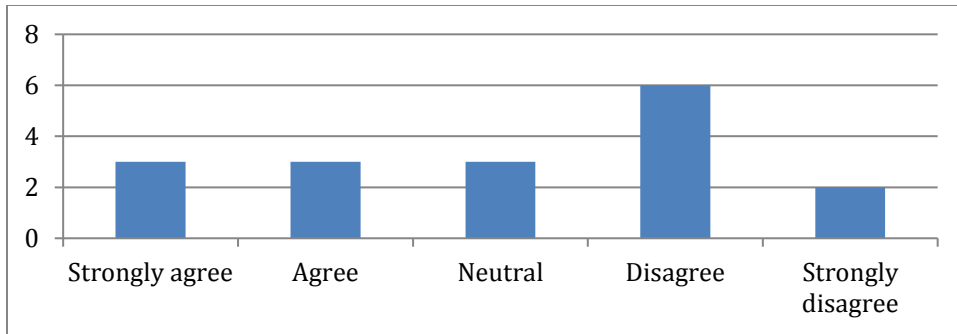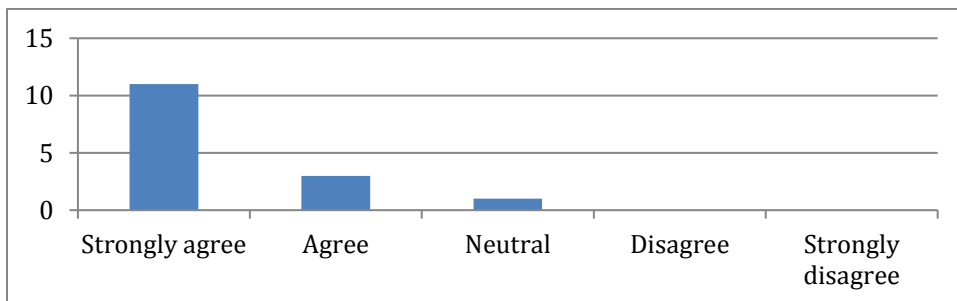
III.   Readiness

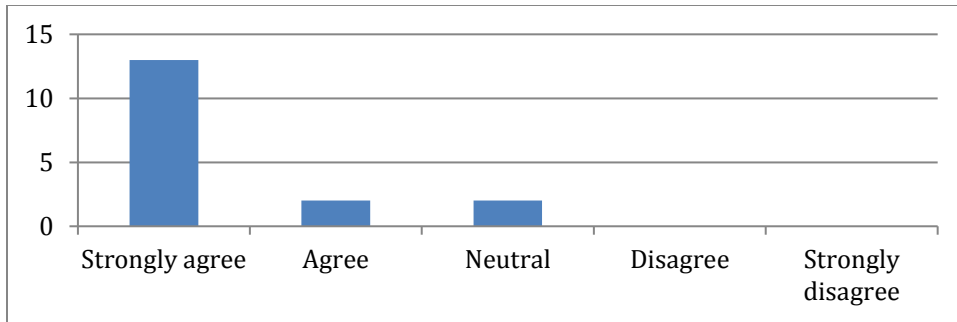Trauma is an important public health issue:
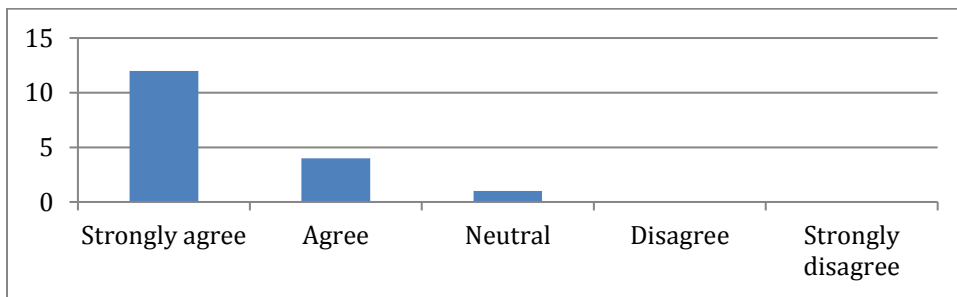
Being trauma-informed is important for everyone in Public Health:
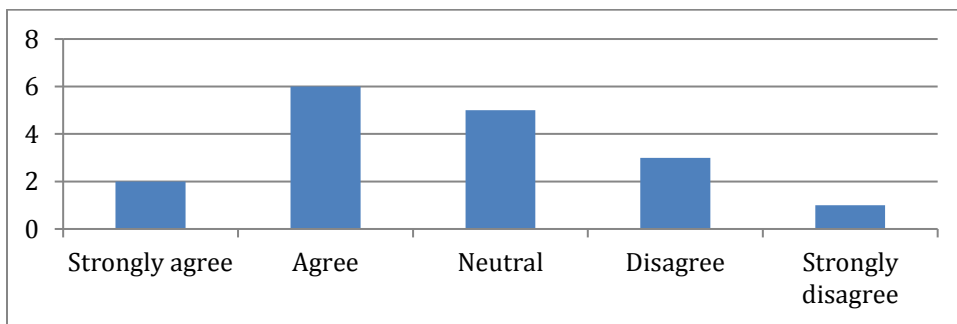

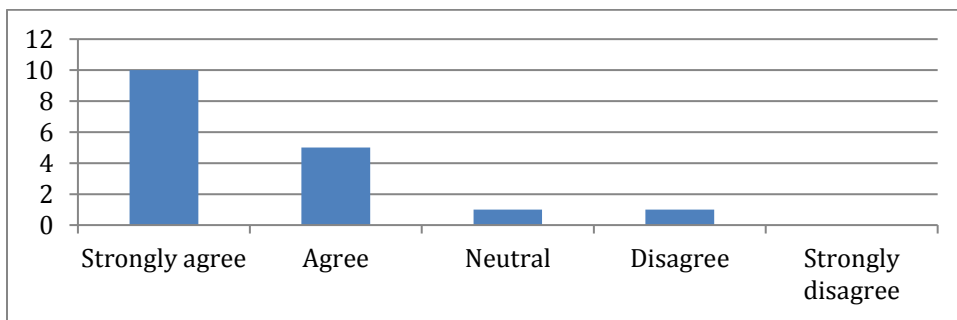It is important for all staff in Public Health to have a common language around trauma:

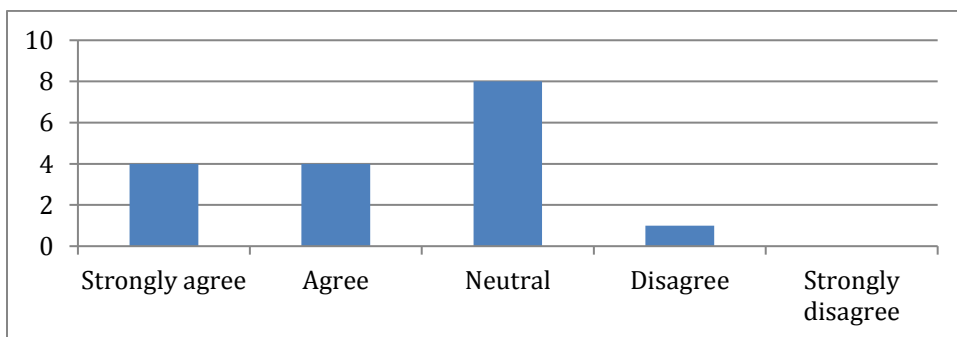I believe that using trauma-informed principles will improve my work-life:

I have a clear understanding of what trauma-informed principles/practice means to my

professional role:

I am willing to adopt trauma-informed interventions that are evidenced based practices:

It will be easy for me to apply trauma-informed principles in my work:

IV.   Strengths:

What strengths currently exist in our work environment that supports a trauma-informed perspective?

Supportive colleagues (12)

Support from supervisors to attend related trainings (9)

Program curriculum or approach (4)

Collaboration with other agencies (3)

V.   Challenges:

What barriers have you recently experienced in promoting trauma-informed practices within your programs?

Lack of time for trainings (6)

Lack of funding for trainings (4)

Difficulty implementing what is learned at the trainings (4)

I haven't experienced any barriers (2)

VI.   Resources

What types of information about trauma are you most interested in receiving?

Notification of upcoming trainings (12)

Web training modules (10)

Research articles (7)

List of related websites (6)

Appendix D: Competencies & Reflection

Competencies

Overall, this fieldwork project addressed the vast majority of USF MPH Competencies, CEPH

Core Knowledge, and Cross Cutting/Interdisciplinary Values. This project entailed a significant

literature review, as well as the creation of a novel survey which relied on knowledge gained

from biostatistics, epidemiology, social and behavior sciences. This project required frequent

communication (verbal, written, electronic) with a variety of Public Health staff. There is great

diversity among the Family Health Section and it was important to honor the importance of

culture humility. Program planning skills were necessary to plan out this pilot project to ensure

that all the key deliverables were completed in a timely manner. Due to the sensitive nature of

the project's topic, professionalism was imperative. Communication was clear and timely.

Confidentiality was extremely important and maintained throughout the duration of this project.

Finally, this issue is broad and requires a systems-thinking approach.

The following MPH Competencies were addressed:

Assess, monitor, and review the health status of populations and their related determinants of health and illness	Reviewed the health status of Berkeley population and data related to trauma
Demonstrate the ability to utilize the proper statistical and epidemiologic tools to assess community needs and program outcomes.	Conducted research on survey tools and utilized components of validated tools to assess knowledge and readiness of the Family Health Section
Identify and prioritize the key dimensions of a public health problem by critically assessing public health literature utilizing both quantitative and qualitative sources.	A substantial literature review was conducted as well as additional exploration through trainings, conferences, and meetings on the issue of trauma. These activities helped identify and prioritize the content for this project.
Apply theoretical constructs of social change, health behavior and social justice in planning community interventions.	Applied theoretical concepts of social justice and socio-epidemiological framework

Demonstrate leadership abilities as collaborators and coordinators of evidence based public health projects	Took a leadership role in the Childhood Cluster meetings; led two presentations on my project
Effectively communicate public health messages to a variety of audiences from professionals to the general public	Conducted two oral presentations to a variety of staff positions and backgrounds
Advance the mission and core values of the University of San Francisco.	At the core of addressing trauma is the issue of social justice. Trauma-informed practices are aligned with the core values of USF.

Application of MPH coursework:

This fieldwork project was truly a culminating experience utilizing the theoretical foundations learned in the classroom. As with any other public health issue, epidemiology is at the forefront of understanding the spread and impact. In this project several epidemiological studies were reviewed, including the Adverse Childhood Experience Study. A survey was created primarily using the Likert Scale and principles learned from Biostatistics were used to analyze the quantitative and qualitative results. Program planning and policy development skills were also important in crafting this project. Finally, the first class in the MPH program introduced keep concepts such as social justice, lifecourse perspective, and socio-ecological framework. These concepts were foundational to this public health project.

Quality of Fieldwork:

Overall, I am grateful to have been a part in creating a vital dialogue about an issue that impacts public health work. My fieldwork agency was supportive of this type of initial assessment and appreciative of the value that this project and what it can bring to the division. Staff was open, interested, and very gracious in participating in what can arguably be an uncomfortable topic. Professionally, this experience has challenged me to critically think about real and difficult public health problems, and I feel reinvigorated and committed to continually look upstream and think big.