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Assessment of Trauma-Informed Care in Sonoma County through ACES Connection

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Assessment of Trauma-Informed Care in Sonoma County through ACES Connection

By

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Abstract

Adverse childhood experiences (ACEs) are stressful or traumatic events that include abuse and neglect. These events also include household dysfunctions such as domestic violence and substance abuse disorders within a household. Other events that fall under ACEs include sexual abuse, physical abuse, emotional abuse, parental separation, intimate partner violence, etc. (SAMSHA, n.d.). Multiple studies have shown that adverse experiences that result in trauma are linked to poor long-term health outcomes. Trauma-informed care practices are essential to aiding victims in building resilience to trauma. The Road to Resilience (n.d.) defines resilience as the ability to adapt or cope with trauma, adversity, family and health problems. Trauma-informed care is a strength-based tool that is used by health professionals to help trauma survivors empower themselves and regain control over their lives (Mental Health Coordinating Council, n.d.). The purpose of this assessment was to learn how health and social service providers involved with the Sonoma County ACES Connection Coalition are implementing trauma-informed care. Six subjects participated in the study. Four individuals filled out a survey containing 10 close-ended milestone questions and 8 open-ended questions while two participated in semi-structured interviews answering the same questions. Survey results found that 17% of the participants did administer ACEs and resilience surveys to their clients while 83% did not. In the assessment, 50% percent of the participants reported that they worked in an organization that integrated policies and trauma-informed care, 33.3% did not, and 17% reported if they did or did not. Participants reported that more human resource policies need to be integrated into trauma-informed care. Others stated that trauma-informed care was not implemented in county government agencies since the current policies were strict. Participants also reported that more outcomes research was needed to evaluate the effectiveness of trauma-

informed care. The ACEs screening tool was used by some organizations while others did not utilize the tool. Findings suggest that policies are needed to frame how trauma-informed care practices are implemented at the organizational level. More outcomes research should be conducted to see if trauma-informed care improves client quality of life.

Literature Review

What is Adverse Childhood Experience (ACES)

Adverse childhood experiences (ACEs) are stressful or traumatic events that include abuse and neglect. These events also include household dysfunctions such as domestic violence and substance abuse disorders within a household. Other events that fall under ACEs include sexual abuse, physical abuse, emotional abuse, parental separation, intimate partner violence, etc. (SAMSHA, n.d.). Multiple studies have shown that adverse experiences that result in trauma are linked to poor long-term health outcomes. Trauma informed care practices are essential to aiding victims in building resilience to trauma. The Road to Resilience (n.d.) defines resilience as the ability to adapt or cope with trauma, adversity, family and health problems. Trauma-informed care is a strength-based tool that is used to by healthcare professionals to help trauma survivors empower themselves and regain control over their lives (Mental Health Coordinating Council, n.d.). The literature review will highlight the prevalence of adverse childhood experiences; the facilitators, barriers, and interventions that influence the utilization of trauma-informed care practices at the organizational level.

Prevalence of Adverse Childhood Experiences.

The first original ACE study was conducted at Kaiser Permanente between 1995 and 1997 with two periods of data collection (CDC, n.d.). Dr. Vincent J. Felitti conducted a study to examine the relationship between health outcomes in adulthood and childhood exposure to

emotional, physical, or sexual abuse. During the study, 13,494 adults were sent a questionnaire about adverse childhood experiences. 9,508 of the 13,494 (70.5%) filled out the survey. The study revealed that 23.5% of the individuals who reported being threatened with or hurt by a gun or knife lived with someone who had a problem with alcohol. 25.6% reported being exposed to substance abuse in the household (Felitti et al. 1998). This study can also be generalized to other populations outside the individuals who participated from Kaiser Permanente.

Adverse childhood experiences are considered to be a nationwide problem. Sacks and Murphy (2018) found that one in ten children have experienced three or more ACEs. The scholars discovered that 45% percent of children who reside in the United States have experiences one ACE, like the exposure rate collected from a survey that was administered in 2011 and 2012 (Sacks and Murphy (2018). Minority populations have experienced adverse childhood experiences more frequently than their counterparts. Nationally, 61% of non-Hispanic black children and 51% of Hispanics have experienced ACEs compared to 40% of whites who have experienced adverse experiences (Sack & Murphy, 2018).

Adverse childhood experiences are linked to poor health outcomes.

Adverse childhood experiences (ACES) have also been linked to high-risk behaviors and morbidity in adults. Campbell, Walker, and Egede (2016) conducted a study and found that individuals with an ACE score of four or more had greater odds for binge drinking, heavy drinking, smoking, and risky HIV behavior. The findings from the study also indicated that sexual abuse and verbal abuse were two forms of aces that independently affected most health outcomes that were investigated. This included diabetes, obesity, diabetes, coronary heart disease, and disabilities caused by poor health (Campbell, Walker, & Egede, 2016). These

findings highlight the importance of integrating trauma-informed practices in medical and mental health services.

Trauma-Informed Care.

It was mentioned earlier that trauma-informed care is a framework that service providers use to create opportunities for trauma services to regain control over their lives (Medical Health Coordinating Council, n.d.). Service providers implement this by teaching clients coping skills that can be used to deal with trauma. The Trauma informed Care Resource Center (n.d.) stated that taking a trauma-informed approach requires an organization to look a patient's life situation from the past to the present. This will allow them to implement effective health care services that will heal the patients and help them build resiliency (Trauma-Informed Care Resource Center (n.d.)).

Perceived facilitators that influence the implementation of trauma-informed care.

There are several facilitators that encourage the implementation of trauma-informed care in the workplace. According to Kirst, Aery, Matheson and Stergiopoulos (2016), participants from their study stated that medical community and the community providers should build a collaborative partnership to integrate services for trauma-informed care. Study participants mentioned that a safe environment needs to be created for the consumers who are being treated for trauma. The participants also mentioned that creating a safe place for clients to come for treatment will reduce stigma. Participants from the interviews felt that providing trauma-informed care could be more feasible if there is someone in a leadership role to promote the use of care (Kirst, Aery, Matheson & Stergiopoulos, 2016).

Attitudes, beliefs, perceived barriers of implementing trauma-informed care among providers.

At the organizational level, service providers have differing attitudes and knowledge about trauma in-formed care practices. Bruce et al., (2018) conducted a study to explore health care provider attitudes, knowledge, practices, competence, and perceived barriers to implementation of trauma-informed care. In terms of knowledge, 93.8% recognized that individuals who were seriously ill had at least one traumatic stress reaction after being exposed to an event. The study found that 44 % of physician, (nurses, 25%), (therapist 19%) stated that did not have anyone to assist them with patients experiencing traumatic stress. When providers rated their competence in providing trauma informed care, 48 % of physicians and 44% of physicians stated that they were not competent in informing patients about symptoms and reactions to stress. Physicians (48%) and therapists (51.9) reported that they were not competent in comprehending the observed evidence assessing traumatic stress and carrying out interventions. Providers also reported that the following barriers make it challenging to implement trauma-informed practices: time constraints, need of training, lack the understanding of evidence on trauma-informed practices, and fear that they may upset or retraumatize patients while trying to address trauma.

Providers in other specialties. Health care providers in other specialized areas have also expressed challenges with implementing trauma informed care. Farrow, Bosch, Crawford, Snead, and Schulkin (2018) conducted a study to evaluate obstetrician-gynecologist knowledge, training, belief, practice patterns, and challenges when screening adult patients for history of childhood abuse. As a result, the obstetrician-gynecologist expressed the following barriers to

screening patients for childhood abuse: not enough time to counsel victims of abuse (70.7%), not enough time to discuss history of child abuse with patient (47.3%), no system to get patients with history of child abuse connected to help (49.7%), and minimal support staff to administer screenings. In terms of screening patients for childhood abuse, 13.5% of providers said they would screen most times while 9.7% said that they would always screen for child abuse. In regards to screening for depression, 35.5% said they screen most of the time and 36.1% said they always screened for depression. Substance abuse was screened most times by 29% of the providers while 48.4% of them always screened from substance abuse.

Mental health service providers experienced barriers that prevent them from implementing trauma informed care practices. Kirst, Aery, Matheson and Stergiopoulos (2016) explored the facilitators and challenges of implementing trauma-informed practices and providing trauma-informed-specific services. The resulted indicated that providers did not use trauma-informed practices because they feared that would retraumatize their clients while trying to treat them. Staff complained that doing trauma-informed work lead to burnout and became stressful to implement due to a lack of available resources.

Changes in Attitudes and Knowledge on Trauma Informed Care Practice (TIC) after Training.

Although healthcare professionals have expressed mixed attitudes about implementing trauma-informed care in the workplace, the use of training has been shown to shift attitudes about these practices. Damian, Mendelson, Bowie, and Gallo (2018) conducted a mix-method study to examine the changes in service provider knowledge, attitude toward traumatized patients, and their self-efficacy to refer patients to trauma services after participating in a trauma-informed care training. A pre-post quantitative survey was use to evaluate trauma-informed care

knowledge, attitude, and beliefs for eighty-eight providers. Then a subset of sixteen providers were interviewed using a semi-structured interview format. The results from the qualitative analysis revealed a few themes from the interviews. The participants in the study stated that the information from the training was useful and felt that there was a need for outreach to upper-level management to promote trauma-informed care practices. In another study, Damian, Gallo, Phillip and Mendelson (2017) found that participants reported that they became more aware of their own trauma and expressed the need to take health approaches to release their own stress when working with traumatized clients.

Service providers felt that they acquired more knowledge about trauma after receiving training. According to Kuhn et al. (2019) a Child Protective Academy had been created to provide members of the child-welfare workforce with the ability to address child and family trauma. The findings concluded that the Academy increased knowledge about trauma among those who participated in the study, with an increase in scores from 3.43 to 3.93 from pre- to post training (Kuhn et al. 2019). Kenny, Vazquez, Long, and Thompson (2017) conducted an exploratory study to examine the effectiveness of a trauma-informed training program that used a modification of a TIC curriculum from National Child Trauma Stress Network. The study found that 42 individuals who participated in the study liked that the trainings had real life cases that included video testimonials, vignettes, and children's personal stories. The other 34 participants liked that the training included interactive activities and gave them the opportunities to connect with others. (Kenny, Vazquez, Long & Thompson, 2017). Training provides service providers with more insight on the adverse effects that shape the lives of trauma survivors.

Web-based and remote trainings. Web-based trainings have been proven to be useful to health providers in their current work. Hoysted, Jobson, and Alisic (2019) conducted a controlled

trial study to evaluate the effectiveness and acceptability of a web-based training program on pediatric medical traumatic stress and trauma-informed care. This study revealed that 74.2% of the providers (physicians or nurses) reported that the training would be useful to their role in the emergency department. The study revealed that 22% percent of the participants said that they found the training moderately useful while 45.2% stated that the training was very useful. Participants also reported that they were “mostly satisfied (29%), “very satisfied” (48.4%), and “extremely satisfied” (9.7%) with the training (Hoysted, Jobson & Alisic,2019). Remote trainings have also increased provider knowledge and improved their ability to implement trauma-informed care practices. Walker and Baird (2019) hypothesized that a remote training method (Achieve My Plan Skills Enhancement training) can improve providers’ skills in providing care to youth adults with mental health conditions from pre- to post training. The findings revealed that their ability to collaborate with treatment/care team scores increased from 81.65 to 87.31 pre-to post training. Providers felt more confident in applying what they learned from the training. Their scores in being confident to apply what they learned increased from 7.76 to 8.52 mid to post training.

Concern about trauma-informed care training. Although attitudes toward training have shifted among providers, there are still concerns raised about the training. Damian, A. J., Mendelson, T., Bowie, J., and Gallo, J. J. (2018) found that employees felt that trainers did not provide any guidance on how to implement trauma-informed care in their agencies after the training. Participants reported that they were not sure how the concepts of trauma and trauma-informed care practices applied to their day-to-day work.

Organizational culture changes in trauma informed care practice after training (TIC)

After training, organizations make changes to their organizational culture in terms of implementing trauma-informed care after being trained. Damian, Gallo, Phillip and Mendelson (2017) found that after agencies received training, participants reported that policies were tailored to meet real-time needs for of clients. The participants developed a greater urgency to prioritize empathy and meeting clients where they are at instead of devoting more time to administrative work (eg, paperwork). Four out of 16 participants reported that their organizations changed to adopt a more trauma-informed workplace environment. Agencies accomplished this by altering the physical layout of their facilities to make clients feel more comfortable. The change in the environment lead to positive interactions between providers and clients.

Problem Statement

Acesconnection is looking to raise ACEs awareness, deepen understanding and provide hope and healing through resilience building. They support individuals, organizations and other communities as they move through this process. However, it has been challenging to keep up with the all the new evidence-based practices (K. Clemmer, personal communication, July2017). In response, an exploratory study was conducted to assess the level of competency among service providers in their ability to implement trauma-informed care in the workplace.

Agency Profile

The ACES Connection Network is a social networking engine that was created to support communities to strengthen the global ACEs science movement. The network is organized by communities that focus on learning about ACES and trauma-informed practices. The organization has set out to raise awareness about the effect that adverse child experiences has on influencing adult health and behavior. It also promotes trauma-informed resilience building practices and influences policy in communities and institutions such as schools, prisons,

hospitals, and churches. The Network has created a safe place for members to share information, access tools, and explore resources to collaborate on creating resilient families, systems, and communities. Aces Connection works closely with professionals interested in becoming more trauma-informed; including policy and evaluation analysis, physicians, child advocates, law enforcement agencies and more. These organizations and individuals participate in this network to improve their skills and knowledge to serve vulnerable populations that suffer from adverse childhood experiences or trauma.

Sonoma County Aces Connection was funded in October of 2015 by the Robert Wood Johnson Foundation (RWJF), and the California Endowment as a part of the Mobilizing Action for Resilient Communities (MARC) initiative, a two-year initiative created to help communities address adverse childhood effects and become trauma-informed. The mission of Sonoma County ACES Connection is to bring the community together to prevent, heal and treat ACEs while promoting resilience.

The primary services provided to members of Sonoma Country ACEs connection group include access to other ACEs connection members, and other communities engaging in trauma-informed practices, opportunities to post questions on ACES to the broader Network regarding, access to resource centers that include information regarding ACEs training, access tools to improve their ACEs initiatives, and receive daily or weekly round updates, informing members about ACES-related activities, including programs, stories, and research studies.

Karen Clemmer was a public health nurse who worked in maternal child adolescent health for 20 years. She co-founded the Sonoma County ACES connection in the year 2014. The group grew quickly to 75 + members that included juvenile justice, public policy, child advocates, physicians, and behavioral health professionals. She is now the Northern California Community Facilitator for ACEs Connection.

Project Goals

Project Goal 1: Understand how far the agencies have come in adopting trauma-informed practices

Objective 1.1: Survey 6 members from the selected agencies in Sonoma County ACES Connection group.

Objective 1.2: Conduct phone interviews of 2 members from the selected agencies in the Sonoma County ACES Connection.

Project Goal 2: Understand facilitators/barriers that influence the agencies readiness to adopt trauma-informed practices.

Objective 2.1: Survey interview 6 members from each agency using open ended questions.

Objective 2.2: Conduct phone interviews of members from each agency using open ended questions.

Project Goals 3: Understanding facilitators/barriers that influence the agencies readiness to adopt trauma-informed practices.

Objective 3.1: By April 25th, I would have phone interviewed 2 members from each agency using open ended questions.

Methods

Objective/Aim

The first objective of this assessment was to learn how members from Sonoma County ACES Connection were implementing trauma-informed care at their place of work. After the project's second objective was to learn what facilitators and barriers influence the adaptation of trauma-informed care at the organizational level.

Design

A mixed method design was utilized to carry out this project. Applying mixed methods can generate broader perspectives of the overall issue that is being studied (Center for Innovation in Research and Teaching, n.d.). Using a mixed method design for this project provided multiple perspectives from the ACES Connection members on why they may or may not

implement trauma-informed care. The use of both qualitative and quantitative data can also provide additional evidence to support findings (Center for Innovation in Research and Teaching, n.d.). For instance, the use of open-ended questions in this project provided an explanation of responses to close-ended questions. Mixed method designs are comprehensive and include other components such as numbers, statistics, words, pictures, and narrative (Center for Innovation in Research and Teaching, n.d.). These components can help Sonoma County ACES Connection gain a deeper understanding of what may be encouraging or hindering the implementation of trauma-informed care at the organizational level.

Participants

Participants in the project included 6 members from the Sonoma County ACES Connection group. All participants held positions in health and social services program planning (E.g. doctors, evaluation analyst, parent resource directors, and health information specialist). Recruitment was done by posting a message on the Sonoma County ACES Connection page to make the members aware that we were looking for participants to take part in the project and by purposive sampling.

Sampling

During purposive sampling, researchers use their own judgement to choose participants that suit their study's 'needs or choose individuals who have certain characteristics (Health Knowledge Education, CPD and Revalidation from Phast, (n.d.). In this project, participants were chosen based on the establishment of rapport with organization's staff. This technique is useful because it is time and cost effective when conducting qualitative research (Health Knowledge Education, CPD and Revalidation from Phast, n.d.). Ayres (2019) stated that when

researchers use purposive sampling, there is a lower margin for error because the information being collected comes straight from the source. The technique allowed for direct contact with project participants involved in the Network community.

Data Collection

Semi-structured interviews were used to collect data from participants in Sonoma County ACES Connection. The semi-structured survey that was administered contained 10 milestones yes or no questions and 8 open-ended questions. This form of interview is effective because it allows the interviewer to appear competent during the interview (Cohen,2016). They are more competent because the semi-structured interviews are organized around predetermined questions (Whiting, 2008). However, for purposes of this project the interview questions were transferred to a document for participants to fill out as a written survey.

Electronic surveys were also used to collect data from participants in Sonoma County ACES Connection. The surveys were sent to the participants through email. Surveys are beneficial for doing research because they are cost effective. Rice, Winter, Doherty, and Milner (2017) found that surveys allow researchers to collect a large amount of data quickly and cheaply as compared to other research methods. The survey that was administered for this project was short and simple to complete. The participants reported that they found this beneficial since they had busy work schedules.

Data Analysis

The responses to the closed-ended questions were analyzed using Google forms, which counts the responses toward each question that was answered. Once the participants completed the survey, Google forms generated the percentages for all responses to the questions. The

qualitative data (open-ended questions) were analyzed using a content analysis. Columbia University Mailman School of Public Health (n.d.) defines a content analysis as a research tool that is used to identify themes or concepts in qualitative data. Content analysis allows researchers to analyze data without paying a large cost. It is also helpful for examining responses from interviews. Content analysis can be used to analyze quantitative data and qualitative data (Columbia University Mailman School of Public Health, n.d.).

Results

To assess how organizations were implementing trauma-informed care, semi-structured interviews were conducted and written surveys administered to present and former members of Sonoma County ACES Connection. Using the purposive sampling method, 6 of the 152 members who are members of Sonoma County ACES Connection received a survey. Of the six participants who received a survey, 3 completed the survey, 2 participated in a semi-structured interview, and 1 participant did not answer all the questions that were asked.

Quantitative Data

Quantitative data was collected using ten of the eleven milestones questions that were adopted from ACES Connection. One of the questions asked participants if they gave ACE and resilience surveys to clients (e.g. clients, students, customers, patients, and prisoners). The responses revealed that 17% of the participants did administer surveys while 83% did not. The response rate on the question regarding who did and who did not give ACE and resilience surveys to clients is shown in Appendix A. When exploring whether or not program staff completed an ACE and resilience survey to learn more about their own ACE scores, 17% reported that they did complete ACE and resilience surveys while 83% did not.

Participants were asked if their organization had made changes to their environment to make it more trauma-informed after examining other examples from other organizations. Of the total, 83% of the respondents reported that their agency did this, while 17% did not respond to the question. Participants were also asked if they educated their clients about ACEs science. This included patients, students, prisoners, and customers or whomever is being served by their organization. The responses revealed that 67% did educate their clients and 33.3% did not. Participants were also asked if the human resource department in their organization integrates policies and trauma-informed care. The responses revealed that 50% of the participants worked in an organization where the human resources department did integrate policies and trauma informed care, 33% reported that their agency did not integrate policies and trauma-informed care and 17% did not report if their agency did or not. All quantitative findings are shown in Appendix A.

Qualitative Data

Qualitative data was collected using eight open-ended questions that were developed by the agency and me. The questions asked participants about their experiences with trauma-informed care and what trauma-informed care practices should look like in the future. A content analysis was used to analyze the themes that were revealed in the semi-structured interviews and surveys. The responses to the open-ended question are shown in Appendix B.

Theme 1: Training and preparation. Participants expressed mixed feelings about the training that was administered to them on trauma-informed care. Some reported that the training did not cover all aspects of trauma-informed care and felt more skilled trainers were needed to teach staff about these trauma-informed care practices. Some individuals stated that they have facilitated multiple staff trainings on ACEs and how to use it when delivering services. Training

also helped some organizations clearly articulate ACEs. However, other organizations reported that staff who worked in human services did not have the training or support to work with clients who were experiencing trauma. In general, participants reported that more training was needed.

Theme 2: Policy implementation. Policy implementation was another theme that came up frequently when participants were asked about trauma-informed care. Participants stated that more human resource policies need to be integrated into trauma-informed care. Others stated that trauma-informed care was not implemented in county government agencies since the current policies that they had were strict. However, other participants reported that policy is used in their agency to shape the way trauma-informed care is implemented.

Theme 3: Challenges with implementing trauma-informed Care. Participants reported that they struggled to implement trauma informed care in their agencies. Participants mentioned that it was difficult to utilize trauma-informed care for populations with higher needs due to a lack of resources. They also stated that their services have changed from being support services to providing emergency services. The participants also mentioned that it was challenging to keep practices consistent while serving clients. Pre-existing organizational culture was one other factor that made it challenging for agencies to shift over to using trauma-informed care to work with clients.

Theme 4: Attitude differences around learning about the use of open-ended questions in this project provided an explanation of responses to close-ended questions trauma-informed care. Some participants reported that their staff had different views on the information on trauma-informed care, with some accepting trauma-informed care while others resisted the information. Other participants stated that their staff felt ACEs science was a helpful tool to use when talking to parents about trauma. Leaders from the organizations expressed that the

information on trauma-informed care was not new, as they had been doing it before the research on it was released. They also wished that the information had been released before they started doing the work with ACEs.

Theme 5: Outcomes trauma-informed. Service providers reported that there is a need for more outcomes research to evaluate the effectiveness of trauma-informed care. The outcomes research should include client outcomes for those who have been in a trauma-informed program. Participants stated that reporting to funders on how trauma-informed care is being provided in their agency will enable their organizations to acquire more funding to continue delivering services.

Theme 6: Utilization of ACEs screening tool. Participants gave different reasons for why they did or did not use the ACEs screening tool. Some of the participants reported that they did not use it at all while others stated that it depended on the programs or services that were being offered. For example, organizations made it optional for parent educators to use the tool when parent services were being offered. Service providers also stated that they did not have staff complete ACEs screenings since the staff were not comfortable disclosing their own traumatic experiences. Others reported that they used the ACEs screening tool to let parents know what factors may be affecting their ability to parent their children. Some service providers also reported that the ACEs screening tool was not used because they felt that clients being serving would eventually bring up the trauma on an ongoing basis while receiving services. They also mentioned that the goal was to help clients deal with their trauma by teaching them new coping skills. These coping skills would enable the clients to recover from their own trauma independently in a healthy way.

Theme 7: Promoting the framework of trauma-informed care. Individuals who participated in this project expressed that trauma-informed care was more feasible to implement when there is someone promoting it. One participant stated that First 5 Sonoma County helped their organization adopt a new lens on how trauma-informed practices can be integrated into the work they do. A former ACEs connection member stated that practices from an MFT who specialized in grief healing were aligned with the way they approached providing trauma-informed care.

Discussion

The purpose of this assessment was to learn how health and social services providers involved with Sonoma County ACEs Connection are implementing trauma-informed care. The ultimate goal of this project is to use these findings to improve the information shared with the organizations on the Coalition website. In this assessment, there were common themes identified that facilitated or hindered the organizations' implementation of trauma-informed care. These themes, which also surfaced in review of the literature, included: training and preparation, policy implementation, challenges with implementing trauma-informed care, attitude differences around learning about trauma-informed care, outcomes trauma-informed care has on clients, utilization of ACEs screening tools, and promoting the framework of trauma-informed care. There were also unexpected findings in the study that were not evident in the literature reviewed. For example, several organizations did not administer ACE and resilience surveys to their employees, because they are concerned about potentially retraumatizing them without having the resources needed for their psychological care. Another unexpected finding was that not all the respondents asked their clients to complete the ACE surveys, unless it appeared relevant to their care.

Other findings from this assessment support the literature from Bruce et al. (2018), in which providers reported that it was challenging to implement trauma-informed care without receiving sufficient training. In addition, some participants stated that more training is needed to incorporate trauma-informed care into organizational policies. However, other participants mentioned that their organization used policies to direct the way trauma-informed care was being implemented in their organization. Findings from this assessment revealed that members believed that policy needs to be integrated into trauma-informed care practices. These findings indicate that there is an opportunity to create more policies that will dictate how trauma-informed care should be implemented.

Farrow, Bosch, Crawford, Snead, and Schulkin (2018) found that 9.7% of obstetricians always screened their patients for child abuse. Participants in this project reported that they did not always screen for ACEs, with some stating that it was optional for them to screen clients when parent services were being offered. Damian, Gallo, Phillip and Mendelson (2017) mentioned that agencies tailored policies to meet client needs after receiving training. The participants in this project stated that there is a need to create more human resource policies for implementing trauma-informed care. Damian, Gallo, Phillip and Mendelson (2017) discovered that agencies were able to acquire a more trauma-informed environment by changing the physical layout of their facility to make it more welcoming to clients. This project showed that providers made their workplace more trauma-informed by learning how other agencies adopted the culture.

Findings from this project were also consistent with the study conducted by Mendelson, T., Bowie, J., and Gallo, J. J. (2018), in which individuals stated that they were unsure about how the concepts that they learned from training applied to their work. This project found similar

findings, in which members of Sonoma County Aces Connection reported that training should cover the science and personal aspect of work. However, some agencies mentioned that training had helped them articulate what ACEs are in a simple fashion. This may suggest that organizations need to closely evaluate training practices to improve the way it is delivered to agency staff members.

The respondents expressed mixed reviews regarding whether the ACEs screening tool was appropriate for every population. Some of the respondents stated that they used the ACEs screening tool depending on what services were being offered by their organization. Others mentioned that they did not use the tool because human service workers were not comfortable with hearing the traumatic stories that their clients had to share. These findings suggest that the language being used in the ACEs screening tool should be modified to prevent re-traumatization among clients and employees. Refining these questions may help organizations determine what questions are appropriate for the services that they deliver.

The participants reported that more outcomes research is needed to highlight the effectiveness of trauma-informed practices. This means that there should be more research that measures individual client health outcomes among clients who have received trauma-informed care services, as compared to those who have not. Some participants felt that service outcomes should be reported to funders in order to receive additional funding. This may also suggest that organizations should report individual client health outcomes so they can learn about the long-term effect that trauma-informed care has on clients receiving services. Doing this may include collecting satisfaction surveys to see if clients are benefiting from these services.

Kirst, Aery, Matheson and Stergiopoulos (2016) reported that service providers felt that providing trauma-informed care could be more feasible if there is someone in a leadership role to

promote the use of trauma-informed care. Similarly, our study found that services providers felt that having a leader to promote trauma-informed care approaches helped integrate practices into their organization. These findings may suggest that organizations should elect a leader or champion from their organization to advocate for implementing trauma-informed care in the workplace.

Limitations

There were several limitations to this project. Time was a significant limitation that made it challenging to recruit individuals to participate in the project, requiring the use of a purposive sampling approach to get current and former members from Sonoma County Aces Connection to participate. Since the project was focused more on individuals who were or are currently engaged with the Sonoma County Aces Connection website, it was not possible to recruit from other organizations outside of this group. As a result, the sample size for this project was quite small.

The data that was collected during the semi-structured interviews and the surveys was self-reported. The University of Southern California (n.d.) stated that self-reported data contain sources of bias. It is possible that participants may have selective memory on the experiences that they had with implementing trauma-informed care. Participants may have also exaggerated about their experiences with trauma-informed care and made them seem more significant than they actually were.

Implications for Practice

Organizations that deliver social services may benefit from having a leader who promotes the implementation for trauma-informed care. A promotional leader can influence employees to

attend conferences that raise awareness about adverse childhood experiences and the importance of being a trauma-informed organization. The leader or champion can organize trainings on trauma-informed care for service providers in the organization. These trainings will keep employees informed and encourage them to think about what it means to take trauma-informed approaches when they are working with clients. The providers will also learn how to tailor their care to each client while using trauma-informed care practices.

Policies should be put in place to facilitate how organizations should be implementing trauma-informed care. This includes mandating that all new hires in an organization be required to participate in trainings on trauma-informed care. Since information on trauma-informed care practices are rapidly evolving, there should be a policy that mandates senior employees to attend trainings on an annual basis. This will ensure that organizational practices are consistent with the new and emerging practices.

Future Research

There are a few areas where future research can be conducted. One area of research should focus on the long-term effects that trauma-informed care has on clients who are receiving services. There is limited research on how trauma-informed care has affected trauma survivors long-term. A longitudinal study may be helpful to discover how client health outcomes have changed overtime among individuals who have participated in trauma-informed care programs compared to those who have not. This form of research can help organizations acquire more funding for services if trauma-informed care has a positive impact on population health.

Another area that of research should be focused on the professionals' comfort with asking or answering questions that are on the ACEs screening tool. Findings from the this assessment

revealed that human service providers were not comfortable asking the questions on the tool. Further research should explore what language in the questions are re-traumatizing to both employees and clients. If the language that is triggering to individuals is removed from the tool, then organizations may increase their utilization of the tool without re-traumatizing the clients and those who are delivering services.

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Appendix A.

Table 1: Responses to Milestone Questions

Milestones	Yes	No	N/A
1. ACEs science presentation to any staff- Any employee of an organization has attended a workshop or presentation about ACEs science	100%	0%	0%
2. Participants in local ACEs Initiatives-Organization representatives attend ACEs initiative meetings, participate in workshops or have signed an MOU with the ACEs initiative.	83%	17%	0%
3. Leadership committed to integrating ACEs science - organization decision-maker(s) publicly state the intention of, approve a committee to lead and provide resources for the entire organization to become trauma-informed.	83%	17%	0%
4. HR integrates trauma-informed practices and policies - Human resources employees, or people responsible for organization’s human resources function, applies an ACES science lens to all policies and practices, including hiring, termination, leave, supervision, etc.	50%	33%	17%
5. Staff receive ACE and resilience surveys - This means that each staff member has anonymously completed an ACE survey to determine their own ACE and resilience scores so that the organization can determine its ACEs burden and resilience foundation. It is important for an organization to do this; it provides impetus for the organization to examine its work-place practices through an ACES science lens and make appropriate changes, to make sure its work force is practicing self-care, and to create a physical and emotional environment that is safe and supportive for staff. Anyone who takes an ACE survey should be educated ACEs science, provided a resilient survey or information about resilience factors, and the opportunity to talk with a peer support specialist or social worker. Employees should not provide their scores to the organizations they work for.	17%	83%	0%
6. Clients educated about ACEs science - “Client” also refers to patient, student, prisoner, customer.... whomever is served by the organization. They have a right to know the most powerful determinant of their...and their children’s...health, safety, and productivity.	67%	33.3%	0%
7. Clients receive ACE and resilient surveys - This means that clients/students/customers/patients/prisoners have completed an ACE survey (original or expanded) for themselves. It does not mean that they have provided that information to the organization that gave it to them; it may be for their own knowledge. It depends on the organization. It’s appropriate for a physician to know the ACE score of a patient; it is not necessary for a school to know the ACE score of a student. However, it would be useful for a school to know the ACE burden of its student body, and gather student ACE scores anonymously. Anyone who takes an ACE survey should be educated about ACES science provided a resilient survey or information about resilience factors, and the opportunity to talk with a peer support specialist or social worker.	17%	83%	0%
8. Implements TI practice for students - Organization has applied ACEs science lens to all practices for clients, students, patients, prisoner, or customers, and change them to become trauma-informed and resilience building.	83%	0%	17%
9. Evaluates TI policies and practices - on an ongoing basis, organizations evaluate changes it has implemented and makes improvements.	83%	0%	17%

<p>10. Physical environment is trauma-informed - organization has examined good examples of the trauma-informed physical environments of other similar organizations and made changes in their own physical environment.</p>	<p>83%</p>	<p>0%</p>	<p>17%</p>
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Appendix B.

Table 2: Responses from participants in the Sonoma County Acesconnection group.

Themes	Experiences with trauma-informed care
Training and preparation	<p>“More training.”</p> <p>“Training that touches the sciences and personal aspects of the work. Small group settings. Skilled trainers.”</p> <p>“I was the early adopter at CPI - I was a co-founder of our local ACES initiative organization. I have conducted multiple staff trainings on ACES and how to use ACES in providing services.”</p> <p>“Again, ACEs are included as part of training on trauma and trauma-informed approaches.</p> <p>“Training has been helpful for articulate ACEs in a simple fashion.”</p> <p>“Staff did not have the training or support to hear about the clients’ stories regarding trauma.”</p>
Policy implementation	<p>“Looking more at HR policies for TIC. Perhaps looking at whether we should routinely require an ACE screen.”</p> <p>“These are not practices that are widely implemented within the department or county government due to stringent policies.”</p> <p>“Policies in our agencies shaped the way we implemented trauma-informed care”</p>
Challenges with implementing trauma-informed care	<p>“It has been difficult to be consistent implementing trauma-informed care practices when other priorities like treating the flu came up”</p> <p>“Populations that had higher needs became more difficult to address due to low access to resources. Our services went from support services to ER services.</p> <p>“Yes. We are trying to change a long-standing organizational culture of "toughness" and there is a schism in our staff members between those who want to preserve tough approaches and those who want to work with clients in a more trauma-informed way.”</p>
Attitude differences around learning about Trauma-Informed care	<p>“As mentioned above, some staff embrace and some resist trauma-informed practices and information. No one has indicated being triggered; some complain and say our clients most need to be kept in line using strict methods.”</p> <p>“Staff appreciate the knowledge and the support. It was hard for some at the beginning when they reflected on their own upbringing, but overall the feeling is that it has been helpful to know especially in working with clients.”</p> <p>“Generally, very open since it helps folks do their jobs more effectively and understand themselves more. No complaints yet.”</p> <p>“Employees feel that ACEs science has been a helpful tool to talk to parents about trauma.”</p> <p>“We have been implementing trauma-informed care before the research on it was even released.”</p> <p>“The research that was released has only affirmed what we have already been doing.”</p> <p>“I wish that the research on ACEs had been released before I started doing trauma-informed care work.”</p> <p>“I wish had known that talking to human service staff about ACEs would be triggering for them.”</p>

<p>Outcomes Trauma-Informed-care has on clients</p>	<p>“Measuring community outcomes and telling the story of how we are making a difference using TI practices and increasing our understanding of the ACEs work.”</p> <p>“Agencies have to report what they are doing to implement trauma-informed and it’s outcomes in order to get funding to continue providing services.”</p> <p>“County-wide outcomes on a long-term scale. What is the lasting impact we are aiming to see with shared outcomes that cross sectors? Population level shared data for the county”.</p> <p>“I wish there had been more research on outcomes for clients who have received trauma-informed programs.”</p>
<p>Utilization of ACEs screening tools</p>	<p>“No”</p> <p>“Yes, the ACEs questions are part of our risk and needs assessments. The assessments are used to develop case plans.”</p> <p>“It is optional for parent educators to use when offering parenting services. It is used in some of our classes. It is helpful in letting parents know what may be affecting their own abilities to parent and also to give parents a goal to strive for.”</p> <p>“We do not use the questions because this information will eventually come up with our clients if they choose to talk about it. They talk about this information on an on-going basis. At this point, we want to teach clients coping skills so they can deal with their trauma and re-frame how they think about it.”</p> <p>“We use ACEs screening for certain programs like “watch me grow”</p> <p>“We do not ask employees about their ACEs scores because they are not comfortable with it.”</p>
<p>Promoting the framework of trauma-informed care</p>	<p>“Having a leadership that championed trauma-informed approaches. Additionally, the legal framework is very important to our work, and relevant legislation that is trauma-focused or based in ACEs science has a great impact on our approaches.”</p> <p>“We had an MFT that specialized in grief practice in healing. Many of the MTF's practice were set in motion that aligned with ACEs science.”</p> <p>“First 5 Sonoma County. Helped us see a new lens on how we can integrate TI practices into our work.”</p>

Appendix C

Sample Interview Questions

Part A:

Milestone Questions:

1. ACEs science presentation to any staff- Any employee of an organization has attended a workshop or presentation about ACEs science.
 - Yes
 - No
2. Participants in local ACEs Initiatives-Organization representatives attend ACEs initiative meetings, participate in workshops or have signed an MOU with the ACEs initiative.
 - Yes
 - No
3. Leadership committed to integrating ACEs science - organization decision-maker(s) publicly state the intention of, approve a committee to lead and provide resources for the entire organization to become trauma-informed.
 - Yes
 - No
4. HR integrates trauma-informed practices and policies - Human resources employees, or people responsible for organization's human resources function, applies an ACES science lens to all policies and practices, including hiring, termination, leave, supervision, etc.
 - Yes
 - No
5. Staff receive ACE and resilience surveys - This means that each staff member has anonymously completed an ACE survey to determine their own ACE and resilience scores so that the organization can determine its ACEs burden and resilience foundation. It is important for an organization to do this; it provides impetus for the organization to examine its work-place practices through an ACES science lens and make appropriate changes, to make sure its work force is practicing self-care, and to create a physical and emotional environment that is safe and supportive for staff. Anyone who takes an ACE survey should be educated on ACEs science, provided a resilient survey or information about resilience factors, and the opportunity to talk with a peer support specialist or social worker. Employees should not provide their scores to the organizations they work for.
 - Yes
 - No
6. Clients educated about ACEs science - "Client" also refers to patient, student, prisoner, customer.... whomever is served by the organization. They have a right to know the most powerful determinant of their...and their children's...health, safety, and productivity.
 - Yes
 - No
7. Clients receive ACE and resilient surveys - This means that clients/students/customers/patients/prisoners have completed an ACE survey (original or expanded) for themselves. It does not mean that they have provided that information to the organization that gave it to them; it may be for their own knowledge. It depends on the organization. It's appropriate for a physician to know the ACE score of a patient; it is not necessary for a school to know the ACE score of a student. However, it would be useful for a

school to know the ACE burden of its student body, and gather student ACE scores anonymously. Anyone who takes an ACE survey should be educated about ACES science provided a resilient survey or information about resilience factors, and the opportunity to talk with a peer support specialist or social worker.

- Yes
 - No
8. Implements TI practice for students - Organization has applied ACEs science lens to all practices for clients, students, patients, prisoner, or customers, and change them to become trauma-informed and resilience building.
 - Yes
 - No
 9. Evaluates TI policies and practices - on an ongoing basis, organizations evaluate changes it has implemented and makes improvements.
 - Yes
 - No
 10. Physical environment is trauma-informed - organization has examined good examples of the trauma-informed physical environments of other similar organizations and made changes in their own physical environment.
 - Yes
 - No

Part B:

1. Thinking back, was there one or more individuals who stood out as early adopters of ACEs science? If yes, describe if or how your organization was influenced by these early adopters.
2. What stood out as most helpful in terms of incorporating ACEs science into your organizational environment? (trainings, materials, etc)
3. Has your organization (group, office, etc) encountered difficulty with operationalizing ACEs science and trauma informed practices? If yes, please describe.
4. Looking back, what do you wish you had known, had as a resource, or prior to embarking on the journey towards embracing ACEs science and incorporating trauma informed practices?
5. Does your organization utilize the 10 ACEs screen questions (or a similar tool) with clients? If yes, how is that information incorporated into care?
6. Among the staff working in your organization, in general, how have they responded (triggered, made sense, or?) to learning about ACEs?
7. What do you see as the “next step” in moving towards incorporating ACEs science into your organization’s policies, practices, or?
8. In an ideal world, what would be your one wish, in terms of improving conditions for those impacted by ACEs?
9. Any last comments / thoughts/ or ideas you would like to share?

Thank you for your time and consideration.....