



SAMHSA's National Center for Trauma-Informed Care (NCTIC)

Report of Project Activities Over the Past 18
Months, History, and Selected Products

March 2012

Background

The National Center for Trauma-Informed Care (NCTIC) was launched in 2005, following the landmark conferences Dare to Vision (1994) and Dare to Act (2004), and in response to research documenting the impact of violence and trauma, including a 5-year SAMHSA-funded study exploring the interrelation between violence, trauma, and co-occurring mental health and substance abuse disorders among women.

NCTIC offers consultation, technical assistance (TA), education, and outreach, and resources to support a revolutionary shift to trauma-informed care across a broad range of publicly-funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education. In September 2010, in response to SAMHSA's Strategic Initiative on Trauma and Justice, NCTIC merged with SAMHSA's Promoting Alternatives to Seclusion and Restraint through Trauma-Informed Practices to support the shared goals of expanding the use of trauma-informed practices to end the use of seclusion, restraint, and other coercive practices. This report provides information on the overall scope of the project since NCTIC's inception in 2005, and current data that reflects the last 18 months of work under the merged contract. NCTIC will be used throughout the report to reflect both the merged contract and the previous body of work completed by NCTIC.

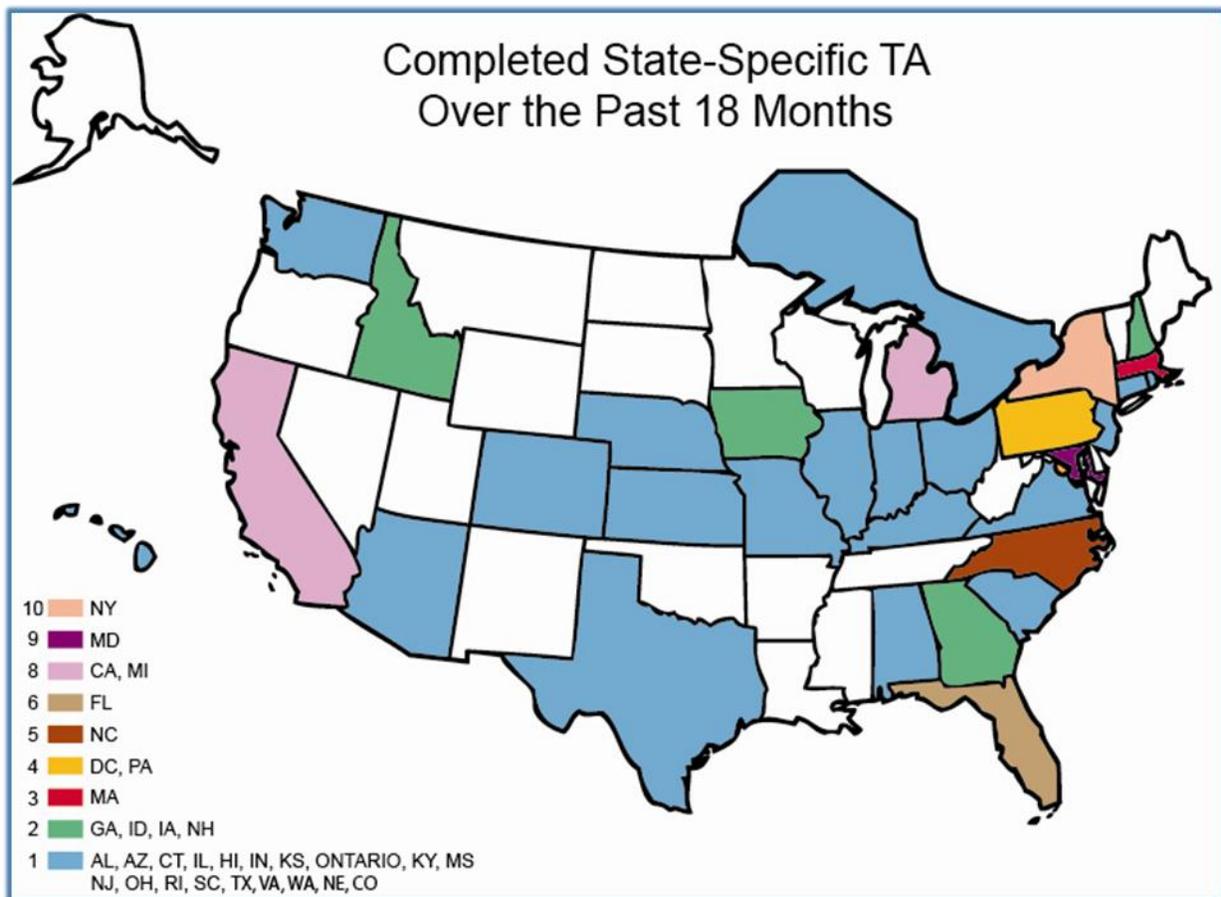
SAMHSA contracted with the National Association of State Mental Health Program Directors (NASMHPD) to implement the project. NASMHPD brings both internal expertise and significant relationships to support SAMHSA in achieving its project goals. NASMHPD has engaged four principal subcontractors: Advocates for Human Potential, Inc. (AHP); the National Council for Community Behavioral Healthcare; TASH (and the Alliance to Prevent Restraints, Aversive Interventions, and Seclusion); and the National Empowerment Center (and the Coalition for Mental Health Recovery). A team of consultants, many of them trauma survivors and nationally-recognized peer leaders, are engaged to provide TA and participate in developing products and materials.

From its inception, NCTIC has maintained a commitment to peer-driven services and has focused on changing the culture of organizations and systems rather than implementing a particular treatment model. NCTIC takes a comprehensive approach towards trauma, recognizing that trauma comes in many forms and that the experience of trauma can have an impact on all areas of a person's life. A gender lens is applied to ensure that services are gender-responsive. Drawing on emerging research and best practices from the field, NCTIC plays a leadership role in developing new applications and making the principles and practices of trauma-informed care available to people in a wide variety of services and settings. NCTIC uses a pragmatic, strengths-based approach to services and systems as well as to individuals, encouraging people to make whatever changes they can immediately, while also working towards long-range goals. NCTIC uses its resources strategically, convening people from across a wide spectrum to work collaboratively towards trauma-informed services, systems and communities.

Scope and Range of NCTIC Services

Geographic Range

Since 2005, NCTIC has worked in 43 states and territories and one Canadian province, and has included representatives from eight other states and territories in national meetings and events. At this point, only Montana, Puerto Rico, Vermont and West Virginia have not had direct contact with NCTIC staff or consultants. NCTIC has also presented at dozens of national and international conferences, provided TA to numerous national organizations and agencies, and consulted with several international teams. In the past 18 months alone, NCTIC has worked directly in 31 states and territories, some with multiple visits (see below). This remarkable geographic coverage is testimony both to NCTIC's success in planting seeds of change and to the increasing level of demand. NCTIC has also been a catalyst for deep transformation in many communities. Since 2005, NCTIC has been in New York, Florida, Maryland, California and other states, multiple times, helping them adopt trauma-informed care throughout their systems.



Overall Demand Across Service Settings

While NCTIC began with a primary focus on mental health, the range of service settings requesting consultation has expanded significantly over the years. Since 2005, NCTIC has worked in a range of systems and settings, including:

Mental Health	Psychiatric hospitals, forensic hospitals, residential programs, community services, state mental health systems, behavioral health units in general hospitals, peer- run services, consumer networks, children and adolescent services, emergency services, community coalitions
Substance Use	Addictions specialist, residential, co-occurring disorders, collaboratives, outpatient, inpatient, local substance abuse prevention coalitions
Justice	Adult corrections (jails, prisons, probation and parole), law enforcement (police, sheriffs), juvenile justice, justice-mental health collaboratives, bar associations, judges and courts, specialty mental health, substance abuse and veterans' courts, offender re-entry programs, victim of crime programs
Health care	Community hospitals, primary care clinics, public health clinics, departments of health, managed behavioral healthcare, HIV programs, maternal health
Housing and Homeless Services	Shelters, supported housing, healthcare for the homeless
Violence against Women	Domestic violence shelters, sexual assault programs, women's resource centers
Military	Military justice system, Fort Mead family program
Education	Public schools, residential schools
Child Welfare	Early childhood services, child protective services, youth shelters, children's service workers, child welfare and family services
Professional Training	Psychiatrists (APA), nursing schools, social work schools, law schools, other colleges and universities, National Association of Case Management, National Association of Criminal Defense Lawyers, Black Psychiatrists Association, National Psychiatric Nursing Association
Advocacy Organizations	NAMI, Mental Health America, Institute on Violence, Abuse and Trauma (IVAT), victim rights groups, International Center for the Disabled, Alliance for Quality Education, Treatment Accountability for Safer Communities, National Disability Rights Network, National Association of State Directors of Developmental Disabilities (NASDDDS), Youth 'N Action, California Protective Parent Association
Government	City government (city councils, mayors' offices, local boards), federal agencies (Office on Victims of Crime, Office on Violence against Women, National Institute of Corrections, Federal Bureau of Probation, CMHS Homeless Division), Federal Partners Committee on Women and Trauma, National Association of Counties
International and Other	Iraq delegation, New Zealand delegation, UN Conference, Hogg Foundation, Toronto correctional system, NH developmental disabilities services

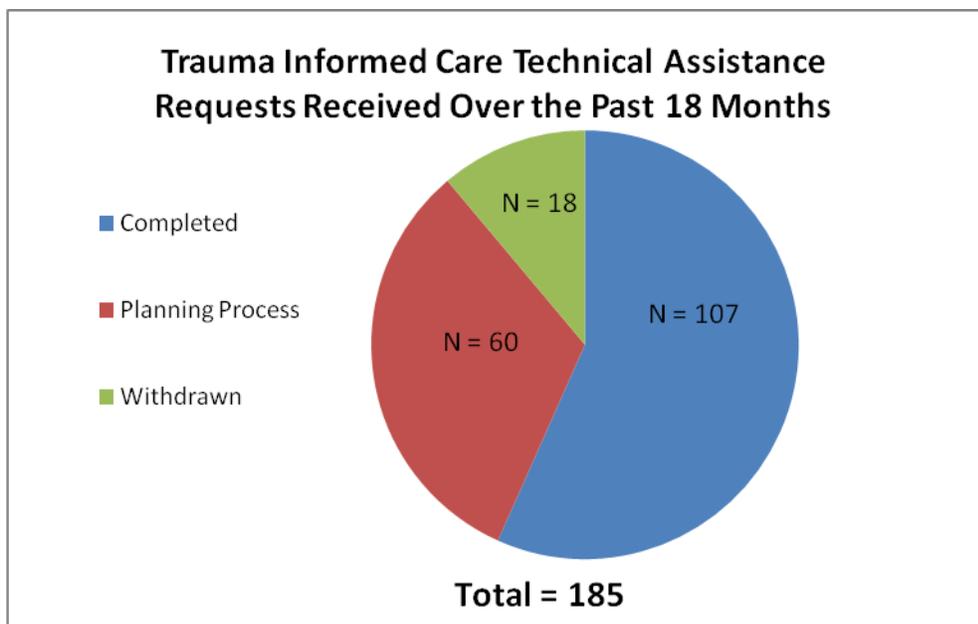
NCTIC Activities

The Knowledge Development, Dissemination and Utilization Cycle

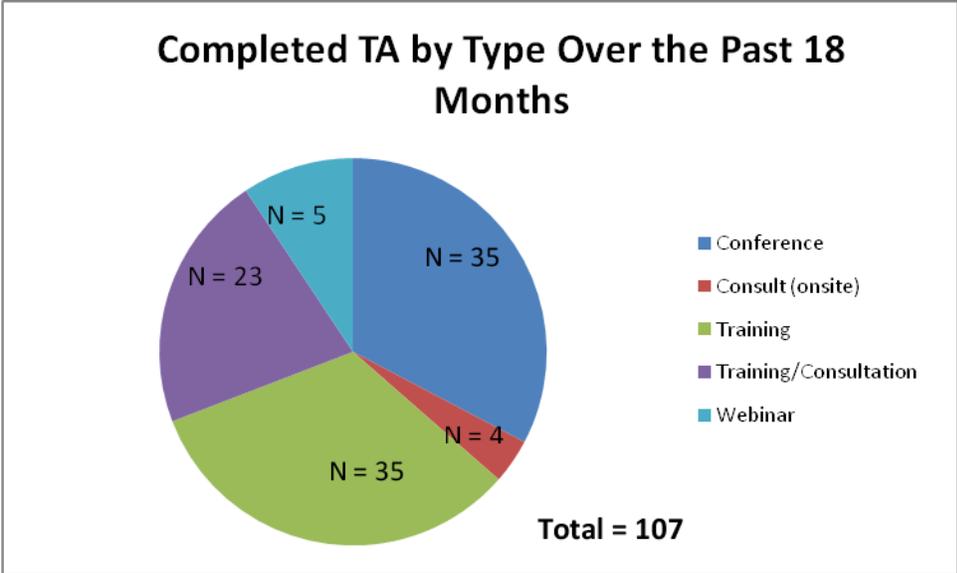
NCTIC contributes to development, dissemination and utilization of new knowledge in an ongoing, mutually reinforcing cycle. Requests for TA and consultation provide an initial indication of gaps and needs in the field. Consultants doing on-site TA gather more in-depth information about the needs faced by service providers, advocates and others. Products are then developed to meet these needs. As final products are disseminated and used in the field, new needs and gaps emerge, and the cycle repeats. As an example of this process, the peer engagement guide for women was developed in response to demand from the peer community. As the guide was tested, it became clear that a similar product is needed to focus on men and trauma. Another example is the need for materials that focus on staff trauma, which is currently one of the most talked-about issues in the field, and one that has few resources available.

Technical Assistance Interventions

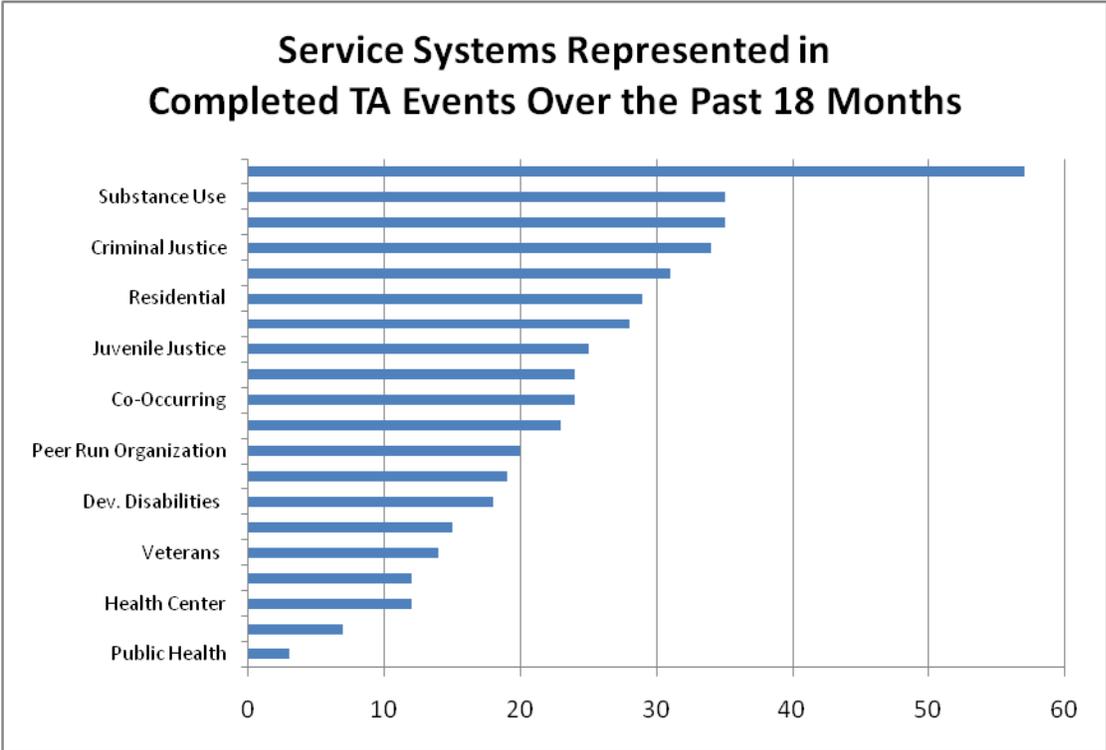
In the past 18 months, NCTIC received 185 applications for TA, of which 107 have been completed, 18 have been withdrawn or cancelled (largely due to changes in the situation of the applicant), and 60 are in process (from just received through already scheduled).



NCTIC individualizes the TA response according to the needs of the applicant. However, for the purpose of data analysis, all TA events are categorized as one of five types: conference presentations (including plenary presentations, workshops and pre-conference institutes); on-site consultation (usually site visits or meetings with system leaders and policymakers); trainings; combinations of training and consultation; and webinars. Conference presentations are the most frequent type of TA, followed by trainings, training/consultations, consultations, and webinars. In the past 18 months, a total of 107 events have been completed.



Applicants requesting TA are asked to describe the nature of the service system or systems that will be involved by selecting from a list of 20 options. Many requests include multiple services. The graph below shows the service systems involved in the 107 TA events completed over the past 18 months. While behavioral health-related services (including mental health, substance abuse, inpatient and outpatient, residential, and forensic) were cited in the highest number of requests, justice-related systems were a close second (including jail/prison, criminal justice, and juvenile justice). It is also interesting to note that more than 50 requests cited peer-run or advocacy services, more than 30 mentioned developmental disabilities or schools, and almost 20 cited domestic violence services.



The Technical Assistance Process

Most TA requests come from applicants who have attended other conferences/trainings where they heard one of the consultants present on trauma-informed care, or they are familiar with consultants through working relationships. Some are referred by other SAMHSA programs (typically grantee programs, and several applicants find NCTIC through web research on trauma and trauma-informed care, particularly through the NCTIC or SAMHSA websites. As interest in trauma-informed care has grown, demand has stretched NCTIC's capacity to respond, and no formal marketing has been necessary.

The TA application form specifies the goals and priorities of the program and criteria for acceptance. Applicants are asked to demonstrate high-level support for the training or TA requested and to develop a plan for implementation and follow-up. The form is also used to collect information that will be helpful in designing the TA, including the stage of readiness of the applicant for TIC and the specific area of focus. The applicant may also request a particular consultant or speaker. A few request specific speakers (most often Tonier Cain or Joan Gillece), but for the most part, applicants rely on NCTIC to create the best possible TA team. All major training and TA events include at least one trauma survivor as a trainer, and many training events include small, peer-led focus groups.

Applications are accepted and processed on an ongoing basis. Every effort is made to respond to all requests, and if necessary, the team will work with the applicant to shape the proposal into an appropriate project. Only a very few requests have not been met, largely because of changing circumstances of the applicant.

Details of the TA are worked out on a planning call involving the NCTIC TA Team (Joan Gillece, Raul Almazar, Pam Rainer and Jeremy McShan) and the applicant. The planning call also serves as the beginning of the intervention, as the team fleshes out some of the fundamental requirements of a trauma-informed approach. For example, applicants are asked about their plans for peer involvement and are strongly urged to include adequate numbers of peers to ensure a strong voice. Applicants are also encouraged to involve community partners who will be critical to systems transformation.

The Consultants

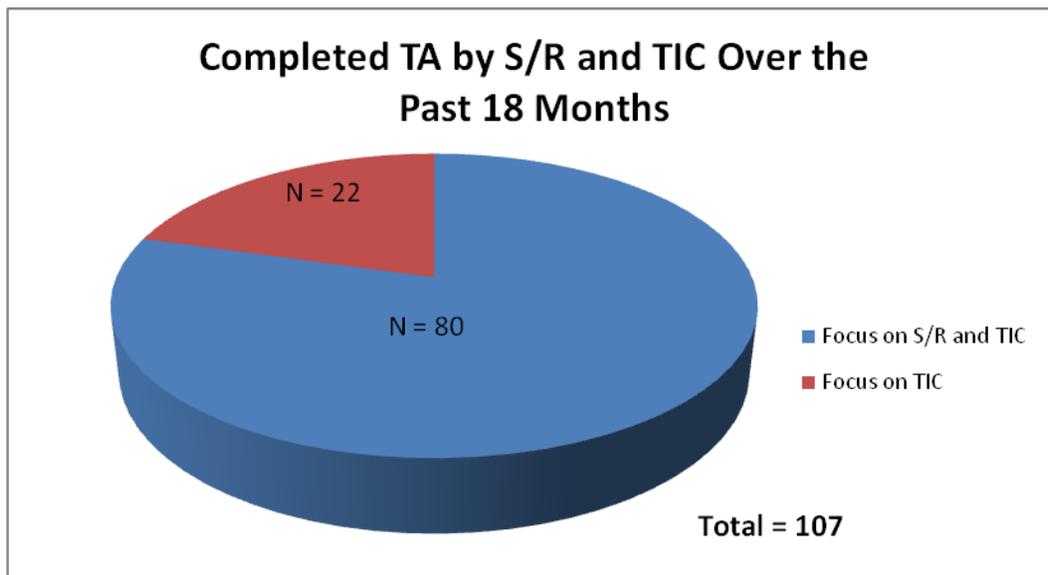
NCTIC has developed a roster of consultants that reflects NCTIC's overall mission and values as well as the wide range of settings requesting NCTIC services. Because people always learn best from their peers—people who have lived or worked in their particular situation—NCTIC uses consultants who have hands-on experience, who can speak and train using their own real-life stories and examples. The roster includes people who have been hospital directors, program managers, clinicians, teachers and family members; who have worked in mental health, substance abuse, homeless services, justice settings and child welfare; and who reflect a wide variety of professional and organizational perspectives. NCTIC has also developed an extensive group of peer consultants. Additionally, consultants represent a broad range of ethnic and racial backgrounds, sexual preference, HIV/AIDS, and both youth and older adults. The depth and breadth of the NCTIC consultant roster, and particularly its extensive use of peers, makes it stand out among organizations promoting trauma-informed care. NCTIC's current consultant roster, along with the number of TA events each consultant has participated in over the past 18 months, is included in the Appendix to this report.

Relationship between TIC and Seclusion and Restraint

Trauma-informed care is built on the premise of respect and mutuality. Because trauma is almost always associated with an abuse of power, trauma-informed approaches begin with an examination of how power is distributed and handled within the setting. Any practice where one party uses power over another is antithetical to TIC. Seclusion and restraint is one clear example; seclusion and restraint are largely

preventable practices that are now widely understood to be treatment failures. Other coercive practices include involuntary medication, handcuffing people for transport, arbitrary rules and “point systems” used to control behavior, threats to call law enforcement or to use sanctions, and rigid staff hierarchies. Coercive practices are a clear indicator that the service or system has not fully incorporated trauma-informed principles.

The vast majority of TA applications to NCTIC request assistance with trauma-informed care; very few requests are made specifically for help in reducing seclusion and restraint. However, the TA team always probes to find out if seclusion and restraint is currently being used anywhere in the system. If it is, this is a clear indicator of a problem to be addressed, and it also provides a concrete example to use as a teaching tool. In many cases, seclusion and restraint turns out to be a problem, although in some service settings, seclusion and restraint are not identified as a problem (see data below). This may be because the organization has developed effective alternatives, or it may be because that particular setting doesn’t have a tradition of using these practices or is legally forbidden to use these practices (e.g., outpatient mental health services). Engaging a service system around their use of seclusion and restraint in the context of trauma-informed care is an effective strategy, since efforts to reduce coercive interventions are far more likely to be effective and to be sustained over time if they are done in the context of an overall culture change than if they are done in isolation.



Product Development

NCTIC develops materials and products to fill gaps and respond to needs expressed by the field. The emphasis is on *practical* tools that can be used by people providing direct services and support in a variety of different settings, and on materials that can assist in culture change. Consistent with the overall approach, NCTIC materials emphasize the importance of peer involvement, and peers are involved in the development and testing of all materials (see example in sidebar on page 8.)

A list of selected products developed by NCTIC is included in the Appendix. Some of these products, such as the issue brief on the Hawaii women’s prison, highlight programs that are breaking new ground in trauma-informed care. Others, such as *Healing Neen*, a 55-minute documentary on the life of NCTIC’s Tonier Cain, are designed to inspire hope and a positive vision for change. Several of these products have been widely distributed and have proven to be effective tools for information dissemination. For example over 1500 free copies of *Healing Neen* have been distributed to trauma survivors, providers, churches, courts, homeless providers, adult and juvenile justice systems, and peer-run organizations.

NCTIC's Impact

In the past 18 months alone, NCTIC TA interventions have directly reached over 10,827 people, with events ranging from 5 to 1,000 participants. The number of people impacted by NCTIC products and other presentations is even higher. Conference presentations usually reach the largest audience, although some TA and training sessions also pull in very large numbers. Consultations involving system leaders and policymakers often have a profound impact, inspiring local leaders to spearhead reform in their systems.

NCTIC also creates a “ripple effect” in the organizations and communities in which they work. By requiring the applicant to involve both peers and community partners in the TA, NCTIC ensures that their message will be heard in a larger circle. Since trauma affects everyone, NCTIC is able to help agencies build partnerships and coalitions with trauma as a central concern. As people begin seeing the commonalities that underlie what have been considered different problems, political momentum for change can be built, systemic reform can occur, and interventions can be sustained over time.

In a typical scenario, the first TA visit raises awareness and initiates a process of self-examination, which leads to further requests for training or consultation. Each of these, in turn, leads to others. In many cases, NCTIC has made multiple trips to a community. In some states, the demand for trauma-informed care has spread quickly, and NCTIC has clearly contributed to a statewide culture change. Two examples, Arizona and Florida, are highlighted in the sidebar.

Florida and Arizona are two examples of how local leaders, inspired by NCTIC, are using TIC to improve their communities.

NCTIC has had a major impact through its work with other governmental partners. NCTIC played a substantial role in shaping the direction of the Federal Partners Committee on Women and Trauma, which currently involves over a dozen federal agencies and more than 35 sub-agencies. Through this group, recognition of the importance of becoming trauma-informed has moved far beyond the field of behavioral health. As the federal agencies responsible for the nation's labor force, housing, health, personal safety, national security and economic well-being begin to recognize how trauma affects their ability to meet their goals, the demand for information and technical assistance on trauma is skyrocketing. NCTIC has also formed strategic partnership with the Council on State Governments, SAMHSA's Center for Substance Abuse Treatment criminal justice grantees, other SAMHSA programs, the GAINS Center, the Domestic Violence and Mental Health Policy Initiative, and other partners that provide platforms for increased return on investment. These partnerships provide increased access to several populations that fall within SAMHSA's strategic initiatives, including Veterans and people who are homeless.

Peer Engagement Guide for Women Survivors

NCTIC developed the first comprehensive guidebook for successfully engaging women in trauma-informed peer support. This guidebook, called *Engaging Women in Trauma-Informed Peer Support*, is the product of nearly three years of dialogue, input, and feedback from trauma survivors and peer supporters across the country.

This guide is designed as a resource for peer supporters in mental health or other settings who want to learn how to integrate trauma-informed principles into their relationships with the women they support or into the peer support groups of which they are members. The goal is to provide peer supporters—both male and female—with the understanding, tools, and resources needed to engage in culturally responsive, trauma-informed peer support relationships with women trauma survivors. Conceptualized, written, and edited principally by peers, the guidebook was rigorously audience-tested with peers in diverse service settings, including women in prison. It is in the final stages of design and layout and is expected to be used to support TA events beginning in April.

State-Wide TIC Change Efforts

In Florida, NCTIC has helped to catalyze a state-wide transformation in Florida. Partnering with State agencies and with the State Peer Network, NCTIC's trainings have reached thousands of trauma survivors, providers and administrators. The juvenile justice system was the first to officially adopt TIC, followed by the Department of Children and Families and others. Statewide and district-level interagency TIC committees were set up to focus on implementation, and, in 2010, the governor signed a proclamation declaring a statewide "Trauma-Informed Care Day." Several local communities have also gotten involved. In Tarpon Springs, a request from the Mayor's office to learn about the impact of trauma has blossomed into what might be the country's first "trauma-informed community," and a NCTIC training at a mental health court in Miami has led to a major reform effort that now includes a local community hospital as well as a broad array of human services and the court system.

NCTIC is committed to measuring the impact of its interventions and to documenting organizational and system change processes. In addition to tracking basic information about interventions, NCTIC is developing a systematic follow up evaluation procedure using a retrospective pre-post design. Six months after all TA interventions of at least one day duration, applicants will be interviewed to assess the impact of the TA on leadership development, the use of data to inform practices, workforce development, the use of S/R reduction tools, peer involvement, overall culture shift towards trauma-informed care, and other goals specific to the TA. Data will be used to help determine next steps at the site as well as to improve NCTIC interventions.

NCTIC is also gathering data from sites to document the change process. In some cases, NCTIC has been asked to assist with and evaluate change efforts instigated by state policymakers. In Arizona, for example, the initiative for widespread change came from state administrators (see sidebar.) In another example, the Maryland state legislature passed a law requiring that all state mental health facilities become trauma-informed. These strategies have potential implications for other states, and NCTIC is documenting their process carefully.

State-Wide TIC Change Efforts

In Arizona, a request for technical assistance for two SAMHSA grantees grew into a statewide effort to adopt trauma-informed practices in all public mental health settings. In 2011, NCTIC received a request from Arizona State University (ASU) to provide training and TA for a Medication Assisted Treatment Drug Court in Phoenix and a program providing treatment, housing and peer support to homeless veterans in Tucson. At about the same time, representatives from the Arizona Department of Behavioral Health Services (DBHS) attended the Regional TIC Meeting in Boston and expressed a desire for training. ASU and DBHS decided to partner in providing the trainings. In working to arrange the visit, the NCTIC team encouraged the expansion of the scope of the TA to address issues related to seclusion and restraint, and urged that additional community members be invited, especially peers. These efforts were buoyed by Dr. Laura Nelson, Arizona's Commissioner of Mental Health and President of NASMHPD's Board of Directors. In her excitement about the potential for trauma-informed care, Dr. Nelson directed each of Arizona's Regional Behavioral Health Authorities to conduct listening sessions with recipients and other stakeholders, and to propose ways in which they could implement trauma-informed care. A Statewide training conference for peers, providers, and administrators in February 2012 jump-started this initiative, which offers a model for statewide implementation strategies.

Conclusions: Future Directions and Anticipated Demand

It appears that trauma-informed care has reached a “tipping point.” While interest in TIC grew steadily from 2005 to 2010, the past 18 months have seen an unprecedented explosion of interest. Trauma-informed care represents a significant culture change towards peer-driven, gender-responsive, recovery-oriented, healing partnerships. With NCTIC’s help, trauma-informed care has been adopted as a fundamental framework for behavioral health systems across the country.

NCTIC’s cross-systems collaborations have also helped open up new audiences. Trauma-informed care provides a way for different agencies and groups to come together around a common concern. In a trauma-informed framework, prevention programs, human services, government agencies, and civic groups work together to create healthier, safer, more healing and more productive communities. As individuals, groups, and organizations become aware of trauma and its consequences, new forms of collaboration emerge and people work together to prevent violence and trauma and to respond effectively when it does occur. Trauma-informed care is an inclusive approach, where everyone has a role to play. During the past year, the NCTIC director has been asked to present at major national conferences representing developmental disabilities services, the disability rights network, and other audiences that are relatively new to trauma-informed care, and interest continues to spread. NCTIC welcomes new opportunities to address trauma and trauma-informed care, wherever they emerge.

Selected NCTIC Products

Behind Closed Doors. The Story of Four Women (2007)

A 20-minute documentary about women struggling to reconcile violence within the psychiatric system. Produced in collaboration with the Maryland Disability Law Center and Sister Witness International. (Official selection, Maryland Film Festival.)

Models for Developing Trauma Informed Behavioral Health Systems and Trauma Specific Services (2008)

A technical report identifying criteria for building a trauma-informed system and describing the increasing range of trauma-based service models and approaches available.

Blueprint for Action: Building a Trauma Informed Mental Health Service System (2008)

Describes current state mental health strategies for implementing trauma informed care.

Transcending Violence: Emerging Models for Trauma Healing in Refugee Communities (2008)

A monograph and annotated bibliography presenting a trauma-informed approach to working with refugees in behavioral health setting (draft).

Creating a Trauma-Informed Criminal Justice System for Women: Why and How (2009)

Issue brief on trauma-informed corrections systems for women and supplementary resource list. Produced in collaboration with GAINS Center.

Healing Neen (2010)

A 55-minute documentary on the life of NCTIC Peer Team Leader Tonier Cain, developed with the State of Maryland's CMHS TSIG grant (Official selection, Clearwater film festival and Global Peace Film Festival.)

Women and Trauma: Report of the Federal Partners Committee on Women and Trauma (2011)

Report from a federal intergovernmental partners committee on mental health transformation (a working document).

Creating a Place of Healing and Forgiveness: The Trauma-Informed Care Initiative at the Women's Community Correctional Center of Hawaii (2012)

An issue brief highlighting a unique collaboration among prison administrators, staff, inmates, community and governmental agencies, educators and volunteers.

Implementation of Trauma Informed Care in Maryland's State Hospitals (2012)

A report on the implementation of Maryland SB 556/HB 1150 requiring that all of Maryland's state psychiatric facilities become trauma-informed.

Engaging Women Trauma Survivors in Peer Support (2012)

A guidebook for peers working with women trauma survivors in the mental health system and other human service settings.

Healing in Community: Trauma Growth and Recovery (2012)

A DVD highlighting a community-based approach to trauma-informed care in Greenfield, MA, based on building an intentional, peer-run community and ensuring that valued social roles are available for all. Produced in collaboration with SAMHSA's Knowledge Application Program (KAP).

Reducing Seclusion and Restraint by Creating Trauma-Informed Service Systems: An Issue Brief for Policymakers and Administrators (forthcoming)

Effective strategies for reducing seclusion and restraint in behavioral health settings.

Ten Things Every Judge Should Know about Trauma (forthcoming)

Practical advice for treatment court judges.

Becoming Trauma Informed in San Mateo County (in preparation)

A program brief describing how human service providers in San Mateo County, California, are introducing trauma-informed care through a co-occurring disorders collaborative.

Peace4Tarpon: A Trauma Informed Community (in preparation)

A program brief describing a unique effort to make an entire community trauma-informed.

Arizona's Statewide Effort to Promote Trauma Informed Care (in preparation)

A program brief describing Arizona's efforts to introduced trauma-informed care in behavioral health systems across the state.

Recent Progress in Reducing Seclusion and Restraint (in preparation)

Describes recent efforts to reduce the use of seclusion and restraint in behavioral health and other human service settings.