TRAUMA-INFORMED CARE
WALKTHROUGH PROJECT REPORT

DATA AND FINDINGS

APRIL 2015

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An increasing amount of research is creating a new understanding of how child welfare services, substance abuse treatment programs, and family drug courts can effectively work with parents and children who have experienced trauma and consequent substance use disorders. This new understanding may allow these systems to disrupt the trauma-substance abuse cycle. Research shows that parents with substance use disorders often have experienced trauma that precipitated their substance abuse.

> *"Trauma results from an event or series of events that is experienced by an individual as physically and/or emotionally harmful or threatening and has lasting, adverse effects on the individual's functioning and well-being. It is the individual's experience of these events that determines whether it is traumatic."* — SAMHSA, 2014

In adult residential treatment programs, childhood physical and sexual abuse is associated with higher rates of addiction and psychiatric disorders, as well as comorbidity between the two.[1] In one study, 30% to 59% of women diagnosed with substance use disorders were also diagnosed with post-traumatic stress disorder (PTSD), most commonly stemming from a history of childhood physical and sexual abuse.[2] The Substance Abuse and Mental Health Services Administration noted that up to two-thirds of men and women in substance use disorder treatment report childhood abuse and neglect.[3] Among patients in an inpatient drug detoxification unit, 81 percent of women and 69 percent of men reported past physical and sexual abuse.[4]

Children affected by parental substance abuse and child maltreatment are also exposed to trauma. The Adverse Childhood Experiences (ACE) study indicated that living in a home with a parent who abuses substances qualifies as an adverse childhood experience that is associated with trauma in children.[5] Compared to persons with ACE scores of zero, individuals with an ACE score of four or more were two times more likely to be smokers, twelve times more likely to have attempted suicide, two times more likely to be alcoholics and ten times more likely to have injected street drugs.[6] Children raised in households with substance abuse by a caregiver were found to have significantly greater risk of experiencing all of the other nine ACEs than those who did not grow up in households with substance abuse by a caregiver.[7] Living with a caretaker who abuses substances was the second highest of the ten adverse experiences recorded. In a study of children living in homes with substance abuse by a caregiver, the children were almost five times more likely to have experienced a traumatic event and were over two times more likely to have a stress response to the traumatic event than children unexposed to substance abuse by a caregiver.[8]

The 10 Categories of ACEs

1. Physical Abuse
2. Sexual Abuse
3. Psychological Abuse
4. Emotional Neglect
5. Physical Neglect
6. Mother treated violently
7. Household substance abuse
8. Household Mental Illness
9. Parental Separation or Divorce
10. Incarcerated household member

Families affected by substance use disorders and who are involved in the child welfare system need a system of care that recognizes the impact of trauma on their recovery. Evidence-based trauma services must be provided within the context of a trauma-informed organizational culture that avoids triggering the unintentional re-traumatization for both parents and children.

Trauma-informed care engages people with histories of trauma by recognizing the presence of trauma symptoms and acknowledging the role that trauma has played in their lives. Being a trauma-informed organization means that every part of the organization—from management to service delivery—has an understanding of how trauma affects the life of an individual seeking services.[9] Trauma-informed organizations, programs, and services understand the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate. As a result, these services and programs can be more supportive and avoid re-traumatization.[10] Trauma-informed services implement screening and assessment practices to identify traumatic histories and symptoms in an effort to avoid organizational practices that lead to re-traumatization for individuals with history of trauma.

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes the Six Principles of a Trauma-Informed Approach:

1. Safety – ensure the physical and emotional safety of clients and staff

2. Trustworthiness and Transparency – provide clear information about what the client may expect in the program, ensure consistency in practice and maintain boundaries

3. Peer Support – provide peer support from persons with lived experiences of trauma to establish safety and hope and build trust

4. Collaboration and Mutuality – maximize collaboration and the sharing of power with consumers to level the differences between staff and clients

5. Empowerment, Voice and Control – empower clients and staff to have a voice, share in decision making and goal setting to cultivate self-advocacy

6. Cultural, Historical and Gender Issues – move past cultural stereotypes and biases, offer gender- and culturally-responsive services and recognize and address historical trauma

OVERVIEW AND GOALS OF THE PROJECT

Developed by Brown, Harris, and Fallot, the *Trauma-Informed Walkthrough* is a process an organization can use to assess how trauma-informed it is by identifying trauma triggers and implementing strategies to mitigate them. Trauma-Informed Walkthroughs: 1) enable organizations to better understand their care through the clients' eyes; 2) assist staff members to understand how they may inadvertently re-enact trauma dynamics; 3) uncover assumptions, inconsistencies and limitations of systems; and, 4) generate ideas for improving system processes.[11] Conducting these walkthroughs and implementing changes lead staff to better address issues of safety for clients and staff members, reduce re-traumatization, improve consistency in practice, and increase client empowerment.

This report describes findings from the National Center on Substance Abuse and Child Welfare (NCSACW) Trauma-Informed Care Assessment Project. NCSACW selected five collaborative partnerships from across the country to participate in the trauma-informed care walkthroughs in 2014. The mission of these partnerships is to improve child welfare programs, substance abuse treatment providers and family drug courts to more efficiently serve families in the child welfare system who are affected by parental substance use disorders and intergenerational trauma. Family drug courts (FDCs) are collaborative courts that utilize a multidisciplinary approach, recognizing that their clients (i.e. parents and families that enter child welfare due to substance abuse) often face a range of challenges in addition to a substance use disorder. FDCs are characterized by judicial leadership combined with significant partnership efforts from child welfare and substance abuse treatment professionals. The result of this intense collaboration is a multi-system focus on family recovery, including early identification, access to treatment and engagement in services.

NCSACW partnered with Dr. Vivian Brown to develop the process for this project and conduct the walkthroughs.

SITE SELECTION AND CRITERIA

In preparation for the project, NCSACW conducted outreach to current and past Children Affected by Methamphetamine (CAM), Regional Partnership Grants (RPG), In-Depth Technical Assistance (IDTA) and Prevention and Family Recovery (PFR) sites to offer this opportunity. NCASCW sent out a project announcement to interested sites and grantees, which solicited a short letter of interest that detailed their readiness for a trauma-informed care assessment and their intention for its use to create system change for the families they serve. To qualify for participation, sites had to meet the following criteria:

- Have already begun some discussions and activities on being trauma-informed

- Have an established collaborative partnership that unites child welfare, substance abuse treatment providers and a family drug court to serve families in the child welfare system who are affected by parental substance use disorders

- Have a steering committee or executive committee available to participate in the walkthrough and planning efforts, with policy-makers or administrators from each system (i.e. court, substance abuse treatment, child welfare)

- Commit to developing an action plan following the walkthrough and implementing site-specific solutions to become more trauma informed

- Commit to participating in follow-up conference calls with NCSACW after the walkthrough

- Participate in a Plan-Do-Study-Act (PDSA) cycle that measures improvements in reducing the number of trauma triggers as a result of completing the goals and activities in the site's action plan.

Upon reviewing the letters of interest, NCSACW selected five sites for participation:
- Robeson County, North Carolina (PFR Site)
- Dunklin County, Missouri (CAM Site)
- Sacramento County, California (CAM Site)
- Travis County, Texas (RPG Site)
- Tompkins County, New York (PFR Site)

WALKTHROUGH PROCESS AND METHODOLOGY

PREPARATION AND PLANNING

In preparation for the walkthrough visit, NCSACW staff and Dr. Brown conducted conference calls with the sites to convene the team (including child welfare, substance abuse treatment, family drug court, peer recovery specialists, and other partners); discuss the process of the walkthrough; coordinate the logistics; and prepare the materials. Following the conference calls, NCSACW administered a baseline survey to each site to gather data on trauma screening measures, trauma-specific interventions, policies and procedures and cross-systems collaboration. See the section below, *Baseline Survey Findings*, for more information on this survey.

ONSITE WALKTHROUGH

Each trauma walkthrough consisted of two full days on site, led by Dr. Brown and two NCSACW staff. Each visit began with a team briefing, during which NCSACW explained the walkthrough process and provided a presentation on trauma-informed care and the trauma assessment. NCSACW lead the team in a physical walkthrough of each system, from the point of view of the clients, utilizing the *Guidelines for Trauma-Informed Assessment* tool, developed by Dr. Brown and SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach,* to facilitate the assessment process.

The team observed an FDC staffing meeting and watched the court in session. The team walked through the child welfare agency to gain insight into the processes and paperwork requirements for families in the system. The team walked through the substance abuse treatment agency, observing drug testing processes and intake and treatment protocols. In some sites, the team also had the opportunity to walk through housing, mental health, domestic violence and children's services processes. In each agency walkthrough, the team identified any observable potential triggers for clients and recorded potential solutions to mitigate the trauma triggers. At the end of each system walkthrough, NCSACW facilitated a de-briefing meeting to give immediate feedback on the trauma triggers identified and recommendations for changes and improvements.

> *The core question of the walkthrough is: Could this practice or procedure upset or trigger the participant?*

ACTION PLAN DEVELOPMENT

Following the walkthrough, NCSACW prepared a preliminary action plan with recommendations for improvements for each site. NCSACW asked the site to expand upon their action plan with site-specific solutions and key small changes they would commit to making in their community. The action plans included a number of possible solutions to eliminate or mitigate each potential trauma trigger that was identified in the

walkthrough. Each team was then asked to implement PDSA cycles on their own to measure concrete changes.

ONGOING TECHNICAL ASSISTANCE

In follow-up of the walkthroughs, NCSACW provided ongoing technical assistance, including emails and conference calls, to ensure sites had the resources and support necessary to make the changes identified on their action plan. NCSACW conducted follow-up conference calls with the sites at six months post-walkthrough to identify the progress of the changes and offer support as needed.

PROJECT EVALUATION

NCASCW conducted evaluation activities to assess the relationship between the trauma-informed care walkthroughs and the improvements in organizational capacity to address the needs of families affected by trauma and who are involved in substance abuse treatment and child welfare systems. The purpose of the evaluation was to investigate, analyze, and report on the key systemic policy and practice changes that occurred following the walkthroughs.

NCSACW recorded the number of the improvements made by each of the sites from their action plans to determine the reach and impact of the innovative solutions developed through the trauma walkthroughs. NCSACW utilized the six-month follow-up calls with the sites to interview the team members and record the changes that were implemented.

One walkthrough site (Tompkins) was unavailable to complete the six-month follow-up call prior to this report and therefore the data reported does not include the changes implemented by this site. NCSACW continues to make efforts to follow up with this site to gather data on the changes they have made and offer technical assistance as needed.

BASELINE SURVEY RESULTS

The baseline survey administered prior to each onsite visit was adapted from Dr. Brown's *Guidelines for Trauma-Informed Assessment* and the *Trauma-Informed Organizational Self-Assessment,* which is part of the Trauma-Informed Organizational Toolkit.[12] The baseline survey aimed to gather information on:
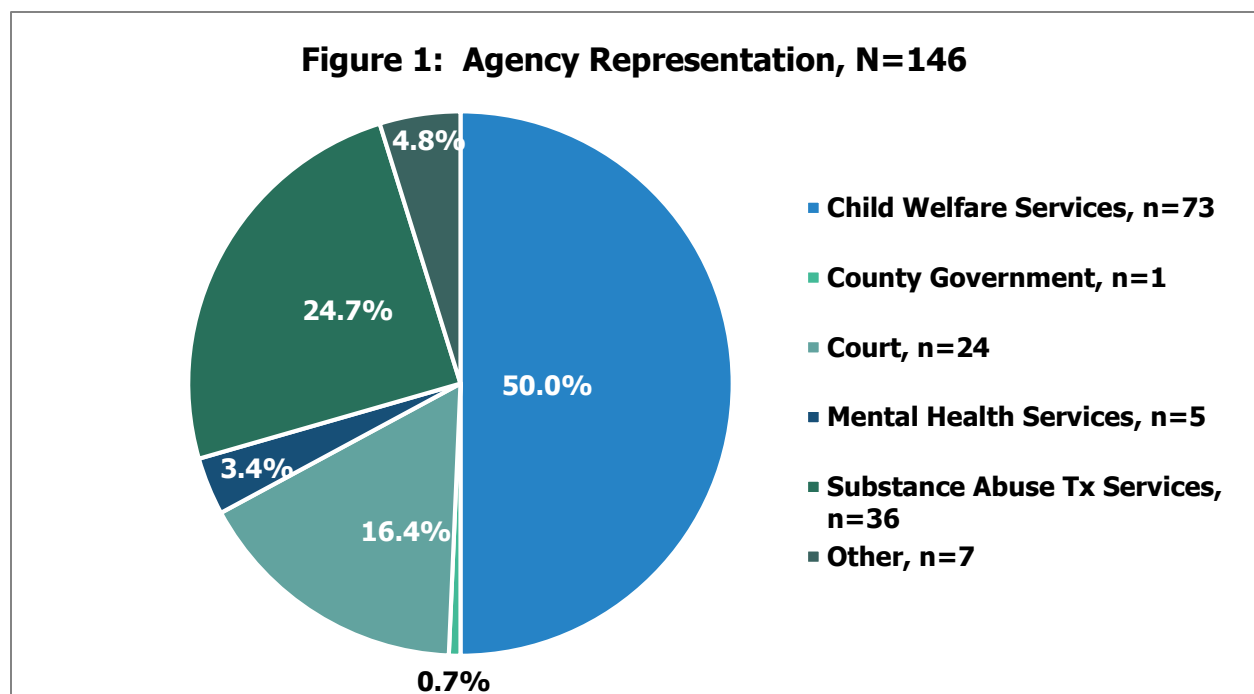
- Respondents' understanding of trauma-informed/trauma-specific services
- Training and staff development on the topic of trauma
- Available funding for services for families who may have experienced trauma
- Implementation of trauma-specific screening, assessment and intervention
- Organizational policy and practice relating to provision of trauma-informed/trauma-specific services

NCSACW administered the baseline survey between May and September 2014. The Project Directors invited their staff from all levels within the agency to complete the survey prior to the site visit. One hundred and forty-six people participated in the survey across the five sites.

The respondents' staff level included:

- Front-line Staff (61.0%)
- Supervisor/Manager (29.5%)
- Administrator (8.9%)
- Other (0.7%)

The respondents represented multiple systems, including child welfare (50.0%), substance abuse treatment (24.7%), and court agencies (16.4%). See Figure 1 for additional breakdown by agency type.

Figure 1: Agency Representation, N=146

- Child Welfare Services, n=73
- County Government, n=1
- Court, n=24
- Mental Health Services, n=5
- Substance Abuse Tx Services, n=36
- Other, n=7

The data was then analyzed across all five sites to offer a snapshot the status of partnerships across the country with regard to trauma-informed care for families affected by substance abuse. These results helped to guide the NCSACW's walkthrough planning and also contributed to the overall findings of this project.

The survey results can be organized into the following categories: Understanding of Trauma, Screening and Assessment, Trauma-Specific Interventions, Policies and Procedures and Training and Staff development.

UNDERSTANDING OF TRAUMA

> **While sites had an understanding of how trauma impacts a family, they did not fully understand the "how to" of providing trauma-informed care.**

- The majority of the respondents (92.4%) indicated that they understand how trauma can impact a person. Similarly, 87.9% indicated that they have an understanding of how trauma affects a family. However, only half of the respondents (50.0%) agreed that they have an understanding of how to provide trauma-informed services.

- Slightly more than half (59.9%) indicated that they knew the difference between trauma-informed care and trauma-specific services. More than a quarter (28.8%) responded "Don't Know" to this question.

- The responses were split when survey respondents were asked to indicate if their agency has a "trauma champion or a staff member who has expertise and experience working with clients with a history of trauma: 28.0% agreed that they had a trauma champion, 30.3% marked "Don't Know," and 33.3% disagreed. Several respondents (8.3%) also indicated that this statement did not apply to their role.

- Slightly more than half (57.5%) indicated that they are aware of current knowledge, theory and treatment models for participants with a history of trauma.

- Two-thirds of respondents (66.7%) agreed that staff is committed to building a trauma-informed system of care for the men, women, children and families they serve.

- Three-quarters of the respondents agreed that their agency offers a safe and inviting environment, 8.3% responded "Don't Know" to this question and 4.5% selected "N/A to Role."

- More than half (59.1%) agreed that their agency employs staff who promote a therapeutic recovery environment built upon trust, respect and safety.

- The majority (75.8%) indicated that their agency is committed to understanding trauma and engaging in trauma-sensitive practices.

- 84.8% agreed that their agency demonstrates respect for cultural differences and practices. Three percent indicated that this statement was not applicable to their role/agency.

SCREENING AND ASSESSMENT

- Less than half of the respondents (40.9%) indicated that their agency conducts trauma screening and assessments and nearly 10.0% indicated that trauma screening and assessment is not applicable to their role and/or agency role.

- The most commonly reported screening tools were:
  - Brief Trauma History Questionnaire (THQ)
  - Civilian PTSD Checklist (PL-C)
  - Clinician-Administered PTSD Scale (CAPS)

- Life Stressor Checklist (LSC-R)
  - PTSD Symptom Scale-Interview (PSS-I)
  - Trauma Assessment for Adults (TAA)
  - Trauma Screening Questionnaire (TSQ)
  - Trauma Symptom Inventory (TSI)
  - Adverse Childhood Experiences (ACE) Screener

TRAUMA-SPECIFIC INTERVENTIONS

- Approximately a third (34.1%) indicated that their agency provided family-centered therapeutic services to trauma survivors and their family and 17.4% disagreed with this statement. The remaining respondents marked that this statement is not applicable to their role/agency.

- Of the 34.1% that indicated their site provided trauma-specific interventions, the interventions most frequently selected by the respondents were:
  - Seeking Safety (26.4%)
  - Trauma-Focused Cognitive Behavioral Therapy (15.4%)
  - Parent-Child Interaction Therapy (12.1%)

- More than half (64.4%) agreed that their agency collaborates with other community agencies or providers to offer trauma-specific services and 16.7% marked "Don't Know" for this statement.

- More than a third of the respondents (37.9%) agreed that their agency has funding for trauma-specific services, 43.9% did not know if their agency had funding and 5.3% responded that this statement was not applicable to their role/agency.

POLICIES AND PROCEDURES

- Less than half of the respondents (38.6%) indicated that their agency regularly reviews its policies and practices to identify whether it is sensitive to the needs of trauma survivors, 25.7% disagreed with this statement, and 28.8% indicated that they don't know.

- About 60.0% agreed that their agency involves <u>staff</u> in the review of policies and procedures, but 18.2% did not agree with this statement (i.e., their agency does not involve staff in the review of policies and procedures). Less than a quarter (16.7%) marked "Don't Know" for this question and 6.1% indicated that this statement was not applicable to their role/agency.

- About a third of the respondents (35.6%) indicated that their agency involves <u>participants</u> in the review of procedures.

- The majority of the respondents (71.3%) indicated that their agency ensures that policies and procedures are clearly communicated to the participants, 9.1% disagreed, and 7.6% indicated that this statement is not applicable to their role/agency.

TRAINING AND STAFF DEVELOPMENT

- Most of the respondents (68.2%) had received training on the <u>topic of trauma</u>. Slightly last than half (42.4%) received training in <u>trauma-specific interventions.</u>

- 65.9% of the respondents indicated they had received some training and education on the relationship between mental health, substance use, and trauma. Approximately a quarter (24.3%) disagreed that some training had been received.

- Of those who responded, 19.7% agreed that their agency has funding available for training on trauma and less than half (46.2%) weren't sure or didn't know if funding was available to fund training around trauma. Only 11.4% indicated that this was not applicable to their role/agency.

- More than half of the respondents (53.0%) indicated that their agency's partners are trauma-informed and 33.3% of the respondents marked "Don't Know" for this statement.

- Overall, the findings of the baseline survey indicated that the sites have a general understanding about trauma, trauma-informed care and trauma-specific services – but they lack and understanding of the "how to" of providing trauma-informed care.

- These findings were in alignment with comments heard from team members when the NCSACW was conducting the walkthroughs. The majority of sites had received training on trauma so that they understood the impact of trauma, but that the training did not offer the concrete practice elements needed to provide

trauma-informed care. To some extent, these sites and their partner agencies have a set of policies and procedures that address the needs of trauma survivors, but they lack the involvement of participants and staff in the review of policies and procedures and a policy that offers clients choice and empowerment.

- There were mixed results with regard to screening and assessment of trauma. In a number of walkthroughs, NCSACW staff and Dr. Brown presented possible screening instruments. Of note, a many respondents to the baseline survey indicated that screening and assessment was not applicable to their job. The majority of these respondents were from child welfare services. In line with the survey findings, NCSACW identified while on the walkthroughs that many child welfare agencies were not implementing any form of trauma screening for the parents or the child, missing an opportunity to identify the needs of families affected by trauma.

KEY RESULTS AND FINDINGS FROM THE WALKTHROUGHS

COMMON TRAUMA TRIGGERS

During the Trauma-Informed Care Walkthroughs, NCSACW staff and Dr. Brown identified trauma triggers as they toured each agency and discussed the processes that the clients experience. NCSACW staff also encouraged the site team members to record the trauma triggers they identified, so that it was a collaborative and mutual process. The most common trauma triggers identified across the sites are categorized and detailed below.

SAFETY AND PHYSICAL SPACE

- Some buildings were unwelcoming and felt dark, cold, and unsafe. Some rooms felt like a closet and some rooms were filled with trash and clutter, which could overwhelm the client.

- There were armed security guards and triggering security screens, especially at court buildings.

- Staff identified loud noises, echoes, and flickering lights in rooms.

- Hallway and office walls lacked artwork or had potentially trauma-triggering artwork.

- Staff desks were arranged so clients had their backs to door or clinician was blocked in behind the desk, which could be triggering for both clients and staff.

- There was not enough space for clients to sit in courtroom.

- Courtrooms felt chaotic and loud upon entering them, and sometimes there were not enough seats that were easily accessed by clients (especially those with strollers and their children).

- Some courtrooms feel like a "tribunal," which give the clients a feeling of "us versus them."

> ***The perspective of past clients proved to be highly important. On one walkthrough, a graduate of the program and peer mentor noted that the intake room "felt like a closet." None of the agency staff had realized that before.***

INTAKE, SCREENING AND ASSESSMENT PROCESS

- Agencies used intake and assessment forms that asked nearly identical information, causing the client to repeat sensitive information multiple times. This experience may cause the client to feel unheard and lose trust in the agency.

- Clients must go through lengthy intake procedures with no breaks (and sometimes with no childcare), causing the client to feel overwhelmed.

- There was a lack of screening questions for trauma and lack of trauma-specific services to which clients can be referred.

- Many of the programs had unclear or inconsistent processes, and therefore the client doesn't know what to expect during the program.

TRAUMA-SPECIFIC INTERVENTIONS

- There was a lack of trauma-specific services for children and parents.

- A lack of (or strained) partnership with mental health services that lead to a gap in client access to mental health services, where trauma treatment needs could be met.

- There was often a lack of widespread knowledge of trauma-specific interventions.

COURT RESPONSES TO BEHAVIOR

- There were inconsistent responses to client behavior or no clear messaging about responses, which can cause the client to lose trust in the team.

- Some courts used potentially triggering sanctions (i.e. jail time), which could re-traumatized the client.

- Some courts used sanctions to address behaviors without taking into account that behaviors could be precipitated by trauma (e.g., if a client misses a drug test, if could be due to feeling triggered by the procedure).

DRUG TESTING SPACE AND PROCEDURES

- Testing was often done in high-traffic areas with a lack of privacy outside the restroom.

- Some bathrooms were uncomfortable, too small, and had limited artwork.

CLIENT CHOICE AND EMPOWERMENT

- Sites reported a challenge in finding a balance between holding the clients accountable and offering the clients choice.

- There was a staff suspicion that clients would "take advantage" if they were offered choice.

- In some agencies, clients did not have choice over therapists or treatment groups.

SECONDARY TRAUMA AND STAFF

- There was a lack of support for agency staff, causing the staff to feel overwhelmed and lose trust in the agency.

- Agencies did not have a "safe space" for staff to decompress after a difficult meeting with a client.

- Staff feel burdened and reported having difficulty with boundaries. This staff trigger was identified in particular with the recovery support specialist roles.

- Front office and security staff lack an understanding of trauma and feel very anxious when interacting with triggered clients.

The issue of secondary trauma was brought up frequently on the walkthroughs, most often by child welfare agency staff.

CONCRETE SOLUTIONS

NCSCAW staff discussed the trauma triggers identified with each site team and brainstormed concrete solutions and changes that the site could make to mitigate these trauma triggers. These identified triggers and solutions then became the sites' Action Plans. In follow-up of the walkthrough, each site was expected to take their Action Plan and prioritize the changes to begin making modifications to become more trauma informed. During the six-month follow-up phone calls, NCSACW interviewed the team members from each site to understand what changes had been made.

The key changes made across sites over the six-month period are listed below and are categorized using SAMHSA's Six Principles of Trauma-Informed Care:

SAFETY

- Two sites reported rearranging staff offices to ensure no one feels "blocked in" or is distracted by noise.

- Two sites reported changing drug testing bathroom spaces by moving to more private and comforting bathrooms.

- All sites noted that they were working on adding artwork to walls.

- One site is creating a safe space or "Zen room" for staff in the child welfare office.

- Two sites are implementing a training for front office staff and security guards on trauma.

- One site noted they are now using peer specialists greeting individuals, helping them through security, and sitting in crowded waiting rooms with the clients.

TRUSTWORTHINESS AND TRANSPARENCY

- One site has made it a priority to develop information-sharing agreements across agencies to minimize duplication of assessments and intake questions.

- All sites noted making changes to their incentives and sanctions in family drug court, including implementing a tiered list of rewards and sanctions and ensuring consistency.

PEER SUPPORT

- Two sites are working on securing paid positions for peer mentors to support families.

- One site implemented a support group for peer mentors and is encouraging more frequent supervision meetings for peer mentors. The site reports already seeing the benefits of this increased support, including increase in morale and decrease in feelings of burnout.

COLLABORATION AND MUTUALITY EMPOWERMENT, VOICE AND CONTROL

- One site created a liaison position between mental health services and alcohol and drug services.

- All sites noted offering clients a choice of therapist.

- All sites reported changes in how they interact and talk with clients, such as asking clients, "What can I do to make you feel more comfortable during this process?" during urine drug screens.

- All sites have reported working on ensuring that staff also have strategies in place to decompress and reduce burden.

- One site employed a gender-specific therapist for S*eeking Safety* groups.

DISCUSSION AND IMPLICATIONS

The findings of this walkthrough project can aid jurisdictions in understanding how to assess for and develop a trauma-informed system. Both the baseline survey and walkthrough process indicated that while agencies have received training and understand how trauma can impact a family, they are experiencing a gap in knowledge of the "how to" of being trauma-informed. While many of the partnerships had implemented trauma trainings and some evidence-based trauma-specific interventions, most had not looked at their procedures and systems through a "trauma lens." As a result of the walkthroughs, the sites indicated that they had a better understanding of what they can do to become more trauma-informed.

A key lesson of this project was that if an agency takes the opportunity to slow down and physically walk through its system, viewing it through the eyes of the clients, the agency can see that some of its standard practices could be potentially triggering for clients. It was the walkthrough process that was most beneficial in identifying these triggers and generating buy-in from the agencies – an electronic self-assessment might not have generated the same results, as did actually gathering a team to physically walk through and experience the space and the procedures.

In addition, it was clear during each of the walkthroughs that the use of peer mentors or recovery coaches is an essential piece of being trauma-informed. Many of the identified trauma triggers could be mitigated or resolved by using peers as support, perhaps to clarify procedures for clients by telling them "what to expect" or to greet clients and walk through triggering security screens together.

Another finding across all sites was that there was a lack of (or strained) partnership with the mental health agency. Many sites indicated that they did not know what trauma-specific mental health services were provided in their county, for children or parents. Should trauma be identified with a screening tool, sites noted not knowing where to send clients, or if they referred them to mental health, that they did not know what services they were actually receiving. This lack of collaboration provides a clear opportunity for agencies serving families affected by substance use disorders to better partner with mental health.

The need for information-sharing agreements was also identified on every walkthrough. NCSACW staff and Dr. Brown asked to examine the intake and assessment forms at each agency. In looking through the paperwork, it was noted that much of the same information was asked at each agency – thus the client must repeat his or her story multiple times. This repetition may result in the client feeling unheard and thus more at risk for losing trust in the agencies. In addition, when clients are asked to repeat traumatic stories multiple times, it may be triggering and therefore affect their behavior and engagement in treatment. As a result of the walkthroughs, the suggested concrete

solution to these situations was to create information-sharing agreements and communication protocols so that agencies can determine which system collects what information and how to then share it with their partners to cut down on the repetition for the client. In follow-up of the walkthrough, one site in particular made this change a priority and has already begun drafting an agreement to formalize this sharing of information.

While most sites indicated that they had offered trauma training for their staff, they did not understand the need for multi-level training. On the walkthroughs, NCSACW identified that many of the non-clinical staff who come in contact with the clients (such as security guards, receptionists and janitorial staff) do not have a basic understanding of trauma and how it impacts client behavior. This lack of understanding cannot only impact the client, but also the staff, as they may feel unprepared and anxious about interacting with clients who may become triggered. In follow-up of the walkthrough, one site is planning for a multi-level trauma training for all staff – including receptionists, security, and janitors – so that each person who comes in contact with clients at the agency has an understanding of how trauma can impact behavior.

During the follow-up interviews, NCSACW heard from nearly all of the walkthrough participants that the process helped them to think differently about their clients and how they provide services. They noted that the walkthrough process helped them to better see through a "trauma lens" and that in the months following the walkthrough, they had even noticed additional practices at their agency or others that may trigger clients. They noted a complete change in thinking and that they were able to take what they learned and apply it to other areas. One team member noted that he even shared his knowledge with another partner agency, after he noted a potential trauma trigger. The walkthrough process itself thus proved to be a beneficial learning process for many team members.

As courts, child welfare and substance abuse treatment agencies are increasingly attuned to the impact of trauma, these findings have important implications for how to better understand how parental trauma impacts engagement and continuation in services and how to assess for and minimize systemic trauma triggers. In disseminating the lessons learned of this project, other jurisdictions can also understand some of the common practices that can unintentionally re-traumatize clients. The concrete solutions that the sites implemented as a result of these walkthroughs can serve as examples of how other agencies can better respond to the trauma needs of their families.

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