Trauma Informed Systems Initiative

San Francisco Department of Public Health

2014 Year in Review

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A Trauma Informed Public Health System for San Franciscans

Trauma is a pervasive, long-lasting, public health issue that affects our public health workforce and system. In recent years the devastating impact of trauma on individuals, families and communities has drawn considerable attention from service providers, researchers and policy makers. Like people, organizations are also susceptible to trauma that affects its workforce in dynamic ways that contribute to fragmentation, numbing, reactivity and depersonalization. When our systems are traumatized, it prevents us from responding effectively to each other and the people we serve. The San Francisco Department of Public Health has developed a Trauma Informed Systems Framework intended to help improve organizational functioning, increase resilience and improve workforce experience. Our Trauma Informed Systems Workgroup, made up of staff and DPH employees is leading this change effort, which includes the following components:

- Mandatory, foundational training to all 9,000 public health employees to create a shared language and understanding of trauma for our workforce
- Development of an embedded Champions Learning Community (CLC) to support, apply and sustain the application of the TIS principles and practices into the entire DPH workforce.
- Train the Trainer program to embed and harness trauma expertise with in our system and establish a permanency of the initiative.
- Intentional efforts to align TIS with all our workforce and policy initiatives to insure TIS implementation increases coherence, unifies our system and improves outcomes.
- Leadership Engagement and outreach to support leaders to integrate TIS principles into day-to-day operations as well as promote system change at the program and policy level.
- Work towards establishing San Francisco as a Trauma Informed City insuring that the entire workforce has a common language and principles.

Rationale

Trauma is broadly experienced, pervasive and has can have long lasting effects. We know from the growing body of research on trauma, that the majority of Americans will experience a traumatic event at some point in their lifetime[1].

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[1] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 1998;14:245–258.

Getting its initial momentum from the work of Vietnam veterans, their families, mental health professionals and clergy, the field of trauma has grown in the past 3 decades. In the 1980's and 1990's a significant body of research accumulated to validate the connection between a past history of trauma, substance abuse and mental illness. Subsequently, programs that specialized in trauma began to spring up through out the country, publishing their research and creating the foundation for what we know now about effective treatment for traumatized people and necessary elements for recovery. [2] The subject of trauma, also sometimes called "toxic stress" has attracted lots of energy in the mental health and public health fields, partly because of a few very high profile studies linking trauma to major health problems and relationship difficulties. The Adverse Childhood Experiences Study (ACEs Study) for example, showed a clear connection between how many ACE's one has experienced (the trauma-dose) and long-term, social problems and chronic illnesses like heart disease, cancer, and diabetes. While the effects of toxic stress are experienced broadly, disparities in health outcomes are acutely experienced in disenfranchised communities suffering the long-term effects of specific traumas such as community violence coupled with the long-term effects of institutional discrimination, poverty, lack of access to adequate resources. Addressing trauma for public health must be a top priority. San Francisco's Trauma Informed Systems (TIS) Initiative extends the focus on the impact of toxic stress and trauma from the community receiving services to the system delivering services.

A Trauma Informed System: Etiology and Recovery

The mission of the public health system at its most basic level is to promote and protect the wellness of our community. The San Francisco Department of Public Health has identified these objectives[3] as a pathway to this mission:

•Assess and research the health of the community
•Develop and enforce healthy policy
•Prevent disease and injury
•Educate the public and train health care providers
•Provide quality, comprehensive, culturally-proficient health services
•Ensure equal access to all

• • •

"A system cannot be truly trauma-informed unless the system can create and sustain a process of understanding itself. A program cannot be safe for clients unless it is simultaneously safe for staff and safe for administrators. Lacking such a process and despite well-intentioned training efforts, there will be no true system transformation in systems that are now for the most part, "trauma organized" repeating, rather than healing, the injuries previously experienced by clients and staff "

-Sandra Bloom*

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[2] Jennings, A. (2008 Update). *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services.* National Center for Mental Health Services, National Center for Trauma Informed Care, Funded by SAMSHA.
[3] From www.sfdph.org. 2012-2013 Annual Report. *San Francisco Department of Public Health*
*From Bloom. S (2010). *Organizational Stress as a Barrier to Trauma Informed Service Delivery*. Becker, M. Levine, B. A Public Health Perspective of Women's Mental Health: New York, Springer (pp. 295-311)

The San Francisco Public Health Workforce has performed this responsibility remarkably for the entire population and as a safety net for those most in need. At the same time, as our system goes about serving the community, we experience direct and indirect effects of prolonged and significant exposure to communities affected by trauma. Organizational trauma can be described as a circular "ripple effect", transmitted between interactions with clients, families and communities and staff, to their supervisors, support staff, administration, across the organization and across service delivery systems.
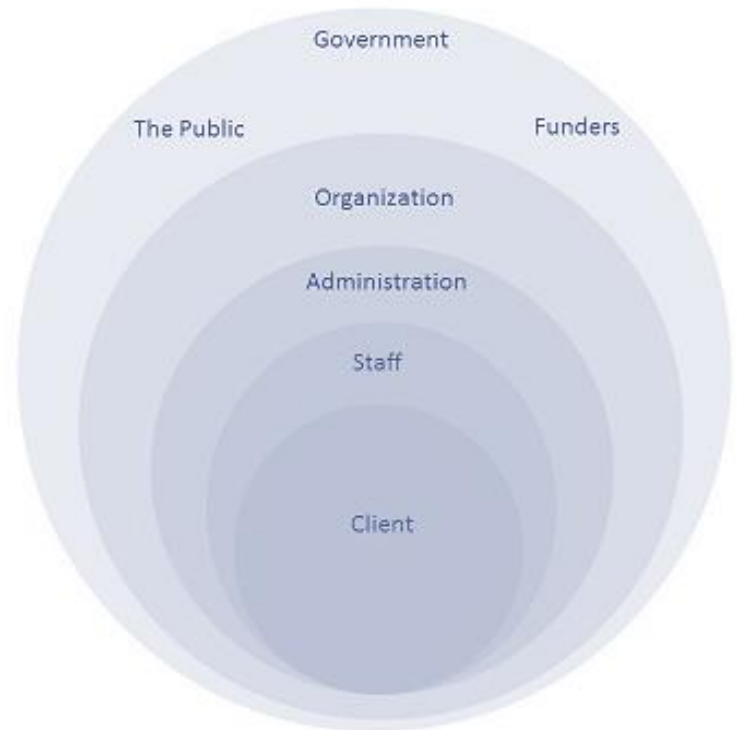
The impact of organizational prolonged trauma exposure can result from a "parallel process" where systems in working relationship with traumatized clients concurrently develop similar affects, cognition, and behaviors and transmit symptoms back and forth. The effect of vicarious trauma on our system is heightened by the personal life experiences of individual service providers, support staff and leadership as which can create more organizational stress and fragmentation, which impedes service delivery.

The Trauma Informed Systems Initiative has been designed to combat the insidious effects of systemic trauma and promotes a paradigm shift change in our organizational culture, most notably, the ways in which repeated exposure to trauma fragments and destroys relationships within the workforce. Shared trauma understanding supports shifting from pervasive thinking within the workforce that our system is a "machine" that performs its job based on a specific set of inputs, to a living organism, built on relationships, that is open, complex and adaptive. Trauma Informed Systems (TIS) principles and practices support reflection in place of reaction, curiosity in lieu of numbing,

> *Trauma Informed Systems principles and practices support reflection in place of reaction, curiosity in lieu of numbing, self-care instead of self-sacrifice and collective impact rather than siloed structures.*

self-care instead of self-sacrifice and collective impact rather than siloed structures. Consistent with the SAMSHA declaration regarding individuals, San Francisco TIS shifts our narrative from what is wrong with the system to what has happened to the system and how can we share responsibility for healing.

Approach

San Francisco Department of Public Health has chosen an innovative approach to responding to the impact of trauma that starts with our own workforce, develops embedded leadership within our system and increases our capacity to have productive conversations about what it means to be a Trauma Informed organization. In September of 2012, San Francisco Department of Public Health's Director, Barbara Garcia commissioned a workgroup led by Dr. Ken Epstein, Director of Children, Youth and Families, to initiate an exploration of how our Department of Public Health system could benefit from and take preliminary steps to become a Trauma Informed System. Under a model of participatory leadership, the work group of subject matter experts from within our system began the vetting process through focus groups and presentations throughout our system. To date, the vetting process has included over 400 people within our public health system including providers, non-providers, primary care and various peer and advocacy groups. Feedback, suggestions and observations from these meetings has guided the development process from the beginning. Out of this process a formal response was born in the Trauma Informed Systems Initiative.

Trauma Informed Systems Initiative Workgroup

The Trauma Informed Systems Initiative Workgroup is led by Dr. Ken Epstein and currently staffed by a full time Coordinator, a team of 4 interns, a work group of subject matter experts and the support of the Community Behavioral Health Services Training Department.   The Initiative has based its change efforts on the Trauma Informed System's Principles and Competencies developed by the work group:

- • Trauma Understanding
- • Cultural Humility & Responsiveness
- • Safety & Stability
- • Compassion & Dependability
- • Collaboration & Empowerment
- • Resilience & Recovery

These six principles provide the framework for the foundational training curriculum as well as the starting place for considering our staff to staff relationships, our programs and policies.[4] Although the formal workforce training is a major component of the initiative's theory of change, we believe the implementation of long term support and sustainable structures for knowledge transfer are the key to organizational change.

Implementation

The Trauma Informed Initiative is a six-pronged approach to developing, sustaining change in organizational and workforce functioning.[5] In addition to training for the entire workforce, TIS is utilizing the principles of implementation science to insure that knowledge transfer is associated with structures that support commitment to change, embedded champions, alignment and collaboration within and across systems,

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[4] For a the Trauma Informed Systems Principles and Competencies full document, see the appendix
[5] For an the Trauma Informed Systems Program Structure, see the appendix

leadership participation and continuous evaluation. [6]Below are brief examples of our current efforts in these areas.

Workforce Training: Shared Understanding & Commitment To Change

In order to promote a shared culture, we must have a shared language and understanding and begin to generate a commitment to change at all levels of the organization. In this regard over a 24-month period the entire Department of Public Health workforce of approximately 9,000 employees will receive foundational information about the effects of trauma and some tools to initiate change. The training initiates a system-wide conversation about the impact of trauma and to build a common language with which to discuss incorporation of the trauma informed principles across all levels of our public health system. After extensive vetting the TIS half-day, interactive training was piloted on February 25, 2014 with Community Behavioral Health Leadership. By year-end 2014, 27 trainings were offered in a total of three sites with morning and afternoon options, including the African American Cultural Center and Laguna Honda Hospital.   The training includes didactic sections, break outs groups and ends with a *Commitment to Change* section where participants are asked to generate ideas about how to integrate the trauma informed principles in their daily work life.   Two evaluation tools are collected from participants at each training:

> **Workforce Training Statistics 2014**
>
> *27 Trainings*
> *3 Locations*
> *1787 Participants*

- A training evaluation designed to collect participant input on the training content, support for the trauma informed systems initiative and ideas on how to improve the training.
- A Commitment to Change form which collects participants' specific commitments to integrate trauma informed principles into their work life. These forms are filled out on carbon copies: one for participants to keep and one collected for the evaluation team.

The results of evaluations collected from March 27, 2014 through September 25, 2014 can be found in the appendix.

Participants

Approximately 1,700 DPH employees have participated in the Trauma Informed Systems workforce training since its first official offering on March 27, 2014 following the pilot. The majority of trainings were comprised of staff who registered themselves based on their availability, resulting in a wide-variety of roles and departments experiencing the training together. Several trainings were initiated by leaders of departments or sections for staff to

> **Early Innovators**
>
> Laguna Honda Hospital and Rehabilitation Center
>
> Minority AIDS Initiative - Targeted Capacity Expansion Program (MAI-TCE),
> Ward 86, San Francisco General Hospital
>
> Primary Care Physicians, Community Behavioral Health Medical Providers, San Francisco Health Network

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[6] Fixsen DL, Naoom SF, Blase, KA, Friedman, RM, Wallace, F. (2005) Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida.

attend together, which resulted in groups of Early Innovators who committed to training and thinking together about how to implement Trauma Informed principles in their context.

San Francisco General Hospital is currently working with our training and coordination team to offer a series of trainings on site for their employees in 2015.

Alignment, Collaboration & Sustainability

Trauma informed systems work highlights the need for thoughtful, collaborative approaches to the complex problems we are presented with as a public health workforce. In an effort to promote the principle of Collaboration and Empowerment, the Trauma Informed Systems Initiative continues to foster collaborations with other initiatives with in DPH and throughout the city and the region.

Alignment within DPH

- *Service Excellence and Relationship Centered Communication (RCC):* RCC training is a staff development model that emphasizes safety, respect, support, and nurturing to achieve seismic shifts in how staff relate to each other and to clients. TIS has been working with RCC to pilot the integration of TIS into RCC. On June 6, 2014, we piloted a pairing of our Trauma Informed Systems Initiative workforce training and a Service Excellence training with Community Behavioral Health Psychiatrists. Behavioral Health is currently working on expanding this pilot in calendar year 2015

- *Black and African American Health Initiative* (BAAHI): Ken Epstein has participated in the initiative to insure that TIS aligns with the department's efforts to address institutional disparities impacting African American staff and the Health Disparities in the African American Community.

- *Cultural Humility:* TIS has consulted with Dr. Ken Hardy since inception to help understand and incorporate a systemic approach to TIS with a deeper understanding of the impact of racism on delivery systems and communities and the connection with trauma. In addition, TIS has now initiated consultation with Dr. Melanie Tervalon regarding the cultural humility section of the training.

- *Training and Workforce Development:* TIS has participated in workforce development representing TIS. Particular focus has been on understanding and aligning the workforce satisfaction survey with TIS evaluation strategies. In addition the Training and Workforce Development department has participated in the core-coordinating group since inception.

Systems of Care Collaboration

Now a leader in the field of Trauma Informed Systems work, SFDPH is providing leadership to the other agencies with in San Francisco and throughout the Bay Area.

- TIS is actively working with other city departments to discuss expanding the training city wide. This includes: Juvenile Probation, SFUSD, First Five, DCYF, HSA, and SFPD.
- TIS has produced early innovator trainings for the San Francisco Child Abuse Prevention Center and HSA which included staff and leadership across systems such as Juvenile Justice, SFPD, District Attorney's Office, SFUSD and Child Welfare.
- TIS has been working with several early innovator CBO's to further expand the training.

- San Francisco as a lead agency has been awarded a 4 year SAMSHA grant to help develop a Trauma Informed Region including Children, Youth and Family Systems of Care from seven bay area counties. *See Appendix for an Executive Summary of the proposal awarded*.
- TIS has met with numerous foundations interested in either funding, expanding and coordinating efforts with TIS. *See Appendix for a full list*.
- Nationally TIS has established a consultation workgroup including other localities that are early innovators in developing Trauma Informed Systems of Care, including Philadelphia, Maine, Upstate New York and San Diego. San Francisco's implementation is the only one that is embedded, lead and implemented by a public agency.

Champions

Organizational change depends on embedded champions at all levels of the organization. Champions help transmit ideas, pilot changes and inspire others to support adoption of the principles and practices. Champions have emerged since we initiated TIS and they have informed the development of the training and shared ideas about implementation. Since the very first workforce training, DPH staff who have attended the training have been contacting our workgroup with inspiring ideas for bringing trauma informed principles to their own workplace. These Champions have come from departments all across our system, various levels and roles and

"Never doubt that a small group of committed citizens can change the world. Indeed it is the only thing that ever has."

– Margaret Mead

all with a unique relationship to the impact of trauma in our workforce and the community we serve. Our first Champions Meeting was held on November 14, 2014 at 1380 Howard Street and December 16, 2014 at 25 Van Ness Ave, and attended by 34 inspiring members of our public health workforce. This first meeting included the practice of Sandra Bloom's Community Meeting Structure, an framework for trauma informed staff meetings, and a sampling of a Relationship Centered Communication technique for quickly promoting relationship building with clients or co-workers.

Still in the program development phase, the Champions Program will be shaped and built upon the research and findings of a team of students from the University of California, Berkeley's School of Social Welfare who are currently conducting research on effective models for staff-led, organizational change. With the findings from their research and an ongoing collaboration with Relationship Centered Communication, our founding champions and initiative workgroup will continue to develop this instrumental piece of implementation in 2015.

Leadership

TIS was initiated as a mandatory training by Barbara Garcia, Public Health Director. The next challenge for leadership is to incorporate all levels of leadership into participating supporting and utilizing the principles and practices of TIS. One of the most striking results from our Six-Month Evaluation Report[7] is the workforce's

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[7] Fields-Loomis, B. (2014) Trauma Informed Systems Initiative Six Month Evaluation Report: March 27, 2014 – September 29, 2014. *San Francisco Department of Public Helath*. See Appendix I for Full Report.

overwhelming support for the initiative coupled with the belief that the initiative will be "poorly implemented or abandoned". The leadership initiative has thus far taken the following steps:

- Regular meetings with the Public Health Cabinet to report on progress and to receive directives and guidance on implementation and strategies for spread.
- Meet with leadership teams in every area of DPH. Prior to training at Laguna Honda, Population Health and Ambulatory care TIS met with the leadership team to describe the training, answer questions and to discuss next steps. Next we will meet with SF General. This process will need to be repeated regularly to access implementation progress and report on the evaluation.
- Children, Youth and Families has piloted incorporating TIS into the system of care including picking priority principles and aligning the 14/15 work plan within the scope of TIS.

Documents suggested for leadership use can be found in the appendix of this report.

Train the Trainer

Through our vetting process we discovered what we had already suspected: that there already exists significant expertise with in our department on trauma and system change, but that access to these sources of expertise varies across our system. Our approach to the Train the Trainer component remains consistent with our theory of change; that embedded, sustained support is crucial to the success of the wide-scale adoption of our principles and system-wide understanding of trauma. The vision for Train the Trainer is to create embedded trauma informed experts and leaders with in our organizations that can lead the transfer of knowledge. This approach is not dependent on resources to fund outside consultants and creates a flexible, efficient and more effective model for training and sustaining trauma informed principles.

The trauma informed principles of recovery and resiliency will remain integrated into our process of teaching and recruiting trainers. We remain committed to our values of social justice and promoting health equity in the development of trainers. Seeking to re-define what we traditionally consider "expert knowledge" on trauma we encourage academics, medical professionals and those with lived-experience to apply for the program and value their unique contribution to the education of our workforce. In the spirit of the Collaboration and Empowerment principle, trainers will deliver the content in pairs of according to complimentary knowledge on trauma.

In September of 2014, we began our first Train the Trainer cohort comprised of eight Laguna Honda Hospital employees: nurse educators, training specialist and lived-experience experts. This training cohort is set to complete the program in 2015. Commencement of our next cohort for is set for Spring 2015.[8]

Evaluation

An evaluation program designed to measure staff's individual experience of the foundational training, readiness and support for change and in implementing the trauma informed principles in their daily work life. The full report in included in the appendix.

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[8] For a conceptual draft of the Train the Trainer Program Flow, see the Appendix

Conclusion

Trauma exacts a great toll on San Franciscans, their families and communities; and in turn impacts our public health system, its leaders, clinicians and staff. It can compromise the well being of our workforce, interactions with one another, and the care we provide to our already vulnerable clients. Over the past year, the Trauma Informed Systems Initiative has rolled out a feasible, very promising and sustainable approach. To date, over 20% of our workforce have been trained with an overwhelmingly positive response to the training, the call to change, and empowerment to apply the TIS principles at all levels. Breaking the echoing cycle of personal to organizational trauma in our system, across other City Agencies and throughout the San Francisco Bay Region is within reach.

Appendix

Directory

Trauma Informed Systems Initiative, SFDPH

DPH Trauma Informed Leadership

Trauma Informed System Initiative:
Six Month Data Report

March 27th, 2014 – September 25th, 2014

Prepared by
Briana Loomis, PhD
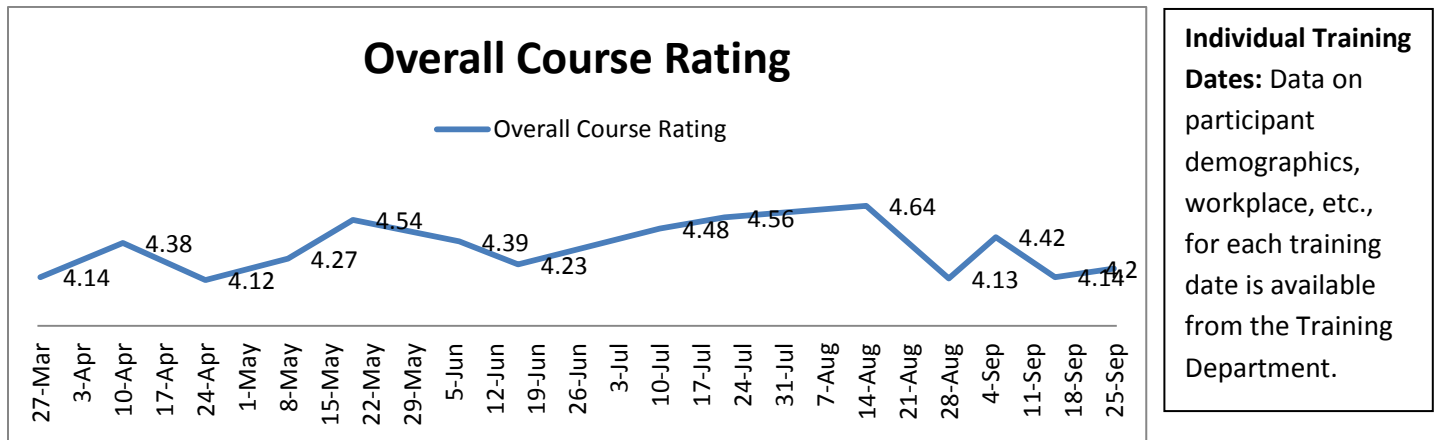
October 23rd, 2014

Contents

Feedback on Trauma 101 Training

Immediate Impressions of Training Experience
All scale based items used a 1 to 5 rating scale with 1=Disagree Most and 5=Agree Most.
Sample sizes for items vary based on response rate and are provided for reference.

Overall Course (n=866)**:** Averaged across all 14 training dates, participants gave the course a moderately high overall rating ("agree" 4.33 out of 5).

Individual Training Dates: Data on participant demographics, workplace, etc., for each training date is available from the Training Department.

Participant **Overall Course** ratings were significantly related to their perceptions of course **Relevancy** to their work and also strongly correlated with perceptions of how well the course achieved its Objectives and overall impressions of the **Speaker**.

Professional Relevancy (n=883)**:** Averaged across all 14 training dates, participants reported a moderately high level of agreement ("agree" 4.19 out of 5) that the course was professionally relevant.

Rating of Training Relevancy to Job and/or Professional Needs	Mean
Discussions were relevant to my current job/professional needs	4.28
Handouts were useful to current job/professional needs	4.18
Exercises were relevant to current job/professional needs	4.07
Overall the course content was relevant to my current job/professional needs	4.23

Objectives (n=885)**:** Averaged across all 14 training dates, participants reported moderately high approval ("agree" 4.45 out of 5) with how learning objectives were identified and met during the course.

Rating of Course Objectives	Mean
The Learning Objectives were clearly identified in conference materials	4.44
The Course was consistent with the stated learning objectives	4.48
All of the Learning Objectives were met	4.42

Speaker (n=888)**:** Averaged across all 14 training dates, participants reported a high approval ("agree" to "strongly agree" 4.59 out of 5) with how well the trainer presented the course (score reflects 2 different speakers)

Rating of Course Trainers	Mean
Demonstrated ability to apply material to culturally diverse population	4.48
Appears to be knowledgeable in the subject area	4.69
Provided a well organized presentation	4.67
Was able to facilitate discussions effectively	4.40
Communicated material in clear language	4.64
Demonstrated ability to provide appropriate examples.	4.57
Overall rating of the trainer	4.65

Participant **Overall Course** ratings were also significantly related to the perceived difficulty **Level of Educational Activity Content** for the training; however, the **Overall Course** ratings did <u>not</u> vary by how participants perceived that the training addressed **Cultural and Linguistic Competency** issues or by participant perceptions of **Commercial Bias**.

> **Level of Educational Activity Content** (n=806): 84% of participants felt the content was "just right", 15% felt it was "too basic", and 1% reported it was "too advanced."

> **Cultural and Linguistic Competency** (n=788): 79% of participants felt these issues were addressed during the training, 16% these issues were not addressed during the training, and 6% reported these issues were not applicable to the training.

> **Commercial Bias** (n=834): 99% of participants felt the training was balanced and free from commercial bias – 1% felt that the training was not balanced and/or contained commercial bias.

Improving the Trauma 101 Training

Most Liked Components

Liked Most	Percent
Speaker	11.0%
Use of Groupwork/Interactive Tools/Exercises	9.0%
Emphasis on Wellness/Selfcare/Relaxation	7.2%
Quality of Trauma/Stress Information	6.0%
Presentation/Materials	5.6%
Empathy Video	5.4%
Roleplays/Demonstrations	3.9%
Practical/Useful Information	3.8%
Personal/Professional Relevance	3.5%
Vignette	3.5%
Integration of Research/Science	3.2%
DPH Approach/Support for Initiative	3.0%
Mandatory/Inclusive of System/All DPH Training	3.0%
Specific Trauma/Stress Tools	3.0%
Analogies/Acronyms	2.6%
PEARLS	2.4%
Organization of Training	2.4%
Incorporation of Culture	1.7%
CTC Activity	1.5%
Logistics	1.4%
Promoting Self-Reflection	.9%
Length/Pace of Training	.5%
Comprehensive Information	.3%
Other	15.6%

"Relatable and easy to apply to my life/work"

"The trainer presented useful information that applies to my work along with simple and useful tools."

"Cleveland Clinic [video], self-care tools. Focus on us as workers, asking for our commitment to change."

"Training covered a lot of ground and was accessible to people with variable positions in the department. It's great to have this common reference point and incredible that SFDPH is taking trauma seriously."

"Provided tools to use; I liked the role play for the PEARLS."

"Facilitators were informed, excited, and engaging."

"Vignettes and role play demonstrations the video was great at the beginning!"

"I truly appreciate Barbara Garcia for making this mandatory. I hope that all high level managers attend."

"Practical tips for handling stress. Scope of training is extensive. Easy enough to understand - not too much jargon."

Least Liked Components

Liked Least	Percent
None/Nothing/N/A (*actual written response*)	14.8%
Lack of Large Group Participation	12.8%
Roleplays/Demonstrations*	12.1%
Cultural Exercises/Info/Representations	10.8%
Triggering/Stressful	6.8%
Biased Focus (e.g., emphasis on only clinical settings)	4.0%
Presenter	3.8%
Vignette	3.1%
Clarity of Instructions/Purpose of Components	2.4%
Length/Pace of Training	2.2%
Missing/Poor Quality/Incomplete Information	2.0%
Overly Didactic/Lack of Learning Tools	2.0%
Logistics	1.3%
Groupwork/Interactive Activities/Exercises	1.3 %
Lack of DPH System or Leadership Involvement/Support	1.1%
Repetition/Redundancy of Information	.9%
Difficulty Level of Content (i.e., too basic/advanced)	.9%
Other	17.7%

A large proportion of participants reportedly disliked the roleplays and demonstrations because they centered on the vignette.

"The quick pace of how the info was presented; wish it could've been so much more interactive. Than just breaking into small groups; would've been nice to discuss in a larger forum of collective IDEAS."

"ARC- it wasn't clear. Role plays don't demonstrate concepts well."

"The room has poor acoustics, limited parking, trainer, while lovely, talked way too fast at times."

"Lack of LGBT examples in context or video. Very youth focused. Included 3 slides on disparities but ignored LGBT."

"I was happy when I came into the training. Some of the examples dredged up old issues made me stressed."

"Too focused on clinical/mental health settings. I would like to broaden the frame of DPH employees interact with community members, not just as clients or patients, but often in advocacy and code enforcement situations.**"**

"Need to better frame course for those whose clients are other employees/colleagues.**"**

"The group discussions and talk on culture - too basic for treating professionals

"Would love to have more science in it."

"Comments from audience were not discouraged, per se, but it would have been good to hear more from the audience as a whole, not just our small groups."

Suggestions for Improvement

Suggested Improvements	Percent
None/Nothing/N/A (*actual written response*)	11.8%
Increase Large Group Participation	9.8%
Provide Additional/Expanded Content (i.e., more detail/info on specific topics)	8.3%
Adjust Length/Pace of Training (e.g., too long/short, rushed/slow)	7.0%
Improve Logistics (e.g., seating, location, snacks, breaks, sound)	5.5%
Customize Trainings (e.g., by types of staff, setting, level of education)	5.3%
Offer More Relevant Materials/Examples (e.g., specific to work setting)	4.3%
Diversify Activities/Reduce Vignette Redundancy	3.8%
Use Smaller Groups (i.e., smaller breakouts and/or smaller whole group)	3.3%
Reduce Cultural Stereotypes/Bias (e.g., characters in vignette)	3.3%
Increase System/Leadership Support and Involvement	2.8%
Provide More Support/Resources/Tools Post-Training	2.8%
Discuss Impact of SFDPH System/Power/Resources (i.e., impact of system functioning)	2.5%
Improve Readability of Materials/Presentation (e.g., blurry slides, poor handout copies)	2.5%
Roleplay in Small Groups	1.8%
Present Vignette in Different Format (e.g., video, role play)	.8%
Use Multiple Presenters	.8%
Clarify Activity Instructions/Purpose of Components	.8%
Other	23.1%

"Have co-facilitators. Develop staff development modules to use in the field."

"More engagement between group such that having small group talks & comparing discussing with other small groups as a whole afterwards."

"Some of the slides are too small (Pg. 45)."

"More information/training on specific community trauma (such as latino immigrant communites, etc.)."

"More examples, more roleplay of situations the audiences gives on the fly."

"Include tools on team building and referrals."

"More interactive work in a large forum with each other; touch-on more examples/ scenarios with complex trauma survivors and the "domino effects" of trauma activation, etc."

"More questions and answer period."

"Break into smaller groups with more facilitated dialogue and more suggestions of applying material to job."

"Clarify that the cleveland clinic video is about general observances 3 of the 5 people in my group got hung up on the people in the video not being "the population I serve""
"I need more time to do the commitment change."

Trauma 101 Training Data Snapshot

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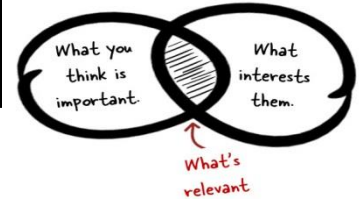
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Level of Content (n=806)**:** 84% of participants felt the content was "just right", 15% felt it was "too basic", and 1% reported it was "too advanced."

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Commercial Bias (n=834)**:** 99% of participants felt the training was balanced and free from commercial bias – 1% felt that the training was not balanced and/or contained commercial bias.

# Feedback on the Trauma Informed System Initiative

Support for TIS Initiative

Support for Initiative (n=890)**:** Averaged across all 14 training dates, participants generally reported overall approval for the initiative ("agree" 4.06 out of 5); however, a number of participants expressed concern that the initiative would be abandoned or poorly implemented (2.8 out of 5).

Rating of Trauma Informed System Initiative	Mean
Being trauma informed is important for everyone in SFDPH.	4.74
I believe that using trauma informed principles will improve my worklife.	4.53
The trauma informed initiative will likely be abandoned or poorly implemented.	2.80
I want to help our system become more trauma informed.	4.19
SFDPH is already trauma informed and new efforts are not needed.	2.15
It will be easy for me to apply trauma informed principles in my work.	3.85

Scale based items used a 1 to 5 rating scale with 1=Disagree Most and 5=Agree Most.

Given that participants complete this scale immediately following the conclusion of the Trauma 101 Training, the Training may need to address weak areas (e.g., abandonment/implementation) more explicitly during the course of the training.
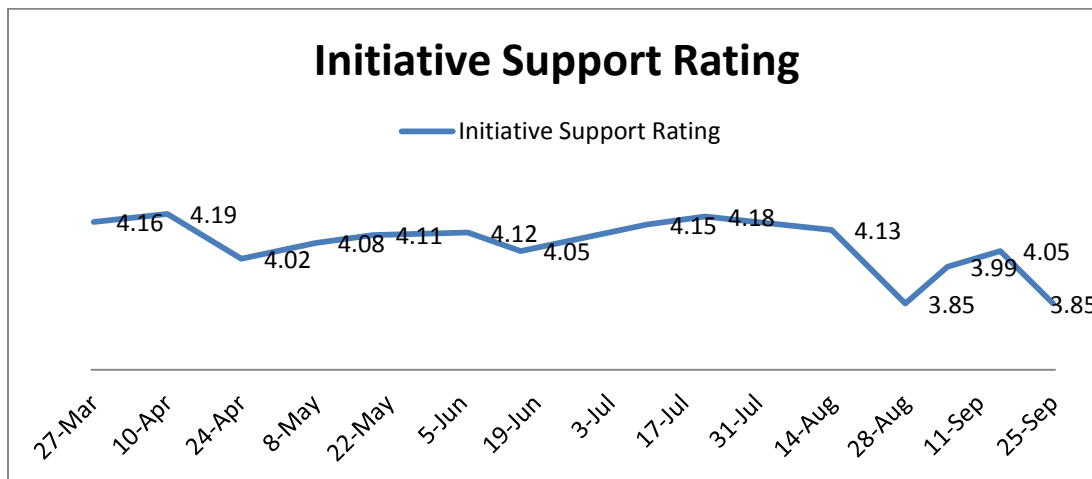
Individual Training Dates: Data on participant demographics, workplace, etc., for each training date is available from the Training Department.

Ideas for becoming a Trauma Informed System

Becoming Trauma Informed	Percent
Improving system functioning (e.g., power dynamics, resources, labor-management)	11.5%
Additional/expanded content on specific topics or for future trainings	9.8%
More trainings	9.0%
Increased attention to social/cultural/diversity components (e.g., language, LGBT issues)	6.1%
Provide tools/reminders (e.g., quarterly reminders, laminated cards, online materials)	5.2%
Outreach/expanded availability (e.g., train schools, reach out to other settings)	4.1%
Follow-up/support for application (e.g., TIS inspector, accountability groups)	4.1%
Customize trainings (e.g., by types of staff, setting, level of education)	3.9%
Employee wellness (e.g., self-care, team building)	3.9%
Support for workplace application (i.e., applying TIS info/skills to specific settings)	3.4%
Optional/mandatory nature of training	3.4%
Improving safety/security	2.2%
Support for interpersonal application (i.e., applying TIS info/skills to interpersonal situations)	1.5%
Champion	.9%
Other	27.3%
None/Nothing/N/A (*actual written response*)	2%

"DPH should make staff satisfaction and wellness a real priority, supported with budget, planning, etc."

"Follow-up education/trainings, tools folks can actually use vs. take to office and file away. Also, all supervisors, managers, directors, etc. should have special, frequent trainings and workgroups so that staff can have trauma-informed support."

"Send out anonymous emails periodically to evaluate potential traumatic situations at the work settings. Drop box at each work site for anonymous input."

"Fix our clinic environments! They are chaotic, ugly, crowded, closed, and messy (safety and stability); fix our computer systems they are slow and we are required to chart and/or use too many systems; provide more training (trauma understanding) so people in the systems are less stressed and more capable working with patients."

"Allow everyone to use sick leave for mental health (selfcare) days. Make this training required for all personnel after they pass probation."

"Those in leadership need to participate & model the tools described rather than subordinates being stressed out and traumatized by their leadership."

"Target administrators and supervisors, have management shadow line workers to get a sense of their daily experience, enhance work environments to solicit solutions/suggestions from line staff versus top-down management style."

"Add some of pocket tools to DPH monthly calendar!"

"DPH Leadership walking the talk of creating safety and stability."

"I feel like there could be some more involvement and impacts directly from those we are serving."

"Management team needs to promote 'trauma informed' They need to act as our 'role model' They need to care their staff. We are not a robot. WE have feeling, emotion. We need to be heard. We have been traumatized for long time. No way to vent. No way to help. No way to channel."

"Annual evaluations of management/ supervisors to give critical but constructive feedback."

"System wide gratitude practice for staff. Examine customer service practice, learn from other industries like Nordstorms!"

"Needs to be BUILT IN to programming and organization of teams within DPH…facing so much pain/heartache."

Trauma Informed System Practice Change

Participants were given two separate opportunities to identify changes they could make to become more trauma informed. First, they were asked to identify two things they might do different after the training. Second, they were asked to commit to making one change in the next month – their Commitment to Change Project.

Practice Change (n=272): The most three most frequently cited practice changes were personal Wellness/Self-care (4.3%), use of skills acronyms PEARLS/ARC/CAPPD (2.3%), and the specific self-care routine of Gratitude (1.5%).

Participant Identified Practice Changes

Practice Change "things you might do differently"	Percent
Practice Wellness/Self-care	17.9%
Utilize Skills/Techniques with Others	12.6%
Use PEARLS/ARC/CAPPD	9.7%
Practice Gratitude	6.2%
Practice Compassion/Empathy/Support	5.4%
Better Perspective Taking/Awareness of Others	4.9%
Practice TIS Principles	3.8%
Teach/Share TIS Knowledge or Skills	3.8%
Ask what has happened?	3.3%
Recognize Personal Triggers/Trauma History	2.8%
Listen to Others More/More Effectively	1.5%
Be More Self-Aware	1.5%
Support Others' Coping/Wellness	1.3%
Be Less Judgmental/More Understanding	1.0%
Use CTC Activity/Ideas	.8%
Get More Information/Training	.5%
Other	5.4%

Commitment to Change (CTC) Project

CTC (n=832): From the list of examples provided, the three most frequently selected CTC goals were taking a 5 Minute Break (8%), Practicing PEARLS (7.5%), Teaching Coping Skills (5%).

CTC Goals

Participants were encouraged to select a primary Commitment to Change goal from a list of examples, but were also permitted to select their own unique Commitment to Change goal. Commitment to the primary goal was assessed on a 1 to 5 scale with 1=Lowest Level of Commitment and 5=Highest Level of Commitment.

| Commitment to Change Project Goals (n=832)	Percent Selecting	Mean Commitment
Self-selected a unique Commitment to Change goal.	62.5%	4.25
Schedule a 5 minute break during every workday to relax away from your responsibilities.	8.0%	4.12
Regularly devote team meeting time to practice PEARLS skills that are specific to your work.	7.5%	4.39
Teach your clients a new healthy coping skill that you will also begin to use on a regular basis.	5.0%	4.23
Regularly offer a private or public thank you to specific coworkers for their effort and support.	4.5%	4.21
Personally call clients who are difficult to engage to check-in in between their appointments.	2.5%	4.14
Begin meetings with a friendly check-in where staff can briefly share positive experiences.	2.0%	**4.50**
Help each staff member identify and develop a particular professional skill or strength.	2.0%	4.31
Ask clients if they feel safe coming to your service site and help them to resolve any concerns.	1.5%	**4.54**
Support your staff in creating and implementing personal self-care plans for their worklife.	1.5%	**4.50**
Meet with your supervisor to discuss a specific safety concern that has not been addressed.	.5%	4.00
Conduct friendly follow ups with clients to whom you provided services or materials.	.5%	4.00
Take time to explain to each client the general process you'll take in resolving their concern.	.5%	4.25
Regularly shadow frontline staff to better understand their needs and worklife experiences.	.5%	4.33
Designate and set a regular meeting with a staff member who acts as your TIS liaison.	.5%	4.33
Set a regular meeting with a supervisor or coworker to discuss how culture impacts your work.	.5%	**4.50**

There was <u>no</u> significant difference in overall level of commitment between participants who selected their goal from the list of examples and those that self-selected their own unique goal. Fifty-eight (58%) percent of participants identified both a primary and secondary Commitment to Change goal, although a secondary goal was optional.

Participant Success with Implementing CTC Goals

At 2-3 months post-training, almost 70% of participants (n=186) were partially or completely successful with implementing their primary Commitment to Change Project goal; however, participants (n=152) struggled to remember if they had identified a secondary goal or any efforts to implement a secondary goal.
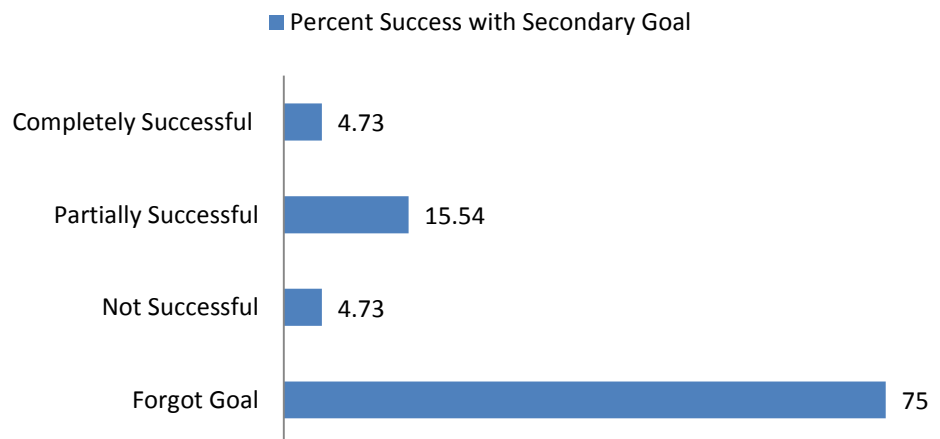
Percent Success with Primary Goal

■ Percent Success with Primary Goal

Category	Value
Completely Successful	18.23
Partially Successful	51.38
Not Successful	11.6
Forgot Goal	18.78
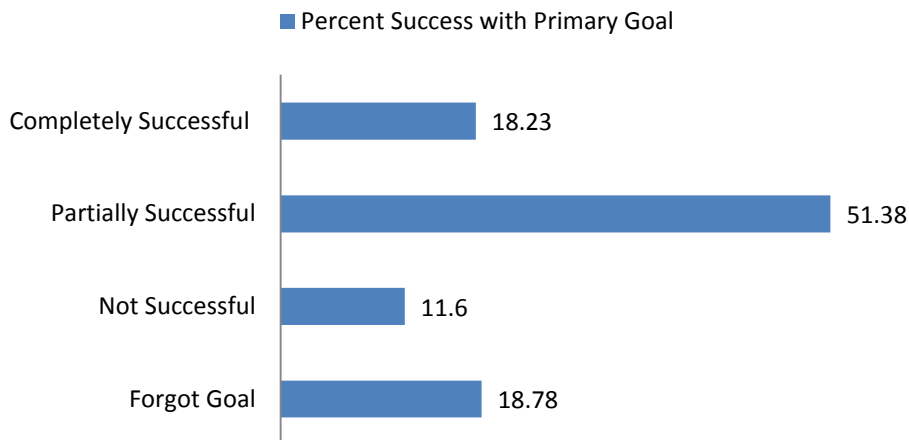
Continued Implementation (n=186)**:** Seventy-three (73.5%) percent of participants stated that they planned to continue implementing their primary Commitment to Change goal. Twenty-four (23.76%) were unsure if they would and 3% stated they would not continue to implement the goal.

Time Pressure (n=169)**:** Thirty-four (34.15%) percent of participants did not feel they had enough time to consider what primary Commitment to Change goal they wanted to select, while an additional 17% percent were unsure if they had sufficient time. Forty-nine (48.78%) percent felt they had enough time to select a goal.

Percent Success with Secondary Goal

■ Percent Success with Secondary Goal

Category	Value
Completely Successful	4.73
Partially Successful	15.54
Not Successful	4.73
Forgot Goal	75

Participant Comments on CTC Experience

Implementing Change – *Qualitative Data*

"What has improved it is just the way I'm thinking. That's what's making it work and making it more successful. It helps me on a confidence level. Sometimes you don't need to achieve necessarily a 100% of your goal, but doing the best you can can be more significant. It also helps to have encouragement from others."

"[It was] challenging to carve out time, even though it is important to my overall well-being. I was partially successful because I knew I made a commitment to myself about practicing better self-care. [I was] encouraged to get out of the building more [for breaks]."

"[It was] somewhat challenging. [I was only partially successful] because of weather, not having appropriate shoes, being too busy to eat lunch and make time to go for a walk. It feels good to continue to have this as a goal (walk outside at least 2-3 times/week)."

"It felt wrong, unacceptable to do it during work. I feel that management may interpret it as being unproductive or not a team player. It's not a priority or recognized need in our branch. [Trying to make this change] was more stressful as I felt I would be judged for taking a moment to myself."

"It made me anxious because it is a change that I am asking my team to participate in. I think most people like it, but it does make some people uncomfortable because it requires an extra level of trust when working with each other. I think our meetings are becoming places where we can share more."

"[It was] good, my team was very receptive and we have been consistently implementing the "gratitude shout out" at our weekly meetings. Everyone likes to be recognized, so I think folks were open to the idea, although not everyone always participates. I think it gives the team something to look forward to about our meetings."

"I don't see how I can make any change, as minimal as I can be, from my position. My management is hostile, punitive and vendictive. I don't see how I can change my work environment or how to deal with that. I do have personal ressources and it helps, but I'm counting the days left before I retire."

"I'm more aware of others and how they are acting, I asked myself more often what happened instead of what's wrong. I do provide education and one exemple of how it has changed is that I had a student falling asleep in class and instead of getting upset or mad I talked to him after class. This training has count on my succes, a lot. The impact is that I feel better about myself, less angry, and I have a better understanding about where the other person comes from."

"More alert. I meet with nurses and try to be more empathetic about the issues with their patients, which alerted me to be more supportive of their struggles. It increased my awareness, but I would have been more successful with more time. The impact was better care of patients."

"It didn't have much of an impact on me. You get up, get a drink of water, not much time. I think it's the nature of the work - a 5 minute break is only enough time to breath - you can't really disconnect from it in that time. I just already do take 5 minute breaks so I'll keep doing it."

Increasing Success – *Qualitative Data*

"I like the follow-up feature, it makes it accountable, makes you think about it. When you call or sent me reminders it reminded me of the training and the changes that I wanted to do."

"[If I had found more/better] reasons to make myself leave the building for a brief break (e.g., getting lunch, going to the post office). Fun reminders and a small reward for myself [would also have helped.]"

"Telling more peers about my goal [would have increased my success]."

"[It would have helped to have] manager buy-in and staffing resources to eliminate their need for me to do more than my designated workload. If managers/directors were trained in leadership and appreciation of "human hours" and resource allocation. This would allow acceptance of employees taking care of their own needs and stress management. As it is, I have to do my meditation, breathing or stretches at home instead. This further reduces personal/home time."

"[It would have helped] if all of our team had attended the training relatively close to each other. Nothing [else], I made it a part of our agenda."

"Nothing, I was succesfull. It was a great change."

"Impressive! You actually did follow up! Follow up is unusual, it makes me see how much DPH values the training. I hope Senior team have the training too. It would help to build more trust and apreciation on the management and trickle down. People don't often trust their management and viceversa. It would be helpful."

"What did help to remember was having people who modeled that behavior to me."

"We should start talking about change from the beginning of the training. It was very helpful but at the end it is not enough."

"Nothing. I saw your e-mails and they made me think of the training and I remembered my commitment to change."

"I started to think about doing it but then reverted back to the status quo because of my busy schedule. I couldn't be consistent especially with all the other things I was learning in my new position. I think it is great though that you guys are wanting to help us apply the training and if I had been more specific with my change I think that would have helped a lot. Also, more reminders until I had integrated it - maybe an accountability group."

Trauma Informed System (TIS) Core Principles & Suggested Competencies
San Francisco Department of Public Health

Understanding Trauma & Stress

Without understanding trauma, we are more likely to adopt behaviors and beliefs that are negative and unhealthy. However, when we understand trauma and stress we can act compassionately and take well-informed steps toward wellness.

1. *Trauma* – We understand that trauma is common, but experienced uniquely due to its many variations in form and impact.
2. *Stress* – We understand that optimal levels of positive stress can be healthy, but that chronic or extreme stress has damaging effects.
3. *Reactions* – We understand that many trauma reactions are adaptive, but that some resulting behaviors and beliefs may impede recovery and wellness.
4. *Recovery* – We understand that trauma can be overcome effectively through accessible treatments, skills, relationships, and personal practices.

Compassion & Dependability

Trauma is overwhelming and can leave us feeling isolated or betrayed, which may make it difficult to trust others and receive support. However, when we experience compassionate and dependable relationships, we reestablish trusting connections with others that foster mutual wellness.

1. *Compassion* – We strive to act compassionately across our interactions with others through the genuine expression of concern and support.
2. *Relationships* – We value and seek to develop secure and dependable relationships characterized by mutual respect and attunement.
3. *Communication* – We promote dependability and create trust by communicating in ways that are clear, inclusive, and useful to others.

Safety & Stability

Trauma unpredictably violates our physical, social, and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our daily lives and having these core safety needs met can minimize our stress reactions and allow us to focus our resources on wellness.

1. *Stability* – We minimize unnecessary changes and, when changes are necessary, provide sufficient notice and preparation.
2. *Physical* – We create environments that are physically safe, accessible, clean, and comfortable.
3. *Social-Emotional* – We maintain healthy interpersonal boundaries and manage conflict appropriately in our relationships with others.

Collaboration & Empowerment

Trauma involves a loss of power and control that makes us feel helpless. However, when we are prepared for and given real opportunities to make choices for ourselves and our care, we feel empowered and can promote our own wellness.

1. Empowerment – We recognize the value of personal agency and understand how it supports recovery and overall wellness.
2. Preparation – We proactively provide information and support the development of skills that are necessary for the effective empowerment of others.
3. Opportunities – We regularly offer others opportunities to make decisions and choices that have a meaningful impact on their lives.

Cultural Humility & Responsiveness

We come from diverse social and cultural groups that may experience and react to trauma differently. When we are open to understanding these differences and respond to them sensitively we make each other feel understood and wellness is enhanced.

1. Differences – We demonstrate knowledge of how specific social and cultural groups may experience, react to, and recover from trauma differently.
2. Humility – We are proactive in respectfully seeking information and learning about differences between social and cultural groups.
3. Responsiveness – We have and can easily access support and resources for sensitively meeting the unique social and cultural needs of others.

Resilience & Recovery

Trauma can have a long-lasting and broad impact on our lives that may create a feeling of hopelessness. Yet, when we focus on our strengths and clear steps we can take toward wellness we are more likely to be resilient and recover.

1. Path – We recognize the value of instilling hope by seeking to develop a clear path towards wellness that addresses stress and trauma.
2. Strengths – We proactively identify and apply strengths to promote wellness and growth, rather than focusing singularly on symptom reduction.
3. Practices – We are aware of and have access to effective treatments, skills, and personal practices that support recovery and resiliency.

Trauma Informed Systems Initiative Workgroup

Ken Epstein, Ph.D., LCSW

Director, Children Youth and Families System of Care
Community Behavioral Health Services
San Francisco Health Network
San Francisco Department of Public Health

Trauma Informed Systems Initiative, Workgroup Leader

Dr. Ken Epstein is currently the Children's System of Care Director for San Francisco County Community Behavioral Health Services, where he also leads the vision and implementation of the Trauma Informed Systems Initiative. While leading the initiative at DPH, Dr. Epstein has initiated and convened numerous groups of trauma experts and interagency collaborations with in San Francisco and across the Bay Area. A notable collaboration is the Bay Area Trauma Informed System of Care (BATISC) Initiative comprised of 7 Bay Area counties, which was recently awarded a four year SAMHSA grant.

Prior to his appointment to this position he has worked within family and youth service programs since 1981 as a line worker, clinician, program director, professor and chief executive officer. His professional interests have focused on providing clinical services and developing comprehensive family based services for children, youth and families experiencing alienation, conflict and loss. He has developed and directed comprehensive and integrated community based service systems including crisis services, hospital diversion, wrap-around, kinship, school-based and intensive outpatient services in Massachusetts, Vermont and California. Dr. Epstein is a Licensed Clinical Social Worker with a Ph.D. in clinical social work from Smith College, an MSW from UC Berkeley and a BA in community mental health from Hampshire College. Since 1991 Dr. Epstein has served as an Associate Clinical Professor and in the Department of Psychiatry at UCSF, where he has developed and directed an Intensive Family Therapy Training Program. In addition he has served as adjunct faculty at UCSF, School of Nursing, University of California Berkeley, School of Social Welfare and Smith College.

Lynn Dolce, MFT

Director, Foster Care Mental Health
Children, Youth and Families
Community Behavioral Health Services
San Francisco Health Network
San Francisco Department of Public Health
Assistant Clinical Professor, UCSF

Curriculum Developer, Master Trainer

Lynn Dolce, MFT, has worked for over 25 years as a clinician, consultant, clinical supervisor, associate director and teacher. For the last fifteen years, in partnership with SFGH Pediatrics, she has and developed and overseen pediatric mental health services for children, youth and families at UCSF SFGH Child and Adolescent Services. She has served on the clinical faculty for UCSF since 2006 and has distinguished herself as an excellent teacher and trainer. Ms. Dolce has worked closely with SFUSD to develop UCSF Healthy Environments and Response to Trauma in Schools (HEARTS), a program that aims to promote school success for children and adolescents who have experienced complex trauma. HEARTS has been awarded a 2013 Excellence in Partnership Award from the University Community Partnership Council for its strong collaboration with San Francisco Unified School District. Currently, Ms. Dolce is the Director for Foster Care Mental Health, SF DPH, CBHS, Children's System of Care. Ms. Dolce also serves as a Master Trainer and Curriculum Developer for the SF County DPH Trauma Informed System of Care Initiative; Transforming Stress and Trauma 101.

Joyce Dorado, Ph.D.

Associate Professor
Department of Adolescent Psychiatry
USCF School of Medicine

Curriculum Developer, Master Trainer

Joyce Dorado, Ph.D., is the Co-Founder and Director of UCSF Healthy Environments and Response to Trauma in Schools (HEARTS), a program that aims to promote school success for children and adolescents who have experienced complex trauma. HEARTS has been awarded a 2013 Excellence in Partnership Award from the University Community Partnership Council for its strong collaboration with San Francisco Unified School District. Dr. Dorado is also the Director of Clinical Research and Evaluation, an Associate Clinical Professor at Child and Adolescent Services (CAS), Department of Psychiatry, UCSF-San Francisco General Hospital, and the former Co-Director of Clinical Training for the CAS Multicultural Clinical Training Program.

Dr. Dorado earned her B.A. in Psychology at Stanford University, and her Ph.D. in Clinical Psychology from the University of Michigan. Her clinical service and research has focused on a public health approach to addressing complex trauma in schools, child victim/witness testimony, family violence, and psychological trauma in children, youth and families from under-resourced urban communities. She has been invited to speak about how to address trauma in schools at numerous events including the California Statewide Summit for Keeping Kids in School and Out of Court, has presented at national and international conferences, and has published her work in a number of books and journals. Dr. Dorado also serves as a Master Trainer and Curriculum Developer for the SF County DPH Trauma Informed System of Care Initiative; Transforming Stress and Trauma 101.

Michael Marcin, MD

Medical Director
O.M.I. Family Center
Community Behavioral Health Services
San Francisco Health Network
San Francisco Department of Public Health

Relationship Centered Communication Liaison

Dr. Marcin is a practicing Child & Adolescent Psychiatrist, General Psychiatrist and the Medical Director of OMI Family Center, a comprehensive mental health clinic serving the richly diverse Oceanside, Merced and Ingleside neighborhoods of San Francisco. OMI is part of the larger network of clinics under the San Francisco Department of Public Health's Community Behavioral Health Service. The need for a more integrated approach to treating mental health disorders in youth, transitional ages, and adults with and without developmental disorders has guided Dr. Marcin throughout his professional career. His clinical interests include children and adults with social, cognitive, and emotional difficulties, such as those associated with Autism Spectrum Disorders and other developmental disorders. He is also the lead psychiatrist for the Anchor Program, a collaboration between CBHS and the Golden Gate Regional Center. He is committed to improving provider-client communication and experience. To this end he has joined the Trauma Informed System executive team with expertise and certification in Relationship Centered Communication by the American Academy on Communication in Healthcare. He received his Medical Doctorate from St. Louis University and completed residencies and fellowships in general and child & adolescent psychiatry at Emory University, where he was Chief Resident. Additionally, he holds a Masters of Clinical Research from Emory where he designed and implemented clinical research supported by an NIH professional development grant.

Dr. Marcin has extensive experience in developing and running a successful small business, which includes strategic planning, setting the clinical standard and serving as clinical supervisor for more than 25 clinicians, wrap facilitators and support staff.

He has served as the program chair and a member of numerous statewide committees and initiatives. He is the recipient of national and international honors from the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the National Institute on Drug Abuse and Emory University School of Medicine. He has published his research in leading international journals and presented at national professional conferences.

Briana Fields Loomis, Ph.D.

Evaluator Psychologist
Child, Youth & Family System of Care
Community Behavioral Health Services
San Francisco Health Network
San Francisco Department of Public Health

Evaluating Psychologist, Commitment to Change Project

Briana Fields Loomis, PhD, is a psychologist and evaluator for the San Francisco Department of Public Health. Over the past decade, she has conducted research, provided treatment, and offered trainings and consultation in the field of trauma psychology. With an emphasis on crimes and trauma affecting women, children and youth, she has worked with first responders and the legal system, child welfare professionals, and local governments, as well as clinicians to improve how we understand and care for those who have been victimized.

Norman Aleman, MSW

Training Manager
Office of Workforce Development
Community Behavioral Health Services
San Francisco Health Network
San Francisco Department of Public Health

Cultural Competence, Training and Education Liaison

Norman Aleman, MSW, is the Training Manager under the Office of Workforce Development. For over eight years, he has been responsible for over forty trainings, seminars, workshops, and conferences with over three thousand SF Department of Public Health staff participating on a yearly basis. Educational activities range from evidence based programs to reduce stigma surrounding mental illness and substance abuse to technical assistance in documentation and supervision in both primary care and behavioral health settings.

Kaytie Speziale, MFT

Trauma Informed Systems, Coordinator
Community Behavioral Health Services
San Francisco Health Network
San Francisco Department of Public Health

Coordinator

Kaytie Speziale, MFT is currently the Coordinator for the SFDPH's Trauma Informed Systems Initiative and overseeing the system-wide training on basics of stress and trauma. A Marriage and Family Therapist by training, Kaytie specialized in the treatment of trauma for children and their families in the Sacramento area at UC Davis Children's Hospital and community mental health clinics before moving to San Francisco. Kaytie's experience includes individual therapy, specialized behavioral support for children in residential treatment or foster care, group facilitation and advocacy for those living with mental health needs.

Students

Post-Doctoral Fellow

Diana Sistiva, Ph.D.

Dr. Diana Sistiva is a Post-Doctoral Fellow with the Trauma Informed Systems Initiative Evaluation Program. Trained as a Clinical Psychologist, Dr. Sistiva has worked for several years as a therapist specializing in traumatized populations. Her experience includes working at the Department of Public Health in Aubervilliers, France, in Early Childhood Wellbeing Promotion, as well as the Center for Psychotrauma in Paris. Dr. Sistiva earned her doctoral degree jointly from University of Quebec in Montreal and University of Bordeaux 2 in France, and is currently dedicated to prevention and metal health promotion.

Graduate Interns

Jane Pomeroy, *University of California, Berkeley*

Lan Vu, *University of California, Berkeley*

Jane Pomeroy and Lan Vu are graduate students at the University of California, Berkeley in the School of Social Welfare. Jane Pomeroy is studying Management and Planning. She is passionate about building healthy communities, and working to prevent gender-based violence. Lan Vu is studying Community Mental Health. She has a great interest in trauma-informed care and aspires to provide early intervention and prevention to improve client outcomes.

Jane and Lan will complete their research on best practices for organizational change by May 2015. They aim to make recommendations to the San Francisco Department of Public Health regarding the implementation of a Change Champions Model, a key step in supporting our staff-led change efforts to become a Trauma-Informed System.
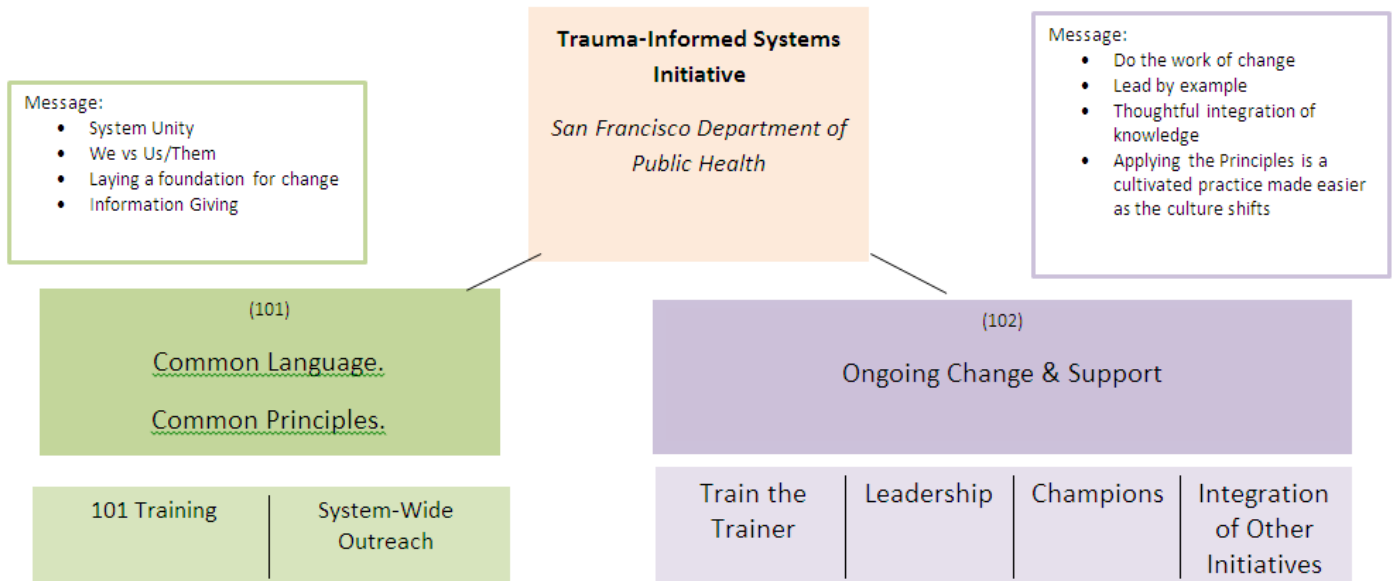
Undergraduate Intern

Tanusree Sreedharan, *California State University, San Francisco*

Tanusree Sreedharan is an undergraduate student of the College of Health and Social Sciences, majoring in Health Education, taking the majority of her coursework around program planning, implementation, and community organizing. Tanu has volunteered for most of her life in her community in the Tri-Valley and she has worked extensively with youth in the San Francisco Unified School District. She continues to volunteer in high schools as a communication and advocacy educator and is committed to promoting resiliency to increase positive health and well-being.

Trauma Informed Systems Initiative

Program Structure

Message:
- System Unity
- We vs Us/Them
- Laying a foundation for change
- Information Giving

Trauma-Informed Systems Initiative

San Francisco Department of Public Health

Message:
- Do the work of change
- Lead by example
- Thoughtful integration of knowledge
- Applying the Principles is a cultivated practice made easier as the culture shifts

(101)

Common Language.

Common Principles.

101 Training	System-Wide Outreach

(102)

Ongoing Change & Support

Train the Trainer	Leadership	Champions	Integration of Other Initiatives

2014

Trauma Informed Systems Workgroup

Master Trainers

Master Trainer

Master Trainer

Master Trainee

Laguna Honda Cohort

2015

Trauma Informed Systems Workgroup

Master Trainers

Master Trainer

Master Trainer

Master Trainer

Laguna Honda Cohort

2 Master Trainees

Ambulatory Care Cohort

2 Master Trainees

Master Trainer

Master Trainer

Laguna Honda Cohort 2

Master Trainer

Master Trainer

Ambulatory Care

Cohort 2

Train the Trainer Program Flow

Draft

Bay Area Trauma Informed System of Care (BATISC)
Executive Summary

Abstract

In October 2014, The Bay Area Trauma Informed Regional Collaborative group, was awarded a SAMHSA grant for their proposal to respond to trauma on a systems level, by creating a shared and trauma informed regional infrastructure to implement, sustain, and improve services for children and youth affected by trauma. The grant award will span 4 years in the amount of $1,000,000 which will include the funding of the group's key activity: a regional clearinghouse and coordinating center designed to integrate existing knowledge, incorporate new ideas, address challenges to training and sustaining an effective and diverse trauma informed work force and develop mechanisms to support implementation and sustainability of best practices.

Background

Regional Directors of County Behavioral Health systems came together in July of 2012 to develop and share plans to take trauma-informed practices, knowledge, and approaches to a new level of regional coordination. The group began a planning process to launch a Regional Trauma Informed System of Care initiative designed to:

- Develop a regional understanding and shared approach to our response to trauma and its effects,
- Embed leaders including youth and parent peers to be champions of change within and across our systems serving children and youth,
- Support and maintain change efforts through deploying experts and consumer voices within our region.
- Address common and pervasive patterns of disproportionality with respect to historical trauma and fragmented service delivery systems.

The Directors have since met on a quarterly basis. Through these meetings, the group has drafted strategic planning documents, shared local approaches to systems change, and identified key goals and strategies for regional collaboration. Initial goals focus on resource sharing, policy coordination, coordination of care, and cross-systems coordination. Early planning efforts have also been vetted at the regional level with systems partners, parent partners, and consumer focus group participants.

Through the BATISC planning group, several of the counties shared their modules and materials with the rest of the members of the Collaborative, and San Francisco, San Mateo and Santa Clara made space available in their local in-person trainings for participation by staff from other counties. The partners continued to share the idea that with a funded and lasting infrastructure and dedicated staff for this regional effort, this type of sharing will be consistent and coordinated. All of the counties will be able to benefit from jointly conducted training and the integration of shared learning approaches across the counties. In addition, the effort to implement an organized response to trauma and complex trauma and to improve access to services for children placed out of county can only be coordinated through a regional body with support and infrastructure.

The Bay Area is fortunate to have national experts in trauma throughout the region. This expertise, however, remains in separate silos in university settings, challenged by needing to constantly seek soft funding, called upon to train other localities in the U.S or around the world, or simply challenged to reach beyond their program or facility. As a result, the opportunities to deliver and translate this local knowledge and expertise into practice for Bay Area community systems and programs have been few.

In 2013, to combat this disconnection and fragmentation, the San Francisco Foundation convened a conference to engage local trauma experts in a conversation about barriers to developing and sustaining a workforce competently trained in the pervasive impacts of trauma on children, families, communities, and institutions. The expert summit concluded that that the Bay Area needed a centralized clearinghouse with a diverse advisory and oversight to help integrate practices, develop common principles and organize resources in a way that focus on knowledge transfer to the workforce, practice changes, and the sustainability of changed practice.

Goals

Overarching Goal: Transform the regional, overlapping systems into a coordinated, trauma-informed, youth-guided and family driven, evidence-based system of care.

1) BATIS Center: Develop a regional center to support and sustain a system of care that is trauma-informed, youth-guided, family-driven, and culturally competent.

2) Training: Develop training resources for dissemination to county staff, providers, and consumers.

3) Coordination of Care: Establish a regional model to provide coordinated services for youth and children placed out of county, and children, youth, and families served by multiple systems within counties.

4) Policy and Practice Sustainability: Develop and sustain promising practices from the project and incorporate them throughout the region.

For more information about the BATISC project, contact Kaytie Speziale with the San Francisco Department of Public Health at kaytie.speziale@sfdph.org

San Francisco Trauma Informed Systems Interest

Government

Worker's Compensation Division

District Attorney's Office
Mayor's Office, Hydra Mendoza-McDonnell
SFPD, Police Chief
HSA
Probation

CBOs/Non-Profits

Child Abuse Prevention Center

SF Hope
Center for Youth Wellness
Bay Area Academy
Edgewood
JVS (@ Laguna Honda)
Castro Mission Health Center
Baker Places Inc.
Glide
Mission Mental Health
Sunset Mental Health
A Woman's Place
Encompass Community Services, Santa Cruz
California Parent Training Institute, Santa Rosa
San Francisco Health Plan
Mercy Housing
National Council on Alcoholism
Stonewall Project
The Sage Project

Foundations

San Francisco Foundation

The Kresge Foundation

Tipping Point Community
The Annie E. Cassey Foundation

UCSF
Alicia Lieberman
Matt State