A Guide to GPRA Data Collection Using Trauma-informed Interviewing Skills

SAMHSA's Performance Accountability and Reporting System

April 2017

Substance Abuse and Mental Health Services Administration
SAMHSA
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Substance Abuse and Mental Health Administration's (SAMHSA) Performance Accountability and Reporting System

The Center for Behavioral Health Statistics and Quality (CBHSQ) funds the the Substance Abuse and Mental Health Administration's (SAMHSA) Performance Accountability and Reporting System contract. SPARS will provide SAMHSA with a consolidated, centralized data resource to support Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) grant performance monitoring, program planning, and policy decisions.

SPARS will support SAMHSA's regulatory reporting requirements and house data and resources that can help grantees improve delivery of behavioral health services to their communities. The new system includes data entry, data download, data validation, reports, a technical assistance request system, a SPARS Training Site, and access to a host of system and programmatic online resources. A live help desk, training, and technical assistance services will also be available to assist grantees and project officers.

QUESTIONS ABOUT SPARS

For general questions, please contact SPARS toll-free at 855-322-2746 or SPARS-support@rti.org, or visit https://spars.samhsa.gov.

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Introduction

The purpose of this Guide is to provide insight on the application of a trauma-informed approach to the data collection interview that programs may consider integrating into their interview practices. The three primary goals are

1. To educate readers on the meaning of *trauma-informed* and other related frameworks of care, and how to build trusting relationships with people while gathering accurate information and avoiding retraumatization.

2. To provide guidance on how to schedule and conduct baseline, assessment, and discharge interviews with a trauma-informed approach.

3. To offer strategies to program administrators as they train staff to transition to a more trauma-informed, person-centered, and recovery-oriented organizational culture through adoption of a universal design.

The first chapter of this Guide provides a review of concepts and background related to trauma and behavioral health; trauma-informed, person-centered, and recovery-oriented frameworks of care; and grantee data collection requirements.

The next four chapters provide strategies and resources for interviewing and data collection using a trauma-informed approach, identifying and handling posttrauma responses from interviews, self-care for program staff, and supervising trauma-informed programs.

The Appendix lists resources for further reading on the topics of trauma-informed interviewing and data collection.

01 Trauma and Behavioral Health

"Trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual and perceived as physically and emotionally harmful or threatening, and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being.

—Concept of Trauma and Guidance for a Trauma-informed Approach, SAMHSA, 2014b

Lifetime exposure to potentially traumatic events is estimated to affect approximately 90 percent of the U.S. adult population (Kilpatrick et al., 2013). Potentially traumatic events include

- acute events, such as the unexpected loss of a loved one, accidents, catastrophic illness, or natural disasters;
- interpersonal trauma, such as rape, intimate partner violence, and stalking;
- community violence or military combat;
- insidious trauma, such as racism, sexism, heterosexism and homophobia, ageism, discrimination based on disability, and other forms of discrimination; and
- historical trauma, such as slavery and oppression of Native communities (American Psychiatric Association, 2013).

Whether these are singular occurrences or continue across long periods or even multiple generations, a traumatic *event* combined with the nature in which an individual *experiences* that event can potentially have ongoing detrimental *effects* on people's lives (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014b).

Research has demonstrated a connection between traumatic experiences in childhood and the incidence of increased physical and behavioral health issues in adulthood. The Adverse Childhood Experiences (ACE) Study, an ongoing research collaboration between Kaiser Permanente and the Centers for Disease Control and Prevention, is examining the associations between adverse events in childhood and well-being in later life. This research has demonstrated that as the number of adverse childhood experiences an individual reports increases, so too does the predicted severity and number of behavioral and physical health conditions in adult life (Felitti & Anda, 2010; Felitti et al., 1998). Numerous studies demonstrate that childhood trauma can be related to social, emotional, and cognitive impairment; health-risk behaviors; disease, disability, and social difficulties; and premature death (Dube, Cook, & Edwards, 2010; Irish, Kobayashi, & Delahanty, 2010; Neumann, Houskamp, Pollock, & Briere, 1996).

Some individuals who experience or witness a terrifying event may develop posttraumatic stress disorder (PTSD). Both adults and adolescents who live with PTSD are more likely to also have substance misuse histories. Studies have shown that in the general population, prevalence estimates of lifetime substance use conditions range from 21.6 percent to 43.0 percent among individuals with PTSD, compared to a range of 8.1 percent to 24.7 percent among individuals without PTSD. Rates of PTSD appear to be higher—up to 42.5 percent—among people receiving inpatient substance misuse treatment (Jacobson, Southwick, & Kosten, 2001).

Research has further demonstrated the bidirectional relationship between trauma and mental health or substance use conditions (Dube, Cook, & Edwards, 2010). Experiencing trauma increases the likelihood that a person will develop behavioral health conditions (Felitti et al., 1998), and living with behavioral health conditions increases a person's vulnerability to further trauma (Giaconia et al., 2000; Perkonigg, Kessler, Storz, & Wittchen, 2000). Additionally,

healthcare providers often lack basic understanding and training of the dynamics and long-term effects of trauma, which can lead to people experiencing trauma within the healthcare system. These failures may contribute to a variety of adverse outcomes, including impact on functioning, dissociation and other re-experiencing symptoms, difficulty with affect regulation, difficulty with attention and concentration, trouble establishing and maintaining healthy relationships, difficulty seeking and following through on treatment, causing the people seeking services to leave treatment (Cohen, 1994; Fisher, 1994; Moses, 2011; Paksarian et al., 2014; Richmond, Trujillo, Schmelzer, Phillips, & Davis, 1996). Additionally, some people bring histories of trauma that have occurred in behavioral healthcare settings, including seclusion and restraint. As a result, some people may be distrustful of service providers.

Given the high prevalence of exposure to traumatic events, it is likely that the majority of people using services funded by SAMHSA have been exposed to a traumatic event and many may experience PTSD. While the research cited above suggests various risk factors associated with trauma, many people are able to successfully recover from their experiences with proper support and protective factors (SAMHSA, 2014c).

RISK FACTORS are indicators that put a person at higher probability of poor outcomes. Risk factors for PTSD include

- Living through dangerous events and traumas
- Having a history of mental illness
- Getting hurt
- Seeing people hurt or killed
- Feeling horror, helplessness, or extreme fear
- Having little or no social support after the event
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home (Brewin, Andrews, & Valentine, 2000)

PROTECTIVE OR RESILIENCE FACTORS are qualities that help people cope with stress and develop optimally. Resilience factors that may reduce the risk of PTSD include

- Seeking out support from other people, such as friends and family
- Finding a support group after a traumatic event
- Feeling good about one's own actions in the face of danger
- Having a coping strategy, or a way of getting through the bad event, and learning from it
- Being able to act and respond effectively despite feeling fear (Charney, 2004)

No single risk or protective factor determines a person's ability to handle trauma. Rather, these factors bundle together so that in combination, they help a person thrive or struggle. To truly move toward healing and recovery, trauma survivors need services that recognize the whole person in context of their full life experience.

Trauma-informed, Person-centered, and Recovery-oriented Frameworks of Care

Over recent decades, three frameworks have emerged to improve the care offered to people seeking behavioral and physical health services. ***Trauma-informed, person-centered,*** and ***recovery-oriented care*** share common principles of a universal approach, but each brings a slightly different focus to our work.

The **TRAUMA-INFORMED APPROACH** emerged as research demonstrating that trauma is pervasive, particularly in the population of people using human services systems. Experiencing trauma affects how individuals access and use services, and practitioners frequently do not have an awareness of trauma and its effects on functioning.

The **PERSON-CENTERED CARE** movement traces its roots back to Florence Nightingale's revolutionary perspective on nursing, which trained nurses to treat the whole person rather than just the disease (Lauver et al., 2002). The central feature is the healing, collaborative relationship between the practitioner and the individual.

The rich histories of both the mental health and addiction recovery movements form the **RECOVERY-ORIENTED PRACTICE** framework. SAMHSA, working with leaders of these recovery communities, articulated a common ground definition for *recovery* as being "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012).

SAMHSA defines a trauma-informed approach as:

A strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

—Key Terms: Definitions, SAMHSA News, vol. 22, no. 2, 2014

SAMHSA defines person-centered care as:

Care that is based on the person's and/or family's self-identified hopes, aspirations, and goals, which build on the person's and/or family's own assets, interests, and strengths, and which is carried out collaboratively with a broadly defined recovery management team that includes formal care providers as well as others who support the person's or family's own recovery efforts and processes, such as employers, landlords, teachers, and neighbors.

—Glossary of Recovery Terms, SAMHSA's Recovery to Practice Resources for Behavioral Health Professionals, n.d.

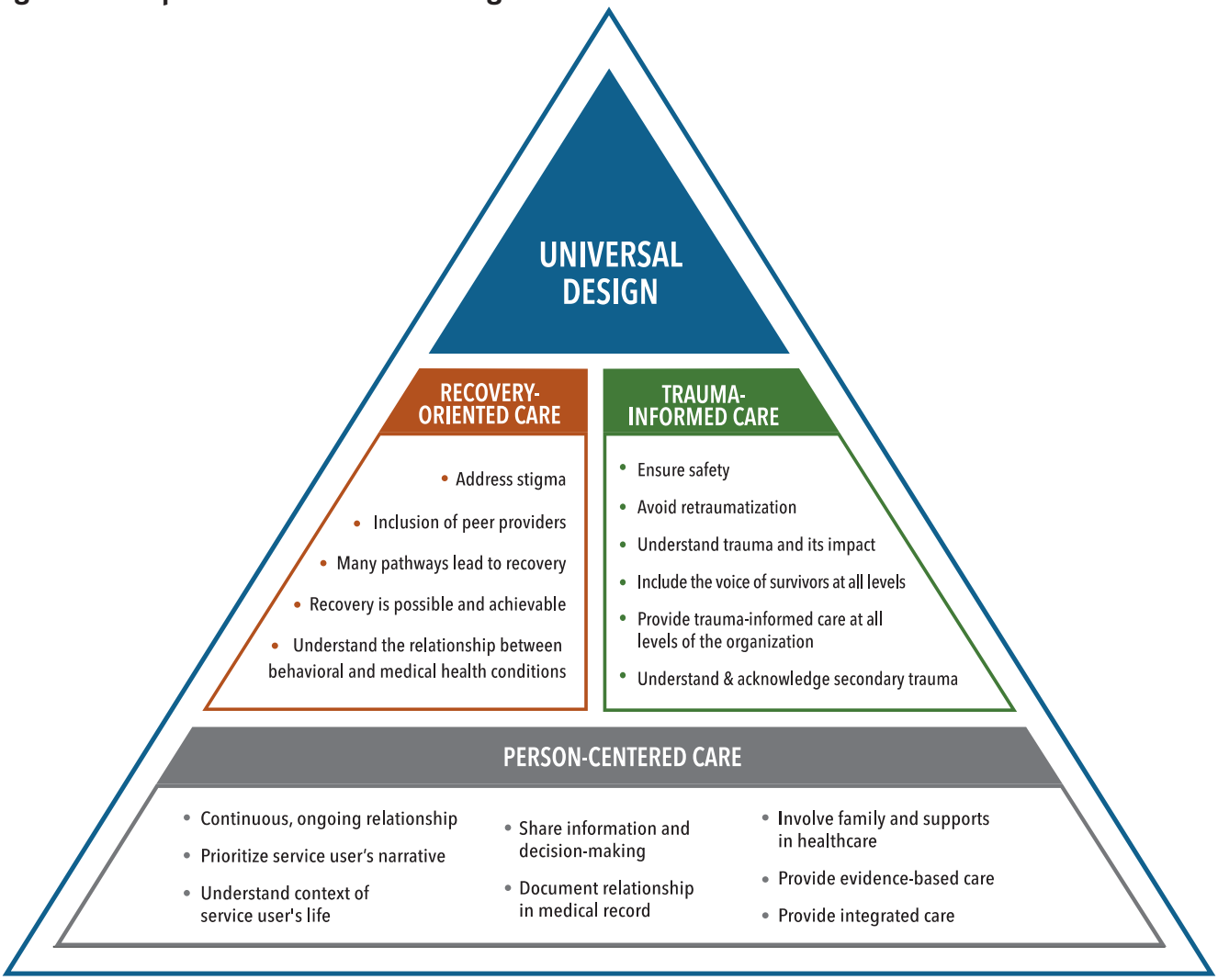
SAMHSA defines recovery-oriented practice as:

A practice oriented toward promoting and sustaining a person's recovery from a mental health and/or substance use condition. Connecticut Department of Mental Health and Addiction Services policy defines recovery-oriented practice as one that 'identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community.'

—Glossary of Recovery Terms, SAMHSA's Recovery to Practice Resources for Behavioral Health Professionals, n.d.

The graphic below integrates the principles of trauma-informed, person-centered, and recovery-oriented approaches into a universal design. Person-centered principles provide the foundation, while recovery-oriented and trauma-informed principles extend the framework to best meet the needs of most every individual seeking services, including those without behavioral health issues (Bassuk, Latta, Sember, & Raja, in press).

Figure 1: Components of Universal Design

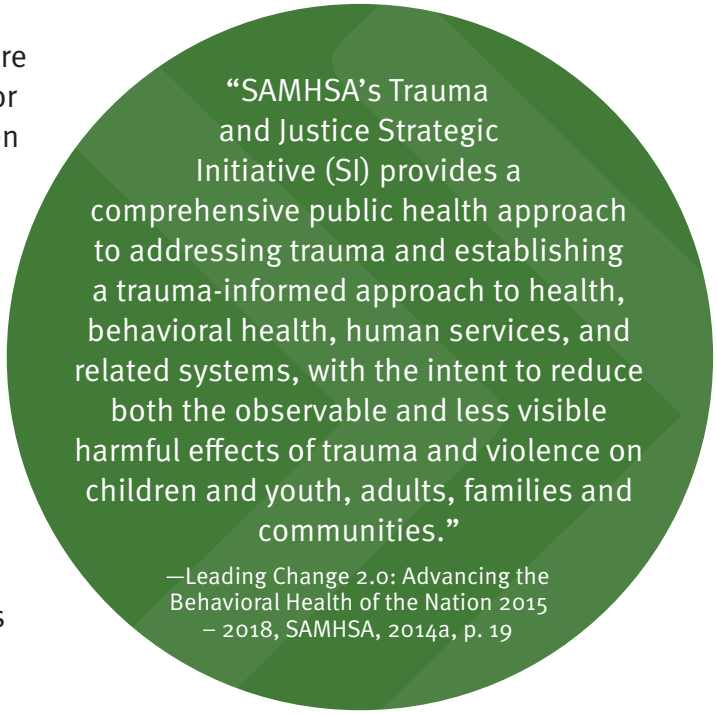


Reproduced with permission from Center for Social Innovation, 2015.

Because we cannot tell by looking at someone whether or not they have experienced trauma, or how trauma affects them, programs benefit from taking a universal approach to serving others.

Data-gathering interviews, though sometimes perceived as being outside the clinical treatment process, can both provide valuable information and have the potential to be retraumatizing (SAMHSA, 2014c). Retraumatization can occur when an environmental cue related to the original trauma triggers a psychological or physiological response, or when healthcare settings use coercive practices, such as seclusion and restraint, creating trauma on top of trauma (Jennings, 2009a).

For example, when a staff member does not assure that the person is feeling safe and comfortable, or insists that a person answer every question—even if he or she has asked to abstain—the person may experience trauma symptoms. However, when staff take time to explain what will be asked and give the person the time they need to answer, interviews provide an avenue for people with trauma histories to have a safe relationship. When staff members understand the wide range of trauma's effects and take care to apply universal design to the data collection process, they can minimize the potential of retraumatization, conduct more effective interviews, and improve outcomes (SAMHSA, 2014c).



Universal design acknowledges that program staff may also live with behavioral health conditions or the long-term effects of traumatic events. These personal experiences can influence how they work with those they serve. Additionally, organizations must pay close attention to the impact on practitioners of working with individuals who have experienced trauma. Understanding secondary traumatization and creating a culture that promotes self-care are essential to ensuring interviewers can best perform their jobs (Center for Social Innovation, 2015).

Grantee Data Collection Requirements

SAMHSA is committed to better understanding trauma and to integrating a trauma-informed approach across service centers. People who have histories of violence, addiction, mental health condition(s), or homelessness will benefit from services that integrate trauma-informed, person-centered, and recovery-oriented principles in practice.

Agencies receiving SAMHSA grants to provide treatment, prevention, or mental health services are typically required to collect data from individuals at specific intervals. Grantee data are necessary to inform program development, to determine and understand impact, and to meet reporting requirements used to assess accountability for the use of federal funds. Grantee staff use standardized instruments created by SAMHSA to conduct in-person interviews and record answers.

The questions in these data collection tools ask people to reveal highly personal information and report information about relationships and events, past and present. Answering these kinds of questions can be difficult—and sometimes retraumatizing—for individuals with trauma histories. Agencies should train interviewers to move through questions during data collection in a sensitive and timely manner, while collecting the most complete and accurate data possible.

02 Interviewing and Data Collection Using a Trauma-informed Approach

Establishing the Individual/Program Relationship

While it may appear to be simply questions on paper, the process of trauma-informed data collection is more intricate. Program staff members start building trust at the first outreach, before asking questions, in order to connect with people seeking services and help them choose to participate.

> *"Clients' motivations to change range from outright resistance to eager anticipation. An [Intensive Outpatient Treatment] program's intake process, from initial contacts through ongoing assessments and treatment planning, strongly influences whether clients complete admission procedures, select appropriate interventions, and engage in treatment."*
>
> *—Substance Abuse: Clinical Issues in Intensive Outpatient Treatment, Center for Substance Abuse Treatment, 2006*

The need for detailed assessment information must not interfere with, but should support the goal of admission activities. This includes engaging the individual in treatment, ameliorating immediate crises, and removing barriers to treatment (Center for Substance Abuse Treatment [CSAT], 2006). Assuring that all staff members who will be scheduling appointments or conducting interviews are well-trained in trauma-informed concepts will help establish a positive relationship between the person seeking services and the program, allowing data collection to go smoothly.

Data collection is not just about quantity of data or fulfilling a grant requirement. In the case of behavioral health programs, the quality of data collected directly affects people's lives and how that information is used. The overall goal is to collect accurate data while maintaining trust and engagement with participants, ensuring that they return for services and not drop out.

Scheduling Appointments

A trauma-informed intake interview process includes time before the appointment, the day of the appointment, and shortly after the appointment. When programs are able to schedule both morning and afternoon intake appointments, they are able to better accommodate the time constraints of those they serve. In addition, the daily schedule of interview appointments should build in flexibility. SAMHSA estimates that it takes 25 – 30 minutes to ask and record answers for all questions on the baseline intake interview, the longest, most intense of the data collection instruments. A trauma-informed approach to scheduling baseline interviews will allow at least 30 minutes per appointment plus an additional 15 – 20 minutes to allow for any extra time a person may need to respond or take breaks in order to continue the interview.

Your program's interview protocol should aim to demonstrate respect towards the individual, build rapport, and avoid activating new anxiety or past trauma. Rushing the interview process may leave the person feeling unheard, misunderstood, and unsupported. This may lead to decreased trust, which in turn can affect their willingness to share important details needed for data collection. To help manage multiple interviews throughout a day, schedulers can build in 15-minute breaks between interview appointments and additional trained staff members can take shifts for walk-in intake interviews, so that the agency does not turn away people seeking services or keep them waiting at length.

Confidentiality is a bedrock principle when people are sharing personal health histories. All people have a legal right to privacy of their health information, and individuals with trauma histories must remain in charge of their stories. Thus, when scheduling the interview, the staff member should explain that a typical interview is a confidential conversation between just the person and the interviewer. The interviewer explains what confidentiality means in this context, who may see the information gathered, how the agency protects data, and situations necessitating the agency breaking confidentiality. This conversation is key to building trust between the individual and interviewer and helps ensure the collection of accurate information during the interview.

Regardless of a person's trauma history, all clients are entitled to general accommodations to ensure the interview process works for them. Whenever possible, programs should seek to

provide language translation services, sign language interpreting and special transportation. Some people may request other trauma-informed accommodations, such as having a support person present during the interview, taking frequent breaks, or assuring that a staff person of a certain gender conducts the interview. The scheduler should ask each person whether he or she would like any accommodations and make those arrangements before the person's appointment. This process allows the person to make requests comfortably and not feel guilty about needing accommodation on the day of the interview.

Physical Environment

A person's first impression of an organization is vital to his or her engagement in services. As much as possible, conduct baseline, reassessment, and discharge interviews in a private, quiet, inviting, and comfortable physical space dedicated to the interview experience. Ensure that the individual has some control in the situation (access to drinking water, choice in seating arrangement, and the ability to take breaks with access to clean, preferably gender-neutral, bathrooms). If your program serves parents and families, have a dedicated children's space in the waiting area with activities and materials, such as books, games, arts and crafts supplies, or blocks. Laws may require programs to have a physical space that is accessible to individuals with disabilities.

The Interview

A key principle of trauma-informed care is to support control, choice, and autonomy (Moses, Reed, Mazelis, & D'Ambrosio, 2003). Data-gathering interviews provide a simple way to express and demonstrate this principle. Before beginning the interview, providing the person seeking services with enough information to make an informed decision about participation in the interview is critical.

The interviewer should let the interviewee know that:

- The providing agency and SAMHSA greatly appreciate their cooperation and willingness to share their personal information.
- Data collected provide critical information for policy and program planning, both locally and nationally.
- Information shared is confidential, except under the mandated limits to confidentiality (Donlon, 2012).
- Participants have the right not to answer any question.
- Participants may end the interview at any time or chose not to participate.

How your program prepares for and implements the actual intake interview will influence the person's experience of seeking and obtaining services, as well as the quality and completeness of the data collected. Programs will need an interview training protocol and a system for training existing staff members and new hires. As turnover in program staff can sometimes be high, it is imperative to institute a training plan that can be conducted multiple times annually, ensuring that new hires are trained before meeting alone with clients. Through training, staff will build confidence administering the data collection instrument in a simulated and controlled learning environment.

Time spent with the individual immediately preceding the interview provides an opportunity to establish a positive interpersonal dynamic where the interviewee feels safe and in control. During this time, the interviewer and individual become acquainted and the person settles into the physical environment. Baseline, reassessment, and discharge interviews each feature different sets of questions and varying amounts of time to complete. The staff member can explain how long the process may take and the types of questions there are, given the interview scheduled.

It is important to explain clearly that several of the questions may be difficult or upsetting. The person has the right to not respond to any question and can take a break at any time during the course of an interview. At this point, it may be helpful for the interviewer to inform the person of any internal and external resources available for them should they become upset by the interview experience.

Participants may have concerns about the confidentiality of their information. Interviewers should describe how the organization assures confidentiality of interview data as well as the limits of confidentiality, including information about who has access to the data and how the agency uses collected data (Donlon, 2012). The staff member should also describe the organization's policies and procedures for maintaining confidentiality, including instances when the interviewer must take the individual's personal information to the attention of a clinical supervisor.

Interviewers should use the FRAMES Strategy (Miller & Sanchez, 1994) to encourage client participation:

FEEDBACK: Provide feedback about the interview experience to help the person make an informed decision about whether or not to participate in the interview.

Example: "Information from this interview will be used to determine the services that will best meet your needs."

RESPONSIBILITY: Encourage the person to take responsibility for deciding to participate.

Example: "The interview process will support the continued improvement of our program's services and services like ours across the U.S."

ADVICE: Provide advice in a gentle, nondirective fashion.

Example: Introduce each transition in topic or section of the interview to help prepare the person for new types of questions. "Now I am going to ask you to talk about your employment status."

MENU OF OPTIONS: Provide a variety of options to support a safe and controlled environment optimal for a successful interview experience.

Example: Offer the person being interviewed multiple seating options in the interview location.

EMPATHY: Both verbally and nonverbally, show that you have an active interest in the individual's well-being.

Example: Maintain eye contact with the person during the introduction to the interview and throughout the interview experience.

SELF-EFFICACY: Provide positive reinforcement.

Example: "Your participation in this intake will help improve our program and others like it across the U.S."

SAMHSA provides a set of standard instructions for interviewers working in its grant programs. These standards help maximize consistency across interviewers and minimize variability in how interviewers administer the instrument and how interviewees understand the process. This level of standardization helps ensure the collection of complete and accurate data, which SAMHSA can aggregate and analyze appropriately at the individual, program, and population levels. Even with the prescribed mode, method, and content of administration, the interviewer's approach toward the person during the interview can significantly alter the level of completeness and accuracy of data collected.

By adopting a universal approach to data collection, trauma-informed staff will be educated about and aware of topics and the types of questions that may evoke a distress response from the individual. This may include questions related to interpersonal violence, combat trauma, gender identity, homelessness, poverty, substance use, or suicidality. Later in this Guide, we provide resources and links to websites related to these sensitive subjects and advice on recognizing and responding to posttrauma responses.

Conducting the Interview: SAMHSA's Interviewing Guidelines for Discretionary Programs Providing Direct Services

Interview Frequency:

- (CMHS Adult, Youth) Intake/Baseline, 6-month reassessment interviews (calculated as 180 calendar days), and discharge.
- (CSAT) Intake/Baseline, 3-month post-intake (for adolescent programs), 6-month reassessment interviews, and discharge.

Mode:

- You must conduct the interview in person, unless you obtain a waiver.
- If the person to be interviewed is a child or adolescent, you may interview either the child or the child's caregiver. Interviews of both individuals are not required. To avoid reporting issues, attempt to maintain consistency in reporter (child/adolescent or caregiver) across reassessment for the duration of treatment.

Reading the Questions:

- Introduce each new section of questions. For example, "Now I am going to ask you some questions about… "
- Do not read instructions written in ALL CAPITALS to the person.
- Read each question as written. Do not change the wording of the question.
- Read response categories.
- Do not read response categories that are in ALL CAPITALS to the person. If all response categories are in capitals, read the question as an open-ended question.
- If the person does not understand a question, use the question descriptions as written in the instrument's companion reference guide.
- The response category REFUSED is available for all questions that you will ask. Select this response if the person refuses to answer a question.

Consent:

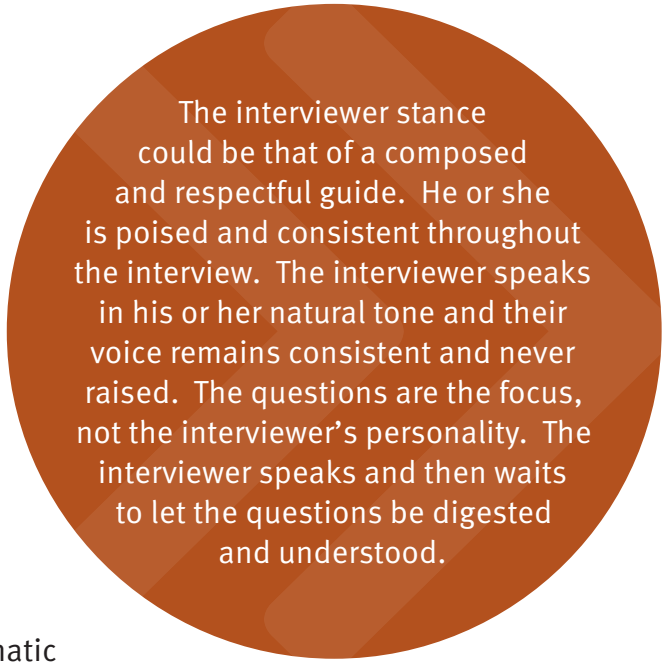
- If the person indicates that they do not want to participate in an interview, do not conduct the interview.
- Attempt to conduct any additional interviews scheduled within current or upcoming care episodes, even if there has been a previous refusal.

Adapted from *NOMs Client-level Measures for Discretionary Programs Providing Direct Services: Question-by-Question Instruction Guide for Adult Programs, Version 15 (CMHS, March 2014); NOMs Client-level Measures for Discretionary Programs Providing Direct Services: Question-by-Question Instruction Guide for Child Programs, Version 16 (CMHS, February 2014); and Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs Question-By-Question Instruction Guide, Version 9.7* (CSAT, August 2013).

For more information, refer to your Center's current data collection instrument or accompanying reference guide, or contact your GPO.

The Role of the Interviewer

The interviewer's stance and tone during the administration of the data collection instrument are essential to maintaining the safe, controlled physical and interpersonal space established before the interview began. Interviewers must be able to manage their own emotions during the interview process. Signs of high anxiety, frustration, fear, or anger can make the interviewee feel unsafe during the process. It is the interviewer's responsibility to manage his or her emotions during the interview, staying calm while displaying compassion when hearing difficult aspects of a person's story and responding rather than reacting to the person's behaviors during the interview.



In the event that the person becomes upset, the interviewer should attend to the person's immediate needs. Before the interview, an interviewer can ask the person directly what typically helps when he or she becomes overwhelmed with emotions. For example, some people may report that they like to take a break and go for a walk to calm down, while others may say they need to call a friend. Using person-specific calming techniques may help diffuse a situation (SAMHSA, 2014c).

If a person does become upset or reveals a traumatic experience during the course of the interview, it is not necessary—nor recommended—to probe for more information about trauma history at this point. Instead, the interviewer should stop, attend to the person's distress, and help him or her regain composure and a sense of safety before resuming.

As the interview ends, the staff member should check in with the individual to assess whether the interview experience has evoked any negative or emotional response that may require program support or a referral to other services. Always ask the individual if they would like follow-up or additional resources or information. It is also essential for interviewers to be mindful of their own reactions to each individual and interview. In Chapter 4, we provide suggestions for interviewer self-care.

03 Identifying and Handling Posttrauma Responses from Interviews

How Traumatic Responses May Be Activated

By definition, a traumatic experience overwhelms our normal coping mechanisms, sending our response to stress into overdrive. Our brains and bodies have evolved to detect signs of danger or threat and activate certain response systems to keep us safe from harm. When the brain detects a threat, it sets off an internal alarm to let us know that we are in danger. While our brains and bodies have learned to react quickly to these signs, the goal is to restore a sense of safety and equilibrium.

People who have experienced trauma can become very sensitive to signs of danger, real or perceived. Situations that make the person feel unsafe may trigger memories of extreme danger experienced in the past. When this occurs, the person experiences the fear, anxiety, and overwhelming feelings associated with the original trauma. In effect, the person triggered is not just remembering an event; they are reliving it.

Any stimulus that evokes a memory, emotional state, or behavior for an individual constitutes a trigger. Given the range of stimuli that can act as a trigger, it can be difficult for a staff member to predict or know exactly how a person will react. Common triggers include smells, sounds, sights, or touch, as well as seasons, time of year, or anniversaries. Physical spaces like a bathroom or a basement, hearing a siren or seeing emergency vehicles speed by, or hearing people arguing can be triggers and instantly cause a trauma survivor to feel helpless, hopeless, or terrified. For individuals who have suffered multiple layers of traumatic experiences, the data collection interview may introduce overt as well as less obvious triggers.

Given the complex dynamics at play among the interviewer (experience, history, current emotional and physical states), interviewee (experience, history, current emotional and physical states), physical environment, and data collection instrument, ***ANY*** question asked during an interview may be upsetting or trigger a traumatic response. It is important, therefore, for interviewers to approach the interview process in a trauma-informed manner rather than trying to determine which questions might be triggering.

Highly Sensitive Questions

In this section, we highlight several categories of questions that may have a greater likelihood to evoke negative memories or activate posttrauma responses.

Gender Identity

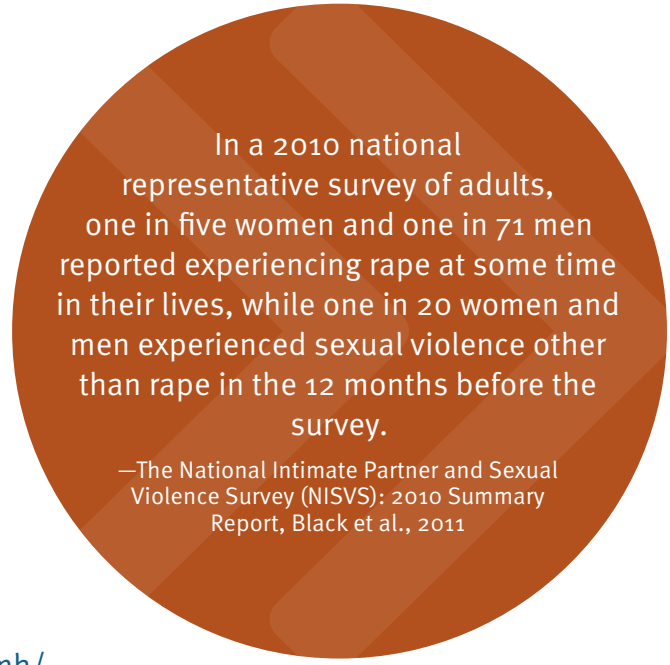
SAMHSA's tools for data collection do include an option for "other" or "different" gender identity, which does not fit neatly either male or female. However, people who do not identify as *male or female* exclusively have experienced a history of not being included among answer choices on most surveys they encounter. Additionally, some people may fear that an honest answer to this question will result in the agency treating them differently than it does others. They may worry about discrimination, fewer services, or substandard services.

For further reading:

- Center of Excellence for Transgender Health | University of California, San Francisco | http://transhealth.ucsf.edu/trans?page=lib-data-collection
- SAMHSA and the Health Resources and Services Administration compiled a list of professional training curricula to improve the LGBT population's health and well-being | http://www.samhsa.gov/behavioral-health-equity/lgbt/curricula

Sexual Orientation

Interview questions that seek to identify an individual's sexual orientation may be upsetting to people whose life experiences related to gender identity, sexual orientation, or sexual activity have been misunderstood or filled with conflict and discrimination. Family, friends, and communities may have ostracized them or generally made them feel excluded. As a result, these individuals may feel vulnerable and not want to risk being revealing, especially to a stranger.



For further reading:

- *Improving Data Collection for the LGBT Community* | http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=57
- *A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children* | http://store.samhsa.gov/shin/content/PEP14-LGBTKIDS/PEP14-LGBTKIDS.pdf

Sexual Activity

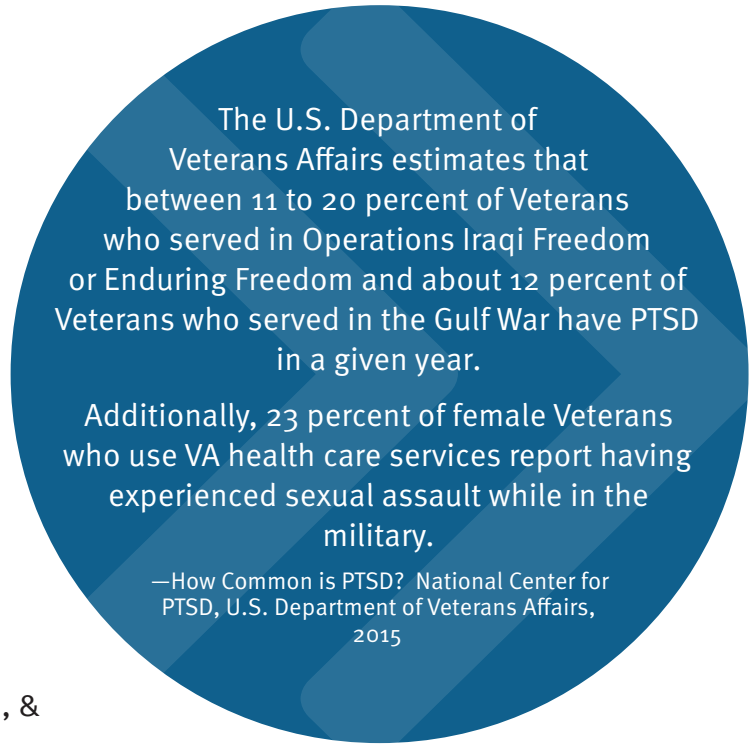
Questions related to an individual's sexual activity might bring up feelings of surprise, embarrassment, or confusion depending on the person's age, experience, background, and mistrust of the interviewer. If the person has experienced sexual trauma, these questions may be particularly triggering.

For further reading:

- Rape, Abuse & Incest National Network (RAINN) | https://rainn.org
- National Sexual Violence Resource Center | http://www.nsvrc.org

Military Experience

People who have served in the military may be hesitant or vague in response to questions about their service and, when applicable, combat experience. Individuals who have experienced, or have family members who have experienced, trauma while serving in the military, either during or outside of combat operations, may have posttrauma responses to inquiries about the trauma. Women veterans report high prevalence rates of sexual harassment, sexual assault, and intimate partner violence, so take particular care when interviewing women who have served in the military (Gerber, Iverson, Dichter, Klap, & Latta, 2014; Kimerling et al., 2010).



For further reading:

- U.S. Department of Veterans Affairs | http://www.mentalhealth.va.gov/msthome.asp
- SWAN Service Women's Action Network | http://servicewomen.org

Housing

People who are experiencing homelessness or have experienced near homelessness may have memories of traumatic experience. Further, the experience of homelessness is traumatic in and of itself, and it may have been the cause of many other losses.

For further reading:

- SAMHSA's Homelessness Resource Center | http://homeless.samhsa.gov/channel/trauma-29.aspx
- *America's Youngest Outcasts* documents the number of homeless children in every state, their well-being, their risk for child homelessness, and state-level planning and policy efforts | http://www.homelesschildrenamerica.org

Family

Questions related to the person's family situation have the potential to raise complex and potentially strong emotional reactions of shame, loss, guilt or grief. Even if questions do not ask explicitly about traumatic events, asking individuals about their family situations may bring up memories of childhood neglect or abuse, death of a parent/child/spouse/sibling, intimate partner violence or other difficult family situations. Experiencing interpersonal trauma in both childhood and adulthood is sadly common.

For further reading:

- Future Without Violence: http://www.futureswithoutviolence.org/resources-events/get-the-facts
- The National Domestic Violence Hotline: http://www.thehotline.org
- Open to Hope—Finding Hope After Loss: http://www.opentohope.com

Suicidality

Risk factors for suicide include existing serious mental health condition(s); alcohol and drug misuse; marital, family, or other interpersonal conflict; and a background involving abuse or violence. These factors may be present in almost all of the people you serve, so there is increased potential for suicidal thoughts or past attempts among this population. Interviewers should follow their organization's predetermined protocol in the case of reports of recent thoughts or attempts of suicide to determine if the person requires immediate referral to specialized suicide interventions.

For further reading:

- American Foundation for Suicide Prevention | https://www.afsp.org
- Suicide prevention resources from the National Institute of Mental Health | http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
- SAMHSA's suicide prevention resources | http://www.samhsa.gov/tribal-ttac/resources/suicide-prevention

Abuse and Trauma

Asking directly about the person's experience of violence is essential, but it can also be difficult for both interviewer and interviewee. Some individuals are able to discuss their experience; they have come to understand it as abuse and have begun to consider its long-term effects. Others have neither labeled the specific acts of violence as being *abuse* or *traumatic,* nor identified some of their behaviors as being coping mechanisms. Just hearing these questions can create turmoil within the trauma survivor, and putting new "labels" on experiences can be disconcerting.

It is important to understand that often these experiences are not in the past. The abuse may be current and very much in the present. In the case of intimate partner violence, it may not be safe for the person to disclose the abuse for fear the information may leak to the perpetrator. Within the context of abusive relationships, it is not uncommon for the violence to escalate when one partner decides to seek help or treatment. Thus, the interviewer must be cautious and not press a person to disclose if they do not feel safe doing so, but also find and offer appropriate referrals for the individual if they are concerned for a person's well-being.

Throughout this process, a well-trained, trauma-informed interviewer will stay present with the person for each question and response, attend to cues that the person is upset, and respond accordingly. Safety planning is essential if the person answers these questions positively. All individuals should leave the interview with a resource list that includes local and national hotlines for domestic and sexual violence services.

For further reading:

- The Trauma Center at Justice Resource Institute | http://www.traumacenter.org/about/about_landing.php
- National Center on Domestic Violence, Trauma & Mental Health | http://www.nationalcenterdvtraumamh.org/about
- The National Child Traumatic Stress Network | http://www.nctsn.org
- The National Domestic Violence Hotline | http://www.thehotline.org

Trauma in Childhood

- 1 in 6 children experience physical or emotional neglect (Stoltenborgh et al., 2013)
- 1 in 3 children experience physical abuse (CDC, 2014)
- 1 in 4 girls and 1 in 6 boys experience sexual abuse (CDC, 2014)

Trauma in Adulthood

- More than 1 in 3 women and 1 in 4 men report experiencing rape, physical violence, or stalking in their lifetime (Black et al., 2011)
- 1 in 3 women report experiencing multiple forms of violence in their lifetimes (Black et al., 2011)
- 1 in 5 women and 1 in 59 men are raped in their lifetime (Black et al., 2011)

Recognizing and Responding to Posttrauma Responses

After finishing an interview, it is important to bring the meeting with the interviewee to a conclusion, and watch for and document signs of possible posttrauma responses. The person may show nonverbal or verbal cues that he or she has been triggered, such as becoming visibly agitated or emotionally detaching or dissociating from the interview experience.

Another form of detachment or disconnection, called *dissociation,* can be mild or severe. Mild forms of dissociation occur everyday for all of us, such as when we are driving a car and become inattentive or distracted while continuing to function as if on autopilot. More severe forms of dissociation, often related to a history of early trauma, may include loss of time, forgetting who and where you are, and "spacing out" or "going blank." Triggers or traumatic stimuli often cause this kind of reaction.

These are potential signs of dissociation:

- Fixed or glazed eyes
- Crying
- Confusion
- Fast speech
- Sudden change of mood to low or no emotion
- Long periods of silence
- Monotonous voice

The staff member may help the person reconnect and regain control over his or her feelings by:

- Normalizing the person's feelings and experience by reminding him or her that it is not unusual for people to have strong feelings arise following this type of interview.

  "We have covered a lot of territory over the past hour. How are you doing right now?"

- Keeping the person involved and in command of what is next for him or her. Use grounding techniques, such as giving the person a glass of water, asking him or her to stand up, or asking basic questions about the present (Prince Edward Island Rape and Sexual Assault Centre, n.d.).

  "What else do you need today?"

  "Do you know what day it is?"

- Letting the individual know what the next steps will be for him or her with the program.

  "I will call you tomorrow to check in."

  "Your counselor, Luz, will be in touch on Monday. What's the best number to reach you?"

  "I know you'll be coming in for XYZ tomorrow. I'll be here between 2 and 3 p.m. Will you drop by my office and let me know how you are doing?"

- Inviting the person to reach out any time after the interview to talk.

  "If anything comes up from this interview or if you just want to check in, please call me at this number, 123-4567. You can leave a voicemail with a number where I can reach you, since during the day I am usually with other people using our services. I try to return calls between 11:30 a.m. and 12 noon and from 4 to 5 p.m."

- Being hopeful.

  "I really appreciate your participation here today. Thank you for taking the time and energy to go through this."

Whatever the appropriate next step response would be for your program, it is essential to document follow-through. A trauma-informed approach requires trustworthy communication and consistent, predictable actions to create a sense of safety. *"Do what you say and say what you'll do"* is the rule. The relationship between you and the individual should be collaborative and include a conversation about what is next, what your program will do, and what to expect.

This data-gathering interview is part of a series of integrated experiences at your agency. Once the interviewer deems the interview is complete and the person confirms that he or she is feeling OK, the interviewer can end the appointment with a "warm handoff," either internally within the program or to external referrals.

04 Self-care for Program Staff

You take yourself to work every day. It sounds obvious, but it is important to pay attention to what we *take with us* to work. We take our own experiences—our culture, beliefs, attitudes, biases, trauma—everywhere we go. Our own life experience determines how we hear and sense things, react to situations, and engage with the people we serve and coworkers. It is critical to be aware of our own feelings as we listen to the details of others' lives.

Working with people who have experienced trauma, listening to their life stories, and assisting them set and achieve goals can be tremendously rewarding. It can also take a toll on interviewers and their own well-being.

The terms *secondary trauma stress (STS), compassion fatigue, or vicarious traumatization* reference the result of working closely with people who have experienced trauma. Interviewers may have their own traumatic response through regular exposure to others' experiences. If interviewers have a history of trauma, their work may trigger past feelings and they may exhibit behaviors counterproductive to the people they serve. For instance, they may not want to ask

certain questions or hear interviewees' answers, or they may avoid following up with interviewees or think about stories they have heard when they do not want to (Simpson & Starkey, 2006).

Self-care is an essential component of working in a trauma-informed way. This includes paying attention to your own physical, emotional, and spiritual needs. Taking care of yourself is part of doing your job well. When you are out of balance, not only do you suffer, but also you may unintentionally cause further harm to those you are trying to help.

Developing self-awareness, having peer support and good supervision, and working in a trauma-informed organizational culture can help prevent or lessen the likelihood of counselors experiencing secondary traumatic stress. If a staff member begins to experience STS symptoms, however, he or she may need professional counseling to resolve the issue.

Here are strategies that interviewers can use—with the support and encouragement of supervisors and administrators—to prevent secondary traumatization:

- **PEER SUPPORT.** Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps staff members share the emotional distress of working with traumatized individuals.
- **SUPERVISION AND CONSULTATION.** Professional consultation will help staff conducting interviews to understand secondary traumatization, their risks, and protective factors that can help them prevent or lessen its impact.
- **TRAINING.** Ongoing professional training can improve staff members' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- **PERSONAL PSYCHOTHERAPY OR COUNSELING.** Engaging in personal therapy can help interviewers become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with people who have trauma histories.
- **MAINTAINING BALANCE IN ONE'S LIFE.** Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- **ENGAGING IN SPIRITUAL ACTIVITIES THAT PROVIDE MEANING AND PERSPECTIVE.** Connection to a spiritual community and spiritual practices, such as meditation or prayer, can help counselors gain a larger perspective of trauma and enhance resilience (SAMHSA, 2014c).

05 Supervising Trauma-Informed Programs

Fostering a More Trauma-informed Organizational Culture

Program administrators and clinical supervisors make it possible for staff members at all levels to maintain a trauma lens when working with people using services. Leaders must demonstrate their commitment to establishing and maintaining an environment that emphasizes a trauma-informed approach for both staff and the people using their agency's services. In many cases, administrators are managing existing treatment and recovery programs and will need to develop new expectations and protocols that change the culture of the system to reflect trauma-informed principles and practices. Although culture change can be slow, as leaders invest in training their staff, new ways of thinking take hold and begin to shift traditional models to being more trauma-informed.

SAMHSA recommends following these steps when creating a trauma-informed organization:

- Commit to creating a trauma-informed agency.
- Create an initial infrastructure to initiate, support, and guide changes.
- Involve key stakeholders, including people you serve who have histories of trauma.
- Assess whether and to what extent the organization's current policies, procedures, and operations either support trauma-informed care or interfere with the development of a trauma-informed approach.
- Develop an organizational plan to implement and support the delivery of trauma-informed care within the agency.
- Create collaborations between practitioners and people using services and among provider organizations and various community agencies.
- Put the organizational plan into action.
- Reassess the plan's implementation and its ability to meet the needs of the people you serve and to take a trauma-informed approach on an ongoing basis.
- Implement quality improvement measures as you identify needs and problem areas.
- Institute practices that support sustainability, such as ongoing training, clinical supervision, participation, and feedback from the individuals you serve, and resource allocation.

—Trauma-Informed Care in Behavioral Health Services, Treatment Improvement Protocol (TIP) #57, SAMHSA, 2014c

Program administrators can access assessment tools, such as the *Trauma-informed Organization Toolkit* or *TICOMETER*, to determine how current policies match trauma-informed principles and set goals for improvement. Revising interviewing procedures to be more trauma-informed is an ongoing process requiring careful planning, leadership buy-in and support, and an active feedback loop to support midcourse corrections.

That feedback loop must also include insights from the people you serve. To achieve trauma-informed competence in an organization or across systems, the people using services must play an active role in providing program feedback. This reinforces the message that collaboration between the program staff members and individuals using services is important, and that the people accessing services are valuable (SAMHSA, 2015).

Administrators must promote—rather than simply announce—the implementation of new, trauma-informed interviewing practices. Promotion includes educating staff about the rationale for trauma-informed services, offering opportunities for discussion and input from staff and those using services, providing training and resources to develop the workforce's interviewing skills (SAMHSA, 2014c), and participating in trainings to demonstrate true buy-in and leadership for the new way of working.

Training staff

To have a trauma-informed interviewing process, staff and their supervisors must share a common understanding of what it means to be trauma-informed. This applies to all staff regardless of role. Whether making appointments, greeting individuals seeking services, maintaining waiting areas, or conducting baseline, reassessment, and discharge interviews, all staff must operate from the same trauma-informed framework. Any interview training for staff should reflect SAMHSA's four key principles of a trauma-informed approach (National Center for Trauma-Informed Care, 2015):

1. **REALIZE** the widespread impact of trauma and understand potential paths for recovery;
2. **RECOGNIZE** the signs and symptoms of trauma in people using services, their families, staff, and others involved with the system;
3. **RESPOND** by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. **RESIST** retraumatization.

"[Employees] should receive orientation and basic education about the prevalence of trauma, and the impact of overwhelming adverse experiences in the lives of service recipients. They must also be educated about the of culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status on individuals' experiences and perceptions of trauma and their unique ways of coping or healing" (Jennings, 2009a, p. 110).

After an initial orientation, staff members who will conduct intakes need to strengthen their competency in SAMHSA's data collection tools and interviewing techniques. Training topics include

- Reviewing the types and order of questions on the instrument.
- Reviewing SAMHSA's Reference Guides so that staff understand the purpose and meaning of each question.
- Learning how to verbally administer the instrument during intakes, especially which answer choices to read aloud.
- Maintaining boundaries with the individual during the interview process, while remaining empathetic and building trust between interviewers and interviewees.

Interviewers must recognize the prevalence of trauma and its possible role in the lives of individuals using their organization's services. *"By being vigilant about the prevalence and potential consequences of traumatic events among clients, you can then tailor your style, approach, and strategies from the outset to plan for and be responsive to their specific needs. Although not every client has a history of trauma, it is important to know that those who have substance use and mental disorders are more likely to have experienced trauma"* (SAMHSA, 2015).

Supervisors should foster a sense of safety for staff and people using services by anticipating environmental stimuli that may generate strong emotions and reactions in trauma survivors. They should also implement and teach strategies to help individuals cope with triggers that evoke their traumatic experiences during interviews. *"Creating safety is about how consistently and forthrightly you handle situations with clients when circumstances provoke feelings of being vulnerable or unsafe. Honest and compassionate communication that conveys a sense of handling the situation together generates safety"* (SAMHSA, 2015). To help set training objectives with the goal of increasing knowledge on a range of skills, see the Trauma-informed Counselor Competencies Checklist, exhibit 2.2-3 (SAMHSA, 2014c).

Current staff members may find the trauma-informed practices inconsistent with what they have done previously. Using new protocols may require unlearning past practices and learning new ways of working. This can be disconcerting and even distressful, especially for adult learners with many years of experience. Staff may appear to be resistant as a way of managing their discomfort about learning a new way of doing things. Supervisors need to be sensitive and provide ongoing support and supervision as they go through this process.

Supervisors will want to improve staff competencies over time using a series of trainings to reinforce material. Staff who conduct interviews need regularly scheduled supervision with managers to avoid burnout and the possibility of secondary trauma (SAMHSA, 2015). In trauma-informed supervision, supervisors are attentive to issues of self-care and check in regularly with staff to assess how they are doing and what they might need.

Supervisory staff are the lynchpin of the implementation process and, as such, need training and self-care resources in order to provide optimal trauma-informed supervision and support for staff. Supervisors should continually seek out new and relevant training in trauma-informed practices and access their own self-care and support resources. Examples include regularly attending webinars and conferences, establishing peer support groups for supervisors in the organization, and having regular check-in meetings with their own supervisors or mentors. A supervisor's process of training, support, and self-care is parallel and complementary to his or her staff's processes; when supervisors feel supported, they are more equipped to support the staff, which allows the staff to better support the client.

Supervising staff

On an ongoing basis, program administrators will want to be keen observers in waiting areas and around interviewing rooms. While staff may fully understand and embrace the trauma-informed concept, they may revert to old patterns of working with people until fully mastering the new skills. Reverting to old patterns can also happen when schedules are overloaded, caseloads are high, and staff members are unable to focus on the nuances of trauma-informed care that make the difference. Supervisors will observe, record, and work with staff on continuous improvement. They will serve as teachers and guides, helping staff to reflect on their own reactions to the individuals they serve and their feelings about the data collection process. Supervisors also need to be prepared to support staff members when they need clinical intervention post-interview.

Staff core competencies

Training existing staff on trauma-informed interviewing principles will help educate and prepare them to provide better service. When supervisors recruit new staff members, they should seek competencies and work history that include

- Past experience implementing screening and assessment tests with similar clientele
- Ability to recognize client reactions that suggest feelings of trauma
- Ability to respect how people seeking services cope and manage their lives
- Recognizing when a person may need clinical intervention beyond the scope of the interviewer's capabilities
- Educational background related to psychology, sociology, social work, counseling
- Work experience with target populations
- Counseling or direct care experience with individuals who have mental health or substance use conditions
- Cultural backgrounds reflective of the population seeking services
- Lived experience

For further reading on supervising trauma-informed programs, see "An Implementation Guide for Behavioral Health Program Administrators," which is part 2 of SAMHSA's *Trauma-informed Care in Behavioral Health Services,* TIP Series 57, 2014c.

Appendix A: Resources for Further Study

- *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach:* http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf
- SAMHSA's *Quick Guide for Clinicians Based on TIP 57: Trauma-Informed Care in Behavioral Health Services*: http://store.samhsa.gov/product/Quick-Guide-for-Clinicians-Based-on-TIP-57/All-New-Products/SMA15-4912
- SAMHSA's *TIP 57: Trauma-Informed Care in Behavioral Health Services:* http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816
- *The Trauma-Informed Organizational Toolkit for Homeless Services:* http://www.familyhomelessness.org/media/90.pdf
- The National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint: http://www.samhsa.gov/nctic
- Trauma-Informed Care Assessment Tool: http://us.thinkt3.com/ticometer
- TICOMETER: http://us.thinkt3.com/ticometer
- Community Connections Creating Cultures of Trauma-Informed Care (CCIT) model: http://www.communityconnectionsdc.org/web/page/673/interior.html
- The Sanctuary Model: http://andruscc.org/?page_id=836
- Maine's *System of Care Trauma-Informed Agency Assessment* for child serving agencies: http://thriveinitiative.org/wp-content/uploads/2012/10/TIAA-General-User-Overview-Manual.pdf
- The National Council for Behavioral Health's *Organizational Self-Assessment*: http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare
- The Chadwick Center's *Trauma System Readiness Tool* for child welfare agencies: http://surveygizmolibrary.s3.amazonaws.com/library/113599/TraumaSystemReadinessTool2.pdf
- The National Center on Family Homelessness's *Trauma-Informed Organizational Self-Assessment,* adapted for homeless service settings, agencies who serve women veterans, and community-based programs: http://www.familyhomelessness.org

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