Guide to Trauma-Informed Organizational Development

Acknowledgements

The THRIVE Initiative wishes to acknowledge the work of trauma-informed pioneers without which this guide and transformational work would not be possible. This information is derived from the works of Roger Fallot, PhD and Maxine Harris, Ph.D. of Community Connections[i], the National Center on Family Homelessness's Trauma-Informed Organizational Toolkit[ii], the Connecticut Women's Consortium[iii] . THRIVE family, youth and stakeholders have also provided invaluable insight to ensure that the guide is family driven and youth guided.

The Guide to Trauma-Informed Organizational Development is designed to help agencies develop strategies to create and enhance trauma-informed system of care service approaches. It is not all inclusive, nor is it intended to be a "one size fits all" approach to becoming trauma-informed. The intent is to provide agencies with information on the options and approaches currently available in the children's mental health field on trauma-informed service delivery.

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Stages of Implementation

Becoming a trauma-informed agency means making a commitment to changing the practices, policies, and culture of an entire organization. This type of change requires that staff at all levels and in all roles modify what they do based on an understanding of the impact of trauma and the specific needs of trauma survivors. This process takes time and requires that an agency understand the stages of change and how to identify its own strengths and challenges. This process varies from agency to agency and requires both adaptive and technical solutions. One training will not result in an agency becoming trauma-informed.

The following are suggested implementation steps:

Steps may look different depending on whether your agency has completed the Trauma-Informed Agency Assessment (TIAA) which is now a Maine state requirement for agencies contracting with Children's Behavioral Health Services. If your agency was not required to complete this assessment or you were unable to complete the assessment you will have an additional step to complete.

Step 1: The program or agency identifies a person or a group of people who have the desire to assist their organization in becoming trauma-informed. This group is known as the "trauma-informed change team".

At least one of these people is in a position of authority to make system wide changes in the program. These are the "champions for change" in your organization and should represent a variety of roles/disciplines in your agency. It is recommended that administrators, direct care staff, support staff and human resources staff be represented on this team and that the team not exceed 10 individuals. These individuals will review the results of the Trauma-Informed Agency Assessment (TIAA) if the agency participated in the completion of the assessment. For agencies that did not complete the TIAA, it is recommended that you still form a team that can assist your organization with identifying strategies to complete the assessment.

Important Tips to Consider:

- It is helpful to have more than one leader identified as a champion for change so that it is not the responsibility of one individual to make change happen.
- Leaders must have the authority to make change happen and should be given the time in their work life to devote to the change process.
- This is not a "clinical only" process. Successful change happens when human resources and operations is included in the discussion. Examples for team members: Human resource director, clinical manager, direct care staff, manager of records, reception supervisor, maintenance staff….
- Families, youth, and adult consumers (if applicable to your agency) should be included in this discussion as an advisory group or as members of the team. Please note that if families and youth are asked to join the team that the team first look at how the team can be youth and family friendly, i.e. time of meeting, clinical jargon, power imbalance. Consulting with a family or youth organization may be helpful. (See resource guide for contact information for Youth MOVE Maine and G.E.A.R.)

- Consider naming this group the "trauma-informed change team" rather than a workgroup, and establish clear deliverables and timelines based on the results of the TIAA. If your agency did not complete the TIAA consider the steps you would undertake to complete the assessment and create a training plan to support the organization.
- Work with a trauma-informed consultant(s) to assist in the development of a strategic plan, discussion of sustainability of trauma-informed learnings, and brainstorming ways to effectively partner with youth and families throughout the process.
- Remind each other of the stages of change and that people may be at different stages at any one time.
    - **Pre-contemplation** is the stage at which there is no intention to change behavior in the foreseeable future. Many individuals in this state are unaware or under aware of problems.
    - **Contemplation** is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action.
    - **Preparation** is the stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action.
    - **Action** is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.
    - **Maintenance** is the stage in which people work to prevent going back to the status quo and consolidate the gains attained during action.

Step 2: Announce the agency's commitment to become trauma-informed to all staff and initiate the Continuous Quality Improvement (CQI) Plan.

The "trauma-informed change team" can begin to prioritize training needs for the organization and use the *Prioritization Matrix.* This matrix can be used with the TIAA results. For agencies who did not complete the TIAA the priority matrix may still be used to determine who and when to assess. This will start the CQI process with follow up steps to further define CQI areas.

In addition to starting the CQI process it is important that the agency director(s) communicate the value of becoming trauma-informed and prepare staff to understand their role in training, education, policy and practice changes**.** This sets the stage for the work that the "trauma-informed change team" will undertake.

Important Tips to consider:

- Make the announcement public in an agency newsletter, e-mail blast, agency wide staff meetings.
- Determine interest that staff have and consider how staff can provide input to the change team.
- Be prepared for staff who express doubts or are in the "pre-contemplation" stage.
- Be transparent about the process and have this be an ongoing conversation, not a "one time" conversation!

Step 3: Staff training.

Program leaders arrange for a consultant(s) with expertise in trauma-informed systems change to provide training on:

- General trauma theory.
- The impact of trauma on families and youth, including behavior and relationship.
- An overview of trauma-informed principles and domains.
- The effects of trauma work on staff including an overview of vicarious trauma or secondary traumatic stress.
- Practical strategies organizations can use to infuse youth guided, family driven, and culturally and linguistically competent principles in daily practice.

Some organizations choose to call this a kickoff as a way to introduce staff to the agencies' commitment to becoming trauma-informed. A general training in the form of a webinar is helpful with more in depth training offered at a later date to sustain trauma-informed learnings and make policy and procedural changes.

Options to consider:

- Participation in a THRIVE introductory webinar
- Foundational face to face one day training
- Participation in a THRIVE sponsored 6 month learning collaborative which will provide for face to face learning, monthly consultation calls, webinars and co-learning. The learning collaborative will prepare these change team members to sustain the trauma-informed trainings in their own organizations and create a continuous quality improvement plan.

Step 3A: Complete the TIAA (for agencies who did not complete it)

Agencies that did not complete the TIAA can now do so. The previous steps have been opportunities to discuss how to support staff and consumers in the completion of the assessment. Challenges to completing the TIAA have been discussed with solutions offered by the "trauma-informed change team" who will take the lead on ensuring that the TIAA is completed.

Step 4: Policy and Practice Change

After receiving formal training in trauma and trauma-informed care, the change team will assess how the agency can create policy and practice changes. For agencies that did not complete the assessment it is recommended that the assessment be completed at this time. Identify the incentives or "hooks" that will keep staff invested in the process such as: safety, secondary trauma and improved treatment outcomes.

Important Tip to consider:

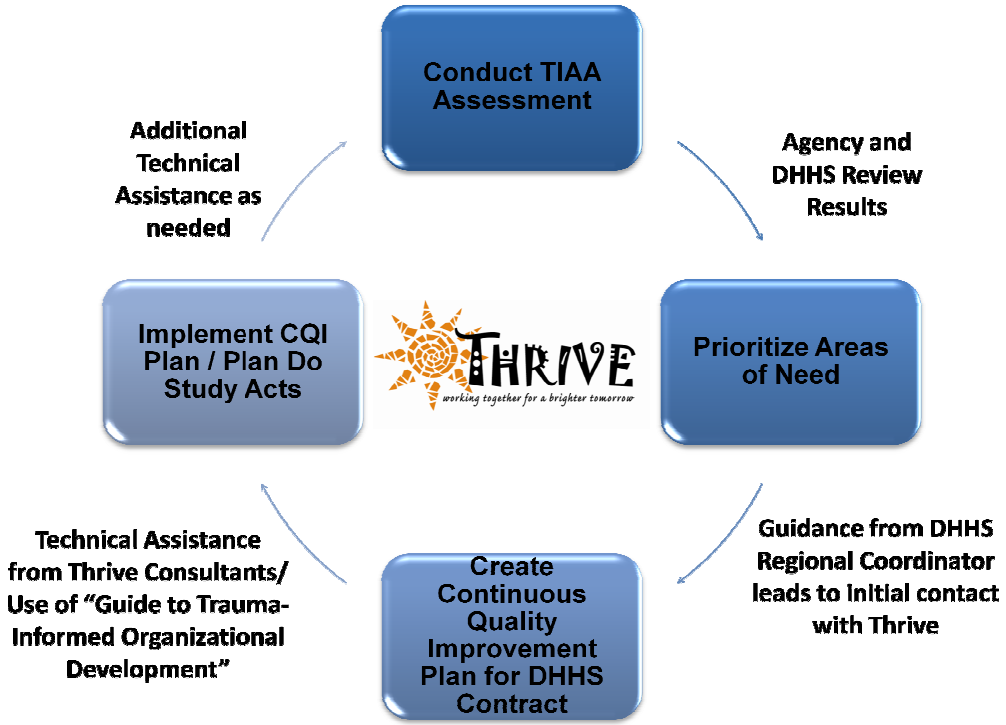
- COMMUNICATE! Create a communication plan that keeps everyone informed including youth and family consumers, i.e. newsletters, flyers posted in waiting areas, e-blast.

Step 5: Collect data, both formal and informal.

Consider collecting information on staff retention, client satisfaction, "no show" rates, community perception of agency and other factors that would enhance how the agency functions. As programs begin to achieve their initial goals and modify their strategic plans it is helpful to brainstorm ways to document the impact that this type of change is having in the program, specifically family and youth feedback and outcomes. Such documentation can justify the use of additional resources to sustain this work. This information becomes part of the agency's continuous quality improvement (CQI) plan.

***Trauma-Informed is a process not a destination*.**

Continuous Quality Improvement



Questions to consider when creating an action plan:

1. What do we want to change (Goals)?
2. Why did we choose this goal?
3. What steps will we need to take to meet these goals?
4. Who will be responsible?
5. When do we want to accomplish these objectives?
6. How will we know that we have accomplished our objectives?

Prioritization Matrix

		Changeability: High	Changeability: Low
Importance	High	*Example: We have youth on an advisory board who are eager to work on a task (changeability). We also scored lower on youth engagement and know that if youth aren't engaged in services outcomes will reflect this (importance).*	
	Low		

*__Changeability__ – Do we have the capacity (**resources** and **readiness**) to make this change?

*__Importance__ – How much will this impact/affect **the issue in our agency**?

Trauma-Informed Domains

The questions of the Trauma-Informed Agency Assessment are grouped by the Domains of Trauma-Informed Service Provision as is this Guide.

I. Domain: Safety – Ensuring Physical and Emotional Safety

Because trauma inherently involves a physical or emotional threat to one's sense of self, survivors are often especially attuned to signals of possible danger. It is essential then, that service organizations prioritize safety as a guiding principle in order to become more hospitable for trauma survivors and to avoid inadvertently re-traumatizing people who come for services.

Key Question	Best Practice Standards
1.1 SPACE To what extent do the program's activities and settings ensure the physical and emotional safety of youth, family and staff? How can services be modified to ensure this safety more effectively and consistently? • Where are services delivered? • When are they delivered? • Who is present? ✓ Other consumers? ✓ Security personnel? • What impact does the presence of others have? • Are doors locked or open? • Are there easily accessible exits? • How would you describe the reception and waiting area, interview rooms? Are they comfortable and inviting? • Are restrooms easily accessible? • What about services that are delivered at the family's home or out in the community? • Are there others in the home that prevent the youth and family from feeling safe?	**1.1 SPACE** ☐ Agency displays map of space showing exits, restrooms, parking, offices. ☐ Rooms are labeled. ☐ All areas are well-lit, i.e. parking lot, hallways. ☐ Alternative meeting spaces are offered to consumers if they have safety concerns about their home environment. ☐ Privacy in the home is established to maintain caregiver/child boundaries.

1.2 PRIVACY Is there adequate personal space for individual consumers? • Do youth and families, understand HIPPA requirements? • Are "Right of Recipients" explained to youth and families?	**1.2 PRIVACY** ☐ Information is secure from unauthorized disclosure (answering machine, waiting room, discussion with other staff). ☐ Individual enjoys space without intervention of another person if desired. ☐ Treatment areas are private. ☐ Agency provides full disclosure when privacy cannot be protected and reason given about why it can't be protected.
1.3 SAFETY Safety Plans: • Do all youth have a safety plan? • Are the safety plans trauma-informed? • Are there standardized forms with family and youth friendly language?	**1.3 SAFETY** ☐ Safety plan includes: o youth and family preferences; o community supports; o strategies that minimize potential re-traumatization such as coercive hospitalization; o discussion of key components of plan (if you do X, Y will occur); o discussion of how plan will be shared and with whom.

II. Domain: Youth and Family Empowerment, Choice, and Collaboration

A trauma-informed approach does not need to be an expensive, complicated process; it only needs to be one that is shaped by an understanding of the impact of trauma. Behavioral health and medical services have come from a historical position of expert superiority. Prioritizing consumer choice can challenge agencies and practitioners to view families and youth as experts in their own care.

Key Question	Best Practice Standards
2.1 Maximizing Choice and Collaboration **2.1a Youth and young adult choice and collaboration** • To what extent do the program's activities and settings maximize youth/young adult experiences of choice and collaboration? • Do youth/young adults have a clear and appropriate understanding of their rights and responsibilities? • How can services be modified to maximize youth/young adult experiences of choice and collaboration? **2.1b Caregiver and family choice and collaboration** • To what extent do the program's activities and settings maximize caregiver and/or family members' experience of choice and collaboration? • Do caregivers and family members get a clear and appropriate message about their rights and responsibilities? • How can services be modified to ensure that caregiver and family experiences of choice and collaboration are maximized?	**2.1 Maximizing Choice and Collaboration** **2.1a and 2.1b** ☐ Written policy, procedure, and practice supports consistency in communication with youth and families, including: • agency mission • eligibility criteria • service/treatment practices • program expectations • clarity of tasks • maintaining personal and professional boundaries • when/how services will be terminated; • limitations to confidentiality (e.g. mandated reporting) • potential risks/benefits • goals of the treatment • limitations of the treatment
2.2 Information Sharing Within the Agency Is information shared in a way that protects youth, young adult, caregiver, and family member privacy?	**2.2 Information Sharing Within the Agency** ☐ Family consent and youth assent are solicited prior to information sharing. ☐ Forms or policies are in place that govern the way information is shared within the agency and programs.

2.3 Information Sharing Across Agencies • Does the youth/young adult have a choice about which pieces of information are shared? • Does the caregiver or family member have a choice about which pieces of information are shared?	**2.3 Information Sharing Across Agencies** Agency policy and practice promote: ☐ Reduced repetition by accepting information from other agencies. ☐ Guidelines for staff as to what information to share and accept. ☐ Interagency exchange with enough detail to avoid repetition of traumatic events. ☐ Interagency exchange with enough detail to provide a proper understanding of the role of trauma.
2.4 Maximizing Collaboration, Sharing Power, and Recognition of Service Preferences • To what extent do the program's activities and settings maximize collaboration and sharing of power between staff, youth and families? • How can services be modified to ensure that collaboration and power-sharing are maximized? • How much choice does each youth/young adult have over what services he or she receives? • Does youth/young adult choice include being able to decide on when, where and by whom the service is provided (e.g. time of day or week, office vs. home vs. other locale, gender of provider)? • Does the youth or family choose how contact is made (by phone, mail, to home or other address)? • Does the program build in small choices (i.e. When would you like me to call? Is this the best number for you? Is there some other way you would like me to reach you or would you prefer to get in touch with me)? • How much say does the youth/young adult have over starting and stopping services (both overall service involvement and specific service times and dates)? • How much control does the caregiver or family have over starting and stopping services (both overall service involvement and specific service	**2.4 Maximizing Collaboration, Sharing Power, and Recognition of Service Preferences** Policy, procedure and practice support: ☐ Informing youth and families about different kinds of agencies and services that are available. ☐ Informing youth and families about different kinds of treatment approaches. ☐ Informing youth and families about medication options and their effects. ☐ Asking youth and families about their preferences. ☐ Permitting choices to extend to using other agencies. ☐ Requiring service plans to reflect consumer preferences. ☐ Informing youth and family of changes to their case management and reasons for them in timely fashion. ☐ Considering youth and family preferences in selecting new providers. ☐ Efforts to make appropriate match with new

times and dates)? • Are youth/young adult and caregiver/family informed about the choices and options available? • Are services contingent on participation in other services? • Do youth or families get the message that they have to "prove" themselves in order to "earn" other services? • Are there negative or arbitrary consequences for exercising particular choices? • How is the youth/young adult, or family/caregiver informed of staff changes?	provider. ☐ Preparing new staff to take over (sharing case files etc). ☐ Sensitivity to the potential for re-traumatization due to the loss of a trusting relationship.
2.5 Youth and Family Involvement • In service planning are youth preferences given substantial weight? • Are youth/young adults involved as frequently as feasible in service planning meetings? • Are their priorities elicited and validated in formulating the plan? • Does the program cultivate a model of doing "with" rather than "to" or "for" consumers? • Do the program and its providers communicate a conviction that the youth is the ultimate expert on her or his own experience? • Do providers identify tasks on which families and youth can work simultaneously, i.e. information-gathering?	**2.5 Youth and Family Involvement** Policy, procedure, and practice support: ☐ Meaningful family and youth involvement in goal setting. ☐ Conflict resolution strategies that are respectful of all parties if family and youth goals are in conflict. ☐ Parent and youth choice in who else is involved in goal setting. ☐ Youth and families in monitoring the progress and effectiveness of their own case plan and treatment. ☐ Community advisory boards made up of 51% youth and families.
2.6 Incident/Grievance Reporting • Is there a policy in place to allow for grievances and incidents to be reported? • Does staff understand that trauma survivors may adopt maladaptive coping	**2.6 Incident/Grievance Reporting** ☐ Reporting an incident is easy. ☐ Staff are aware of the process for reporting an incident.

mechanisms as a way of dealing with the impact of trauma on their lives? These coping strategies/mechanisms may be viewed as non-compliance/resistance by untrained staff. Does staff view with a "trauma-informed" lens client resistance/reluctance? • Are the actions that lead up to an incident report viewed and reviewed through a trauma-informed lens? • Does the agency include youth and families in the review and follow-up/settlement of incidents?	☐ Youth and family are informed of process. ☐ Family anonymity is granted if requested. ☐ Agency provides quick turnaround response and provides appropriate follow-up. ☐ Process involves family and youth. ☐ Finding/reasoning is clearly stated and provided to person(s) filing report. ☐ Grievance policy and "Rights and Responsibilities" are explained verbally and are written in a format that is easy to understand by both youth and family members. ☐ Agency identifies individuals trained in policy to be point persons to help navigate grievance process. ☐ Grievances are reviewed by agency staff, "trauma champions" and youth and family members.

III. Domain: Trauma Competence **Trauma Competencies are specific to agency staff knowledge, skills and abilities. These competencies support the provision of treatment to youth and families and support a trauma-informed agency environment.**	
Key Question	**Best Practice Standards**

3.1 Trauma Competencies as part of professional expectations of all staff
 	
Does the hiring process include identified competencies that are tied to job functions and evaluated in job performance?
 	
• Identifying these competencies at hiring ensures that potential employees who are trauma informed are able to demonstrate this knowledge.
• This also demonstrates that the agency is committed to hiring trauma informed individuals across all disciplines.
• The agency reinforces this commitment by having this competency identified in personnel policies and employee performance evaluations.
	3.1 Trauma Competencies as part of professional expectations of all staff
	
	☐ Hiring process includes questions about trauma:
	  • How it manifests in youth, adults, caregiver
	  • How organizations can (re) traumatize
	☐ Employee evaluation takes into account employee's receptiveness to trauma training and efforts to increase knowledge of trauma.

3.2 Trauma training for all staff To what extent have staff members received appropriate training in trauma and its implications for their work?	**3.2 Trauma training for all staff** ☐ Trauma training is available for all staff including non-service staff (i.e. frontline, maintenance…) on at least a yearly basis. ☐ Training includes impact of trauma, how to avoid re-traumatizating in everyday interactions, and recognizing unsafe situations. ☐ Training includes self care for staff and the effects of trauma on staff. ☐ Staff members have received education in a trauma-informed understanding of unusual or difficult behaviors. (One of the emphases in such training is on respect for people's coping attempts and avoiding a rush to negative

	judgments.) ☐ Staff members have received basic education in the maintenance of personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment). ☐ Clinical staff members have received trauma education involving specific modifications for trauma survivors in their content area (e.g. clinical, residential, case management, substance abuse treatment). ☐ Direct service staff receives training on how to screen and assess for trauma. This training addresses staff reluctance to ask the difficult questions.
3.3 Available evidence-informed trauma treatments To what extent are evidence-informed trauma treatment modalities available? • A trauma-informed agency recognizes that trauma specific treatments are effective for certain populations and demonstrates a commitment to offering these treatments or collaborating with agencies who can offer these treatments. • A trauma-informed agency also reviews existing treatment practices to ensure that they are not coercive, punitive or exclude family and youth voice.	**3.3 Available evidence-informed trauma treatments** ☐ Agency uses or has access to at least two trauma specific evidence-informed practices, e.g.Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Child Parent Psychotherapy (CPP), Trauma Systems Therapy (TST), Trauma Recovery and Empowerment Model (TREM), Cognitive Behavioral Intervention for Trauma in Schools (CBITS) . These treatments and others are identified on the National Child Traumatic Stress Network Site, www.nctsn.org. ☐ Referrals to other agencies for trauma specific treatment are made when appropriate. ☐ All service staff, youth, and families are familiar with available evidence-informed practices. ☐ Clinical staff members have received training in trauma-specific treatment models. ☐ Staff members offering trauma-specific services are provided adequate support via supervision and /or consultation including the topics of vicarious trauma and clinical self-care

3.4 Supports for Staff and their Families To what extent does the agency provide support to employees working with consumers who have experienced trauma? • Trauma-informed agencies understand the "effects of working with trauma", including the risk of experiencing vicarious traumatization. • These agencies make every effort to support employees and their families when the effects of working with trauma are manifested in the lives of employees.	**3.4 Supports for Staff and their Families** ☐ Agency provides any of the following supports to staff to assist them with the effects of agency trauma work: • Employee assistance program • Stress reduction techniques are taught • Regular weekly supervision provided • On call debriefing available • Recreation or wellness activities offered as a benefit (gym membership, nutrition counseling) • Variety of job responsibilities and the ability to shift client load so that not all staff work is "trauma related"
3.5 Observable Staff Sensitivity to Trauma To what extent does the agency monitor staff sensitivity and responses to consumers who have experienced trauma? • Staff sensitivity is often impaired when staff are experiencing the effects of working with trauma. Staff can become frustrated with the families and youth who seek services and can begin to label, or blame. A trauma-informed agency recognizes that these behaviors are often the by-product of "trauma work". Unfortunately, some of these behaviors can also be culturally destructive and display a negative bias towards families, youth and those struggling with mental health issues. It is important that such staff behaviors be addressed with staff education, high quality supervision and clear expectations that are tied to staff performance.	**3.5 Observable Staff Sensitivity to Trauma** ☐ Staff are respectful and avoid judgment of families in difficult situations. ☐ Staff recognize that "resistance" is related to trust and avoid using punitive or labeling language when addressing how families and youth engage in services. ☐ Staff ask permission before they approach a person, engage in conversation or make physical contact. ☐ Staff use this same "non-judgmental" approach with their peers and co-workers. ☐ Staff self-reflect with supervisors and peers about challenges they experience working with trauma.

IV. Domain: Trustworthiness

A trustworthy organization is one that demonstrates appropriate boundaries, task clarity, clear and consistent policies and reasonable expectations for providers, families, and youth. Survivors of trauma report a violation of boundaries resulting in a justified inability to trust others; especially those in power and authority. The trauma-informed organization recognizes how trust has been violated and seeks to earn trust.

Key Question	Best Practice Standards
4.1 Boundaries • To what extent are expectations and boundaries clearly communicated to consumers of services? • How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately?	**4.1 Boundaries** ☐ Information is provided to youth and family members about the nature of treatment and services with a clear explanation about boundaries and expectations of the provider, family and youth. ☐ Staff are provided with regular training and supervision on boundaries.
4.2 Informed Consent To what extent are family consent and youth assent clearly communicated? • Family consent and youth assent are understood as not just paperwork requirements but valuable aspects of treatment in order to establish trust. • Because youth cannot legally consent to treatment and to ensure that minors have been advised of their rights.	**4.2 Informed Consent** ☐ Each program provides clear information about what will be done, by whom, when, why, under what circumstances, at what cost, and with what goals. ☐ There is a policy and an understanding that informed consent has limitations for youth under the age of 18 and those limitations are discussed with youth so that they may give assent to treatment. ☐ The goals, risks, and benefits are clearly outlined and youth and family have a genuine choice to withhold consent or give partial consent. The provider is also able to distinguish between consent vs. assent.

4.3 Recognition of Power Dynamic To what extent are power dynamics between providers and consumers acknowledged? Power Dynamics exist between providers, youth, and family members: • When, if at all, do boundaries veer from those of the respectful professional? • Are there pulls toward more friendly (personal information sharing, touching, exchanging home numbers, contact outside professional appointments, loaning money, etc) and less professional contact in this setting? • Does all staff (not just clinical staff) receive training on ethics, boundaries, and expected behavior? • Does the agency have clear policies and expectations that establish parameters for self disclosure? • Are youth forced to self disclose and are they given the option to answer questions at a later time? • Are there clear parameters established to govern how expected or unexpected contact outside of the professional role are to be handled? • Are alleged violations of boundaries taken seriously and investigated thoroughly?	**4.3 Recognition of Power Dynamic** Policy, procedure, and practice support: ☐ Recognition of the power dynamic of the service provider over the consumer, particularly those with trauma history. ☐ A clear definition of professional boundaries that all employees are expected to uphold. ☐ Setting consequences with staff for failure to maintain proper boundaries. ☐ Training and supervision for service providers which addresses the power differences inherent in families and with their youth. ☐ Training and supervision on appropriate incorporation of the "youth voice" throughout the course of treatment.

V. Domain: Commitment to Trauma-informed Philosophy **Agencies committed to a trauma-informed philosophy support and promote a trauma-informed agenda that includes the creation of policies and procedures to address trauma, inclusion of trauma-informed language in mission statement, use of resources for training, review of screening and assessment tools to include traum,a and trauma informed leadership in the community.**	
Key Question	**Best Practice Standards**
5.1 Policies To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges?	**5.1 Policies** ☐ Policies regarding confidentiality and access to information are clear, provide adequate protection for the privacy of youth, and are communicated to the family. ☐ The program avoids involuntary or potentially coercive aspects of treatment—involuntary hospitalization or medication, representative payee ship, whenever possible. ☐ The program has developed a de-escalation or "code blue" policy that minimizes the possibility of re-traumatization. ☐ The program has developed ways to respect youth and family preferences in responding to crises—via "advance directives" or formal statements of youth and caregiver choice. ☐ The program has a clearly written, easily accessible statement of youth and family rights and grievance procedures.
5.2 Trauma Screening and Assessment To what extent do programs have a consistent screening process to identify individuals who have been exposed to trauma? • Screening is a brief tool administered right away. This tool does not necessarily need to be administered by a clinician but should be administered by someone with training on how to screen for trauma.	**5.2 Trauma Screening and Assessment** ☐ Staff members have reviewed existing instruments to see the range of possible trauma screening tools and assessments and/or include trauma questions in existing tools. ☐ Screening avoids over-complication and unnecessary detail so as to minimize stress for youth, and/or caregivers. ☐ The program recognizes that the process of trauma screening is usually much more important than the content of the

To what extent do programs use trauma-specific assessment tools to inform service planning? • A trauma assessment is administered by a clinical service provider for the purpose of gathering specific information about events identified in the initial screening. This assessment would include a diagnosis and a risk assessment.	questions. The following have been considered: • What will it mean to ask these questions? • How can they be addressed most appropriately—for the youth, for the service context, for the time available, and considering any prior or potential future relationships? ☐ The need for standardization of screening across sites is balanced with the unique needs of each program or setting. ☐ The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or assessment process, there is often a good rationale for returning to the questions after some appropriate time interval. ☐ Training is made available to all staff who would administer a trauma screening tool or trauma assessment. Elements of the training would include tips on addressing staff reluctance to ask questions, stigma associated with asking the questions, staff becoming triggered by trauma material, and risk assessments.
5.3 Trauma-Informed Development Plan To what extent does the program support the integration of knowledge about violence and abuse into all program practices?	**5.3 Trauma-Informed Development Plan** Includes: ☐ Agency policy that incorporates language and values to the importance of trauma and the need to account for consumer experiences of trauma in service delivery. ☐ The existence of a "trauma initiative" (e.g., workgroup, trauma specialist). ☐ A chief administrator who meets periodically with trauma workgroup or specialists. ☐ Administrator supports the recommendations of the trauma workgroup or specialists and follows through on these plans. ☐ Administrators and staff working closely with a "Consumer Advisory" group. It is recommended that consumer advisory

	group have subgroups that be broken up into family, youth and adult (if the agency provides adult services). Distinguishing the groups by their "consumer roles" acknowledges the unique needs of each of these groups. ☐ Administrators and staff who are willing to attend trauma training themselves (vs. sending designees in their places). ☐ Administrators and staff who make basic resources available in support of trauma-informed service modifications and trauma training(e.g., time, space, training money). ☐ Administrators and staff who support the availability and accessibility of trauma-specific services where appropriate; they are willing to be creative about finding alternative reimbursement strategies for trauma services. ☐ Administrators and staff who monitor the program's progress by identifying and tracking core objectives of the trauma-informed change process.
5.4 Agency Practices Sensitivity to Trauma in Crisis Situations To what extent does the agency recognize that crisis situations can be traumatizing to staff, families and youth?	**5.4 Agency Practices Sensitivity to Trauma in Crisis Situations** ☐ Agency has written policies and or procedures designed to minimize retraumatization when the potential for the use of coercive or disruptive practices are used: • Involuntary hospitalization • Use of physical restraints • Residential placement • Contacting police or emergency medical personnel in an agency ☐ All staff are familiar with these policies and review them on a regular basis. ☐ Community providers, such as the police, are also made aware of these policies and understand how to respond to a crisis at this agency. ☐ Staff, youth and families are provided with an opportunity to debrief within a reasonable amount of time should one of these practices be used.

5.5 Agency Demonstrates Trauma-Informed Leadership in the Community To what extent does the agency model trauma-informed principles in the community?	**5.5 Agency Demonstrates Trauma Informed Leadership in the Community** ☐ Agency representative(s) belongs to a community collaborative and actively promotes the adoption of trauma informed principles among other service providers. ☐ Agency Board of Directors are trauma-informed champions who champion the principles in their own organizations and the community. ☐ Agency actively collaborates with other trauma informed agencies to promote state and local policies that are trauma informed.

VI. Domain: Language Access and Cultural Competence

The extent to which policies, procedures, staff, services and treatment are sensitive to family and youth culture, traditions, beliefs and language/communication preferences. The agency's policies and procedures acknowledge that client behaviors and responses to trauma are influenced by culture.

Key Question	Best Practice Standards
6.1 Cultural Competence To what extent are agency administrators and program staff aware of culture and the importance of incorporating this awareness in daily practice and organizational operations? Cultural competence requires that organizations: • Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally. • Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve. • Incorporate the above in all aspects of policy making, administration, practice, and service delivery. • Systematically involve consumers, key stakeholders and community members. Cultural competence is a developmental process that evolves over an extended period. (adapted from Cross et al., 1989)	**6.1 Cultural Competence** ☐ Cultural Organizational Assessments are administered on a regular basis. ☐ There is a cultural and linguistic competency strategic plan in place created by staff, youth, and families from diverse backgrounds. ☐ Agency conducts a regular needs assessment of the community that incorporates demographics which impact care, i.e. socio-economic status, race and ethnicity, sexual orientation. ☐ Treatments are reviewed and adapted for cultural population. ☐ Staff, youth, and families are provided with orientations and trainings on culture. ☐ Hiring and performance plans weigh cultural awareness and willingness to learn as standards. ☐ Staff conduct values exercises and review cultural considerations in supervision. ☐ Funds are allocated to trainings that enhance cultural awareness and sensitivity. ☐ Agency space reflects and incorporates different cultural perspectives through artwork, diverse reading material, etc.. ☐ Mental Health and stigma is understood through different cultural lenses. ☐ Staff recognize the unique trauma issues specific to different populations i.e., refugees, immigrants, GLBTQI, homeless youth/families

	and others. ☐ Staff recognize that resilience is inherent in the cultural experiences of many and empower youth and families to guide their own treatment as experts. ☐ Provider culture is valued by agency administrators through Human Resource policies and practices that are sensitive to religious/cultural holidays, "non-traditional" health and wellness activities, employee assistance programs to address vicarious trauma, etc.. ☐ Internal audits, satisfaction assessments and outcome-based evaluations reflect the cultural and linguistic competency measures as outlined by the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. ☐ Agency ensures that data on race, ethnicity, and spoken and written language are collected and integrated into the organization's management information system.
6.2 Linguistic Access To what extent are youth and family provided with language access? Linguistic Competency: The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. Goode & Jones (modified 2009). National Center for Cultural Competence,	**6.2 Linguistic Access** ☐ There are written policies and procedures on interpretation and translation services. ☐ Training on these language access policies and procedures are offered on a quarterly basis to all staff; i.e. use of language interpretation phone line. ☐ There are visible signs displayed in agency areas that indicate the availability of interpreter services in a variety of languages spoken in the community. ☐ Agencies have TTDY or other comparable technology and have staff knowledgeable regarding use.

Georgetown University Center for Child & Human Development.	☐ Funding is in place to ensure that youth and family have timely language access at no cost to them; i.e. agencies contract with interpretation services for phone and in person interpretation. ☐ Agencies must ensure the competence and quality of language assistance provided by interpreters and bilingual staff. ☐ Youth and families are provided with supportive education about the use of professional interpreters versus the use of family and friends as interpreters to ensure that youth and family choice is respected. ☐ Written materials are translated and available to all and easily understood in youth and family friendly language. ☐ Staff are available to read the material and discuss with families and youth without making assumptions about literacy.
6.3 Diversity To what extent is diversity valued and supported in the agency structure?	**6.3 Diversity** ☐ Memorandas Of Understanding (MOUs) are in place with ethnic self-help organizations and family and youth organizations to offer consultation and peer to peer support that is culturally relevant. ☐ There is active recruitment, hiring and support of staff and board members to reflect diversity of youth and families. ☐ Use of cultural brokers in service. ☐ Collaboration with community members, businesses, faith-based organizations, indigenous healers, and others reflect cultural diversity and

	sensitivity. ☐ Human resources implements strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are represent the demographic characteristics of the service area. ☐ Conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by agency staff and community members.

This information is derived from the works of Roger Fallot, PhD and Maxine Harris, Ph.D., the National Center on Family Homelessness's Trauma-Informed Organizational Toolkit, the Connecticut Women's Consortium[iv] and the family, youth and stakeholders of the THRIVE Initiative, Maine.

[1] *Fallot, R.D. M. Harris, M. (2009). Creating Cultures of Trauma–Informed Care: A Self-Assessment and Planning Protocol. Community Connections, Washington, DC.*

[2] *Guarino, K., Soares, P., Konnath, K., Clervil, R., and Bussuk, E. (2009). Trauma-Informed Organizational Toolkit. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation*

[3] *The Connecticut Women's Consortium, 2321 Whitney Ave., Hamden, CT 0651*

Youth and Family Perspectives

The following reflections were gathered by youth and families currently involved with THRIVE, Youth MOVE Maine and Gaining Empowerment Allows Results Parent Network (G.E.A.R.), Maine's chapter of the National Federation of Families for Children's Mental Health. Youth and families were asked to share how the current "traditional" system is or was experienced by them in the areas of safety, collaboration, choice, empowerment, trustworthiness and cultural and linguistic competency. They were then asked to imagine what a "trauma-informed" system might look and feel like. These reflections are written in their voices in the hope that agencies and organizations will hear them and incorporate these reflections in their daily practices.

Safety:

Current System	Trauma-Informed System
YOUTH: • Group (unisex) Bathrooms are unclearly marked. • I don't have family and friends to talk to about being gay. • I don't feel safe saying that I'm in a relationship. Afraid I will be called names. FAMILY: • Staff do not have training on how to keep themselves and the families safe. A staff hit my daughter. • I hear thinks like "the state will wash their hands of you" which feels angry and threatening. • I live in unsafe housing and am threatened by neighbors. When I tell my team about this they don't take me seriously or appear not to care and don't address it in my team meeting. • The language in my plan sounds threatening: "you must or you will…."	YOUTH: • Clearly marked single occupancy bathrooms. • Not sharing consumer information without permission. • There are low barrier programs for youth, i.e."safe house". • Available Homeless Teen shelters. • Having a phone, even if it only calls 911. FAMILY: • Provide staff and families training on de-escalation. • Be aware of how your statements impact me. They are scary and I'm already scared enough as it is. • Take me seriously and make this a priority by helping me find safe housing. • Use family friendly language. "Jane will receive help or will make an effort to…." Ask how I want to word this.

Family and Youth Empowerment, Choice, and Collaboration:

Current System	Trauma-Informed System
YOUTH: • Youth do not get to pick who they get to see for providers. • When adults collaborate with other adults they often use what one provider says against the youth, or tells them "we are gonna tell so and so!" • They often say they will not tell people certain things I don't want shared but then they do and I get in trouble • I see my doctor and he just talks "to me" & tells me about all my problems. • It's great to have team meetings but at the same time I feel like I can't trust providers there because they target me. • My wraparound team did not get along. • System is punitive. I really don't have choice. • With my probation officer I had no choice what my probation activities looked like. • I did not have a choice of who I wanted to see for a provider, male/female young/old etc.. • Threatened to be court ordered to be put in the psych hospital. • I feel forced to do the stuff my provider asks. I have no choice. • My provider just lists the goals they want the person to work on. • I don't always have choice on who is collaborating for me in my meetings. Other people pick who comes.	YOUTH: • I have a say in who I work with for providers. • Therapist and medication management talking regularly to make sure my treatment is working well for me. • In meetings adults should look at youth accomplishments and strengths not just focus on the struggles and mistakes. • Doctors should "talk with" me so it is more of a conversation. That would lead to better results • People in my family working together and not fighting • Assets based I have choices (positive youth development). • To choose which programs we WANT to participate in. • Having other options other than being forced into the hospital. Hospital can set you back. • Let people choose and don't make them do what you (provider/system) want them to do. • Case managers could be creative with how they show us our goals such as a spread sheet or a graph so that I understand it better (more visual). • Should be able to choose what family you want to be with (foster situation). • People in my life asking me for my opinion

• Didn't have choice about whether or not my parents would fight. • I feel as if I am always talked "to" not "with". • I get punished or penalized if I don't stick with the plan. • Not having accessible group therapy. • Not a lot for me to really contribute to outside of my appointment. • I don't get to talk to others who are like me. • I didn't have a choice to stand up for myself because he was stronger and more powerful than me.	• I like to be a part of the conversation and talked with. • Focus more on my strengths and the good things I have going. • Having an opportunity to connect with others in similar situations. • Empower me to be an artist and use my talents. • Have youth peer partners. • Feel that I am strong.
FAMILY: • Providers not having the proper information for my child, i.e. IEP copies. • Each person working for the family has a different goal for the family. • Every time a new staff starts working with my son we have to re-explain our story. • Provider picks team members that they prefer to work with regardless of how the family feels about those people. • ISP shows up in the mail with a note that says, "please sign and return" • At a family team meeting a parent is given a list of things to do in 2 weeks and mom feels like she can't say no even though she doesn't think she can complete all the tasks because she is afraid of what the team might do.	FAMILY: • Providers take the time to get the proper information about my child and family. • Let's work on agreeing to work on goals instead of creating different ones. • New staff actually read charts before seeing my son. • Family gets to decide who is on the team. • Schedule meetings with family to develop plans that are family driven and youth guided. Family understands the IEP and has a provider discuss this with them. • Team or a trusted provider checks in with the mom to see if the tasks are doable. Team acknowledges that they can be seen as powerful and that mom may have a hard time disagreeing with them out of fear.

• Parent is upset at a meeting and leaves. Team continues to discuss the family even though the family is no longer present. • DHHS tells the family support partner that they are still going to terminate parental rights even though that mom is working her plan to get her children back. • Child's evaluation recommends residential treatment but parent disagrees with team. Team not listening to parent's concern and invites consultant to team meeting without mom's permission in order to convince mom. • Decisions are made about and for the family without their input. • Lack or no choice for youth in their treatment or in their home. • My daughter didn't have a choice as to who she would work with. • Family doesn't get to decide who participates in family treatment. • System has a "zero tolerance" policy that doesn't take into account why someone is still using or celebrate small successes if that person's use is decreasing. • Being told that even though I work and go to school and can't fit my visit into the group home schedule that it's my fault. • Staff does everything for families. • There are no opportunities for me to be involved in the organization and offer my opinion. • Some workers don't empower the family. • Parent and family are "systemized" and expect providers to fulfill all their needs. Family has been involved with the system for years.	• When family leaves a team meeting the team ends the meeting and does not continue to discuss the family. • DHHS worker is positive and works on strength based approaches to support this mom and offers encouragement to the mom and to the family support partner. • Team hears mom's concerns, brainstorms other ideas and doesn't invite consultant without mom's permission. • Family gets to provide input. • Family decides who attends what treatment sessions. • If system has a "zero tolerance" policy they at least ask why someone is struggling to meet that goal and figure out how to help or at least acknowledge that the person is trying. • I'm praised for working and going to school and the group home accommodates my schedule. • Skill building training to develop family voice that is effective. • Staff gives families the knowledge and skills to do things for themselves. • Recognize that families have skills that can be used. • Providers can assist families to make connections to services and supports over time slowly allowing families to do this on their own.

Trustworthiness:

Current System	Trauma-Informed System
YOUTH: • Agency giving out information to others that the youth does not want to share. • Feeling targeted. • I could not be honest with my counselor for the things I really wanted to be honest about because everything was being reported back to my drug court case manager. • Don't have much time to get to know a provider for who they are in order to build trust and know how they can help me. • I often feel ignored by my providers. I try talking about what is important to me and they change the subject to something that they feel needs to be discussed. I shut down after that. • Not knowing who I can trust to "come out" to (sexuality). • Not having trusting relationships with caregivers. • Assumptions are made before meeting the youth. FAMILY: • Mental Health system does not always value parent input. • Staff make rude comments and embarrass family and youth. • Provider says: "I'll have it tomorrow". Tomorrow comes and it's not done. Family feels failure and unable to believe people when they say they are going to do something.	YOUTH: • Feeling supported by my providers. • Get to know each other a few times prior to getting into the hard stuff. • Explain my confidentiality right in advance so I can understand them and know what will be shared and to whom. • Gain trust by having adults keep their word and know that it takes time. • Having people that like me for me. FAMILY: • Mental health system realizes that parents know their child better than they do. • Listen to parents and youth respectfully. • Follow through on what you say you are going to do and if you can't take responsibility and explain why.

• Family is afraid to go to family team meetings because they don't trust providers. • Some tasks given to me aren't clear. • "I haven't seen my children in two weeks and my next visit will be cancelled because my worker is sick". • I don't know what is happening. Feels like no one is talking to me.	• Family discusses fear and helps to create the agenda so they feel in control. • Be clear with tasks and instructions. Don't assume I understand or know what you mean. • Follow through with appointments and if you can't make it have a backup plan so that the family doesn't suffer. • Worker updates me on progress and returns calls promptly.

Cultural Competency and Language Access:

Current System	**Trauma-Informed System**
YOUTH: • I can't always understand the people at the front desk when I go into DHHS. • They talk above me so it's hard to follow what they are saying. • Not able to have materials needed for my religious holidays, and rituals in my group home setting. Others can have a cross or a bible. • Gender boxes on forms must fit into male and female. • Focus on the problem and not who I am and they don't ask.	YOUTH: • People working with me talk in a way I can understand and follow. • People don't talk down to me because I'm young. This doesn't mean I don't get it • Options of food choices at residential placements that meet my needs (religious, vegetarian or vegan). • Allow me to be ambiguous about my gender. • Someone to talk to that looks like me and speaks my language.

FAMILY: • Paperwork is handed to a family assuming they can read and understand it. • I have a learning disability and don't understand the documents. • Don't assume that my definition of health care is the same as yours. • Why are they not fair to me? Is it because of the way I look or the way I talk? • Youth is transgendered and doesn't want to wear clothes that are female gender specific but there is a rule that says she must wear a blouse and skirt. • Providers who don't have children provide "expert" parenting advice and it upsets me because they are not in my shoes. • Group home rules are different than my home rules, i.e. child receives money to purchase a luxury item that at home she wouldn't be able to do because of lack of money.	FAMILY: • There are interpreters and translators for people who need them. • Providers take the time to explain paperwork and don't make assumptions about what I understand. • Health care providers need to ask and listen to me about my preferences and beliefs. • I'm treated like everyone else regardless of how I look and talk. I feel accepted and hopeful. • Youth is allowed to wear clothes that makes the youth feel comfortable and able to participate. • Provider is honest about not having firsthand knowledge about parenting a child with special needs as opposed to taking on an expert role. • Group home asks family and youth about their culture and their rules and incorporates these preferences as much as possible.

Technical Assistance Resources for Trauma-Informed Services

National Resources:

1. Adverse Childhood Experiences Study
   http://www.acestudy.org/

   Primary focus is to share the findings of the Adverse Childhood Experiences Study, in a format readily accessible to both professionals, and the lay community. A free, electronic, quarterly publication, ACE Reporter, about the findings of the Study is available on line.

2. The Association of Child & Youth Care Practice, Inc.
   http://www.acycp.org/index.htm

   Promotion and development of child and youth care professional competencies and code of ethics.

3. Building Refugee Youth and Children Services
   http://www.brycs.org/

   Bridging Refugee Youth and Children's Services (BRYCS) provides national technical assistance to organizations serving refugees and immigrants so that all newcomer children and youth can reach their potential.

4. Child Trauma Institute
   http://www.childtrauma.com/

   This site includes parent information, trauma measures, publications, training programs & links. The Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults.

5. Child Welfare League of America
   www.cwla.org

   Trainings and resources available on site.

6. Children's Mental Health Initiative – Digital Library
   www.cmhi-library.org

Information on Collaboration, cultural and linguistic competence, family involvement, recruitment and retention, youth involvement.

7. Georgetown Center for Trauma and the Community
   http://ctc.georgetown.edu/

   Focus on how to deliver low-cost mental health interventions that are effective in primary care and social service settings with low-income clients.

8. Georgetown University Center for Child and Human Development
   http://gucchd.georgetown.edu/index.html

   National Center for Cultural Competence, National Technical Assistance Center for Children's Mental Health, and training and technical assistance resources.

9. National Center on Family Homelessness
   www.familyhomelessness.org

   Developing Trauma-Informed Services for Families Experiencing Homelessness, Understanding Traumatic Stress in Children.

10. National Center for Children in Poverty
    http://www.nccp.org/about.html

    The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Specific recommendations are available on this site around strengthening policies to support children, youth and families who experience trauma.

11. The National Center for Trauma-Informed Care
    http://mentalhealth.samhsa.gov/nctic/

    Technical Assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services. Majority of information is specific to adult populations.

12. National Child Traumatic Stress Network
    www.nctsn.org

    Multiple resources on child trauma including free education lecture series, list of trauma treatments.

13. National Federation of Families for Children's Mental Health
    http://www.ffcmh.org/

    The National Federation, a national family-run organization serves to provide advocacy, leadership and technical assistance on family driven care.

14. National Network for the Elimination of Health Disparities in Behavioral Health
    http://www.nned.net/

    The NNED will support information sharing, training and technical assistance among organizations and communities dedicated to the behavioral health and well-being of diverse communities.

15. National Registry of Evidence-based Programs and Practices
    www.nrepp.samhsa.gov

    Searchable database of interventions for the prevention and treatment of mental and substance use disorders.

16. The National Trauma Consortium
    www.nationaltraumaconsortium.org

    Technical Assistance, resources on service delivery and integration of services (adult focused).

17. Points of Wellness Partnering for Refugee Health and Well-Being
    http://www.refugeewellbeing.samhsa.gov/

    Since 1995, through an Intra-Agency Agreement with the Office of Refugee Resettlement (ORR), the RMHP provides refugee mental health consultation and technical assistance to Federal, State, or local agencies.

18. Portland Research and Training Center
    www.rtc.pdx.edu

    Multiple resources on children's mental health including youth involvement in treatment planning: AMP (Acheive My Plan).

19. Research & Training Center for Children's Mental Health
    http://rtckids.fmhi.usf.edu

    Multiple resources on the latest research on trauma-informed care.

20. The Sanctuary Model
    www.sanctuaryweb.com

    Multiple resources for organizational change, organization stress and trauma.

21. Sidran Institute
    www.sidran.org

    Helps people understand, recover from and treat traumatic stress (including PTSD), dissociative disorders, and co-occurring issues, such as addictions, self injury, and suicidality. Sidran develops and delivers educational programming, resources for treatment, support, and self help, trauma-informed community and professional collaboration projects, and publications about trauma and recovery.

22. Technical Assistance Partnership for Child and Family Mental Health
    www.tapartnership.org

    Resources for systems of care including: Family involvement, youth involvement, and cultural and linguistic competency.

23. Trauma Center and Justice Resource Center
    www.traumacenter.org

    Articles by Bessel van der Kolk, MD, Medical Director and Founder of the Trauma Center and internationally recognized leader in the field of psychological trauma, are available on this site.

24. Trauma-informed.ca
    www.suicideline.ca/trauma-informed.html

    Canadian Trauma Informed Toolkit provides recommended practices that will assist service providers to increase their capacity in delivering trauma-informed services

25. Trauma Recovery Initiative for Youth Center
    http://cfs.fmhi.usf.edu/project-details.cfm?projectID=405

Maine Resources:

1. Gaining Empowerment Allows Results (G.E.A.R.)
   http://www.gearparentnetwork.org

   G.E.A.R. is a parent run organization by and for parents of children with emotional and behavioral health concerns. G.E.A.R. provides training and support to families and is also a partner with THRIVE in the delivery of trauma-informed trainings for professionals on the principle of family driven care.

2. Maine's Office of Multicultural Affairs: Resource Guide
   http://www.state.me.us/dhhs/oma/MulticulturalResource/intro.html

   This website offers information on immigration, differences between refugee and immigration status, resources available in Maine for these populations, workforce diversity development and advocacy.

3. Maine Trans Network
   www.mainetransnet.org

   Maine based transgender advocacy organization offering numerous trainings on cultural and linguistic competency for transgender people in systems of care.

4. Outright L/A
   www.outrightla.org

   Maine based Gay, Lesbian, Bisexual and Transgender youth serving agency offering culturally and linguistically competent trainings on LGBT Youth Safety and Mental Health.

5. THRIVE Initiative
   www.thriveinitiative.org

   The THRIVE Initiative provides training, consultation and support to agencies, organizations and individuals seeking to become trauma-informed, family driven, youth guided and culturally and linguistically competent.

6. Youth M.O.V.E. Maine
   www.youthmovemaine.org

   Youth M.O.V.E. Maine is an affiliate of Youth M.O.V.E. National and offers comprehensive training and technical assistance, outreach, advocacy and skills building to youth and young adults. Youth M.O.V.E. Maine is also a partner with THRIVE in the delivery of trauma-informed positive youth development.

[i] Fallot, R.D. M. Harris, M. (2009). Creating Cultures of Trauma–Informed Care: A Self-Assessment and Planning Protocol. Community Connections, Washington, DC.

[ii] Guarino, K., Soares, P., Konnath, K., Clervil, R., and Bussuk, E. (2009). *Trauma-Informed Organizational Toolkit*. Rockville, MD: Center for Mental Health Sercices, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the national child Traumatic Stress Network, and the W.K. Kellogg Foundation

[iii] The Connecticut Women's Consortium, 2321 Whitney Ave., Hamden, CT 06518