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The Infusion of Trauma Informed Care in Organizations:

Experience of Agency Staff

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Abstract

The implementation of trauma informed care is a transformational organizational change, incorporating all levels of staff and fundamentally changing the hierarchical structure of the organization (Bloom, 2006). Using the principles of Fallot and Harris (2006), this study explored the impacts of trauma informed care implementation on staff, and how staff experience the principles of trauma informed care- safety, trustworthiness, choice, collaboration, and empowerment. Findings suggest that different levels of staff experience trauma informed care implementation differently. They also suggest that more exploration is needed on the factorial structure of trauma informed care.

Keywords: Trauma-informed care, implementation, staff

Introduction

A trauma-informed service system recognizes the neurological, biological, psychological, and social effects (McSparren, 2007) of violence and victimization on an individual's life and development (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). Unlike trauma-specific interventions designed to treat PTSD and other trauma disorders, trauma-informed care provides services that are "welcoming and appropriate to the special needs of trauma survivors (Harris & Fallot, 2001, p. 5)." A trauma-informed setting has a therapeutic milieu, with staff and patients operating as a team, working towards the patients' recovery (Bills & Bloom, 1998). Key features include a flattened hierarchy, shared assumptions, and close teamwork (Madsen, Blitz, McCorkle, & Panzer, 2003). Therapeutic communities increase cohesiveness among patients and between patients and staff, group decision making, and shared responsibility, and reduce violent events (Rivard, Bloom, McCorkle, & Abramovitz, 2005). Becoming trauma-informed

involves organizational change. All staff must understand how trauma affects clients so that all interactions in the agency support recovery and avoid re-traumatization (Elliot et al., 2005).

Individuals served by mental health and social service systems have high rates of exposure to traumatic events (Elliot et al., 2005). Living in low income urban areas increases the risk of trauma due to family violence, drug activity, incarceration of family members, and personal victimization in schools and communities (Kiser et al., 2010). Lifetime exposure to traumatic experiences in urban dwelling African Americans is disproportionately high.

Childhood contact can lead to lifelong consequences (Gillespie et al., 2009) and children reared in these areas have high rates of chronic traumatic stress (Kiser, 2007). Poverty is associated with depression, PTSD, and illicit drug use in African American sexual assault survivors (Bryant-Davis et al., 2010). Refugee women may have a buildup of these factors, often desperately poor, and having experienced many varied traumatic events (Onyut et al., 2009).

In Western New York, high rates of poverty, domestic violence, and a growing refugee population support the need for trauma-informed care. Poverty in the city of Buffalo is twice (26.9%) the national average (12.6%) and 36% of children live in poverty (Institute for Local Governance and Regional Growth, 2006). Median income in Buffalo (\$27,311) is well below the national average (\$46,243) (ILGRG, 2006). In all of Upstate New York, there was a 27% increase in homicides involving domestic partner violence from 2007 to 2008 and between November 2008 and June 2009, male partners in Erie and Niagara counties murdered 13 women (Tan & Gee, 2009). A growing number of immigrants (5.5 per 1,000 residents between 2003 and 2006) come from areas such as war-torn Sudan and Somalia (ILGRG, 2008). Within this context, this study examined social service organizations in the Buffalo, NY area on their

knowledge and use of the five main components of trauma-informed care: safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2008).

Literature Review

Organizations are living systems (Bloom, 2006). Organizational culture, a set of shared beliefs and assumptions, emerges from interactions between staff, clients, and administration (Bloom, 2006). Organizations become trauma-informed by engaging a lens which presumes everyone in the agency, from clients through management, may have a history of direct or indirect trauma exposure. For some agencies, this is a significant change in thinking (Elliot et al., 2005). Implementation of a trauma informed care model challenges organizations to examine how policies and environments foster physical and emotional safety and non-violence (Rivard, Bloom, McCorkle, & Abramovitz, 2005).

Organizational change begins with management's investment in the importance of using trauma-informed principles in service delivery (Elliot et al., 2005). Once leadership has committed to change, change takes place in stages. An agency must be ready before real change can take place (McSparren, 2007). The first change must be the flattening of the administrative hierarchy to ensure that all staff members are equally important members of the team (Madsen, Blitz, McCorkle, & Panzer, 2003). Implementation includes staff dialogues, self-evaluation, and formal training (Rivard, 2004), as a trauma-informed system must understand itself (Bloom, 2006). Self-evaluation includes examining beliefs about authority and comparing current organizational process realities to the organization's stated goals (Bloom, 2003).

Staff's training components include principles of trauma-informed care, the use of trauma theory in recovery, the trauma recovery model, and instruction on infusing trauma-informed principles into treatment (Rivard et al., 2004). Training occurs in several sessions (Rivard et al.,

2004) and may include ongoing coaching (Rivard, 2004). Rivard and Bloom (2006) believe that there needs to be as much staff training as possible, and it needs to be experiential, interactive, diverse, and multidisciplinary (Rivard, 2006). Staff feedback about the process and ongoing self-evaluation enhance implementation (Rivard, 2004).

The current study assesses attitudes about trauma-informed care within community agencies. The intent was to evaluate whether organizations that followed trauma-informed care methods were including a focus on staff throughout the implementation process.

Methods

A survey was constructed using Fallot & Harris (2006)'s five principles of trauma-informed care: Safety, Trustworthiness, Choice, Collaboration, and Empowerment. Once the assessment tool was prepared and the Institutional Review Board approved the web-based survey, the questions were pilot tested. After the pilot test, the committee revised the survey to make it more user-friendly.

The revised survey was sent to social service workers through their organizations. Emails were sent to leaders of 617 organizations introducing the study using an information sheet similar to an informed consent. The email asked the leaders to forward the email and the survey link to all of their staff. A total of 282 individuals from at least 93 different organizations completed the survey. Some respondents did not specify their organizations, so the actual number of agencies may be larger.

Measures

The survey encompassed the components of trauma-informed care and used a five point Likert scale ranging from strongly disagree (1) to strongly agree (5). The item breakdown was as follows: 8 items representing safety; 6 items representing trustworthiness; 6 items

representing choice; 6 items representing collaboration; and 8 items representing empowerment. The survey also included demographic questions; a Human Rights question; 4 questions on staff rights; 4 items on gender roles; and 5 questions about organization and personal experience.

Results

Demographics and Experience

A total of 282 surveys were downloaded from Survey Monkey though not all surveys were complete. Two hundred eleven (74.8%) individuals answered the gender identity question, with the majority being female (84.8%). The remaining individuals were male except for one indicating transgender and one indicating other. Only 169 provided their age, with a mean of 44.36 (12.76) years. Age was fairly evenly distributed, with 19% 18-30 years, 22% 31-40 years, 23% 41-50 years, 30% ages 51-60, and 6.5% over the age of 60. Two hundred three (72%) individuals provided ethnicity/race information. The majority were Caucasian (90.18%), with 7% African American. No respondents indicated a Hispanic background

Of the 282 respondents, 178 (63%) provided education information. Of the 178 individuals, 52 (29.2%) had a Bachelor's degree, 111 (62.4%) had a Master's degree, 9 (5.1%) had a Ph.D., and six (3.4%) had some post-high school training. A total of 61 respondents (34.3%) had a Master's in Social Work; nine (5.1%) had a Bachelor's in Social Work only.

For years of experience, 193 (68.4%) respondents provided information. The mean years of experience was 16.75 (9.83), with a median of 16 years. Experience ranged from less than a year to 52 years, with 38 (19.7%) individuals with 5 or fewer years, 53 (27.5%) with 6-15 years, 65 (33.7%) with 16-25 years, and 37 (19.2%) with over 25 years. As far as position in the agency, of the 203 (72%) individuals who provided information, 65% had direct client contact,

26.6% were in administration, and 8.4% were support staff. Of the 198 individuals (70.2%), who provided information concerning shift work, 95.5% worked the first shift.

Finally, we were able to determine the agency of employment for 264 respondents. We grouped agencies according to type of service. Categories were: community action organizations linked with head start ($n = 17$); community action organizations not associated with head start ($n = 17$); both mental health and chemical dependency services ($n = 36$); inpatient chemical dependency services ($n = 13$); outpatient chemical dependency services ($n = 28$); hospitals ($n = 24$); schools ($n = 40$); county social services ($n = 39$); non-county social services ($n = 11$); counseling centers ($n = 13$); elderly nursing care ($n = 11$); youth residential for runaways ($n = 10$); and colleges ($n = 5$). Thus, respondents represented a wide range of service provision.

Item Analyses

Item analyses were based on the participants' responses across different categories of the survey. The item analyses for this study were an attempt to determine the fit of the initial five trauma-informed care components identified by Falloot and Harris (2006): safety, trustworthiness, choice, collaboration, and empowerment. While a factor analysis of the total survey instrument is needed to confirm the overall structure, our sample was too small to allow for any meaningful factor analytic results. As such, we retained the initial subscales for the overall instrument but used factor analysis to evaluate whether each subscale was one-dimensional. The ratings for items were 1 through 5, with 1 being very low concern for a trauma-informed approach and 5 being very high concern.

Safety A total of 217 individuals (76.9%) completed all safety items. The item mean score was 4.05 (0.6854), with a range of 1.88 to 5.00. The alpha coefficient was .728, with a mean inter-item correlation of .257 and a range of inter-item correlations from .098 to .505.

Some inter-item correlations were non-significant, so we considered the prospect of multiple dimensions within the safety subscale. We performed an exploratory factor analysis using principal axis factoring with varimax rotation. The results found two factors accounting for 49.41% of the total variance. Factor one had an Eigen value of 2.81, accounting for 35.11% of the total variance. This factor included three items, which suggested emotional safety. Factor two had an Eigen value of 1.14, accounting for an added 14.29% of the variance. The five items in this factor suggested structural/physical safety.

A total of 233 individuals completed all three items of the emotional safety sub-dimension. The overall mean item score for emotional safety was 4.06 (0.906), with a range of 1.33 to 5. Reliability estimates showed an alpha coefficient of .655, with a mean inter-item correlation of .398 and a range of .344 to .490. Emotional safety item response rates were between 84.8% (n = 239) and 98.2% (n=277). The mean item scores for the emotional safety items all were at or near four (3.97 to 4.03), suggesting that the agencies showed a high concern for staff emotional safety. Over 70% of respondents indicated a high or very high concern for items in the emotional safety subscale.

For the physical safety sub-dimension, 220 individuals completed all five items. The mean item score was 4.03 (0.736), with a range of 2.00 to 5.00. The alpha was .625, with a mean inter-item correlation of .257 and a range of .132 to .387. Mean scores for three items reflected a high level of TIC concern by the respective agencies. The item about physical surroundings in the building showed the lowest mean score, suggesting a lack of consideration for how decor influences staff well-being. The last item in this sub-dimension was about whether the agency showed more concern for client safety than staff. While not as high as the items concerning physical safety, the mean for this item was 3.83.

Trustworthiness A total of 216 respondents completed all six of the trust items. The mean item score was 3.78 (0.817), with a range of 1.17 to 5.00. Reliability assessments showed an alpha level of .721, with a mean inter-item correlation of .300 and a range of .174 to .409. Factor analysis confirmed the items represented one basic dimension. The response rate for the items in the trustworthiness subscale varied from 80.5% ($n = 227$) to 97.8% ($n = 276$). The mean item scores ranged from 3.53 to 4.21. Thus, while the mean item responses were close to the high concern level of 4, there was variability across items. Trustworthiness items focused on two facets, communication within the agency and fairness. In our analysis, the three items with the lowest response rates and the lowest mean scores were those that focused on clear communication within the agency. While the factor analysis did not yield separate dimensions, the mean scores suggest there may be a benefit in considering how these elements separately influence performance. The response rates reinforce the mean item conclusions.

Choice A total of 213 respondents completed all of the choice items. The mean item score was 3.75 (0.860), with a range of 1.33 to 5. The reliability assessments showed an alpha level of .804, with a mean inter-item correlation of .415 and a range of .271 to .551. As with trustworthiness, a factor analysis of the choice items confirmed they represented one basic dimension. Response rates for the choice items ranged between 99.3% ($n = 280$) and 81.6% ($n = 230$). Mean item scores ranged from 3.34 to 3.98. Five of the six choice items seem to truly reflect choice; the remaining item focused on being uncomfortable voicing their thoughts.

Collaboration A total of 211 respondents completed all of the collaboration subscale items. This was the lowest response rate of any of the subscales. The mean item score was 3.61 (0.893), with a range of 1.17 to 5. The reliability assessments showed an alpha of .789, with a mean inter-item correlation of .382 and a range of .174 to .583. As with the trustworthiness and

choice subscales, a factor analysis confirmed the collaboration items represented one basic dimension. The collaboration subscale showed response rates from 81.6% ($n = 230$) to 97.9% ($n = 276$). Item means ranged from a low of 3.15 to a high of 4.05.

Empowerment A total of 225 respondents completed all the empowerment items. The mean item score was 3.88 (0.823), with a range of 1.38 to 5. Reliability assessments showed an alpha of .830, with a mean inter-item correlation of .390 and a range of .008 to .614. As with safety, given some non-significant inter-item correlations, we considered the prospect the empowerment subscale had multiple dimensions. We performed an exploratory factor analysis using principal axis factoring with varimax rotation. The results showed two factors accounting for 63.4% of the total variance. Factor one had an Eigen value of 3.86, accounting for 48% of the variance in the total scale. The five items in this factor signify agency support for staff learning new things. Factor two had an Eigen value of 1.21, accounting for an additional 15.4% of the variance. The three items in this factor suggest a desire for more training opportunities.

The alpha coefficient for the support factor was .829, with a mean inter-item correlation of .491 and a range of .369 to .619. The mean item score was 3.98 (0.907), with a range of 1.2 to 5. The items for support for trying new things were all in the higher range, suggesting that for the most part, respondents felt they had sufficient support to try new things. The alpha coefficient for the desire factor was .678, with a mean inter-item correlation of .428 and a range of .369 to .545. The mean item score was 3.73 (0.996), with a range of 1 to 5.

Relationship Between TIC Components

Table 1 shows correlations between TIC components. The mean correlation was .594, with the weakest relationship between physical safety and empowerment-desire for more training. All other relationships are at or above .40, with many in the .7 and above range.

Table 1. Correlations Between Trauma-Informed Care Subscales
Comparison of Mean Item Scores for the TIC Components

The relative means for the trauma-informed care components are shown in Figure 1. Results for subscale comparisons suggest that the agencies address safety more thoroughly than other components. After Bonferroni adjustments for the 21 paired t-tests ($p < .0024$), the results suggest that the emotional safety subscale mean was significantly higher than the means for the trust, $t(210) = 5.40, p < .0001, \eta^2 = .1221$; choice, $t(209) = 6.09, p < .0001, \eta^2 = .1506$; collaboration, $t(207) = 8.70, p < .0001, \eta^2 = .2677$; and the empowerment desire for more training, $t(229) = 5.07, p < .0001, \eta^2 = .1009$, subscales. In addition, the paired t-tests also showed that the physical safety mean was significantly higher than the means for trust, $t(201) = 3.79, p = .0002, \eta^2 = .0668$; choice, $t(202) = 5.34, p < .0001, \eta^2 = .1238$; collaboration, $t(196) = 6.72, p < .0001, \eta^2 = .1870$; and the desire subscale of empowerment, $t(216) = 3.70, p = .0002, \eta^2 = .0597$. The two safety subscales did not differ from one another.

The empowerment subscales also seemed higher than the trust, choice, and collaboration components. Paired t-tests showed the agency support empowerment subscale was significantly greater than the desire for training empowerment subscale, $t(224) = 4.200, p = .0001, \eta^2 = .0731$; the trust subscale, $t(213) = 4.897, p < .0001, \eta^2 = .1012$; the choice subscale, $t(212) = 5.86, p < .0001, \eta^2 = .1395$; and the collaboration subscale, $t(208) = 10.15, p < .0001, \eta^2 = .3313$. The empowerment desire for more training did not differ from the trust or choice subscales but was significantly higher than the collaboration subscale, $t(207) = 2.48, p = .014, \eta^2 = .0290$.

The trust subscale was significantly greater than the subscale for collaboration, $t(201) = 4.62, p < .0001, \eta^2 = .0961$. There were no differences between the trust and choice subscales, or

the choice and collaboration subscales. Overall, of the 21 comparisons between means, after making Bonferroni adjustments, 12 still showed significance.

Figure 1: Mean Item Scores for TIC Components

Differences in TIC Responses as a Function of Person Characteristics

Subscale scores did not vary significantly as a function of gender, age, or race.

For education, we had 172 responses categorized as Bachelors ($n = 52$), Masters ($n = 111$), or Ph.D. ($n = 9$). Because of the small number of Ph.D. respondents, we collapsed the Masters and Ph.D. categories. Figure 2 shows the results. The Master's/Ph.D. level respondents were more positive about the agency's approaches to staff than the Bachelor level respondents. Using a Bonferroni adjustment for the 7 tests ($p < .0075$), significant differences were found for the Physical Safety subscale, $t(153) = 3.59, p = .00045, \eta^2 = .07761$; the Trustworthiness subscale, $t(158) = 2.84, p = .0051, \eta^2 = .04864$; the Choice subscale, $t(161) = 3.23, p = .0015, \eta^2 = .0608$; and the Empowerment Support subscale, $t(168) = 3.01, p = .0030, \eta^2 = .0512$.

Figure 2: TIC Subscale as a Function of Education Level.

Position with TIC Subscales

Positions were identified as support staff ($n = 17$), direct line staff ($n = 132$), and administration ($n=54$). Results are presented in Table 2. There were significant differences across all but the two safety subscales. Six of the seven subscales had significant linear trends, with the lowest scores for support staff and the highest for administration. The physical safety subscale was non-significant effect for linear trend. Using a Bonferroni adjustment for multiple group comparisons, support staff was significantly lower than both line and administrative staff on all but the physical safety subscale.

Table 2. TIC Subscale Results as a Function of Position held in the Agency

We considered that some of the differences might have been due to education. However, when a crosstab analysis was performed between position and education, it showed that 64% of support staff, 68% of line staff, and 74% of administrative staff held masters level or higher degrees, suggesting that higher level education was present in the support staff group at levels comparable to the other two position groups. Even so, ANCOVAs were also performed using education level as a covariate, with results showing similar effects to the standard ANOVAs. Thus, the position differences remained significant even controlling for education level.

Discussion for Organization Survey Construction

In this discussion, the term TIC will refer to the five components of trauma-informed care specified by Bloom (1997) and Falloot and Harris (2006). When the term subscale is used, it refers to the survey instrument representation of the previously mentioned components. “Sub-dimensions” refer to the divisions within the subscales that were identified in the current study.

One critical finding of this data was the identification of sub-dimensions within components of the trauma-informed model, specifically the sub-dimensions within the safety (emotional and physical) and empowerment (support for new things and desire for more training) scales. Regrettably, there were insufficient responses to conduct a factor analytic approach to know how the survey items fit within the proposed overall construct of trauma-informed care. The second critical finding was strong correlations between the TIC component subscales. This suggests that it is important to consider all trauma informed care components together, and that it is difficult to achieve one without considering the others. It is unclear whether what was measured actually coincides with the five components of Falloot and Harris (2006) or Bloom (1997; Bloom and Sreedhar, 2008). These findings underscore the need for more work on the construct validity of the survey. In this case, we did not evaluate what organizations were doing,

separate focus groups had suggested the application of policies and procedures may be sub-optimal. We decided that a perceived satisfaction approach would give a better understanding of the extent to which staff felt the organization was treating them in a trauma-informed manner.

Item Responses

The response rates for items varied considerably, ranging from 80.5% to 99.3%. This suggests specificity in how respondents were answering questions, ignoring some and answering others. Only 181 of the 282 (64%) respondents completed all items in the TIC components. We need to explore what this means for understanding what the organizations may be doing from a TIC perspective. Future work should consider qualitative methods to address this issue.

Regarding the reliability of the proposed subscales and those discovered in the current analyses, most alpha coefficients were above .700. More work is needed to identify potential sub-dimensions within the subscales and how items relate to those sub-dimensions. For example, when we considered the inter-item correlations within original subscales, some items were not related to others within the same component. The safety subscale is a good example. Yet, when we then consider emotional and physical safety separately, we find that the physical safety reliability is .625, suggesting that interpretation of the content was not consistent across the items. This also occurs with the empowerment sub-dimension, where we find that the desire for more training sub-dimension has a reliability coefficient of .678. However, one item in this subscale may have had ambiguous interpretations. When asking whether more in-house workshops and training were needed, a response indicating a need for more might suggest that the agency was not doing enough in this area. However, a negative response could indicate there was a sufficient amount, or that the in-house workshops and training were not very good. There

is a need to gain more information around this, perhaps using qualitative approaches to add information and help in the rewording of the question.

Evaluation of items within each subscale and sub-dimension suggests that there was some differential responding. All of the items in the emotional safety sub-dimension were rated near four, suggesting that overall; there were high levels of TIC concern. On the other hand, for physical safety, building decor had the lowest ratings, suggesting that in many cases the physical space was not “user friendly.” Research suggests that the decoration of office space can influence employee productivity (McCoy and Evans, 2002) and possibly, the moods of the clients (Gilboa and Rafaeli, 2003), thus it may be a consideration in the implementation of TIC. Organizations need to understand the impact that décor may have on staff and client outcomes.

Responses within the other four subscales also showed differential responding. Taken together, this indicates a need to consider the specific questions that showed lower TIC concern and a need to understand how low score items relate to the overall component. When implementing TIC, if only some elements of a component are emphasized it may lead to an overall lower level of TIC concern. Future research needs to clarify our understanding of relationships between elements within components, as well as across the TIC components.

Summary of Item Outcomes

The item analyses suggest a need for further evaluation of the survey instrument. Respondents may view TIC differently than how it was originally constructed. There is a need to understand the overall construct of TIC, how it is viewed, and how it is implemented at the organization level. Discovery of sub-dimensions within some components and low scores on items within subscales suggests a strong need for factor analysis of the current survey. In addition, it is important to try to understand why respondents were willing to answer some

questions but not others. Given the large discrepancies in response rates within subscales, it may help us to understand how staffs view the TIC components.

Relationships Between Subscales and Sub-dimensions of TIC

Physical safety had the weakest correlations to the other subscales. This may have been due to the item about the physical décor of the agency. Desire for more training/workshops also showed weak relationships. However, emotional safety, choice, trustworthiness, collaboration, and empowerment support for trying new things all were strongly related. This reinforces the need to clarify this construct of TIC.

Comparisons between mean scores for the subscales and sub-dimensions showed physical and emotional safety were significantly higher than the trustworthiness, choice, and collaboration subscales, and the desire for more training empowerment sub-dimension. It seems that safety is a concern for most organizations and is related to scores in other dimensions. How these relationships progress should be a target for future work in this area. Maslow's Hierarchy of Needs might help when considering these relationships, as safety appears to be a primary concern in organizations. From an implementation perspective, it is important to understand why the scores on the trustworthiness, choice, and collaboration subscales were lower. This seemed to be especially true for collaboration, which tended to be the lowest subscale score. When implementing TIC in an organization, what is necessary to ensure that the staff feels the environment is safe, trustworthy, provides for choice, collaboration and empowerment?

Factors Associated with Subscale and Sub-dimension Scores

We found no significant differences by age, gender, or race. Not all respondents reported these characteristics so it is uncertain if the distributions reported were representative of all respondents. The sample was predominantly female and white. The lack of African American

and Hispanic/Latina respondents is worrying. We need to determine how these demographic characteristics influence perceptions of TIC concern in an organization. Future work will need to be cognizant of this by targeting sufficient numbers to identify if actual differences exist.

There were significant differences for education, with a linear trend apparent, from individuals with a bachelor's degree as having the lowest scores to those with a Ph.D. the highest. There may be several reasons for this difference. One might consider the potential for advancement that education provides, thereby improving the individual's perceptions of the environment. A second possible reason may be due to what education provides for the individual, more knowledge of how to work with staff and clients that can be used to gain access to more choice and collaborative opportunities. It may also provide new insights into why certain approaches are taken, thus resulting in more favorable views of the organization.

We also found differences related to type of position held within the organization. Support staff were lowest and administrators highest. Initially, we thought this was a function of education but we found support staff had a similar educational distribution to the other two groups (direct line and administrators). These results may be important. They suggest that support staff may be less involved in training and implementation of TIC than other staff. Yet, they may be critical to success of TIC because they have as much or more client contact as other staff. Unfortunately, we need to be cautious here, as only 17 individuals indicated they were support staff. Future work needs to consider this element more in-depth.

There were significant differences as a function of organization type. These findings are also of critical importance. We did not have sufficient information to identify all specific organizations, thus we need to be cautious with these interpretations. Even so, it was clear that the community action organizations and county social services units had the lowest scores across

all dimensions. We thought this might be an education effect but had too few respondents to test interactions of education by organization type. However, the four organization types with the fewest individuals with Masters/Ph.D. were all in the lowest scoring group, possibly supporting the idea that education was related to lower scores. However, the individuals from the elderly nursing care organizations were also in the lower educated group, yet their scores were at the high end. Are the lower scores due to the education of the respondents or does it have to do with the services being provided, policies and procedures that are state or federally regulated, or simply how that organization approaches its staff?

Limitations

There are a number of limitations in this study. This was a first attempt to gain information about staff perceptions concerning TIC in their organizations. We used a web-based survey to provide anonymity for respondents. In taking this approach, we relied on top administrators to provide the survey link to all of their employees. We suspect this may not have happened. Given we had only 17 responses from support staff it seems administrators may have neglected this group. We have no way of knowing whether this was intentional, an oversight, or if this was a function of position such as this group lacking email in some settings. This reinforces the earlier concern about the exclusion of support staff in training and implementation processes for new services. Our ability to generalize is limited by our inability to identify who was given access to the survey and who was not.

The small number of responses in positions and certain demographic categories limited our ability to understand fully the underlying TIC constructs. Support staff scored lower, but the question is whether they assigned different meanings to the items than did the line staff or administrators. There is a definite need to gain more understanding of how the position and

education of staff influence their understanding of TIC. Additionally, there were few males and minorities in the sample. It would be important to understand if the different genders assigned different meanings to the items, or if the different races had differing perceptions of the items. There may be factorial invariability but the numbers in the current sample did not allow this to be determined. Future work needs to include more males and minorities.

Another limitation to the current study has to do with the number of staff respondents from individual organizations. Based on the identities we were able to discern, numbers within organizations were too small for us to do within and between groups analyses. Gaining an understanding of the relationship between what and how services are provided, and the make-up of organizational staff is critical in building a good training program for implementing TIC.

Despite these limitations, the study has provided important information about how the staff views the organization's attempt to take a TIC approach with them.

Future Directions

The results provide us with direction towards where we need to go in our future work. The first is a need to understand what the survey items actually reflect for respondents. Are they separate elements of job satisfaction? This seems to call for a mixed methods approach within organizations, using the qualitative face-to-face interviews to clarify staff survey responses.

As part of the above, there is a need to look more critically at the items and components described by Falloot and Harris (2006). Given our identification of sub-dimensions within the safety and empowerment components, there is a need to look at the underlying construct of the TIC approach. The survey should be repeated with more respondents and with sufficient numbers in subgroups to allow for assessment of factorial invariance.

Another important future consideration is to link results of the current survey to staff and client outcomes. We need to consider organizational analyses to understand how subscale scores relate to staff outcomes such as lateness, absenteeism, performance, and turnover? What about client outcomes? Do higher scores produce more TI approaches and better outcomes?

Challenges to Mental Health Organizations that Support TIC

Mental health organizations face significant challenges. Declines in funding have led to uncertain budgets and uncertain jobs. Employees who remain do more with less and may wear several “hats” within an organization (Ugboro, 2006). Organizations and human service workers may be traumatized by the constant sense of crisis in their agencies. Agencies that are treating trauma survivors have themselves become like the dysfunctional situations their clients have tried to escape. Bolstered by promising research, staff members of human service organizations have looked to the principles of trauma-informed care to break this cycle. (Bloom & Farragher, 2011)

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