TRAUMA-INFORMED ECOLOGICAL RESPONSE (T.I.E.R.)

A Model for the Implementation and Evaluation of Trauma-Informed Care

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OVERVIEW

Trauma-Informed Ecological Response T.I.E.R. ™was developed by Artemis Associates under the leadership of Carmela J. DeCandia, Psy.D. Grounded in practical, on-the ground, experience, and based on best practices for building psychologically healthy workplaces, organizational culture change, and addressing trauma, T.I.E.R.™ provides a concrete and flexible roadmap for implementing trauma-informed care in systems serving vulnerable populations. The Artemis T.I.E.R.™ model can be scaled up or down to meet an organization's needs. Generally, 18 months is recommended for systems to begin to make changes that have a measurable impact. Agencies can choose to engage in a full 18-month engagement (recommended), or contract per phase as resources becomes available. A three year engagement inclusive of community impact measures is also available.

T.I.E.R.™ Framework

T.I.E.R.™ 1: Needs and Readiness

The first tier in building a trauma-informed model is getting to know an agency and its readiness for implementation. This includes establishing a common language through awareness and knowledge building, conducting focus groups, reviewing documents, policies and procedures, and planning calls with leadership to guide the process. During this time, following the knowledge building process, a workgroup is identified among representative staff who will participate in strategic action planning, building communication channels, and be the guides of the implementation process within the organization.

T.I.E.R.™ 2: Evaluate and Action Plan

The second tier in building a trauma-informed model involves a process of evaluation. Although one-time evaluations are generally not effective in changing systems, conducting a basic evaluation of program's level of trauma-informed care using an instrument such as the Ticometer can be useful to determine readiness, help establish a baseline, and guide the process of implementation within realistic parameters. During this tier, quantitative data from organizational measures is obtained and integrated with the focus group and qualitative process data (obtained during the readiness assessment) to develop an action plan for implementation. Tier 2 typically culminates with the trauma workgroup meeting for 1-2 days to review all the data and develop an organization specific strategic action plan to guide implementation.

T.I.E.R.™ 3: Ongoing Implementation

The third tier focuses on ongoing implementation and evaluation. This may include ongoing work with leaders, supervisor training, consultation on implementation challenges, and additional trainings for specific staff roles and programs. During site visits, focus groups with staff and clients, and periodic re-evaluations are conducted, as is updating of action plan as needed.

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Sample 18-month Implementation and Evaluation Plan

To effectively implement and evaluate trauma-informed care, a minimum of 18months is recommended. This allows time to evaluate baseline organizational functioning and implement required trainings, adapt policies and procedures, and measure changes in staff attitudes, knowledge, and skills. It also allows enough time to measure any initial changes in organizational culture. For maximum effectiveness, 3-years is generally needed to see deeper system level changes and client level impacts. A sample outline of how an 18-month process would looks is outlined below. It is broken into two main phases with project periods that correspond to the T.I.E.R.™ framework.

Phase One (months 1-12) includes baseline assessments, evaluation planning, TIC implementation and ongoing evaluation at Center for Transforming Lives. It is broken down in two project periods.

Project Period I, months 1-4 focuses on several key features:

1. An initial 2-day site visit for all partners.
2. A 2-day face to face training for all staff (this is maintained as it sets the frame for the consultation work ahead), to build providers' knowledge and to set the frame for implementing action steps during a second site visit.
3. Document reviews of policies and procedures.
4. Focus groups with managers, staff and consumers.
5. Identifying and building the trauma workgroup.
6. Program level baseline evaluations using a standardized instrument to measure TIC, as well as other organizational measures as identified by the team. Additional existing data sources are identified (e.g., High School Equivalency diplomas, employment rates, etc.) to evaluate program performance and the impact.
7. Provision of a baseline evaluation report to guide action planning and implementation. Results are interpreted and used to guide a strategic action planning process with a trauma workgroup and for implementation activities.
8. Remote consultation with the workgroup.

Project Period II, months 5-12

1. Implementing trauma-informed care through onsite and remote consultation, and action planning. This generally includes two site visits for action planning and review of results of baseline assessment, and ongoing implementation support.
2. Evaluating agencies' progress. This generally includes two onsite meetings to gather data and evaluate progress. Re-evaluation occurs at multiple time points over the 18-month project period. Other identified measures appropriate for the program evaluation will be determined during the initial meeting and implemented as appropriate.

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Phase II: Months 13-18

1. Ongoing implementation support and outcomes monitoring at the program level.
2. At least one additional onsite training as requested on chosen topics (full day or two half days). Additional trainings may be added to budget.
3. Re-evaluation of the agency's progress and impact of trauma-informed, remotely, in coordination with an onsite designated program staff supporting data collection. (If a staff is not available, a local research assistant can be hired to support data collection).
4. Provision of an 18-month final report of outcomes
5. Provision of a final presentation to stakeholders.

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About Artemis Associates

Artemis Associates, LLC is a woman-owned business that promotes resilience and creates committed, values-based partnerships to support children and families, and the providers that serve them. Grounded in direct service and person-centered care, Artemis Associates conducts assessments, provides consultation and training, engages in research, develops and shares knowledge, and advocates for compassionate, high-quality services for children and families in need. Unbounded, passionate, and purposeful, Artemis Associates will go the distance to ensure all children, families, and their providers are seen, heard, and understood.

Carmela J. DeCandia, Psy.D., Owner and President

Dr. DeCandia is the founder and owner of Artemis Associates, LLC where she provides training and consultation to organizations to build trauma-informed and family-centered services for children and families. A licensed psychologist, she has dedicated her career to advancing best practices and policies to support vulnerable children and families, and to improve the systems which serve them.

For more than 27 years, she has worked with children and families struggling against a variety of life adversities and led direct service and national agencies including St. Mary's Women and Children's Center, and The National Center on Family Homelessness. She maintains a clinical practice providing assessment of children birth to age 17 at Strong Roots Counseling in Watertown Massachusetts, and is an Adjunct Faculty at Boston College where she lectures on applied child and human development and psychological assessment.

Dr. DeCandia has being working to advance trauma-informed care for two decades. During her tenure at St. Mary's, she helped lead the implementation of a trauma –informed service delivery model over three years as a partner site for the NTCSN funded project led by The National Center on Family Homelessness and The Trauma Center. The training and implementation occurred across six programs including a family shelter, group home for teen mothers, adult basic education, and workforce development. This early project contributed to the NCFH's development of the first Trauma-Informed Organizational Toolkit.

After 20 years in direct service, she transitioned to the national stage and served for four years as Director of the National Center on Family Homelessness (NCFH). Here, she focused on developing the evidence based to document child and family homelessness. She oversaw the completion of the *Services and Housing Interventions for Families in Transition (SHIFT)* study funded by the Wilson Foundation, co- authored the cost study report (Hayes & DeCandia, 2013), and led four community forums at participating sites in upstate New York to disseminate findings and advance the call for trauma-informed care among providers. In addition, Dr. DeCandia led several technical assistance projects and served as a senior technical advisor on various research projects. She was the Project

Director for a 3-year W.K. Kellogg funded initiative to integrate trauma-informed care in community agencies serving the Haitian community in Miami, Florida, and she supervised the team implementing trauma-informed care over three years in three shelters serving homeless Veterans in Massachusetts, funded through the Bristol-Myers Squibb Foundation. These projects helped form the basis for learning how trauma-informed care needs to be embedded and implemented in systems over time to achieve sustainable change.

Dr. DeCandia has published articles for academic journals and educational publications, and presented in numerous public forums and on expert panels. Among her most recent publications is *Trauma-Informed Care: An Ecological Response* (DeCandia & Guarino, 2016). This article explores the history and evolution and evidence base for trauma-informed care, including a review of quantitative and qualitative studies and other supporting literature. The authors clarify the definition of trauma-informed care versus trauma-specific services, discuss what is known about trauma-informed care based on an extensive literature review, and discuss implications for practice, programming, policy, and research.

Dr. DeCandia is actively engaged in research. As Co-Principal Investigator for the NICHD funded project- *Child Assessment in Low Resourced Settings* (Grant No. 1 R44 HD088291-01). She co-leads a team to develop, test, and validate a unique, online instrument - *Neurodevelopmental Ecological Screening Tool - NEST early childhood-* for children ages 3-5. She is also working to developing *NEST* Infants for children under age three.

Dr. DeCandia brings more than 15 years of executive leadership and management experience and deep content expertise in trauma-informed care and practical knowledge of working in shelters, schools, and community centers. She has built strong collaborative relationships with the homeless provider community across the country, and has been sought after to train on implementation of trauma – informed care. She is highly regarded as a national expert on child trauma, family homelessness, and trauma- informed care; her knowledge and experience will ensure a successful partnership and implementation project.

Maureen Hayes, Ph.D., Associate and Evaluator
Dr. Hayes is a social science researcher specializing in homelessness, children and families, and mental health. She was the Senior Researcher at the National Center on Family Homelessness, where she was the Project Director of the SHIFT Study, a longitudinal study of homeless families, housing programs, and the impact of trauma on residential stability.

Dr. Hayes has conducted several mixed-methods evaluations, which have often focused on services related to trauma and trauma informed care. For example, she evaluated *Strength At Home,* a demonstration project of an evidenced-based intervention for veterans with PTSD and their families to prevent intimate partner violence (Hayes et al., 2015). She also evaluated a multi-site demonstration project implementing trauma-informed care in community-based organizations to improve service

delivery to homeless female veterans, as well an intervention designed to prevent and reduce the impact of violence on homeless children and their families.

Prior to her work at the National Center, Dr. Hayes worked on research studies related to chronic homelessness, juvenile criminal justice, and personality disorders at Columbia University and the New York State Psychiatric Institute. She was also a mental health clinician at a homeless shelter.

Dr. Hayes has worked with vulnerable populations for over 20 years. She was recently named a Visiting Scholar at the People's Emergency Center (PEC), a non-profit organization in West Philadelphia that provides comprehensive supportive services to homeless women and their children, works to revitalize the neighborhood, and advocates for social justice. The Visiting Scholar Program at PEC brings together academically talented researchers, as well as regional and statewide networks of public and nonprofit agencies to assist and support families who are experiencing homelessness.

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SELECT PUBLICATIONS

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