National Strategy for Trauma-Informed Care Operating Plan

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INTRODUCTION

On October 24, 2018, the SUPPORT for Patients Substance Use-Disorder Prevention that Promotes Opioid Recovery and Communities (SUPPORT for Patients and Communities) Act (P.L. 115-271) became law.[1] The SUPPORT for Patients and Communities Act is a comprehensive piece of legislation devoted to combatting substance use and the opioid epidemic and it includes a bipartisan commitment to supporting children and families who experience trauma and adverse childhood experiences (ACEs), including trauma from substance misuse. The law has a provision to establish the Interagency Task Force on Trauma-Informed Care (hereafter referred to as the "Task Force"). The purpose of the Task Force is to harness the expertise, reach, and resources of the federal government to address the impact that trauma can have on the healthy development of children. This development includes their long-term health, as well as their academic, employment, and social outcomes.

The Task Force is charged with identifying, evaluating, and making recommendations regarding (1) best practices with respect to children and families who have experienced trauma or are at risk of experiencing trauma; and (2) ways federal agencies can better coordinate responses to families affected by substance use disorders and other forms of trauma.[2]

Childhood trauma is a serious public health problem in the United States. More than two thirds of children report experiencing at least one traumatic event by age 16.[3] Exposure to trauma influences the developing brain and can have long-lasting negative impacts on physical and behavioral health.[4] The social and economic costs of trauma exposure are estimated to be hundreds of billions of dollars per year.[5] While most people exposed to traumatic events do not experience long-term mental and behavioral disorders, many can benefit from assistance. Yet, most people exposed to trauma do not receive supports and services that may help them cope and recover.[6] Communities need support to build infrastructure and capacity to prevent trauma, respond to those impacted by trauma, and build resilience.

It is important to acknowledge the changes that have occurred in the United States since the passage of the SUPPORT for Patients and Communities Act in 2018. The COVID-19 pandemic and its associated health, social, and economic challenges; the national conversation on racial inequality, systemic racism and injustice; and the increase in children arriving unaccompanied at the border have created a heightened need for attention to the adversities faced by children, youth, families, and communities.

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[1] Act, S. N.–o. (2018). *Interagency Task Force on Trauma-Informed Care.* Retrieved from Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/sites/default/files/programs_campaigns/trauma_informed_care/support-act-section-n.pdf

[2] 115-271, P., & 7132(a)(1)-(2), S. (2018). *Interagency Task Force on Trauma-Informed Care.* Retrieved from Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/sites/default/files/programs_campaigns/trauma_informed_care/support-act-section-n.pdf

[3] *Understanding Child Trauma*. (2020). Retrieved from Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/child-trauma/understanding-child-trauma

[4] *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* (2014). Retrieved from Substance Abuse and Mental Health Services Administration: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

[5] *Preventing Childhood Adverse Experiences (ACEs): Leveraging the Best Available Evidence.* (2019). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

[6] *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* (2014). Retrieved from Substance Abuse and Mental Health Services Administration: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

These events highlight the importance of coordinated, evidence-based efforts, to provide programs and systems serving children, youth, and families impacted by trauma with evidence-based tools for identification of needs and evidence-based practices for addressing short- and long-term risks and needs. It is also important to acknowledge, assess, and address gaps in the existing evidence base. Preventing and responding to trauma requires a whole-of-government approach, especially those agencies that interact directly with children and families (e.g., Health and Human Services (HHS), Department of Education, Department of Labor (DoL), Department of Defense (DoD), Department of Justice (DoJ).

To comply with section 7132(a)(1) and Section (a)(2) of the SUPPORT for Patients and Communities Act, this document proposes a National Strategy for Trauma-Informed Care ("National Strategy") and a corresponding Operating Plan that describes the proposed activities to implement the National Strategy.

Throughout this report, we use the term "trauma" to encompass a variety of experiences, including such things as child maltreatment, exposure to substance misuse (either from in-utero substance exposure to opioids and other substances or child abuse or neglect due to having a parent or a caregiver with a substance use disorder), exposure to domestic violence, community violence, natural and human-caused disasters, prolonged family disruption, separation of children and youth from their families, historical trauma, medical trauma, and systemic racism. We acknowledge that economically vulnerable children those identifying as Lesbian, Gay, Bisexual, Transgender, Queer and/Questioning, Intersex, and Asexual/Ally (LGBTQIA), and children and youth with disabilities often face living situations and adverse community environments that can compound traumatic experiences. We acknowledge that people may use substances as a form of self-medication following exposure to traumatic experiences. The geographic context in which a child and family reside is also a key consideration. Rural communities often do not have the same capabilities as urban communities to implement promising practices, build their workforce, access relevant research, and collect and share data. This report also uses the term "children" to refer to infants, children, and youth.

National Strategy for Trauma-Informed Care

To provide a theoretical foundation for the development of the National Strategy and Operating Plan, the Task Force reached consensus on a statement of the problem and a desired outcome. This theoretical foundation will enable the Task Force to evaluate the process of implementing the Operating Plan and will ensure that Task Force activities are linked to expected outcomes and meet the intent of the legislation.

> ***Problem Statement:*** Childhood trauma, including exposure to substance misuse, is a serious public health problem in the United States. It has potentially long-lasting negative impacts on physical and mental health. Communities need support to build infrastructure and capacity to prevent trauma, respond to those impacted by trauma, and enhance resilience. A robust evidence base for a continuum of interventions (e.g., prevention of traumatic exposures, early intervention to address acute reactions and responses, treatments for

identified health, education and other adverse conditions) at the individual, system, and community levels are needed to promote the provision of best practices.

Outcome Statement: A national, trauma-informed, and coordinated federal strategy to build community capacity to identify, disseminate, foster, and refine evidence-based, evidence-informed, and best practices regarding childhood trauma to reduce the incidence of trauma, improve the response to families with exposure to substance misuse, enhance recognition of and response to trauma, strengthen resilience, and improve outcomes for children, youth, and families.

DEFINITIONS OF KEY TERMS

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach,[7] developed in 2014, provided the first framework upon which much work in the field has been built. It sought to guide systems to become more trauma-informed and advanced the idea that trauma is a widespread, costly public health problem. This framework presents a definition of trauma (described below) with four guiding assumptions, referred to as the "4 Rs." The "4 Rs" are: Realizes, Recognizes, Responds, and Resist Re-Traumatization. Through preliminary Task Force efforts to develop the National Strategy and Operating Plan, it became clear that a necessary step was to develop consensus on language and terminology. As work in this field has become more sophisticated and nuanced, more specificity in the terminology and framework needs to occur. These assumptions, along with other components of the Substance Abuse and Mental Health Services Administration (SAMHSA) Concept and Guidance, need formal revision to reflect updated evidence, particularly related to resilience and equity. The definitions below are the Task Force's attempt to bring consistency to definitions of key terms to foster collaboration and accurate data collections. A full glossary of relevant terms is included in Appendix C.

Trauma

SAMHSA defines trauma as the three Es: **events,** the **experience** of those events, and the long-lasting adverse **effects** of the event. Individual trauma results from an event, series of events, or a set of circumstances that is experienced by an individual as physically, emotionally harmful, or life threatening, and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. This definition recognizes that not all exposures to traumatic events result in adverse outcomes. We must acknowledge that individual and community resilience is widespread. In practice, an approach to discussing and addressing "trauma" that is widely used is to distinguish between exposure to potentially traumatic events (e.g., abuse, neglect, violence, disaster) and trauma-related health and other outcomes. This may be a useful strategy in that it recognizes the results of research demonstrating that not all people who are exposed to the same or similar events experience adverse outcomes, acknowledges that resilience is common, provides a framework for efforts to reduce or prevent exposures at a public health or population level, and emphasizes the importance of interventions designed to address specific trauma-related needs/conditions.

Trauma-Informed Care

Trauma-informed care (TIC) can refer to either evidence-based trauma interventions (e.g., Trauma-Focused Cognitive Behavioral Therapy[8]) or to a broader systems-level approach that integrates trauma-informed practices (acknowledging that potentially traumatic exposures have

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[7] *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* (2014). Retrieved from Substance Abuse and Mental Health Services Administration: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

[8] *Trauma-Focused Cognitive Behavrioal Therapy.* (2012). Retrieved from The National Child Traumatic Stress Network: https://www.nctsn.org/interventions/trauma-focused-cognitive-behavioral-therapy

taken place) throughout a service delivery system (e.g., health care system, educational system, law enforcement). The implementation of individual and family level intervention is one part of a trauma-informed system, but alone does not constitute trauma-informed care.

Best Practices

Best practices is an overarching term for interventions or models of care that are accepted based on the highest likelihood to be effective relative to other approaches and meet either the definition of evidence-based, evidence-informed, or promising practices, depending on evidence available and are delivering the service and assessing outcomes in ways that accommodate individual and community needs. and preferences. Research evidence exists on a continuum, reflecting a range of strength of evidence that demonstrates the extent to which a program or intervention produces positive outcomes. The level of evidence may vary by the group receiving the practice. For example, a specific program may be evidence-based or well-supported in one population but may only be evidence-informed or a promising best practice when applied to another population. This occurs because researchers often use narrow definitions in the context of a rigorous methodological design with specific populations, while those implementing trauma-informed approaches and interventions in communities often need to make adaptions based on their specific community context. Where evidence doesn't exist, what may be called best practice is based on the opinion of experts.[9] Specific definitions of evidence-based, evidence-informed, and promising practices can be found in Appendix C.

Equity

As defined in the Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, equity means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. The term "underserved communities" refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of "equity."[10]

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[9] *Understanding Evidence.* (2014). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/pdf/continuum-chart-a.pdf

[10] *Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. (2021, January). Retrieved from The White House: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

NATIONAL STRATEGY FRAMEWORK

The Task Force developed a structure and framework for the National Strategy that captures the components of the legislation and its collective experience (Figure 1). The strategy focuses on implementing a coordinated approach among member agencies. It also reflects the priorities of the authorizing statute and the extensive work done by member agencies in trauma intervention.

Figure 1. National Strategy for Trauma-informed Care.

The four pillars of the National Strategy framework are **Best Practices, Research, Data,** and **Federal Coordination.** A commitment to equity underlies the work of all four pillars. Stakeholder engagement and feedback is also integrated throughout each pillar. This commitment to equitable trauma-informed systems will include supporting a range of programs that are accessible to (and culturally and linguistically appropriate for) various populations.

- The **Best Practices** pillar seeks to identify and make recommendations on evidence-based and evidence-informed practices with respect to prevention of exposure to potentially traumatic events, identification of trauma-related behavioral health and other health needs, referral, and implementation of trauma-focused interventions and practices. The Best Practices pillar also seeks to identify, evaluate, and make recommendations on promising practices with respect to trauma-informed systems and individual level interventions.
- The **Research** pillar seeks to, evaluate and expand the knowledge base in the areas of preventing exposure to potentially traumatic events, identifying trauma related health, behavioral, academic, employment, and social needs, and interventions (individual and systems). The research pillar also seeks to expand the knowledge base for children and families at risk for traumatic events and experiencing trauma-related needs.
- The **Data** pillar seeks to coordinate data gathering, measurement, and tools used by programs and systems serving children and families impacted by trauma to better assess

children, youth and family needs, and streamline services for, and enhance the care of children and families impacted by trauma.

- The **Federal Coordination** pillar seeks to promote communication, coordination, and collaboration in the areas of trauma, trauma risk and resilience, and trauma-informed care across the federal government.

Federal Partner and Stakeholder Engagement

The inaugural meeting of the Task Force was held on May 31, 2019. Since that time, fifteen meetings of the entire Task Force and eight subcommittee meetings have been held. In Fall 2020, Task Force members volunteered to participate in subcommittees to develop the Operating Plan within each pillar. Across meetings, agency representatives engaged in meaningful participation. Specific agency representation can be found in Appendix B.

To facilitate meaningful contributions to the development of the National Strategy and Operating Plan, the Task Force solicited input from stakeholders including frontline service providers; educators; mental health professionals; substance use professionals; researchers; experts in infant, child, and youth trauma; child welfare professionals; and the public. To carry out these duties, SAMHSA developed a memorandum of understanding (MOU) with the United States Digital Service (USDS) who then participated in every Task Force meeting thereafter. USDS completed the activities listed below:

1. Solicit input from stakeholder groups regarding the duties of the Task Force;
2. Make recommendations as to how the Task Force can:
    a. Identify and make recommendations regarding best practices for trauma-informed care.
    b. Engage federal government agencies to collaborate with one another in promoting trauma-informed care.
3. Meet with the Task Force to review stakeholder input and recommendations to inform the development of:
    a. A National Strategy.
    b. Best practices.
    c. Recommendations for the federal government.

Beginning in April 2020, USDS conducted a total of 52 interviews, including 11 with federal staff and 41 with stakeholders across 23 states. USDS used a referral-based approach to identify stakeholders to interview. Federal staff and Congressional staffers provided the initial group of referrals. Additional referrals for frontline providers and individuals impacted by trauma were made by key stakeholders. The distribution of stakeholders by group can be found in Figure 2.

Figure 2. Interviews by Stakeholder Group.

USDS integrated insights from stakeholder input with an extensive literature review in a report [see Appendix A] that highlighted existing areas of need and offers recommendations to address some of the complex challenges in the field. As these stakeholder engagements occurred, USDS reported on them at Task Force meetings, informing the Task Force's dialogue and decision making. These recommendations helped guide the Specific Activities described in the following section.

Through their stakeholder engagement, USDS reported that trauma-informed care experts, researchers, frontline providers, and people impacted by trauma face similar difficulties such as a lack of trained professionals, challenging care coordination, and research and communication gaps. Stakeholders pointed out that it is necessary for the federal government to align language, research priorities, outcome measures, and funding approaches to support and promote trauma-informed care. Key insights from the USDS work are described below:

The Importance of Language

Deficit-based language is very powerful and contributes to feelings of being damaged, broken, or in need of fixing. The federal government can set the standard for strength-based language through their general communication and in funding announcements. Language must be clear and use clearly defined terms.

Trauma-Informed Care Spectrum

Implementation of trauma-informed care and practices often appears very different across organizations, providers, schools, and other community contexts. Although there were a wide range of definitions of trauma-informed care among stakeholders, many recognized being

trauma-informed as a spectrum on which one fell, and that spectrum could be used to measure their progress (Figure 3).

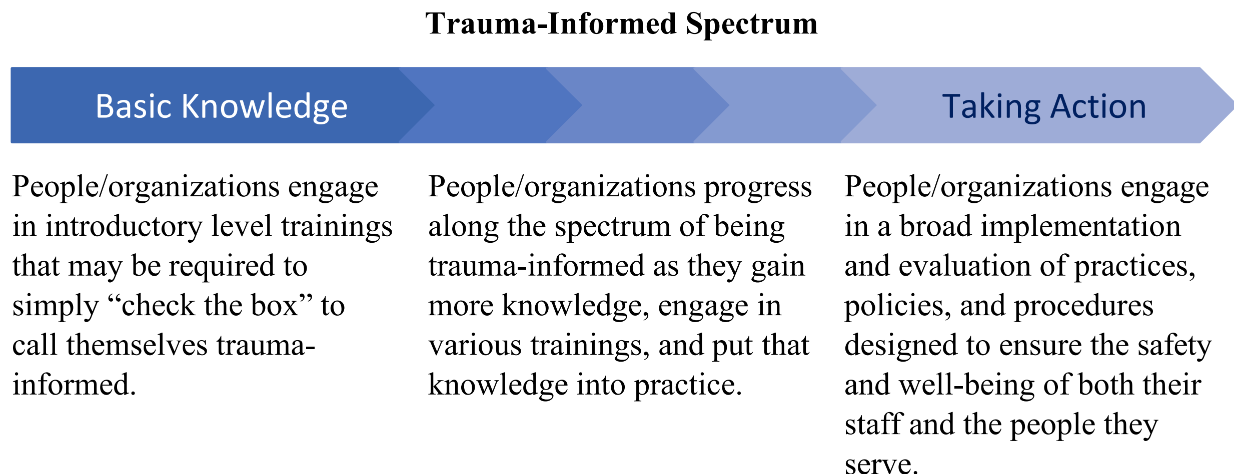


Figure 3. Trauma-Informed Spectrum.

Trauma-Informed Outcomes Assessment

While there is evidence of the effectiveness of individual level interventions for trauma related health and behavioral concerns, there is a lack of evidence on the implementation and impact of trauma-informed systems. Reasons for this challenge include that trauma-informed systems are not uniform in their approach and services. Further research and evaluation are often a low priority for organizations. Rigorous evaluation is expensive and requires organizational commitment and resources. There is a need to develop standardized measures that assess the impact of various models and components of trauma-informed care on child and family outcomes that can be adapted to meet the needs of different programs.

Workforce Challenges

Nearly all the stakeholders interviewed, but especially those frontline providers and individuals with lived experience, stressed how widespread workforce challenges limit the ability of organizations to provide the level and coordination of care that children need. Overworked and overburdened providers often have a negative impact on the families they serve, and these interactions affect the quality of care they provide.

Behavioral health and health care providers need to have increased access to training and consultation on how to conduct comprehensive assessments and implement evidence-based treatment. Training to recognize and feel equipped to address (directly or through referral) trauma-related concerns is an important component of delivering health and human services in a way that does not exacerbate concerns or “re-traumatize” the people organizations are trying to

help. However, knowledge acquisition through training is often not enough. It must be paired with comprehensive consultative efforts to support implementation and ensure consistency with best practices.

Stakeholder Resource Needs

Stakeholder groups did not express a need for a new resource identifying best practices, as this would duplicate efforts with existing clearinghouses. However, there was interest from one set of stakeholders; researchers and trauma experts indicated that having the government endorse an existing clearinghouse or specific evidence-based practices within a clearinghouse would be very beneficial to their work and to moving the field forward. There was also interest from these stakeholders in having the federal government pull together existing resources and tools that would provide clear guidance to frontline providers and organizations about the utilization of different assessments, practices, and tools. Such a resource would allow both researchers and frontline practitioners to make informed decisions about what to implement and could be used by trauma experts to guide them in their decision-making. The table below indicates the kinds of resources that stakeholders use most frequently to obtain information about trauma-informed care.

Table 1. Common stakeholder resources on trauma-informed care.

Experts and Researchers	Frontline Providers
• Colleagues • Academic Journals • National Child Traumatic Stress Network (NCTSN) • California Evidence-Based Clearinghouse for Child Welfare • SAMHSA	• Partner and Peer Organizations • National Organizations and Associations • Local Experts and Universities • Academic Journals • PACEs Connection • National Child Stress Network (NCTSN) • SAMHSA

Information Collection and Sharing

Challenges in data sharing between organizations and/or incomplete sharing of data between frontline providers can lead to duplicative services, potential re-traumatization of a child, and leave a child without a sufficiently knowledgeable advocate.

Recommendations from USDS

USDS made recommendations that fall into five categories which are summarized here but can be found in more detail in their full report.

- Continue interviews to engage stakeholder groups including representation among historically underserved groups
    - Prioritize interviews with individuals with lived experience of trauma
    - Conduct additional interviews across stakeholder groups
- Expand access to data to improve care coordination
    - Automate data for coordination of care within communities
    - Expand access to grantee data across the government
- Improve federal coordination on trauma-informed care
    - Create interagency boards
    - Codify a common language
    - Develop partnerships
    - Restructure grant funding opportunities
    - Develop a workforce strategy
- Develop a federal portal for trauma-informed care
    - Build a portal to consolidate federal resources
    - Highlight existing external resources on best practices
- Develop trauma-informed care resources
    - Develop educational information
    - Develop training and technical assistance (TTA) provider toolkit
    - Develop grant-writing toolkit

SPECIFIC ACTIVITIES

Under the proposed governance structure below, SAMHSA and the Task Force's recommendations and activities fall within one of the four pillars of the National Strategy – Best Practices, Research, Data, and Federal Coordination. Although the four pillars are distinct, there is a dynamic interplay between the activities within each pillar, and activities undertaken in one pillar may influence activities within a second pillar. It may seem that activities in one pillar are very similar to those in another pillar, however, each activity is uniquely focused on that particular pillar.

The Task Force adopted a phased approach to implementation of the specific activities described below. Some recommendations serve as building blocks for others. This approach was recommended by the USDS following extensive stakeholder interviews conducted in Summer 2020. Phase One includes activities that lay the groundwork for subsequent Task Force work and will occur in Year One. Phase Two includes activities that deliver value to stakeholders and will occur in Years Two and Three. Phase Three includes activities that sustain change and will occur in Years Four and Five.

The Task Force will carry out the following list of specific activities for purposes of fulfilling its duties as described in the legislation:

Governance Structure, and Stakeholder Engagement

The Specific Activities will be guided by the Task Force with input from a Stakeholder Council (Figure 4). SAMHSA will lead this work by facilitating and coordinating the work of the Task Force, stakeholder groups, and by authoring the required annual reports to Congress and other necessary documents.

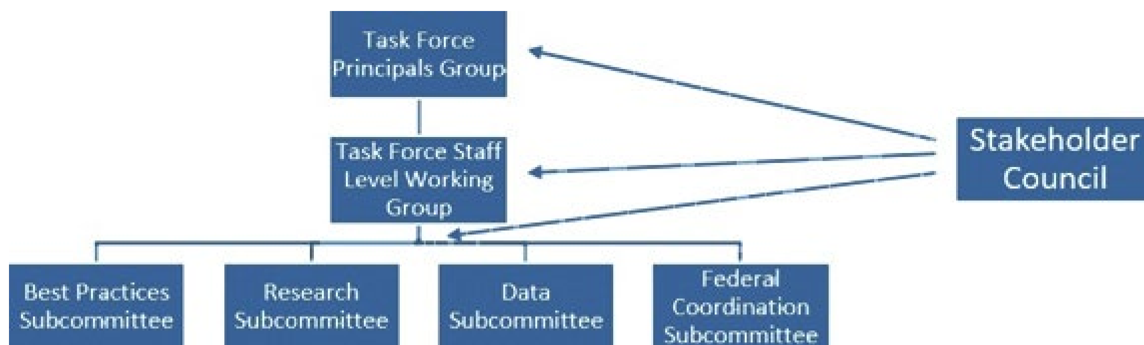


Figure 4. Proposed organizational structure.

The Task Force will include a Principals Group and a Staff-Level Working Group. The Principals Group will be comprised of Agency leadership or their designated representatives with decision-making authority. This group will meet quarterly. The Staff-Level Working Group will be comprised of career staff who will support the day-to-day progress of the activities and

will meet monthly. There will be four subcommittees staffed with Task Force members and Stakeholder Council members as appropriate to provide input on the activities and progress within each pillar. The subcommittees will meet monthly as well. Members from each subcommittee (to be determined by the Task Force) will comprise an Editorial Board. The Editorial Board will make recommendations to assist the Task Force in identifying, evaluating, and curating a list of best practices. These recommendations may include but are not limited to the strategies to evaluate the available evidence for identified practices.

The Stakeholder Council will be comprised of a diverse group of federal and non-federal stakeholders, including frontline service providers; educators; mental health and substance use disorder professionals; researchers and evaluators; experts in infant, child, and youth trauma; child welfare professionals; and individuals with lived experience. In addition to stakeholder engagement from the Stakeholder Council, the Task Force will also undertake opportunities to solicit ongoing input from stakeholders regarding specific activities within each pillar as appropriate. The Task Force proposes to contract with USDS to carry out information gathering from stakeholders.

Best Practices Pillar

Identify, evaluate, make, and annually update recommendations regarding a set of evidence-based, evidence-informed, and promising best practices with respect to prevention of exposure to potentially traumatic events, identification (screening) of trauma-related behavioral health and other health concerns referral for specific care needs, and implementation of practices and supports for infants, children, youth and their families using whole-family, multigenerational, and community-based approaches.

Goal 1: Support the evaluation, dissemination, implementation, and sustainability of best practices in preventing exposure to potentially traumatic events, identification of trauma-related behavioral health and other health care needs, referral, and treatment for specific concerns.

Goal 2: Support the promotion of wellness and resilience for those who have experienced or are at risk of experiencing trauma exposures, including exposure to substance misuse.

Goal 3: Build the capacity of the workforce to address the needs of children and families impacted by, or at risk for, exposure to potentially traumatic events and trauma-related conditions through training of the current workforce as well as supporting workforce pipeline initiatives.

Goal 4: Support the dissemination, implementation, and sustainability of best practices in systems-level trauma-informed approaches

Goal 5: Promote the dissemination, implementation, and sustainability of best practices.

Phase One..*Year One*

Activities conducted in Phase One will lay the groundwork for identifying, evaluating, and making recommendations of best practices. These activities may include but are not limited to:

- Reach consensus on common language and definitions (e.g., evidence-based, evidence-informed, historical trauma).
- Develop a strategy to:
  - Curate and evaluate a list of best practices, including evidence for those practices, related to trauma prevention, screening, referral, and treatment for those who have experienced or are at risk of experiencing trauma, including trauma as a result of exposure to substance misuse.
  - Curate and evaluate a list of best practices related to trauma-informed systems.

- Curate and evaluate a list of best practices related to workforce strategies available to address the needs of children and families impacted by, or at risk for, trauma, including trauma because of exposure to substance misuse.
- Identify best practices that center equity and inclusion and/or identify gaps and emerging needs related to equity across best practices.
- The Task Force will establish an editorial board that will identify, evaluate, and curate a list of best practices related to items listed in Phase One.

- SAMHSA will issue a NOFO to up to the community and organizational level (grant program will be referred to as the SAMHSA trauma-informed demonstration grant program hereafter).

- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Phase Two..*Years Two and Three*

Activities conducted in Phase Two will deliver value to stakeholders. These activities will include but are not limited to:

- Develop a federal portal to house best practices and deliver value to stakeholders.
- SAMHSA trauma-informed demonstration grant program: The work of the SAMHSA trauma-informed demonstration grant program will inform the ongoing work of the Task Force through regularly reports to the Task Force, the pillar subcommittees, and the stakeholder council.
- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Phase Three..*Years Four and Five*

Activities conducted in Phase Three will sustain the progress achieved in Phases One and Two. These activities may include but are not limited to:

- Coordinate and publish educational and training guidelines for professional development for front-line providers including school personnel, early childhood education program providers, childhood education program providers, special education providers, providers from child- or youth-serving organizations, housing and homeless providers, primary and behavioral health care providers, child welfare and social services providers, juvenile and family court personnel, health care providers, individuals who are mandatory reporters of child abuse or neglect, trained nonclinical providers (including peer mentors and clergy), and first responders.

- Expand workforce pipeline initiatives and enhanced workforce supports with an emphasis on secondary traumatic stress to maintain a trauma-informed workforce.
- SAMHSA trauma-informed demonstration grant program: Final reports and sustainability plans from the grantees will inform the ongoing work of the Task Force through the implementation and evaluation of best practices in specific communities that may provide the foundation of sustained systems and community level trauma-informed care. The work of the grantees will be published on the developed federal portal and through other avenues. Additional grants may be funded to continue to build the evidence of trauma-informed systems.
- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Research Pillar

The Task Force will undertake a variety of efforts to further the research base in the area of best practices for children and families who have experienced potentially traumatic events or are at risk of experiencing such events and trauma-related conditions by furthering the research base in the area of trauma identification, approaches, and trauma-informed systems for families and individuals impacted by or at risk for trauma.

Goal 1: Promote the development of an evidence base in the area of trauma and trauma-informed systems with respect to children and families.

Goal 2: Enhance research on the behavioral health and social benefits of implementation and evaluation of individual and systems-level approaches to address trauma-related needs.

Goal 3: Promote research on trauma-informed care approaches for children and families of different backgrounds and cultures.

Phase One..*Year One*

Activities conducted in Phase One will lay the groundwork for furthering the research base. These activities may include but are not limited to:

- Reach agreement around common terms and definitions to guide research in consultation with the Stakeholder Council.
- Curate a list of federal funding streams and resulting grants for research on trauma-informed child, family, and systems-level interventions.
- Identify gaps in the evidence base, with specific attention to the following areas:
    - Screening and referral processes that identify early signs and risk of trauma and resilience in infants, children, youth, and their families.
    - Implementation and evaluation of individual-level child and family interventions to address trauma.
    - Implementation and evaluation of systems-level interventions to address trauma.
    - Racial equity across trauma-informed care.
    - Equity across other historically marginalized groups including, but not limited to, children and youth with disabilities and those identifying as LGBTQIA.
    - The effect of historical trauma.

- SAMHSA's trauma-informed demonstration grant program: The Task Force will provide advice and consultation to SAMHSA on the development of evaluation questions. . Regular reporting of the work of the demonstration grant program will inform the ongoing work of the Task Force, the subcommittees, and the Stakeholder Council.

- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Phase Two..*Years Two and Three*

Activities conducted in Phase Two will deliver value to stakeholders. These activities may include but are not limited to:

- Integrate consensus language into grant announcements across agencies.
- Identify, develop, and implement a set of standardized, theory-based outcomes and outcome measures that can align across agencies and grant programs to guide common data collection.
- Develop common evaluation criteria for use across federal agencies.
- Develop research and evaluation to fill gaps in the evidence base, reduce health disparities, and address racial equity and inclusion.
- Cultivate strategic partnerships with national organizations and associations to develop opportunities for public/private research partnerships. Grant opportunities could partner providers and researchers to build the knowledge base in key areas. For example, how and when and why to screen, what are effective early interventions, what are scalable models of comprehensive care that include screening, intervention and referral?
- SAMHSA trauma-informed demonstration grant program: Continue to monitor the evaluation and report to the Task Force, the subcommittees, and the Stakeholder Council.
- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Phase Three...*Years Four and Five*

Activities conducted in Phase Three will sustain the research progress achieved in Phases One and Two. These activities may include but are not limited to:

- Issue cross-agency grants or coordinate funding announcements to fill research gaps.
- Implement and evaluate standardized outcome measures across agencies and grant programs.

- Implement and evaluate research to fill gaps in the evidence base, reduce health disparities, and address racial equity and inclusion.
- SAMHSA trauma-informed demonstration grant program: Develop a set of recommendations, logic models, and/or other tools that can be used across the government to evaluate similar programs.
- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Data Pillar

The Task Force will undertake a variety of efforts to further the ability to coordinate data gathering and sharing. This will ensure that the needs of children and their families will be better assessed through screening and referral, and will streamline services, enhance communication and collaboration between federal agencies and stakeholders, and improve the care of children and families impacted by trauma.

Phase One..*Year One*

Activities conducted in Phase One will lay the groundwork for furthering the ability to collect and share data across federal agencies. These activities may include but are not limited to:

- Develop common definitions, measures, and tools in the area of trauma and trauma-informed care that facilitate the collection of data that could be used across agencies and programs. These definitions would mirror those developed under the best practices and research pillars.
- Conduct policy research to identify the various federal and state policies governing information-sharing, particularly around information found in electronic health records, educational records, and administrative and claims data.
- Create templates of data-sharing agreements or memoranda of understanding between different agencies to allow for the sharing of specific types of information.
- Issue guidance and/or templates that can be used by local community and state organizations address privacy concerns, ensure compliance with applicable federal laws (i.e. HIPAA, FERPA, 42 CFR part 2), and have the flexibility to be adapted to comply with state and local laws.
- Conduct an environmental scan that illustrates federal grantee reporting systems, what data is available, and how that data might be leveraged by the government, grantees, and researchers.
- Suggest possible modifications to contract vehicles that would facilitate the implementation of the changes needed to make data more accessible.
- Solicit input from stakeholders on Task Force activities as appropriate. Potential strategies for information gathering include:
  - Request for information; and
  - Expert convenings or consensus conferences.
- SAMHSA trauma-informed demonstration grant program: In partnership and in concert with the work done under the Research Pillar, identify a set of data indicators that can be

collected through the grant projects and through readily available local, state, and federal data sources that can inform the evaluation of the project.

- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Phase Two .... *Years Two and Three*

Activities conducted in Phase Two will deliver value to stakeholders. These activities may include but are not limited to:

- Create guidelines and promote systems and infrastructure investment for communication/collaboration around data across federal agencies.
- Incorporate data-sharing as authorities allow into grant requirements to facilitate the dissemination of valuable information to other organizations.
- Continue to conduct additional research into how data and information sharing might improve care coordination, research, and outcomes of trauma-informed care.
- SAMHSA trauma-informed demonstration grant program: Continue to monitor the data collection activities and make recommendations that can be implemented in other communities and jurisdictions. These activities and regular reporting will inform the ongoing work of the Task Force, the pillar subcommittees, and the Stakeholder Council.
- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Phase Three .... *Years Four and Five*

Activities conducted in Phase Three will sustain the research progress achieved in Phases One and Two. These activities may include but are not limited to:

- Issue guidance on the collection and utilization of aggregate data from screenings, referrals, and the provision of services and supports to evaluate outcomes and improve processes for trauma-informed services and supports.
- Develop a feasibility study regarding the ability of making grantee data government wide (e.g., grantee activities, client-level outcomes, systems-level outcomes) open access, and determine how such access might benefit their federal partners, researchers, and future grantees.
- Promote technology to enhance data-sharing, communication, and collaboration in the area of trauma affecting children, adolescents, and families.
- SAMHSA trauma-informed demonstration grant program: In partnership and in concert with the best practices and research pillar work, identify a set of recommendations, data

indicators, and/or other tools that can be used across the government to collect data from similarly situated programs.

- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Federal Coordination Pillar

To promote communication and collaboration in the area of trauma, trauma risk, and trauma-informed care across the federal government and to perform the duties set forth in the SUPPORT* for Patients and Communities *Act, the Task Force will undertake a variety of activities ranging from knowledge sharing to coordinated funding opportunities in order to provide support to children and their families who have experienced or are at risk for exposure to potentially traumatic events and trauma-related health and behavioral needs.

Goal 1: Develop systems to coordinate across the government for the benefit of children and families at risk for or impacted by trauma and to promote resilience.

Sub-goal 1a: Identify options for coordinating existing grants that support children and their families as appropriate, who have experienced, or are at risk of experiencing, exposure to substance misuse or other trauma.

Goal 2: Coordinate workforce development efforts in the area of trauma and trauma-informed systems.

Goal 3: Align priorities and standardize concepts of trauma and trauma-informed care across federal agencies.

Sub-goal 3a: Create and share clear interagency federal guidance.

Sub-goal 3b: Update and standardize language through guidance and white papers.

Phase One..*Year One*

Activities conducted in Phase One will lay the groundwork for successful federal coordination. These activities may include but are not limited to:

- Provide opportunities for knowledge sharing across federal agencies serving children and families who have experienced or are at risk of experiencing trauma.
- Develop coordinated agency priorities for inclusion in agency strategic planning, with buy-in from agency leadership.
- Conduct a scan of existing programs and legislation that funds or delivers trauma-informed care.
- Identify options for coordinating existing federal grants and developing new coordinated funding opportunities, including the potential creation of an Interagency Grant Review Board.

- Identify options for other ways to improve coordination, planning, and communication within and across agencies, including coordinated guidance and technical assistance.
- Solicit input and coordinate development of the funding opportunity announcement for the SAMHSA trauma-informed demonstration grant program.
- Solicit input from stakeholders on the proposed and ongoing activities of the Task Force. Include this feedback in the required annual report to Congress.
- Build a federal website/information portal to consolidate and disseminate federal information on best practices in trauma-informed care to the public.

Phase Two..*Years Two and Three*

Activities conducted in Phase Two will deliver value to stakeholders. These activities may include but are not limited to:

- Implement common language across federal resources and funding opportunities for trauma-informed care to ensure that language is consistently used and implemented.
- Develop a model of providing technical assistance to build community and organizational trauma-informed systems and coordinate technical assistance provided to federal grantees providing care to children and families who have experienced or are at risk of experiencing trauma across federal agencies.
- Issue federal joint guidance and policy statements emphasizing the importance of trauma-informed care across the landscape of child and family serving systems.
- Create a handbook for funding announcement development that provides resources to federal agencies.
- Continue the monitoring of the SAMHSA trauma-informed demonstration grant program and other federally funded grant projects and develop coordinated funding opportunities for efforts to build and sustain a trauma-informed workforce.
- Solicit input from stakeholders on activities, make recommendations to the Task Force to Congress through an annual report.

Phase Three...*Years Four and Five*

Activities conducted in Phase Three will sustain the federal coordination achieved in Phases One and Two. These activities may include but are not limited to:

- Continue to promote changes to language, funding announcements, and grant programs to improve federal coordination.
- Promote statutory changes needed to sustain federal coordination.

- Solicit input from stakeholders on the proposed and ongoing activities of the Task Force. Include this feedback in the required annual report to Congress.

Implementation Plan

- Contract with USDS to facilitate stakeholder engagement.
- To achieve the Specific Activities described above, under SAMHSA's leadership, the Task Force will use the governance structure detailed below. All the activities will be guided by the Task Force with input from a Stakeholder Council described previously. The Task Force will include a Principals Group and a staff-level Working Group from the agencies listed in the legislation. The Principals Group will be comprised of Agency leadership or their designated representatives with decision-making authority and will meet quarterly. The staff-level Working Group is comprised of career staff who will support the day-to-day progress of the activities and will meet monthly. There will be four subcommittees comprised of Stakeholder Council members to provide input on the activities and progress within each pillar.
- The Task Force will receive ongoing input from a Stakeholder Council comprised of federal and non-federal stakeholders, including frontline service providers; educators; mental health and substance use professionals; researchers and evaluators; experts in infant, child, and youth trauma; child welfare professionals; and individuals with lived experience.

Barriers to Implementation

This plan is ambitious, reflecting both the need to support children, families, and communities who have experienced or are at risk of experiencing trauma and the opportunity to develop a comprehensive and coordinated federal response that builds a trauma-informed system. It cannot be accomplished in its entirety within existing or anticipated resource constraints. For this implementation plan to be successful, four categories of barriers will need to be overcome:

Funding: Consistent funding that is responsive to the phased approach recommended herein will be critical to guaranteeing that the work is adequately resourced and useful to the stakeholder and wider federal community. The ability to fulfill the activities and accomplish the proposed outcomes is dependent on adequate funding. Future Reports to Congress will detail what the Task Force was able to achieve based on the available funding.

See the budget request (enclosed) for specific resources necessary to achieve these goals.

Leadership Commitment: Federal Coordination will require the commitment from leadership at all levels of federal agencies and may be challenging for several reasons:

- Each agency has their own templates and mechanisms for establishing priorities, developing funding announcements, data collection, and evaluation.

There must be commitment at all levels to ensure that developed common data measures, evaluation protocols, and other mechanisms created by the Task Force can be implemented by the various agencies.

- Each agency must ensure that trauma-informed care, as defined by the Task Force, is integrated into their strategic and organizational plans.

Existing Agency Policies: Existing grant-making policies in federal agencies may prohibit the addition of common research and/or data collection mechanisms. Legislative change may be necessary to address such barriers.

Task Force Sunset: As currently written in section 7132(i) of the SUPPORT for Patients and Communities Act, the Task Force is set to dissolve not later than September 30, 2023.

Outcomes by Phase

The anticipated outcomes by phase, dependent on funding, are detailed below.

Phase One

Lay the groundwork for subsequent Task Force work *(Year One)*

- Dedicated SAMHSA and identified federal agency staff to spearhead Task Force work
- Increased communication between agencies through regular meetings sharing of documents through the federal portal
- Technical expert panel convened, and meetings held that include people with lived experiences
- Common language and common definitions developed
- The Editorial Board will develop clear processes for curating best practices and workforce strategies that will be uploaded on the federal portal.
- Curated list of federal data sources
- Templates of data sharing agreements and MOUs created
- SAMHSA trauma-informed demonstration grant program funded, and implementation planning begun
- Outcomes developed and guided by stakeholder involvement and input

Phase Two

Activities that deliver value to stakeholders and increase federal agency collaboration and coordination *(Years Two and Three)*

- Interagency grant review board and Editorial Board work continues
- Coordinated federal research strategy developed
- Expanded research on implementation of individual and systems-level interventions
- Federal guidelines for data and information sharing developed
- Coordinated educational information and guidance created
- Training and technical assistance provider toolkit
- Enhanced workforce pipeline initiatives
- Grant-writing toolkit
- Enhanced partnerships with federal and non-federal staff
- Outcomes developed and guided by stakeholder involvement and input

Phase Three

Activities that sustain change *(Years Four and Five)*

- Aligned, strengths-based approach across federal programs, initiatives, and funding opportunities
- Federal portal/database of consolidated information and resources on best practice in trauma-informed care
- Expanded access to data collected through federal grants to facilitate research
- Improved care coordination across sectors
- Expanded workforce available to address the needs of children and families impacted by trauma
- Enhanced workforce supports for frontline staff
- Outcomes developed and guided by stakeholder involvement and input

BUDGET BY PHASE

The Task Force budget projection includes the development of a federal portal, ongoing stakeholder research (as mandated), ongoing meetings with the federal staff and stakeholders per pillar, and the pilot grant program for Phase One.

Budget Projections

Phase One – Year One	**Budgeted Amount**
Federal Portal Development Federal Portal Development Design Research Effort	$5,100,000
Virtual Task Force and Stakeholder Council Meetings	$56,000
Stakeholder Consultation/Listening Sessions (one for each pillar)	$76,000
Expert Consultation	$350,000
Briefing, White Papers, and environmental scan	$300,000
SAMHSA Trauma-Informed Demonstration Grant Program	$2,500,000
Total:	$8,382,000

Phase Two – Years Two and Three	**Budgeted Amount**
Federal Portal Development Federal Portal Development Design Research Effort	$5,100,000
Ongoing Stakeholder Research (year three)	$500,000
Virtual Task Force and Stakeholder Council Meetings	$112,000
Stakeholder Consultation/Listening Sessions (one for each pillar)	$152,000
Expert Consultation	$700,000
Briefing and White Papers – one per year	$300,000
SAMHSA Trauma-Informed Demonstration Grant Program	$5,000,000
Total:	$11,864,000

Phase Three – Years Four and Five	**Budgeted Amount**
Federal Portal Maintenance and Ongoing Stakeholder Research	$1,000,000
Virtual Task Force and Stakeholder Council Meetings	$112,000
Stakeholder Consultation/Listening Sessions (one for each pillar)	$152,000
Expert Consultation	$700,000
Briefing and White Papers	$340,000
SAMHSA Trauma-Informed Demonstration Grant Program	$5,000,000
Total:	$7,304,000

CONCLUSION

Childhood trauma is a significant public health problem in the United States and the COVID-19 pandemic, and the resulting social isolation and economic crisis has created a heightened need for attention to the adversities faced by children, youth, families, and communities. The establishment of the Task Force in the SUPPORT for Patients and Communities Act provides the opportunity for an ambitious, whole of government approach to preventing and responding to trauma and building resilience. This National Strategy and Operating Plan proposes to identify and disseminate evidence-based, evidence-informed, and promising practices; build the research and evidence base; further the ability to coordinate data gathering and sharing; and develop a coordinated approach among member agencies. We propose a series of specific activities that will be implemented in a phased approach and with input from stakeholders, and a corresponding Budget. Full implementation of the proposed Plan, depending on funding, will guide the development of a coordinated, equitable trauma-informed system in the United States.

Appendix A: USDS Report

Appendix B: Membership Lists and Meetings

ITF-TIC Agency Attendance Record

Department/Agency Name	Acronym
Administration of Children and Families	ACF
Agency for Healthcare Research and Quality	AHRQ
Office of the Assistant Secretary for Planning and Evaluation	ASPE
Centers for Disease Control and Prevention	CDC
Centers for Medicare and Medicaid Services	CMS
Department of Defense	DoD
Department of Education	DoE
Department of Justice	DoJ
Food and Drug Administration	FDA
Human Resources and Services Administration	HRSA
Department of Housing and Urban Development	HUD
Indian Health Service	IHS
National Institutes of Health	NIH
Office of the Assistant Secretary for Health	OASH
Office for Civil Rights	OCR
Office of Justice Programs	OJP
Office of Minority Health	OMH
Substance Abuse and Mental Health Services Administration	SAMHSA
U.S. Digital Services	USDS
Department of Veterans Affairs	VA

ITF-TIC Agency Attendance Record

Year	2019				2020						2021				
Month	05	07	11	12	02	04	06	08	10	12	02	04	04	06	07
Day	31	12	21	12	03	16	18	14	15	17	25	01	15	24	22
ACF	v	v		v	v	v			v	v	v	v	v	v	v
AHRQ					v			v		v	v	v	v	v	
ASPE	v	v	v	v	v	v		v	v	v	v	v	v	v	v
CDC		v		v	v			v		v	v	v		v	
CMS	v				v	v		v	v	v	v	v	v	v	v
DoD	v				v							v			
DoE	v	v	v	v	v	v			v	v	v	v	v	v	
DoJ	v		v	v	v			v			v				v
FDA		v			v	v		v		v	v	v	v	v	v
HRSA	v	v			v	v		v	v			v	v		v
HUD		v	v		v										
HIS	v	v		v	v	v		v	v	v	v	v		v	v
NIH	v	v	v	v	v			v	v	v	v	v	v	v	v
OASH				v	v	v						v			
OCR		v								v	v	v		v	v
OJP					v					v					
OMH	v	v										v			
SAMHSA	v	v	v	v	v	v	v	v	v	v	v	v	v	v	v
USDS			v	v	v	v		v			v		v	v	
VA														v	v

Appendix C: Definitions

Definitions of Key Terms

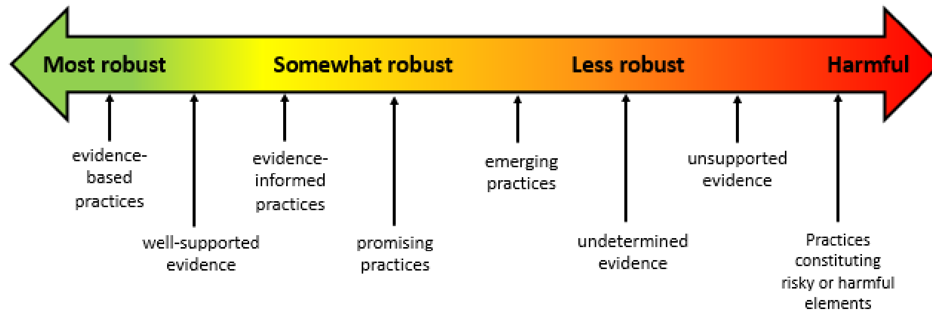
Adaptation: Adaptation is the process of making changes to an Evidence-Based Program (EBP) so that it is more suitable for a particular population or an organization's setting or program structure without compromising or deleting its core components.[11]

Adverse Childhood Experiences: Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems, or instability due to parental separation or incarceration of a parent, sibling, or other member of the household.[12] It is important to note that ACEs may overlap with trauma, but are not necessarily traumatic.

Best Practices: A resource that describes the available strategies to address a specific circumstance or condition, and the current evidence associated with these strategies.[13] An overarching term for interventions or models of care that meet either the definition of evidence-based, evidence-informed, or promising practices and are delivering the service and assessing outcomes in ways that accommodate individual and community needs and preferences. Where possible, "best practices" should designate the level of evidence available about a strategy. The task force acknowledges that evidence exists on a continuum, ranging from "unsupported" or even "harmful" to "well supported" and "supported." In the area of trauma-informed care, much of the evidence is in the "emerging" category, but some may be in the "unsupported" or "promising" category.[14]

[11] *Making Adaptations Tip Sheet.* (n.d.). Retrieved from Administratin for Children and Families: https://www.acf.hhs.gov/sites/default/files/documents/prep-making-adaptations-ts_0.pdf
[12] *About the CDC-Kaiser ACE Study.* (2021). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/aces/about.html
[13] Spencer, L. M., Schooley, M. W., Anderson, L. A., KOchtitzky, C. S., DeGroff, A. S., Devlin, H. M., & Mercer, S. L. (2013). *Seeking Best Practices: A Conceptual Framework for Planning and Improving Evidence-Based Practices.* Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/pcd/issues/2013/13_0186.htm
[14] *Understanding Evidence.* (2014). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/pdf/continuum-chart-a.pdf

Figure 1: continuum of evidence-based practices and the common terms used



Complex Trauma: Complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's development and the formation of a sense of self. Since these events often occur with a caregiver, they interfere with the child's ability to form a secure attachment.[15]

Cultural Competence: Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.[16]

Equity: As defined in the Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government[17], equity means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. The term "underserved communities" refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of "equity."

[15] *National Child Traumatic Stress Network.* (2021). Retrieved from National Child Traumatic Stress Network: https://www.nctsn.org/
[16] *Our Mission*. (2021). Retrieved from The Office of Minority Health: https://minorityhealth.hhs.gov/default.aspx
[17] *Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. (2021, January). Retrieved from The White House: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

Evidence-based Practice: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of the individual patient. Evidence-based practice is the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations, and values. The best evidence is usually found in clinically relevant research that has been conducted using sound methodology.[18]

Evidence-based and evidence-informed interventions and models of care are well-supported or supported by evidence of effectiveness that includes replication. Evidence-based programs are evaluated by randomized controlled trials or meta analytic reviews in applied studies across two different settings, while evidence-informed programs include evidence from quasi-experimental designs in applied studies across two similar settings.[19]

Evidence-Informed: Interventions or models of care that are supported by research evidence from one randomized or statistically controlled evaluation OR that meet important methodological requirements as specified in the above description for evidence-based practice.

Families impacted by substance use disorders: Exposure to substance misuse affects families in a variety of ways. This exposure is inclusive of neonatal withdrawal due to opioids and other substances, exposure to substance misuse, abuse, and neglect resulting from parental substance misuse, and adolescent substance misuse.[20]

Historical trauma:[21] Historical trauma is a concept can be understood as consisting of three primary elements: a "trauma" or wounding; the trauma is shared by a group of people, rather than an individually experienced; the trauma spans multiple generations, such that contemporary members of the affected group may experience trauma-related symptoms without having been present for the past traumatizing event(s).[22]

Implementation: A specified set of activities designed to put into practice an activity or program of known dimensions. Implementation processes are purposeful and are described in sufficient detail such that independent observers can detect the presence and strength of the "specific set of activities" related to implementation. In addition, the activity or program being implemented is described in sufficient detail so that independent observers can detect its

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[18] *Evidence-Based Decision-making.* (2018). Retrieved from Agency for Healthcare Research and Quality: https://www.ahrq.gov/prevention/chronic-care/decision/index.html

[19] *Understanding Evidence.* (2014). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/pdf/continuum-chart-a.pdf

[20] *Treatment Improvement Protocol (TIP) 39: Substance Use Disorder Treatment and Family Therapy*. (2020, September). Retrieved from Substance Abuse and Mental Health Services Administration: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-02-012-508%20PDF.pdf

[21] The taskforce identified a gap in the literature regarding the definitions of historical trauma as well as intergenerational trauma. More work is necessary to develop an agreed upon definition of these terms that attends to the concerns of all groups, including all races and ethnic groups. The definitions agreed upon by the task force are "working definitions," but more work is required to develop clear terminology that adequately reflects the needs and experiences of all groups and recognizes the individual and community resilience evident in communities of color.

[22] Mohatt, N. V., *Historical trauma as public narrative: A conceptual review of how history impacts present-day health*, Social Science Medicine, (2014 April) 106; 128-136. doi: 10.1016/j.oscscimed.2014.01.043, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4001826/pdf/nihms569976.pdf

presence and strength. When thinking about implementation, the observer must be aware of two sets of activities (intervention-level activity and implementation-level activity) and two sets of outcomes (intervention outcomes and implementation outcomes).[23]

Intergenerational trauma:[24] Intergenerational trauma generally refers to the ways in which trauma experienced in one generation affects the health and well-being of descendants of future generations.[25]

Interventions: "Interventions" encompass therapeutic and clinical interventions and can be provided at the individual, family or community level. Interventions are provided to prevent or treat a specific condition and can be tested using a randomized controlled trial.[26]

Post-traumatic stress disorder (PTSD): As defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), PTSD is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event. Symptoms can include intrusive thoughts, avoidance of reminders of the event, negative thoughts and feelings, and arousal and reactive symptoms.[27]

Practice-based evidence: The term practice-based evidence acknowledges that efficacy or effectiveness is only one of many pieces of information required to make the case that an intervention will ultimately impact public health. It requires a deep understanding of the challenges faced by both those who deliver and those who receive the intervention, and requires formative work in the community and the use of partnership models such as community-based participatory research where both the public health intervention and the research strategy are informed by the combined wisdom and experience of health care consumers, practitioners, and researchers.[28]

Prevention: Prevention includes a wide range of activities, known as "interventions", aimed at reducing risks or threats to health.[29]

Promising practices: Promising practices are those that show some evidence of effectiveness through evaluations using non-experimental designs without replication. Promising programs

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[23] Fixsen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005, January). *Implementation Research: A Synthesis of the Literature*. Retrieved from National Implementation Research Network: https://nirn.fpg.unc.edu/resources/implementation-research-synthesis-literature

[24] The taskforce identified a gap in the literature regarding the definitions of historical trauma as well as intergenerational trauma. More work is necessary to develop an agreed upon definition of these terms that attends to the concerns of all groups, including all races and ethnic groups. The definitions agreed upon by the task force are "working definitions," but more work is required to develop clear terminology that adequately reflects the needs and experiences of all groups and recognizes the individual and community resilience evident in communities of color.

[25] Sangalang, C. C., & Vang, C. (2017, June). Intergenerational Trauma in Refugee Families: A Systematic Review. *Journal of Immigrant and Minority Health*, 19(3): 745–754. doi:10.1007/s10903-016-0499-7

[26] McKibbon, A. K. (1998). Evidence-base practice. *Bulletin Medical Library Association*, 86(3): 396–401. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC226388/pdf/mlab00092-0108.pdf

[27] Association, A. P. (2013). *Diagnostic and statistical manual of mental disorders.* (5, Ed.) doi:https://doi.org/10.1176/appi.books.9780890425596

[28] Ammerman, A., Woods Smith, T., & Calancie, L. (2014). Practice-based evidence in public health: improving reach, relevance, and results reach, relevance, and results. *The Annual Review of Public Health*, 35:47–63. Retrieved from https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-032013-182458

[29] *Picture of America.* (2017). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

tend to be real-world informed or adaptations of an evidence-based practice to reflect a different community context.[30]

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[31]

Resilience: The process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress.[32]

Secondary trauma: The term "Secondary Traumatic Stress" is used to describe individuals' subclinical or clinical signs and symptoms of PTSD that mirror those symptoms of clients, friends, or family members who have experienced trauma.[33] While it is not recognized by current psychiatric standards as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to or associated with PTSD. These symptoms include hyper-arousal; intrusive symptoms, avoidance or emotional "numbing," anxiety, and depression.[34] Related terms include "vicarious trauma," "burnout," and "compassion fatigue."

Social determinants of health: Conditions in the environment in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of *social determinants* include: availability of resources to meet daily needs (e.g., safe housing and local food markets); access to educational, economic, and job opportunities; access to health care services; quality of education and job training; availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities; transportation options; and, public safety.[35]

Toxic Stress: Toxic stress results from adverse experiences that may be sustained for a long period of time. This type of stress can disrupt early brain development, compromise the functioning of important biological systems, and lead to long-term health problems.[36]

Trauma: Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[37]

Trauma-informed care: Trauma-informed care (TIC) can refer to either evidence-based trauma interventions (e.g., Trauma-Focused Cognitive Behavioral Therapy[1]) or to a broader

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[30] *Understanding Evidence.* (2014). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/pdf/continuum-chart-a.pdf

[31] *Recovery.* (2014). Retrieved from Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/sites/default/files/samhsa-recovery-5-6-14.pdf

[32] American Psychological Association https://www.apa.org/helpcenter/road-resilience

[33] Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

[34] *PTSD: National Center for PTSD*. (2019). Retrieved from U.S. Department for Veterans Affairs: https://www.ptsd.va.gov/professional/treat/type/work_with_survivors.asp#three

[35] *Social Determinants of Health*. (2021). Retrieved from HealthyPeople.gov: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[36] Middlebrooks JS, Audage NC. (2008) *The Effects of childhood stress on health across the lifespan.* Retrieved from Centers for Disease Control and Prevention: https://stacks.cdc.gov/view/cdc/6978

[37] *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* (2014). Retrieved from Substance Abuse and Mental Health Services Administration: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

systems-level approach that integrates trauma-informed practices (acknowledging that potentially traumatic exposures have taken place) throughout a service delivery system (e.g., health care system, educational system). The implementation of individual and family level intervention is one part of a trauma-informed system, but alone, does not constitute trauma-informed care.

Trusted adult: A person whom a child, adolescent, or young adult can turn to, and who will take them seriously. A trusted adult may include a parent, teacher, coach, or other adult figure.[38]

[38] Pringle, J., Whitehead, R., Milne, D., Scott, E., & McAteer, J. (2018). The relationship between a trusted adult and adolescent outcomes: a protocol of a scoping review. *Systematic Reviews*, 7:207. doi:10.1186/s13643-018-0873-8