Summit County Trauma-Informed Care Initiative: Needs Assessment Report to the Summit County Opiate Abatement Advisory Council

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Preface

The landscape of public health and social services is evolving, with an increasing recognition of the pervasive impact of trauma on individuals and communities. Trauma-informed care (TIC) has emerged as a critical framework that acknowledges the widespread impact of trauma and integrates this understanding into policies, procedures, and practices to promote healing and resilience.

This needs assessment report is a comprehensive analysis of trauma-informed care initiatives across our county. It aims to evaluate the current state of TIC implementation, identify gaps in services, and recommend strategies for enhancing our collective response to trauma.

Summit County, like many other regional systems, faces significant challenges related to trauma, including but not limited to, adverse childhood experiences, domestic violence, and community violence. These traumatic experiences can have profound and lasting effects on physical and mental health, educational outcomes, and overall well-being. Therefore, our systems of care must be equipped to address these complex needs with sensitivity and effectiveness.

This report is the culmination of extensive research, including surveys, interviews, and focus groups with stakeholders from various sectors such as healthcare, law enforcement, and social services. It reflects the voices of those on the front lines of service delivery, as well as the experiences of individuals who have navigated these systems.

Our findings highlight the strengths and innovative practices currently in place, as well as the areas that require attention and improvement. By understanding the current landscape, we can better allocate resources, train our workforce, and develop policies that foster a supportive and responsive environment for all individuals, families, and communities affected by trauma.

We are grateful to all the participants who contributed their time and insights to this assessment. Their commitment to enhancing trauma-informed care in our county is both inspiring and essential for driving meaningful change. We also extend our appreciation to the organizations and agencies that supported this endeavor, which demonstrates their dedication to advancing the well-being of our community.

As we move forward, let this report serve as a catalyst for action and a guide for developing a cohesive, county-wide approach to trauma-informed care. Together, we can build a more resilient and compassionate community where every individual can heal and thrive.

Sincerely,

John, Becky, Dawn, Faii, & Rikki

June 30th, 2024

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Section I: Executive Summary

Introduction

This needs assessment report summarizes our efforts to evaluate trauma-informed care (TIC) initiatives across Summit County. Recognizing the profound impact of trauma on individuals, families, and communities, this report seeks to identify current strengths and gaps in services and propose recommendations for improved care.

Objectives

This project had two primary deliverables.

1) A comprehensive *Trauma Informed Care Needs Assessment*: The needs assessment involved working with systems and sectors that are encountered by persons with substance use disorders (SUDs) to identify strengths, weaknesses, gaps, and barriers as they relate to TIC, an assessment of readiness within these sectors to adopt TIC practices, and targeted recommendations for change. This report is the culmination of the findings from this process.
2) A Provisional *Implementation Plan*: In collaboration with county-level stakeholders, we will utilize the completed needs assessment and recommendations as a foundation to develop a comprehensive TIC implementation plan. The implementation plan will be developed after the needs assessment is disseminated.

Methodology

Data were collected through a combination of surveys, interviews, and focus groups with key stakeholders working or living in Summit County, including administrators, direct service providers, community members, and individuals with SUD-related lived experiences. Additionally, relevant literature and archival data from organizations and systems in Summit County were reviewed to support the findings.

Key Findings

Several insights emerged from each data collection modality utilized in this project. A review of the archival data highlighted the significant prevalence and trends of both substance use and trauma in Summit County. Through the process of gathering and analyzing the archival data, it became clear that a more systematic and efficient process is needed for evaluating the data being collected across the county. Furthermore, existing data related to TIC initiatives within Summit County was lacking, underscoring the need for a more comprehensive and integrated approach to tracking and assessing local TIC initiatives.

Results from the survey data identified that trauma is not exclusively a consumer experience; our behavioral health, first responder, and child protective services workforces experience is impacted by trauma as well. This finding highlighted the importance of fostering a cultural shift across organizations about embracing TIC. This may include integration within and across sectors, as well as efforts to acknowledge the trauma experiences of both consumers and the workforce. There were diverse responses regarding the implementation of trauma-informed principles, with direct service providers tending to score lowest across domains as compared to consumers and administrators. Relatedly, administrators tended to score highest across domains, indicating that they may perceive the organization is doing better at TIC integration than direct service providers

do. This finding supports the need for a deeper understanding of how trauma-informed principles are currently being implemented within and across systems of care to help consumers, the workforce, and the communities they serve. **It is worth noting that the survey was emailed to 3,379 local participants and included multiple reminders to complete it. Yet, the response rate was low, with 12% of consumers and 8.3% of professionals responding.** We need to see a significant improvement in community buy-in and engagement as we move forward. Increased engagement would enable a more comprehensive view of the TIC landscape in Summit County.

Findings from the key stakeholder interviews and focus groups showed that trauma impacts consumers, our workforce, and surrounding communities. This is congruent with survey findings. Wellness and healing initiatives are necessary at every level and should be tailored to specific sectors. Qualitative findings indicated a low consensus and depth of knowledge on definitions of trauma and TIC. This emergent theme highlighted the need to develop and use a shared language and definitions when approaching TIC in our work. Multiple themes related to the ongoing needs of the workforce were identified, including increased training requirements, wellness initiatives, and strategies for addressing the workforce shortage.

Additional key findings from a synthesis of the data were as follows:

- While several promising efforts are underway across the county, a coordinated trauma-informed response is lacking within our county, and there are few known evidence-based resources to support these efforts. We need a more systematic approach to coordinating the integration of trauma-informed care across the diverse service sectors in Summit County.
- There is a lack of buy-in or systemic integration of TIC within the community and organizations across Summit County. Specifically, within organizations, data evidenced the need for an organizational cultural shift toward trauma-informed care as everyone's responsibility, not simply a consumer-focused, clinical imperative.
- There are apparent disparities in health and trauma among the people we are serving, and we need to identify strategies to combat this.
- Our workforce needs more tailored support to strengthen staff wellness.

Recommendations

Based on the findings, the following unranked recommendations should be considered to improve TIC efforts in Summit County:

- Develop and support the 'Summit County Trauma-Informed Coordinating Center' (SCTICC), a centralized, neutral hub responsible for organizing a response to these recommendations and facilitating the implementation of a TIC approach across the county.
- Adhere to a standard definition of TIC across the various service sectors throughout the county.
- Generate community buy-in by disseminating the current findings and establishing a communication subcommittee that can engage with the community.
- Adapt government and philanthropic funding contracts to include language about TIC implementation organizationally, in addition to clinical services.

- Engage and train existing coalitions so they can continue their current TIC-focused efforts and develop strategies for further integrating TIC considerations into their work with diverse community partners.
- Address health and trauma disparities in the African American community.
- Expand recovery coach and peer support.
- Improve trauma-informed training and education across diverse sectors serving persons impacted by addiction.
- Continually evaluate the quality of patient-centered services across the county.
- Improve workforce wellness.
- Implement stigma reduction strategies throughout the county at the individual, interpersonal, and organizational levels, as well as across various sectors.

As may be noted, these recommendations may be clustered around the following categories:

I. Coordination of efforts, accountability & evaluation
II. Coalition focusing
III. Client/Consumer-related initiatives
IV. Workforce initiatives
V. Systemic (macro) initiatives

Utilizing these categories to systematically develop an implementation plan for acting on the recommendations listed above will provide clear guideposts for the next steps in improving TIC efforts throughout Summit County.

Conclusion

Addressing the recommendations outlined in this report is crucial for enhancing the well-being of our community; however, there are limitations to relying solely on existing funding to achieve this goal. This report may also help leverage funding from federal, regional, and philanthropic sources. By implementing the recommended actions, we can enhance TIC implementation and integration across sectors and organizations throughout Summit County, thereby creating a more resilient and supportive environment for individuals, families, and communities affected by SUD and trauma. These Summit County efforts can become a model for replication elsewhere.

Section II: Overview, Goals, and Methodology

Overview: Key Highlight

The goal of this project was to conduct an initial needs assessment of trauma-informed care (TIC) implementation across Summit County, in support of a county-wide strategic effort to implement TIC across sectors routinely touched by persons struggling with opioid use disorder (OUD) and other substance use disorders (SUDs). Domains of focus included criminal justice, child protective services, behavioral health entities, public health, and the faith community. Archival data, survey data, interviews with key stakeholders, and focus group data with providers and consumers were examined as part of the needs assessment. A synthesis of the findings from data collection was utilized to develop a set of recommendations for next steps in TIC implementation in Summit County.

Overview

Trauma has been recognized as an underlying risk factor in the development of substance use issues, as well as a complicating factor in the treatment and recovery from these maladies. Leza et. al.[1] conducted a scoping review to explore the relationship between Adverse Childhood Experiences (ACEs) and diagnosis of substance use disorders later in life. Results indicated ACEs are prevalent among persons with SUDs, but there is a positive association of ACEs and SUDs later in life. The relationship between interpersonal trauma and increased opioid misuse has also been identified by previous research[2]. Childhood trauma is associated with an earlier age of opioid use initiation, intravenous drug use, and overdose risk[3]. ACE scores of persons in SUD treatment may even be able to predict relapse potential. Derefinko et. al. demonstrated that relapse odds increased by 17% for each point increase on the 10-point ACE score[4]. It should be noted that there are disparities in ACE scores among different racial groups and regions as well. Ohio is one of

[11] Leza L, Siria S, López-Goñi JJ, Fernández-Montalvo J. Adverse childhood experiences (ACEs) and substance use disorder (SUD): A scoping review. Drug Alcohol Depend. 2021 Apr 1; 221:108563. Doi: 10.1016/j.drugalcdep.2021.108563. Epub 2021 Jan 29. PMID: 33561668.

[2] Williams, J.R., Girdler, S., Williams, W., & Cromeens, M.G. (2021). The effects of co-occurring interpersonal trauma and gender on opioid use and misuse. Journal of Interpersonal Violence, 35(23-24), NP13185-NP13205

[3] Stein MD, Conti MT, Kenney S, Anderson BJ, Flori JN, Risi MM, Bailey GL. Adverse childhood experience effects on opioid use initiation, injection drug use, and overdose among persons with opioid use disorder. Drug Alcohol Depend. 2017 Oct 1; 179:325-329. Doi: 10.1016/j.drugalcdep.2017.07.007. Epub 2017 Aug 5. PMID: 28841495; PMCID: PMC5599365.

[4] Derefinko KJ, Salgado García FI, Talley KM, Bursac Z, Johnson KC, Murphy JG, McDevitt-Murphy ME, Andrasik F, Sumrok DD. Adverse childhood experiences predict opioid relapse during treatment among rural adults. Addict Behav. 2019 Sep; 96:171-174. Doi: 10.1016/j.addbeh.2019.05.008. Epub 2019 May 8. PMID: 31102882.

five (5) states where over 15% of youth have three or more ACEs, categorizing them as exceptionally high risk. The highest scores are found among Black non-Hispanic youth[5].

Posttraumatic Stress Disorder (PTSD) is one of the most common outcomes of experiencing trauma, and it is often comorbid with SUDs[6]. Research also finds that both PTSD and the experience of trauma are associated with poorer outcomes in OUD treatment. For example, one study of buprenorphine-seeking veterans found that veterans who received trauma treatment had 43.36 times greater odds of remaining in buprenorphine treatment relative to those who did not receive trauma treatment.[7]

There is an impact of traumatic experiences on the onset, treatment, and recovery from SUDs. Local leaders were wise to target funding and expertise to better identify and address trauma across social service sectors. It responds to the question, *if you knew the persons you served had suffered from traumatic experiences, how might you serve them differently?*

This initiative seeks to understand the relationship between trauma and OUDs in Summit County and to identify barriers to the implementation of trauma-informed programs and procedures that may mitigate the impact of trauma on addiction treatment and recovery processes.

The first step in this grant effort involved conducting a trauma-informed care needs assessment. The results were synthesized to inform recommendations for policy change, training, and/or new trauma-informed augmentations to services currently rendered. Once the TIC needs assessment and recommendations are completed, the research team will work with key stakeholders to rank recommendations and determine a process for implementation and program reporting.

The University partnered with a trauma consultant from the *National Council on Mental Well-Being* to develop and deploy TIC assessment instruments, gathering information from direct care workers, leaders, and consumers of targeted community social and public service domains.

Goals

The present project involves two primary deliverables.

3) A comprehensive **Trauma-Informed Care Needs Assessment** involves identifying systems or sectors encountered by persons with SUDs, assessing strengths, weaknesses, gaps, and barriers related to TIC, evaluating readiness within these sectors to adopt TIC practices, and providing targeted recommendations for change.

[5] Sacks, V., &Murphey, D. (2018) Report: The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity. Child Welfare. Feb 12, 2018. Retrieved from https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity

[6] Dahlby, L., & Kerr, T. (2020). PTSD and opioid use: Implications for intervention and policy. Subst Abuse Treat Prev Policy, 15 (1), 22. https://doi-org.ezproxy.uakron.edu:2443/10.1186/s13011-020-00264-8

[7] Meshberg-Cohen, S., Black, A. C., DeViva, J. S., Petrakis, I. L, Rosen, M. I. (2019) Trauma treatment for veterans in buprenorphine maintenance treatment for opioid use disorder. Addict Behav, 89, 29-34 https://doi-org.ezproxy.uakron.edu:2443/10.1016/j.addbeh.2018.09.010

4) An **Implementation Plan**: Using the completed needs assessment and recommendations as a platform, the research team will work with project funders and other key stakeholders/coalitions to develop a comprehensive TIC implementation plan. This will include, but not be limited to:
    a) Rank recommendation priorities by sector.
    b) A strategy for funding and quality control of recommendations requiring financing.
    c) A structure for coordination, accountability, and reporting on TIC initiatives born from this process.

Data Collection Strategy

To gain a comprehensive TIC overview and analysis of Summit County resources, the university collected and reviewed three types of data: archival, quantitative, and qualitative.

Archival data. Where possible, we collected archival (secondary) data from organizational leadership and various websites to evaluate or report on key service domains. This was matched with national trends or published literature on trauma or behavioral health. Archival data reviewed include:

- 5-year Summit County Victim Assistance Data: Statistics, outcomes, client surveys, policies, and procedures.
- Local, state, & national overdose data, fatality review reports
- State and County Public Health Reports
- Summit County Community Corrections utilization
- County and State Suicide and Assault Data/Reports
- County Gun Violence Emergency Department visits and Gun Violence reports
- County and state drug trends
- Local Social Service Advisory Board reports
- ADM Board Global Ends Reports, and Community Plan
- Summit County Youth Risk Behavior Survey (2013 & 2018)
- Summit County Profiles (Demographics from US Census)
- Local BH Treatment Resources
- County Children's Services Community Report
- Recovery-Oriented System of Care Assessment
- Select Service Utilization Data
- Agency Utilization
- Summit and Montgomery County Sheriff Department Annual Reports
- Ohio Substance Abuse Monitoring System
- Ohio Department of Mental Health and Addiction Services Behavioral Health Data Group Reports (BHDG)
- Literature Reviews

Archival data is summarized in **Section III** of this report. We thank all organizations that volunteered to provide us with this vital information. *Note*: Some proprietary databases, protected by federal healthcare privacy or confidentiality laws, were not available for review.

Quantitative Survey Assessment. A Trauma-Informed Care Survey was distributed to care providers and administrators working in Summit, as well as to consumers who have received local services. An email distribution list comprising 420 local individuals in addiction recovery and 2,959 clinical professionals, first responders, and organizational leaders (e.g., agency directors, police chiefs) was used to forward the survey. The professional survey garnered 354 responses, while the consumer survey yielded 51. The following validated surveys were used as part of our survey assessment:

- The Trauma Informed Practice (TIP) Scales[8]
- The Life Events Checklist for DSM-5 (LEC-5)[9]
- Items adapted from tools provided by, and with permission from, the National Council for Mental Wellbeing, including:
    - Non-Clinical Organizational Self-Assessment[10]
    - Trauma-Informed, Resilience-Oriented Equity-Focused Systems Organizational Self-Assessment Long Form Draft[11]

Qualitative Data. We utilized qualitative data because it offers insights that cannot be captured in numbers, helps identify nuanced information regarding services from multiple perspectives, and facilitates an understanding of the why, how, and what. In completing this report, the research team gathered information from four different perspectives: 1) key stakeholders, 2) organizational administration/management, 3) direct service providers, and 4) consumers. Asking similar questions to people from each perspective enables us to compare, contrast, and draw conclusions regarding the intent of services versus how they are received.

The two data collection strategies used include focus groups and key stakeholder interviews. Copies of the focus group questions, key stakeholder questions, and the TIC Survey Instruments can be found in the Appendices Section of this report.

Focus Groups. Focus groups are a research method that brings together a small group of people to answer specific questions in a moderated setting. Each focus group was anonymous, facilitated by researchers and graduate students, and fully transcribed to ensure accuracy of all disclosures. A total of 7 focus groups were conducted between December 2023 and February 2024. These included specific focus groups designated for special populations, including women in SUD treatment, men in SUD treatment, African American treatment participants, persons involved in community corrections, Faith leaders, and professionals who have provided clinical services.

Key Stakeholder Interviews. Our team also completed 10 individual key stakeholder interviews between December 2023 and February 2024. Participants included leadership representatives in local government, healthcare, behavioral health, crisis services, law enforcement, public health, community planning, and child protective services. Interviews were not recorded to protect respondent confidentiality. Instead, the research team member who

[8] Sullivan & Goodman (2015)
[9] Weathers et al., 2013
[10] (National Council for Mental Wellbeing, 2020)
[11] (National Council for Mental Wellbeing, 2023)

conducted the interview completed field notes and interview summaries, which were used in data analysis.

Data Analysis Methodology

We collected all archival, survey, and qualitative data concurrently. After completing data collection, we followed the data management and analytic plan approved by our institutional review board. Archival data were compiled, and research team members reviewed the documents, extracting findings relevant to the needs assessment aims. The survey data were cleaned and screened to ensure the inclusion of complete data files. We utilized data visualization and descriptive statistics to summarize the quantitative data. Transcriptions were created during each focus group, and the data were analyzed using thematic analysis principles. Data from key stakeholder interviews included field notes and memos from each of the interviewers. The team reviewed all key stakeholder interview notes together and developed a list of themes based on their review. After the data analysis was completed for archival data, survey data, focus groups, and key stakeholder interviews, the research team convened to discuss the significant findings and the intersections between the data points.

Section III. Archival Data Report

Archival Data Report: Key Highlights

Extant data highlights the prevalence and both trauma and substance use in Summit County. Existing data related to trauma patterns available for examination included violent crimes, trauma victimization, criminal justice/corrections data, and trauma data specific to youth. Available data specific to substance use patterns available for review included substance use trends, including overdose, service access and utilization, and crisis calls. Findings from synthesizing the archival data indicate that 1) prevalence of trauma and substance use in our county is significant and 2) there is a clear gap in systematic, efficient processes in place for continual evaluation of data being collected across the county as it relates to both trauma and substance use.

Further, existing data related to trauma-informed care initiatives within Summit County was lacking, evidencing a clear need for a more comprehensive, systematic approach for trauma-informed care initiatives in Summit County.

The purpose of reviewing archival data was to 1) provide a more comprehensive overview of the context in which this needs assessment occurred and 2) summarize recent findings relevant to trauma, addiction, recovery, and trauma-informed care within Summit County, Ohio. The Archival Data Report is broken down into the following major categories:

1. Demographic Overview of the County
2. Overview of Trauma Patterns in the County
3. Overview of Substance Use Patterns in the County

Summary of secondary data sources as part of the archival data review, including publicly available datasets, reports provided by community organizations, and information available via organization websites. A complete list of archival data sources is included in Section II. Examples of the archival data sources are also included throughout this chapter to aid in the visualization of the findings.

Demographic Overview of the County

Information about the demographic overview of the county is available via the U.S. Census, with the most recent estimates from July 2023[12]. Summit County Public Health also published demographic information about the county in its most recent Community Health Assessment (SCPH CHA), which includes data from 2020[13]. The numbers reported are relatively comparable

[12] U.S. Census Bureau quickfacts: Summit County, Ohio. (n.d.). https://www.census.gov/quickfacts/fact/table/summitcountyohio/PST045223

[13] Summit County Public Health (2022) Community health Assessment. Retrieved at: https://www.scph.org/sites/default/files/editor/RPT/SCPH%20CHA%202022-FINAL.pdf

across data sources. See Table 1 for a summary of the demographic overview of the county, per these data sources.

Table 1. *Demographics*	US Census	Summit Co
Race		
American Indian or Alaska Native	0.2%	0.2%
Asian	4.5%	3.7%
Black or African American	15.3%	14.4%
Hispanic or Latino	2.7%	2%
White	77.1%	77.7%
Two or more races	2.9%	3.6%
Sex: Female persons	51.2%	52%
Age: Persons 18 and older	79.5%	~75%
Persons under 5	5.3%	6%
Persons 65 and older	19.6%	18%
Education (for persons aged 25+)		
High School Graduate	92.5%	~94%
Bachelor's degree	34.6%	15%
Median Household Income	$68,360	NR
Persons in poverty	12.6%	NR

According to the 2023 Census Report for Summit County[1], the population size of the county was estimated at 535,733. The CHA data indicate that Summit County is the fourth most populous county in the state, and the city of Akron accounts for 35% of the county's population[13].

Overview of Trauma Patterns in the County

Available data allowed us to review the following trauma patterns in the county:

- Violent crime
- Trauma victimization
- Crisis calls and responses
- Criminal justice, corrections
- Trauma and youth

Violent Crime Data. See Table 2, which summarizes Summit County homicide data between 2000-2017 by age group. Homicides are impacting Summit County's young people particularly hard. Between 2000 and 2017, homicide was the #2 leading cause of death, only behind unintentional injury, for youth 5-14 years old. It is the #3 leading cause of death for 15 to 34-year-olds. Assault-related deaths have been trending upward since 2003.

Table 2.
Homicide Causes in Summit County 2000-2017

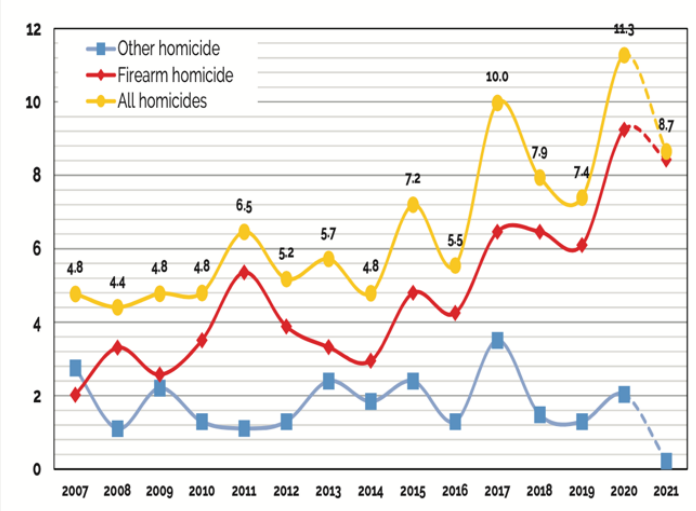
Rank	<5 YO	5-14YO	15-24YO	25-34YO	35-44YO
1	Prenatal Condition	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
2	Congenital Anomalies	Homicide	Suicide	Suicide	Heart disease
3	Unintentional Injury	Cancer	Homicide	Homicide	Cancer
4	Homicide	Heart Disease	Cancer	Cancer	Suicide
5	Influenza/Pneumonia	Suicide	Heart Disease	Heart Disease	Homicide

Data Source: SCPH Population Health Vital Statistics Brief: Vol1: Death and life expectancy

Figure 1 visualizes the homicide rates per capita during the period from 2007 to 2021 [14] . Within this timeframe, the lowest homicide rate was 4.4 per capita, while the peak occurred in 2020 at 11.3. Assault-related deaths are the highest in the 15–34-year-old age group. Gun deaths in Summit County have been trending up since 2007. It had been 2.0/100,000 in 2007, up to a peak of 9.2/100,000 in 2020, an increase of 360%. Over 2/3 (69%) of all homicide victims were between 15 and 44, and 64% of all homicide victims were African American. **Looking at this same data in terms of per capita rates, from 2014 to 2021, the homicide death rates were 2.9/100k among White residents and an alarming 37.5/100k among Black residents.** Notably, this rate doubled from 2013 to 21, from 21.4 to 37.5.

Figure 1.

Assault Related Death in Summit County 2007-2021



Graph Source: SCPH_ Ohio Department of Health Death Certificate Data

[14] SCPH (2022) Population Health Vital Statistics brief: Assault related deaths and ER visits 2007-2021. https://www.scribd.com/document/672004322/Assault-Data-Brief-August-2023

Data outlining assault-related deaths and ER visits between 2016 and 2021 were also made available for analysis[15]. This data indicated there were 1000 local emergency room visits for gunshot wounds (GSWs) during this timeframe. These events doubled from 0.2/day in 2016 to 0.4/day in 2021. Notably, Summit County has 38 zip codes, and over half of all GSWs were from the following 5: 44306, 44320, 44311, 44310, and 44305. During this same time period, there were 585 GSWs from an accidental discharge. Eighty-five percent of these victims were male, and 61 (15%) were under 18 years of age. Other violence-related emergency room statistics are outlined in Table 3.

Table 3.

2016-2021 Violence-related Summit County Emergency Room Visits

Sexual Violence	1 event/2.6 days
Elderly Assault	1 event/7.8 days
Child Assault	1 event/4.5 days
Assault by firearm	1 event/ 5.4 days
Accidental Firearm Injury	1 event/4.2 days.

Data Source: SCPH (2022) Population Health Vital Statistics brief: Assault-related deaths and ER visits 2007-2021.

Per the 2023 census, African Americans comprise 15.3% of the Summit County population, yet 26% of all emergency room visits for gunshot wounds are[16]. We must look at all these gun violence disparities beyond the violent crime and safety lens and into the traumatic impact on our local communities. **For every violent death, there is also a grieving mother, father, sister, brother, teacher, pastor, coach, and community.** In the spirit of trauma-informed approaches, emphasis must be placed on safety and healing within the Black community.

Summit County Trauma Victim Information. In 2022, Summit County Victim Assistance reported 4,666 victimizations, outlined in Table 4[17]. It should be noted that victimization is often underreported. In the US, ~30% of Domestic Violence cases go unreported to law enforcement. A recent article in the National Library of Medicine states, *"Virtually all healthcare professionals will at some point evaluate or treat a patient who is a victim of domestic or family violence."*

Summit County Victim Assistance (SCVA) provides much of the on-scene or post-scene support for persons victimized by violence locally. They provided services to 4,666 individuals in 2022, including criminal justice support, court advocacy, crisis intervention, safety planning, and check-in calls/contacts. A 5-year view of the number of consumers served is presented in Table 5.

[15] SCPH (2022) Population Health Vital Statistics brief: Assault related deaths and ER visits 2007-2021. Retrieved at https://www.scribd.com/document/672004322/Assault-Data-Brief-August-2023

[16] Ibid.

[17] 2022 Victim Assistance Agency Statistics Flex Report

They have received referrals from most local police departments, courts, Children's Services, Legal Aid, the University of Akron, Behavioral Health agencies, hospitals, and through word of mouth. They do well to collect meaningful data from these services, including the client's perspective of the services received. In 2022, **95% of clients indicated that they were respected and had their emotional and mental needs met during their Victim Assistance encounter.** Client demographics lean towards lower-income citizens. The mean income range of persons involved in their services is 15-19k/year; 75% of clients are women. Notably, there were fewer referrals in 2020 due to COVID-related dynamics. The numbers have not returned to pre-COVID peaks.

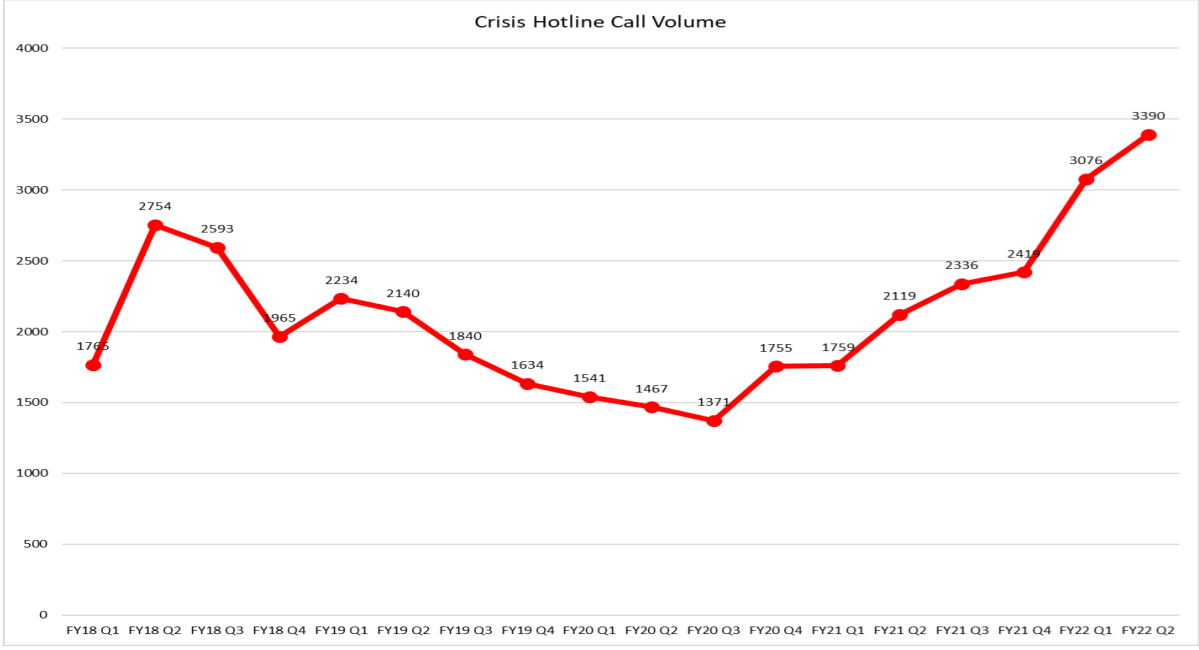
Table 5.
Summit County Victim Assistance
 # Consumers Served 2018-22

2018	6,329
2019	5,879
2020*	3,931
2021	4.591
2022	4,666

Data Source: 2022 Victim Assistance Agency Statistics Flex Report

Figure 2.

Summit Co. Crisis Hotline Call Volume



Data source: 2023 SSAB Report

Crisis calls and responses. Summit County houses multiple crisis call options, including the traditional 911, and specific numbers for both mental health and addiction-related crises. In October 2023, the Sheriff's Office became part of the Summit Emergency Communications Center, or SECC. This consolidates numerous police and fire departments throughout Summit County. In 2023 alone, there were 22,773 911 calls received, or over 62/day[18].

According to the 2023 ADM Board Report to the Summit County Social Services Advisory Board (SSAB) [19], there had been a campaign to increase awareness and utilization of the crisis hotline. As a result, we witnessed a 63% increase in call volume during Fall 2022 compared to the average quarterly call volume over the previous three years.

Criminal Justice and Corrections Data. Data from the Summit County Jail[20] and Summit County Community-Based Corrections[21] were utilized to examine trauma patterns within this specific context. See Tables 6-8 for data visualization.

Table 6.
Jail Incident Reporting (Capacity 671)

Incident	2023	2022	2021
Bookings	8327	9318	6189
Assaults	62	22	12
Assaults on staff	25	10	1
Disorderly Conduct	249	150	92
Illegal Conveyance	7	7	3
Medical/mental health	62	67	21
Falsification/Forgery	8	6	18
Drugs	22	10	12
Sex Offense	22	8	11
Theft	1	1	1
Vandalism	32	14	X
Use of Force	95	115	71
Restraints	217	159	xxx

Data Source: Summit County Sheriff's Annual Reports 2020-23

Summit County Jail. The Summit County Jail effectively utilizes meaningful data to identify trends within its facility. It maintains public transparency by publishing these numbers in its annual reports, which are available on its website. Montgomery County is similar to Summit County in population size and demographics. The Montgomery County Jail has a capacity of 903, with 2022 annual bookings totaling 18,319, more than double our local booking numbers. Yet, the Montgomery County Jail report offers little public transparency regarding incident or

[18] 2023 Summit County Sheriff Annual Report. Retrieved at https://sheriff.summitoh.net/files/34434/file/2023-scso-annual-report.pdf
[19] County of Summit ADM Board (2023) 2023 Social Services Advisory Board Report
[20] 2021, 2022, 2023 Summit County Sheriff Annual Report. Retrieved at https://sheriff.summitoh.net/files/34434/file/2023-scso-annual-report.pdf
[21] Oriana House (2023) Internal Utilization report.

programmatic data in its annual reports. Both Jails operate near their designed capacity. The Incident Reporting for the Summit County Jail over the past three years is summarized in Table 6.

Summit County Jail collaborates with community resources to provide in-house behavioral health care services for inmates. Activities and events include regular Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings, psychiatric services, medications, and mechanisms to receive inmate requests (See Table 7-8).

Table 7.
Summit County Jail Activities

Activity	2023	2022	2021
AA meetings	364	691	286
NA meetings	362	540	316
Christmas Gift Bags	532	600	650

Data Source: Summit County Sheriff's Annual Reports2020-23

Behavioral healthcare has a strong focus on medication, psychiatry, and suicide prevention. The facility now has three contract psychiatrists working within their population. Per reports, approximately 1/3 (>200) of all inmates are on some type of medication for mental illness. If we were to use persons on psychiatric medication as a proxy measure for mental illness, it would indicate that the Summit County Jail houses more mentally ill persons than all local hospital-based psychiatric beds combined. Some of this is illustrated in Table 8.

Table 8.
Key Health/Behavioral Healthcare Indicators

Service or measure	2023	2022	2021
Kites	56,199	59,115	46,888
Kites responded to	4720	5033	4235
Suicide precautions	951	802	679
Suicide Attempts	11	11	7
Suicide Deaths	0	0	0
Psychiatric Visits	2456	5169	4042
Avg Monthly on Psych Rx	209	201	203
Pregnant	49	52	31
Inmate deaths	3	1	2

A *Kite* is a jail term for the procedure an inmate follows to request services. This kite system is far from exclusive to Summit County; it is a standard protocol in jail and prison systems throughout the US. It is also highly inefficient. Over the 3-year reporting period at the Summit County Jail, 162,202 kites were submitted and 13,988 responded to, resulting in an 8.62% response conversion rate. The volume of kite requests equates to a whopping 150/day. While many of these may be duplicative or low priority, they still must be reviewed, triaged, and responded to if possible. This process may be daunting and overwhelming for staff and frustrating for inmates requesting services. **Exploring a more efficient and effective service request model is recommended.**

The Summit County Jail excels in suicide prevention activities. They cast a wide net in determining how to implement suicide precautions. Over 3 years, they have placed 2,432 inmates on suicide precaution; there have been 29 attempts **and zero suicide deaths.** There are substantial mental health encounters between inmates and mental health professionals. Over the 3-year reporting period, there are 36.5 mental health encounters/day. It is unclear whether these numbers are appropriately sized to meet the need, or if inmates are smoothly transitioned to community services.

Overall, the Sheriff's Department does well to report on the training and certifications staff have received. Many of the trainings listed in the reports are related to tactics and strategies. While this writer is aware that Sheriff Deputies and Corrections officers have received Crisis Intervention Training, there is no mention of CIT in the annual reports.

Summit County Community-Based Corrections & Special Docket Courts. Summit County also houses a Community-Based Correction Facility (CBCF) and multiple Special Docket Courts. Summit County is home to multiple Special Docket Courts designed to provide additional support for veterans, persons struggling with addiction and mental illness, and families. Success in the program typically involves periods of recovery and the completion of behavioral health treatments. The behavioral healthcare component of these courts involves clinical support from Oriana House, an organization that implements evidence-based cognitive programming[22]. In 2022, the CBCF completed intake assessments for 867 clients, of whom 57% completed programming. Other 2022 program outcomes are outlined in Table 9. To note, the program with the lowest success rate was SHARP (dual diagnosis) at 44%, whereas the Family Intervention Court had the highest success rate (92%).

Table 9.
2022 Program Outcomes for the Summit Count CBCF

Program	Participant Intakes	Successful Completions
Multiple Offender program	100	86%
Alternative Sentencing Center	2002	81%
Halfway House	1476	53%
Work Release/Employment	154	52%
SHARP (Dual Diagnosis)	106	44%
Reentry Court	31	84%
Felony Drug Court	48	77%
Akron Drug Court	24	72%
Valor Court	33	86%
Family Intervention Court	46	92%
Cognitive Skills program (for probationers)	126	60%

Data Source: 2022 Oriana House Community Report

[22] Oriana House (2022) Community Report: Change takes time. Retrieved at https://assets.ctfassets.net/l2xdt0lxpjhb/2HXNiMjGBDlmLsh0l9clkk/2bf66f4adf866148091540da4abeccab/Oriana_House_2022_community_report_electronic2.pdf

Trauma and Youth. Per the Centers for Disease Control and Prevention, adverse childhood experiences are related to chronic health problems, mental illness, and substance use problems in teenage years through adulthood. Much of this information was gleaned from a 1995-97 survey conducted by the CDC and Kaiser Permanente. The original ACEs instrument is a 10-item questionnaire that includes questions about living with persons who had substance abuse or mental illness issues. In 2015, a Public Children Services Association of Ohio survey showed that over half of the youth taken into custody by Ohio child protection agencies were removed due to parental drinking or drug use. Over half of those removals were due to opioid use.

In 2022, Summit County Children's Services screened 3,605 allegations of child abuse or neglect. In SFY 23, 1622 local youth were taken into custody[23].

Table 10.
Reports screened in by Summit County Children Services in SFY2023[24].

Type	Proportion	
Physical Abuse	27%	**Over half of youth taken into custody by children's services are due to caregiver substance use[25]**
Neglect	28%	
Sexual Abuse	5%	
Emotional maltreatment	3%	
Multiple allegations	18%	
Family in need of services/Other	14%	
Data Source: PCSAO Summit County Profile		

Table 11.
Key Indicator Summit County High School Student YRBS results 2013 and 2018[26]

Indicator	2013 N=12,548	2018 N=12,112
Ever used Heroin	4.1%	1.6%
Ever used methamphetamine	5%	1.8%
Every used Rx Pain medication	15.6%	6.4%
Sexual intercourse before age 13	6.8%	3.4%
Texted/Emailed while driving	37.3%	36.7%
Physically hurt on purpose by someone you were dating	13.1%	12.3%
Forced to do sexual things (kissing, touching, intercourse)	12.6%	**13.9%**
Did not go to school due to feeling unsafe	7.5%	**9%**
Bullied at school in last 12 month	20.6%	20.4%

[23] PCSAO Factbook for year ending 2023: https://www.pcsao.org/factbook
[24] PCSAO Summit County Profile SFY2023: https://www.pcsao.org/pdf/factbook/2023/Summit.pdf
[25] PCSAO Opiate Survey, 78 county Children Serving Agencies responded, April 2016.
[26] ADM Board (2019) 2018 Summit County Youth Risk Behavior Survey: High School Report. Spetember 2019. Retrieved at https://admboard.org/wp-content/uploads/2024/05/2018-YRBS-HS-report.pdf

Felt sad or hopeless to degree you stopped usual activities in last year	29.4%	**34.4%**
Seriously considered suicide in the last 12 months	16.9%	**17.7%**
Data Source: 2018 Summit Co. YRBS High School Report		

Summit County does well to assess mental health needs among its youth. Beginning in 2013, the ADM Board has periodically conducted a Youth Risk Behavior Survey on a large sample of school-aged youth between 6th and 12th grades. This was conducted in 2013, 2018, and 2023; results for the latter will be available sometime in 2024. As a national survey, local results can be benchmarked against similar data from other states and the nation. Table 11 outlines a sample of key findings among high school students related to mental health, violence, bullying, and substance use.

As can be observed from the data in Table 11, local youth have improved in categories related to substance abuse between 2013 and 2018. However, rates of mental health distress have increased. Please note that all the data captured here is pre-COVID. There may be some significant differences in youth experiences that will be captured in the upcoming YRBS report. Other notable items include those related to gender disparities. Girls were much more likely than boys to be bullied at school (B-16% vs. G-25%) or through social media (B-12% vs. G-23%). Boys indicated "*they could get and be ready to fire a loaded weapon within 24 hours,"* at a rate of 53.7%, versus girls' response of 33%.

Overview of Substance Use Patterns in the County

Archival data from the Summit County ADM Board, Summit County Public Health, OHMAS, and OSAM allowed us to examine the following county-level findings:

- Substance use trends
- Service access and utilization
- Crisis calls and responses
- Drug overdose patterns

Substance Use Trends. In examining available data related to substance use patterns, we were able to discern information about 1) substance use patterns, 2) substance availability, and 3) substances identified in the cause of death. Notably, the ADM Board reported in their 2023 Community Assessment and Plan (CAP) that adult substance use, heavy drinking, illicit drug use, and deaths due to drug overdose continue to be major challenges for the county. Examining substance use patterns, substance availability, drug use trends, and drugs associated with overdoses across the county provides some context for better understanding county-wide trends we should consider.

Substance Use Patterns. Per the OHMAS County Profiles Report from the 2023-2025 ADAMH Community Plan[27] (last report from March 2024), county-level substance use rates were compared to state level rates and ranked as either a) not an issue of concern due to being significantly less than the state level; b) comparable to the state level; and c) an area of concern due to being significantly higher than the state level. See Table 12 for a visual breakdown of the

[27] OHMAS County Profiles Report from the 2023-2025: https://mha.ohio.gov/research-and-data/data-and-reports/county-assessment-data-profiles/summit

findings. Notably, while most illicit substance use was similar to state rates, alcohol use was identified as an area of concern.

Table 12. *Summit Co. Rates, compared to Ohio*
Not an Issue of Concern • Tobacco Product Use • Cigarette Use • Marijuana Use
Similar to State Levels • Illicit drug use • Illicit drug use other than marijuana • Pain Reliever Misuse • Heroin Use • Cocaine Use • Methamphetamine Use
Area of Concern • Alcohol use
Data Source: OHMAS County Profiles

Substance Availability. Summit County Public Health (SCPH) provides an annual summary of drug trends as part of its *Population Health Vital Statistics Brief,* including information about drug availability across the county. Table 13 provides a summary of information reported in 2021 and 2022[28]. Of note, the availability of fentanyl and methamphetamine continued to remain high. Additionally, the availability of some emergent drugs (i.e., xylazine) was not included in these reports.

The Ohio Substance Abuse Monitoring Network (OSAM) also provides a report on the Surveillance of Drug Use Trends in the State of Ohio. In their most recent report from June 2023, the following trends were noted[29]:

- Increased incidence of cocaine, heroin, fentanyl, and methamphetamine.
- High availability of crack cocaine and synthetic marijuana.
- Cocaine and methamphetamine mixed with fentanyl.
- Akron was identified as a hub city for the trafficking of methamphetamine.
- Xylazine is showing up in toxicology reports.

Table 13.

[28] SCPH (2022) Health Statistics Brief: Drug Overdoses Jan-Dec 2022: https://www.scph.org/sites/default/files/editor/RPT/Drug%20overdoses%20data%20brief%20August%202023.pdf

[29] ODMHAS (2023) OSAM: Surveillance of drug use trends in the state of Ohio. June 2023: https://dam.assets.ohio.gov/image/upload/mha.ohio.gov/ResearchandData/DataandReports/OSAM/FINAL-OSAM-Drug-Trend-Report-June-2023.pdf

Availability by Substance		
Drug	July-Dec 2021	July-Dec 2022
Powdered cocaine	High (assessed cocaine only)	No consensus
Crack cocaine		Moderate/high
Heroin	Moderate/High	Low
Fentanyl	High	High
Prescription opioids	Low	Low
Buprenorphine	NR	Moderate/High
Sedative-Hypnotics	Low	High
Marijuana	High	High
Methamphetamine	High	High
MDMA	Moderate	NR
Prescription stimulants	Moderate	NR
Data source: SCPH Population Health Vital Statistics Briefs		

Substances Identified as Cause of Death. The Summit County ADM Board Overdose Death Data Dashboard also provided information about the type of drug related to each overdose. Information associated with the top five substances listed as the cause of death between 2018 and 2023 is summarized in Table 14 below. Based on this data, fentanyl and methamphetamine continue to be the primary culprits in drug overdose deaths in Summit County.

Table 14.
Summit County ADM Board Overdose Death by Drug

2018	2019	2020	2021	2022	2023
Fentanyl (94) Meth (40) Cocaine (31) Ethanol (14) Carfentanil (12)	Carfentanil (92) Meth (86) Fentanyl (69) Cocaine (42) Ethanol (38)	Fentanyl (165) Meth (72) Cocaine (35) Ethanol (28) Carfentanil (26)	Fentanyl (192) Meth (84) Cocaine (56) Ethanol (28) Fentanyl Analogue (7)	Fentanyl (195) Meth (101) Cocaine (62) Ethanol (32) Opiate (12)	Fentanyl (186) Meth (88) Cocaine (70) Ethanol (24) Opiate (13)
Data Source: ADM Board Death Data Dashboard[30]					

Service Access and Utilization. This section includes data summaries related to access to care, detox admissions, and disparities in access and utilization.

Access to Care. Access to care has been identified as one of the ADM Board's priority areas, and they provided a summary of their efforts to address access to care in Summit County in their 2023 SSAB Report, page[31]. Specifically, they identified the following efforts to increase access to care:

[30] ADM Board (2013) Summit County ADM Board overdose death data dashboard. Online at https://admboard.org/about/data-and-reports/

[31] County of Summit ADM Board (2023) 2023 Social Services Advisory Board Report

- Growing list of partner agencies.
- Expand services for those who are uninsured/underinsured.
- Partner with higher education to streamline recruitment efforts into the field.
- Invest in agency infrastructure.
- Continually monitor access to services.

The OHMAS County Profiles Report from the 2023-2025 ADAMH Community Plan included data highlighting county-level and state-level rates for individuals who needed but did not receive treatment at a specialty facility for various substance use disorders. In the most recently released report (March 2024), access rates in Summit County were similar to state levels for alcohol use, illicit drug use, and substance use.

The limited number of healthcare workers also impacts access to care. Both the mental health and SUD treatment workforces were identified as a major challenge for the county in the 2023 Summit County ADM Community Assessment and Plan. In this same document, the ADM Board identified the strategy of increasing the recruitment and retention of the SUD workforce to support access to services, thereby increasing the utilization of SUD services across the county (from 5,609 people served in 2021 to a goal of treating 6,095 in 2025).

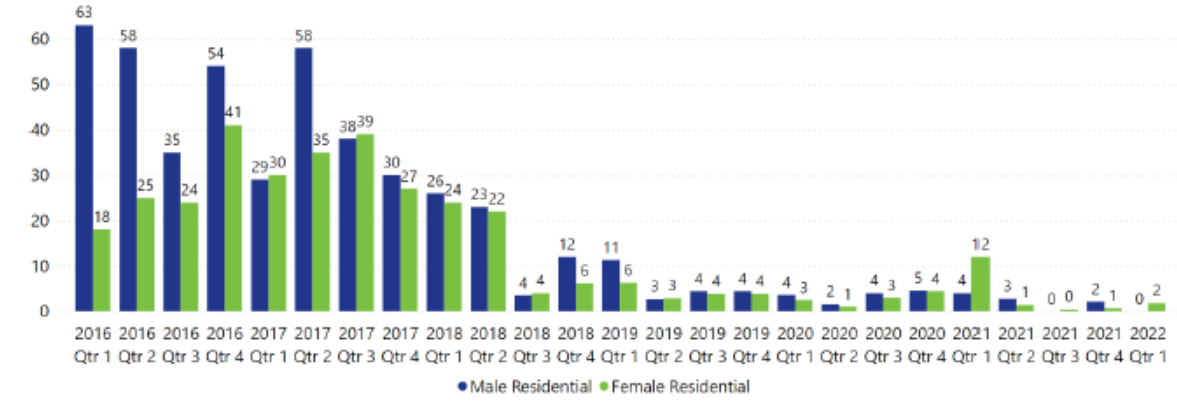
Further, challenges with recruiting and retaining staff across multiple disciplines were identified in the ADM 2023 SSAB Report. Notably, it was highlighted that staff turnover among Summit County behavioral health providers averaged 31.5% annually, ranging between 8% and 50%. This average turnover rate is similar to the national industry average (i.e., 31%). The SSAB Report also highlighted that having unfilled positions across different roles negatively impacted access and programming availability.

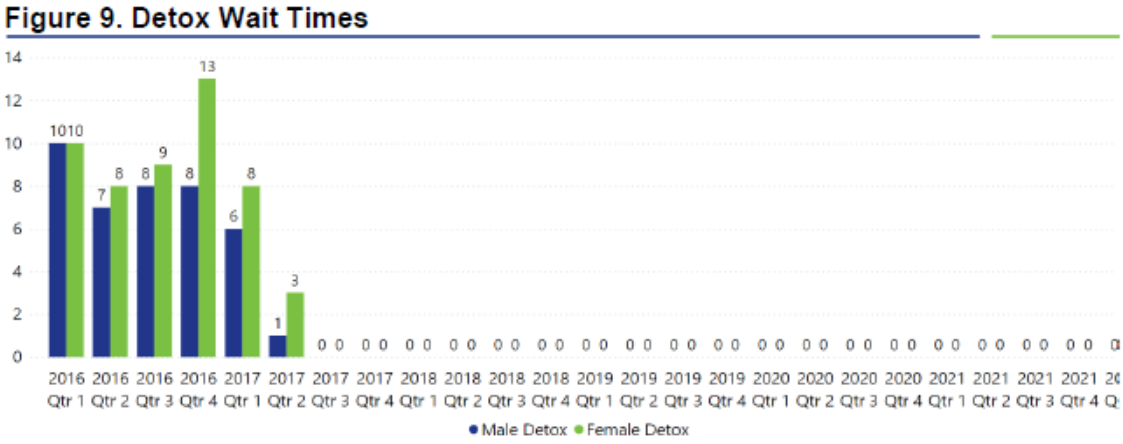
The Summit County ADM Board has outlined several strategies to address the workforce shortage, which were also outlined in the 2023 SSAB Report. Specifically, they reported engaging in larger conversations and workgroups to discuss strategies, providing recruitment and retention mini-grants in 2021, and considering different partnerships to increase technical assistance and pipelines between training and the workforce. Further, the ADM Board reported in their 2023 CAP that SUD treatment services and recovery supports are moderate challenges for the county. They also noted that a lack of follow-up after an ED visit for substance use was a moderate challenge for the county. Further, though, residential and detox wait times have shown a decreasing trend since

2016. In their 2023 SSAB Report, the ADM Board highlighted these trends with the graphic depicted in Figure 3.

Figure 3.

Graphic displaying residential treatment (top) and detox (bottom) admission wait times.





Source: 2023 ADM 2023 SSAB Report

Detox Admissions. One of the key clinical crisis services for SUDs is detox services. Below is a 10-year view of detox admissions at the ADM Crisis Center[32]. While overdoses have been increasing since the COVID era, detox admissions have reduced significantly. There are already local efforts to better understand the causality and impact of this trend.

An optimistic reason for "*some*" of the reduced admissions can be gleaned from the 1st Detox and Referral subject lines. While admissions are down, the percentage of first-time admissions is up. This can mean fewer clients are returning for multiple detox admissions; in other words, we are

[32] Oriana House: ADM Crisis services utilization CQI data.

retaining more people in the continuum of care who previously may have dropped out. Having doubled the number of direct referrals to residential treatment post-detox over the last several years supports this logic.

Figure 4.

Detox admissions, past 10 years

ADM Crisis Center Report 2014-2023											
Sub-Acute Detox		**2014**	**2015**	**2016**	**2017**	**2018***	**2019**	**2020**	**2021**	**2022**	**2023**
N		1282	1577	1355	1731	1113	1246	764	775	602	454
% Opiate Involved		70%	68%	78%	76%	69%	70%	60%	63%	53%	47%
1st Detox		34%	39%	36%	33%	32%	32%	42%	42%	41%	49%
Discharge Type	AMA	19.00%	26%	30%	36%	39%	41%	33%	48%	42%	42%
	ASA/Admininstrative	3%	4%	4%	6%	6%	5%	1%	1%	2%	1%
Referral to	IOP/ % of Admissions	350/ 28%	442/28%	384/28%		258/23%	120/10%	116/15%	92/12%	61/10%	22/4%
	Residential	340/27%	445/28%	427/32%		369/33%	252/20%	375/49%	397/51%	321/53%	287/63%
	None	123/ 10%	59/4%	42/3%		68/6%	25/2%	3/0%	0	0	0
	Refused	130/10%	227/14%	162/12%	330/19%	155/14%	60/5%	17/2%	0	0	0
	Left prior assessment/ % of Admissions			145/11%	330/19%	207/19%	285/20%	108/14%	205/26%	146/24%	124/27%

Data Source: Oriana House: ADM Crisis services utilization CQI data.

Disparities in Access and Utilization. Disparities in utilization were identified based on race, per the 2023 Summit County ADM CAP. Specifically, persons who identified as African American were less likely to utilize the ADM provider network as compared to persons who identified as Caucasian. The ADM Board also stated in their 2023 CAP that considerations about disparities for other minoritized populations, including the LGBTQ+ and refugee populations, need to be taken into consideration when considering service needs and gaps.

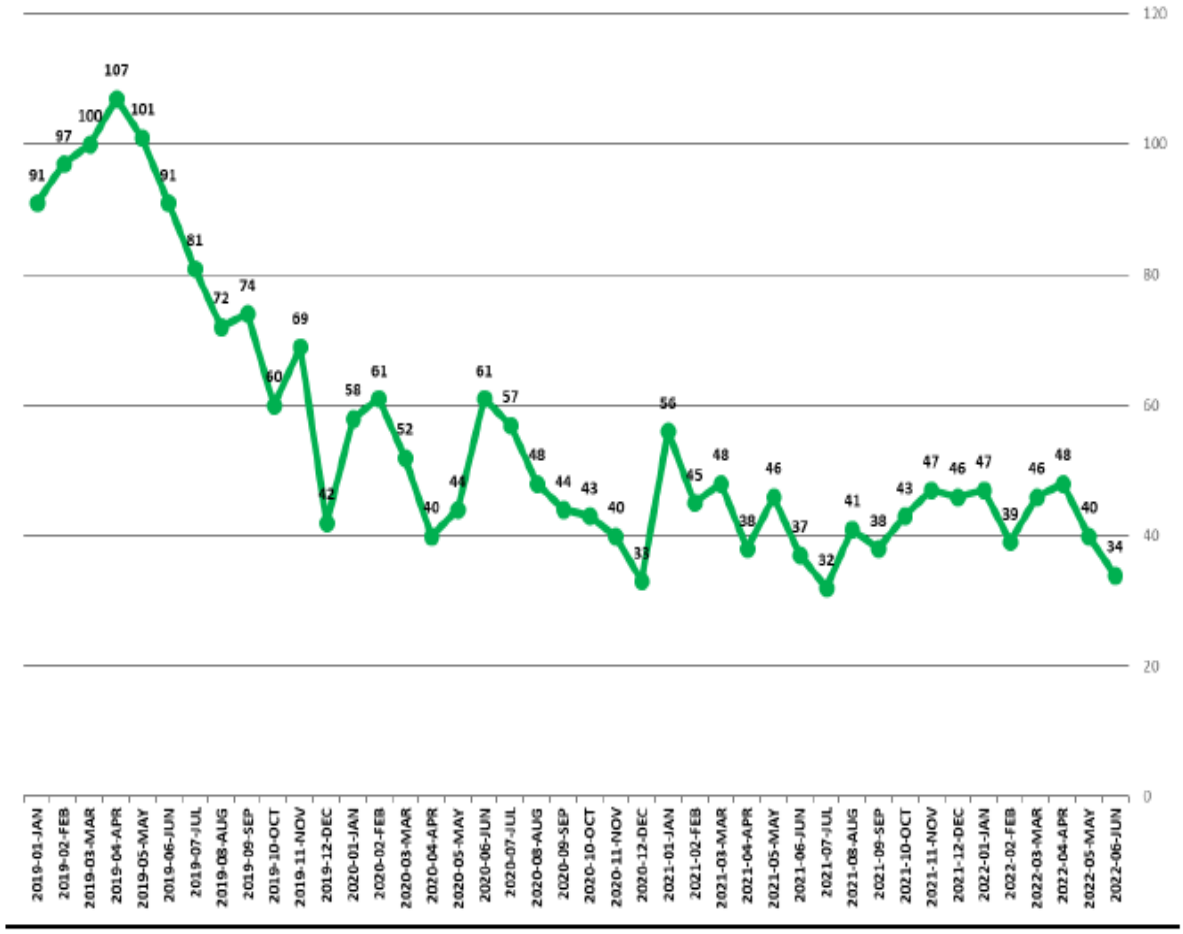
The ADM Board identified targeting efforts to improve inclusion and health equity in Summit County in their 2023 SSAB Report as well (p.8). Specifically, they highlighted that the ADM Board is participating in the Multiethnic Advocates for Cultural Competency (MACC) Cultural Competency Certification Program and has provided funding for several programs aimed at improving services for migrant and refugee populations.

Crisis Calls and Responses. The ADM Board identified Crisis Services as one of its priorities in the 2023 SSAB Report and provided a summary of current efforts to address this priority in the report. Specifically, they stated that they are working with collaborative partners to identify and implement best practices in crisis services, including the implementation of 988, and collaborating with local police departments on a program that provides virtual access to clinicians while in the community.

Addiction Hotline. Data included in the 2023 ADM SSAB Report highlighted that there has been a decrease in calls to the addiction hotline between 2019 and 2022. The following graphic was included in the SSAB Report. Notably, it was also reported that the ADM Board initiated 24/7 coverage of the Addiction Hotline in September 2022; however, this data is not displayed in the graphic depicted in Figure 5.

Figure 5.

Addiction Helpline Call Volume



Data Source: 2023 ADM SSAB Report

Drug Overdose Patterns. Ohio has been an opioid hotspot since the epidemic began in the early 2000s. As of 2021, Ohio ranked seventh in the U.S. in opioid death rates per capita (43.92/100K) and ranked 4th in overall overdose deaths with 5,175 deaths in 2021.

Table 15.

Drug Overdose Deaths (per 100,000) between 2017-2021

	2017	2018	2019	2020	2021
Unintentional drug OD death	46.4	24.7	40.0	42.4	41.4
Fentanyl-related OD death	33.1	17.9	30	36.8	35.9
Heroin-related OD death	3.7	NR	3.2	NR	NR
Prescription opioid-related OD death	7.4	NR	2.7	2.7	NR
Psycho-stimulant related OD death	11	7	15	12.9	15
Data Source: OHMAS AOD dashboard[33]					

As outlined in the 2023 Summit County ADM Board Community Assessment & Plan[34], drug overdose deaths continue to be a major challenge for the county. Further, unintentional drug overdose deaths were identified as an area of concern, as the county indicator (40.0 per 100,000) was higher than the state indicator (35.4 per 100,000), per the OHMAS County Profiles Report from the 2023-2025 ADAMH Community Plan.

Table 16.
2022 SCPH Drug Overdose Data

Race Group	*2022*
African American/Black	8.3%
Caucasian/White	91.7%
Other Races	0.0%
Gender Group	
Female	35.8%
Male	64.2%
Age group	
0-24	14.5%
25-49	68.8%
50-64	13.4%
65+	5.4%
Data source: SCPH Vital Statistics Brief	

Overdose rates (per capita) in Summit County between 2017 and 2021, as per the OHMAS AOD dashboard, are outlined in Table 15. Furthermore, the County of Summit ADM Board and Summit

[33] Ohio Department of Mental Health and Addiction Services AOD Overdose Dashboard at https://analytics.das.ohio.gov/t/MHAPUB/views/AODDashboard/AODDashboard?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n

[34] ADM Board Community Assessment and Plan (CAP) at https://admboard.org/2023-community-assessment-and-plan-now-available/

County Public Health have been tracking overdose trends for several years, including breaking down the data by zip code, race, and gender.

Summit County Public Health (SCPH) Overdose Data. SCPH provides updated information about drug overdose patterns in its Population Health Vital Statistics Briefs, which can be found on its website. Data from SCPH originated from the emergency department. See Table 16, which outlines SCPH overdose data from 2022, reported by age, gender, and race. As can be noted, the majority of ED-reported overdoses are from patients who were identified as White. Additionally, there was a larger proportion of males experiencing overdose than females, and most people who overdose and receive an emergency room intervention were between 25 and 49 years old.

The Summit County ADM Board Overdose Data. The ADM Board provides data related to overdose deaths via a publicly available dashboard on their website. This data is from the Medical Examiner. An overview of findings from the ADM data sources on drug overdose between 2018 and 2023 is summarized in Table 17, breaking down by age, gender, and race. Data shows overdose deaths have increased year over year, and the proportion of overdose deaths by race has shifted; rates of overdose deaths have increased for Black/African American citizens from 19% in 2018 to 25% in 2023. Trends in overdose death based on gender and age stayed relatively stable over time.

Additionally, Summit County Public Health updated its Alcohol-related Deaths Dashboard in November 2023. In 2022, there were a total of 42 alcohol-related deaths. Of those, over two-thirds of the deaths were among men, and the largest age group impacted by alcohol-related deaths was those between 35 and 44 (35.7%). Relatedly, data from the OHMAS AOD dashboard outlined 43% of traffic fatalities in 2021 were alcohol-involved.

Table 17.
Drug Overdose Data from ADM Dashboard

Race Group	*2018*	*2019*	*2020*	*2021*	*2022*	*2023*
Total Confirmed Overdose Deaths	144	216	219	235	247	228
African American/Black	19%	12%	21%	22%	24%	25%
Caucasian/White	81%	87%	77%	77%	74%	71%
Other Races	NR	1%	1%	0%	2%	5%
Gender Group						
Female	35%	29%	25%	25%	26%	31%
Male	65%	71%	75%	75%	74%	69%
Age group						
0-25	10%	12%	12%	10%	9%	7%
26-50	68%	65%	63%	62%	56%	65%
51-75	22%	23%	25%	28%	36%	28%

Data Source: ADM Overdose Dashboard at https://admboard.org/about/data-and-reports/

Section IV: Quantitative Survey Results

Quantitative Survey: Key Highlights

Our response rates were relatively low for both providers (8.3%) and consumers (12%), and different service sectors were disproportionately unrepresented in the data. In considering an implementation plan moving forward, it will be important to devise strategies for ongoing assessment and quality improvement efforts of trauma-informed care that are tailored across the multiple sectors (i.e., behavioral health, children services, criminal justice, medical services, public health, etc.).

In examining respondent experiences with trauma, we learned that administrators, providers, and consumers alike report experiencing trauma. This finding highlights the importance in recognizing that trauma is not just a consumer experience; we need to devise an implementation plan that accounts for trauma comprehensively throughout our organizations and communities.

Data exploring administrator, provider, and consumer perspectives on trauma-informed care principles in Summit County organizations indicated direct service providers tended to score lowest for most prompts related to trauma-informed principles, followed by consumers. Managers and executives typically scored higher than consumers and direct service providers across trauma-informed principles. Further, among providers' summary scores, all domains sans Domain 1 had at least one principle in with an average score less than 4, indicating the need for further exploration.

The quantitative survey results are reported as follows:

- Response Rate
- Demographic Characteristics
- Service Sectors Represented (Provider Work Settings and Consumer Utilization)
- Respondent Experiences with Trauma (Life Events Checklist)
- Provider and Consumer Perspectives on Trauma-Informed Care Principles in Summit County Organizations (National Council Surveys)
- Qualitative Feedback from the Survey

Response Rate

The survey was sent to 3,379 local participants, including 2,959 targeted professionals and 420 persons in recovery from addiction. Multiple reminders were sent out over the 8 weeks it was open. We received responses from 12% of individuals in recovery and 8.3% of professionals.

Demographic Characteristics.

Providers. A total of n = 196 providers completed the survey instrument in its entirety. Demographics of the provider sample are as follows:

- *Age:* The average age was 46.60 years (SD = 13.29, range = 23-82).
- *Gender:* Most participants identified as a cisgender woman (64.8%), while 27.6% self-identified as a cisgender man, and the remainder of the sample identified as gender non-binary/gender fluid (1.0%), an identity not listed (2.6%) or did not respond to this question (4.1%).
- *Race:* Participants were asked to select all that applied to their racial identity, resulting in a total of n = 199 responses overall. Notably, n = 5 participants did not respond to this question. Most of the sample identified as White (82.4%), while 10.0% self-identified as Black, 6.0% identified as an identity not listed, and 1.5% self-identified as Native American, Alaska Native, or American Indian.
- *Recovery status:* A total of 15.3% of respondents identified themselves as being in recovery (n = 30).
- *Sexual orientation:* Regarding sexual orientation, most of the sample identified as heterosexual/straight (85.2%).

Of the sample of providers, 10% (n =20) identified as serving in an executive role, 26% (n = 51) reported identifying as a Clinical Director or management role, and the remaining 64% (n = 125) identified as a direct service professional.

Consumers. A total of n = 31 consumers completed the survey instrument in its entirety, all of whom reported having a history of SUD and/or being in recovery from a substance use problem. Demographics of the sample are as follows:

- *Age:* The average age of the sample was 44.57 years (SD = 10.27, range = 29-67 years).
- *Gender:* The majority of the sample identified as cisgender women (n=21, 67.7%), 25.8% identified as cisgender men (n = 8), one person identified as a transgender man, and one person identified as agender.
- *Parental Status:* Approximately one-third (n = 10) reported having a minor child (or children) with whom they have at least partial custody.
- *Race:* Most participants reported identifying as White (n = 21, 67.7%), while 25.8% of respondents identified as Black (n = 8), and 6.5% (n = 2) identified as a racial group that was not listed.
- *Sexual Orientation:* Most respondents identified as heterosexual/straight (n = 28; 90.3%), one person identified as asexual, and two participants reported their identity was not listed.

Service Sectors Represented.

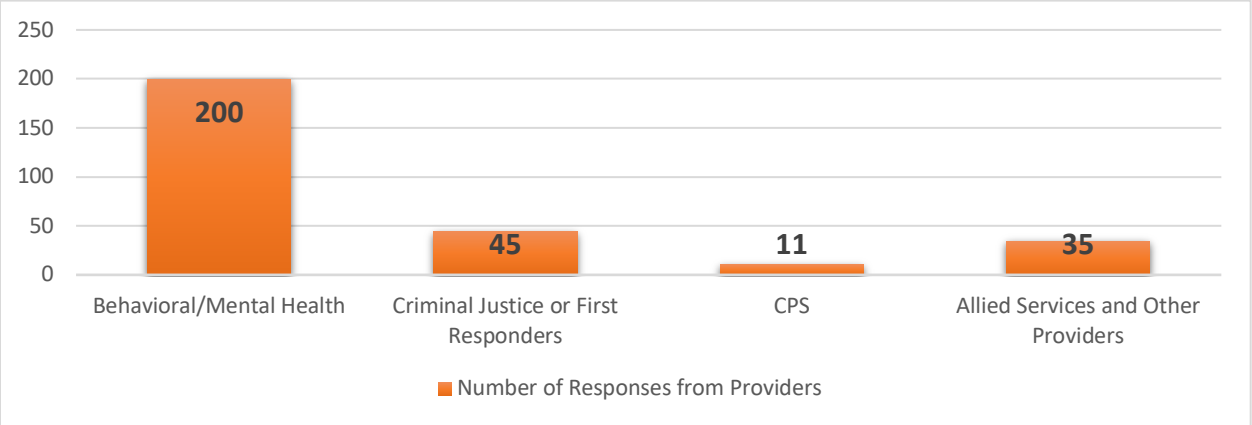
All respondents were asked about the service sectors in which they engaged in Summit County. Specifically, provider respondents identified their current work settings, their primary work setting, and their perspectives on their current work setting. Consumers identified settings in Summit County where they received services (lifetime, past-year, and most recent experience). Participants were asked to select *any* services from a pre-identified list of seventeen possible settings, which were then clustered as follows:

- *Behavioral/mental health*: inpatient addiction, outpatient addiction, inpatient mental health, outpatient mental health, Recovery support, detox
- *Law enforcement and First Responders:* Law enforcement, Courts or Probation, Jail or Prison, Fire or EMS
- *Children Protective Services:* CPS
- *Allied Services:* Victim assistance, Housing support, Veterans services
- *Physical Health:* Primary care, urgent care, or ER

Provider Work Settings. Providers were asked to *report on all current work settings*. See Figure 6. Providers working in behavioral or mental healthcare were overrepresented in the sample.

Figure 6.

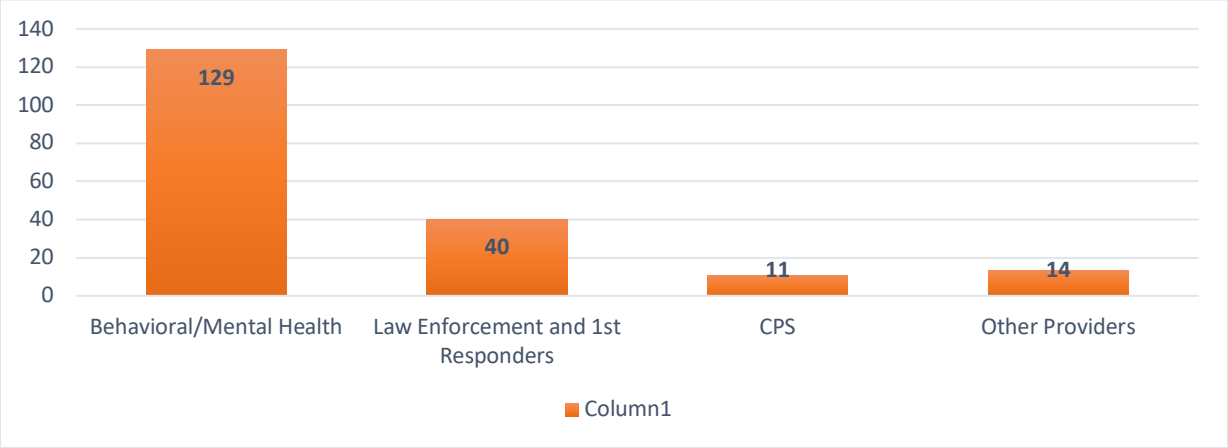
Provider's response about all current work settings



Providers also reported on their *primary* work setting type. The breakdown of the sample into these groups is outlined in Figure 7. Similar to all current work settings, behavioral/mental healthcare providers were over-represented in the sample.

Figure 7.

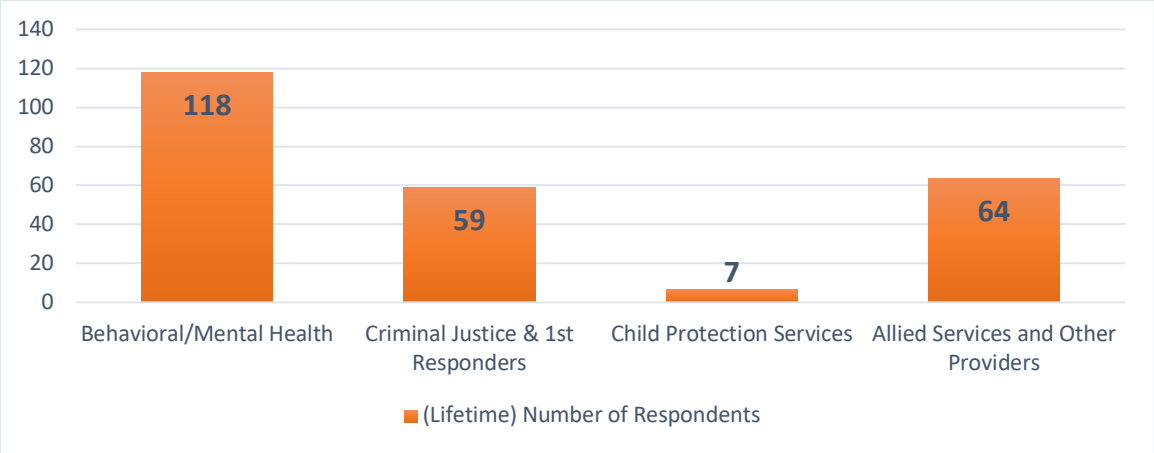
Provider responses regarding their primary work setting



Consumers: Lifetime Services in Summit County. Respondents identified which types of organizations they had *ever* received services from in Summit County, Ohio (see Figure 8). Accessing behavioral/mental health was endorsed most often, followed by allied services and other providers. Consumers reported the lowest lifetime utilization of child protective services.

Figure 8.

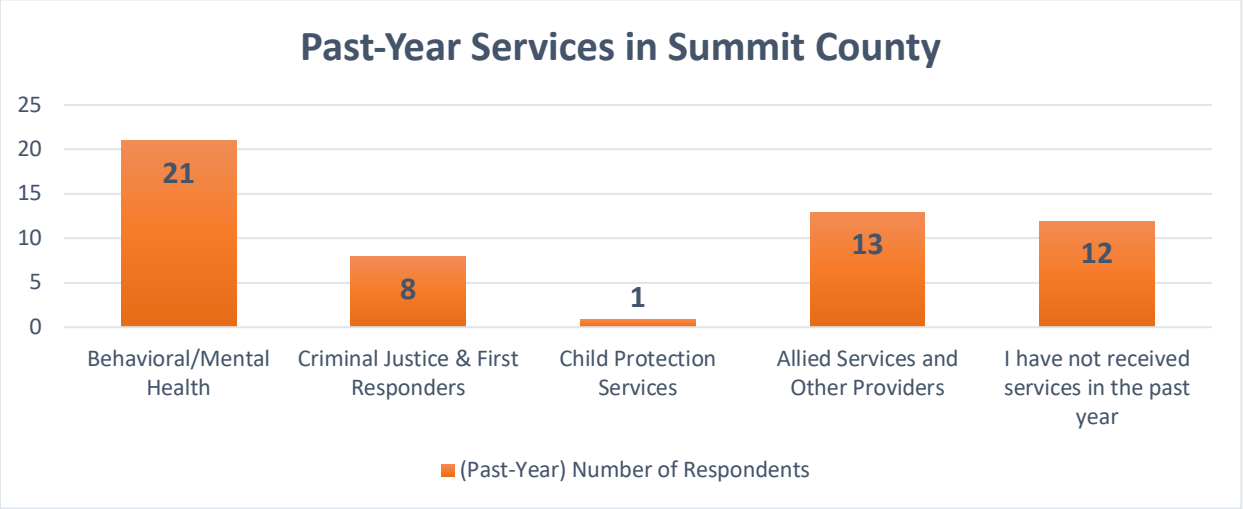
Consumer report of lifetime receipt of services



Consumers: Past-Year Services in Summit County. Respondents identified which type(s) of organization(s) they received services from in Summit County, Ohio, within the *past year* (see Figure 9). The pattern of utilization, by sector, within the past year was similar to lifetime utilization. Notably, 12 consumer respondents reported not receiving any services in Summit County from the list provided in the past year.

Figure 9

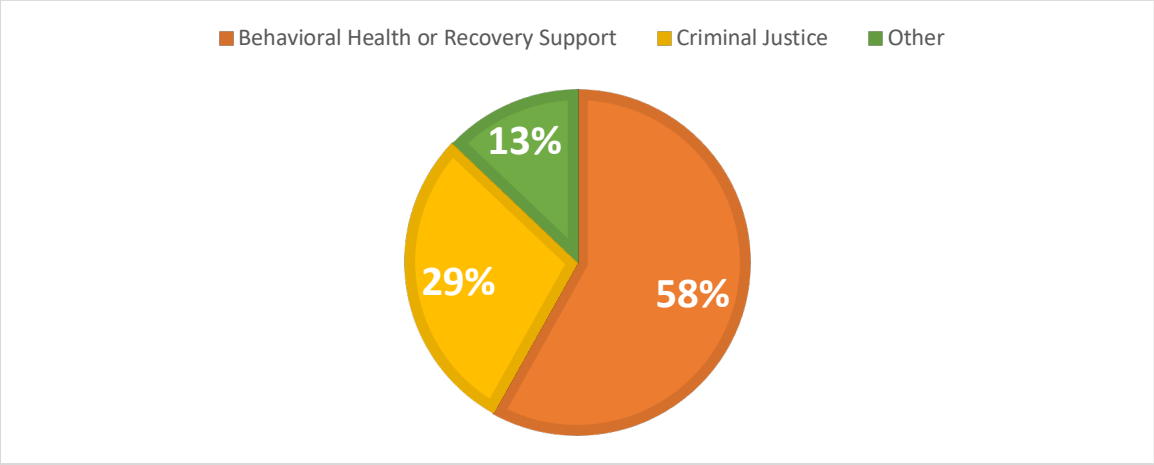
Consumer report of past-year service utilization



Consumers: Most Recent Service Received. Participants were asked to respond to the following question about which service they most recently received within Summit Co. – "Of those organizations, which type of organization within Summit County, Ohio did you most recently receive services (you may check only one)?" See Figure 10 for a breakdown of their responses. Consumers who received services through behavioral health/mental health or criminal justice were over-represented in the sample.

Figure 10.

Consumer report of the most recent service received



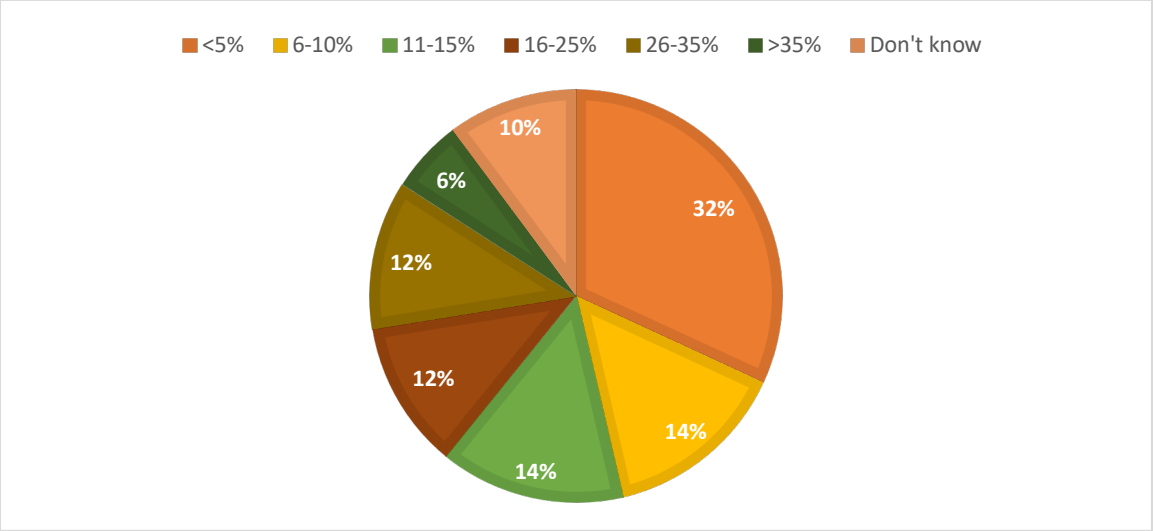
Provider Perceptions of Current Work Contexts. Additional information was gathered from providers regarding their perceptions of current work contexts to gain a deeper understanding of their current experiences. Specifically, executives and managers were asked to respond to a prompt about staff turnover; in contrast, direct service providers were asked to respond to prompts about considering leaving their agency (commitment to their agency) and the most significant stressor in their work.

Staff Turnover and Commitment. Executives and managers responded to the following question about staff turnover: "The annual clinical staff turnover at my agency is most closely

described by…". Figure 11 summarizes their responses. Notably, nearly 1/3 (32%) of executives/managers reported a staff turnover rate of <5% and nearly 1/3 (30%) reported a staff turnover rate of 16% or higher.

Figure 11.

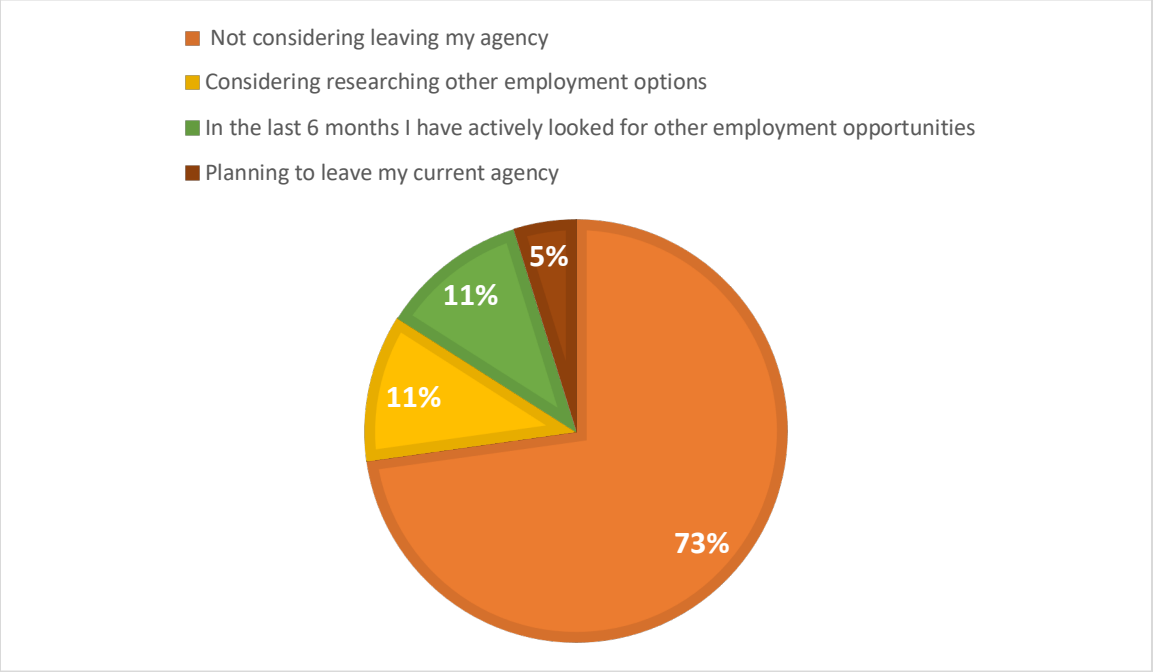
Executive/Management Perspective on Staff Turnover.



Alternatively, direct service providers responded to a question about whether they were considering leaving their agency. Figure 12 depicts the response breakdown for this question. While most responders (73%) were not currently considering leaving their agency, 27% were at least considering other employment options.

Figure 12.

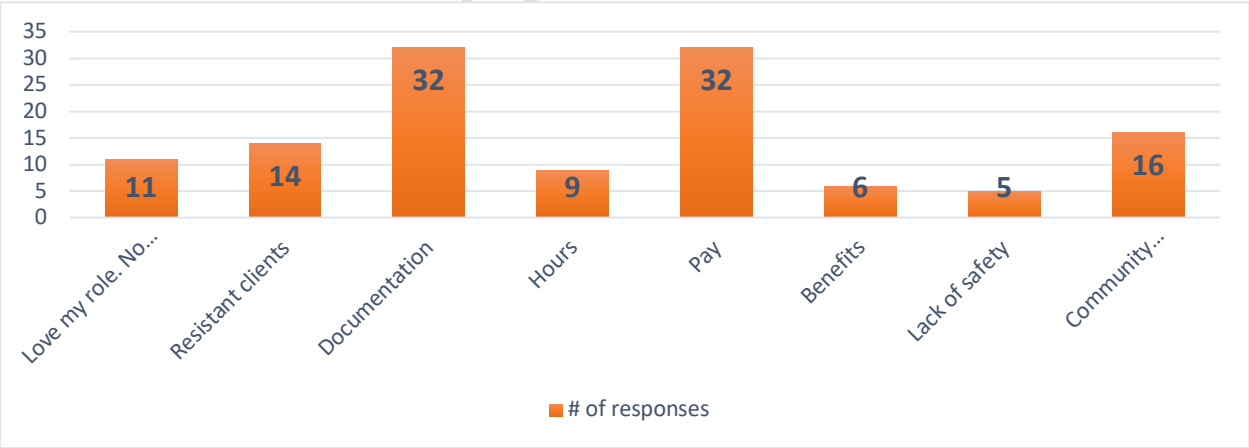
Direct Service Providers' considerations of leaving their agency



Largest Stressor for Direct Service Providers. Direct service providers were asked to identify the stressor they believed to be the largest in their field from a pre-selected list of options. Figure 13 demonstrates a summary of their responses. As the data shows, both documentation and pay were most often endorsed as the most significant stressor by direct service providers.

Figure 13.

Provider's response to the most significant work-related stressor



Respondent's Experiences with Trauma

The Life Events Checklist (LEC) was utilized to assess exposure to potentially traumatic events. The LEC consists of a list of 17 different events considered difficult or stressful. Respondent were asked to endorse any of the events, over throughout their lifetime, that may of 1) happened to them personally, 2) they witnessed it happen to someone else, 3) they learned about it happening to a close family member or friend, 4) they were exposed to it as part of their job, 5) they weren't sure,

or 6) it didn't apply to them. The average number of experiences ranged across the sample from 0 to 17, with the mean number of experiences for all participants outlined in Figure 14 below. For both providers and consumers, the highest rate of experiencing trauma was in the "learned about it" category.

Figure 14.

Average number of trauma experiences among all participants

Providers: Breakdown of Experiences with Trauma. We also examined provider data by 1) the employment role (e.g., direct service, management/supervision, or executive) and by the service sector (e.g., behavioral/mental health, law enforcement and first responders, child protective services, and other providers). See Figure 15, which outlines average LEC score by employment role, and Figure 16, which outlines average LEC score by service sector, and Table 18, which outlines frequencies of responses on the LEC by item.

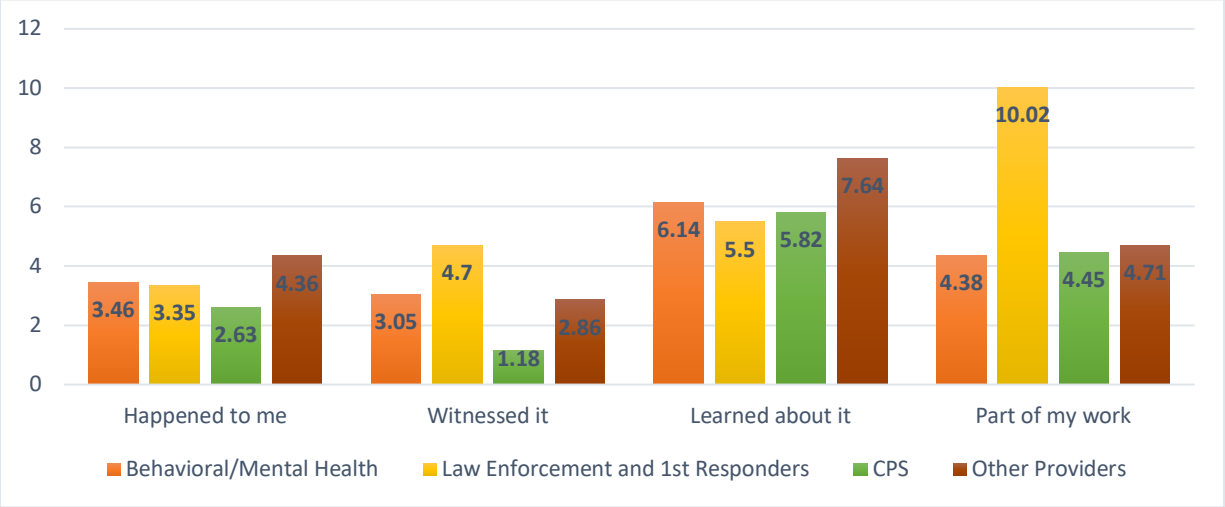
Figure 15

Average provider LEC by employment role

As Figure 15 illustrates, a general trend is evident in the data, where direct service providers scored higher on the LEC than management and executives. Executives endorsed the lowest score on the LEC in all categories except 'Part of my work".

Figure 16.

Average provider LEC score by service sector



Data visualized in Figure 16 shows that professionals across sectors are experiencing trauma events personally and as part of their work. One notable outlier is the higher score on the "part of my work" category for law enforcement and first responders.

Data in Table 18 highlights the frequency of provider respondents who endorsed specific trauma events. As is observed in the table, the most frequently experienced trauma events were as follows: 44.9% of respondents reported a transportation accident happening to them, 32.7% reported witnessing a life-threatening illness or injury, 40.3% reported learning about a sexual assault, and 45.4% reported experiencing a sudden violent death as part of their work.

Table 18. Provider frequencies on LEC by item

Trauma Event	Happened to me	Witnessed	Learned about it	Part of my job	Not sure	Doesn't apply
Natural disaster	40 (20.4%)	30 (15.3%)	59 (30.1%)	35 (17.9%)	3 (1.5%)	42 (21.4%)
Fire or explosion	22 (11.2%)	36 (18.4%)	52 (26.5%)	47 (24.0%)	3 (1.5%)	41 (20.9%)
Transportation accident	88 (44.9%)	52 (26.5%)	56 (28.6%)	51 (26.0%)	3 (1.5.%)	17 (8.7%)
Serious accident	35 (17.9%)	39 (19.9%)	59 (30.1%)	52 (26.5%)	6 (3.1%)	36 (18.4%)
Exposure to toxic substance	19 (9.7%)	12 (6.1%)	37 (18.9%)	38 (19.4%)	10 (5.1%)	69 (15.2%)

Physical assault	68 (34.7%)	51 (26.0%)	69 (35.2%)	72 (36.7%)	1 (0.5%)	18 (9.2%)
Assault with a weapon	25 (12.8%)	26 (13.3%)	62 (31.6%)	66 (33.7%)	4 (2.0)	43 (21.9%)
Sexual assault	47 (24.0%)	6 (3.1%)	79 (40.3%)	66 (33.7%)	1 (0.5%)	30 (15.3%)
Other unwanted sexual experience	73 (37.2%)	22 (11.2%)	66 (33.7%	62 (31.6%)	3 (1.5%)	22 (11.2%)
Combat or exposure to warzone	4 (2.0%)	2 (1.0%)	64 (32.7%)	14 (7.1%)	6 (3.1%)	81 (41.3%)
Captivity	3 (1.5%)	1 (0.5%)	52 (26.5%)	34 (17.3%)	11 (5.6%)	77 (39.3%)
Life-threatening illness or injury	24 (12.2%)	64 (32.7%)	64 (32.7%)	55 (28.1%)	4 (2.0%)	32 (16.3%)
Severe human suffering	14 (7.1%)	47 (24.0%)	58 (29.6%)	74 (37.8%)	11 (5.6%)	34 (17.3%)
Sudden violent death	9 (4.6%)	35 (17.9%)	73 (37.2%)	89 (45.4%)	2 (1.0%)	23 (11.7%)
Sudden accidental death	11 (5.5%)	33 (16.8%)	65 (33.2%)	84 (42.9%)	6 (3.1%)	26 (13.3%)
Serious injury, harm or death you caused to someone else	5 (2.6%)	18 (9.2%)	28 (14.3%)	42 (21.4%)	2 (1.0%)	95 (48.5%)
Any other stressful event	72 (36.7%)	49 (25.0%)	48 (24.5%)	66 (33.7%)	8 (4.1%)	36 (18.4%)

Providers also reported whether they received treatment or counseling related to any of the experiences they endorsed; 55.1% (n = 108) reported receiving treatment or counseling related to at least one of those experiences.

Consumers: Breakdown of Experiences with Trauma. The frequencies and percentages for each item on the LEC reported are reported in Table 19. Like providers, the most cited trauma event that happened to them was a transportation accident (74.2%), and the most frequently reported trauma event they witnessed was a life-threatening illness or injury (38.7%). The most reported trauma event consumers learned about was a natural disaster (64.5%), and the most frequently endorsed trauma event that was part of consumers' work was severe human suffering (29.0%).

Table 19. Consumer frequencies on LEC by item

Trauma Event	Happened to me	Witnessed	Learned about it	Part of my job	Not sure	Doesn't apply

Natural disaster	5 (16.1%)	4 (12.9%)	20 (64.5%)	2 (6.5%)	-	13 (41.9%)
Fire or explosion	7 (22.6%)	7 (22.6%)	8 (25.8%)	2 (6.5%)	1 (3.2%)	10 (32.3%)
Transportation accident	23 (74.2%)	7 (22.6%)	7 (22.6%)	2 (6.5%)	-	4 (12.9%)
Serious accident	11 (35.5%)	4 (12.9%)	6 (19.4%)	3 (9.7%)	3 (9.7%)	10 (32.3%)
Exposure to toxic substance	4 (12.9%)	3 (9.7%)	9 (29.0%)	4 (12.9%)	2 (6.5%)	13 (41.9%)
Physical assault	20 (64.5%)	9 (29.0%)	6 (19.4%)	4 (12.9%)	-	1 (3.2%)
Assault with a weapon	11 (35.5%)	8 (25.8%)	10 (32.3%)	2 (6.5%)	-	4 (12.9%)
Sexual assault	17 (54.8%)	1 (3.2%)	10 (32.3%)	2 (6.5%)	-	5 (16.1%)
Other unwanted sexual experience	21 (67.7%)	3 (9.7%)	8 (25.8%)	3 (9.7%)	-	3 (9.7%)
Combat or exposure to warzone	2 (6.5%)	1 (3.2%)	11 (35.5%)	2 (6.5%)	-	15 (48.4%)
Captivity	5 (16.1%)	1 (3.2%)	13 (41.9%)	3 (9.7%)	-	13 (41.9%)
Life-threatening illness or injury	6 (19.4%)	12 (38.7%)	10 (32.3%)	6 (19.4%)	-	8 (25.8%)
Severe human suffering	2 (6.5%)	10 (32.3%)	9 (29.0%)	9 (29.0%)	2 (6.5%)	8 (25.8%)
Sudden violent death	2 (6.5%)	4 (12.9%)	14 (45.2%)	5 (16.1%)	-	9 (29.0%)
Sudden accidental death	-	7 (22.6%)	12 (38.7%)	4 (12.9%)	-	9 (29.0%)
Serious injury, harm or death you caused to someone else	4 (12.9%)	5 (16.1%)	9 (29.0%)	2 (6.5%)	1 (3.2%)	16 (51.6%)
Any other stressful event	14 (45.2%)	7 (22.6%)	4 (12.9%)	6 (19.4%)	2 (6.5%)	4 (12.9%)

Examining Trauma-Informed Care Principles

Trauma-informed care principles were assessed for both providers and consumers using assessment tools from the National Council for Mental Wellbeing (NCMW). Specifically, for providers, we utilized select questions from the *Organizational Self-Assessment: Adoption of Trauma-Informed, Resilience-Oriented Care Practice in Non-Clinical Settings (TIROC-*

Nonclinical OSA) and the *Organizational Self-Assessment Long Form* to assess provider perspectives regarding TIC principles in their professional contexts. For consumers, we used modified questions from the *Organizational Self-Assessment Long Form* to determine their perspectives on TIC principles within the organization(s) where they receive services.

As a reminder, these domains were assessed using a survey with Likert-style questions, with a score range of 1-5, where higher scores indicate greater agreement. *After consultation with the National Council for Mental Wellbeing, we devised a potential threshold of 4 for these scales; any variables with a score below four (4) should be further examined.*

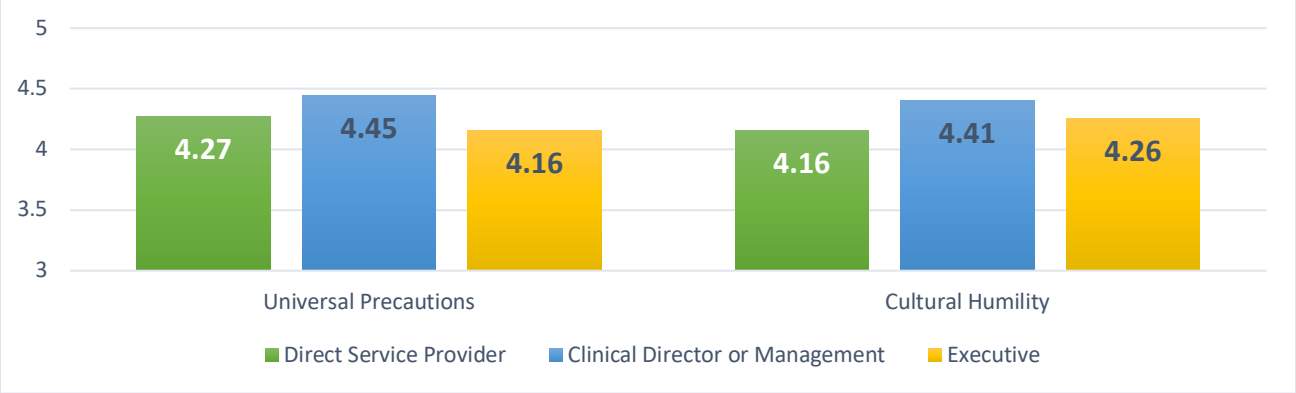
Findings from the TIROC-Nonclinical OSA (Providers only). The TIROC-Nonclinical OSA assessed TIC principles within the context of seven professional domains, and the conclusions of this survey are outlined herein.

Domain 1. Early Screening and Comprehensive Assessment. Two questions were asked to assess Domain 1 (see Figure 17), including:

- **Universal Precautions:** "Our organization promotes universal expectations in which staff and those served are assumed to have experienced adversity and are treated with sensitivity and respect."
- **Cultural Humility:** "Our organization promotes cultural humility in which staff and those served are considered to have their own cultural identity and are treated with sensitivity and respect."

Figure 17.

Provider Responses to Domain 1



Domain 2. Person-Driven Care and Services. Four questions were utilized to assess Domain 2 (See Figure 18). These questions were as follows:

- **Employment:** Our organization employs individuals who have served in the past or are currently serving.
- **Customers' Rights:** When appropriate, all people served are educated about their rights specific to our services in a manner that is understandable to them.
- **Hiring Process:** Our organization's hiring process includes people served or alums as part of the interviewing process.

- **Cultural Humility:** Our services are tailored to the population we serve, ensuring cultural and linguistic appropriateness.

Figure 18.

Provider responses to Domain 2

Domain 3. Resilient and Trauma-Informed, Educated and Responsive Workforce. The survey included a total of nine questions to assess Domain 3. The questions were as follows:

- **Leadership Internal Communication:** Our Leadership internally communicates a clear message that we are dedicated to trauma-informed, resilience-oriented practices.
- **Leadership External Communication:** Our Leadership externally communicates a clear message that we are dedicated to trauma-informed, resilience-oriented care (website, bylaws, mission statement, etc.).
- **Job Advertisements:** Our job postings prioritize experience with or knowledge of trauma-informed, resilience-oriented care.
- **Job Descriptions:** Our job descriptions include expectations related to trauma-informed, resilience-oriented care.
- **Staff Training:** All staff receive ongoing educational opportunities on the importance of being a trauma-informed, resilience-oriented care organization.
- **Performance Appraisals:** Our performance appraisals include expectations that staff behaviors are aligned with trauma-informed, resilience-oriented care.
- **Trauma-Informed, Resilience-Oriented Supervision:** Staff supervision includes practices aligned with trauma-informed, resilience-oriented care.
- **Staff Self-Care:** We have a way to prevent, identify, and appropriately respond to workforce concerns (burnout, secondary traumatic stress, compassion fatigue, etc.).
- **Cultural Humility:** Our workforce development procedures (i.e., hiring, orientation, training, and ongoing professional development) ensure diversity, equity, and inclusion and are culturally and linguistically appropriate.

Figures 19a-19d depict the mean scores for these variables.

Figure 19a.

Provider responses to Domain 3 – Leadership Communication

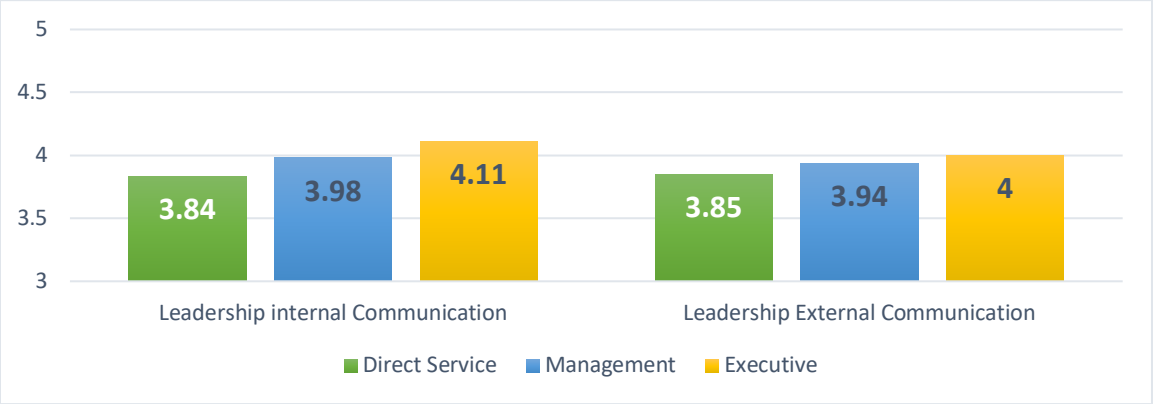


Figure 19b.

Provider responses to Domain 3 – Job Advertisements and Descriptions

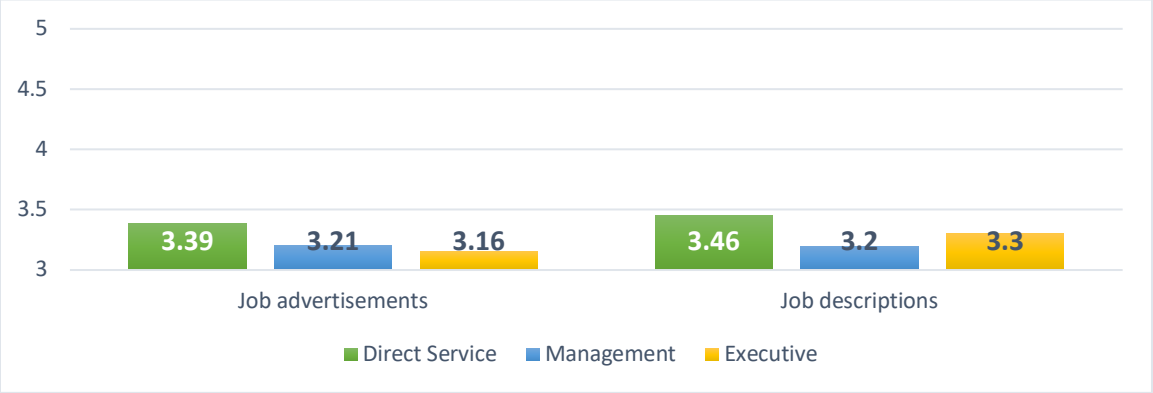


Figure 19c.

Provider responses to Domain 3 – Training, Appraisals, and Supervision

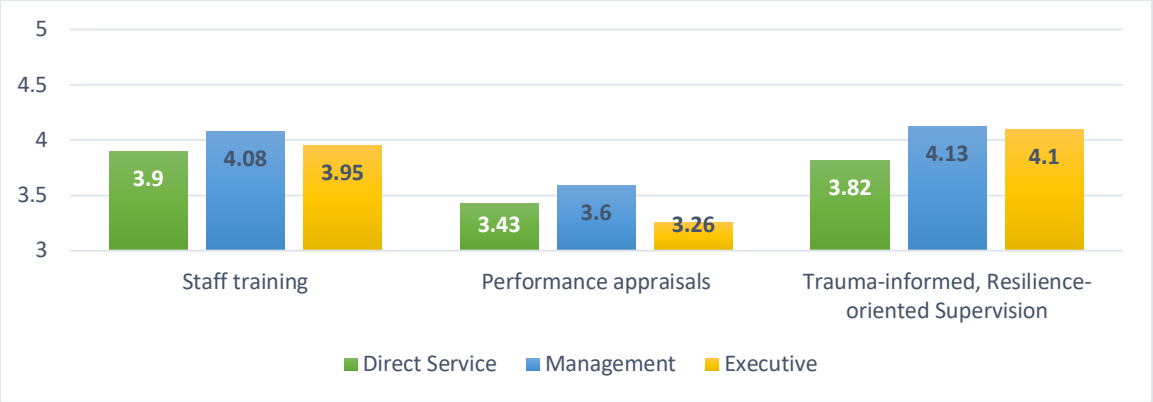
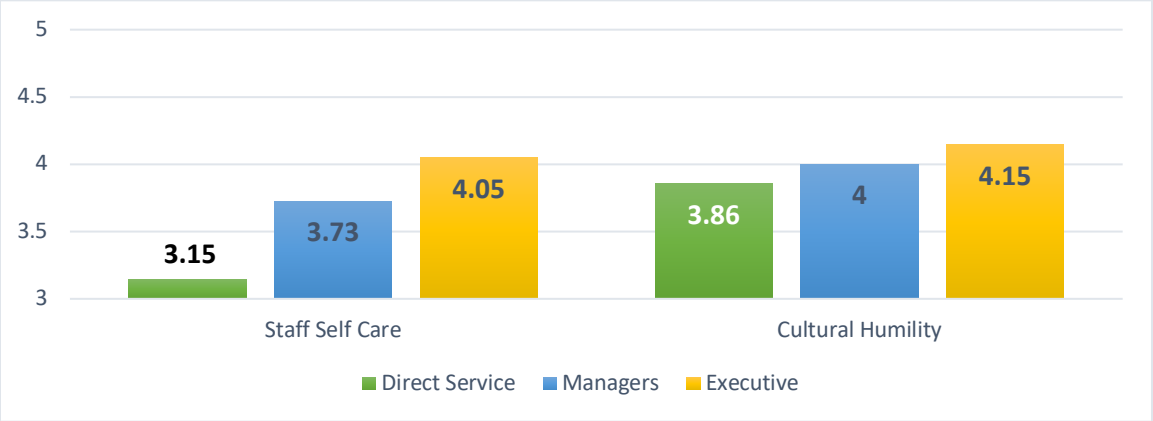


Figure 19d.

Provider responses to Domain 3 – Self-Care and Cultural Humility



Domain 4. Provision of Trauma-Informed, Resilience-Oriented, Evidence Based and Emerging Best Practices. Five questions were included to assess Domain 4, including:

- **Informed Support:** With necessary consents in place, we provide trauma-related information to those working directly with the individuals we serve.
- **Evidence-Based Practices:** The organization utilizes evidence-based practices in its delivery of service.
- **Shared Decision-Making:** Shared decision-making between staff and the people we serve is a key aspect of our work.
- **Care Coordination:** With necessary consents in place, we regularly share case data with outside organizations.
- **Cultural Humility:** Our organization employs evidence-based or evidence-informed practices to minimize bias and ensure diversity, equity, and inclusion for the people we serve.

The average scores for Domain 4 questions are outlined in Figures 20a and 20b.

Figure 20a.

Provider response to Domain 4: Informed support and evidence-based practice

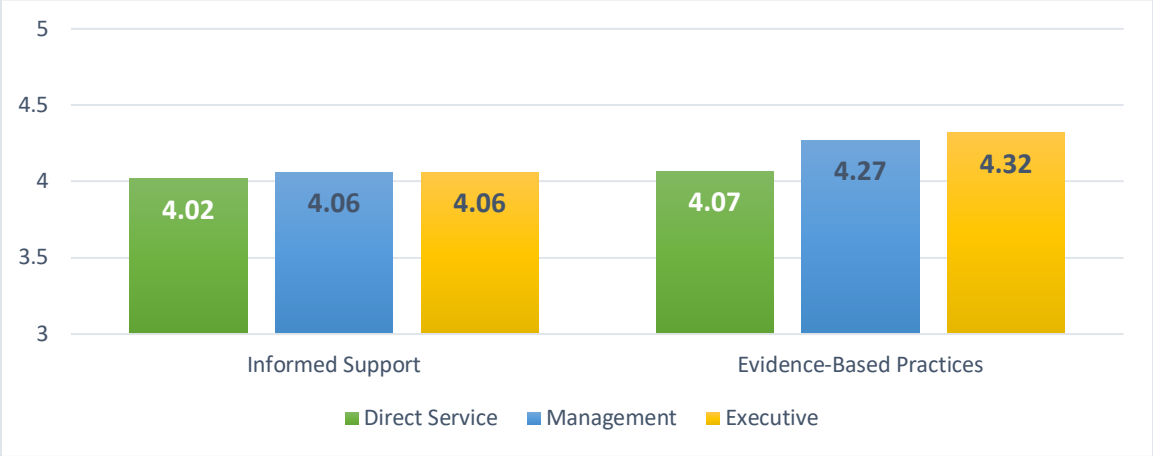
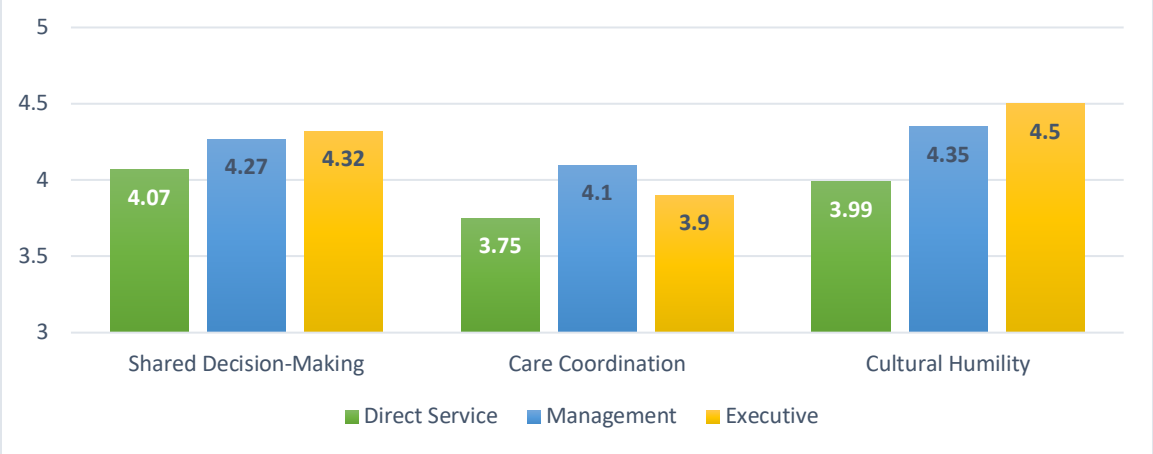


Figure 20b.

Provider response to Domain 4: Decision-making, care coordination, and cultural humility



Domain 5. Create Safe and Secure Environments. A total of nine questions were included in the survey to assess Domain 5. The questions were as follows:

- **Trauma-Informed, Resilience-Oriented Leadership:** Our leadership practices align with trauma-informed, resilience-oriented principles.
- **Safety Team:** We maintain a team that includes representatives from leadership, practitioners, support staff, and people served, who are responsible for ensuring a safe and secure (physical, social, psychological, and moral) environment.
- **Conflict Resolution:** Our organization has established strategies to resolve conflicts and address aggression among staff members and between staff and the people we serve.
- **Interpersonal Interactions:** Our organization has a policy or protocol in place for determining when interpersonal interactions at work are unsafe among staff members and between staff and the people we serve.

- **Adverse Incidents:** We have a system in place to review incidents that compromise a safe environment.
- **Adverse Incident Support:** We have a system in place to support those affected by adverse incidents that compromise safety.
- **Adverse Incidents:** We ensure staff are trained in resilience-oriented trauma-informed approaches to manage adverse incidents.
- **Physical Environment:** We have a process in place for communicating when our work environment is unsafe.
- **Cultural Humility:** Processes related to the environment of care are culturally and linguistically appropriate.

The resulting mean scores for each of the Domain 5 questions are summarized in Figure 21a-d.

Figure 21a.

Provider response to Domain 5: Conflict resolution and interpersonal interactions

Figure 21b.

Provider response to Domain 5: Adverse incidents, support, and management

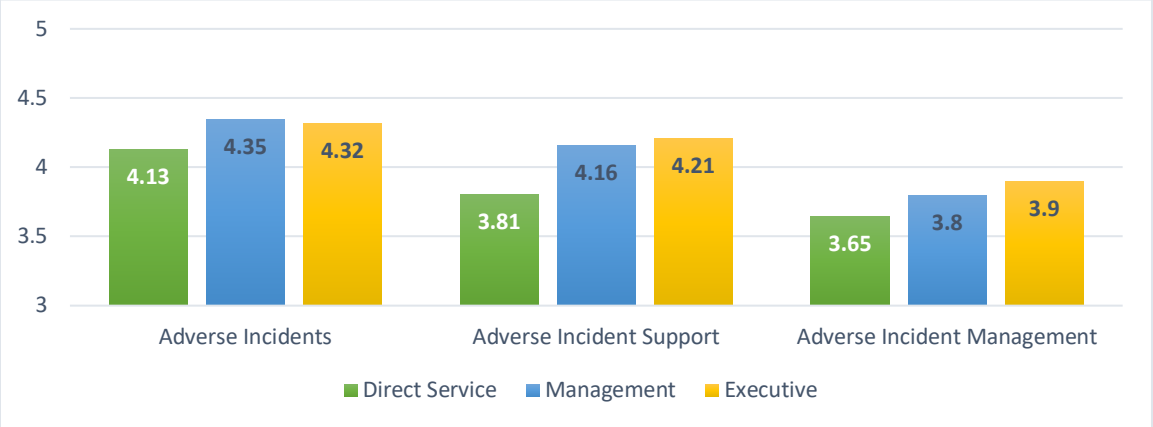


Figure 21c.

Provider response to Domain 5: Leadership and safety team

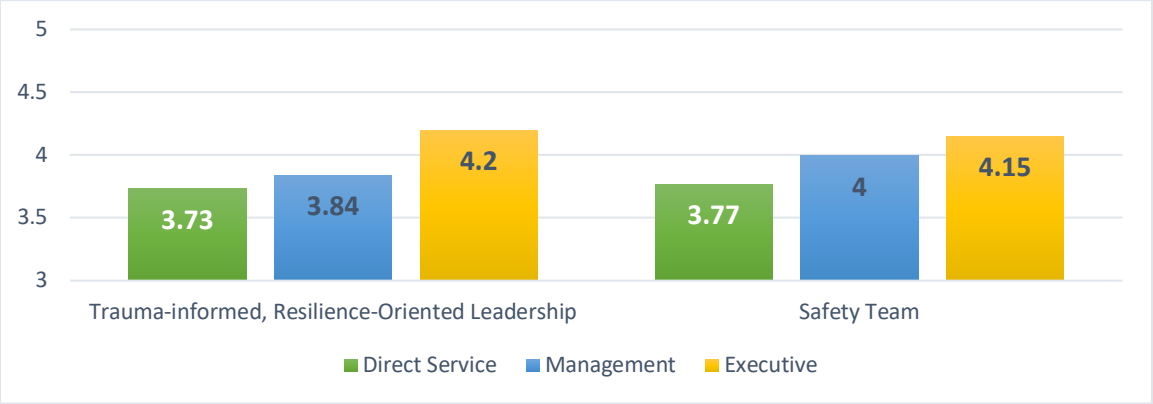
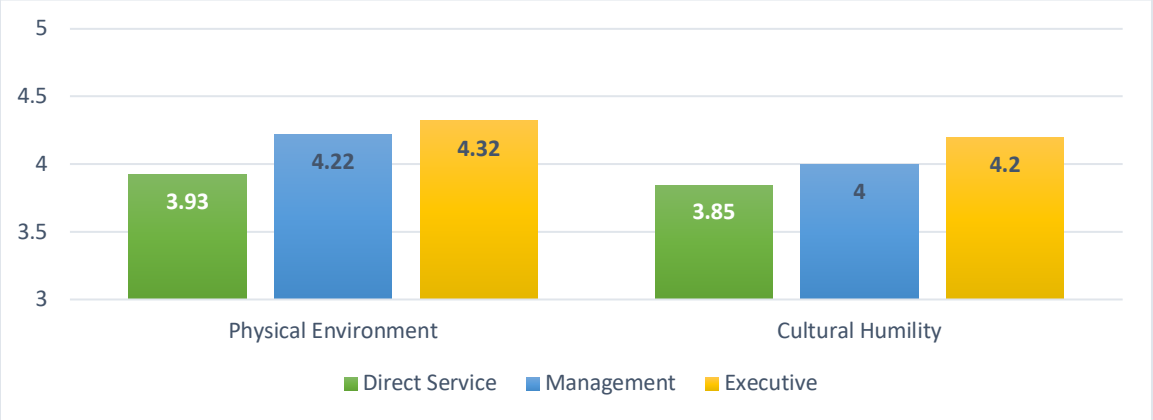


Figure 21d.

Provider response to Domain 5: Physical environment and cultural humility



Domain 6. Engage in Community Outreach and Partnership Building. Five questions were included in the survey that assessed Domain 6 (see Figures 22a-22 b). The questions were as follows:

- **Leadership:** Our organization assumes a leadership role in delivering trauma-specific, resilience-oriented awareness and education activities to community agencies.
- **Training:** The people we serve share their lived experiences during community engagement and partnership-building efforts.
- **Community Partnership:** Our organization participates in community workgroups or task forces related to building resilience.
- **Advocacy:** Our organization engages in training, community support, advocacy, and cultural humility to create trauma-informed, resilience-oriented communities.
- **Cultural Humility:** We connect people we serve with social, religious, cultural, and other community resources that align with their identities, interests, and needs as a routine part of interactions.

Figure 22a.

Provider response to Domain 6: Leadership, Training, and Community Partnership

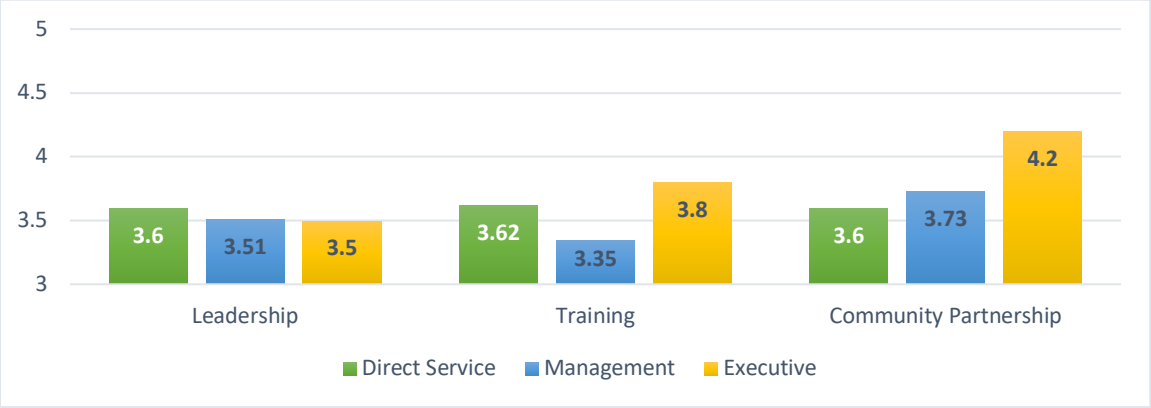
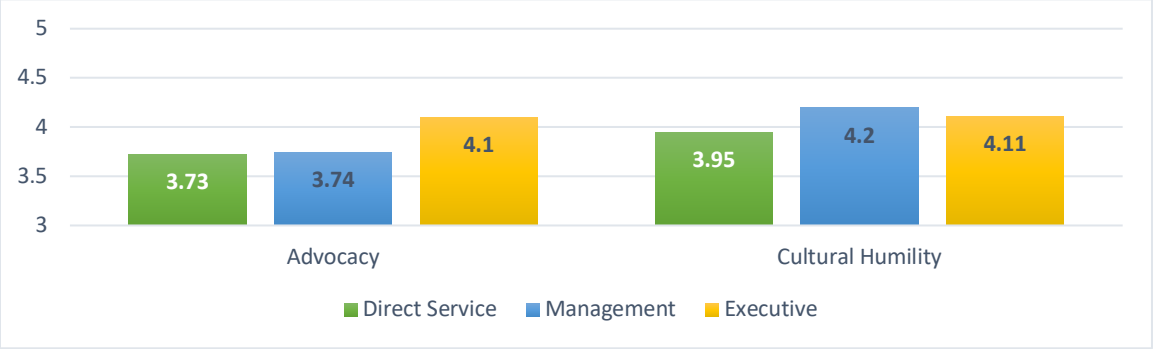


Figure 22b.

Provider response to Domain 6: Advocacy and cultural humility



Domain 7. Ongoing Performance Improvement and Evaluation. In total, six questions were included in the survey to assess Domain 7. Figures 23a-c below outline the mean scores for these six questions. The questions included:

- **Data Collection:** Our organization collects and analyzes performance data on one or more trauma-informed, resilience-oriented care domains.
- **Data-Informed Decision Making**: Our organization utilizes internal data to address challenges and celebrate successes related to providing trauma-informed, resilience-oriented care.
- **Presentation of Data:** Our organization presents trauma-informed, resilience-oriented care data to a wide array of audiences (leadership, board, staff, Customers, community partners, etc.).
- **Data Reports:** Our data reports about trauma-informed, resilience-oriented care are clear and easy to understand.
- **Continuous Quality Improvement:** Trauma-informed, resilience-oriented care performance metrics are incorporated into our organization's continuous quality improvement processes.
- **Cultural Humility**: Our data collection, reporting, and continuous quality improvement processes are designed to mitigate the impacts of implicit bias, are culturally and linguistically appropriate, and reflect the diverse needs of the people we serve.

Figure 23a.

Provider response to Domain 7: Data collection and data-informed decision making

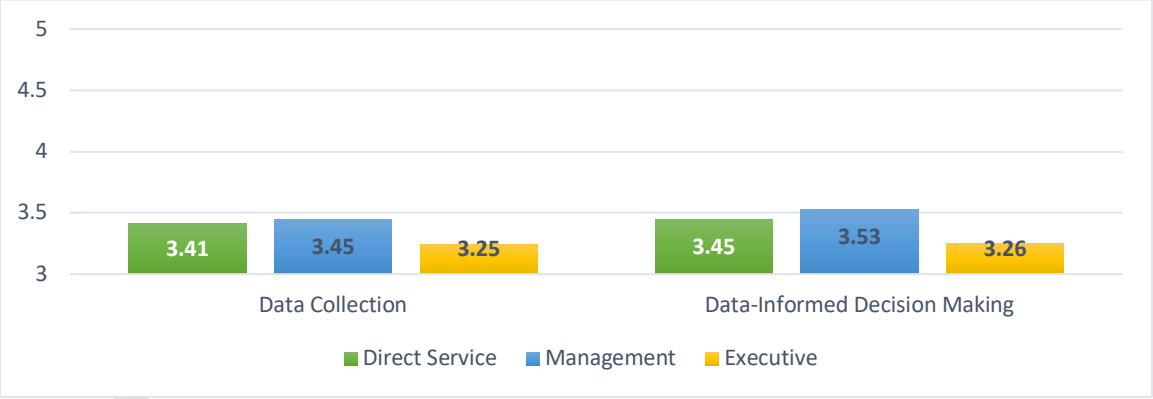


Figure 23b.

Provider response to Domain 7: Data presentation and reports

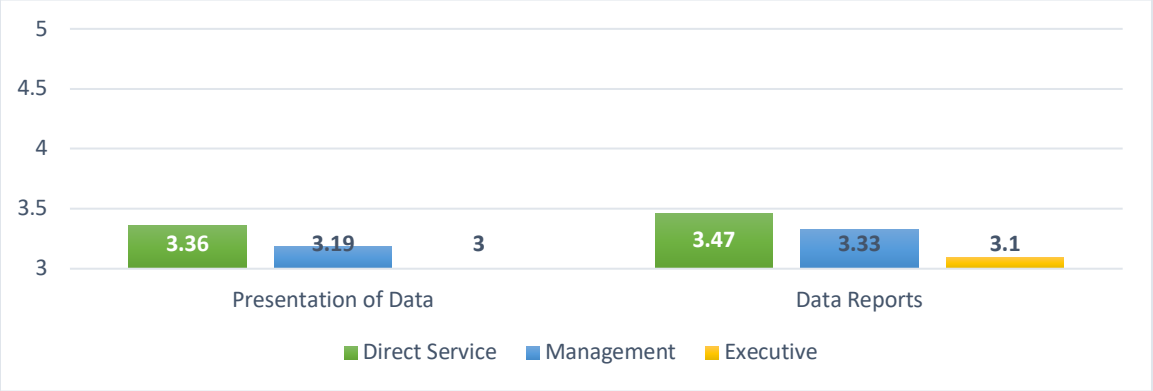
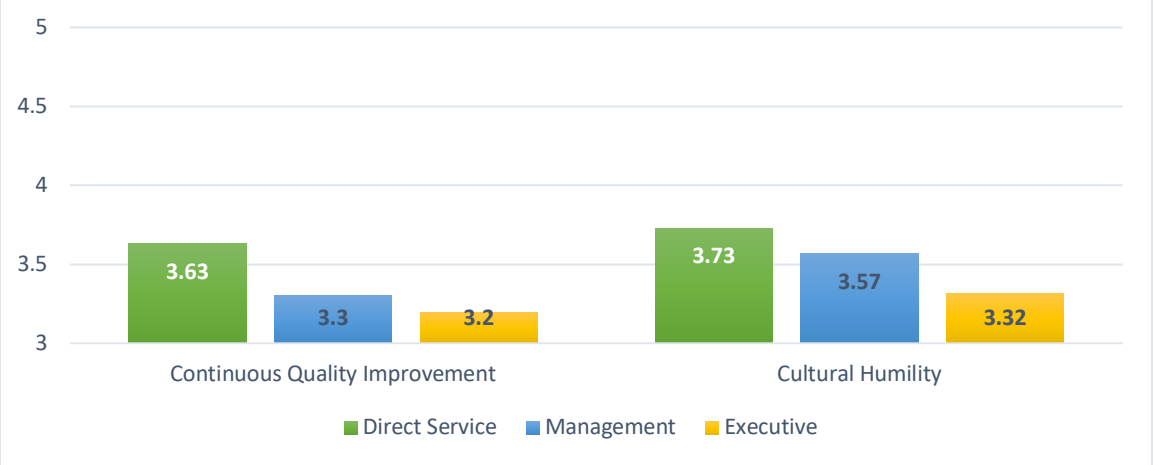


Figure 23c.

Provider response to Domain 7: Quality Improvement and cultural humility



Findings from the Organizational Self-Assessment Long Form (Providers & Consumers). The OSA Long Form is structured to assess TIC principles from an organizational engagement perspective, utilizing various prompts to evaluate organizational philosophy and practice (outlined below). Results from the selected questions from this survey are defined herein.

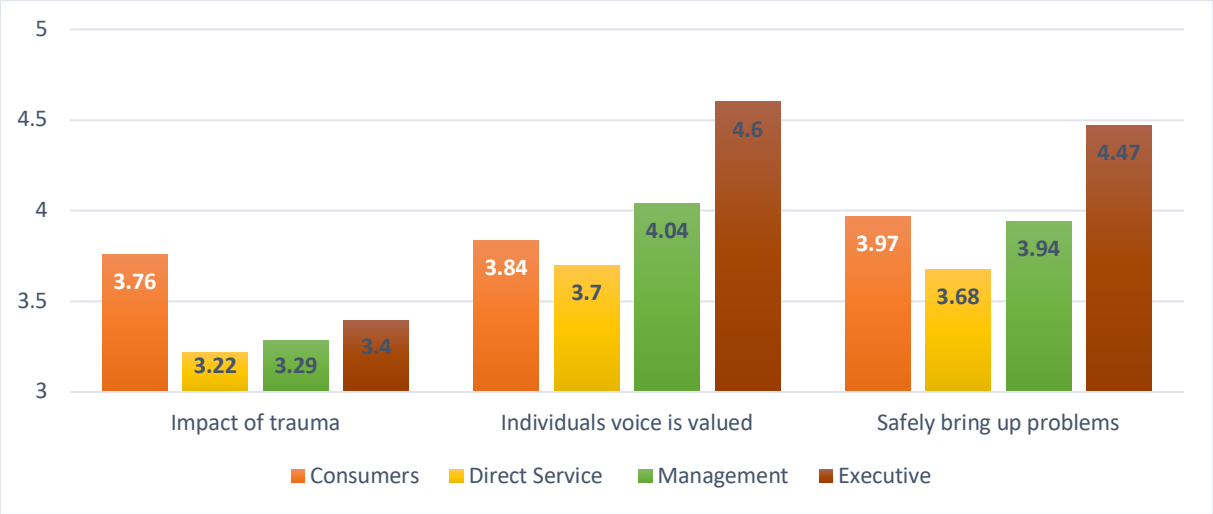
Prompt 1: "When interacting with each other…" (for providers) or "As a consumer or client…" (for consumers)

- …I see examples of the *impact of trauma* within our/ organization, such as posters on the walls, websites, etc.
- Regardless of position of power, an *individual's voice/my voice is valued*, welcomed, and respected.
- …Members of our organization/ can *safely bring up problems* and tough issues. (C1)

The mean scores for these three prompts are visualized in Figure 24 below.

Figure 24.

Consumer and Provider Response to Prompt 1



Prompt 2. "My organization practices cultural humility by ensuring…" (for providers) or "As a consumer or client…"

- …*I am treated with respect* here.
- …*People are treated with respect* here.
- …*I am safe* to be my whole self (culture, gender, etc.).
- …*Others are safe* to be their whole selves (culture, gender, etc.).
- …*My culture* is respected here.
- …*The culture of others* is respected here.
- …*I am offered opportunities* to reflect on my possible bias and ramifications within my work.
- …*Others are offered opportunities* to reflect on their bias and the ramifications in their work.
- …*I can speak* about inequality and inequity without fear of reprisal/negative consequences, or judgment.
- …*Others can speak* about inequality and inequity without fear of reprisal/negative consequences, or judgment.

The following five (5) figures outline the average scores for each of these questions below.

Figure 25a.

Consumer and Provider response to Prompt 2: Respect

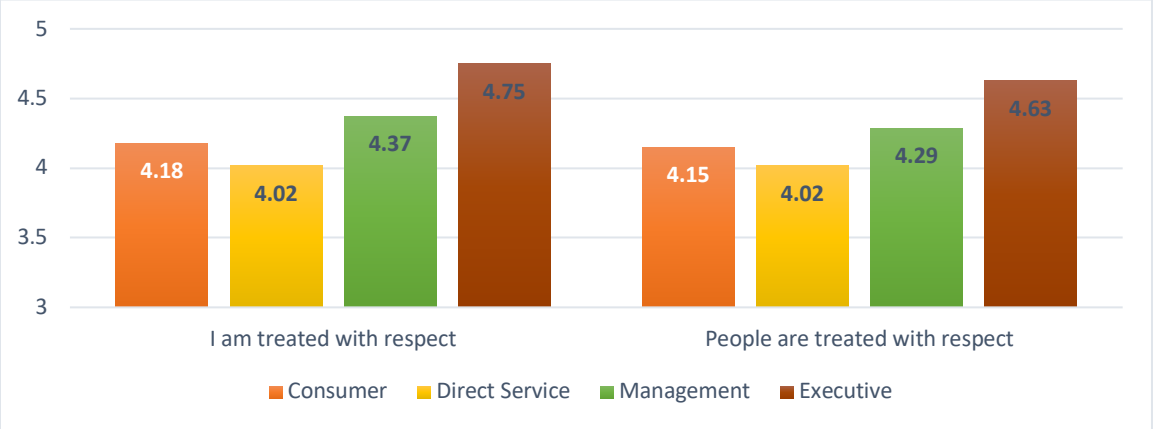


Figure 25b.

Consumer and Provider response to Prompt 2: Safety

Figure 25c.

Consumer and Provider response to Prompt 2: Culture

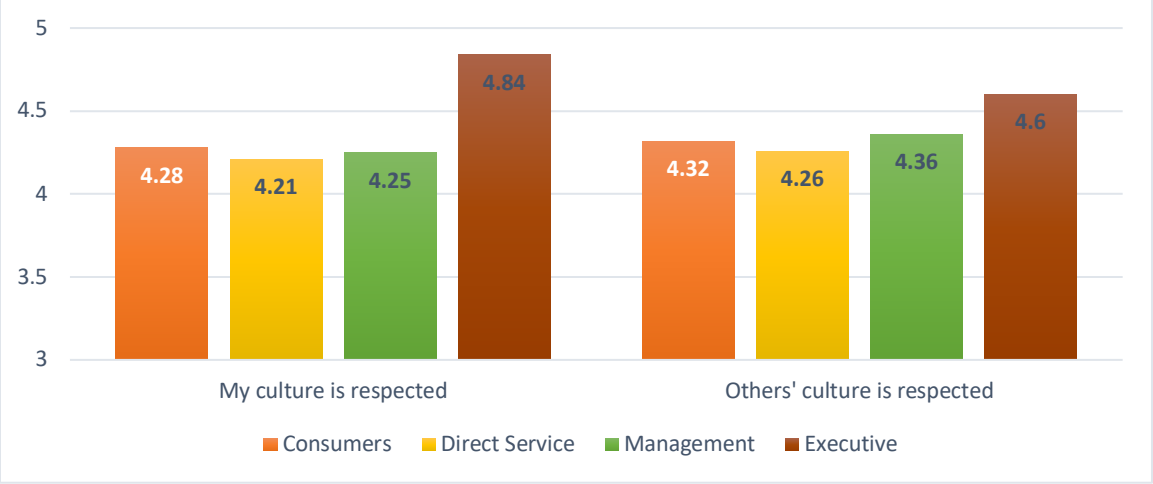
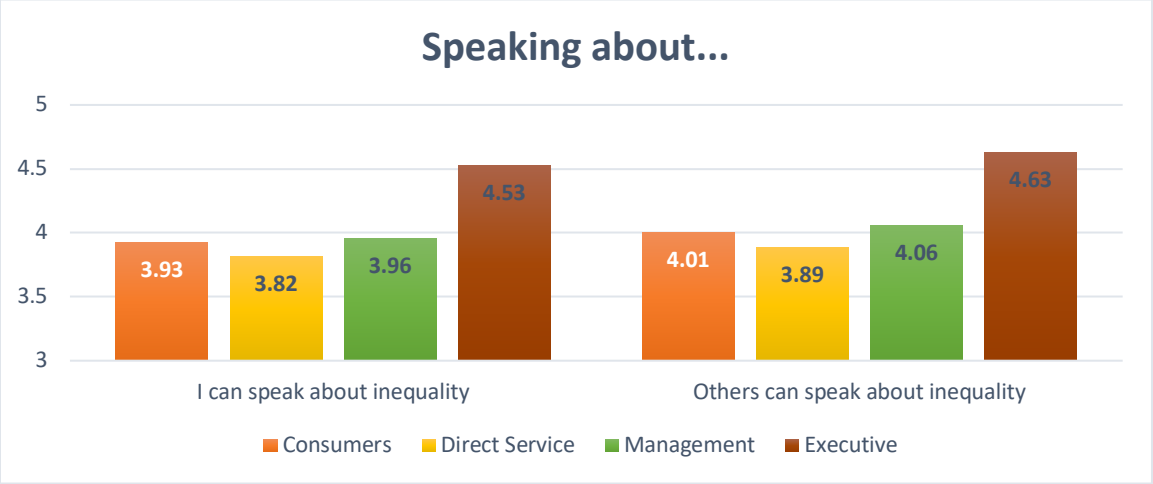


Figure 25d.

Consumer and Provider Response to Prompt 2: Opportunities

Figure 25e.

Consumer and Provider response to Prompt 2: Speaking about inequality



Prompt 3. " The people we serve and their supports have opportunities to actively engage in…" (for providers) or "As a consumer or client, I have opportunities to actively participate in …" (for consumers).

- …Decision-making about services
- …Evaluation of services
- …Quality improvement efforts
- …Providing feedback about their experience
- …Where services are provided

- …How services are provided
- …When services are provided

The mean scores from the results of each of these questions are outlined in the following three (3) Figures.

Figure 26a.

Consumer and Provider response to Prompt 3: Decision-making and evaluation

Figure 26b.

Consumer and Provider Response to Prompt 3: Quality Improvement and Feedback

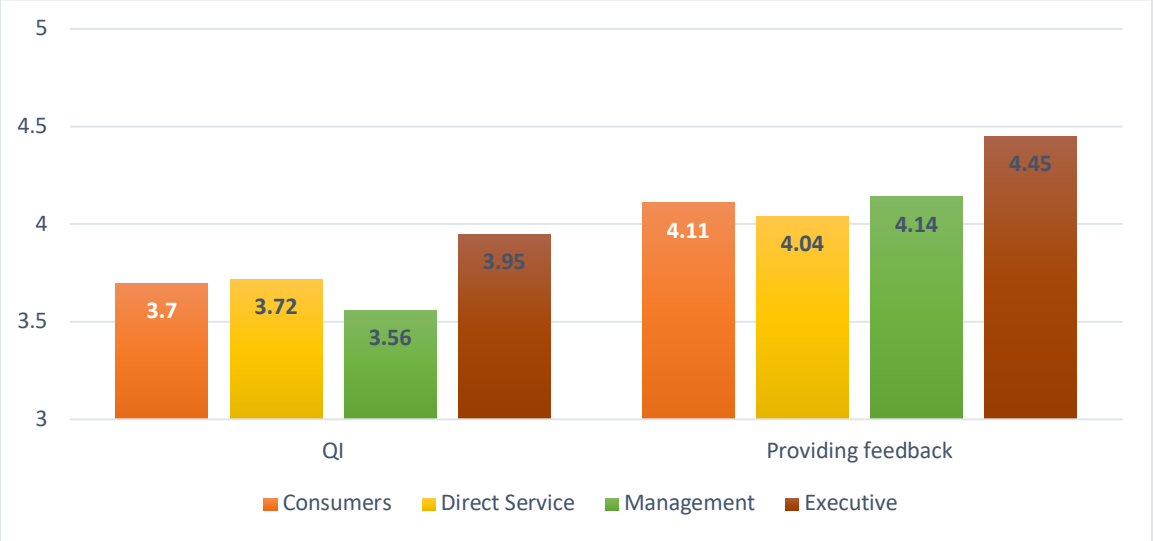


Figure 26c.

Consumer and Provider response to Prompt 3: Where, How, and When

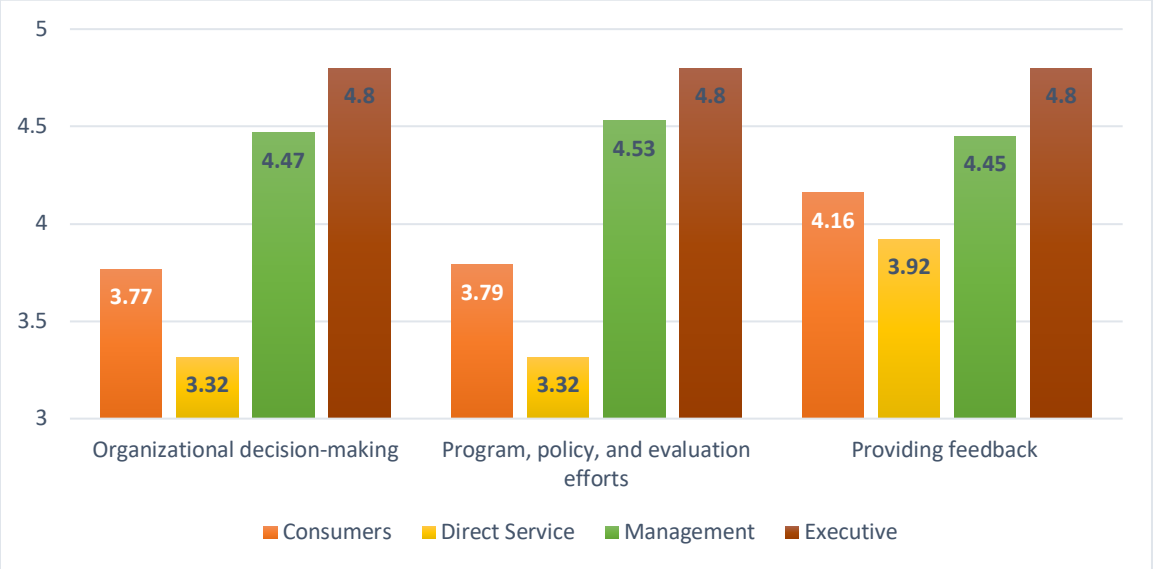
Prompt 4. "I have the opportunity to participate in..." (for providers) or "As a consumer or client, I have opportunities to actively participate in …" (for consumers)

- …Organizational decision-making
- …Program, policy, and evaluation efforts
- …Providing feedback

Results from the Prompt 4 questions are outlined in Figure 27.

Figure 27.

Consumer and Provider responses to Prompt 4 questions



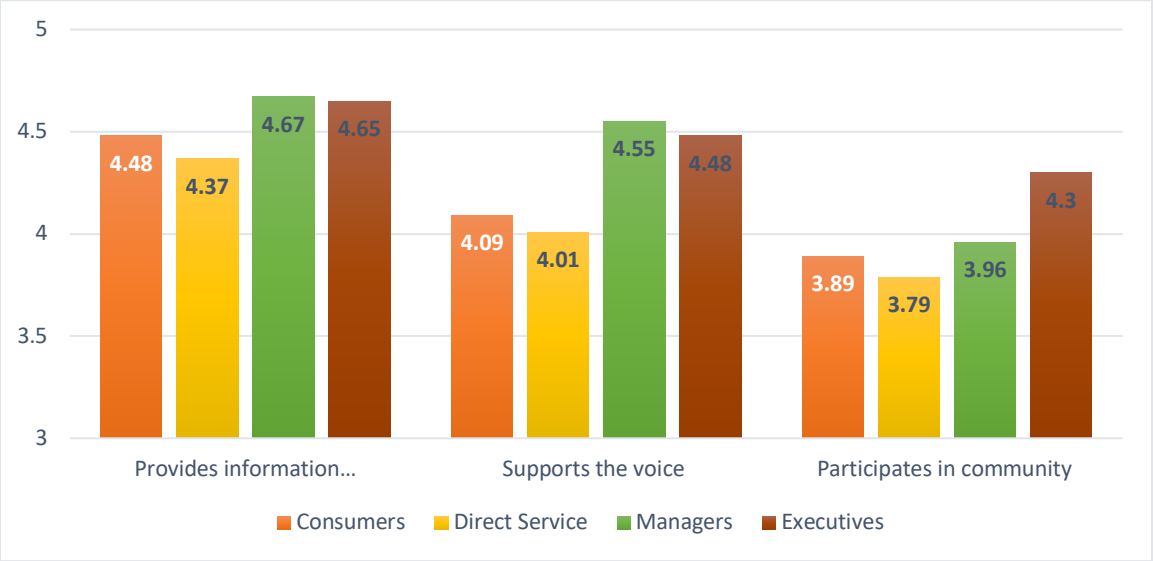
Prompt 5. "Our organization(s)…" (for providers) or "This organization..." (for consumers)

- …*Provides information* (I understand) about the rights of those receiving services.
- …*Supports/Includes the voice* of lived experience during community engagement and partnership building.
- …*Participates in community* workgroups and task forces related to trauma-informed, resilience-oriented approaches.

Figure 28 presents a graphical representation of the mean scores from the questions in Prompt 5.

Figure 28.

Consumer and Provider responses to the five questions



Trauma-Informed Practice (TIP) Scales (Consumers Only). Additionally, consumers were asked to respond to the Trauma-Informed Practice (TIP) Scales to provide their perspective on the environment of the agency, access to information on trauma, opportunities for connection, whether staff interactions emphasized strengths, cultural responsiveness, and support for parenting The TIP questions were measured using a Likert-style scale, with each question having a score ranging from 0 to 3. Higher scores for each question suggested the respondent felt the statement was more true. When combined into the sub-scales, higher scores indicated a higher level of trauma-informed practice. TIPS data can be utilized at the item or scale level; we have provided a breakdown of both in this report.

The TIPS Scales. The TIPS Scales consist of three parts, including 1) assessment of interactions with staff in the program (20 items), 2) cultural responsiveness and inclusivity (7 items), and 3) responses about parenting support only if the participant has children. Notably, Part 1 includes four sub-scales: environment of agency and mutual respect (9 items), access to information on trauma (5 items), opportunities for connection (3 items), and emphasis strengths (3 items). The average scores for all subscales are listed in Table 20 below.

Table 20.

Consumer Responses to the TIPS Scales

Subscale	# of respondents	Possible Range	Summary Mean Score (SD)	Average Mean Score
Agency	26	0-27	22.08 (6.29)	2.45
Information	28	0-15	11.64 (3.90)	2.31
Connection	29	0-9	7.14 (2.46)	2.38
Strengths	27	0-9	7.33 (2.20)	2.44
Inclusivity	20	0-21	16.35 (4.58)	2.33
Parenting	6	0-15	12.00 (4.00)	2.40

TIPS Items. The average scores for each of the items are included in the following five (5) figures, based on subscales.

Figure 29.

Consumer Response to Agency Subscale

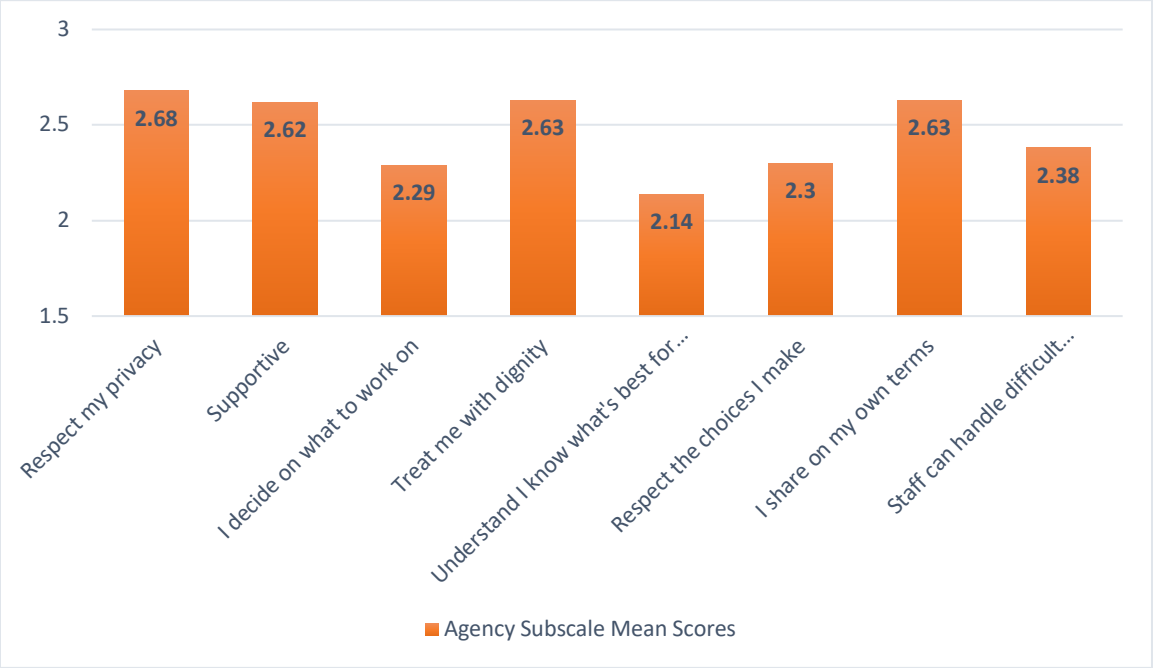


Figure 30.

Consumer Response to Information Subscale

Figure 31.

Consumer Response to Connection Subscale

Figure 32.

Consumer Response to Emphasis on Strengths Subscale

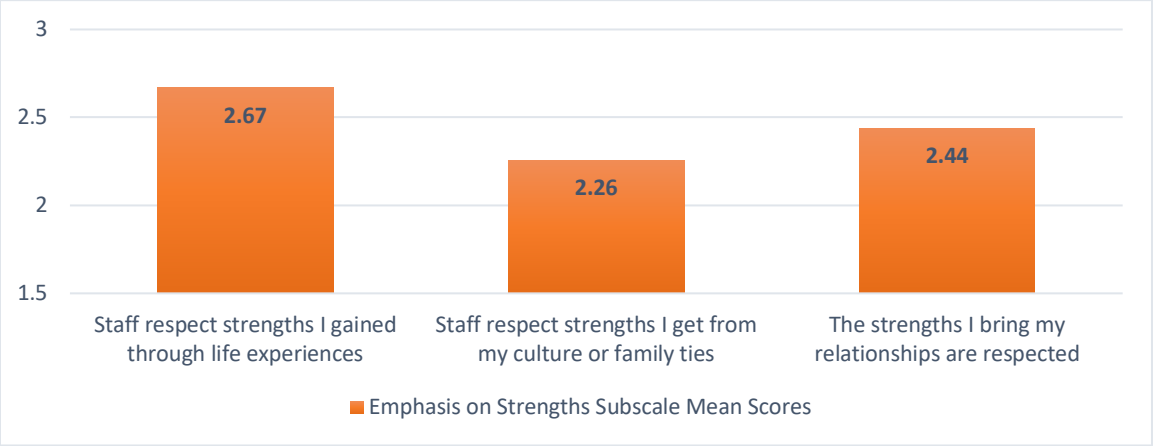


Figure 33.

Consumer response to Inclusivity Subscale:

Qualitative Feedback from Survey

Participants were offered the opportunity to add any additional information related to trauma-informed care in their organization that they thought may be helpful for us to know, using an open-ended text box. A total of n = 40 providers and n = 10 consumers provided text responses. Several topics were elaborated on in the responses, emphasizing the multifaceted nature of TIC within our community. The major issues that emerged from the open-ended responses include the following:

For Providers:

- *The importance of engagement in Trauma-Informed Care (TIC):* Emphasis on the significance of TIC, the need for ongoing training, and implementation efforts.
- *Concerns about Equity and Respect:* Concerns about equity and respect for marginalized groups, including women, LGBTQ+ individuals, and survivors of trafficking.
- *Need for Organizational Leadership Buy-in and Cultural Shift:* Recognition of the role of leadership in fostering a trauma-informed environment and addressing discrepancies between rhetoric and practice.
- *Need for Training and Education:* Calls for enhanced workshops, training sessions, and cultural competency education to support the implementation of TIC.
- *Importance of Community Collaboration:* The Importance of collaboration between agencies and community resources to provide adequate support.
- *Suggestions, Feedback, and Strategies for Improvement:* Suggestions for soliciting feedback, ensuring staff sensitivity, and continuous improvement in trauma-informed practices.

For Consumers:

- *Supportive Environment and Client-Centered Care:* Some respondents reported that they perceived the organizations as safe and supportive spaces, where clients feel cared for and their issues are prioritized.
- *Staffing and Resource Challenges:* Several participants expressed concerns about staffing shortages and inadequate resources within their agencies, which hindered their ability to provide comprehensive care. This included the need to hire more people with lived experience.
- *Therapy and Trauma Resolution:* Several people shared the importance of individual therapy in addressing trauma and other life issues, with varied experiences regarding the focus on trauma within therapy settings.
- *Cultural Diversity and Equity in Recovery:* Multiple respondents emphasized the need for increased awareness, training, and equitable pathways to recovery, particularly about cultural diversity and the accessibility of services.

Section V: Qualitative Findings

Qualitative Findings: Key Highlights

We conducted individual interviews with key stakeholders and focus groups with providers and consumers. Several emergent themes were identified during analysis. First, there is a lack of consistency in definition of trauma and TIC. Additionally, few respondents were aware of the six (6) TIC principles. Additionally, all groups agreed there is a need for additional supports for the workforce, including staff training, wellness initiatives, and addressing the workforce shortage. There was also an acknowledgement that TIC is emphasized in clinical care settings, but that we need to integrate TIC in other sectors as well, where possible. Respondents also spoke about current sociopolitical events having an impact on individual and community well-being and highlighted the need for community healing initiatives. Finally, minoritized consumers may have a difference experience in treatment than their counterparts and strategies are needed to improve equitable care.

Overview

Like the TIC survey, the qualitative data approach gathered information from three primary perspectives: key community or organizational leaders, individuals working directly with clients, and consumers of Summit County services. Where the survey responses were limited to a finite number of drop-down menu choices, focus groups and interviews provided unfiltered responses through open-ended questions. This allows for a more nuanced and insightful input from participants. Once all the data were collected, the research team compared all responses to illuminate key themes.

Key Stakeholder Interviews. A total of 10 key stakeholder interviews were conducted between December 23 and February 2024. Each interview subject was given a description of the project, a 1-page flyer summarizing the principles of trauma-informed care, and a list of the following questions being asked:

1. How do you define trauma-informed care?
2. What are the biggest threats facing your organization right now?
3. What are your thoughts about trauma-informed care initiatives?
4. What do you think would be the best approach in implementing trauma-informed care policy in your organization?

Community Stakeholders Themes. Emergent themes from the key stakeholder interviews were as follows:

1. *How do you define TIC?*
    - There was a wide variety of definitions among stakeholders, though several key themes emerged:
        - A holistic approach
        - What happened to you rather than what's wrong with you?
        - There is societal, community, and individual trauma.

- It looks different in different settings (*e.g., law enforcement versus*
  - *clinical*)
- Meeting a person where they are and understanding triggers.
- Several stakeholders urged a need to challenge the stigma of trauma.
- Emphasis on TIC in clinical settings, though there is some understanding
  - of trauma at the community level or non-clinical contexts.

2. *What are the biggest threats facing your organization right now?*
   - Workforce shortages combined with compassion fatigue and staff burnout. Staff and consumers are both stretched to their limits.
   - Politicization of public health and healthcare. People are more concerned about public health since the COVID-19 pandemic.
   - Insufficient funding
   - Staff shortages compound clients with higher symptom acuity.
   - Community compassion fatigue in the context of increased violence, overdose deaths, and political vitriol.

3. *What are your thoughts about a TIC initiative?*
   - The TIC Initiative requires a dedicated figure/group with the authority and resources to support *action* for systemic culture change.
   - Initiatives must be tailored by sector.
   - Coalitions must have funding and goals, "*no money, no mission*."
   - Too much focus on clinical domains
   - It will be most difficult in the criminal justice sector.
   - Many initiatives don't follow through on it all the way, *and trauma* has become a buzzword to check off.

4. *What do you think would be the best approach in implementing TIC?*
   - It must be a dedicated hub with accountability to drive it. A neutral entity with the authority to support implementation
   - Must include an evaluation plan.
   - Must be a common language and definitions that can be incorporated into policies and training.
   - Designate funding for staff wellness.
   - Include workforce development and training.

Focus Groups. Seven focus groups were conducted between December 2023 and February 2024. All participants consented to participate, were informed about the project and received a 1-page flyer summarizing trauma-informed care. These activities were transcribed through the MS Teams software and were fully anonymous, with no names being collected or used. The resulting transcription held no protected health information for consumers. Focus groups included: 2 focus groups of consumers in minority serving behavioral health agencies, one focus group of clients involved in community corrections, one focus group of men in SUD treatment, 1 focus group of

women in SUD treatment, 1 focus group representing faith leaders, and 1 focus group of social service professionals.

Consumer focus groups were asked the following questions:

1. How do you define trauma?
2. How do you define trauma-informed care?
3. Domain 1: To what extent do the agencies with whom you interacted ensure your physical and emotional safety? How can services be modified to provide this safety more effectively and consistently?
4. Domain 2: To what extent do the agencies with whom you interacted maximize your experiences of choice and collaboration?
5. Domain 3: To what extent do staff members in the agencies with whom you interact seem competent in addressing trauma and trauma-related issues?
6. Domain 4: To what extent are expectations and boundaries communicated to you? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately?
7. Domain 5: To what extent do the agencies with whom you interact provide screening and/or assessment of your experience (or the experience of someone you know) with trauma?
8. Domain 6: To what extent are agency administrators and program staff aware of culture and the importance of incorporating this awareness in their care?

Professional focus groups were asked the following questions.

1. How does/your organization define trauma?
2. How do you/your organization define trauma informed care?
3. What does your organization do well about trauma-informed care?
4. What does your organization do best?
5. What advantages does your organization have in terms of TIC?
6. What would other people see as the strengths of your organization regarding TIC?
7. How do people within your organization engage in trauma-informed care practices?
8. What are the areas of growth for your organization regarding trauma-informed care?
9. What tasks may be avoided due to these areas of growth?
10. What resources are you lacking?
11. What areas need more training/education?
12. What are the negative traits within/ the organization that may inhibit TIC efforts?
13. What are the major obstacles within your organization?
14. What are the compelling factors within your organization?
15. How are your organization/people within your organization limited in their engagement with trauma-informed care practices?
16. What resources are available in the county/community that may support your organization in enhancing trauma-informed care efforts? (How about beyond the county?)
17. What opportunities are there within the county/community for your organization to enhance trauma-informed care efforts? (and how about beyond the county?)
18. What could you do today that isn't being done?

19. How is the field changing, and how can your organization keep pace with or take advantage of these changes?
20. What new technologies may help enhance TIC efforts? What contacts may help your organization?
21. What are potential negative factors in the county/community that may inhibit your organization from enhancing its trauma-informed efforts?
22. What are the major obstacles outside of your organization?
23. What are the compelling factors outside of your organization?

Themes resulting from the Professional Focus Groups. The following themes emerged during qualitative data analysis of the professional focus groups:

I. How does your organization define trauma-informed care?

- A good understanding of trauma from a clinical patient care perspective is most common. Only a few identified a definition from an organizational perspective. Several indicated they don't have an operating definition of TIC in their organization.
- Some recognition of the impact of vicarious trauma in a community or demographic.
- Define trauma as an event that has happened in someone's life that is either acute or chronic, that adversely impacts their mental well-being.

II. What elements of TIC has your organization implemented? Are there examples implementing the six principles of TIC (i.e., safety, trustworthiness, transparency, peer support, collaboration, empowerment, and humility + responsiveness)?

- Most participants are familiar with the six principles of TIC once they are mentioned, but none have implemented all six principles on an organizational level.
- The principles of safety, collaboration, and peer support were most mentioned. Transparency, empowerment, and humility/responsiveness were the least mentioned.
- One participant indicated both clients and staff are carrying trauma, "*that makes for an explosion, or an exacerbation of the trauma to the weaker of the two. These are the waters we're navigating.*"

III. What does your agency do well regarding TIC?

- Most agreed that their organizations have done well in raising awareness of trauma and TIC in a general sense. However, there were few examples of actual programming outside of the behavioral health sector. Responses ranged from a keen focus on the identification and healing of trauma, to an organization hesitant to implement ACES screening for fear of triggering consumers.
- Faith-based and criminal justice organizations have the most extensive expertise, but also face significant implementation gaps.

IV. What are some areas of growth your agency needs regarding TIC?

- This question elicited the most robust responses from the professional focus group participants. Key takeaways include the need for funding, training on best practices (e.g., grief recovery methods), ensuring staff deliver best practices correctly, and fostering a work-life balance among employees. Other themes/items of note include:

- "*How safe can I be if I'm working 14-hour days?*"
- *"How do we honor the vocabulary differences?"*
- Workforce shortages are placing a heavier workload on those providing direct services.
- There has been considerable discussion on the need to increase pro-health-seeking behavior in minority communities.
- Inertia: Potential for resistance to change among seasoned staff.
- "*Trust in the system is a barrier for us."*

V. Other than these, not previously noted:

- No consistent TIC definitions across systems.
- The solution goes beyond training; it's a shift in how we view consumers.
- Current events are impacting our younger generation.
- Church and faith spaces lack understanding and training on trauma.

Themes resulting from the Consumer Focus Groups. The following themes emerged during qualitative data analysis of the consumer focus groups:

1. *How do you define trauma?*

- Trauma involves events that occur in one's life that are recurring and affecting their mental health and day-to-day living.
  - Things that one has gone through in life, which start from childhood.
  - Things that happened and leave wounds/scars/mental injuries/dramas.
  - Things that happened and keep you thinking about them.
  - Bad things that happened and changed your life forever.

2. *How do you define trauma-informed care?*

- Trauma-informed care is a treatment approach that helps providers become educated in and understand trauma, provide emotional safety and a sense of trust, take a whole-person perspective, and attend to diversity.
- Most participants could not verbalize/define trauma-informed care during the focus group, and from the combined interview data. The focus of the data is on providers (i.e., my counselor/therapist did XYZ) rather than administration and organizations.

3. *Domain 1 Physical and emotional safety*

- Participants reported that their providers provided a sense of safety regardless of the setting in which they received services.
- Treatment/providers that/ help one feel safe, create trust, and provide a balance of power.

4. *Domain 2: Choice and collaboration*

- There are mixed experiences. While most participants reported that their providers were transparent and discussed treatment information, some felt that this did not happen. Those in community residential treatment programs were caring and collaborative. Those

involved in corrections-based treatment programs did not feel there was choice or collaboration in treatment planning.

5. *Domain 3 Trauma competency*

- Most participants believe their providers are not trained in trauma treatment and that providers should talk about their trauma with them. Participants voiced that there should be more training and education in trauma.

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6. *Domain 4 Boundaries*

- Participants reported that their providers/organizations provide appropriate boundaries and expectations concerning treatment and professional relationships.
- Most participants received treatment or facilities for SUD. Therefore, by nature, rules/regulations/expectations are typically clear and concrete. It is uncertain /how much their overall interactions with their providers/agencies were considered based on the interview data.

7. **Domain 5 Trauma screening/assessment**

- There seem to be mixed experiences. While some participants (1/3) reported agencies provided trauma screening/assessment upon their initial encounter, others did not believe their experiences with trauma were screened/assessed.

8. **Domain 6 Trauma-informed care culture**

- Although there was no direct response to this domain, most participants agreed that there should be an increase in education/training about trauma to promote trauma-informed care culture.
- All participants appeared to struggle with this question. Essentially, this is because they focus on their interactions with providers and do not regularly interact with the administration.

9. **Experience of minority participants**

- Minority respondents indicated feeling more comfortable with therapists who looked like them.
- Some minority respondents indicated feeling like the reception areas or other participants treated them differently, especially if they were part of the LGBTQ community.
- Identified the need for therapists to be more honest in their actions and to be more genuine.
- They feel they are not informed about trauma.
- Respondents emphasized the need for more cultural awareness.
- Some verbalized feelings related to their safety.

Key conclusions from focus groups. The following conclusions were drawn from the evaluation of the data findings:

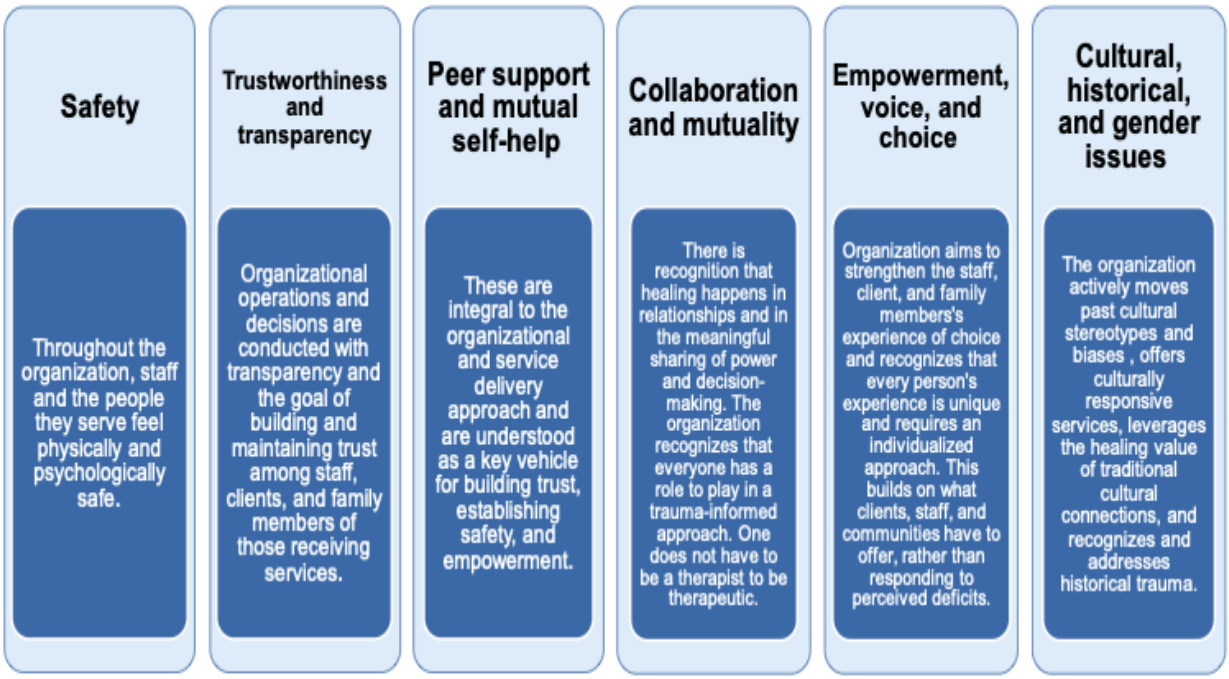
1. Lack of consistency in definitions of trauma and trauma-informed care. Few are aware of the 6 TIC principles.

2. All agree on the need for additional training for direct care workers.
3. Emphasis on TIC in clinical care settings, yet acknowledged the need to introduce it, where possible, in other sectors.
4. There is a need for staff wellness initiatives in all sectors.
5. Need for community healing initiatives and outreach.
6. Current events, inclusive of political vitriol, are having an impact on community and personal well-being.
7. Minority consumers may have a different experience in treatment than their counterparts.
8. Workforce shortages are impacting services.

Section VI: Recommendations

How we arrived at these conclusions: An evaluation is a process of continually questioning and gaining available information. The recommendations in this section are the result of a year-long data collection and analysis process, where we examined Summit County service delivery systems through the lens of trauma-informed care. According to SAMHSA, trauma-informed care (TIC) is a behavioral health approach that acknowledges the impact of trauma on individuals, groups, and communities. It involves understanding a patient's life experiences and being aware of how words, attitudes, and behaviors can retraumatize people. TIC aims to improve patient engagement, treatment adherence, and health outcomes, while also supporting the well-being of providers and staff.

SAMHSA's Trauma-Informed Approach (TIA) identifies six key principles for TIC:



Overarching these principles are four fundamental assumptions, which are referred to as the 4 R's.

Realization: Understanding how trauma impacts individuals, organizations, and communities.

Recognition: Conducted through screening, workforce development, and community outreach.

Response: Applying these principles to organizational policies, workforce training, procedures, etc.

Resisting Retraumatization: Knowing how activities can trigger retraumatization and working to avoid those triggers where possible.

As mentioned throughout these principles, trauma has an impact at multiple levels: individual, group, and community. This report has structured recommendations for each of these levels and various domains. The following information is based on local and state data made available for

this report, including surveys, focus groups, stakeholder interviews, and referenced literature. The recommendations outlined are not ranked; that task belongs to the implementation team and stakeholders. Recommendations are sorted into the following categories.

I. Coordination of efforts, accountability & evaluation
II. Coalition focusing
III. Client/Consumer related
IV. Workforce
V. Systemic (Macro)

I. Coordination, Accountability, and Evaluation:

A solidifying theme rising from the qualitative data cited the need for a centralized coordinating entity, or hub, to organize a response to these recommendations and facilitate the implementation of a trauma-informed approach to services and domains touched by persons with substance use disorders. The **Summit County Trauma-Informed Coordinating Center (SCTICC)** is requested to serve as a neutral, centralized entity with the authority and resources to support action. This section outlines the structure and nomenclature of the TICC, including missions and how it is incorporated with key community leaders and resources.

The following problem statement and outcomes statements are adapted and localized from SAMHSA's national strategy and trauma-informed operating plan[iii].

Problem Statement: Childhood, adult, and community trauma are a serious public health risk in Summit County, with potential lasting impact on physical and mental health. It remains a risk factor in the manifestation of substance use disorders and a possible barrier to recovery if left unaddressed. We must build community infrastructure and capacity to mitigate the impact of trauma, foster resilience, and promote healing at the individual, systemic, and community levels.

Outcome Statement: A Summit County strategy to build community capacity to identify, disseminate, foster, and implement practices that will reduce the impact of trauma as a barrier to positive outcomes for those with substance use disorders who are engaged with local systems and services. Likewise, develop and implement resources to aid in the healing of communities or demographics struck by violence, overdoses, and poverty.

Role of the SCTICC: To maximize continuity, it is recommended that the SCTICC be infused into existing committee and coalition infrastructure where possible. *This allows for synergy and efficiency with existing coalitions and task forces, rather than creating a separate meeting structure. It also helps* leverage buy-in while ensuring the project is informed by, and accountable to, key stakeholders, consumers, and topic experts. The Coordinating Center is to partner with local resources to review, monetize, and rank recommendations from this report, and move towards their implementation. The initial stage will be to recruit members for

The following are elements of the proposed governance structure (nomenclature) and embedded stakeholder engagement.

Opiate Abatement Advisory Council (OAAC): Born, in part, to turn local opiate settlement funds into action. Their mission responds to the loss of life due to opioids in Summit County, expands the treatment capacity, and fosters a new landscape for services where there is no wrong door. The Council serves as the gatekeeper for settlement funds and is the author of the Trauma-Informed Care initiative.

Coordinating Entity (Contracted): This entity, along with its subcommittees, serves as a central hub for training, implementation planning, establishing measurable goals, evaluating initiatives and goals, progress reporting, fidelity monitoring, and continuous quality improvement.

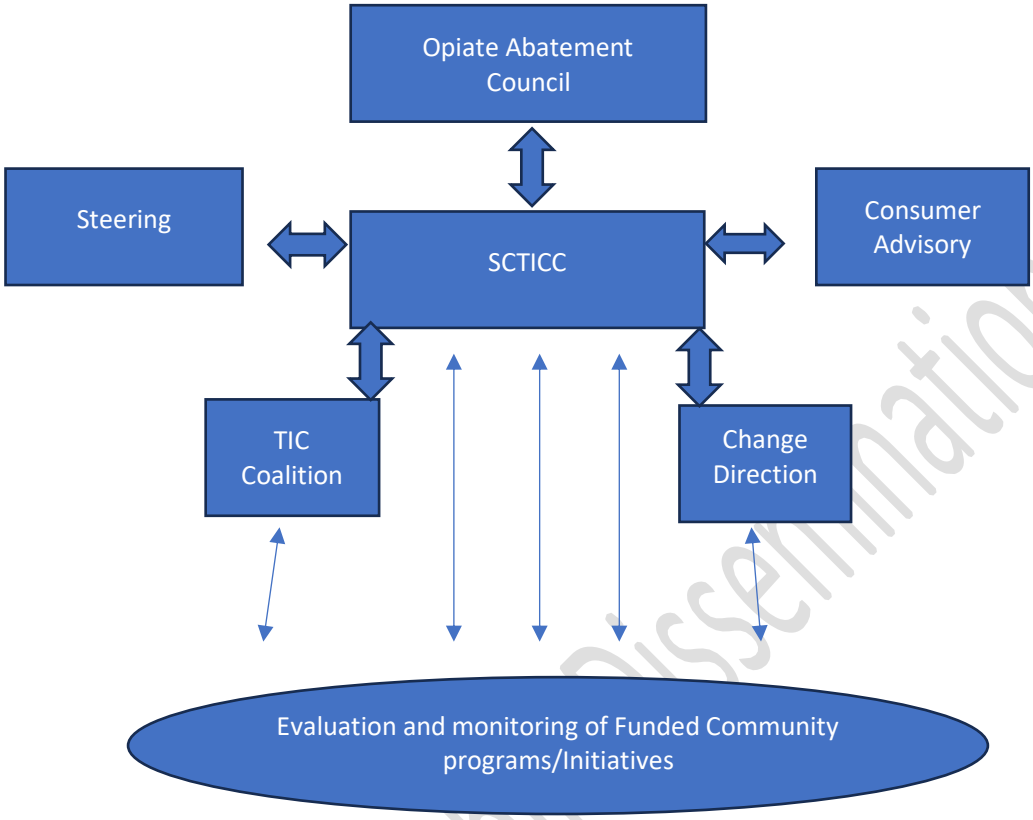
Project Steering Committee: A group of stakeholders who collaborate on the project and assist with some of the hands-on activities. The makeup can include designees (or actual members) of the Opiate Abatement Advisory Council. The makeup of this group must consist of representatives from the following sectors: Faith Community, Law Enforcement, Probation or Corrections, Hospital, Behavior Health entities (x2), Chairpersons of the Trauma Informed Care Coalition and Change Direction Coalition, Consumer advocate, public health, Child Protective Services, Special Docket Court, Funders, Public Health, the Summa Trauma Stress Center, and University of Akron College of HHS.

Consumer Advisory Board. The culture of persons with lived experience is too diverse and dynamic to have a single designated voice. Through the Summit Recovery Hub, a group will be established to help review recommendations from a consumer perspective. The group will have a designated chairperson who represents the group on other committees. Membership to be comprised of persons in recovery from addictions and include members who have experienced one or more of the following: criminal justice system, child protective services system, local BH treatment program, recovery housing, Medication Assisted Treatment. Recruitment should ensure representation from minority groups and be diverse in terms of race, gender, orientation, religion, and age.

Existing **Community Coalitions** are essential to the success of this initiative. They are already comprised of members willing to assist in implementing trauma-informed approaches in Summit County. Key coalitions to be incorporated are the following:

Trauma Informed Care Coalition: Comprised of voluntary members or organization designees invested in addressing trauma from clinical and community perspectives. To date, their efforts as a group have been in-kind with no direct funding. They provide an able network of professionals across multiple sectors.

Change Direction (Faith-based Coalition). Comprised of a diverse group of multi-denominational faith leaders and community allies advocating for addressing mental health and addiction issues beyond the clinical landscape. Their efforts have been in-kind with no direct funding. They provide a network of non-clinical professionals who have reach into multiple communities and demographics.



Start-up functions and processes: These activities focus on developing the infrastructure and division of labor necessary to create and implement a **trauma-informed care Plan.** Initial activities involve reviewing and approving this Needs **Assessment & Recommendation Report** by the Opiate Abatement Advisory Committee. Once done, the information in this report will be disseminated and presented to the TIC Coalition and Change Direction. Members of these three groups, along with the research team, will be the core startup team.

Step One: Build membership for the Steering and Consumer Advocacy Committees.

Step Two: Any directed funding within this initiative must have targeted goals and reporting requirements to ensure accountability. If a specific recommendation is to be funded, a Request for Proposals document should be developed. This document must include an outline of the overall project goals, specific recommendations to be implemented, entities eligible to implement the recommendations, measurable reporting outcomes and targets, reporting guidelines, budget parameters, and plans for sustainability. If the project chooses to use a competitive funding process, the document will include a scoring rubric to help evaluate project requests. A procedure will be developed to ensure objective vetting of proposals. A secondary Mini-Grant process for smaller initiatives can be considered.

Step Three: The Coordinating Center, in collaboration with the steering committee and OAAC, will develop a Quality Improvement Plan that includes, but is not limited to, procedures for project evaluation, program evaluation and reporting, fidelity monitoring, training, target setting, lessons learned meetings, and course correction. The Coordinating Center, unless otherwise specified, will be the primary evaluator of programs and activities funded through this initiative.

Step Four: The Steering Committee, Consumer Advisory Committee, TIC Coalition, and Change Direction are to develop the Mission Statement and Vision as they relate to this initiative.

II. Recommendations (Unranked)

1. Adhere to a **standard definition** of trauma-informed care. It became clear from the focus groups that, while most participants agreed on some core concepts, there is no local consensus on a definition of Trauma-Informed Care. SAMHSA's national strategy indicates that a lack of leadership buy-in is a significant barrier to implementing TIC initiatives.
    a. *Recommendation:* Provide trauma-informed training to include key community leaders and stakeholders, i.e., judges, court officers, social service executives, police/fire chiefs, and local government leaders.
    b. *Recommendation:* Adhere and commit to known definitions of Trauma Informed Care (TIC) and Trauma Informed Approach (TIA):

    Trauma Informed Care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment [iv]" It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services[v] six core principles of Trauma-Informed Care (TIC), as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), to inform its work with health and behavioral healthcare systems and organizations:

    - Safety
    - Trustworthiness and Transparency
    - Peer Support
    - Collaboration and Mutuality
    - Empowerment, Voice, and Choice
    - Cultural, Historical, and Gender Issues[vi]

    Trauma Informed Approach: A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families,

staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to resist re- traumatization[vii] actively

2. **Generate Community Buy-In:** Trauma-resilient communities can be developed through community capacity building, which involves the dissemination of trauma-informed education, training, community outreach, and linkage of the community to resources. Success is linked to buy-in from community leaders.

    a. *Recommendation*. Disseminate findings and recommendations from this report to a convened group of community leaders and stakeholders. Recruit key leaders to participate in workgroups and committees.

    b. *Recommendation*. Develop Trauma-Informed Care/Community Resolution language that can be adopted by county/local governments, departments, or community-serving organizations. A master record of all entities that adopt TIC resolutions will be maintained.

    c. *Recommendation*. Establish a communication subcommittee, or work within an existing communication structure, to develop and launch an information strategy and goals for this initiative.

3. **Funding Contracts:** Currently, many funding contracts with behavioral health treatment and prevention entities do not include language on Trauma-Informed Care or the Trauma-Informed Approach.

    a. *Recommendation:* Local behavioral health funders (including government subdivisions and philanthropy) should incorporate language about trauma-informed care into contracts with funded agencies where appropriate. Verbiage shall include the consensus definition of TIC and willingness to complete the TIC Agency Self Survey when requested. This ensures TIC remains on the radar of the funded programs while offering the funder a mechanism to measure progress on TIC efforts.

4. **Coalition Engagement:** The strengths of the TIC Coalition and the Change Direction Committee lie in the passion and reach of their membership. The TIC Coalition has members representing multiple agencies and systems, including those with clinical, criminal justice, youth, and adult focuses. Change Direction membership includes advocates and a diverse array of interfaith representation. Both groups are insightful and well-intentioned, but they lack the resources to develop new initiatives or foster the growth of existing ones.

    a. Recommendation. Neither group has ever received formal Coalition Training. Community Anti-Drug Coalition of America (CADCA- www.cadca.org) is a national resource for communities and community coalitions fighting drug abuse on a macro level. They provide technical assistance and evidence-based resources

for community programs. Trainings include Cultural Competence for Coalitions, Policy Change and Medical Advocacy Campaigns, and How to Use Data to evaluate short and long-term goals:

i. TIC Coalition, Change Direction, and other identified coalitions/task forces to participate in tailored CADCA Coalition Training.

ii. Upon completion of the training, the TIC Coalition and Change Direction will be considered for a program budget by local TIC funders.

iii. TIC Coalition develops a project plan inclusive of a short-term goal (i.e., activity that can be completed within 6 months) and a long-term goal (i.e., activity that can be completed in more than >1 year, <2 years). Example activities are **stigma reduction or social norming campaign**, community training event, trauma coaching,

iv. Change Direction develops a project plan inclusive of a short-term goal (i.e., activity that can be completed within 6 months) and a long-term goal (i.e., activity that can be completed in more than >1 year and less <2 years. Example activities include faith-based speakers' training, **Community Healing training**, an interfaith speakers' bureau, trauma-informed agenda-building collaboration with the Interfaith Justice Alliance, and Summit County High School Athletic Directors/Coaches.

5. **Health and Trauma Disparities in the African American Community:** Race, ethnicity, socioeconomic status, and access to healthcare drive outcome disparities among trauma patients. Local data indicates disproportionate impact of death by homicide, gunshot wounds, and overdose deaths within the local Black community. Our qualitative data indicated that persons of color have a lesser trust in public health and criminal justice and may prefer to work with persons who "look like" them.

   a. Recommendations: Increase pro-health seeking behavior within minority communities.

      i. Develop and launch an Afrocentric Mental Health stigma reduction Campaign. The initiative must have some targeted emphasis on the 14–34-year-old minority youth hit hardest by overdose and violence. Utilize credible reporters as spokespersons to disseminate information and facilitate community dialogue. Examples of credible reporters may include high school athletic coaches, sports personalities, or persons within the music industry. CADCA provides training on stigma reduction campaigns.

      ii. Fund mental health outreach programs through existing Afrocentric services where possible (e.g., Akron Urban League, Urban Minority Alcohol and Drug Outreach Program). Goal to increase admissions to behavioral health organizations, special docket courts, and diversion programs. Some emphasis on the 14–34-year-old males hit hardest by overdose and violence.

iii. Provide Mental Health identification and referral training, such as Mental Health 1st Aid and Question, Persuade, Refer (QPR), to teachers, coaches, students within Akron Public Schools, and local faith leaders.

iv. Build a diverse Minority workforce in areas such as law enforcement, law, criminal justice, behavioral health, and medicine.

v. Recruit and develop Minority candidates for trauma-informed recovery coaching.

vi. Given the goal of increasing pro-health-seeking behaviors in local minority groups, it will be essential to develop a data dashboard to monitor trends in minority utilization of programs and services by racial/ethnic/age/ and sexual preference demographics.

6. **Recovery Coach Expansion:** Peer support is a key principle of TIC. Going back a decade to the Ohio Access to Recovery Grants, Summit County has been an early adopter of recovery coaching, embracing the value of augmenting services with paraprofessionals who have lived experience. There is an opportunity to build on the platform of existing efforts from the ADM and Child Protection Services systems to expand and organize a pool of recovery coaches and peer support specialists that can match peer experiences with consumer needs. For instance, a certified recovery coach whose life experience included losing custody of her children due to addiction. Prior involvement with. Through involvement with local treatment and children's services, she was reunified with her children, has remained sober, and now has a college degree. Who better to be a recovery coach for a young mom who recently was charged with neglect due to addiction? Similarly, having a recovery coach who was incarcerated due to addiction issues, and is now sober, with an expunged record and a stable career in the skilled trades. Who better to match with a young man recently released from prison who is just beginning his recovery path? Effective *matching* of coaches to consumers can lead to potential positive outcomes.

a. <u>*Recommendation*</u>: Foster the development of a recovery coach organization that develops and trains a robust pool of recovery coaches and peer support specialists that can be sorted by *lived experience, and demographics (age, race, ethnicity, or sexual preference).*

b. *Recommendation:* Provide trauma-informed coaching training to existing and future recovery coaches.

7. **Trauma-Informed Training/Education:** It is essential to establish a training strategy that tailors trauma-informed best practices to specific sectors. Qualitative data indicate that TIC training is not one-size-fits-all. Local systems differ in their structure, missions, and interfaces within our communities. Police officers and other first responders are not expected to provide psychotherapy on the scene routinely, nor are mental health therapists expected to restrain a combative client physically. Similarly, not all core principles can be equally distributed across all domains. Take, for instance, peer support. A recovery coach can easily be implemented in special docket courts, child protective agencies, and

behavioral health programs; they cannot, as easily, be a part of police "*ride-alongs*" if for no other reason than efficiency or liability.

a. *Recommendation:* Identify and implement Best Practice TIC training strategies tailored by discipline. Even in jails and prisons, trauma-informed correction lends itself to favorable outcomes in rehabilitation and staff safety[ix]

i. The GAIN Center is a SAMHSA-funded national resource that provides technical assistance for professionals in criminal justice and behavioral health. They provide trauma training for criminal justice professionals through a 'train-the-trainer' model. Contracting with GAIN to develop local trainers enables us to provide sustainable training for criminal justice staff using our personnel. Details in the GAIN Trauma Response training can be found here: https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals.

ii. The Criminal Justice Coordinating Center of Excellence at NEOMED provides training and expertise as it relates to persons with mental illness in the criminal justice system. One of their products is helping to establish Crisis Intervention Teams. These are Community Based programs that bring law enforcement, mental health professionals, and persons with mental illness together to improve community responses. They can also provide training and technical Assistance on CIT in corrections. Recommend working with jurisdictions to increase the depth and spread of these programs in Summit County. https://www.neomed.edu/cjccoe/cit/

iii. Develop a list of local trauma experts and trainers to provide ongoing continuing education workshops and technical assistance related to best practices for the treatment of trauma-related conditions. Examples of best practices include, but are not limited to:

1. Cognitive Processing Therapy: A specific type of Cognitive behavioral Therapy effective in reducing PTSD symptoms.

2. Eye Movement Desensitization and Reprocessing, or EMDR, is a mental health treatment technique that helps in healing from traumatic life experiences.

3. Prolonged Exposure Therapy: A form of behavioral and cognitive therapy helps individuals gradually approach trauma-related feelings and memories.

iv. Increase the depth and spread of training and resources that help laypersons to assist with community healing or referrals to behavioral health resources. Including, but not limited to:

a. Mental Health First Aid: A training available to students, pastors, coaches, and other lay persons. It teaches how to identify, understand, and respond to signs of mental illness or substance use disorders. It offers skills to provide initial

help and support to someone developing a mental health problem or experiencing a crisis. Summit County already has multiple certified trainers. https://www.mentalhealthfirstaid.org/about/

b. Grief Recovery Method: An evidence-based, action-oriented grief program that helps individuals navigate the pain of loss. Laypersons and recovery coaches can become certified to deliver this strategy to individuals or groups. Summit County already has certified Grief Recovery Specialists.

b. *Recommendation:* Integrate Trauma-Informed Care and Trauma-Informed Approach focus into the University of Akron's curricula in the disciplines of social work, nursing, counseling, psychology, criminal justice, and law. This helps equip the next generation of Summit County professionals with the knowledge and practice through a trauma-informed lens.

i. Develop a trauma-informed certification that is available to students across multiple disciplines.

ii. Enhance trauma-informed language and skills practice in the UA Police and Fire Academies.

iii. Enable trauma-informed elements of online classes to become available to non-students in the community as a Continuing Education Option.

c. *Recommendation:* Create a virtual Summit County Learning Community through the Project ECHO (Extension for Community Healthcare Outcomes) platform. ECHO is a telementoring program designed to create virtual communities that bring together health providers and subject matter experts. Regularly scheduled 1-hour sessions will include a 30-minute presentation by a trauma-related topic expert, followed by 30 minutes of Q&A-related dialogue with participants. A rotation of topics will include those tailored for clinicians, safety forces personnel, lay persons, educators, and faith leaders. Continuing education credits will be made available for clinical personnel. More on the ECHO model here: https://projectecho.unm.edu/model/

8. **Patient-focused:** Key principles of trauma-informed care include transparency, empowerment, peer support, and collaboration. For these to occur, consumers of services are to have a voice in their clinical treatment plans and the evaluation of their agency experience. According to Ohio Administrative Code, ADAMHS Boards must have mechanisms to evaluate agency programs or practices; however, the code doesn't prescribe specifics on how this evaluation should take place.

a. *Recommendation:* Periodically conduct a walkthrough survey of ADM-funded programs and agencies, to include help lines, initial call for help, assessment, consumer-used spaces, navigating agency websites, etc. Persons conducting walkthroughs are to be members of the consumer advisory board or UA graduate students who have been oriented to trauma-informed services. Reports will include

experience with front door services, highlighting both positives and negatives, as well as a debrief with agency staff and an ADM designee. For can be found on a behavioral health walkthrough here: https://chess.wisc.edu/niatx/Content/ContentPage.aspx?NID=146

b. *Recommendation:* Ensure cultural competency training and practice at individual and organizational levels that recognize trauma prevalence among different sub-groups, including but not limited to persons of color, LGBTQ persons, the elderly, and minority ethic groups.,

c. *Recommendation:* Behavioral Health and Child Protection Systems: Offer the opportunity, where possible, to match a consumer with a professional of a similar gender or background, e.g., "*would prefer to work with a female therapist*?" *Would you prefer to talk with an African American clinician*?

9. **Workforce Wellness:** A recurring theme throughout this assessment process has been the workforce shortage. This shortage is adding to the workload burdens of those who continue to work in community mental health, child protection, law enforcement, and corrections. This shortage is creating economic burdens on service providers due to diminished billing review or paid overtime rates. It is also exacerbating burnout among staff in the context of seeing clients/patients with higher symptom acuity. Increased documentation requirements over the last several years have also been cited as a primary cause of workplace stress. The request for workplace wellness initiatives has been nearly universally requested, as per the qualitative data collected for this report.

a. *Recommendation:* Examine mechanisms of stressors related to workload and develop policies to mitigate the negative impact. Documentation requirements are listed as a leading cause of employee burnout. Paperwork reduction initiatives to be implemented where possible. A successful practice starts with creating staff & management teams to discuss documentation requirements and determine areas for improvement in efficiency. Is all data collected being used or reviewed? If not, do we continue to collect it?

b. *Recommendation:* Develop staff wellness activities by sector, including volunteers, management, and executives. Programs should have buy-in from both leadership and staff before launch.

i. *Resources for law enforcement wellness programs:* https://www.justice.gov/asg/officer-safety-and-wellness-resources

ii. Resources for creating workplace wellness programs in healthcare: https://www.cdc.gov/workplacehealthpromotion/initiatives/resource-center/case-studies/engage-employees-health-wellness.html

iii. Resources for creating workplace wellness programs in child protection services: https://www.acf.hhs.gov/ecd/staff-wellness-initiatives

c. *Recommendation:* Develop recruitment and retention pipelines, with an emphasis on diversifying the workforce.

i. Offer sign-on bonuses to preferred candidates.

ii. Annualize Workforce job fairs for students at University of Akron, Wayne State Community College.

iii. Provide opportunities for local corporate professionals and leaders to interact with and mentor Akron Public High School students, while also offering corporate work-study programs.

10. **Stigma reduction:** Stigma related to mental illness, stress, trauma, and receiving helpful services all serve as barriers to pro-health seeking behaviors. Per Canada's Centre of Addiction and Mental Health, there are seven things' individuals can do to reduce stigma:
    1) Know the facts. Educate yourself about mental illness, including substance use disorders.
    2) Be aware of your attitudes and behavior.
    3) Choose your words carefully.
    4) Educate others.
    5) Focus on the positive.
    6) Support people.
    7) Include everyone.

    In short, stigma can be reduced.

    a. *Recommendation:* Launch a countywide mental illness stigma reduction campaign that uses multimedia to disseminate messaging that promotes pro-health seeking behavior. The campaign would include credible spokespersons of diverse backgrounds to normalize help-seeking and recovery. California recently launched a mental health stigma reduction campaign using social media that resulted in increasing utilization of mental health services[x]. Summit County must be alerted to adjust to increases in service utilization upon launch.

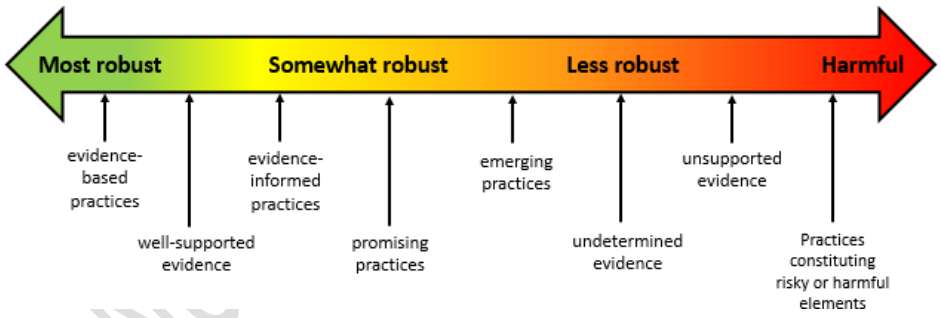
11. **Local Media buy-in:** Qualitative data illuminated that current levels of political vitriol and sensationalized news cycles exacerbate individual and community stress. Trauma Informed Journalism is a new approach to train reporters and journalists to be more sensitive to trauma[35]

    a. Recommendation: Incorporate local media in the stigma reduction campaign and launch a dialogue with their editorial committees on trauma-informed journalism training and practices.

Section VII: Glossary

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.[xi]12 It is essential 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.[xii] 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 falls into the "emerging" category, while some may be classified as "unsupported" or "promising."[xiii]



CCOE-CJ: Criminal Justice Coordinating Center of Excellence housed within the Department of Psychiatry at NEOMED promoted jail alternatives for persons with mental health disorders: https://www.neomed.edu/cjccoe/

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, as well as 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.[xiv]

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, enabling practical work in cross-cultural situations. "Culture" refers to the integrated patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs, values, and institutions characteristic 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.[xv]

Evidence-based Practice: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of the individual. 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 their own personal and unique concerns, expectations, and values. The best evidence is typically found in clinically relevant research conducted using sound methodology.[xvi]

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 through randomized controlled trials or meta-analytic reviews in applied studies across two different settings. In contrast, evidence-informed programs incorporate evidence from quasi-experimental designs in similar applied studies across two settings.[xvii]

Fidelity Monitoring: Monitor and evaluate evidence-based practices to ensure they are faithful to their model.

GAINS Center: A national resource funded by SAMHSA focused on expanding access to services for people with mental illness or substance use disorder who encounter the criminal justice system: https://www.samhsa.gov/gains-center

Historical trauma: 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).[xviii]

Medication-assisted Treatment (MAT): Alcohol or drug addiction services that are accompanied by medication that has been approved by the United States Food and Drug Administration for the treatment of substance use disorder, prevention of relapse of substance use disorder, or both.[xix]

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.[xx]

Prevention: A planned sequence of culturally relevant, evidence-based strategies, which are designed to reduce the likelihood of or delay the onset of mental, emotional, and behavioral disorders. [xxi]

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. [xxii]

Resilience: Ability to recover from setbacks, adapt well to change, and keep going in the face of adversity. It is the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress such as family and relationship problems, serious health problems, or workplace and financial stressors.[xxiii]

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. While current psychiatric standards do not recognize it 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. Related terms include "vicarious trauma," "burnout," and "compassion fatigue." [xxiv].

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.[xxv]

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.[xxvi]

Trauma Informed Care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment [xxvii]" It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services [xxviii] six core principles of Trauma-Informed Care (TIC), as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), to inform its work with health and behavioral healthcare systems and organizations:

- Safety

- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice, and Choice
- Cultural, Historical, and Gender Issues[xxix]

Trauma Informed Journalism: Views living victims as survivors and comes from the approach of "*what happened*" as opposed to *what's wrong*. It emphasizes empathy and avoids retraumatization[xxx]

Section VIII: Appendices

The following items are included in the appendix:

1. Qualtrics Survey - Professional
2. Qualtrics Survey - Consumer
3. Handout for all focus group and interview participants
4. Professional Focus Group questions and instructions
5. Consumer Focus Group questions and instructions
6. Key Stakeholder Questions
7. ACEs Instrument

[iii] SAMHSA (2014) National Strategy for Trauma-Informed Care Operating Plan. Retrieved at https://www.samhsa.gov/sites/default/files/trauma-informed-care-operating-plan.pdf

[iv] Hopper, E. K., Bassuk, E. L., and Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homeless service settings. The Open Health Services and Policy Journal, 3, 80-100

[v] Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

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