Empowering public authorities and professionals towards trauma-informed leaving care support

GOOD PRACTICE GUIDE ON TRAUMA INFORMED LEAVING CARE SUPPORT

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1. INTRODUCTION

1.1 Purpose and Scope of the Document

Transferable good practices of integrated support services for traumatized children are presented in this guide with a particular focus on trauma screening and assessment, integrated mechanisms for cases documentation and reporting, and collaborative strategies for providing therapeutic services, healthcare, housing and living support, and vocation training. These core issues are particularly important in organizing the services for the care leavers because this perspective calls for particular attention to the factors favouring and hindering their development in the life cycle.
Trauma Informed Care (TIC) is an emerging value that could be seen as a fundamental and effective framework of mental health care for traumatized persons (Muskett, 2014). Muskett (2014) underlines that the key principles of trauma-informed care are: "(i) clients need to feel connected, valued, informed, and hopeful of recovery; (ii) the connection between childhood trauma and adult psychopathology is known and understood by all staff; and (iii) staff work in mindful and empowering ways with individuals, family and friends, and other social services agencies to promote and protect the autonomy of that individual" (p. 5)

The starting point of this Guide is what Elliott and colleagues (2005) stated: "Trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life and development" (p. 462) and "Many common procedures and practices in service settings retrigger trauma reactions and are experienced as emotionally unsafe and disempowering for survivors of trauma" (p. 463).
According to that general principles, good practices could be evaluated according to specific criteria identified and detailed in scientific literature.
Given the great risks for physical and psychological health due to the impact of traumatic events (ACEs), many interventions aimed at helping "institutions and

individuals serving people with stories of trauma to adopt a trauma-informed care (TIC) approach" (Baker et al., 2016, p. 61) have been developed over the years. Specifically, a "TIC approach looks at a person holistically, not just as a list of issues he or she is experiencing" (Hepburn, 2017, p. 7). In US, "NASMHPD prioritizes TIC and continues to see the difference that TIC makes in environments across the spectrum of public health programs" (p. 21).

1.2 A brief overview of scientific literature

As indicated by many authors (Bryson et al., 2017; Bridgett, Valentino & Hayden, 2012; Ellis & Boyce, 2011; Perry, 2002; Rothbart, Ziaie, O'Boyle, 1992), in the case of Adverse Childhood Experiences (ACE), a protective effect (buffering effect) is played by good care and support relationships exercised by attentive and responsive caregivers: relational safety reduces the harmful effects of trauma in children. The traumatic stress is a common condition in the case of ACE and often causes significant clinical manifestations (internalizing and / or externalizing symptoms) in hospitalized or hosted in residential facilities minors (Bryson et al., 2017; Greenwald et al, 2012; Hummer, Dollard, Robst, 2010; Ko et al., 2008). In these conditions, "a trauma informed public health and social welfare approach to prevention, risk reduction, and early intervention for traumatized youth [...] less restrictive ... community-based trauma-informed interventions [...] trauma-informed treatment in psychiatric hospital settings" are recommended (Bryson et al., 2017, p. 2). In this field to promote trauma-informed approaches is a core issue: trauma-informed care (TIC) and trauma-informed practice (TIP) are treatment frameworks of choice because "aiming to transform entire systems of care by embedding an understanding of traumatic stress response" in all aspects of service delivery and focusing on the priority of individual's safety, choice, and control. Moreover, "This philosophy aims to create a treatment culture of nonviolence, learning, and collaboration in which a universal precautions approach is highlighted in all environmental and interpersonal interactions" (Bryson et al., 2017, p. 3).
Unfortunately, scientific research on the effectiveness of this type of trauma approach is still lacking (Bryson et al., 2017); as underlined by Valenkamp, Delaney and Verheij (2014) and by Chandler (2008), we could observe a lack of randomized controlled trials testing interventions and exploring critical factors implicated in the implementation of TIC-oriented treatments.
In their systematic review of literature, Bryson and colleagues (2017) concluded that:

- "the reduction of physical coercion in routine psychiatric and residential care" (p. 11) is emphasized such as the reduction/elimination of seclusion or restraint
- a core aspect in TIC is "the critical importance of senior leaders prioritizing TIC [...] especially as staff adjust to new ways of working" (p. 11)
- researchers underline the necessity of supporting staff by means of advanced training - especially on the sequelae of trauma – and "ongoing supervision, coaching, and debriefing of seclusions, restraints, and patient/staff injuries" (p. 11)
- in this, listening to patients and families is fundamental, with particular attention paid to their experiences, needs, priorities regarding the treatment process
- the importance attributed to the area of the constant updating of research data and the analysis of the outcome indicators are transversal dimensions finalized to motivate services performance and efficacy improvement
- literature deals extensively with "the need to align policy and practice, formal and informal, with the overarching principles of trauma-informed practice" (p. 11).

Regarding the role of leadership, Bryson and colleagues (2017) underlined the necessity that – specifically at a managerial level – leaders of services or organizations should have a strong commitment to the change process. This implies that they could have the willingness to support practically the process of implementation of the principles of TIC: "Senior leaders made TIC a standing item in high level meetings, allocated resources, set clear targets, communicated the rationale for the initiative with staff, and articulated 'an unwavering belief' that TIC goals were achievable" (p. 11). According to this vision, from the review the urgency for a comprehensive staff training emerged. Examples of initiative in this direction are the Risking Connection model (Giller, Vermilyea, Steele, 2006) and the Sanctuary model (Bloom, 1997, 2013; Rivard et al., 2003; Rivard et al., 2004; Rivard et al., 2005).
Research studies had demonstrated that "training is important because it gives staff common language to use regarding patient experience and particular informed interventions to be used with patients" (Bryson et al., 2017, p. 11). This issue was well explained also by Le Bel, Huckshorn and Caldwell (2008) and by Brown, Baker and Wilcox (2012).
Moreover, a specific training on best practices and the participation of patient in staff training activities (reporting on their experiences) demonstrated to be useful (Holstead, Lamond, Dalton, Horne & Crick, 2010), such as involving minors

in debriefing critical incidents in care provision (Lebel et al., 2008), data sharing and performance/process monitoring (at individual, collective and unit levels) (Bryson et al., 2017).
Another focus of scientific literature on TIC effective strategies is the proficiency of organizations to align policies and practices with trauma informed principles (Bryson et al., 2017). According to this vision, the environment and the culture of organizations are therapeutic instruments themselves and both contributed to built a "therapeutic community". Of particular relevance are: 1) the attention to create a safe treatment space both for patients and for staff and 2) the inclusion of TIC principles in mission and vision statements. The core strategies focused by Bryson and colleagues (2017) are presented in Table 1.

Tab. 1 Core strategies in TIC (Bryson et al., 2017)

Core strategies
Community inclusion
Leadership commitment
Model selection
Workforce transformation
Outcome orientation
Shared maintenance

These strategies are aligned with the ones at the basis of the S/R reduction intervention (NASMHPD, National Association of State Mental Health Program Directors) (see Table 2).

Tab. 2 Core strategies in TIC according to NASMHPD

NASMHPD - Core strategies
Leadership towards organizational change
Use of data to inform practice
Workforce development
Use of restraint and seclusion reduction tools
Improve consumer's role in inpatient setting
Vigorous debriefing techniques

In a study by Azeem and colleagues (2011) this strategic elements (based on TIC) had been longitudinally tested in order to analyse the reduction in the use of restraint and seclusion. In particular, authors underlined that:

- ✓ leadership plays a fundamental role in bringing culture change in particular when the TIC vision is shared with all the staff
- ✓ data collection and sharing has "an integral role in the performance improvement projects" (p. 12) and in monitoring processes
- ✓ regular staff education and training on principles of recovery-oriented care, person-centred care, and TIC with the related performance evaluations were carried out with relevant benefits
- ✓ an important focus must be dedicated to primary prevention principles using individual treatment plans that include trauma history and communication with patient, family and staff strategies
- ✓ a good principle for TIC practice is the patient and family involvement
- ✓ supportive debriefing activities - in particular regarding emotive aspects and needed changes in treatment plans - such as interventions to mitigate traumatization and re-traumatization impact were effectively implemented.

2. BARRIERS AND INSTRUMENTS

From a general perspective, it is possible to underline how varied the scientific literature is, mainly coming from the United.
Analyzing scientific literature, it is interesting observing some critical issues in the field:

- there is not a only one, clear and shared definition of TIC
- the consensus about criteria and methodologies is not established
- the growing number of publications on TIC relevance in care systems is counterbalanced by small number of evidence-based studies about its efficacy.

The use of an evidence-based practices - although it is a particularly stressed topic in the recommendations for implementing best-practices - it is still today an element of resistance from some professionals, organizations and researchers (Gray, Elhai, Schmidt, 2007): this should be a subject of analysis, discussion and attention by the organizations dealing with clinical intervention on trauma and in their attempt to create a cooperative definition of standards.

Hanson and Lang (2016) and Johnson (2017), reviewing multiple approaches to TIC, identified themes that could be considered important to explore TIC services approaches and concluded that there were 15 core components of trauma informed care for children and young people.
The identified components have been organized into three levels (Hanson & Lang, 2016):

1. workforce development (WD)
2. trauma focused services (TFS)
3. organizational delivery (ORG).

In Table 3 the core domains and components described by authors are presented.

Tab. 3 Core domains and components of TIC (Hanson & Lang, 2016, p. 98)

Domain	***Component***	***Source(s)***
WD	Required training of all staff in awareness and knowledge on the impact of abuse or trauma	SAMHSA NASMHPD AG NCTSN JRI NCTIC H&F
WD	Measuring staff proficiency in defined criteria to demonstrate trauma knowledge/practice	NASMHPD JRI

WD	Strategies/procedures to address/reduce secondary traumatic stress among staff	SAMHSA NASMHPD JRI H&F
WD	Knowledge/skill in how to access and make referrals for evidence-based trauma focused best practices	SAMHSA AG NCTIC JRI
TFS	Use of standardized, evidence-based screening/assessment measures to identify history and trauma-related symptoms or problems	SAMHSA NASMHPD AG NCTSN JRI NCTIC H&F
TFS	Inclusion of child's trauma history in child's in case record/file/service plan	Not specified (suggested by screening in SAMHSA, NASMHPD, AG, NCTSN, JRI, NCTIC)
TFS	Availability of trained, skilled clinical providers in evidence-based trauma-focused practices	SAMHSA AG NCTIC JRI
ORG	Collaboration, service coordination, and information sharing among professionals *within the agency* related to trauma-informed services	Not specified (suggested by cross-system collaboration definitions from SAMHSA, NASMHPD, AG, NCTSN, NCTIC)
ORG	Collaboration, service coordination, and information sharing among professionals *within other agencies* related to trauma-informed services	SAMHSA NASMHPD AG NCTSN NCTIC
ORG	Procedures to reduce risk for client re-traumatization	SAMHSA NASMHPD

		AG NCTSN JRI NCTIC H&F
ORG	Procedures for consumers engagement and input in service planning and development of a trauma-informed system	SAMHSA NASMHPD AG NCTSN JRI NCTIC H&F
ORG	Provision of services that are strength-based and promote positive development	SAMHSA NCTSN H&F
ORG	Provision of a positive, safe physical environment	SAMHSA AG JRI H&F
ORG	Written policies that explicitly include and support trauma-informed principles	SAMHSA NASMHPD AG JRI NCTIC H&F
ORG	Presence of a defined leadership position or job function specifically related to TIC	NASMHPD NCTIC

Indeed, although the TIC approach is taking on an important role in the organization of services and in the provision of care for traumatized people at present, there are still some barriers in its application and, even earlier, in its conceptualization (Baker, 2016):

- an unclear operational definition
- the shortage of psychometrically validated instruments to evaluate TIC dimensions.

To fill this gap, Baker and colleagues (2016), for example, have built and validated a tool – the Attitudes Related to Trauma-Informed Care (ARTIC) Scale - to assess TIC-relevant attitudes of staff working in different areas or settings serving individuals with traumatic histories (the 7-factors structure is presented in Table 4).

Tab. 4 ARTIC domains (Baker et al., 2016, p. 67)

Subscale name	Description
Underlying causes of problem behavior and symptoms	*Emphasized internal and fixed versus external and malleable*
Responses to problem behavior and symptoms	*Emphasized rules, consequences, and eliminating problem behaviour versus flexibility, feeling safe, and building healthy relationships*
On-the-job behavior	*Endorses control-focused behaviors versus empathy-focused behaviors*
Self-efficacy at work	*Endorses feeling unable to meet the demands of working with a traumatized population versus feeling able to meet the demands*
Reactions to the work	*Endorses underappreciating the effects of vicarious traumatization and coping by ignoring versus appreciating the effects of vicarious traumatization and coping through seeking support*
Personal support of TIC	*Reports concerns about implementing TIC versus being supportive of implementing TIC*
System-wide support for TIC	*Reports feeling supported by colleagues, supervisors, and the administration to implement TIC versus not feeling supported*

Fallot and Harris (2009) in their publication *Creating cultures of trauma-informed care (CCTIC): a self-assessment and planning protocol*, had structured a Self-

Assessment and Planning Protocol. It included six domains that address both services-level and administrative or systems-level changes.
As they have specified:

> "In each domain, there are guiding questions for a collaborative discussion by a comprehensive workgroup of a program's activities and physical settings, followed by a list of more specific questions and/or possible indicators of a trauma-informed approach. [..] The CCTIC Self-Assessment Scale Following the questions and indicators are brief notes linking the Self-Assessment and Planning Protocol to the Trauma-Informed Self-Assessment Scale. The structure and format of the Program Self-Assessment Scale are similar to those of "fidelity scales" commonly used to assess the extent to which a service model is actually being implemented as intended (e.g., consistent with a plan or a manual). [...] The Self-Assessment Scale is intended primarily for the use of programs to assess their own current practices and/or to track their progress in relation to a specific understanding of trauma-informed services (Harris & Fallot, 2001). [...] Its patterns may be helpful in prioritizing areas for change. Subsequent dates for completion of the Scale may be scheduled based on the key timelines in a trauma-informed Program Implementation Plan. Self-monitoring can therefore be built into the change process. Some programs may choose to have the assessment completed by raters from outside the program. Outside raters would need access to administrative and clinical records and also be able to conduct interviews, surveys, and/or focus groups as necessary to gain a complete picture of the agency's culture" (pp. 4-5).

The protocol is summarized in Table 5.

Tab. 5 The CCTIC protocol (Fallot & Harris, 2009, pp. 6-18)

Part	Domain / Sub-domains	Questions	Steps
A: Services-level Changes	1. Program Procedures and Settings	*"To what extent are program activities and settings consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?"* (p. 6)	1. "Identify Key Formal and Informal Activities and Settings" (p. 6) 2. "Ask Key Questions about Each of the Activities and Settings" (p. 6) 3. "Prioritize Goals for Change" (p. 6) 4. "Identify Specific Objectives and Responsible Persons" (p. 7)
	1A. Safety—Ensuring Physical and Emotional Safety	*"To what extent do the program's activities and settings ensure the physical and emotional safety of consumers? How can services be modified to ensure this safety more effectively and consistently?" (p. 7)*	
	1B. Trustworthiness — Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries	*"To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximize honesty and transparency?" (p. 8)*	

	1C. Choice—Maximizing Consumer Choice and Control	*"To what extent do the program's activities and settings maximize consumer experiences of choice and control? How can services be modified to ensure that consumer experiences of choice and control are maximized?" (p. 8)*	
	1D. Collaboration—Maximizing Collaboration and Sharing Power	*"To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers? How can services be modified to ensure that collaboration and power-sharing are maximized?" (p. 9)*	
	1E. Empowerment—Prioritizing Empowerment and Skill-Building	*"To what extent do the program's activities and settings prioritize consumer empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximized?" (p. 10)*	
	1F. Safety for Staff—Ensuring Physical and Emotional Safety Trustworthiness for Staff—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries	*"To what extent do the program's activities and settings ensure the physical and emotional safety of staff members? How can services be modified to ensure this safety more effectively and consistently?" (p. 10)*	

	1G. Trustworthiness for Staff—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries	*"To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services and work tasks be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximize honesty and transparency?" (pp. 10-11)*	
	1H. Choice for Staff—Maximizing Staff Choice and Control	*"To what extent do the program's activities and settings maximize staff experiences of choice and control? How can services and work tasks be modified to ensure that staff experiences of choice and control are maximized, especially in the way that staff members' work goals are met?" (p. 11)*	
	1I. Collaboration for Staff—Maximizing Collaboration and Sharing Power	*"To what extent do the program's activities and settings maximize collaboration and sharing of power among staff, supervisors, and administrators (as well as consumers)? How can services be modified to ensure that collaboration and power-sharing are maximized?" (pp. 11-12)*	

	1J. Empowerment for Staff—Prioritizing Empowerment and Skill Building	*"To what extent do the program's activities and settings prioritize staff empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of staff skills are maximized? How can the program ensure that staff members have the resources necessary to do their jobs well?" (p. 12)*	

	Domain / Sub-domains	Questions	Possible indicators
B: Systems-level/Administrative Changes	2. Formal Services Policies	*"To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges? Of staff needs? Are these policies monitored and implemented consistently?" (p. 12)*	1. "Policies regarding confidentiality and access to information are clear; provide adequate protection for the privacy of both consumers and staff members; and are communicated to the consumer and staff in an appropriate way" (p. 13) 2. "The program avoids involuntary or potentially coercive aspects of treatment—involuntary hospitalization or medication, representative payee ship, outpatient commitment—whenever possible" (p. 13) 3. "The program has developed a de-escalation or "code blue" policy that minimizes the possibility of re-traumatization" (p. 13) 4. "The program has developed ways to respect consumer preferences in responding to crises—via "advance directives" or formal statements of consumer choice" (p. 13) 5. "The program has a clearly written, easily accessible statement of consumers' and staff members' rights and responsibilities as well as a grievance policy" (p. 13)

			6. "The program's policies address issues related to staff safety" (p. 13)
	3. Trauma Screening, Assessment, Service Planning and Trauma-Specific Services	*"To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, to conduct appropriate follow-up assessments, to include trauma-related information in planning services with the consumer, and to provide access to effective and affordable trauma-specific services?" (p. 13)*	1. "Staff members have reviewed existing instruments to see the range of possible screening tools" (p. 13) 2. "At least minimal questions addressing physical and sexual abuse are included in trauma screening" (p. 13) 3. "Screening avoids overcomplication and unnecessary detail so as to minimize stress for consumers" (p. 13) 4. "The program recognizes that the process of trauma screening is usually much more important than the content of the questions" (p. 13) 5. "The need for standardization of screening across sites is balanced with the unique needs of each program or setting" (p. 14) 6. "The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or

			assessment process, there is often a good rationale for returning to the questions after some appropriate time interval" (p. 14) 7. "Screening is followed as appropriate [...] by a more extensive assessment of trauma history (type, duration, and timing of trauma) and of trauma-related sequelae (addressing resilience-related strengths and coping skills as well as vulnerabilities and problems)" (p. 14) 8. "In service planning, clinicians and consumers discuss ways in which trauma may be taken into account in clinicians' work with the consumer to achieve the consumer's goals" (p. 14) 9. "The program either offers or makes referrals to accessible, affordable, and effective trauma-specific services. Group and individual approaches to trauma recovery and healing are both available" (p. 14)

	4. Administrative Support for Program-Wide Trauma-Informed Services Key	*"To what extent do program or agency administrators support the integration of knowledge about violence and abuse into all program practices?" (p. 15)*	1. "The existence of a policy statement or the adoption of general policy statement from other organizations that refers to the importance of trauma and the need to account for consumer experiences of trauma in service delivery" (p. 15) 2. "Existence of a "trauma initiative"" (p. 15) 3. "Administrators work closely with a Consumer Advisory group that includes significant trauma survivor membership. Consumer-survivor members of this group identify themselves as trauma survivors and understand a part of their role as consumer advocacy. They play an active role in all aspects of service planning, implementation, and evaluation" (p. 15) 4. "Administrators are willing to attend trauma training themselves [...]; they allocate some of their own time to trauma-focused work" (p. 15) 5. "Administrators make basic

			resources available in support of trauma-informed service modifications” (p. 15) 6. “Administrators support the availability and accessibility of trauma-specific services where appropriate; they are willing to be creative about finding alternative reimbursement strategies for trauma services” (p. 15) 7. “Administrators find necessary sources of funding for trauma training and education (this sometimes requires going outside the usual funding mechanisms in a creative way)” (p. 15) 8. “Administrators are willing to release line staff from their usual duties so that they may attend trainings and deliver trauma services. Funding is sought in support of these activities” (p. 15) 9. “Administrators participate actively in identifying objectives for systems change” (p. 15)

			10. "Administrators monitor the program's progress by identifying and tracking core objectives of the trauma-informed change process" (p. 16) 11. "Administrators may arrange pilot projects for trauma-informed parts of the system" (p. 16)
	5. Staff Trauma Training and Education Key	*"To what extent have all staff members received appropriate training in trauma and its implications for their work?" (p. 16)*	1. "General education (including basic information about trauma and its impact) has been offered for all employees in the program with a primary goal of sensitization to trauma-related dynamics and the avoidance of re-traumatization" (p. 16) 2. "Staff members have received education in a trauma-informed understanding of unusual or difficult behaviors. (One of the emphases in such training is on respect for people's coping attempts and avoiding a rush to negative judgments.)" (p. 16) 3. "Staff members have received basic education in the maintenance of

			personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment)" (p. 16) 4. "Clinical staff members have received trauma education involving specific modifications for trauma survivors in their content area: clinical, residential, case management, substance use, for example" (p. 16) 5. "Clinical staff members have received training in trauma-specific techniques for trauma clinicians. Staff members offering trauma-specific services are provided adequate support via supervision and/or consultation (including the topics of vicarious traumatization and clinician self-care)" (p. 16)
	6. Human Resources Practices	*"To what extent are trauma-related concerns part of the hiring and performance review process?" Key Question: "To what extent are trauma-related concerns part of the hiring and performance review process?" (p. 16)*	1. "The program seeks to hire (or identify among current staff) trauma "champions," individuals who are knowledgeable about trauma and its effects; who prioritize trauma sensitivity in service provision; who communicate the

			importance of trauma to others in their work groups; and who support trauma-informed changes in service delivery" (p. 16) 2. "Prospective staff interviews include trauma content (What do applicants know about trauma? about domestic violence? about the impact of childhood sexual abuse? Do they understand the long-term consequences of abuse? What are applicants' initial responses to questions about abuse and violence?)" (p. 17) 3. "Incentives, bonuses, and promotions for line staff and supervisors take into account the staff member's role in trauma-related activities (specialized training, program development, etc.)" (p. 17)

Addendum A: Possible Items for Consumer Satisfaction Surveys

Safety
Trustworthiness
Choice
Collaboration
Empowerment
Trauma Screening Process

3. TRANSFERABLE GOOD PRACTICES BASED ON TRAUMA SCREENING AND ASSESSMENT

Analysing literature and protocols for TIC practices evaluation it is possible to conclude that transferable good practices have to include (Figure 1):
1) a permanent training of all staff members on trauma and its correlates. This training should not be provided only to professionals who work directly at a clinical level with users but to all those who are included in various ways and with different functions in the organization
2) a constant updating of the internal staff on evidence-based practices (EBPs) in trauma care and an attention on practitioners' attitudes toward EBPs
3) cooperation with experts in the field in order to increase the availability of trained clinical providers
4) the inclusion of standardized, evidence-based screening in clinical practice and the use of specific and validated assessment measures/instruments to identify traumatic events (ACEs)
5) a shared attention dedicated to the history of users and its association with trauma-related symptoms or difficulties
6) in line with the previous point, the recognition of the specificity of each users' life history guarantied by means of an active and empathetic listening by all staff members
7) the inclusion and a careful sharing of the children's trauma history in planning the intervention or in recording the cases
8) a deep evaluation and a constant monitoring of staff proficiency (use of specifically set procedures)
9) in-depth monitoring to maintain the standards set by a good TIC service and, possibly, to improve the points on which it is lacking
10) the implementation of procedures to reduce secondary traumatic stress and to increase the well-being of staff
11) the construction and maintenance of a good collaboration network not only within services but also with other agencies in the field
12) the attention to the centrality of the communicative dimension: the higher level goal should be to have attentive and collaborating professionals in pursuing shared and co-constructed objectives and procedures
13) the focus on procedures to reduce the risk of re-traumatization for users
14) encourage participation of consumers to the design of the treatment plan
15) to engage users in the service planning: attention to their feedback and suggestions to improve the organization and the services provided

16) a particular focus on the provision of services strength-based, aimed at promoting factors for positive development (for example resilience, empowering)
17) training on strategies to organize a positive environment for users and for the staff
18) particular attention to the physical and structural dimensions of the service
19) adherence to and promotion of the TIC principles with specific and clear policies
20) a central role assigned to the leadership dimension and its functions in service organization.

Fig. 1 Transferable good practices based on trauma

Johnson (2017) wrote about the practical implementation of TIC principles: "[...] translating all components into practical and tangible actions and processes presents a challenge to practitioners working in difficult environments, with challenging children and limited resources" (p. 18). The analysis of data on some good practice assessed in the CarePath Project confirmed the complexities and challenges connected to this field and the necessity to face with its core criticism, because in TIC a "key criticism of the approach is that it has been subject to very limited evaluation and little is known about whether it can increase the effectiveness of care in meeting the needs of young people who have faced traumatic experiences" (Johnson, 2017, p. 18). TIC, in fact, is a vision of services that considers a client-centred care as an essential value (Muskett, 2014). In particular, these aspects are particularly important in the case of organizations operating in the field of leaving care support services for minors in which the aim could and should be an integration of good practices at multiple levels. This, we think, could be one of the CarePath project tasks and a universal aim of professionals operating in trauma care.

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