COMMENTARY

Advancing Trauma-Informed Care in Hospitals: The Time Is Now

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Recent events confirm the widespread impact of trauma on health and well-being and have led many to call for incorporation of trauma-informed care (TIC), particularly in health care settings. Even before the COVID-19 pandemic, highly visible racial violence, and escalating climate disasters, decades of research demonstrated that trauma[1] profoundly affects health and well-being across the life course. Nevertheless, based on our experience in practice, conversations with other experts in the field, and review of the literature, it is clear that the current evidence base supporting TIC is grossly insufficient. In fact, as we note below, this deficiency has been clear to scholars for many years. Therefore, rather than writing another critique of the inadequacies of TIC, we offer this commentary to identify specific action steps needed to advance TIC to its rightful place as a driver of quality care.

Background

DEFINING TIC AND ACKNOWLEDGING ITS POTENTIAL

In order to define TIC, Hopper and Bassuk combined common elements from multiple proposed definitions and described TIC as a science-based approach to individual care and organizational transformation that "emphasizes strengths and is grounded in an understanding of and responsiveness to the impact of trauma. It emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment."[2p82] Thus, implementation of TIC requires integrating a multicomponent and multilayered strategy into all departments, policies, and activities of an organization.

TIC is especially relevant for hospitals because personal history of trauma is so common: approximately 60% of US adults[3] and 40% of children ages 6–17[4] report at least 1 type of childhood trauma (eg, sexual abuse or domestic violence). Insufficiently buffered trauma, particularly when it occurs in childhood, is a root cause of physical and psychological illness, health-compromising behaviors, injury, social problems, and disability across the lifespan. At least 5 of the 10 leading causes of death in the United States have childhood trauma at their root.[3] Moreover, hospitals themselves can be a source of trauma for patients and staff. While in the hospital, patients and staff may experience

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retraumatization and/or new primary or secondary trauma. For example, procedures and care may be painful and frightening; hospitalization often forces loss of autonomy and agency; and hospital policies and practices often mirror the oppressive, racist, and discriminatory systems of the society from which they emerge. The demands on the current health care system, as well as its long-standing emphasis on the individual responsibility of its workers, are also stoking compassion fatigue, moral injury, and system-induced distress among staff—critical and enduring problems in health care that also require a trauma-informed approach.[5]

A Call From the Field

LOCAL IMPLEMENTATION AND STATE OF THE EVIDENCE

Local efforts

Although it is clear that applying the science of trauma and healing through TIC is imperative for hospitals, most US hospitals and health care systems have not yet adopted this approach in a comprehensive way. Yet, their motivation is growing. In 2017, a group of Chicago-area hospitals began collaborating to advance TIC in their institutions as part of a citywide effort. Convened by 2 local advocacy groups and the local health department, the trauma-informed working group consists of 18 diverse hospitals and health care systems. These include academic, community, and safety net hospitals located in urban and suburban areas, with some rural sites across Illinois as well. The working group encouraged participants to share resources and learn from existing evidence. Two co-authors of this commentary (AS and LA) also led the working group as co-chair/hospital representative and convening staff.

Exploring the evidence base

Through our efforts to identify resources for the working group, we realized the limitations of existing evidence to structure and guide the work into meaningful and sustainable change for patients, staff, and organizations. We searched for materials from some of the leading agencies that promote TIC. Not only did we find few resources specifically about system-level change in hospitals, but we also realized there was no consensus on an empirically supported conceptualization and operationalization of TIC. Notably, the Sanctuary Model® was the only resource designed in a hospital setting, yet this model emerged in an inpatient psychiatric unit rather than as a whole hospital effort, which may limit its application more broadly. When we tried to identify the return on investment for TIC to persuade hospital leadership, we came up short. Our search of the academic and gray literature between 2015 and 2020 yielded only 1 reference to a single intervention (stress management activities for employees) at an Illinois hospital. Although the results were encouraging with a decrease in employee turnover and longitudinal cost savings, we could not glean any return on investment information about implementation of a multicomponent TIC framework.[6]

After encountering the limitations above, we began a second formal scoping review of the academic and gray literature from 2015 to 2020 to systematically assess the evidence on TIC in US hospitals more broadly, beyond return on investment. We included articles based on 2 criteria: (1) a focus on trauma in general rather than a single type of trauma, such as medical trauma or intimate partner violence, and (2) a description of TIC interventions implemented with patients, staff, or the organization as a whole. Thirty-six articles of 492[7] fit the eligibility criteria. Although the academic literature describes some important work, there was not enough material to warrant preparing a full review. There were too many gaps in knowledge to share actionable conclusions that might advance the field.

What we learned

Specifically we noted that: (1) TIC definitions and frameworks were either not described or varied from 1 study to the next; (2) more general implementation processes were absent; (3) descriptions of TIC were of single rather than multicomponent interventions, and it was impossible to tell whether they were part of a more comprehensive TIC effort within the organization; (4) many articles focused only on trainee or staff education without follow-up; (5) the evaluation plan was limited to feasibility of and/or proximate outcomes related to offering a training, such as number of participants trained, their satisfaction, and short-term retention of information; (6) there was no plan presented to bring the work to scale across the whole organization or system; and (7) an emphasis on primary prevention or trauma-specific treatment was lacking. Also noteworthy was that few, if any, connections were drawn between TIC and antiracist, antidiscriminatory practices—a newly acknowledged yet long-standing source of trauma for patients of color and other marginalized and oppressed groups.

Our preliminary results align with other systematic reviews that have assessed TIC in homelessness services settings[2]; child welfare[8,9]; health care without specific inclusion of hospitals[10]; pre-K through 12 school settings[11]; and across sectors, with a focus on staff training.[12] These reviews consistently concluded that definitions of TIC remain murky; TIC applications are varied; and methodological and analytic limitations compromise evaluation efforts, making implementation of TIC challenging across all sectors, not just in health care. Thus, although the science of trauma and healing is well established as essential for optimal policy and practice, and there is growing interest in implementing TIC in hospitals, little evidence exists to guide intentional TIC translation, implementation, and evaluation.

Call to Action

SYSTEM TRANSFORMATION, EVALUATION, AND OPPORTUNITIES

Why are we still in the early phases of translation and implementation of TIC in hospitals and other sectors when it has been 40 years since the development of the Sanctuary Model® and 30 years since the first adverse childhood experiences publication? Why have we not made more progress when the human and economic costs of needless and preventable excess morbidity and early mortality from trauma and **trauma-uninformed services** have injured so many patients and health care workers? Could it be that our reductionist, punitive, profit-driven system of health care has been unwilling or unable to commit sufficient time and money to something that is not a new drug or device? Fortunately, TIC—whose principles are safety, trust, peer support, collaboration, and empowerment and social justice—has the potential to guide us to a wholistic, restorative, person-centered health care system that can deliver true prevention and healing.

SYSTEM TRANSFORMATION

It is clear that the field can no longer rest on good intentions and maintain the status quo. We must hold the government, insurance companies, and hospital administrators accountable to deliver in support of this effort. The time is now for the nation to adopt a systematic, longitudinal, science-based, multicomponent strategy for embedding trauma-informed healing-centered principles into all aspects of US health care practice and culture, including health professional education. To succeed, we must translate, master, and apply the foundational science; invest money, time, and public policy to support the transformation; cultivate collaboration among government, corporations, academic institutions, philanthropy, staff, and patients, while intentionally centering the individuals and communities with lived experience who are part of and connected to them; build a new financing structure oriented to value-based vs fee-for-service care; and have the patience and commitment to stick with it for decades rather than 1 to 2 years. This will require equitable partnerships among hospital leadership, staff, patients, and communities to transform hospital policy and practice through: (1) employing a clearly articulated TIC definition and theory of change; (2) actively dismantling institutional racism and implicit bias; (3) attending to the social and structural factors influencing health; (4) emphasizing prevention and treatment strategies for individuals as well as the organizational change process itself; and (5) committing to sustainability for translation, implementation, and evaluation of TIC processes and principles.

AN URGENT CALL FOR RIGOROUS EVALUATION

In addition to the issues noted above, there is also a critical need to provide a thorough and rigorous evaluation of key mechanisms and outcomes. Specifically, evaluation must include a priori co-development of meaningful short-, medium-, and long-term process and outcome measures affecting patients, staff, finances, the organization as a whole, and the surrounding community. Existing individual and hospital benchmarks, such as length of stay, readmission rates, hospital-acquired infections, and staff retention rates, could function as some of these indicators and must be built on with additional indicators reflecting longer term health and well-being. Effective TIC transformation necessitates the use of evaluation methodologies that can assess multilayered interventions designed to solve complex problems AND that are built on inclusive, nonhierarchical collaboration between “the people” and “the experts”, from start to finish. The evaluation process must be iterative, to develop an evidence base informed by both the science of trauma and healing a lived experience, and flexible enough to be useful across cultures and locales. Rapid, ongoing, and accessible dissemination to all stakeholders, especially the public and their health care workers, of what is working and what is not, will be key. Without clearly defined benchmarks and evaluation processes that are methodologically sound, welcome the multiple perspectives of all stakeholders, AND privilege diverse ways of knowing, we will not develop what we need to create truly

trauma-informed, healing-centered hospitals and health care systems. If we do this right, the potential benefits are vast.

CURRENT REAL-WORLD OPPORTUNITIES

Unfortunately, it seems to have taken a syndemic for our country to recognize the tremendous cost of failing to invest in the public's health. But perhaps now we are at a tipping point. The American Rescue Plan contains more than $450 billion, much of which is discretionary, for local governments and other agencies to support trauma-informed training for professionals and caregivers and to retool health care services and spaces to be safer and more supportive.[13] At the same time, health insurance companies are beginning to invest in implementation and evaluation of TIC delivery as they more fully understand that their most traumatized patients are their costliest.[14] In addition, several states are requiring contracted Medicaid managed care organizations to invest in the communities they serve to address unmet social needs.[15] This investment can provide the incentives needed for hospitals to attend to structural and social drivers of health. These funding streams and others could finance TIC implementation and evaluation of high-priority synergistic, multilayered pilot programs across the country that incorporate interventions in multiple prevention, treatment, and organizational domains and that bring the right elements and the right sequence of interventions to scale in hospitals across the country. The easiest way to begin might be to invest federal dollars in rigorous evaluation of programs already in progress (eg, the Children's Hospital of Wisconsin's use of the Sanctuary Model®,[16] and Cincinnati Children's Hospital Medical Center's use of the National Council on Behavioral Health's model)[17] with rapid and broad dissemination of findings to begin to build an empirical base for widespread adoption.

The Time Is Now

Most importantly, we **cannot waste** this opportunity. Specifically, we call on federal and local policy makers to provide necessary funds and incentives and health care leadership to champion the transformation process **now**. We can then learn what works best for whom under which conditions and use that knowledge to build on current promising work through rapid implementation, scaling up, and continued refinement of best paradigms and practices as they emerge. Preventing and treating trauma and fostering positive experiences must be a national priority for everyone involved in health care. Intentionally building an evidence base for trauma-informed healing-centered care in hospitals will help us move beyond the buzz phrase that TIC has become to create something both meaningful and universal at the patient care, staff, and organizational levels. It is about time our field advances this work through targeted and sustainable action. Although we realize these efforts will be neither cheap nor easy, our lives and those of the patients who trust us depend on it, both now and in the future!

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