

Implementing a Trauma-Informed Public Health System in San Francisco, California

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Abstract

Background. Trauma is a ubiquitous and harmful public health concern. Much like individuals, organizations experience trauma and can embed it within their culture. Left unaddressed, trauma inhibits staff from confronting problems, communicating effectively, and generating solutions, factors that undermine organizational functioning. In response to trauma's far-reaching impact, recent efforts have focused on creating "trauma-informed" systems that emphasize safety and avoid retraumatization. Trauma-informed systems are uniquely connected to relationships, as the impact of trauma both impairs relationships and is heightened in the absence of quality relationships. Developing trauma-informed relationships is therefore critical to creating a healing organizational culture. **Aims.** The objective of this article is to describe the process through which the San Francisco Department of Public Health (SFDPH) developed and implemented their Trauma-Informed Systems (TIS) Initiative, an organizational model to address trauma at the systems level. The article highlights the centrality of trauma-informed relationships to the initiative's guiding principles, activities, and implementation process. **Discussion.** Six core principles underlie the work of the SFDPH's TIS Initiative: (1) Understanding Trauma & Stress, (2) Compassion & Dependability, (3) Safety & Stability, (4) Collaboration & Empowerment, (5) Cultural Humility & Responsiveness, (6) Resilience & Recovery. Initiative components focus on creating and sustaining trauma-informed knowledge (i.e., foundational training, train-the-trainer program) and organizational practices (i.e., aligned efforts, leadership, and champion engagement). **Conclusion.** Trauma-informed systems represent an emergent organization-level intervention designed to address trauma and its sequelae. SFDPH's TIS Initiative is creating a healing organization through its innovative response to the impact of trauma.

Keywords

health policy, trauma-informed systems, workforce development, worksite health, worksite health promotion

Trauma, a physical and emotional response to a threatening event(s), can be the result of individual (e.g., accident), interpersonal (e.g., abuse, bullying), or social experiences (e.g., war, disaster). Trauma reactions also result from chronic, often intergenerational, sociocultural stressors, like racism, poverty, historical oppression, or marginalization (American Psychological Association, 2016; Jolley et al., 2012; National Child Traumatic Stress Network, 2015). While rates vary by type of event and population (ranging from 6% to 68%), research suggests that many Americans experience at least one trauma during their life (Bell & Jenkins, 1993; Copeland, Keeler, Angold, & Costello, 2007; Costello, Erkanli, Fairbank, & Angold, 2002; Kessler et al., 2002; Kilpatrick & Saunders, 1997; Schwab-Stone, Ayers, Kaspro, & Voyce, 1995; Singer, Anglin, Song, & Lunghofer, 1995). For many, exposure to significant stressful or traumatic events (e.g., abuse, parental divorce) occurs as early as childhood (Felitti et al., 1998); in a multistate health survey of adults ($n = 53,784$),

more than half reported at least one adverse childhood experience (Centers for Disease Control and Prevention, 2010).

Trauma can have lasting adverse effects on functioning and mental, physical, social, emotional, or spiritual well-being (Barile, Edwards, Dhingra, & Thompson, 2015; Brown et al., 2010; Corso, Edwards, Fang, & Mercy, 2008; Dube, Anda, Felitti, Edwards, & Croft, 2002; Dube et al., 2009; Gilbert et al., 2015; Hillis, Anda, Felitti, & Marchbanks, 2001; McFarlane, 2010; Remigio-Baker, Hayes, & Reyes-Salvail, 2014; Substance

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Abuse and Mental Health Services Administration [SAMHSA], 2014; Strine et al., 2012). Childhood exposure to trauma is a risk factor for risky health behaviors (e.g., unintended pregnancy, substance use; Anda et al., 2002), chronic health conditions (e.g., cancer, heart disease) (Brown et al., 2010; Dietz et al., 1999; Dong et al., 2004), and mental health issues (e.g., depression, suicidality) (Dube et al., 2001; Remigio-Baker et al., 2014). Given the diverse causes and consequences of trauma, trauma survivors are likely to interact with public service systems (e.g., child welfare, justice, public and behavioral health), with greater trauma exposure predicting higher utilization (Briggs et al., 2012; SAMHSA, 2014).

Systems often serve and employ trauma survivors without ever being aware of their experiences (Harris & Fallot, 2001). These individuals may receive inadequate or inappropriate care and may risk retraumatization (i.e., the reemergence, exacerbation, or maintenance of traumatic stress) when navigating organizational policies, procedures, and practices (Harris & Fallot, 2001). Employees may carry personal trauma while coping with workplace trauma and stressors (e.g., client and staff injuries or death, funding threats, lawsuits) (Bloom, 2010). Secondary trauma, which shares features with vicarious trauma and compassion fatigue, presents as traumatic stress from exposure to the trauma of others. It is correlated with employee absenteeism (Bockerman & Ilmakunnas, 2008; Institute of Medicine, 2004; Michiel & Williams, 2003), perceived effectiveness at one's job (Schaufeli, Keijsers, & Miranda, 1995), positive affect (Thoresen, Kaplan, Barsky, Warren, & de Chermont, 2003), depression (Ahola, Hakanen, Perhoniemi, & Mutanen, 2014; Lu, Dresden, McCloskey, Branzetti, & Gisoni, 2015), staff turnover (Bockerman & Ilmakunnas, 2008), provision of suboptimal care (Lu et al., 2015; Shanafelt, Bradley, Wipf, & Back, 2002), and medical errors (DiMatteo et al., 1993; West, Huschka, & Novotny, 2006). Secondary trauma is also negatively related to patient outcomes, including satisfaction (Anagnostopoulos et al., 2012; Argentero, Dell'Olivo, & Ferretti, 2008; Halbesleben & Rathert, 2008; Leiter, Harvie, & Frizzell, 1998; Schaufeli et al., 1995; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004), treatment adherence (DiMatteo et al., 1993), patient-reported recovery times (Halbesleben & Rathert, 2008; Scheepers, Boerebach, Arah, Heineman, & Lombarts, 2015). Secondary trauma's negative association with workforce performance and service quality suggests that it may contribute to fractured and ineffective health service systems.

Organizations serving physical, mental health, and social service needs may be particularly susceptible to secondary trauma and are often described as being in a "state of chronic crisis" (Applebaum, 2002). Coping resources are depleted as these organizations operate under unsustainable demands on employee productivity; inadequate time for supervision, collaboration, and peer support; staff turnover; structural discrimination; hostile political and social environments (Bloom, 2010). Some service organizations are pitted "against"

communities, exacerbating organizational stress. For example, a child welfare program's mission to protect children's health and safety leads to conflict with families and communities. Chronic stress undermines the foundations of shared meaning necessary for effective organizational culture (Bloom, 2010; Peterson & Wilson, 2002) and is accompanied by increased conflict and emotional distress, compromised and reactive decision making, and unnecessary conformity (Ryan & Oestreich, 1998). Staff are inhibited from confronting problems, communicating effectively, and generating solutions, factors that undermine organizational functioning (Barsade & Gibson, 2007; Othman & Hashim, 2004) and negatively relate to service provision (Kanter & Stein, 1992).

When chronic stressors are coupled with in-system traumas, particularly while serving and employing trauma survivors, the result is an organization that embeds trauma within its culture. In a parallel process, the organization develops its own pattern of trauma symptoms: reactive, reliving, avoidant, numb (Bentovim, 1992; Bloom, 2010). Leadership styles, hiring practices, service policies, and relationships may reflect these qualities, perpetuating a cycle of traumatic stress. Employees can be caught between meeting client needs and system demands, while struggling to maintain their own well-being. Consequently, leaders and staff may lose sight of the overall mission of their work and find themselves unable to support the interrelated wellness of their workforce and community.

Trauma-Informed Systems

In response to trauma's far-reaching impact, there has been considerable investment in developing "trauma-specific services," which directly treat the impact of trauma (Harris & Fallot, 2001; Muskett, 2014; SAMHSA, 2015). Although *trauma-informed systems* might incorporate trauma-specific services, these organizations embrace a "trauma-informed approach" independent of specific treatments (Harris & Fallot, 2001). These approaches, embraced by trauma-informed systems, aim to reduce the negative consequences of trauma (Hodas, 2006) by integrating trauma-informed values into policies, procedures, and practices to promote safety and avoid retraumatization (SAMHSA, 2015; Woll, 2013).

Recent years have seen diverse efforts toward creating trauma-informed systems. However, such systems are built not by implementing a particular service or mission statement, but via organizational culture, as a set of shared values, beliefs, and practices. Organizational culture, which influences workforce well-being and performance (Harenstam, 2005; Millet & Sandberg, 2005; Morin et al., 2016), emerges from interactions between individuals, from relationships that build shared meaning and practices (e.g., Moran & Volkwein, 1992). Trauma-informed systems are uniquely tied to relationships, not just by their necessity for shared organizational culture, but because trauma can impair relationships (SAMHSA, 2015) and, reciprocally, the absence of

quality relationships undermines resilience in response to trauma (Feeny, Rytwinski, & Zoellner, 2014). Organizations cannot be trauma-informed without recognizing relationships as the basis for a sustained transformation from systems that can be trauma inducing to those that heal trauma.

The San Francisco Trauma-Informed Systems Initiative

The San Francisco Department of Public Health (SFDPH) developed an organizational model to address systems-level trauma. Trauma-Informed Systems (TIS) is an intentional effort to create an organizational culture which improves public health services for individuals affected by trauma, while addressing the impact of trauma on the workforce. The following sections describe the development of San Francisco's innovative TIS Initiative, highlighting the centrality of trauma-informed relationships to its guiding principles, activities, and implementation process.

Setting

The SFDPH serves all San Franciscans (U.S. Census Bureau, 2016), including the “most socially and medically vulnerable” (SFDPH, 2016b), through two divisions: the Health Network Division and the Population Health Division. The Health Network Division integrates primary and specialty care, dentistry, emergency and trauma treatment, substance use, and behavioral health services. The Population Health Division provides essential services, including consumer safety, health prevention and promotion programming, and public health threat monitoring and response. Together, these divisions represent a diverse workforce of 9,000 individuals (SFDPH, 2016a).

History and Development

In 2012, the Director of the SFDPH commissioned a workgroup to explore becoming a trauma-informed system. The workgroup consisted of content experts, primary care and behavioral health representatives, leadership, and individuals with lived experiences of trauma. Two existing TIS models provided influential conceptual and applied content: the Sanctuary Model (Bloom, 2017) and Trauma-Informed Service Systems (Harris & Fallot, 2001). The SFDPH TIS model shares key implementation aims with these approaches: (1) all staff, even those not providing direct services, must be educated on a core set of TIS values; (2) these values, including addressing bias and discrimination, must be practiced across an organization, not just within service delivery; (3) an organization must assess and regularly evaluate their implementation of these values; (4) a collaborative process must be used to embed these values within the system; and (5) both staff and the community served must benefit from these values.

Guiding Principles

The workgroup reviewed literature on trauma-specific services (e.g., Foa, Keane, Friedman, & Cohen, 2010), trauma-informed care, and TIS models (e.g., Harris & Fallot, 2001), and addressing sociocultural inequities (e.g., Tervalon & Murray-Garcia, 1998) to develop a set of aspirational principles. Deliberately worded to highlight the impact of trauma and strategies for healing, these six core principles underlie the SFDPH's TIS model: (1) Understanding Trauma & Stress, (2) Compassion & Dependability, (3) Safety & Stability, (4) Collaboration & Empowerment, (5) Cultural Humility & Responsiveness, (6) Resilience & Recovery. A detailed description is presented in Table 1.

Initiative Model

A guiding tenet that emerged from the literature and adoption of TIS principles is that restoring and nurturing trauma-informed relationships is critical to healing (Feeny et al., 2014), as well as building organizational culture (Moran & Volkwein, 1992). Recognizing that organizations are inherently “relational” and that the workforce develops in the context of “structures that build connection and thereby encourage, facilitate, and inspire people to engage in change” (Markoff, Finkelstein, Kamerer, Kreiner, & Prost, 2005), the workgroup adopted a relational change model. Thus, each element of the implementation process was considered for its ability to create relationships that reinforce a set of shared and trauma-informed values, beliefs, and practices.

Beginning this process, a series of focus groups and presentations connected with more than 400 individuals from a diverse cross-section of the workforce. Participants' feedback on the proposed principles, methods, and core curriculum informed the development of the TIS Initiative. Initiative components fall into two categories: creating and sustaining trauma-informed knowledge (i.e., foundational training, train-the-trainer program) and creating and sustaining trauma-informed practices (i.e., aligned efforts, leadership, and champion engagement) (see Figure 1). These activities are intentionally designed to construct and leverage trauma-informed relationships *within the organization*, creating change that is (1) independent of outside resources and (2) embedded within organizational culture.

Initiative Components

Creating and Sustaining Trauma-Informed Knowledge. The foundation for TIS Initiative activities is the mandatory workforce training, *Trauma-informed Systems 101: Transforming Stress and Trauma* (TIS101), and corresponding *Train-the-Trainer* program. Together, these programs provide the SFDPH workforce with shared knowledge of trauma and TIS values.

Table 1. Core Principles of the San Francisco Department of Public Health’s Trauma-Informed Systems (TIS) Initiative.

TIS principle	Description
Understanding Trauma & Stress	This principle focuses on improving knowledge specifically related to <i>trauma, stress, trauma reactions, and recovery</i> . Without understanding trauma, we are more likely to adopt behaviors and beliefs that are negative and unhealthy. However, when we understand trauma and stress we can act compassionately and take well-informed steps toward wellness.
Compassion & Dependability	This principle focuses on improving interpersonal relationships through communication, compassion, support, dependability, and/or respect. Trauma is overwhelming and can leave us feeling isolated or betrayed, which may make it difficult to trust others and receive support. However, when we experience compassionate and dependable relationships, we reestablish trusting connections with others that foster mutual wellness.
Safety & Stability	This principle focuses on reducing threats to physical, social, or emotional safety. Trauma unpredictably violates our physical, social, and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our daily lives and having these core safety needs met can minimize our stress reactions and allow us to focus our resources on wellness.
Collaboration & Empowerment	This principle focuses on seeking out successful opportunities for choice and control, for oneself or for others. Trauma involves a loss of power and control that makes us feel helpless. However, when we are prepared for and given real opportunities to make choices for ourselves and our care, we feel empowered and can promote our own wellness.
Cultural Humility & Responsiveness	This principle focuses on learning about social, racial, and cultural backgrounds, how they affect relationships, and how they are related to trauma. We come from diverse social and cultural groups that may experience and react to trauma differently. When we are open to understanding these differences and respond to them sensitively we make each other feel understood and wellness is enhanced.
Resilience & Recovery	This principle focuses on promoting personal skills, practices, or strengths that reduce stress or the impact of trauma. Trauma can have a long-lasting and broad impact on our lives that can contribute to feelings of hopelessness. Yet when we focus on our strengths and clear steps we can take toward wellness we are more likely to be resilient and recover.

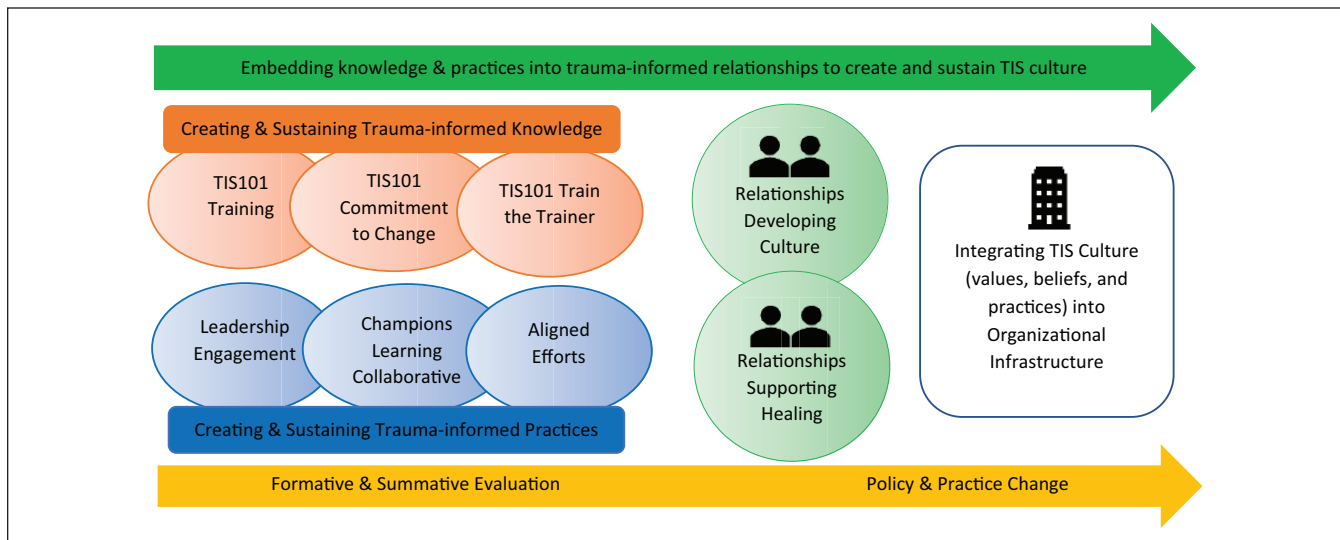


Figure 1. Components of San Francisco Department of Public Health’s (SFDPH) Trauma-Informed Systems (TIS) Initiative.

TIS101: Foundational Training. The TIS101 was created to meet the principle of *Understanding Trauma & Stress*. Adapted from the University of California at San Francisco’s Healthy Environments and Response to Trauma in Schools (HEARTS) program (Dorado, Martinez, McArthur, & Lei-

bovitz, 2016), the SFDPH half-day curriculum consists of didactic and interactive content structured on the TIS principles. It is uniquely designed for all levels of organizational hierarchy (from clerks to executive leadership) to learn together, in recognition that it is not individual learning but

the pattern of interaction across learners that develops values (Avnet, 2015). An innovative closing exercise catalyzes the application of TIS knowledge by asking participants to each commit to a small trauma-informed change. Almost 40% of participants focus on improving relationships through *Compassion & Dependability*. Collectively, as the 9,000-person workforce implement these commitments, it has the potential to promote trauma-informed relationships beyond the practice of any individual alone.

Requests for trainings customized to specific positions or programs, or for the training to be shortened or held online, are not typically accommodated, as these methods fail to generate relationships that foster organizational culture. After the foundational training launched in 2014, several SFDPH leaders quickly trained their full staff rosters, creating cohorts of “early adopters” committed to embedding TIS principles across department culture. Furthermore, by offering monthly trainings across multiple sites and incorporating registration into employee orientation, more than 6,000 employees were trained within 3 years.

TIS101: Train-the-Trainer Program. A key implementation goal was to generate internal SFDPH trainers; thereby positioning staff with existing workforce relationships as sources of valued TIS knowledge. Not only does this method maximize sustainability, it also leverages existing institutional expertise and resources to enhance knowledge transfer within the formal training program and across informal relationships. Individuals from diverse racial and ethnic, gender, trauma-experience, and professional backgrounds are encouraged to become trainers. Small cohorts complete a 2-day curriculum training and a 1-year learning collaborative. Participants (1) become certified trainers; (2) conduct at least two trainings; (3) volunteer for curriculum development, leadership/champions’ engagement, or policy development; and (4) participate in organizational change efforts. It is anticipated that 25 trainers will graduate from the program within 4 years. The result is a sustainable model for training and for embedding content experts to model and reinforce TIS culture within a network of organizational relationships. Together, the TIS101 training and Train-the-Trainer program create an ever-widening network of workforce and leadership with knowledge of TIS principles.

Creating and Sustaining Trauma-Informed Organizational Practice. Large systems, such as the SFDPH, operate with multiple competing priorities and initiatives at any given time; knowledge and values introduced through the TIS101 training provide the foundation for alignment with other efforts. The *aligned efforts* and *leadership and champions’ engagement* activities are integral to expanding TIS culture within organizational practices through layered workplace relationships.

Aligned efforts. The TIS Initiative aligned efforts reflect the creation of collaborative relationships to highlight the

intersection of TIS principles within other workforce programming. By integrating with these valued organizational development initiatives, staff are increasingly likely to share interactions with each other that reinforce TIS principles and promote trauma-informed relationships. TIS values are reflected in workforce efforts, such as *Service Excellence and Relationship Centered Communication* (a model for health care providers on sensitive and responsive communication), the *Black African American Health Initiative* (an initiative aimed at improving care for the Black and African American communities), and *Reflective Supervision* (a model emphasizing the supervisory relationship for personal and professional growth). Leadership from these efforts partnered with the TIS workgroup to offer contributions to the curriculum and/or strategies for designing complementary workplans. Consequently, tools from the *Service Excellence* curriculum were integrated into the TIS training, staff from the TIS initiative and *Black African American Health Initiative* collaboratively developed healing circles for the community and workforce, and the *Reflective Supervision* program incorporated TIS principles into their training academy. These collaborations and alignment strategies are fostered as evolving long-term relationships rather than a one-time partnering.

Leadership engagement. Leadership practices significantly affect organizational readiness to adopt programming and the quality of program implementation (Chilenshki, Olson, Perkins, & Spoth, 2015). Supportive leaders increase the workforce’s confidence and commitment to organizational goals and actions (Burge, Lawson, Johnston, & Flowerdew, 2005; Norrish & Rundall, 2001). TIS Initiative staff meet regularly with leadership teams throughout the SFDPH to build relationships supportive of TIS culture. Because verbal commitment alone is insufficient to effect change, and commitment needs to be expressed through actions observable to employees (Burge et al., 2005; Norrish & Rundall, 2001), leaders are charged with (1) dedicating support and resources to TIS activities (e.g., policies and procedures for practice improvement); (2) promoting TIS efforts and celebrating achievements; (3) attending quarterly TIS Initiative meetings to discuss implementation progress, challenges, and successes; (4) maintaining a supportive relationship with staff in the Champions Learning Collaborative (described below); and (5) responding to feedback from the Champions Learning Collaborative.

Champions’ engagement. In 2016, a pilot Champions Learning Collaborative (CLC) was introduced to promote organizational change through networks of staff and leaders. Within the CLC, program leaders sponsor staff champions tasked with using their existing workforce relationships to support idea transmission, pilot changes, and adopt practices supporting TIS culture. Champions commit to (1) understand the TIS Initiative and its impact on employees, (2) plan and implement TIS change efforts, (3) provide feedback to leadership on the TIS Initiative, (4) disseminate relevant project

Table 2. Sample Change Efforts Implemented Through the Trauma-Informed Systems' (TIS) Champions Learning Collaborative.

TIS principle	Sample change efforts
Cultural Humility & Responsiveness	<ul style="list-style-type: none"> • Introduction of workforce training on racial humility • Alignment of preexisting racial equity efforts with TIS principles • Creation of a comprehensive staff wellness lounge • Development of an incentive system for staff self-care activities • Creation of a “respectful culture” workplace campaign • Team building activities built into monthly meetings
Resilience & Recovery	
Compassion & Dependability	
Understanding Trauma & Stress	
Safety & Stability	
	<ul style="list-style-type: none"> • Discussion of a TIS principle at each staff meeting • Offering complementary trainings (e.g., Nonviolent Communication) • Hosting of “town halls” on safety to gather and address concerns • Distribution of personal safety alarms to staff

communication, and (5) support coworkers with adopting TIS culture. Monthly CLC meetings provide training and technical assistance toward these goals and build cross-program relationships for peer learning and idea exchange. Participating programs self-pace through the process of completing a needs assessment, selecting TIS principle(s) of focus (e.g., Resilience & Recovery), implementing change (e.g., staff wellness lounge), and evaluating progress. Additional change efforts are described in Table 2. As with other TIS programming, the CLC layers TIS principles across formal and informal networks of relationships, over time creating a convergence of shared beliefs, practices, and values.

Challenges to Implementing TIS. Not surprisingly, the process of developing and implementing a TIS is challenged by the very issues that necessitate its implementation. Competition for time and resources undermine relationships that actualize change. Evolving priorities, mandates, and needs makes it difficult to sustain involvement across the organizational hierarchy, particularly, within leadership. Culture-building collaborations change and falter with turnover and reassignment. Organizationally, there remains a tendency to fall back into homeostatic bureaucratic habits rather than pushing forward, experiencing dissonance, and sustaining mechanisms and processes of change.

One surprising challenge is the overwhelming demand that sometimes outpaces resources. Introducing the TIS model unleashed a genuine desire for organizational culture that addresses stress, trauma, inequities, and relational healing. An intentional and essential approach has been to build from within and use organizational resources sparingly. Rather than relying on outside resources, TIS programming is layered across networks of formal and informal organizational relationships, allowing TIS values to embed in daily operations and resist inevitable resource swings. However, though requests for support from external organizations stoked model development, resources at times limited the iterative and evaluative processes. Ideally, implementation would proceed at a reflective pace and with the benefit of continuous quality improvement cycles.

Finally, the most daunting challenge in the development of the SFDPH TIS remains that systemic change is a generational process, dependent on the transfer of knowledge, values, and practices within relationships. The adoption and integration of TIS principles must outlast leaders and be built into the DNA of organizational culture. Change must withstand ever-fluctuating financial demands, staffing patterns, and political climates, and be embraced as operating principles across the organization. Doing so necessitates the embedding of TIS principles into the infrastructure of employee onboarding, community relationships, policy and practice, and evaluation, continually reinforcing TIS culture across shifts in the workforce.

Next Steps

Moving forward from a successful mandate to educate the workforce on TIS principles, as well as promising organizational change work with leaders and champions, the Initiative will deepen efforts to develop trauma-informed relationships and embed the practice of TIS principles. This involves defining the SFDPH as an organization that incorporates practices such as reflection into supervision, mindfulness into meetings, which focuses on safety and fosters participatory decision making. Innovations in trauma-informed methods will continue to emerge and, rather than reflexively adopting specific interventions, a sustained cultural shift arises through an infrastructure to evaluate and select practices that reflect TIS principles. Embracing a structured process promotes the stability of TIS changes and increases the likelihood that they are sustained long enough to produce discernible benefits.

The SFDPH TIS approach is the process of mending fractured relationships through intentional and embedded practices that reinforce TIS culture. Consistent with the centrality of trauma-informed relationships to the SFDPH model, next steps focus on expanding the breadth and depth of connections within TIS programming. Engagement efforts are moving from “early adopters” to those who may be more reluctant to adopt TIS principles, or for whom the relevancy is less

clear. The CLC is currently integrating middle management to bridge line staff and executive leaders, creating a relational catalyst for change. Given that the benefit of a TIS is for both the workforce and community, community relationships are increasingly central to promoting TIS culture. Focus groups with community members are already informing the content and methods of public health programming and are a growing part of the TIS model.

Last, the benefits of a TIS must be more than theoretical. An evaluation program is in place to capture the impact of the TIS Initiative, with a purpose that is shifting from formative to summative. Evaluation supported TIS model development, including iterative improvements to the training curriculum, and is already demonstrating preliminary outcomes, such as capturing the emphasis on *Compassion & Dependability* among training participants committing to TIS changes. Ultimately, it is anticipated that an organizational culture characterized by trauma-informed relationships may be captured through metrics such as endorsement of TIS values, staff days on job, employee engagement, client satisfaction, and progress toward performance or treatment goals.

Conclusion

Trauma is a ubiquitous and harmful public health concern, the consequences of which are collectively experienced by individuals, families, communities, and the systems that serve them. Trauma-informed systems represent an emergent organization-level intervention constructed through relationships and designed to address trauma and its sequelae. San Francisco's TIS Initiative is creating a healing organizational culture through its innovative response to the impact of trauma.

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