

Trauma-Informed Practice — SAMHSA Six Principles Flagship

Trauma-informed practice (TIP) is an organizational and service-delivery framework grounded in the recognition that trauma — the experience of deeply distressing or disturbing events that overwhelm one's capacity to cope — is pervasive across the populations that disability services exist to support.

Content

Trauma-Informed Practice — SAMHSA Six Principles Flagship

Resource type: Tier 1 Flagship — Methodology / Framework

Adapted from: SAMHSA (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (HHS Publication No. (SMA) 14-4884)

Library home: L04 Trauma-Informed Practice Library

Companion to: T04_05 Goleman EI; T04_07 Person-Centered Planning; T04_13 Historical Trauma; T04_11 Intersectionality

What this framework is

Trauma-informed practice (TIP) is an organizational and service-delivery framework grounded in the recognition that trauma — the experience of deeply distressing or disturbing events that overwhelm one's capacity to cope — is pervasive across the populations that disability services exist to support. The Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency responsible for advancing behavioral health in the United States, published its foundational guidance on trauma-informed approaches in 2014, identifying six key principles that define what it means for an organization or program to be genuinely trauma-informed.

The six SAMHSA principles, as described by SAMHSA's resource center (<https://www.samhsa.gov/resource/dbhis/infographic-6-guiding-principles-trauma-informed-approach>) and elaborated by BCcampus Open Education (<https://opentextbc.ca/peersupport/chapter/samhsas-six-principles-of-trauma-informed-care/>), are:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice
6. Cultural, Historical, and Gender Issues

Trauma-informed practice is not trauma treatment. It does not require DSD staff to treat trauma, diagnose trauma, or be therapists. It requires DSD staff to recognize that trauma is likely present in the lives of the people they serve, to resist practices that inadvertently re-traumatize, and to actively create service conditions that support safety, agency, and recovery.

Why DSD uses this framework

The people DSD serves include:

- Individuals with disabilities who have experienced institutionalization, abuse, neglect, and the loss of rights.
- Families navigating systems that have historically failed, overridden, or harmed them.
- Communities with deep histories of structural racism, forced assimilation, family separation, and institutional violence.
- Individuals with complex trauma histories related to poverty, immigration, housing instability, and medical trauma.

These experiences are not background noise to service delivery; they are a primary condition of service delivery. A service interaction that feels routine to a DSD staff member may feel threatening, controlling, or re-traumatizing to the person on the other side — because that person has encountered similar institutional settings in contexts that were harmful.

Trauma-informed practice is also a workforce issue. DSD staff themselves may have trauma histories, and they are exposed to secondary traumatic stress — the occupational cost of sustained empathic engagement with people experiencing trauma. A trauma-informed organization supports its staff, not just its clients.

The six SAMHSA principles in DSD context

Principle 1 — Safety

Safety means creating physical and emotional conditions in which people feel genuinely secure — not just technically safe. BCcampus describes (<https://opentextbc.ca/peersupport/chapter/samhsas-six-principles-of-trauma-informed-care/>) this as requiring staff to "ask people what safety means to them" rather than imposing an institutional definition. Safety is not a static condition; it requires ongoing attentiveness to how the service environment is experienced by the person in it.

What safety looks like in DSD work:

- Physical space: Is the meeting room intimidating? Are there clear exits? Is there privacy?
- Interpersonal safety: Does the person know who will be in the meeting? Are they allowed to bring a trusted support person? Is consent genuinely sought before information is shared?
- Institutional safety: Can the person trust that the information they share will not be weaponized against them in eligibility determinations?
- Cultural safety: Is the service environment one where the person's cultural identity is recognized and respected, not treated as a deviation from a neutral norm?

Across DSD service contexts, safety assessments should include sensory, physical, relational, and cultural dimensions. A trauma-informed safe space is not one size; it is negotiated with the person.

Principle 2 — Trustworthiness and Transparency

SAMHSA's guidance (<https://www.samhsa.gov/resource/dbhis/infographic-6-guiding-principles-trauma-informed-approach>) states that operations and decisions must be made with transparency at the forefront, with the goal of building and maintaining trust with service recipients, staff, and stakeholders.

For people with trauma histories, trust is not a given — it has often been violated by institutions that promised one thing and delivered another. Trust is built slowly through consistent, honest communication; it is destroyed quickly through unexplained changes, broken commitments, or decisions that feel made about the person rather than with them.

What trustworthiness looks like in DSD work:

- Explaining what will happen in a meeting before it happens.
- Being honest about constraints: "I don't have the authority to change this, but here's who does and how to reach them."
- Following through on commitments, and naming it clearly when you cannot.
- Being transparent about how information will be used before asking for it.
- Making decisions visible: not just "what" but "why."
- Naming power differentials honestly rather than pretending they don't exist.

Principle 3 — Peer Support

Peer support — the mutual support of people with shared experiences — is a recognized evidence-based practice in behavioral health and disability services. BCcampus notes (<https://opentextbc.ca/peersupport/chapter/samhsas-six-principles-of-trauma-informed-care/>) that trauma-informed organizations "prioritize practices like peer support" and create opportunities for peer support to be integrated throughout the organization, not just in specific programs.

What peer support looks like in DSD work:

- Connecting people with peer specialists — individuals with lived experience of disability and of navigating disability systems who are trained to support others.
- Creating opportunities for families to connect with other families navigating similar situations.
- Recognizing that peer relationships are not supplementary to professional services; for many people, peer connection is the primary vehicle of recovery and resilience.
- Staff peer support: creating conditions within DSD where staff can support each other's wellbeing, not just manage upward.
- Recognizing community and cultural peer networks as existing, valuable supports — not competing with, but strengthening, DSD's professional services.

Principle 4 — Collaboration and Mutuality

BCcampus describes (<https://opentextbc.ca/peersupport/chapter/samhsas-six-principles-of-trauma-informed-care/>) collaboration as "a shoulder to shoulder approach and a focus on breaking down hierarchies." Collaboration recognizes that healing happens in relationships, not to passive recipients of expertise. SAMHSA's guidance via LWW (https://cdn-links.lww.com/permalink/jcehp/a/jcehp_2024_01_31_joshuakopstick_23-0207_sdc2.pdf) states: "healing happens in relationships and in the meaningful sharing of power and decision-making."

This does not mean that professional expertise disappears. It means that the relationship between staff and the people they serve is explicitly understood as a partnership — with different roles, but with shared goals and genuine mutual influence.

What collaboration looks like in DSD work:

- Service plans that are genuinely co-authored, not professionally prescribed and consumer-signed.
- Meeting structures that make space for the person and family to set the agenda, not just respond to the professional's agenda.
- Acknowledging when the person or family knows something the professional doesn't.
- Supervisory relationships that model collaboration: supervisors who learn from staff, not just supervise them.
- Organizational structures that give community members genuine voice in service design, not just advisory roles.

Principle 5 — Empowerment, Voice, and Choice

BCcampus notes (<https://opentextbc.ca/peersupport/chapter/samhsas-six-principles-of-trauma-informed-care/>) that empowerment in a trauma-informed framework "comes from the person's own inner wisdom and strength, rather than power given to them from an outside 'expert.'" Trauma often involves profound experiences of powerlessness and voicelessness. Trauma-informed services work to actively reverse that dynamic.

What empowerment looks like in DSD work:

- Structuring service interactions so that the person makes real choices — not just selects from a professionally pre-approved menu.
- Noticing when a person's apparent compliance may be a trauma response rather than genuine agreement.
- Supporting people to express preferences, disagree, and advocate for themselves without fear of losing services.
- Recognizing that supported decision-making (T04_08) is the structural expression of empowerment within disability services.
- Honoring stated preferences even when they do not match what the professional would choose.
- Building capacity, not dependence: service relationships that leave people more capable of directing their own lives, not more dependent on professional judgment.

Principle 6 — Cultural, Historical, and Gender Issues

This is the explicitly equity-oriented principle. BCcampus summarizes (<https://opentextbc.ca/peersupport/chapter/samhsas-six-principles-of-trauma-informed-care/>) SAMHSA's language: "The organization actively moves past cultural stereotypes and biases, offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma."

This principle insists that trauma is not only individual and clinical; it is also historical, communal, and cultural. Historical trauma (T04_13) — the cumulative, multigenerational wounding of communities through slavery, forced assimilation, genocide, internment, and institutional violence — shapes how individuals in those communities experience service systems. A Somali family's wariness of government systems is not irrational; it is historically informed. A Native family's response to an institutional planning process is not resistance; it may be a historically grounded protective response.

What cultural, historical, and gender responsiveness looks like in DSD work:

- Understanding and acknowledging historical trauma in the communities DSD serves.
- Designing services that honor and leverage traditional cultural healing practices, community connections, and family structures — not requiring people to choose between their cultural identity and their services.
- Gender-responsive practice: recognizing that gender shapes trauma experiences, help-seeking, service access, and recovery trajectories.
- Actively examining how service policies and practices may reproduce racial, gender, and disability bias.
- Deferring to tribal nations on cultural and healing matters within their authority.

What trauma-informed practice is not

It is not trauma treatment. DSD staff are not therapists, and TIP does not require clinical skills. It requires attentiveness to the context and relational conditions of service delivery.

It is not asking people to disclose their trauma history. Trauma-informed practice does not mean soliciting trauma narratives. It means creating conditions where people are less likely to be re-traumatized, regardless of whether trauma is disclosed.

It is not an excuse to avoid accountability. Trauma-informed practice does not mean permitting harmful behavior because trauma explains it. It means responding to behavior with curiosity about context before judgment, and with consequences that are transparent, proportional, and relational.

It is not only for clients. Organizational trauma-informed practice applies to staff, too. Staff wellbeing, secondary traumatic stress, and the institutional conditions of professional care are within scope.

How to apply this in your role

As a DSP:

- Before a new service interaction, ask: "What might this person's history with service systems look like? How might today's meeting feel to them?"
- When behavior surprises you, lead with curiosity: "What might this behavior be communicating about this

person's experience?" before interpreting it as non-compliance.

- Practice the transparency principle: tell people what you are doing and why before you do it.

As a supervisor:

- Create space for staff to name when they are experiencing secondary traumatic stress. It is a normal occupational risk, not a personal failure.
- Use trauma-informed language in supervision: "I noticed you seemed activated in that meeting — what was happening for you?"
- Model the safety principle within your team: can staff bring concerns to you without fear?

As a leader or program designer:

- Audit service environments through a trauma-informed lens: What does the physical space communicate? What does the process communicate? Who has power in the interaction, and is it equitably distributed?
- Require trauma-informed practice training as a baseline for all staff, not a specialty add-on.

Common misconceptions

"Trauma-informed is for behavioral health, not disability services." The SAMHSA framework explicitly applies to all health and human services settings. DSD serves populations with high rates of trauma exposure; TIP is directly applicable.

"We already do person-centered practice — that's the same thing." Person-centered planning is necessary but not sufficient. TIP adds explicit attention to safety, empowerment, and the historical/cultural dimensions of service relationships that PCP frameworks do not always address.

"If I ask about trauma, I'll make things worse." Research does not support this concern. Thoughtful, attentive practice that creates safety is more likely to reduce re-traumatization than to increase it. The key is not asking people to tell their story, but creating conditions where their story — whatever it is — can be held safely.

Connection to other frameworks

- Historical Trauma (T04_13): Principle 6 of the SAMHSA framework is a direct call to address historical trauma. The two frameworks are deeply integrated.
- Intersectionality (T04_11): Trauma is not experienced identically across all identity dimensions. Race, gender, disability, and immigration status all shape how trauma is experienced and how recovery is supported.
- Emotional Intelligence (T04_05): EI — particularly self-awareness and empathy — is the practitioner capacity that makes trauma-informed practice possible at the interpersonal level.
- Cultural Humility (T04_04): Cultural, historical, and gender responsiveness (Principle 6) requires cultural humility as its personal and organizational foundation.
- Person-Centered Planning (T04_07): TIP's empowerment principle and PCP's person-centered orientation share foundational values; practiced together, they reinforce each other.

Connection to DSD's six program goals

DSD Goal — TIP Connection

Goal 1 — Eliminate Disparities — Trauma-uninformed practice disproportionately harms communities with the highest rates of historical and institutional trauma. TIP is a disparity-reduction strategy.

Goal 2 — Community Engagement — Trust with community partners is built through consistent, transparent, collaborative practice — the core of TIP principles 2, 3, and 4.

Goal 3 — Hiring and Retention — Organizational TIP — staff safety, peer support, empowerment — directly affects DSD's ability to retain staff, especially from communities with trauma histories.

Goal 4 — Learning and Development — TIP training is a foundational learning-and-development requirement for DSD staff at all levels.

Goal 5 — Contracts and Procurement — Community-based providers serving high-trauma populations need DSD to model TIP in its contracting relationships, not just in its direct services.

Goal 6 — Communication and Accessibility — Trauma-informed communication is explicit, transparent, predictable, and power-aware. These are also accessibility requirements.

When to escalate / where to refer

- If a person discloses active suicidal ideation, imminent risk, or acute crisis: Follow DSD's crisis response protocol. Contact emergency services if necessary. Do not attempt crisis treatment.
- If a staff member is experiencing secondary traumatic stress: Refer to DSD's EAP, HR, and the supervisor. This is an organizational responsibility, not a personal failure.
- For trauma-specific clinical referrals: Coordinate with the person's behavioral health care team if one exists; connect the person to behavioral health services if they do not.
- For questions about trauma-informed service design: Contact the Equity and Inclusion Operations Consultant and the L04 Trauma-Informed Practice Library.

Reflective questions for your practice

1. In your most recent service interaction, what signals might have told you the person was not feeling safe? Did you respond to those signals?
2. When have you asked someone to do something that, in hindsight, required them to trust you more than your institution had earned?
3. What does peer support look like in the community of the person you most recently served? How can DSD connect with and leverage that, rather than replacing it?
4. Where do you experience secondary traumatic stress in your own work? What helps you recover?
5. What would it look like for your team to apply the empowerment principle — not just to the people you serve, but to your own working conditions?

Sources

- SAMHSA. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS

Publication No. (SMA) 14-4884). SAMHSA. <https://www.samhsa.gov/resource/dbhis/infographic-6-guiding-principles-trauma-informed-approach>

- BCcampus Open Education. (2022). SAMHSA's Six Principles of Trauma-Informed Care. <https://opentextbc.ca/peersupport/chapter/samhsas-six-principles-of-trauma-informed-care/>
- Joshuakopstick, J. (2024). SAMHSA's Six Key Principles of a Trauma-Informed Approach. Journal of Continuing Education in the Health Professions. https://cdn-links.lww.com/permalink/jcehp/a/jcehp_2024_01_31_joshuakopstick_23-0207_sdc2.pdf
- Substance Abuse and Mental Health Services Administration. (2014). Trauma-informed care in behavioral health services (TIP Series No. 57). SAMHSA.
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. The Open Health Services and Policy Journal, 3(1), 80–100.
- Harris, M., & Fallot, R. D. (Eds.). (2001). Using trauma theory to design service systems. Jossey-Bass.

Always defer to the person in front of you. Frameworks describe patterns; people are individuals.

Create space for staff to name when they are experiencing secondary traumatic stress. It is a normal occupational risk, not a personal failure.

Use trauma-informed language in supervision: "I noticed you seemed activated in that meeting — what was happening for you?"

Ask: When have you asked someone to do something that, in hindsight, required them to trust you more than your institution had earned?

Ask: What does peer support look like in the community of the person you most recently served? How can DSD connect with and leverage that, rather than replacing it?

Ask: Where do you experience secondary traumatic stress in your own work? What helps you recover?

Ask: What would it look like for your team to apply the empowerment principle — not just to the people you serve, but to your own working conditions?

Verify current authority, preserve rights and exceptions, and route interpretation questions using Trauma-Informed Practice — SAMHSA Six Principles Flagship.

For policy regulatory analysts, use Trauma-Informed Practice — SAMHSA Six Principles Flagship to verify current authority, preserve rights and exceptions, and route interpretation questions; trace each recommendation to current authority, preserve exceptions, and document the decision record. Start by create space for staff to name when they are experiencing secondary traumatic stress. It is a normal occupational risk, not a personal failure.

For facilitators learning leads, use Trauma-Informed Practice — SAMHSA Six Principles Flagship to verify current authority, preserve rights and exceptions, and route interpretation questions; build the guidance into preparation, practice, debrief, access checks, and follow-up. Start by use trauma-informed language in supervision: "I noticed you seemed activated in that meeting — what was happening for you?"

This resource is not clinical care, crisis response, or a substitute for a trained practitioner when the situation requires one.

Do not replace official legal, policy, clinical, supervisory, program, or Tribal authority.

Do not infer an individual's identity, preferences, needs, or experience from group-level information.

State uncertainty, use current authoritative sources, and escalate when the decision exceeds the user's role.

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