**The Business Case for a Trauma-Informed Approach**

***A Brief Literature Review***

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To meet the triple aim of patient satisfaction, improved health outcomes and decreased costs, service providing organizations and systems, along with communities, should consider using a trauma-informed approach. This promising approach to organizational structure and treatment delivery, often also referred to as trauma-informed care, seeks to realize, recognize and respond to the widespread impact of trauma and to prevent re-traumatization (SAMHSA, 2015). Rooted in the Adverse Childhood Experiences study (ACES), there is a wide body of research that demonstrates an association between traumatic childhood experiences and poor health outcomes in adulthood (Felitti et al., 1998). In fact, the greatest individual predictor of health care spending, utilization and outcomes is the number of adverse experiences sustained in childhood (Brenner, 2015). Individuals exposed to violence are not only more likely to have diabetes, heart disease, mental illness and asthma but their symptoms are often more severe (Dolezal, McCollum & Callahan, 2009). And, individuals who have experienced trauma have been shown to be more likely to utilize costly health care services compared to individuals without a trauma history (Raphael, Zhang, Liu, & Giardino, 2009).

In the United States, it is estimated that child abuse costs $5.87 trillion dollars (Institute for Trauma and Trauma-Informed Care, 2016). Putting underlying childhood adversity at the forefront of treatment and service provision could significantly cut costs, help to retain staff and contribute to better clinical outcomes (Dolezal, McCollum & Callahan, 2009). In Washington State, a 2009 study by the Washington Family Policy Council found that counties using trauma-informed care in their schools and social services saved $1.4 billion over a decade (Mongeau, 2017).

Domino et al. (2005) completed a highly-cited research study that proves cost effectiveness of using a trauma-informed approach for women with co-occurring mental and substance use disorders with a history of violence. The research found that without expending additional funds, better clinical outcomes could be achieved with a trauma-informed approach. A research study completed in Australia by Adults Surviving Child Abuse determined the economic impact of unresolved childhood trauma costs the Australian government $9.1 billion annually (Browne, 2015). The key recommendations from the report were to improve training for health care providers so they could identify underlying trauma and make appropriate referrals, to raise awareness of the possibility of trauma in patients, and to increase investment in specialist services, including helplines and online services.

The Center for Healthcare Strategies identified trauma-informed care to be effective with difficult to engage Medicaid populations (Davis & Maul, 2015). This population is small but expensive due to a complex mixture of physical conditions, behavioral health needs and environmental circumstances like homelessness that result in inordinate numbers of hospital visits. Davis & Maul noted that using a trauma-informed approach can help providers build trusting relationships with individuals and may enhance quality and cost effectiveness for Medicaid programs. This approach is cost effective with child and adolescent populations. For children and youth served in a trauma-informed care facility in Maine, inpatient mental health services decreased by half, from 18% to 9%, and Medicaid inpatient hospital costs decreased by approximately $122,000, yielding a 51% savings (Stroul et al., 2015). For populations who use substances, a 2007 study found that a trauma-informed approach in substance use treatment increased retention rates as the intervention group was 31% less likely to discontinue treatment within four months (Amaro et al., 2007).

Maintaining qualified staff not only decreases costs related to turnover but also improves patient satisfaction. A trauma-informed organization has lower rates of staff turnover and lower usage of sick leave (Baker & Brown, 2016). Additionally, workforce development for trauma-informed care is relatively low-cost and high-yield (DeCandia et al., 2014). There is also opportunity to remove redundancies in assessment processes. The return on investment for a hypothetical 100 clinician agency (assumes a clinician cost of $75.00 per hour, a trauma assessment time of one hour, an annual readmission rate of 30%, and an average clinician caseload of 90), is $225,000 per year in increased productivity, based solely on the fact that they will not duplicate trauma assessments for readmitted clients (Calhoon, 2016).

Despite all this data supporting the use of a trauma-informed approach, research on detailed cost-effectiveness of using it in service delivery and organizational management is still in the early stages. Currently, two long-term pilot projects are underway to prove the return on investment and effectiveness. The Center for Healthcare Strategies (2015) is overseeing a pilot program of six organizations implementing a trauma-informed approach focusing on patient outcomes, decreased costs and increased staff resiliency. The Administration of Children and Families Children’s Bureau funded a five-year pilot study with five organizations across the U.S. to provide child welfare services in a trauma-informed manner (DeCandia et al., 2014). The results from these pilots are expected to affirm the current data, that a trauma-informed approach can improve patient satisfaction and outcomes while decreasing overall costs.

**References**

Amaro, H., et al. (2007). Does integrated trauma-informed substance abuse treatment increase

treatment retention? Retrieved from

<http://web.a.ebscohost.com.ezproxy.saintleo.edu/ehost/pdfviewer/pdfviewer?vid=1&sid=092ce1c7-001b-4017-b88b-b910caf58cb0%40sessionmgr4008>

Baker, C. & Brown, S. (2016) Measuring Trauma-Informed Care Using the Attitudes Related to

Trauma-Informed Care (ARTIC) Scale [PowerPoint Slides]. Retrieved from <http://traumaticstressinstitute.org/wp-content/uploads/2016/04/ARTIC-Webinars-2016_Final.pdf>

Brenner, J. (November 2015). The Cost-Saving Potential of Trauma-Informed Primary Care.

Retrieved from <https://ldi.upenn.edu/news/cost-saving-potential-trauma-informed-primary-care>

Browne, R. (February 2015). Report finds Australian government could save $9 billion in

healthcare costs by addressing childhood trauma. Retrieved from <http://www.smh.com.au/nsw/report-finds-government-could-save-9-billion-in-healthcare-costs-by-addressing-childhood-trauma-20150203-134ozc.html>

Calhoon, C. (August 2016). Calculating the ROI on Trauma Informed Care software. Retrieved

from <https://www.10e11.com/blog/calculating-the-roi-on-trauma-informed-care-software>

Center for Healthcare Strategies. (2015). Advancing Trauma-informed care. Retrieved from

<https://www.chcs.org/project/advancing-trauma-informed-care/>

DeCandia, C., Guarino, K. & Rose, C. (October 2014). Trauma-Informed Care and Trauma-

Specific Services: A Comprehensive Approach to Trauma Intervention. Retrieved from http://www.air.org/sites/default/files/downloads/report/Trauma-Informed%20Care%20White%20Paper\_October%202014.pdf

Davis, R & Maul, A. (March 2015). Trauma-Informed Care: Opportunities for High-Need, High-

Cost Medicaid Populations. Retrieved from <http://fhop.ucsf.edu/sites/fhop.ucsf.edu/files/custom_download/TIC-Brief-031915_final%20(1).pdf>

Dolezal, T., McCollum, D. & Callahan, M. (2009) Hidden Costs in Health Care: The Economic

Impact of Violence and Abuse. Retrieved fromhttp://www.ccasa.org/wp-content/uploads/2014/01/economic-cost-of-vaw.pdf

Domino, M., Morrissey, J., Chung, S, et al. (2005). Service use and costs for women with co-

occurring mental and substance use disorders and a history of violence. *Psychiatric Services, 56*, 1223–1232. <https://doi.org/10.1176/appi.ps.56.10.1223>

Felitti, V. et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many

of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14, 4, 245-258. http://dx.doi.org/10.1016/S0749-3797(98)00017-8.

Institute for Trauma and Trauma-Informed Care. (2016). Building an expanded, effective, and

integrated trauma informed system of care in NYS. Retrieved from <https://socialwork.buffalo.edu/content/dam/socialwork/social-research/ITTIC/TIC-whitepaper.pdf>

Mongeau, L. (August 2017). What happens when a regular high school decides no student is a

lost cause? Retrieved from <http://hechingerreport.org/what-happens-when-a-regular-high-school-decides-no-student-is-a-lost-cause/>

Raphael, J.L., Zhang, Y., Liu, H., & Giardino, A. P. (2009). Parenting stress in U.S. families: Implications

for pediatric healthcare utilization. *Child: Care, Health and Development,* 36, pp. 216-224.

Stroul, B., Pires, S, Boyce, S. et al. (February 2015). Return on Investment in Systems of Care

for Children with Behavioral Health Challenges. Retrieved from <https://gucchdtacenter.georgetown.edu/publications/SOCReturnOnInvestmentIssueBrief.pdf>

SAMHSA. (2015). Trauma-Informed Approach and Trauma-Specific Interventions. Retrieved

from https://www.samhsa.gov/nctic/trauma-interventions