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Trauma Informed Care

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July 10, 2018
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Outline :

- Definitions
- Prevalence and Effects of Trauma
- What a Trauma-Informed system looks like?
- Community Connection's Core Principles of Trauma-Informed Care
- Creating a Trauma Informed System of Care

Trauma

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"Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being"

(From SAMHSA's Concept Paper 2014, p. 7)

Secondary Trauma

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This term describes trauma-related stress reactions and symptoms resulting from exposure to another individual's experiences, rather than from exposure directly to a traumatic event.

(Substance Abuse and Mental Health Services Administration.(2014).

Retraumatization

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This term not only refers to the effect of being exposed to multiple traumatic events, but also implies the process of re-experiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences.

(Substance Abuse and Mental Health Services Administration.(2014).

Trauma Survivor

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- This phrase can refer to anyone who has experienced trauma or had a traumatic stress reaction. Knowing that the use of language and words can set the tone for recovery or contribute to further retraumatization.

(Substance Abuse and Mental Health Services Administration, TIP57 (2014).

Trauma-Informed

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- A Trauma-Informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations.

Trauma-Informed Care (TIC)

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- TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p.82)
- TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

(Substance Abuse and Mental Health Services Administration.(2014).

Traumatic Event Vs. Traumatization

- An intense event, more overwhelming than a person would normally expect to occur, where a person feels they have no power or control over the situation.
- When a traumatic event causes lingering and pervasive emotional, behavioral, physical and developmental effects.

Prevalence of Trauma

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- Among 12-17 year old youth, 8% reported a lifetime prevalence of sexual assault, 17% reported physical assault, and 39% reported witnessing violence (Kilpatrick & Saunders, 1997).
- Female college students have the greatest risk for sexual and interpersonal violence (Smyth et al., 2008; Vrana & Lauterbach, 1994).
- 90% of public mental health clients have been exposed to multiple experiences of trauma (Goodman, Rosenburg et al., 1997; Mueser et al., 1998).
- Teenagers with alcohol and drug problems were 6 to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems (Clark et al., 1997).
- 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, 87% experienced this type of abuse both as children and as adults (Goodman, Dutton et al., 1997)

Prevalence of Trauma

- The majority of adults and children in psychiatric treatment settings have trauma histories.
- A sizable percentage of people with substance use disorders have traumatic stress symptoms that interfere with achieving or maintaining sobriety.
- A sizable percentage of adults and children in the prison or juvenile justice system have trauma histories

(Hodas, 2004, Cusacket al., Mueseret al., 1998, Lipschitzet al., 1999, NASMHPD, 1998)

Trauma is widespread

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Prevalence in Adult Substance Use Disorder Treatment Settings

- Study of male veterans in an inpatient unit
  - 77% exposed to severe childhood trauma
  - 58% history of lifetime PTSD *(Triffleman et al, 1995)*
- 50% of women in substance abuse treatment have a history of rape or incest

  (Najavits et. al., 1997; Gov. Commission on Sexual and Domestic Violence, Commonwealth of MA, 2006)

Effects of Trauma

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- Alcohol and Substance Use
- PTSD
- Depression
- Anxiety
- Life and Relationships

Impact of Trauma Over the Lifespan

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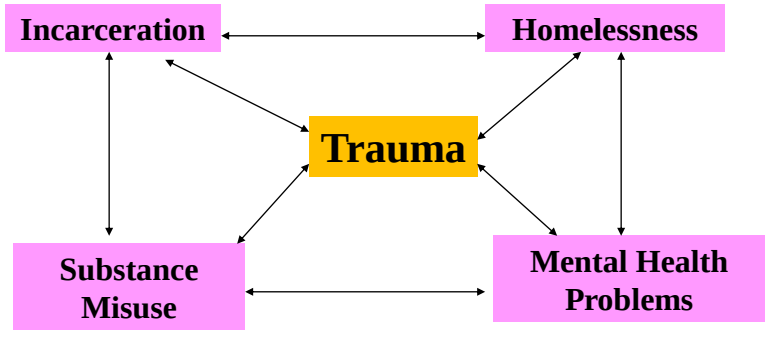
- Neurological, biological, psychological and social in nature. They include:
  - Changes in brain neurobiology
  - Social, emotional and cognitive impairment
  - Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self harm, sexual promiscuity, violence)
  - Severe and persistent behavioral health, health and social problems, early death (Felitti et al., 1998).

The Impact of Trauma

- Trauma exposure increases the incidence of mental and emotional health disorders, substance use disorders, physical health problems, struggles in interpersonal relating, and self-harmful urges and behaviors.
- Trauma can be fundamentally life-changing, especially for those who have faced complex trauma in which abuse was repeated and prolonged, or when the violence was perpetrated by those in the roles of caretakers.

The Centrality of Trauma



Childhood trauma impacts brain development . . .

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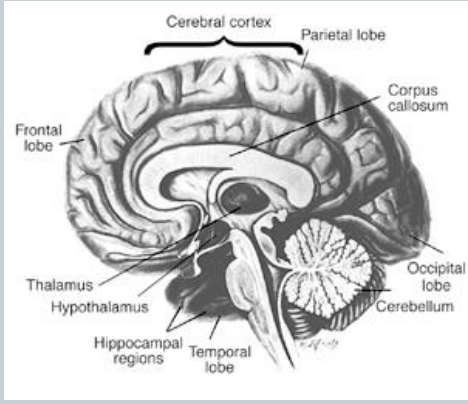
- The experience of significant trauma during developmental years can hardwire the brain differently than in the absence of trauma.
- "primitive brain" vs executive functioning use



Trauma is insidious and preys particularly on the most vulnerable among us

- People who are impoverished, who are homeless, who have been diagnosed with severe mental health problems, who struggle with alcohol or drug abuse, or who have developmental disabilities – all of these groups are at increased risk of traumatic victimization
- Various subpopulations have higher rates of co-occurring PTSD and substance use disorders, including combat veterans, inmates, victims of domestic violence, the homeless, and adolescents

Trauma affects the way people approach potentially helpful relationships

- Not surprisingly, individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many behavioral healthcare and other social services.
- Hypervigilance and suspicion are often important and thoroughly understandable self-defense mechanisms in coping with trauma exposure – yet they make it difficult to engage in services that may be needed.

Trauma has sometimes occurred in the service context itself

- Involuntary and physically coercive practices, as well as many other activities that trigger trauma-related reactions, are still too common in some of our centers of help and care.
- *Unintentional retraumatization is still retraumatizing!*

The Adverse Childhood Experiences (ACE) Study

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Provides retrospective and prospective analysis in over 17,000 individuals on the effect of traumatic experiences during the first 18 years of life on adolescent and adult medical and psychiatric disease, sexual behavior, healthcare costs, and life expectancy.

(Felitti et al., 1998)

Demographic information is from the entire ACE Study sample (n=17,337).

Gender	
Female	54.0%
Male	46.0%
Race/Ethnicity	
White	74.8%
Hispanic/Latino	11.2%
Asian/Pacific Islander	7.2%
African-American	4.5%
Other	2.3%
Age (years)	
19-29	5.3%
30-39	9.8%
40-49	18.6%
50-59	19.9%
60 and over	46.4%
Education	
Not High School Graduate	7.2%
High School Graduate	17.6%
Some College	35.9%
College Graduate or Higher	39.3%

What are considered ACEs?

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. Lack of adequate love or support
5. An alcohol and/or drug abuser in the household
6. Household member chronically depressed, mentally ill, institutionalized, or suicidal
7. Mother treated violently
8. Parents separated or divorced
9. Emotional or physical neglect
10. An incarcerated household member

The Adverse Childhood Experiences (ACE) Study

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- Over 17,000 adults studied from 1995-1997
- Almost 2/3 of participants reported at least one ACE
- Over 1/5 reported three or more ACEs, including abuse, neglect, and other types of childhood trauma
- Major links identified between early childhood trauma and long term health outcomes, including increased risk of many chronic illnesses and early death.

ACE Categories- Abuse

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- **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.

Center for Disease Control and Prevention,2016

ACE Categories - Household Challenges

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- **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
- **Household substance abuse:** A household member was a problem drinker or alcoholic or a household member used street drugs.
- **Mental illness in household:** A household member was depressed or mentally ill or a household member attempted suicide.
- **Parental separation or divorce:** Your parents were ever separated or divorced.
- **Criminal household member:** A household member went to prison.

Center for Disease Control and Prevention,2016

ACE Categories- Neglect

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- **Emotional neglect:** Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and felt close to each other, and your family was a source of strength and support.[2]
- **Physical neglect:** There was someone to take care of you, protect you, and take you to the doctor if you needed it[2], you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

Center for Disease Control and Prevention,2016

ACE STUDY FINDINGS

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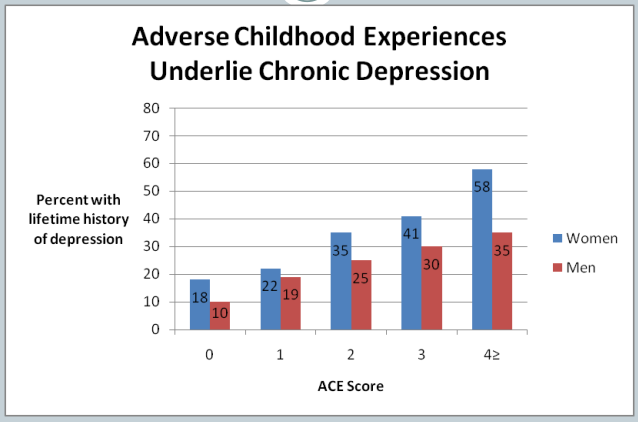
ACE's increased the chances of being a user of street drugs, tobacco, having problems with alcohol, overeating, sexual behaviors.

Individuals with an ACE score of

- 4 or more were twice as likely to be smokers
- 12 times more likely to have attempted suicide
- 7 times more likely to be alcoholic
- 10 times more likely to have injected street drugs compared to those with an ACE score of 0.

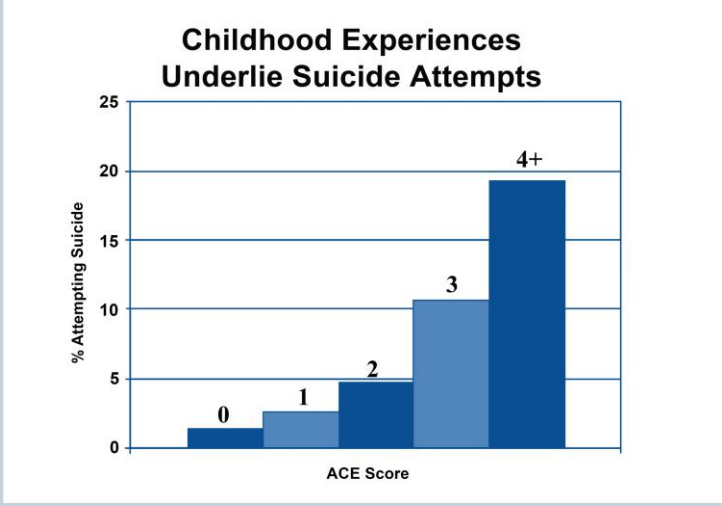
Center for Disease Control and Prevention,2016

ACE's and Depression

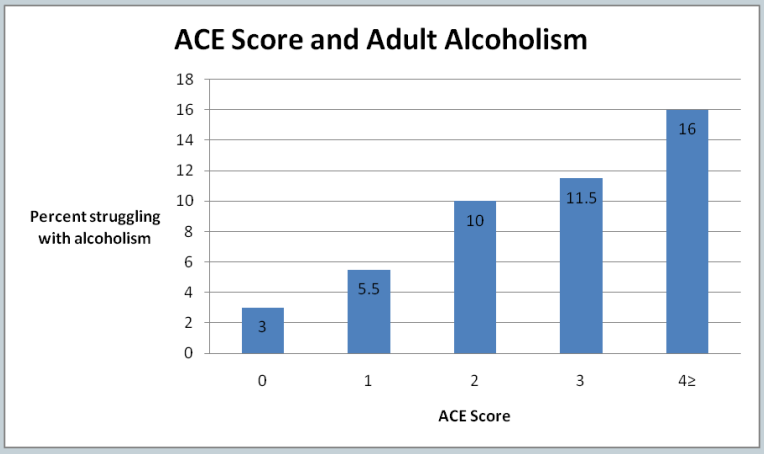


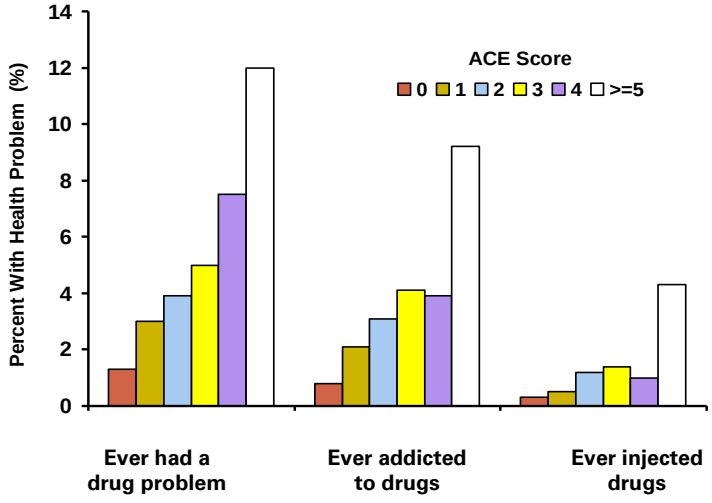
- Men and Women with ACE scores => 4 are more than 3 times more likely to have depression than those with an ACE score of 0.

ACE's and Suicide

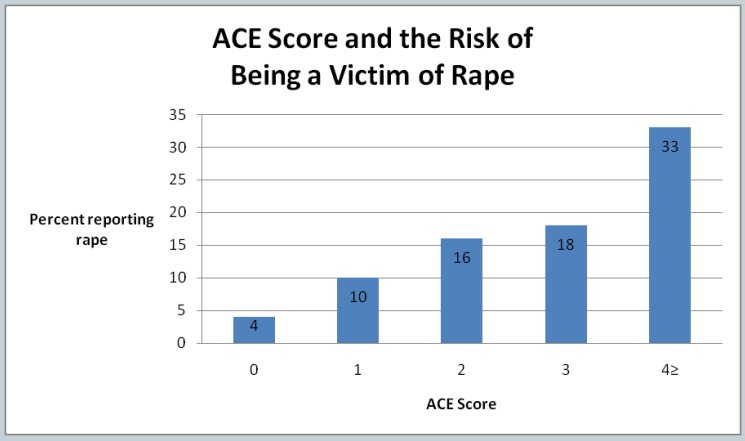


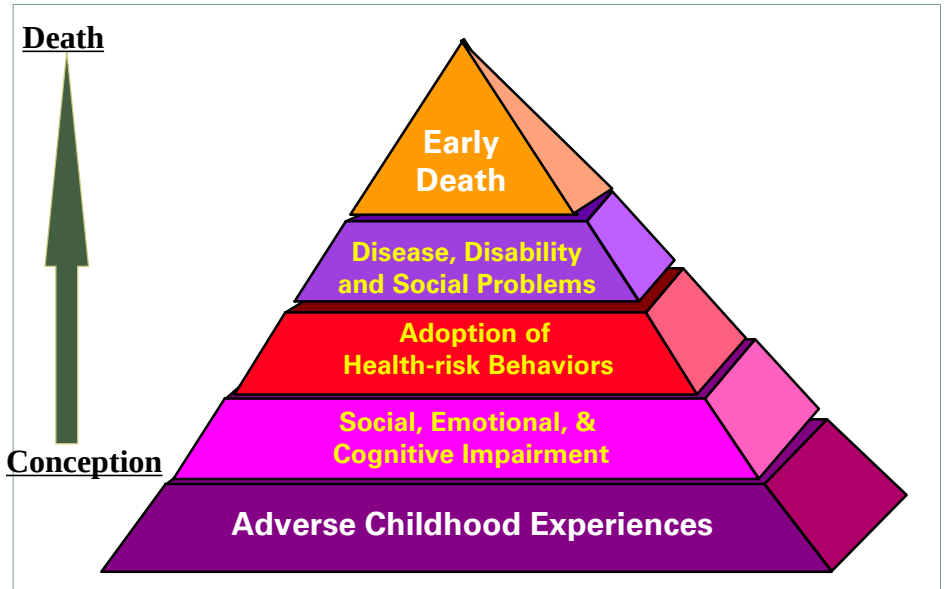
ACE's and Alcoholism





ACE'S and Rape Reporting





Mechanisms by which ACES influence health and well-being throughout the lifespan

ACE STUDY FINDINGS

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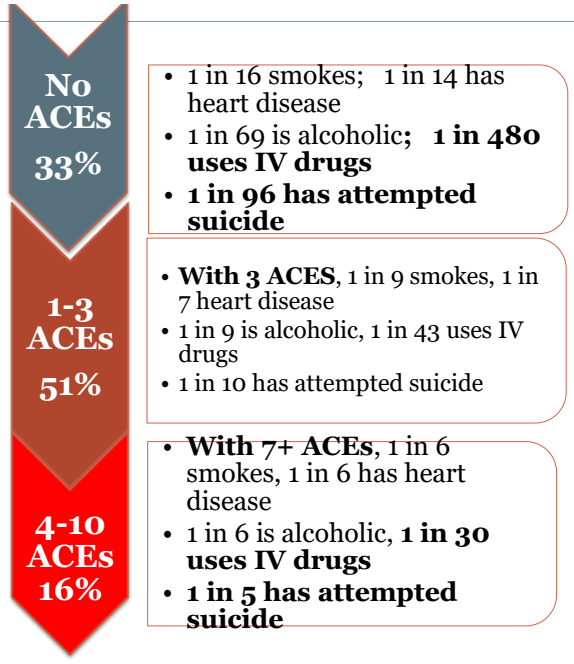
Physical Health Issues

ACE scores were related to increased heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis, high blood pressure and poor self-rated health.

Dose-Response Relationship

Study findings repeatedly reveal a graded dose-response relationship between ACEs and negative health and well-being outcomes across the life course

Center for Disease Control and Prevention,2016



- 1 in 16 smokes; 1 in 14 has heart disease
- 1 in 69 is alcoholic; **1 in 480 uses IV drugs**
- **1 in 96 has attempted suicide**

- **With 3 ACES**, 1 in 9 smokes, 1 in 7 heart disease
- 1 in 9 is alcoholic, 1 in 43 uses IV drugs
- 1 in 10 has attempted suicide

- **With 7+ ACEs**, 1 in 6 smokes, 1 in 6 has heart disease
- 1 in 6 is alcoholic, **1 in 30 uses IV drugs**
- **1 in 5 has attempted suicide**

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More Findings of the ACE study

- ACE score of 6 and higher – an almost 20-year shortening of lifespan.
- ACE score of 4 – 260% more likely to have Chronic Obstructive Pulmonary Disorder (COPD) than a person with an ACE Score of 0.
- ACE score of at least 7 increased the likelihood of childhood/adolescent suicide attempts 51-fold and adult suicide attempts 30-fold.
- ACE scores of 4 or higher increases the chance of having self-acknowledged alcoholism as an adult by 500% (with a history of parental alcoholism).
- ACE scores of 4 or more were 12 times more likely to have attempted suicide, 7 times more likely to be alcoholic, and 10 times more likely to have injected street drugs.

Dr. Nadine Burke Harris

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Click to view this TED talk:
https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

"You are just as likely to develop heart disease from an ACE as you are from high blood pressure, high cholesterol or family history"

Vince Felitti, MD
Co-Principle Investigator

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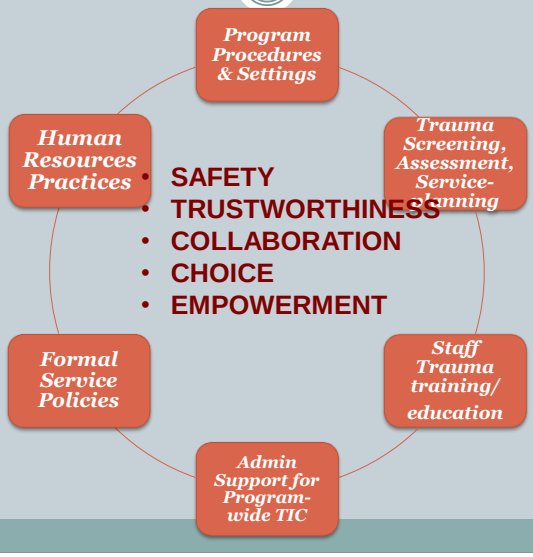
What a Trauma-Informed System looks like?

Trauma-informed



Shapes our Beliefs

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Worldview

Identity

Spirituality

Trauma Informed System

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- Acknowledges and understands the effects of trauma and values client participation.
- Takes into account knowledge about trauma, its impact, interpersonal dynamic, and paths to recovery and incorporates this knowledge into all aspects of service delivery.
- Has an understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual.
- Presumes that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences.

Key Features

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Systems without Trauma Sensitivity	Trauma Informed Care Systems
Clients are labeled & pathologized as manipulative, needy, attention-seeking.	Are inclusive of the survivor's perspective.
Misuse or overuse of displays of power - keys, security, demeanor.	Recognition that coercive interventions that cause traumatization/re-traumatization are to be avoided.
Culture of secrecy - no advocates, poor monitoring of staff.	Recognition of the high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults with mental illness.
Staff believe key role are as rule enforcers	Early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness.
Little use of least restrictive alternatives other than medication	Recognition that mental health treatment environments are often traumatizing, both overtly and covertly.
Institutions that emphasize "compliance" rather than collaboration .	Recognition that the majority of mental health staff are uninformed about trauma, do not recognize it and do not treat it.

Key Features

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Systems without Trauma Sensitivity	Trauma Informed Care Systems
Institutions that disempower and devalue staff who then "pass on" that disrespect to service recipients.	Value clients in all aspects of care.
High rates of staff and recipient assault and injury.	Neutral, objective and supportive language.
Lower treatment adherence.	Individually flexible plan approaches.
High rates of adult, child/family complaints.	Avoid all shaming/humiliation.
High rates of staff turnover and low morale.	Awareness/training on re-traumatizing practices.
Longer lengths of stay/increase in recidivism.	Institutions that are open to outside parties: advocacy and clinical consultants.
	Training and supervision in assessment and treatment of people with trauma histories.
	Focusing on what happened to you in place of what is wrong with you. Asking questions about current abuse.
	Addressing the current risk and developing a safety plan for discharge/termination.

The Core Principles of a Trauma-Informed System of Care

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- Safety: Ensuring physical and emotional safety
- Trustworthiness: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries.
- Choice: Prioritizing client choice and control.
- Collaboration: Maximizing collaboration and sharing power with clients.
- Empowerment: Prioritizing client empowerment and skill-building.

(Fallot & Harris, 2009)

Safety: Physical and Emotional Safety

- To what extent do service delivery practices and settings ensure the physical and emotional safety of consumers? of staff members?
- How can services and settings be modified to ensure this safety more effectively and consistently?
- Do staff feel supported in their relationships with administrators and supervisors?
- Do staff members feel physically safe?

Trustworthiness: Clarity, Consistency, and Interpersonal Boundaries

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- To what extent do the program's activities and settings maximize trustworthiness by making tasks involved in service delivery clear?
- How can the program maximize honesty and transparency?
- How can services be modified to ensure that tasks and boundaries are established and maintained clearly, consistently and appropriately?
- Is self care encouraged and supported with policy and practice?
- Staff appreciation?
- Is supervision available for everyone not just clinical staff?

Choice: Choice and Control

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- 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?
- When possible, are staff members given the opportunity to have meaningful input into factors affecting their work: size and diversity of caseload, hours and flex-time, when to take vacation or other leave?
- Do staff give input on opportunities for training, approach to clinical care, caseload size?

Collaboration: Collaborating & Sharing Power

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- To what extent do the programs activities and settings maximize collaboration and the sharing of power between providers and consumers?
- How can services be modified to ensure that collaboration and power-sharing are maximized?
- Are staff encouraged to provide feedback and ideas? Staff surveys?
- Do program directors supervisors communicate that staff members' opinions are valued even if they cannot be implemented?

Empowerment: Recognizing Strengths and Building Skills

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- 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?
- How can the program ensure that staff members have the resources necessary to do their jobs well?
- Are staff offered development, training, or opportunities to assist with work-related challenges difficulties?

Creating a Trauma Informed System of Care

Psychologically Healthy Workplaces

- Employee involvement
- Work-life balance
- Employee growth and development
- Health and safety
- Employee recognition

Toxic vs. Healthy Work Cultures

- People do not help each other.
- Human needs are ignored.
- People feel alienated and dehumanized.
- Alternative approaches are met with derision.
- Cliques are common.
- There is systemic rigidity; boss Is always right.

- Workers know what is expected of them.
- Workers have the resources to do the work.
- Workers have daily opportunities to do what they do best.
- Praise is offered regularly.
- Personal and professional development is encouraged.

Adapted from Kahn & Langlieb, 2003 and Russo, 2007

What Helps? Organizational Responses

- Supervision/consultation/case discussion
- Time off for staff
- Education/training/new skills
- Opportunities to discuss and debrief about client- and work-related stressors
- Variety in caseload and work tasks
- Mental health benefits

Adapted from Russo, 2007

What Helps? Professional Responses

- Understand your own work needs
- Take time off from work
- Find education/training for new skills
- Take advantage of supervision/consultation
- Identify strengths—consumers' and your own
- Accept reality of stress and strain
- Nurture your sense of humor

Adapted from Russo, 2007

What Helps? Personal Responses

- Be honest about your exposure to emotionally stressful material
- Attend to inner experience; therapy?
- Build in transition times between work and home
- Use coping skills common in trauma curricula
- Have fun, be spontaneous, laugh
- Personal life? Balanced life? Spiritual life?

Adapted from Russo, 2007

What Helps on a Daily Basis?

- Pace yourself; take breaks when possible
- Talk to someone else—someone helpful
- Develop your own list of self-soothing activities that "fit" at work—and use them
  - Breathing, relaxation, meditation
  - Self-talk that is reassuring
- Monitor your body's reactions to the day

Adapted from Russo, 2007

Helping Yourself/Helping Others

- Accept stress and related feelings as legitimate—for yourself and for coworkers
- Express support and find supportive others
- Promote solutions rather than complaints
- Contribute to cohesion of your workgroup
- Strive for open and direct communication
- Frame problems and solutions as group concerns rather than individual ones

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When a human service program takes the steps to become trauma-informed, every part of the organization, management, and services delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual receiving services.

A Culture Shift: Scope of Change in a Distressed System

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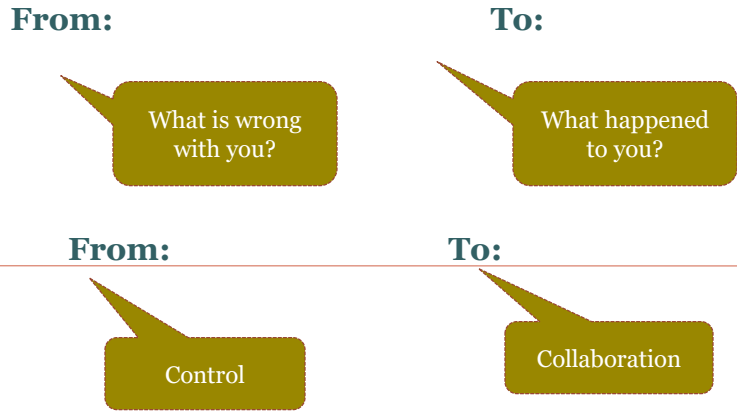
- Involves all aspects of program activities, setting, and atmosphere (more than implementing new services).
- Involves all groups: administrators, supervisors, line staff, consumers, families (more than direct service providers).
- Involves making change into a new routine, a new way of thinking and acting (more than new information).

Trauma-Informed Care (TIC) provides a new paradigm under which the basic premise for organizing services is transformed.



Trauma Informed Systems

Universal Precautions:

Operate as if every child in your care has been exposed to abuse, violence, neglect, or other traumatic event(s).

What happened to you?

Reactions to Trauma

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Remember the acronym, PEARLS…

- Partnership: "Let's work together."
- Empathy: "That sounds frustrating."
- Apology: "I am sorry that happened."
- Respect: "You have gone through a lot."
- Legitimization: "I understand why you're upset."
- Support: "Let's see what we can do."

Montefiore University Hospital &
Albert Einstein College of Medicine, TIC 2017

Protocol for Developing a Trauma-Informed Service System

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- Services-level changes
  - Service procedures and settings
  - Formal service policies
  - Trauma screening, assessment, and service planning
- Systems-level/administrative changes
  - Administrative support for program-wide trauma-informed services
  - Trauma training and education
  - Human resources practices

Review of Formal Policies

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- Confidentiality policies are clear and shared with clients.
- Policies avoid involuntary or coercive elements of treatment.
- De-escalation policy is formalized and minimizes possibility of retraumatization.
- Program prioritizes client preferences in responding to crises (e.g., use of preference forms).
- Program has clearly written, accessible statement regarding client rights and grievances.

Trauma Screening, Assessment, and Service Planning

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- Universal trauma screening that is appropriate to the setting.
- Follow-up with appropriate assessment of trauma exposure history and impact.
- Including trauma-based information in collaborative planning for services.
- Offering, or linking to, trauma-specific services.

Administrative Support for Program-Wide Trauma-Informed Services

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- Support for the integration of knowledge about trauma and violence into all aspects of agency functioning.
- Possible indicators:
  - Formal policy or mission statements
  - Developing a "trauma initiative"
  - Making resources available
  - Active administrator participation

Expected Outcomes

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Program:
- Improvement in trauma self-assessment
- Increased provision of trauma-specific services
- Decrease in client management problems

Client:
- Increased program retention
- Lower relapse rates
- Decrease in self-harming behaviors

Staff:
- Increased trauma education
- Lower turnover
- Increased job satisfaction

Conclusion

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- What we know about trauma, its impact, and the process of recovery calls for trauma-informed service approaches.
- A trauma-informed approach involves fundamental shifts in thinking and practice at all program levels.
- Trauma-informed services offer the possibility of enhanced collaboration for all participants in the human service system.

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