

# Trauma and PEI strategies

**“Many providers may assume that abuse experiences are additional problems for the person, rather than the central problem...”**

(Hodas, 2004)



# **What is Trauma?**

**The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism, and disasters.**

**(NASMHPD, 2004)**

# Trauma leading to persistent mental health problems:

- Are *usually* not a “single” event, e.g. natural disaster, car accident
- Are interpersonal in nature: intentional, prolonged, repeated, severe
- Begin in childhood and adolescence and may extend over an individual’s life span

# List of traumas

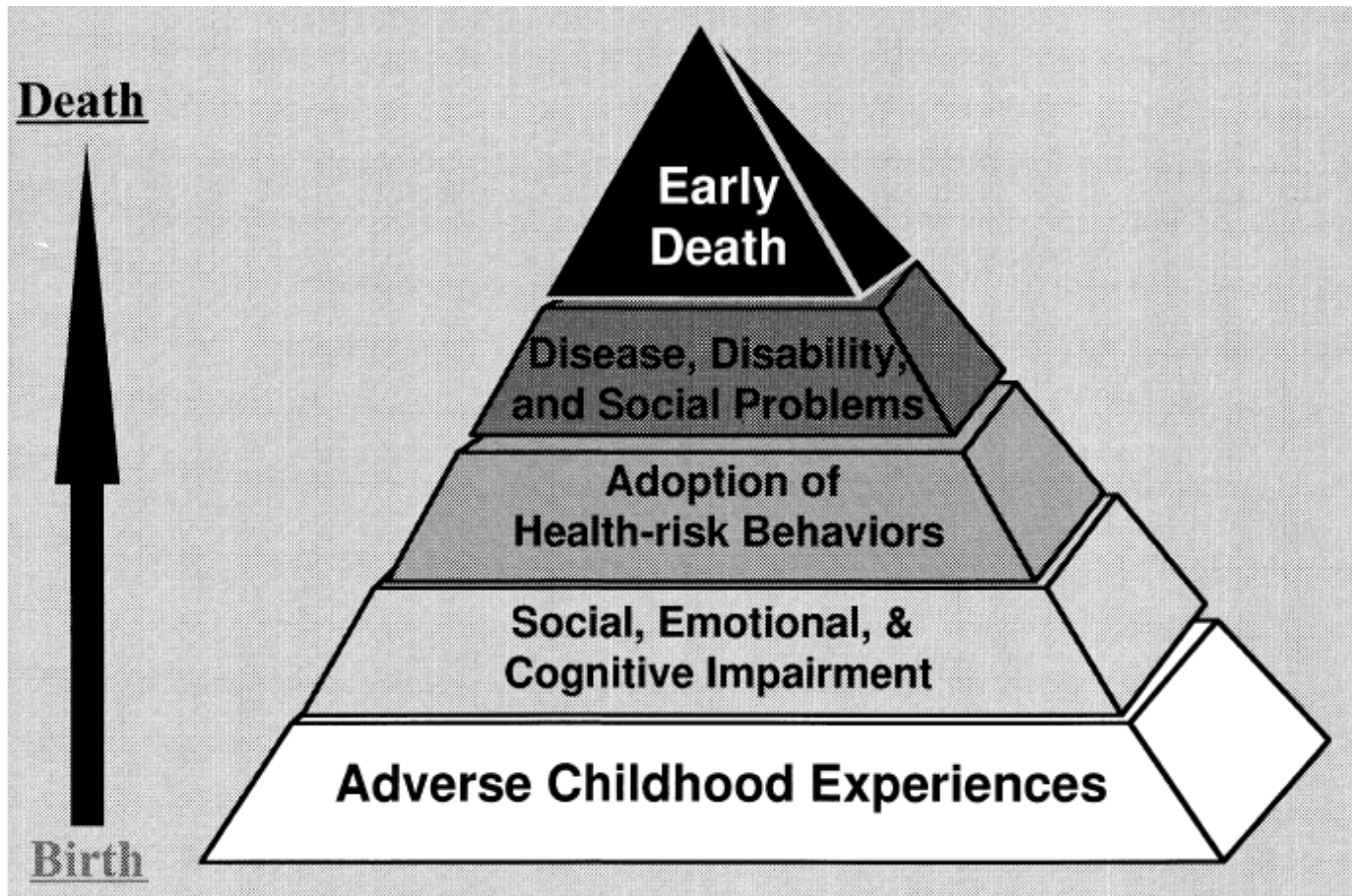
- **Examples of traumas experienced by our consumers / clients / participants / residents?**

# Impact of Trauma over the Lifespan

- Effects are neurological, biological, psychological and social in nature, including:
  - Changes in brain neurobiology
  - Social, emotional & 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, and early death

*(Felitti et al, 1998; Herman, 1992)*

# Adverse childhood experiences (ACE)



# ACE – Before 18

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- An alcohol and/or drug abuser in the household
- An incarcerated household member
- Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
- Mother is treated violently
- One or no parents
- Emotional or physical neglect



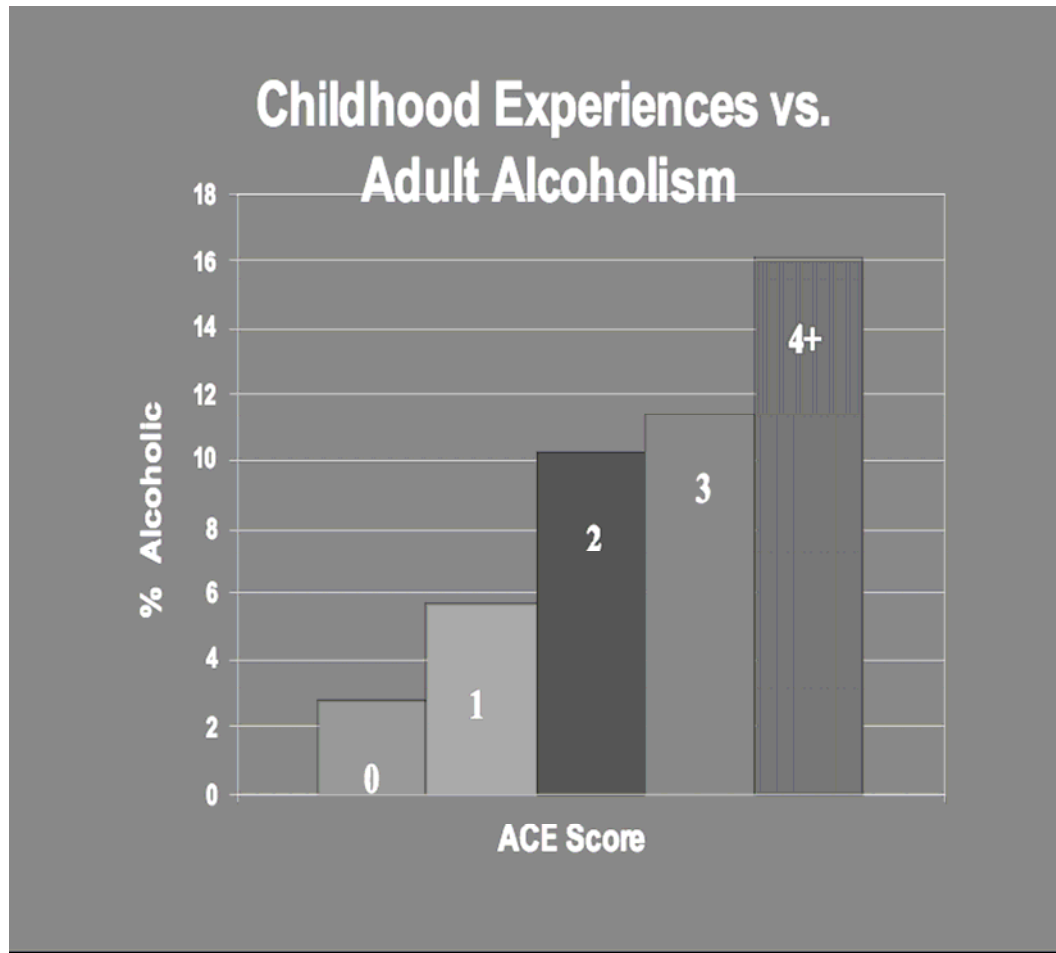
# ACEs have a strong influence on

- Adolescent health
- Teenage pregnancy
- Smoking
- Alcohol abuse
- Illicit drug abuse
- Sexual behavior
- Mental health disorders
- Risk of victimization
- Stability of relationships
- Performance in the workplace

# Trauma Symptoms and Substances Associated with their Relief

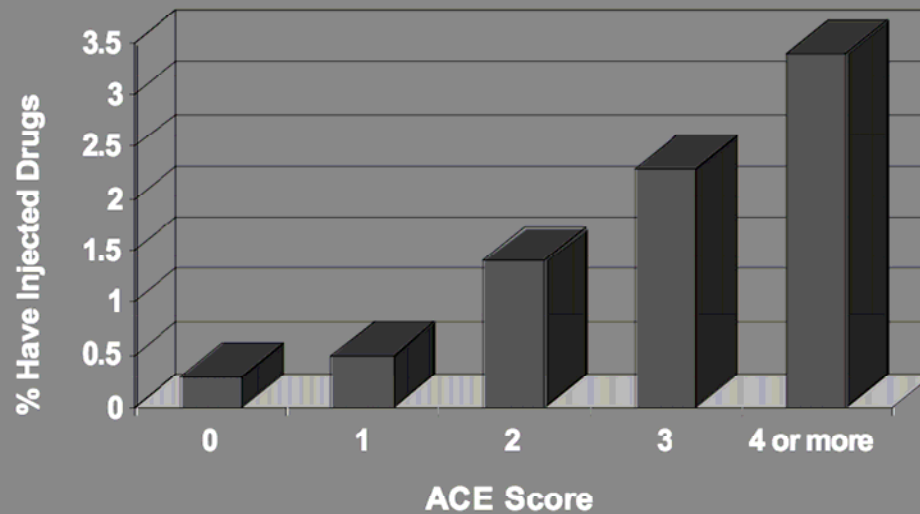
<u>Symptom</u>	<u>Substance</u>
• Depression	Cocaine, methamphetamines
• Anxiety	Alcohol; tranquilizers
• Inner turmoil & pain	Opioids; methamphetamines
• Emotional numbness	Cocaine; methamphetamines
• Passivity	Alcohol, PCP
• Excessive anger/rage	Alcohol, marijuana, opioids
• Sexual numbness	Alcohol; amyl nitrate; hallucinogens, methamphetamines

# ACEs and Alcoholism



# ACEs and IV Drug Use

## ACE Score vs Intravenous Drug Use



$p < 0.001$



# Percentage of CALworks Clients with Barriers

▪ Mental Health	85.3
▪ Alcohol/Drug	60.6
▪ Domestic Conflict	55.8
▪ Attitude	35.5
▪ Education	32.9
▪ Children	30.4
▪ Work	25.6
▪ Medical Problems	22.4
▪ Housing	19.6
▪ Legal	16.8
▪ Transportation	15.9

# Poverty is a link

- **Better Homes Fund Report looking at intimate partner violence among extremely poor women**
  - More likely to have suffered childhood sexual abuse
  - More likely to have had a foster care placement
  - Lower current self esteem
  - Partner much more likely to abuse substances
  - Parents more likely to have fought physically
  - Mother much more likely to have been battered
  - The female caretaker (mother) more likely to have had mental health problems

(2001 Bassuk, et al)

# Trauma Informed Services

# Definition: Trauma-Informed Care

**Mental Health Treatment that is directed by:**

- ✓ a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and
- ✓ an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services *(Jennings, 2004)*

# Trauma Informed Care Systems

## Key Features

- Focusing on what happened to you in place of what is wrong with you

*(Bloom, 2002)*

- Asking questions about current abuse
  - Addressing the current risk and developing a safety plan for discharge
- One person sensitively asking the questions
- Noting that people who are psychotic and delusional can respond reliably to trauma assessments if questions are asked appropriately

*(Rosenburg, 2002)*

# Dimensions of care

1. **Self-care**
2. **Consumer and staff (direct [customer] services)**
3. **Structure and design (program)**
4. **System interaction (policy/advocacy)**



# Stages of Trauma Recovery

## Stage One: ESTABLISHING SAFETY

- Securing safety
- Stabilizing symptoms
- Fostering self-care

## Stage Two: REMEMBRANCE & MOURNING

- Reconstructing the trauma
- Transforming traumatic memory

## Stage Three: RECONNECTION

- Reconciliation with self
- Reconnection with others
- Resolving the trauma

# Trauma-informed vs. Traditional

- Trauma-informed
  - How do I understand this person?
  - Services are strengths-based
  - Minimize risk to consumer, weighing risk to providers
  - Services a collaboration between consumer and provider
  - Trust and safety earned and demonstrated over time
  - Both parties acknowledged for bringing information and expertise to the relationship.
- Traditional
  - How do I understand this symptom/problem?
  - Services are crisis-driven
  - Minimize risk to system/service
  - Consumers perceive services as hierarchical
  - Trust and safety assumed from beginning
  - Can recreate abuse dynamics in which the trauma survivor was forced to accept an unequal relationship to avoid worse treatment

# **A trauma-informed agency**

- Welcoming and appropriate to the special needs of consumers/participants with histories of trauma, mental health and substance abuse**
- Understanding that violence, abuse and subsequent coping have altered her worldview.**
- Understanding her and her situation and offering new modes of relating and coping**
- Connected to a larger system of care that is likewise trauma-informed and integrated.**

# Administrative commitment

- Departs from the outlook that violence, addiction and mental health problems form **a complex and interrelated network of connections** within the lives of women and within the experience of any given woman.
- Commitment begins with the people who allocate resources, set priorities and sponsor or design programs that assert that **trauma and its aftermath are an important part of what ails people.**

# Universal screening

- Screening all individuals seeking services to determine whether they have a **trauma history**
  - Example: SBCS universal screen
- It gets everyone thinking about trauma
- Agency sees itself as a place where histories of violence and victimization matter.

# Training and Education

- All staff – from receptionists to ED – have an overview of trauma and its effects
- Better a **general introduction for the many** than a in-depth knowledge for the few.
- “What is Trauma” by Community Connections
  - Example: An Intro to Trauma for Women on Short Stay
- Identify **trauma champions**: front-line worker who thinks “trauma first”

# Systems without Trauma Sensitivity

- Consumers are labeled & pathologized as manipulative, needy, attention-seeking
- Misuse or overuse of displays of power - keys, security, demeanor
- Culture of secrecy - no advocates, poor monitoring of staff
- Staff believe key role are as rule enforcers
- Institutions that emphasize “compliance” rather than collaboration
- Lower treatment adherence
- High rates of adult, child/family complaints
- Higher rates of staff turnover and low morale

*(Fallot & Harris, 2001)*

# Universal Precautions- Core Trauma Informed Concept

Presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences.

Respond kindly.

# Potential outcomes

- Reduction in substance abuse
- Reduction in psychiatric symptoms (PTSD, anxiety, depression)
- Identification of triggers
- Ability to identify safer coping, choices
- Increased successful program completion
- Increased staff morale, empowerment
- Improved system of care interaction (appropriate referrals, identification of gaps, overlaps in service)
- Reduced costs for emergency care

# Thank you!

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