

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

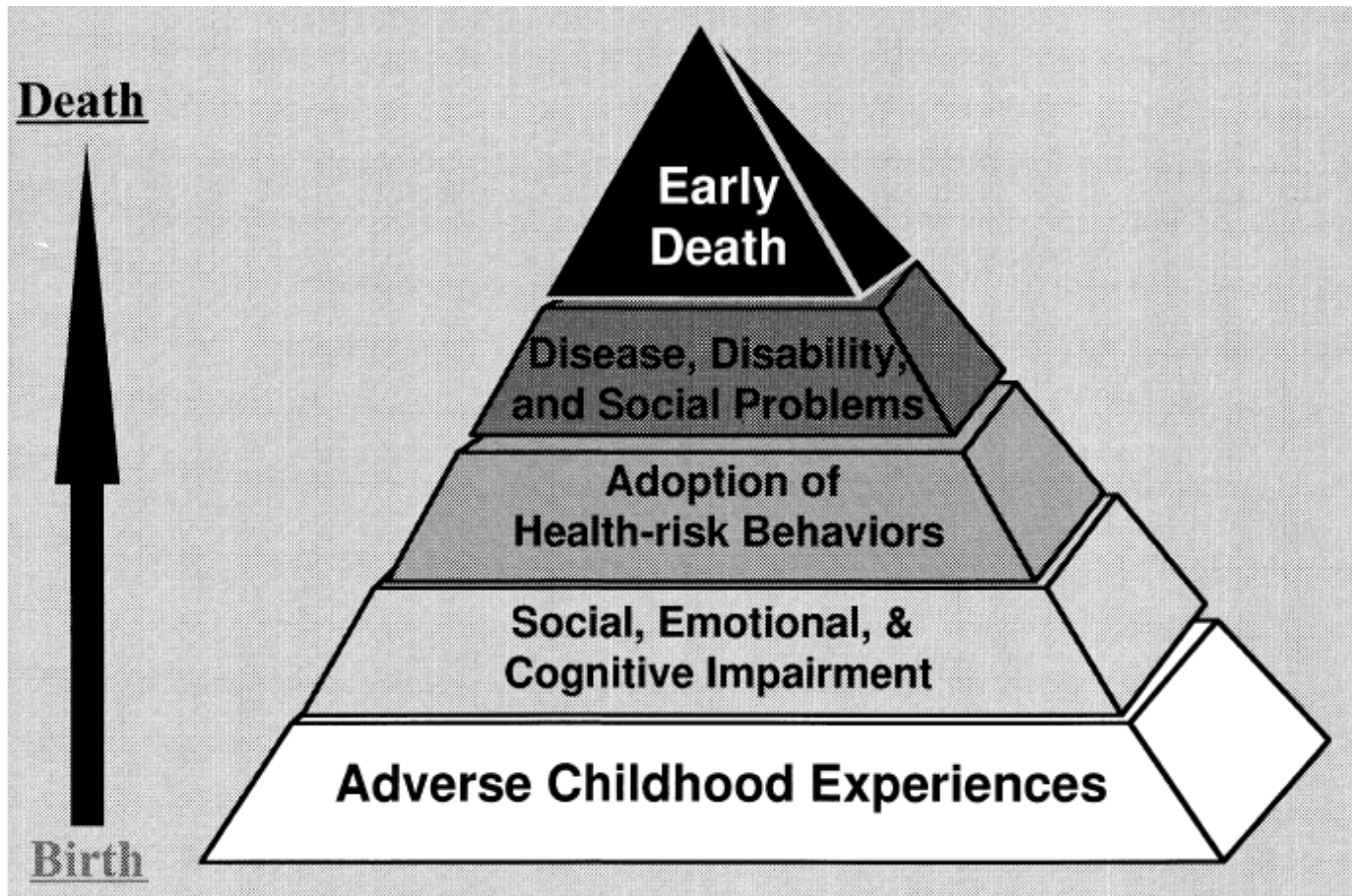
- **Examples of traumas experienced by our consumers / clients / participants / residents?**

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



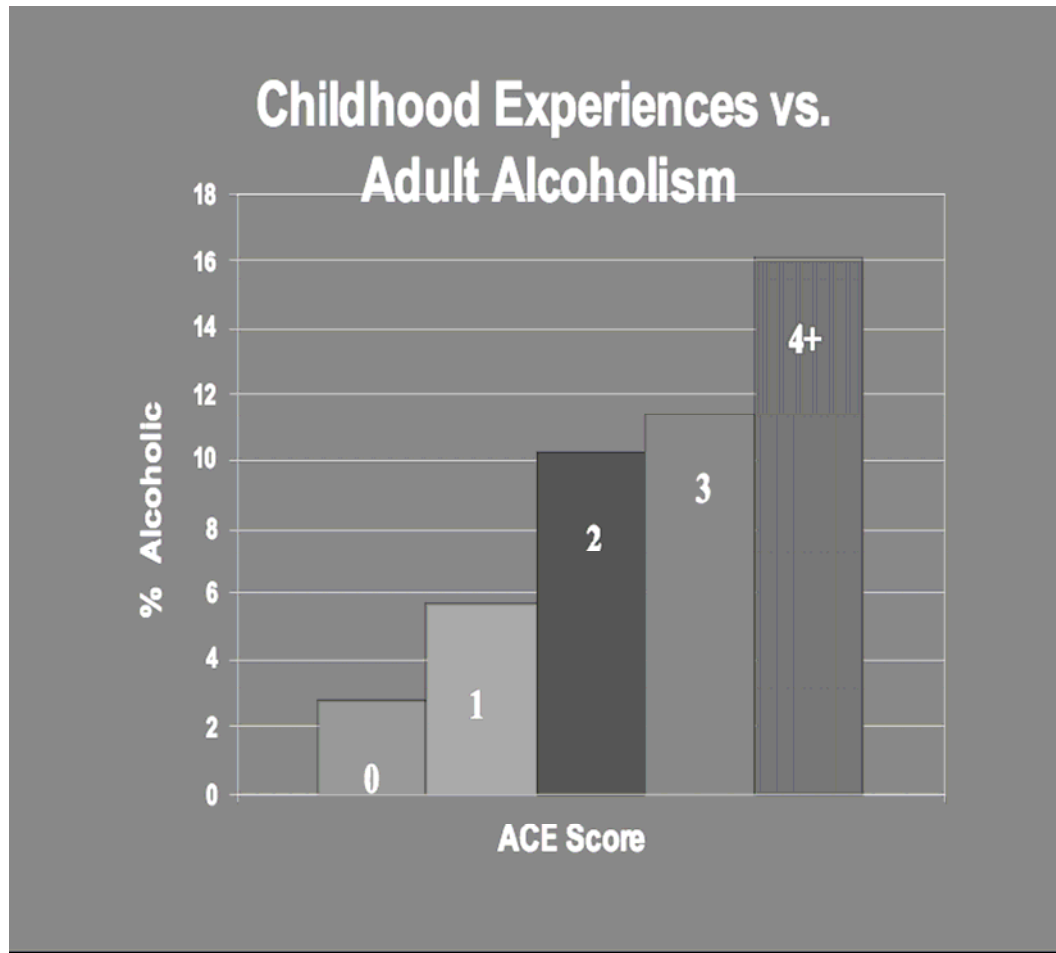
ACEs have a strong influence on

- 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

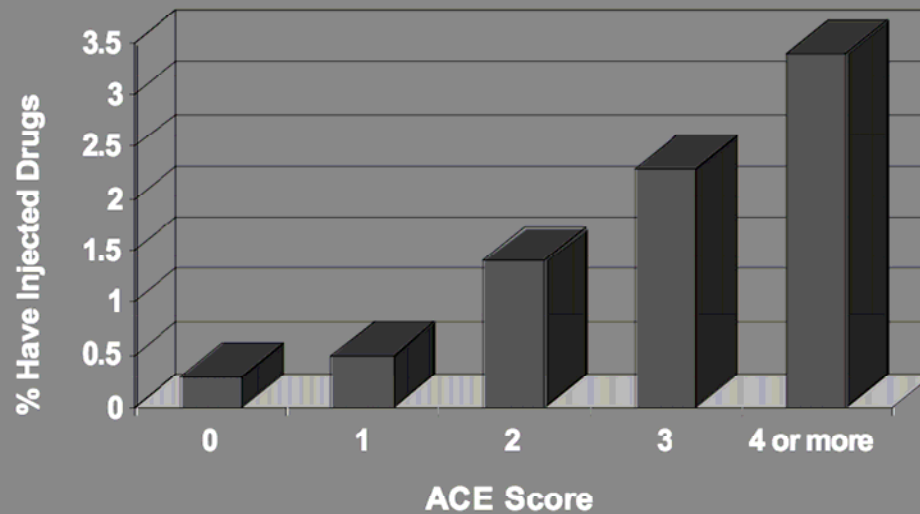
<u>Symptom</u>	<u>Substance</u>
• Depression	Cocaine, methamphetamines
• Anxiety	Alcohol; tranquilizers
• Inner turmoil & pain	Opioids; methamphetamines
• Emotional numbness	Cocaine; methamphetamines
• Passivity	Alcohol, PCP
• Excessive anger/rage	Alcohol, marijuana, opioids
• Sexual numbness	Alcohol;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