Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint

Trauma Informed Care

An Overview of Fundamental Concepts

NASMHPD

A Primary Prevention Tool

ntac

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2

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3

Trauma Informed Care

Outline

- Defining Trauma & Trauma Informed Care
- Prevalence & Implications
- Trauma Informed & Trauma Insensitive Systems
- Organizational Commitment
- Trauma Assessment & Models of Care

4

I'll be going over the following content: Defining trauma and trauma informed care; the prevalence and implications of trauma; trauma informed and trauma insensitive systems; organizational commitment, trauma assessment and some comments on models of care.

What is Trauma?

- Definition (NASMHPD, 2004):
  - The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism and/or disasters.

5

What is trauma? For the purposes of this presentation, the definition of trauma that NASMHPD uses is "the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss and/or the witnessing of violence, disasters or terrorism. I want to draw your attention to the fact that we are not just talking about physical violence here because you'll note severe neglect and loss is included in this definition.

What is Trauma?

DSM-IV-TR *(APA*, 2000*)*

- Defines "traumatic event" as one in which "a person experienced, witnessed or was confronted with an event(s) that involved actual or threatened death or serious injury or threat to the physical integrity of self or others".
- The person's response involved intense fear, helplessness or horror (*Ibid*)

6

What is trauma, according to the DSM-IV? DSM defines traumatic event as one in which a person experiences, witnesses or was confronted with an event that involved actual or threatened death or serious injury or threat to the physical integrity of themselves or others. The person's response also then includes intense fear, helplessness or horror.

Types of trauma resulting in serious and persistent mental health problems:

- Are *usually* not a "single blow" event e.g. rape, natural disaster
- Are interpersonal in nature: intentional, prolonged, repeated, severe
- Occur in childhood and adolescence and may extend over an individual's life span

(*Terr*, 1991; *Giller*, 1999)

7

Types of trauma resulting in serious and persistent mental health problems are emerging in the research literature over the last five, six years are not usually characterized as single events but are more often events that occur in a repetitive kind of pattern. That isn't to say that someone who, for instance, experiences a rape or the loss of their family in a terrible accident or a natural disaster, would not have sequelae or signs and symptoms resulting from that traumatic experience. This is just speaking to the fact that most of the types of traumatic experiences that I will be talking about are the result of repetitive experiences and not single events. As with everything else, you must take an individualized history.

These events are most often interpersonal in nature; in other words, they're personally felt; they're intentional, someone meant to harm the other person. They're prolonged, repeated, as I mentioned before, and severe. Often they start in childhood, through adolescence and progress up through adulthood. That's not always the case but again when you're taking information down in a trauma history, this is where more critical findings are that you need to know about because the more trauma someone experiences and the earlier age often indicates pretty much across the board a more serious set of signs and symptoms.

Definition of 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*)*

8

Trauma informed care is a relatively new term that has just come out in the literature in the last five or six years, although many people in the country and in other countries have been working on many of these issues for many, many years. The issue of trauma informed care pretty much emerged from the work in domestic violence and also the work that was done after WWII in terms of soldiers returning who had post-traumatic-stress-disorder. These two different fields of study have come together now in these last years and we're starting to look at kind of the overall effect of trauma and violence on human beings and, with respect to this training, on people with serious and persistent mental health problems who get services in the public mental health sector.

In terms of trauma informed care in mental health, we're talking about mental health treatment that is directed by a thorough understanding by leaders and staff of the profound neurological, biological, psychological and social effects of trauma and violence on the individual human being and an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. This is not commonly known and I'm going to explain this statement right now.

Prevalence of Trauma
&
Implications

9

Prevalence of Trauma and Implications.

Exposure to Trauma
General Population

- Until recently, trauma exposure was thought to be unilaterally rare (combat violence, disaster trauma)

  (*Kessler et al*., 1995)

- Recent research has changed this. Studies done in the last decade indicate that trauma exposure is common even in the middle class

  (*Ibid*)

- 56% of a general population adult sample reported at least one event

  (*Ibid*)

10

Up until recently, trauma exposure was thought to be relatively limited, really kind of reserved for people who had been in combat situations or had been victims of disaster or possibly accidents or an attack like a mugging or a rape. What we now know in terms of the general population is that the experiences of trauma are much more prevalent than we ever thought. Studies done in the last decade indicate that trauma exposure is quite common, even in the middle class. 56% of a general population, adult sample, reported at least one event in a study done by Kessler in 1995.

Prevalence of Trauma
Mental Health Population

- 90% of public mental health clients have been exposed

  (*Muesar et al.,* in press*; Muesar et al.,* 1998)

- Most have multiple experiences of trauma

  (Ibid)

- 34-53% report childhood sexual or physical abuse

  (*Kessler et al.,* 1995*; MHA NY & NYOMH* 1995*)*

- 43-81% report some type of victimization

  (Ibid)

11

When you start looking at the population of people with mental health disorders it becomes even more significant; actually, I found these data shocking. 90% of public mental health clients had been exposed according to research that's been done by Muesar and colleagues. Most have multiple experiences of trauma. 34% and up to 53% of people seeking services in mental health systems of care report childhood sexual and/or physical abuse and up to 81% report some kind of victimization.

Prevalence of Trauma
Mental Health Population

- 97 % of homeless women with SMI have experienced severe physical and sexual abuse - 87% experience this abuse both as child and adult

  (*Goodman et al.*, 1997)

- Current rates of PTSD in people with SMI range from 29-43%

  (*CMHS/HRANE*, 1995; *Jennings & Ralph*, 1997)

- Epidemic among population in public mental health system

  12

  (*Ibid*)

97% of homeless women with serious mental illness have experienced severe physical and sexual abuse with 87% of those individuals reporting these experiences as both children and adults. Current rates of PTSD in people with serious mental illness in this particular study went up to 43%, which is significantly higher than what is indicated in the DSM-IV. It appears that PTSD is epidemic among a population in a public mental health system where this one large study was done in South Carolina in all the community mental health settings. So as you can see, this issue of trauma, though it still needs to be researched and studied, appears to have great significance for the people that we try and serve every single day.

Prevalence of Trauma
What this means…

- A majority of adult and children in inpatient psychiatric treatment settings present with trauma histories

(*Cusack et al.; Muesar et al.,* 1998*; Lipschitz et. Al, 1999, NASMHPD,* 1998)

"Many providers may assume that abuse experiences are additional problems for the person, rather than the central problem…"

(*Hodas*, 2004)

13

What this means is that we now need to add to our knowledge base that the majority of children, youth and adults coming into care in our service systems are coming in with significant trauma in their lives and significant traumatic experiences that have probably complicated the illness and signs of symptoms that they're presenting with. Many providers may assume that abuse experiences are additional problems for the person, but what we're finding and what providers are finding that are focusing on this issue, that rather than being an adjunctive problem it is actually the central problem.

Impact of Trauma over the Life Span

- 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, early death

(*Felitti* et al, 1998; *Herman*, 1992) 14

The impacts of trauma over the life span include neurological effects, biological effects, psychological and social effects. We're seeing changes in brain neuro-biology that are able to be viewed. Social, emotional and cognitive impairment; in other words, the way people relate to others; the way they feel and the way they think has been impacted. That people who have been traumatized seem to have a higher rate of adoption of risky health behavior such as eating disorders, smoking, substance abuse, promiscuity, self-harm and even violence or other anti-social behaviors and that their adoption of these kind of risky behaviors seem to be coping mechanisms that they have identified as helpful for them to manage whatever, their stress or their emotions and that because of these health risk behaviors, to some extent, that we're also seeing severe and persistent behavioral health, health and social problems including early death.

Just a few weeks ago, the NASMHPD Medical Director's Council had a meeting where they talked about the morbidity and mortality rates of people who are receiving services in public mental health settings and we have identified that people with serious mental illness appear to be dying much earlier and in terms of 15 to possibly 20 years or more earlier than the general population. This is a significant concern.

Impact of Trauma on Development

The ability to form healthy relationships is highly dependent on learned social skills

- Children's social skill learning is directly related to the characteristics of their environments
- Disordered environments=dysfunctional skills
- Violence teaches withdrawal, anxiety, distrust, over-reaction and/or aggression as coping behaviors
- Extreme behaviors are rooted in dysregulated emotional states

(*NF Commission,* 2003*; SG Report,* 1999*; Hodas,* 2004*; Saxe,* 2003*)*

15

A couple of other comments on the impact of trauma on normal human development. What this research is showing is that the ability to form healthy relationships is highly dependent on learned social skills, usually learned from parents or caregivers. Children social skill learning is obviously directly related to the characteristics of their environments. If they're coming from disordered or chaotic environments, they're going to learn dysfunctional skills most of the time.

We're also seeing that violence, violent environments, teach withdrawal, anxiety, distrust, over-reaction or what we call hyper-vigilance and/or aggression as coping mechanisms, and that extreme behaviors, extremely problematic behaviors are rooted in very disregulated emotional states where these individuals have not learned how to manage their own emotions in a way so they have learned to self-soothe, which is basically a normal developmental task that we all need to learn as we're growing up through pretty much some of our younger stages of development. You will get a module on the neurobiological, psychological effects of trauma, so I'm not going to go into specifics here but I will strongly recommend that you do view that module because it goes into detail in a user-friendly way on what actually happens in the brain.

Traumatized Children: Observations and Experiences

- Appear guarded and anxious
- Are difficult to re-direct, reject support
- Are highly emotionally reactive
- Have difficulty "settling" after outbursts
- Hold onto grievances
- Do not take responsibility for behavior
- Make the same mistakes over and over

(Hodas, 2004*)*

16

When we start looking at traumatized children and for those of you who are in adult facilities, I just want you to remember that very often the people that we're serving in our adult systems have come through the children's system. In other words, they were children once. Some of the observations and experiences, noted by Gordon Hodas who is the State Medical Director for the children's system in Pennsylvania, include that these kids appear guarded and anxious. They are often difficult to redirect. They tend to reject support. They react quickly and they may have difficulty settling down. Sometimes they hold on to grievances for a long time; don't seem to take responsibility for behavior; and make the same mistakes over and over again. Dr. Hodas believes that trauma and behavior demonstrate a direct relationship in many of these situations and that, very often, the traumatic experiences and chaotic lifestyles that they've learned are in effect coping behaviors. This is so, even though these behaviors appear to us, adults and professionals, very problematic and only to cause the child problems and harm over and over again. But for that child they are meaningful and have been incorporated as coping behaviors.

Core Issue: Avoidance of Shame and Humiliation

- Gilligan, in his prison research identified shame/humiliation as core element in violence. He says:

"The basic psychological motive or cause of violent behavior is the wish to ward off or eliminate the feelings of shame and humiliation - a feeling that is painful and can even be intolerable- and replace it with…a feeling of pride"

(*Hodas*, 2004)

Another core issue that has emerged recently is the issue of shame and humiliation. Gilligan, in his prison research, identified shame and humiliation as a core element in violence. He states: "The basic psychological motive or cause of violent behavior is the wish toward off or eliminate feelings of shame and humiliation – a feeling that is painful and can even be intolerable – and by doing that replace it with a feeling of pride" and sometimes the way that kids or people who feel shame and humiliated do that is they become aggressive and violent because then they can take back control of their environment.

James Garborino who wrote *Lost Boys* and other publications also has identified shame and humiliation as a very critical issue in terms of looking at predicting violence and that very often the only out that a child or adolescent has when they feel overwhelming shame and humiliation is to become violent and aggressive.

What Happens when Traumatized Consumers are Restrained or Secluded?

- Research studies have found that children who were secluded experienced vulnerability, neglect, shame
- Repeatedly express being reminded of original abuse
- Express feelings of fear, rejection, anger and agitation (verbal and drawings)

(Wadeson et al., 1976*; Martinez,* 1999; *Mann et al.,* 1993*; Ray et al.,* 1996*)*

18

What happens when traumatized consumers or customers are restrained and secluded. Research studies have found that children who were secluded experienced vulnerability, neglect and shame. They stated that they were repeatedly being reminded of the original abuse that they had endured earlier; that they also expressed feelings of fear, rejection and anger both in verbally and in drawings after the event.

What Happens when Traumatized Consumers are Restrained or Secluded?

- Felt they were being punished
- Confused by staff use of force
- Do not feel protected from harm
- Feelings of bitterness and anger 1 yr later

(Wadeson et al., 1976*; Martinez,* 1999; *Mann et al.* 1993*; Mohr,* 1999*; Ray et al.,* 1996*)*

19

Adults also talked about they felt they were being punished; confused by staff use of force; they didn't know why this was happening; it was very frightening to them, the whole procedure. They did not feel protected from harm and in some cases documented feelings of bitterness and anger a whole year after the event.

Trauma Informed Care Systems

20

Now I’m going to move on to what a trauma informed system of care looks like.

Trauma Informed Care Systems
Key Principles

- Integrate philosophies of care that guide all clinical interventions
- Are based on current literature
- Are inclusive of the survivor's perspective
- Are informed by research and evidence of effective practice
- Recognize that coercive interventions cause traumatization and re-traumatization and are to be avoided

(*Fallot & Harris*, 2002; *Ford*, 2003; *Najavits*, 2003)

21

A trauma informed system of care integrates philosophical approaches to care that guide all clinical practices. These clinical practices or interventions are seeded in a philosophy of care that's very congruent and that will talk about these principles and then demonstrate how to crosswalk actual policies and procedures. So everything that happens operationally on a daily basis in that facility is checked against that original philosophy; value statement and mission statement to make sure they're being congruent.

Practices are based on current literature. They include the survivor's perspective. Trauma informed care systems spend a lot of time talking to the people they're serving and finding out how they're experiencing their treatment and how they're experiencing problems and how they're experiencing getting better and if they are getting better. They spend a lot of time including the child, the adult and the family in terms of getting their feedback in a real meaningful and sincere way.

TIC systems are very careful to implement practices that are informed by recent research and evidence of effective outcomes. By that I mean that these trauma informed care systems are very careful to look at what they are using as treatment activities; why are they using it; they go back to the literature and they're very interested in looking at outcomes and using evidence based practice.

Finally, trauma informed care systems recognize that coercive intervention such as seclusion and restraint cause traumatization and re-traumatization in any person who has already had traumatic life experiences and are to be avoided at all costs.

Trauma Informed Care Systems

Key Features

- Recognition of the high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults with SMI/SED
- Early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness

(*Fallot & Harris*, 2002; *Cook et al*., 2002; *Ford*, 2003; *Cusack et al*.)

22

Key features of trauma informed care systems. They recognize that high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults with SMI and SED are those being experienced by the very people that they're serving in their facilities. They also provide early and thoughtful diagnostic evaluation with the focus on trauma in people with complicated treatment resistant illnesses; possibly even people that have not been able to identify a traumatic life experience but based on their knowledge of trauma and their knowledge of the affects of trauma, that they would go back and try and follow up with that person and make sure that they have a good differential diagnosis.

Trauma Informed Care Systems
Key Features

- Recognition that mental health treatment environments are often traumatizing, both overtly and covertly
- Recognition that the majority of mental health staff are uninformed about trauma and its sequelae, do not recognize it and do not treat it

(*Fallot & Harris*, 2002; *Cook et al.*, 2002; *Ford*, 2003; *Cusack et al.; Jennings*, 1998; *Prescott*, 2000*)*

23

Trauma informed care systems recognize that mental health treatment environments are often traumatizing both overtly and covertly. In other words, staff that work in trauma informed care systems are able to look at their own facilities and their daily practices objectively and include the perspective of the consumer and/or family member and how it would feel if they were in their shoes. They also recognize that the majority of mental health staff are completely uninformed about trauma, its sequelae, do not recognize trauma and of course don't treat trauma.

Trauma Informed Care Systems
Key Features

- Valuing the consumer in all aspects of care
- Neutral, objective and supportive language
- Individually flexible plans and approaches
- Avoid shaming or humiliation at all times

(*Fallot & Harris*, 2002; *Cook et al.*, 2002; *Ford*, 2003; *Cusack et al.; Jennings,* 1998; *Prescott,* 2000*)*

24

Trauma informed care systems value the consumer in all aspects of care. They use neutral and supportive language which you'll hear about a little bit later but what I'm talking about for right now is person-centered or person-first language; they don't label people. They create individually flexible plans and approaches and they avoid shame and humiliation at all times, especially in any kinds of level systems that could be considered shaming or humiliating.

Trauma Informed Care Systems
Key Features

- Awareness/training on re-traumatizing practices
- Institutions that are open to outside parties: advocacy and clinical consultants
- Training and supervision in assessment and treatment of people with trauma histories

(*Fallot & Harris*, 2002; *Cook et al.*, 2002; *Ford*, 2003; *Cusack et al.; Jennings,* 1998; *Prescott,* 2000*)*

25

Trauma informed care systems create a high awareness of traumatizing practices and constantly train staff about that. They're open to outside parties and clinical consultants and advocates to come in and give them feedback on the work they're doing and they basically do a lot of training and supervision in how to assess and provide treatment to people with trauma histories.

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)

(*Fallot & Harris*, 2002; *Cook et al.*, 2002; *Ford*, 2003; *Cusack et al.; Jennings, 1998; Prescott*, 2000*)*

26

Trauma informed care systems approach people with trauma by asking a question, what happened to you; not what's wrong with you. Sandy Bloom identified that critical difference in how asking that question could illicit a very different response and again, the difference would be between me, coming to you and sitting down and saying what's wrong with you, as opposed to what happened to you that brought you here.

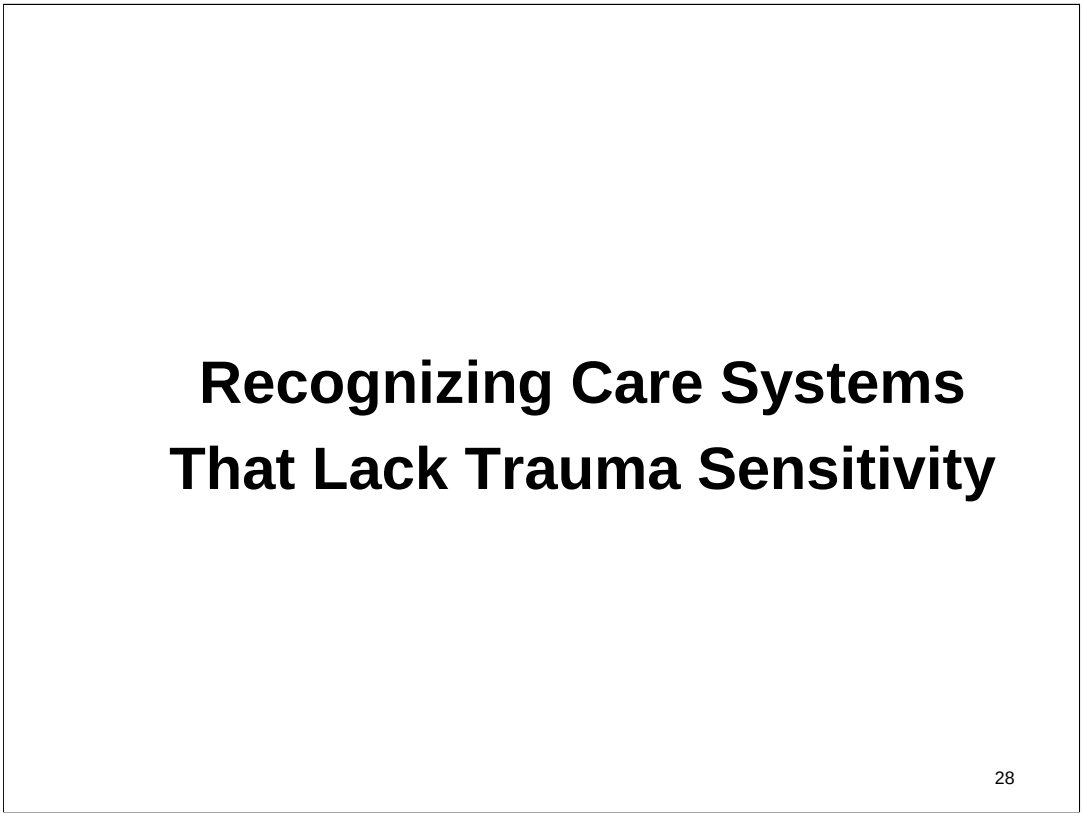
Asking questions about current abuse; making sure that there's a safe discharge place for this person to go. Using one person to sensitively ask the question and doing it in a sensitive way and in an environment where the phone's not ringing, people aren't walking in and out because very often these are very hard events to talk about and to recreate from a person and sometimes you may be the first provider that's ever asked this question. Knowing that people who have a psychosis and/or are delusional can also be asked these questions but the questions need to be adapted a bit and there may need to be more time elapsed before you actually follow up with that person.

Universal Precautions as a Core Trauma Informed Concept

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

27

Trauma informed care systems presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other events, so again I bring you back to that whole issue about universal precautions. Trauma informed care systems basically treat everyone like they've been traumatized.



Recognizing care systems that lack trauma sensitivity.

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

(*Fallot & Harris*, 2002) 29

Consumers are labeled and pathologized as manipulative, needy and attention seeking and I invite you to go to your medical records, read a few, and see how your staff have been trained to write about the people they're serving and if you see words like needy, attention seeking, manipulative, uncooperative, aggressive, non-compliant. I would basically draw your attention to the fact that your staff will need some training on trauma informed care; person-first language, and the whole issue of person-centered holistic approaches and strengths-based care.

Misuse or overuse of displays of power. These are facilities where a majority of the staff walked around with large jangling key rings which signal to everybody in the facility who has the power, who has the keys, who can get out and who is locked in. Over-reliance on security staff; sometimes that even means that a clinical staff step back and security staff come in whenever there's a violent event where seclusion and restraint is used. Just demeanor; how do people talk and walk around and interact with each other. Is it in a more autocratic way or is it in a more collaborative kind of way

Cultures of secrecy. Systems without trauma sensitivity often don't particularly invite advocates to come in and they don't do a good job of monitoring staff practices, especially at helping staff change practice and staff believe that their key role is as a rule enforcer.

Systems without Trauma Sensitivity

- Little use of least restrictive alternatives other than medication
- Institutions that emphasize "compliance" rather than collaboration
- Institutions that disempower and devalue staff who then "pass on" that disrespect to service recipients.

(*Fallot & Harris*, 2002)

30

Systems without trauma sensitivity. You'll see little use of other least restrictive alternatives except for medication and when you ask staff what they understand least restrictive intervention to mean, most of the time they'll say medication.

Institutions that emphasize compliance rather then collaboration; institutions that have lots of rules, that post those rules all around. You hear a lot of talk between staff and consumer or staff and service user about you can't do that or that's against the rules or you know that's not the rule here. Institutions that disempower and devalue their own staff who then "pass on" that disrespect to service recipients.

Systems without Trauma Sensitivity Related Characteristics

- High rates of staff and recipient assault and injury
- Lower treatment adherence
- High rates of adult, child/family complaints
- Higher rates of staff turnover and low morale
- Longer lengths of stay/increase in recidivism

(*Fallot & Harris*, 2002*; Massachusetts DMH*, 2001*; Huckshorn*, 2001)

31

Systems without trauma sensitivity. Also you may see high rates of staff and recipient assault and injury; lower treatment adherence; higher rates of complaints and grievances; higher rates of staff turnover; possibly lower morale; longer lengths of stay and an increase in recidivism.

Organizational Commitment to Trauma Informed Care

32

When we talk about an organizational commitment to trauma informed care, what we're really talking about is that this is something that the leadership of the facility will have to take on and make a commitment to.

Organizational Commitment to Trauma Informed Care

- Adoption of a trauma informed policy to include:
  - commitment to appropriately assess trauma
  - avoidance of re-traumatizing practices
- Key administrators get on board
- Resources available for system modifications and performance improvement processes
- Education of staff is prioritized

(*Fallot & Harris*, 2002; *Cook et al*., 2002)

33

This goes hand in hand with reducing seclusion and restraint and it includes first, the adoption of a trauma informed policy that includes a commitment to universally assess for traumatic life events in everybody coming in the door and also to avoid retraumatizing practices at all times as best as you can. Again, it is critical the key administrators get on board. This is not the kind of thing that staff can do. The key administrators and clinical leadership need to provide the direction, the focus and the resources to help do this kind of large change process, change project. Again, resources may need to be available to modify systems or reallocate in terms of training in performance improvement processes. And that education of staff is prioritized.

Organizational Commitment to Trauma Informed Care

- Unit staff can access expert trauma consultation
- Unit staff can access trauma-specific treatment if indicated

(*Fallot & Harris*, 2002; *Cook et al*., 2002)

34

Also important in systems of care that are trauma informed; unit staff know how to access expert trauma consultation from the trauma consultants in the community that actually provide trauma-specific care. When we talk about the implementation of the trauma informed care system, we are really talking about what this kind of universal approach to principles and policies, procedures and demeanor and kind of milieu issues in terms of a general facility. When you actually admit someone who has got serious trauma issues up to PTSD and who the physician or the treatment team determines needs actual trauma treatment, that's when you need to call the consultants for that kind of thing and staff need to have access to those consultants.

Unit staff also need to have user-friendly, confidential, easy access to EAP kinds of services. What we've found as we've gone around the country training is in many cases staff are very traumatized also. They've witnessed the same kinds of violence; sometimes they've been victims of violence and they've often not felt comfortable getting help for that. So systems of care that are trauma informed; make sure that they take care of their staff and that their staff have easy access to what they need in terms of support.

Organizational Commitment to Trauma Informed Care

- Assessment data informs treatment planning in daily clinical work
- Advance directives, safety plans and de-escalation preferences are communicated and used
- Power & control are minimized by attending constantly to unit culture

(*Fallot & Harris*, 2002; *Cook et al*., 2002)

35

Organizations that implement trauma informed care make sure that any kind of assessment data coming out of a trauma evaluation informs treatment planning because if it doesn't then you might as well have not done it.

They also understand the importance of advanced directives, safety plan and de-escalation preferences and how that then comes out of the treatment plan and the information gathered from the trauma system. We'll be having several modules on that process.

Power and control are minimized by attending constantly the unit culture and having leadership role model the way leadership wants staff to treat others.

Trauma Assessment

36

Trauma assessment.

Trauma Assessment

- Purpose
  - Used to identify past or current trauma, violence, abuse, and assess related sequelae
  - Provides context for current symptoms and guides clinical approaches and recovery progress
  - Informs the treatment culture to minimize potential for re-traumatization

(*Cook et al*., 2002; *Fallot & Harris*, 2002; *Maine BDS*, 2000)

37

There are multiple kinds of trauma assessments being used currently in the field. Again, please notify any one of the faculty or NTAC if you'd like to see some examples. Some are very simple; some are a little bit longer; some are valid and reliable tools; others are kind of home-grown based on the literature. But basically the overall purpose of the trauma assessment (and this is this assessment that you're going to use in a universal precautions way) is that it is used to try and identify past or current trauma, violence, abuse and any kind of related signs and symptoms.

A good admission trauma assessment will help you provide a context for current symptomology and also help you kind of start to develop your clinical approach and how you're going to approach helping this person to recover.

It also informs the treatment staff so that they're aware that again, here's someone who you really want to avoid the use of any kinds of coercive measures including seclusion and restraint because of the issues of retraumatization.

Trauma Assessment

- Trauma measurement tools increase diagnostic reliability
  - Post-Traumatic Diagnostic Scale for adults (*Foa et al.*, 1997)
  - Child PTSD Symptom Scale (*Foa et al.*, 2001)
  - Trauma Symptom Checklist for Children (*Briere*, 1995)
  - Child Stress Disorders Checklist, CSDC (*Saxe*, 2003)

38

These are just some trauma assessment tools that are valid and reliable. I'm not going to really go through those but I just wanted to make you aware that they are out there. The post traumatic diagnostic scale for adults; the child PTSD symptom scale; trauma symptom checklist for children and the child stress disorders checklist and all those are available usually through your psychology department if you decide you want to use one of those tools.

Trauma Assessment

- Continued follow-up, preferably with same provider/clinician is suggested, due to sensitivity of issue.
- Can be done with de-escalation preference survey.

(*Ibid*)

39

Trauma assessments require follow-up and preferably with the same clinician as originally or someone that has developed a relationship with the person served. These are not easy topics to discuss and for many it may be the first time anyone every asked the question.

Trauma Assessment

- Should minimally include:
  - **Type:** sexual, physical, emotional abuse or neglect, exposure to disaster
  - **Age:** when the abuse occurred
  - **Who:** perpetrated the abuse
  - Assessment of such symptoms as: dissociation, flashbacks, hyper-vigilance, numbness, self-injury, anxiety, depression, poor school performance, conduct problems, eating problems, etc. (*Ibid*)

(See resource manual for examples of trauma assessments)

40

In general, a trauma assessment should minimally include type of trauma, i.e. sexual, physical, emotional, neglect, exposure to disaster, exposure to terrorism. Age; when did the abuse occur. Who; perpetrated the abuse and the timeframe of that abuse. Was it repetitive; did it all end when they were 13; those kinds of issues that will start to paint a picture of the kind of traumatic experiences, as well as the traumatic sequelae, that a person your are trying to help is experiencing.

A clear assessment of symptoms such as dissociative experiences, flashbacks, hyper-vigilance, numbness, self-injury, anxiety, depression, poor school performance, conduct disorder problems, eating problems, etc are symptoms that you will want to look for. Often those commonly noted problems are masking trauma histories.

Trauma Assessment

- Results and "*positive responses*" must be addressed in treatment planning or assessment is useless.
- Interview is conducted upon intake or shortly after
- Importance of therapeutic engagement during interview cannot be over emphasized
- For children, assessment through play and behavior observations (*Ibid*)

41

Results and positive responses on the trauma assessment must be addressed in treatment planning. The interview should be attempted shortly after admission or very quickly thereafter. Sometimes when people come in they're a little too unstable to be able to sit down and go through this information but, in general, most people need to be approached very quickly upon admission for a lot of reasons. One is to manage your risk and manage their risk in terms of finding out who is at risk for seclusion and restraint or aggression or violence.

The importance of creating a therapeutic alliance during the trauma assessment interview cannot be overemphasized and again, you need to use your staff that are quite good at creating therapeutic relationships very quickly for service users.

Trauma Assessment

- Other MH factors to assess
  - History of S/R; involuntary IM medication experiences
  - Individual experiences in inpatient settings – fear, dissociation, anger, powerlessness
  - Homelessness, addiction, domestic violence
  - What happened when disclosed? More loss? Validation and protection?
  - Interest in working on a safety plan (see tools module)

42

Other factors to assess; the history of seclusion and restraint; history of being held down and medicated involuntarily. Individual experiences in inpatient settings; how did that person feel about being the last time they were in a setting. Did they experience fear? Did they disassociate? Were they angry? Did they feel helpless? Did they get aggressive? Sometimes we'll find that the service users that we're trying to help have been severely traumatized in our own system or someone else's system of care.

We also want to look at homelessness, addiction and domestic violence because obviously people with those kinds of life experiences show much higher rates of exposure to trauma. You will want to explore interest in working on a safety plan which you will learn about in the tools, the seclusion and restraint prevention tools module that goes hand in hand with developing a trauma assessment and implementing that piece. Safety planning is a first step toward assisting people to manage their own emotions and learn to self soothe.

Immediate Concerns that Require Intervention

- Continued trauma experiences including partner violence
- Lack of safety in home, community or treatment setting
- Understanding by staff re need to collaborate with/report to other agencies (child welfare, elder abuse, domestic violence)

43

Immediate concerns that require intervention by staff are situations where a consumer or service user reports continued traumatic experiences in the home environment. This will then indicate a lack of safety in the home or community or even the treatment setting; if the person in the home is abusing the individual that you're talking to. And the also important issue here is that staff clearly understand how best to handle those kind of situations; who are they to contact or communicate with and that they understand the laws and regulations, how to report this; and the need to collaborate with other agencies such as child welfare, elder abuse and domestic violence agencies.

Critical Components of CBT

- Cognitive Behavioral Therapy (CBT) in various forms is regarded as either "promising" or "evidenced based" for traumatized individuals
- Includes education and goal setting
- Coping skill development including recognition of triggers
- Termination and relapse prevention
- Booster sessions *(Hodas,* 2004*)*

44

Also trauma treatment includes education and goal setting. It also includes helping people learn new coping skill sets, including recognition of triggers; what sets them off. What causes them to feel bad and then what happens. This is where you'll start to have to learn to help the person how to interrupt their cycle where they get triggered, they shut down, they disassociate, they become violent, they become depressed, they self-mutilate and this is where we have to insert a new way of thinking and new coping behaviors so a person can start to manage those emotions in a more healthy, pro-social way.

And then termination of the actual treatment and relapse prevention. Those of you who work in substance abuse will recognize some of these clinical pathways. It's in some ways very similar but again, most of you will not be providing trauma treatment; you're really going to be focused on creating systems of care that are trauma informed and you'll be hiring or brining in consultants to provide actual trauma treatment.

Core Elements in Most Effective Treatment Programs

- Memory identification, processing and regulation
- Anxiety management
- Identification and alteration of maladaptive cognitions
- Interpersonal communication and social problem solving
- Direct intervention in the home/community
- Appropriate use of medication *(Hodas, 2004)*

45

In Summary

- Trauma is a significant issue in the people we serve
- Understand definitions (prevalence and effects)
- Know difference between systems that are trauma informed and those not
- Start with universal assessments that inform plan of care
- Link to other strategies in upcoming "Tools Module"

46

In summary, trauma is the significant issue in the people that we serve in mental health settings. We need to understand the definitions, prevalence, and the effects of trauma. We need to know the difference between systems of care that are trauma informed and those that are not and we need to be able to go back and look with open, objective eyes at our own facilities and take our own temperature, if you will.

When implementing trauma informed system of care, start with the universal trauma assessment and link this to an informed plan of care so that those two are tied together and then link to other strategies to give you direction. Much of these guidelines will be covered in the upcoming modules. Thank you very much.

47