

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

A Primary Prevention Tool



Created by Huckshorn, Stromberg, LeBel, 2004; Adapted Caldwell 2006



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: are intentional, prolonged, repeated, severe
- Occur in childhood and adolescence and may extend over an individual’s life span

(Terr, 1991; Giller, 1999)

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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)*

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

(Hodas, 2004)

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Trauma

- Trauma is under-reported and under-diagnosed *(NTAC, 2004)*
- Trauma symptoms can include inattention, disorganization, depression, problem eating behaviors and impulsivity

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Prevalence of Trauma Mental Health Population

- 90% of public mental health clients have been exposed *(Mueser et al, 2004; Mueser 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)*

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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

(Ibid)

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Prevalence of Trauma Children and Adolescents - Juvenile Justice Settings

- Being abused or neglected as a child increases the likelihood of arrest as juvenile by 59%
- Rates are up to 8 times higher than community samples of same-age peers
- PTSD prevalence data varies widely: 3%-50% in JJ settings
- 70% - 92% of incarcerated girls reported sexual, physical, or severe emotional abuse in childhood

(Widom, C.S., 1995)

(Saiigh et al, 1999; Saltzman et al, 2001)

(Arroyo, 2001; Garland et al, 2001; Teplin et al, 2002)

(DOC, 1998; Chesney & Shelden, 1992)

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Prevalence of Trauma Substance Abuse Population –

- Up to two-thirds of men and women in SA treatment report childhood abuse & neglect

(CSAT/SAMSHA, 2000)

- Study of male veterans in SA inpatient unit
 - 77% exposed to severe childhood trauma
 - 58% history of lifetime PTSD

(Triffleman et al, 1995)

- 50% of women in SA treatment have history of rape or incest

(Governor's Commission on Sexual and Domestic Violence, Commonwealth of Massachusetts, 2006)

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Prevalence of Trauma Correctional Settings

Some researchers describe a pathway in which exposure to violence and pervasive feelings of not being safe develop into a state of chronic threat requiring the youth/ adult to use physical aggression in order to manage

(Schwab-Stone et al, 1995)

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Incarcerated Women with Mental Health, Substance Abuse and Trauma Histories

- Correctional Institute for Women, Massachusetts
 - 90% receiving mental health services or substance abuse services have trauma histories

(Dedicated External Female Offender Review; Governor's Task Force, Commonwealth of Massachusetts, 2005)

- Correctional Institute for Women, Rhode Island
 - 40% - Childhood sexual abuse
 - 55% - Childhood physical abuse
 - 53% - Adult rape
 - 63% - Adult physical assault
 - 34% - Lifetime PTSD

(Zlotnick, 1997; Zlotnick, Najavits et al, 2003)

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Prevalence of Trauma MR/DD Population

- Risk of abuse increases by 78% due to exposure to the "disabilities service system" alone
- Increased vulnerability to abuse in institutional settings
- Sexual abuse incidents are 4 times as common in institutional settings as in community

(Sobsey & Doe, 1991)

(White, Holland, Marsland & Oakes, 2003)

(Blatt & Brown, 1986)*

*Citations from Charlton et al (2004)

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Prevalence of Trauma MR/DD Population

- Widely believed to be prevalent and under-reported due to:
 - Difficulty communicating the abuse has occurred
 - Difficulty being believed

(Charlton, Kliethermes, Tallant, Taverner, Tishelman, 2004; Beil & Warden, 1995)

- Estimates vary widely: 8% to 100%
(Beil & Warden, 1995; Ryan, 2000; Sobsey, 1994)
- People with developmental disabilities are exposed to trauma and abuse more frequently than other people
(Ryan, 2005; Sobsey, 1994; Blatt, 1970)

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Other Correlates: The Relationship of Childhood Trauma to Adult Health

- Adverse Childhood Events (ACES) have serious health consequences
- Adoption of health risk behaviors as coping mechanisms
 - eating disorders, smoking, substance abuse, self harm, sexual promiscuity
- Severe medical conditions: heart disease, pulmonary disease, liver disease, STDs, GYN cancer
- Early Death *(Felitti et al, 1998)*

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What does the prevalence data tell us?

- The majority of adults and children in psychiatric treatment settings have trauma histories
- A sizable percentage of people with substance abuse 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
- Growing body of research on the relationship between victimization and later offending

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Trauma and Diagnostic Issues

- People with trauma histories may have the following as primary or co-occurring disorders: PTSD, Borderline Personality Disorder, Schizophrenia, Depression and other affective disorders, Anxiety Disorders, Eating Disorders, Psychosis, Dissociative Disorders, Substance Abuse, Somatoform Disorders
- Need to be aware of the possibility of misdiagnosis

(Ford et al, 2004; Saxe et al, 2003; Felitti et al, 1998; Mueser et al, 2002)

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What does the prevalence data tell us?

- Children and adults in MR/DD settings are at particular risk
- Many people with trauma histories have overlapping problems with mental health, substance abuse, and are victims or perpetrators of crime
- **Victims of trauma are found across all systems of care**

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Implications

- **A majority of adults and children in inpatient and residential psychiatric treatment settings have trauma histories**
- There is considerable evidence that trauma and abuse are of urgent concern

(Cusack et al, 2004; Mueser et al, 1998; Lipschütz et al, 1999; NASMHPD, 1998)

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Universal Precautions as a Trauma Informed Concept

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

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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)

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Impacts of trauma over the lifespan

- Are neurological, biological, psychological and social in nature. They include:
 - 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)

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Traumatized Children: Observations and Experiences

- World is threatening and bewildering
- World is punitive, judgmental, humiliating and blaming
- Control is external, not internalized
- People are unpredictable and untrustworthy
- Defend themselves above all else
- Believe that admitting mistakes is worse than telling truth

(Hodas, 2004)

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Impact of Trauma on Child Development that Informs Adult Behavior

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 et al, 2003)

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J. Garbarino’s “lost boys” research

- Issues of shame are paramount, allowing child to “save face” important
- Violence can be seen as an attempt to achieve justice as child sees it
- These children cannot afford empathy as their needs are so great and overwhelming; tend to de-personalize others

(Hodas, 2004)

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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)

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TRAUMA INFORMED CARE

- Organizational Commitment/Trauma Policy/Philosophy
- Train/Supervise All Staff in Prevalence, Impact, Organizational Treatment Philosophy & Expected Interactions
- Universal, Reliable & Developmentally Appropriate Trauma Assessments

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What Happens when Traumatized Children 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)

(Wadson et al, 1976; Martinez, 1999; Mann et al, 1993; Ray et al, 1996)

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TRAUMA INFORMED CARE

- Using/Integrating Assessments to Identify Risk Factors Associated with Conflict & Violence
- Universal Individualized Safety Planning (integrated with other assessments and fully operationalized in program and in community)

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What Happens when Traumatized Children 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

(Wadson et al, 1976; Martinez, 1999; Mann et al, 1993; Mohr et al, 1998; Ray et al, 1996)

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TRAUMA INFORMED CARE

- Organizational Culture:
 - Physical Environments
 - Treatment & Support Environments Infused with Recovery & Resiliency Focus (e.g., Respect/Kindness/ Collaboration versus Control/Empowerment/Hope)
 - Individualized Approaches
 - Program Practices (e.g., Variety of Activities, Choice, Holistic Offerings)

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TRAUMA INFORMED CARE

- Sensory Modulation
 - Comfort/Sensory Rooms/Corners/Carts
 - A Range of Sensory Approaches
- Use of Trauma Specific Treatment Models

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Trauma Informed Care Systems Organizational Commitment

- 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)

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Trauma Informed Care Systems Organizational Commitment

- 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)

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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)

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Trauma Informed Care Systems Organizational Commitment

- Staff can access expert trauma consultation
- Staff can access trauma-specific treatment if indicated

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

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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 et al, 2003)*

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Trauma Assessments/Information

- Bessel van der Kolk:
<http://www.traumacenter.org/assessment.html>
- The Child Trauma Institute:
<http://www.childtrauma.com/ax.html>
- Child Trauma Academy (Bruce Perry):
<http://www.childtrauma.org>

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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)

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Trauma Assessment

- Continued follow-up, preferably with same provider/clinician is suggested, due to sensitivity of issue.
- Must be integrated with safety planning.

(Ibid)

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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)

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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)

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Immediate Concerns that Require Intervention

- Continued trauma experiences including domestic or partner violence
- Lack of safety in home, community or treatment setting
- Presence of other external stressors that create hypervigilance, anxiety (Hodas, 2004)
- Need to collaborate with/report to other agencies (child welfare, elder abuse, domestic violence)

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Trauma-Specific Treatment Models

Examples:

- **Sanctuary Model** *(Bloom, 2002)*
 - Applied to two inpatient services
 - Democratic, non-violent community environment
 - Safety, affect management, grieving, emancipation
 - Applicable to children, adolescents and adults

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Biggest Barrier: Transforming Organizational Culture

Operationalizing TIC by:

- Truly using strength-based approaches
- Moving from Control to Collaboration (e.g., level systems; consequence focus; rule enforcers; individual strategies, such as music/late bed time/late night food seen as reinforcers)

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Trauma-Specific Treatment Models

Examples:

- **Trauma Focused Cognitive Behavior Therapy** *(Cohen, Deblinger, Mannarino, & Steer, 2004)*
 - For children and non-offending parent
 - 12 sessions with joint sessions with parent
 - ✓ Stress management
 - ✓ Psychoeducation
 - ✓ Cognitive coping (Trauma Narrative)
 - ✓ Cognitive Processing
 - ✓ Behavior Management

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Trauma-Specific Treatment Models

Examples:

- **Seeking Safety** *(Najavits, 2003)*
 - Trauma treatment for adults and adolescents with substance abuse disorders
 - Coping skills focused on behavior, thinking, relationships
 - 25 skills areas including: compassion, asking for help, setting boundaries in relationships, grounding, self-care
 - Positive results in 4 outcome trials

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Trauma-Specific Treatment Models

Examples:

- **Trauma Systems Therapy (TST)** *(Saxe, Ellis, Kaplow, Grant, Tames, Boston University Medical Center, 2004)*
 - Two Overarching Themes:
 - ✓ Traumatized child has difficulty self-regulating
 - ✓ Social environment unable to help child regulate
 - Focus
 - ✓ Intervening in the environment itself: home or community based
 - ✓ Developmentally appropriate
 - ✓ Emotional regulation skills

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Trauma-Specific Treatment Models Examples:

- **Trauma Adaptive Recovery Group Education and Therapy** (Juvenile Justice) *(Ford, Chapman, Pearson, Hawke, Albert, University of Connecticut Health Center, 2005)*

SOS Skills (Gain Control of Brain's Alarm)

- Slow Down: One Thought/Feeling/Goal at-a-time
- Orient: Shift Attention to the Immediate Moment – Breathe, Notice your Body, Observe the Environment
- Self Check: Stress Thermometer (1-10), Personal Control Level (10-1), Personal Safety Plan (1-10)

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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)*

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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 *(Ibid)*
- Direct Intervention in the home/community *(Saxe et al., 2004)*
- Role of Medication *(Hodas, 2004)*

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TRAUMA INFORMED CARE

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"I have learned two lessons in my life: first, there are no sufficient literary, psychological, or historical answers to human tragedy, only moral ones. Second, just as despair can come to one another only from other human beings, hope, too, can be given to one only by other human beings."

Elie Wiesel
Author and Holocaust Survivor

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Contact Information

Beth Caldwell
Caldwell Management Associates
413-644-9319
bethcaldwell@mailcity.com

Kevin Huckshorn / Sarah Callahan
National Technical Assistance Center (NTAC)
NASMHPD
703-739-9333, ext 140 & 141
kevin.huckshorn@nasmhpd.org or
sarah.callahan@nasmhpd.org

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