

National Council

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Breaking the Silence Trauma-informed Behavioral Healthcare

We Must Do More

Linda Rosenberg

Breaking the Silence

Kathryn Power

The Invisible Suffering of War

Jason Schiffman

Culture Shock

Roger Fallot, Maxine Harris

Intentional and Informed Connections

Beth Filson, Shery Mead

PLUS

Trauma-informed Care from the Field

Stories of Change

Cover Art: Beth Filson "We Live Between the Clouds"



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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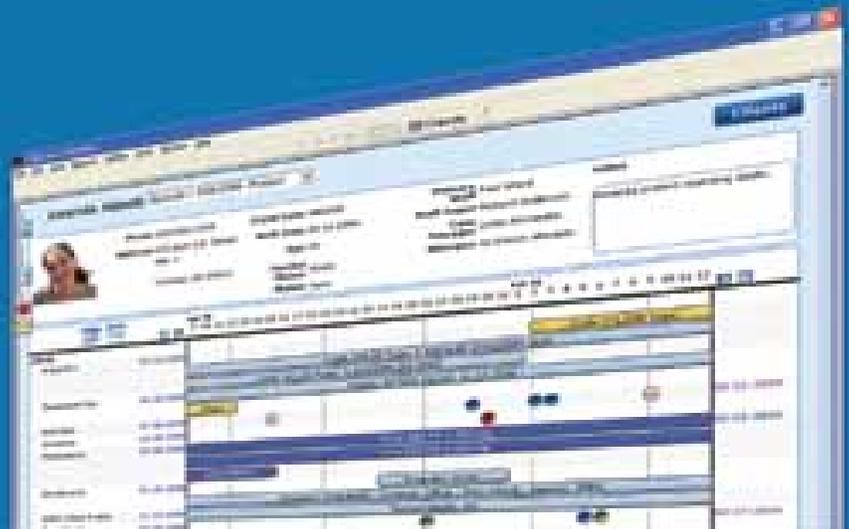
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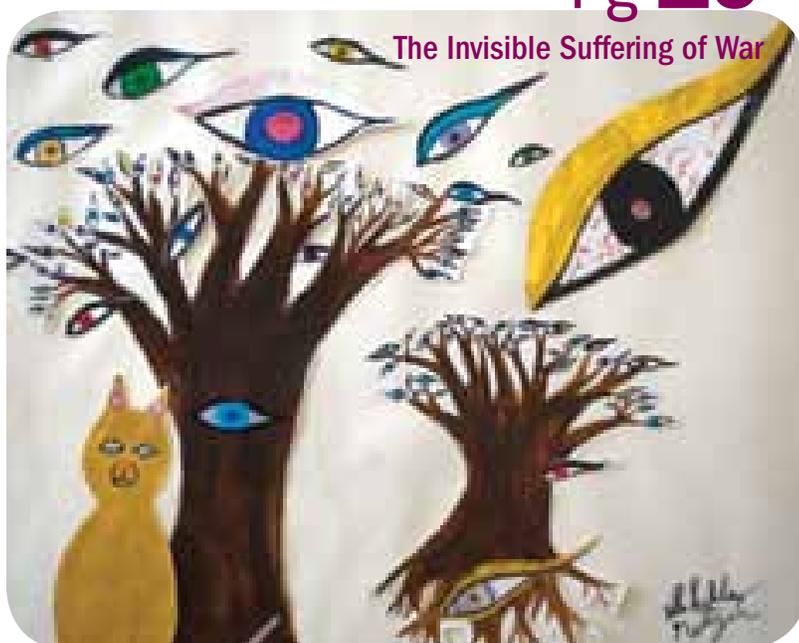
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Trauma-informed Behavioral Healthcare

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(look under About Us/National Council Magazine)



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Mike Drummond, CEO, Arundel Lodge Inc.

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Gayle Bluebird, RN, Peer Services Director, Delaware Psychiatric Center



To view and purchase the works of various consumer artists, visit

The Open Eye Gallery at
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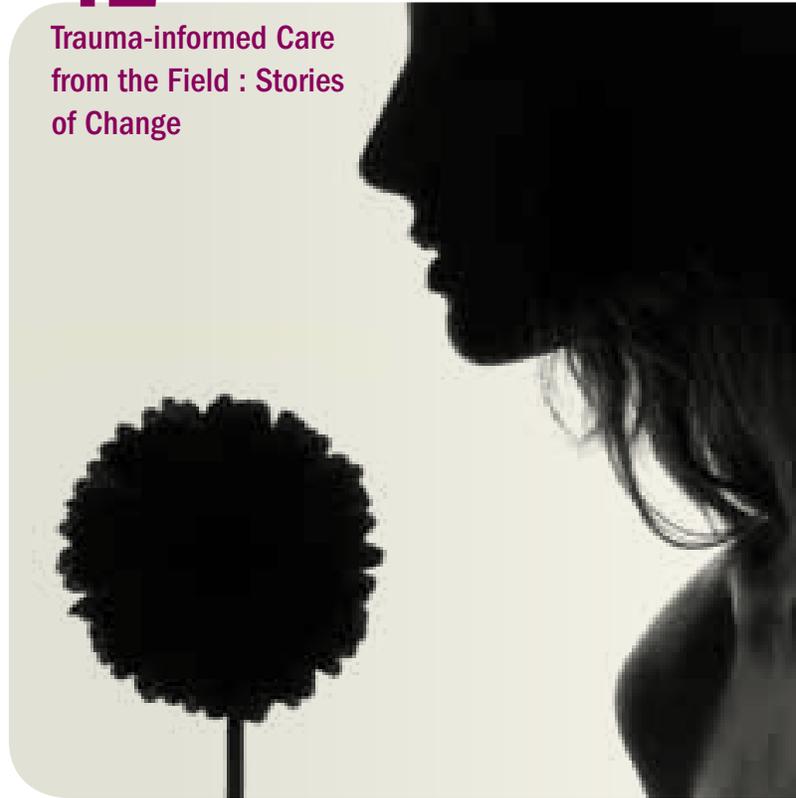
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WE MUST DO MORE

Linda Rosenberg, MSW, President and CEO, National Council for Community Behavioral Healthcare

Shelley Netzer "Masks"

"During every incarceration, every institutionalization, every court-ordered drug treatment program, it was always the same: I was always treated like a hopeless case. All people could see was the way I looked or the way I smelled. It wasn't until I finally entered a recovery-oriented, trauma-informed treatment program a little more than four years ago, where I felt safe and respected, that I could begin to heal...Someone finally asked me 'What happened to you?' instead of 'What's wrong with you?'"

Tonier Cain

Tonier Cain is a success story. Today, she is a team leader with SAMHSA's National Center for Trauma Informed Care. But for every Tonier Cain, there are hundreds of thousands of women and men who pass through our programs every day with painful histories of personal trauma – including sexual assault, domestic violence, child abuse and neglect, and witnessing interpersonal violence – that we all too often ignore. The good news is that people with behavioral health conditions and trauma histories can and do recover. But we can and must do more.

It is important that we shift our focus from asking the people who seek our help what is wrong with them to asking what happened to them. Our success in helping to improve their health, the health of our organizations, and the health of the nation depends on it.

WHY IS A FOCUS ON TRAUMA IMPORTANT?

First, we know that violence is pervasive. In the United States, a woman is beaten every 15 seconds; a forcible rape occurs every 6 minutes. Trauma is now considered to be a near universal experience

of individuals with behavioral health problems. According to the U.S. Department of Health and Human Services Office on Women's Health, from 55 to 99 percent of women in substance use treatment and from 85 to 95 percent of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood. More than 92 percent of women who are homeless have experienced severe physical and/or sexual abuse during their lifetime. Significant numbers of women in the criminal justice system report

neglect, or family dysfunction, and more than one of five reported three or more such experiences.

ACE researchers discovered that the greater the number of adverse experiences, the greater the risk for negative outcomes. These include alcoholism and alcohol abuse, depression, illicit drug use, risk for intimate partner violence, sexually transmitted diseases, suicide attempts, and unintended pregnancies. Heart disease, liver disease, and chronic obstructive pulmonary disease are also affected by adverse childhood experiences.



Someone finally asked me

'What happened to you?' instead of

'What's wrong with you?'

Tonier Cain

physical and sexual abuse, and national surveys suggest that as many as one-third of women veterans have experienced rape during their military service.

Second, we know the physical and psychological consequences of violence are highly disabling. The Adverse Childhood Experiences study, a general population study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente, is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and wellbeing (<http://www.cdc.gov/ace/>). Almost two-thirds of the study participants reported at least one adverse childhood experience of physical or sexual abuse, ne-

We can't begin to address the totality of an individual's healthcare, or focus on promoting health and preventing disease – both tenets of healthcare reform – unless we address the trauma that precipitates many chronic diseases. Nor can we begin to bring down the spiraling costs of healthcare. The ACE Study revealed that the economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at \$161 billion in 2000. The human costs are incalculable.

Third, we know that trauma is shrouded in secrecy and denial and is often ignored. Nobody wants to talk about interpersonal violence. Both women and men who have been physically or sexually assaulted



PRESS RELEASE

National Council Selects 21 Organizations to Participate in Trauma-informed Practices Learning Community

In June 2011, the National Council for Community Behavioral Healthcare (National Council) announced the 21 organizations chosen to participate in the first National Council Learning Community for Adoption of Trauma-Informed Practices. The learning community is a group of healthcare organizations committed to creating environments and services that address the needs of individuals who have experienced significant trauma. The learning community is supported by an award from the Substance Abuse and Mental Health Services Administration.

“We can’t begin to address the totality of an individual’s healthcare, or focus on promoting health and preventing disease unless we address trauma,” said National Council President and CEO Linda Rosenberg.

Trauma is pervasive – and now considered to be a near universal experience of individuals with behavioral health problems. According to the U.S. Department of Health and Human Services Office on Women’s Health, 55 to 99 percent of women in substance use treatment and from 85 to 95 percent of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood.

“Understanding what happened to us, not what is wrong with us, sometimes takes a lifetime” says learning community participant Gayle Bluebird of the Delaware Division of Substance Abuse and Mental Health. “Hopefully focus on trauma will allow us to talk about our histories and be understood so that we can move on and have meaningful lives.”

The 21 organizations participating in the National Council Learning Community for Adoption of Trauma-Informed Practices are:

- A New Leaf, Inc., Mesa, AZ
- Advantage Behavioral Health Systems, Athens, GA
- Beech Brook, Cleveland, OH
- Colorado Coalition for the Homeless, Denver, CO
- Congreso de Latinos Unidos, Philadelphia, PA
- Division of Substance Abuse and Mental Health Services (DSAMH)-State of Delaware, New Castle, DE
- Easter Seals Michigan, Auburn Hills, MI
- Family Health Centers, Inc. Phoenix Health Center, Louisville, KY
- Gateway Healthcare, Inc., Pawtucket, RI
- Hill Country Community MHMR Center, Kerrville, TX
- Lutheran Family Services of Nebraska, Inc, Omaha, NE
- Mental Health Services for Homeless Persons, Inc., Cleveland, OH
- On Our Own of St. Mary’s Inc. & Prince George’s County Wellness & Recovery Center, Leonardtown, MD
- Presbyterian Hospital, Charlotte, NC
- Refugee Services, Minnesota Council of Churches, Minneapolis, MN
- Region 3 Behavioral Health Services, Kearney, NE
- Salvation Army Haven, Los Angeles, CA
- San Diego Youth Services, San Diego, CA
- Santa Maria Hostel, Inc., Houston, TX
- Seminole Behavioral Healthcare, Fern Park, FL
- Truman Medical Centers, Kansas City, MO

are afraid to talk about their experiences for fear that they will be mislabeled, mistreated, or simply not believed. In some cases, their fears are well founded.

We don’t talk about trauma because often we aren’t prepared to hear it or address it. But when we don’t ask, we do harm. We may pathologize an abuse survivor’s coping mechanisms. Or worse, we may unintentionally recreate the abuse by the use of forced medication, seclusion, or restraints. We must offer trauma-informed services and supports.

WHAT DOES IT MEAN TO BE TRAUMA INFORMED?

There is emerging evidence that trauma treatment is effective. As part of SAMHSA’s Women, Co-occurring Disorders, and Violence study, several clinical approaches have been manualized and guidelines have been developed. These include the Trauma Recovery and Empowerment Model developed by National Council member Community Connections in Washington, DC, which has become one of the major trauma recovery interventions for women. A good resource for

learning about trauma-specific services is the report Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services. (www.theannainstitute.org/MDT2.pdf)

Trauma-specific interventions are one piece of the puzzle, but I am talking about something much broader. We must adopt a systemic approach which ensures that all people who come into contact with the behavioral health system will receive services that are sensitive to the impact of trauma. They must be able to receive such services regardless of which

“door” they enter or whether they ever find their way to a trauma-specific treatment program.

We can begin by recognizing the primacy of trauma as an overarching principle. Being trauma informed means realizing that the vast majority of people we come in contact have trauma histories. Trauma must be seen as the expectation, not the exception, in behavioral health treatment systems.

Trauma-informed care means that regardless of the reasons an individual comes to our door, clinical staff asks them about their trauma history. We must ask respectfully, and we must be prepared to listen.

In a trauma-informed system, services are designed to accommodate the needs of trauma survivors. Roger Falot, clinical psychologist and director of research and evaluation at Community Connections, tells us that trauma-informed services:

- » Incorporate knowledge about trauma in all aspects of service delivery.
- » Are hospitable and engaging for survivors.
- » Minimize revictimization.
- » Facilitate recovery.

As Roger and others have noted, in a trauma-informed human services system:

- » Repeated trauma is viewed as a core life event around which subsequent development organizes. Symptoms are understood not merely as complaints but as attempts to cope and survive.
- » Treatment for individuals who have been traumatized recognizes both their vulnerabilities and their strengths. By the very fact that the people we serve have experienced violence or the threat of violence and have come out on the other side, they are survivors, not victims.
- » Services for trauma survivors are based on the principles of safety, voice, and choice as defined by the people we serve. Our primary goals as helpers and healers must be the individual's empowerment and recovery. The consumer must be an active planner and participant in services. Peer support can be lifesaving.
- » Trauma services are ethnically, racially, and spirituality relevant to the individual and gender-specific. Cultural competence is more than the latest buzzword in our field. It is the best way to ensure that the people we serve receive treat-



Colin Lacey “Open Eyes”



ment that is meaningful to them.

- » Finally, trauma treatment is coordinated across multiple service systems. The problems engendered by violence cut across emergency services, mental health care, primary healthcare, substance abuse treatment, and domestic violence. But all too often trauma survivors cycle in and out of these various systems without ever receiving appropriate services. We can't let that continue.

HOW CAN NATIONAL COUNCIL MEMBERS DO MORE?

The Kent Center, a National Council member in Warwick, RI, has been working to increase awareness about the impact of trauma throughout Rhode Island. They are partners with the state in a SAMHSA grant to develop the Jail Diversion and Trauma Recovery Program, which aims to create trauma-informed criminal justice and behavioral health care systems.

Many of you are already far down the road in offering trauma-informed services and others are starting to think about how you step up. Here are some things you can do, beginning today, to make your services and systems more trauma informed:

- » **Engage leadership at the top.** You must have top-down recognition of the importance of trauma for it to become embedded in the system.
- » **Make trauma recovery consumer-driven.** The voice and participation of consumer/survivors should be at the core of all activities, from service development and delivery to evaluation.
- » **Emphasize early screening.** Make early screening for trauma, assessment of the impact of trauma, and referral for integrated trauma services common practice.

- » **Develop your workforce.** Create workforce orientation, training, support, competencies, and job standards related to trauma. Don't just train clinical staff – train and educate everyone who comes into contact with consumers, from the receptionist to the maintenance staff.

- » **Institute practice guidelines.** Centralize clinical practice guidelines for working with people with trauma histories. Develop rules, regulations, and standards to support access to evidence-based and emerging best practices in trauma treatment.

- » **Avoid recurrence.** Implement procedures to avoid retraumatization and reduce impacts of trauma.

HOW WILL THE NATIONAL COUNCIL SUPPORT YOU?

We believe we have much to contribute to leadership in the area of trauma-informed care and will work with you to raise awareness, educate our members and the general public, and, ultimately, improve client outcomes. As Kent Center president and CEO David Lauterbach points out, “Becoming trauma informed is an ongoing process. We are all in the process of becoming more trauma informed each day, if we work at it.”

Linda Rosenberg has more than 30 years of mental health policy and practice experience, focusing on the design, financing, and management of behavioral health services. Under Rosenberg's leadership since 2004, the National Council has more than doubled its membership; helped to secure the passage of the federal mental health and addiction parity law; expanded financing for integrated behavioral health/primary care services; and was instrumental in bringing behavioral health to the table in federal healthcare reform. Prior to joining the National Council, Rosenberg served as the Senior Deputy Commissioner for the New York State Office of Mental Health.

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BREAKING THE SILENCE

A. Kathryn Power, MEd, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

The year was 1975. Armed with a freshly minted Master's degree in counseling, I started work as victim services and volunteer coordinator at the Harrisburg Area Rape Crisis Center in Harrisburg, Pennsylvania. This was one of the first centers in the country to respond to the sexual assaults of women, men, and children as a public health issue and clinically significant traumatic event. Founded

on a philosophy that the act of sexual assault was a crime of power, these centers began to spring up all over the state and the nation. The rape crisis movement worked hard to change protocols in police stations, emergency rooms, and courtrooms, successfully passing rape shield laws and changing the language we used, replacing the word "victim" with "survivor." We called this work "advocacy," from the Latin *advocare* – to speak on behalf of another.

But perhaps the most important contribution of these courageous women, who came together to share their stories of victimization, pain, and betrayal, was their willingness to break their silence. Their stories were painful to listen to, but important to hear. They became self-advocates.

As I listened, I heard again and again that a woman's searing exposure to the raw trauma of physical or sexual assault put her overall emotional health at very high risk for both the short and long term. I heard how women learn not to trust their feelings or believe they are worth anyone's time or help. I heard that the power of traumatic life events to destabilize individuals had been systematically missed by the mental health field altogether. I heard the depths of their pain, but I also saw the tremendous heights to which they could soar. I was a witness to resilience, hope, and recovery. As one abuse survivor poignantly said, "even broken hearts can heal."

I have never forgotten those voices. For over 40 years, they have inspired me to work tirelessly to help open the nation's eyes to the impact of violence and trauma and the need to promote emotional wellness and recovery for every man, woman, and child who has been affected by traumatic events.

Trauma occurs when an external threat overwhelms a person's coping resources. Interpersonal violence – including physical and sexual assault such as rape, incest, battering, and murder – shatters trust and safety, fragments relationships, narrows hope, and impedes recovery. Untreated trauma that begins in childhood – which is often intentional, prolonged, and repeated – exerts a powerful impact on adult emotional health, physical health, and major causes of mortality in the United States.

Interpersonal violence is so common for women, regardless of cultural affiliation and socioeconomic class, that it has been described as a "normative" part of female experience in the United States today. It is widely accepted to be a near universal experience of individuals with mental and substance use disorders and those involved in the criminal justice system. Our children are witnesses to and victims of violence themselves. Military sexual trauma affects as many as one-third of our women in uniform. We cannot hope to rein in healthcare costs and improve healthcare quality if we don't attend to trauma and its consequences.

I began to do so as director of the Rhode Island Department of Mental Health, Retardation, and Hospitals by instituting screening for trauma across the behavioral health system and in my role as President of the National Association of State Mental Health Program Directors. In 1998, NASMHPD membership unanimously passed a policy statement about the presence and effects of trauma for individuals with mental and substance use conditions. The statement said in part, "It should be a matter of best practice to ask persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives."

We must have these conversations. The focus is not on what went wrong in the individual's life. The focus is on what allows them to bend rather than break in the face of life's adversities. This is the very definition of resilience. As Richard Mollica, MD, author of *Healing Invisible Wounds*, has written, "Ultimately, traumatized people heal themselves, and what's more, their experience can teach the rest of us how to deal with the tragedies of life."

For nearly 20 years, the Substance Abuse and Mental Health Services Administration, in the U.S. Department of Health and Human Services, has recognized the need to address trauma as a fundamental obligation for effective public mental health and substance abuse services delivery. Through demonstration projects, national conferences, and services grant programs focused on trauma,



Dawn Jackson
"Music Man"

Dawn J



When trauma survivors have the courage to speak about their fear, their isolation, and their pain, we must have the courage to listen. Together, we will be healed.



Christian McCarroll "Shower Room at Dachau"

SAMHSA is the leader in the development and dissemination of trauma-informed principles and practices. Technical assistance activities such as the National Center for Trauma-Informed Care and the National Child Traumatic Stress Initiative have provided tools for states and communities to promote recovery and healing for trauma survivors.

Since 1994, SAMHSA's Center for Mental Health Services has sponsored conferences that have helped shape the national agenda for women with mental and substance use conditions who are trauma survivors. The conference titles, Dare to Vision, Dare to Act, and Dare to Transform, speak to the evolution of our understanding and our goals for the future.

The first conference in 1994 focused attention on the fact that many individuals who sought our help were revictimized in the mental health, substance abuse, and criminal justice systems by the dangerous practices of forced medication, seclusion, and restraint. We are perpetrating violence ourselves when, in the words of a woman subjected to forced treatment, we "lock them up, shock them up, tie them up, or drug them up." Seclusion and restraint are not treatment options — they are treatment failures. They cannot co-exist with a recovery-oriented system. SAMHSA has been a leader in promoting the reduction and elimination of seclusion and restraint, helping psychiatric hospitals, emergency rooms, nursing homes, and schools understand how to promote an individual's ability to provide self-care to prevent the possibility of violence. The elimination of seclusion and restraint saves money and improves outcomes for individuals and staff working conditions.

In the past decade, a new understanding of the impact of trauma stemming from violence has begun to fundamentally alter the way services are delivered. In 1998, SAMHSA launched a five-year study on Women, Co-occurring Disorders, and Violence that highlighted the extent to which trauma can become the central organizing principle in a person's life, affecting her ability to form relationships, keep a job, or live in stable housing. This study made clear that many individuals previously labeled as "mentally ill," "substance abusers," or "criminals" were coping with the

results of severe trauma histories. This understanding helps us view much of what we once considered pathological — such as IV drug use or self-injury — as coping mechanisms that have allowed individuals to survive some of the most horrific experiences a person can endure. We now approach trauma as a public health issue that can be addressed by creating safe, stable, and nurturing environments for children, youth, and families; in fact, preventing abuse and trauma before they occur.

Based on what we know about the prevalence and impact of trauma in individuals' lives, any assistance we offer — in the community, in jails and prisons, and to our women and men in uniform — must be characterized both by trauma-specific diagnostic and treatment services, and by a trauma-informed environment capable of sustaining these services. In a trauma-informed environment, everyone — clinical staff, support staff, and service recipients — is educated about trauma and its consequences. Individuals and organizations are alert for ways to make their environments more healing and less retraumatizing for both staff and the individuals they serve.

No one organization or federal agency can do this work alone. The effects of trauma spill over into our hospitals, our jails, and our social welfare systems, and these organizations also must be part of a comprehensive solution. The Women and Trauma Federal Partners Committee is an outgrowth of the voluntary Federal Partners for Mental Health Transformation. It consists of representatives from more than 20 federal agencies and operating divisions. In April 2010, the committee held a Roundtable on Women and Trauma to begin a dialogue on the behavioral health impacts of trauma affecting women and girls and to develop recommendations for a comprehensive agenda for systems change, integration, and collaboration.

A collective momentum emerged from the meeting and agencies have followed up with concrete actions designed to promote trauma-informed services and systems. A second roundtable planned for December 2011 will focus on effective strategies for prevention and intervention as we implement trauma-informed approaches across the service spectrum.

As we go forward, our work is about bringing to scale the visibility, understanding, and response to trauma throughout the lifespan and across multiple experiences (e.g., maternal depression, combat exposure, etc.). Healing and integrated care must respect, honor, and validate survivors' experiences in a positive way. Above all, we must follow the wisdom of Winston Churchill, who reminded us, "Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen." I learned long ago that when trauma survivors have the courage to speak about their fear, their isolation, and their pain, we must have the courage to listen. Together, we will be healed.

A. Kathryn Power, M.Ed. is the director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration, an operating division of the U.S. Department of Health and Human Services. Prior to federal appointments, Power served for over 10 years as the as president of the National Association of State Mental Health Program Directors and director of the Rhode Island Department of Mental Health, Retardation and Hospitals. Power previously directed substance abuse prevention and policy programs including the Rhode Island Office of Substance Abuse, the Governor's Drug Policy Office, the Rhode Island Anti-Drug Coalition, and the Rhode Island Council of Community Mental Health Centers. Earlier professional experiences include teaching at elementary, secondary, and university levels; providing counseling, leadership, and advocacy for rape crisis and domestic violence service systems and agencies; and working as a computer systems analyst at the Department of Defense. Power is a graduate of the Toll Fellowship program of the Council of State Governments. She completed programs in senior executive leadership development, mental health leadership, and substance abuse leadership at the John F. Kennedy School of Government. Ms. Power is a retired Captain in the U.S. Navy Reserve.

Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014 Trauma & Justice (Initiative #2) Purpose

Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

“ACE”ing Trauma-informed Care

Jeannie Campbell, Executive Vice President, National Council for Community Behavioral Healthcare

WHAT IS THE ACE STUDY?

The ACE Study looks at the connection between adverse childhood experiences (ACEs) and later health, social, and behavioral outcomes. More than 17,000 study participants were recruited over a decade ago and ACE continues to provide important data to understand these relationships. Led by Robert F. Anda, MD, and Vincent J. Felitti, MD, with the Centers for Disease Control and Prevention and Kaiser Permanente, the ACE Study is perhaps the largest scientific research study of its kind involving the general population.

WHAT HOUSEHOLD CONDITIONS DID THE ACE STUDY EXAMINE?

Study participants were asked about experiences and conditions that occurred within their households prior to age 18. The study looked at 10 stressful or traumatic childhood experiences: recurrent physical abuse; recurrent emotional abuse; contact sexual abuse; a household member who abuses alcohol or drugs; an incarcerated household member; someone within the household who has chronic depression, a person in the household who has a mental illness, has been institutionalized, or is suicidal; mother who treated them violently; one or no parents; and emotional or physical neglect. The scoring method is quite simple. Exposure to one ACE qualifies as one point and the ACE score is the sum of these points. An ACE score of 0 means no exposure and a score of 10 means exposure to all categories of trauma.

WHAT OUTCOMES WERE ASSOCIATED WITH ADVERSE CHILDHOOD EXPERIENCES?

Investigators found that ACEs were common among all participants, even amongst those in higher socio-economic families. They found that as the ACE score increases, so does the risk of numerous health, social, and behavioral health problems throughout the lifespan. Almost two-thirds of ACE study participants reported at least one adverse childhood experience of physical or sexual abuse, neglect, or family dysfunction, and more than one of five reported three or more such experiences.

WHAT CAN BEHAVIORAL HEALTH ORGANIZATIONS LEARN FROM THE ACE STUDY?

Child abuse plays a causal role in most behavioral health problems. Additionally, Fink Read and colleagues found that “psychiatric patients subjected to childhood sexual and physical abuse have earlier first admissions and longer and more frequent hospitalizations, spend longer time in seclusion, receive more medication, are more likely to self-mutilate, have high symptom severity and are more likely to attempt suicide.”

Smoking, overeating, and alcohol and drug abuse are behaviors associated with premature death. These are also coping strategies that provide immediate relief from the emotional scars left by traumatic childhood experiences. Unfortunately, these experiences often go unnoticed for long periods, hidden beneath secrecy, shame, and social taboos.

Early exploration by health and behavioral health personnel is critical.

A renewed understanding, appreciation for, and willingness to improve outcomes can greatly enhance services and care across health, social, and behavioral health systems. There is a need to better understand and accept the strong causal relationship between traumatic stressors during childhood and adolescence and later health, social, and behavioral health problems such as alcoholism, suicide, depressive disorders, heart disease, cancer, and teen pregnancy.

A better appreciation for the impact of childhood stress on neurodevelopment is also needed as stressful and traumatic childhood experiences affect brain structure and function, as well as endocrine, immune, and other biologic functions that can lead to persistent harmful effects. With this knowledge and understanding of the health implications comes a responsibility to improve.

Continued on page 12

HEALTH AND SOCIAL RISKS ASSOCIATED WITH ACE	
Health Domains	Conditions Associated with ACEs
Medical Conditions	Heart, lung, liver diseases, cancers, sexually transmitted diseases, and skeletal fractures
Risk Factors for Common Disorders	Smoking, alcohol abuse, illicit drug use promiscuity, obesity, poor self-rated health, high perceived risk of AIDS
Behavioral Health	Depressive and anxiety disorders, PTSD, eating disorders, substance abuse, personality and dissociative disorders, hallucinations, suicide
Sexual and Reproductive Health	Early age at first intercourse, sexual dissatisfaction, teen pregnancy, unintended pregnancy, teen paternity, fetal death
General Health and Social Problems	High perceived stress, poor job performance, relationship problems, spouse with alcoholism



Finding Your ACE Score

This chart shows the sequence of events that unaddressed childhood abuse and other early traumatic experiences set in motion. Without intervention, adverse childhood events (ACEs) can result in long-term disease, disability, chronic social problems, and early death. 90% percent of public mental health clients have been exposed to multiple physical or sexual abuse traumas. Importantly, intergenerational transmission that perpetuates adverse childhood experiences will continue without implementation of interventions to interrupt the cycle. Multiple studies reveal the origin of many mental health disorders may be found in childhood trauma, including borderline personality disorder BPD, anti-social personality disorder, PTSD, schizophrenia, bipolar disorder, dissociative identity disorder, anxiety disorders, eating disorders (including severe obesity), attention deficit hyperactivity disorder, oppositional defiant disorder, and others.

Sources: Adverse Childhood Experiences Study (CDC and Kaiser Permanente, see www.ACEstudy.org) The Damaging Consequences of Violence and Trauma (see www.NASMHPD.org) and Trauma and Recovery (J Herman). Cost data: 2007 Economic Impact Study (PCAA). Chart created by Ann Jennings, PhD. www.TheAnnalInstitute.org Revision: Feb 2011

While you were growing up, during your first 18 years of life:			
1	Did a parent or other adult in the household often or very often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	Yes	No
	If yes enter 1		
2	Did a parent or other adult in the household often or very often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	Yes	No
	If yes enter 1		
3	Did an adult or person at least 5 years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	Yes	No
	If yes enter 1		
4	Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	Yes	No
	If yes enter 1		
5	Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No
	If yes enter 1		
6	Were your parents ever separated or divorced?	Yes	No
	If yes enter 1		
7	Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	Yes	No
	If yes enter 1		
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No
	If yes enter 1		
9	Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No
	If yes enter 1		
10	Did a household member go to prison?	Yes	No
	If yes enter 1		
Now add up your "Yes" answers: _____ This is your ACE Score.			

continued from page 10

WHAT CAN BEHAVIORAL HEALTH ORGANIZATIONS DO TO IMPROVE CARE?

ACE Study findings strongly suggest a shift in the paradigm of behavioral health and medical care from a focus solely on biological to a true biopsychosocial approach. All consumers of medical and behavioral health services should be asked early in the assessment process about childhood stressors and traumatic experiences, which, if necessary, must then be addressed through prevention or trauma-informed treatment and systems of care.

According to Roger Falot, PhD, “A trauma-informed service system or organization is one that thoroughly incorporates, in all aspects of service delivery and in all staff, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to put “safety first” and to avoid retraumatizing those who come seeking assistance. The culture of a trauma-informed organization is built on core values of safety, trustworthiness, choice, collaboration, and empowerment. When a program can say that its culture reflects each of these values in every contact, physical setting, relationship, and activity, and that this culture is evident in the experiences of staff as well as consumers, then the program’s culture is trauma-informed. This kind of environment is capable of supporting and sustaining the positive effects of “trauma-specific” services, which are designed to directly address sequelae of trauma.”

The National Council for Community Behavioral Healthcare, with support from SAMHSA, is taking a lead role in helping behavioral health organizations become trauma-informed. The creation of a trauma-informed care organization begins with a commitment by leadership to achieve the following:

- >> **Consumer Driven Services**—The organization employs consumers in active, integral roles throughout all organizational levels, including on policy and decision making groups. Consumers are involved in making informed decisions about their own care.
- >> **Early Screening and Comprehensive Assessment**—Procedures are in place and staff is trained to sensitively explore childhood and current traumatic experiences during intake and at other points during treatment.

Christian McCarroll “Madness of Butu-Butu- Daybreak of the Fine Artist”



Emotional scars left by traumatic childhood experiences often go unnoticed for long periods, hidden beneath secrecy, shame, and social taboos. Early exploration by health and behavioral health personnel is critical.”

- >> **Workforce Development**—All staff receive orientation and training on their role in creating and maintaining a trauma-informed care organization, and on building trusting relationships and creating a safe, healing environment.
- >> **Trauma Informed Practices**—The mission, values, and principles of trauma-informed care are applied to policies and procedures, orientation and training curricula, practice guidelines, the environment, and all other aspects of care.
- >> **Safe and Secure Environments**—The organization employs a system to continually assess and improve policies and procedures, environmental conditions, activities, social climate, documentation, and treatment practices that are inconsistent with a safe, secure, and supportive environment. Efforts are directed toward avoiding retraumatization and revictimization such as restraint and seclusion or other coercive acts.
- >> **Community Outreach and Partnership Building**—The organization assumes a leadership role in

reaching out to and educating others (e.g., family members, consumers, courts, police, primary care, residences, behavioral health and other agencies, the public) about the impact of trauma and how to promote trauma-informed care.

The National Council is committed to helping its members receive the information, education, tools, and resources needed to improve care for all those they serve.

To read ACE Study findings and articles, visit the CDC website at www.cdc.gov/ace.

Jeannie Campbell serves as the chief operating officer of the National Council for Community Behavioral Healthcare, leading the administrative and fiscal management of the organization as well as overseeing the member services, communications, public policy, and practice improvement functions. A veteran of the U.S. Navy, Campbell also leads the National Council's efforts to enhance trauma-informed behavioral healthcare and to improve care for our veterans. She orchestrates the annual National Council Conference, healthcare's largest and most reputed specialty conference.



Is Anyone Really Listening?

Beth Filson, CPS, MFA, Trauma-informed Peer Support Consultant, NCTIC/NASMHPD, National Center for Trauma Informed Care

As a leader in trauma-informed peer support, I recently conducted work in New England on trauma-informed care. Over a number of weeks, I interviewed a group of providers and people who self injure. Out of all these interviews, one woman in particular stood out to me. We sat across from each other in the small backyard of her housing complex. Her face was expressionless. Her manner was that of an observer more than a participant. Over an hour, she shared with me the horrors of early sexual violence in her life. She recounted her history as if from some great distance; it was as if there was a thick plate of scarred Plexiglas between us through which we could see each other but never really meet. I got the impression that she had recounted the same facts numerous times, and already knew that it would make no difference – this telling or not telling. She would return to an apartment. I would leave. Nothing would be different. Nothing satisfied, satiated, or changed.

It's like that – how weary we become of trying to tell someone, trying repeatedly to make someone listen. In desperation you come to know that the story doesn't matter, that somehow the telling, the talking, the trying to communicate is superfluous – unnecessary compared to tasks of daily living, coping, medication that will quiet even the desire to be heard.

I asked this woman: "Did anyone ever understand what happened to you?" "Yes." She had been hospitalized once in a private clinic specializing in treating trauma survivors. However, she lost her job, and, with it, her insurance. She was transferred to state facilities that did not incorporate understanding of trauma in service delivery; the thread between her past and present seemed to break. "I became a mental patient," she said. "I wasn't a trauma survivor anymore."

Personally, I was about 30 when I could not build a structure strong enough to lean against, or that could bear my regret; I could not turn off the grief machine. I could not anchor my body to the earth, my life to meaning. I skittered frightened on the street, and woke in terror, hearing someone calling my name so

Beth Filson "What Grief Becomes"



insistently that I finally roared, "What do you want?!" Silence. Constant silence. What I knew: there was reason for what was happening to me and that reason was far more integral to my distress than its obvious manifestations. If asked, I would have said, "The house is on fire and I must carry the heart out of the burning house now!"

That was not the doctor's opinion upon my admission to the psychiatric hospital. When observed out of context, who we are doesn't always make sense. Thinking of trauma-informed care in anthropological terms, the only way to comprehend a tribe is through the context of their own history, their own language, and their own meaning – not an outsider's. The medication I was prescribed formed a tight band around my chest, one that would not let me gasp, cry out, or even breathe. This was noted as progress in my chart. Indeed, I could no longer cry at all – though I had reason. These chemical restraints hurled me into a new frenzy of anguish. My refusal to continue the medication became the focus of all my relationships with care providers. Their interpretation? I chose to be miserable.

Care providers could not see my behavior as a

response to interventions that were not addressing my real need. The focus on compliance became the treatment goal – "patient will attend group three times a week" – and had nothing to do with why I was there in the first place, much less with why I might not want to go to group.

On one hand I was battling for identity, and on the other engaging in a frenzied attempt to create the perfect sequence of language that would at last explain it all, would serve as a kind of Rosetta Stone or key that revealed the truth, finally saying everything *just so* – and others would stop trying to out-shout me, saying "Oh. Oh, I see." Failing this, I turned on myself. Whether through self-injury, psychosis, dissociation, or suicide one must – one will – find a way to cope with the anguish inside. One must retreat. In hiding, one recreates the blueprint, figuring out where the doors go and where the windows are—finding some way out.

I remembered lying in restraints in a dark seclusion room a couple years after admission to that hospital thinking, "Is *this* what I meant?" There was and always had been a story that I must tell, a life I carried that needed sorting out. I needed to weave the chaos of events into something that could bear all of my regret, become greater than my grief, and hold me up, transforming "What happened Beth?" to "this is what happened, what meaning I made out of it, what self-hood means to me now, and what I will do with it all."

As the young woman stubbed out her last cigarette and looked up at me I thought, "None of us is ever really broken – it's the world that breaks."

Beth Filson is a nationally recognized trainer and curriculum developer in trauma-informed peer support and peer workforce development and certification since 2002. She is co-author of *Engaging Women Trauma Survivors in Peer Support—A Guidebook—a joint project of the Substance Abuse and Mental Health Services Administration and the National Center for Trauma-Informed Care*. Beth co-facilitates *Intentional Peer Support* and is also working with *The Transformation Center* and the *Massachusetts Department of Mental Health* to pilot trauma-informed guidelines for engaging men and women who use self-inflicted violence.

Shining the Light on Trauma-informed Care

National Association of State Mental Health Program Directors

The psychological effects of violence and trauma are pervasive and highly disabling, yet largely ignored. Responding to the behavioral healthcare needs of all trauma survivors across the lifespan is crucial to treatment and recovery and should be a priority of state mental health programs; the prevention of traumatic experiences is a fundamental value held by state mental health authorities. Toward this goal, it is important to implement trauma-informed systems and trauma-specific services in mental health systems and settings.



Shelley Netzer "Reflections"

State mental health authorities are committed to recognizing and responding to the needs of persons with mental illnesses and their families within a cultural and social context. Asking persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives, is becoming a standard of care.

The experience of violence and trauma can cause neurological damage and can result in serious negative consequences for an individual's health, mental health, self-esteem, potential for substance use, and involvement with the criminal justice system. Indeed, trauma survivors can be among the people least well served by the mental health system as they are sometimes referred to as "difficult to treat"—they often have co-occurring mental health and substance use disorders, can be suicidal or self-injuring, and are frequent users of emergency and inpatient services.

Trauma crosses service systems and requires specialized knowledge, staff training, and collaboration among policymakers, providers, and survivors. Study findings indicate that adults in psychiatric hospitals have experienced high rates of physical and/or sexual abuse, ranging from 43% to 81%. Studies have shown that up to two-thirds of men and women in substance abuse treatment suffer from posttraumatic stress disorder and acute stress disorder or symptoms, and up to 80% of incarcerated women are victims of abuse.

Children are particularly at risk: more than 3.9 million adolescents have been victims of serious physical violence and almost 9 million have witnessed an act of serious violence. Adverse childhood experiences are related to health risk behaviors and adult diseases, including heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Especially significant for behavioral healthcare service systems are findings from the National Child Traumatic Stress Network that have linked serious behavioral problems to the biological, neurological, and psychological effects of childhood violence and trauma. Early abuse is now believed to create a particular vulnerability to hyper-arousal, explosiveness, and depersonalization that results in ineffective coping strategies and difficult social relationships.

Confounding and complicating trauma's prevalence of in public mental health service recipients is the fact that mental health services themselves are of-

ten experienced as traumatic. The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment, rather than empowerment and choice, often cause unintentional re-traumatization in already vulnerable populations.

The President's New Freedom Commission Report *Achieving the Promise: Transforming Mental Healthcare In America* calls for the promise of community living for everyone and for the transformation of our mental health systems of care to meet shared goals that facilitate recovery and build resiliency. The implementation of systems of care that are trauma-informed is a cornerstone in building service systems that do not traumatize or re-traumatize service recipients or the staff that serve them. Recovery-based services are sensitive to trauma issues and are never coercive. The concept of universal precautions is quite valuable when identifying and implementing the principles and characteristics of trauma-informed systems of care to avoid traumatization and re-traumatization.

A NASMHPD-sponsored trauma experts meeting in 2003 developed a set of criteria for building a trauma-informed mental health system, and a number of state mental health authorities have begun to address these issues in the public mental health system. Trauma-informed prevention strategies adopted by states and service systems include reducing and eliminating the use of seclusion and restraint; using prevention tools such as trauma assessments safety planning, advance directives, and identifying violence or self-harm risk factors; workforce training and development, and the full inclusion of consumers and families in formal and informal roles.

Services for trauma survivors must be based on concepts, policies, and procedures that provide safety, voice, and choice, and — like all good care — must be individualized. Trauma services must focus first on an individual's physical and psychological safety; they must also be flexible, individualized, culturally



competent, promote respect and dignity, and based on best practices. The most effective approaches for supporting recovery from trauma are well-integrated behavioral health services that reflect the centrality of trauma in the lives and experiences of consumers.

NASMHPD is dedicated to better understanding trauma and violence's effects; implementing emerging culturally competent best practices in trauma treatment within the public mental health system; and considering the role of prevention and early intervention programs in decreasing the prevalence of trauma-related behavioral health problems. Its members, state mental health authorities, are committed to recognizing and responding to the needs of persons with mental illnesses and their families within a cultural and social context. Asking persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives is becoming a standard of care. NASMHPD has taken the lead in recognizing that some policies and practices in public and private mental health systems and hospitals, including seclusion and restraint, may unintentionally result in the re-victimization of trauma survivors, and therefore need to be changed (see sidebar).

NASMHPD is committed to working with states, consumers, and professionals to explore ways to improve services and supports for the public mental health service recipients, including trauma survivors, consistent with the President's New Freedom Commission Report's recommendations. These efforts may include, but are not limited to, developing and disseminating information and technical assistance on best practices; supporting research as recommended by the field; providing forums for national dialogues on trauma survivors; consistent advocacy in creating trauma-informed and recovery-based systems of care; including consumers and families in the planning, design, implementation, and monitoring of best and promising practices; and cooperating with other state and national organizations to develop treatment, prevention and education initiatives to address the issue of trauma.

The National Association of State Mental Health Program Directors (NASMHPD) represents the \$36.7 billion public mental health service delivery system serving 6.8 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association and is the only national association to represent state mental health commissioners/directors and their agencies. While NASMHPD's primary members are the commissioners/directors of the 55 state and territorial mental health departments, the NASMHPD structure also includes 5 divisions comprised of directors of special populations/services (Children, Youth & Families; Financing and Medicaid; Forensic; Legal; and Older Persons) as well as a Medical Directors Council.

NASMHPD on Seclusion and Restraint

Seclusion and restraint, including "chemical restraints," are *safety* interventions of last resort and *are not treatment* interventions. Violence-free and coercion-free mental health treatment environments can be accomplished using the "Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool" developed by the National Technical Assistance Center. Seclusion and restraint should never be used for the purposes of discipline, coercion, or staff convenience, or as a replacement for adequate levels of staff or active treatment.

The use of seclusion and restraint creates significant risks for all individuals involved. These risks include serious injury or death, re-traumatization of people who have a trauma history, and loss of dignity, and other psychological harm. In light of these potentially serious consequences, seclusion and restraint should be used only when there an imminent risk of danger to the individual or others exists and no other safe and effective intervention is possible.

NASMHPD aims to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel. This goal can best be achieved by: (1) early identification and assessment of individuals who may be at risk of receiving these interventions; (2) high quality, active treatment programs (e.g., peer-delivered services); (3) trained and competent staff who effectively employ individualized alternative strategies to prevent and defuse escalating situations; (4) policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures; and (5) effective quality assurance programs to ensure this goal is met and to provide a methodology for continuous quality improvement. These approaches help to maintain an environment and culture of caring that will minimize the need for the use of seclusion and restraint.

States should have a mechanism to report deaths and serious injuries related to seclusion and restraint, ensure that these incidents are investigated, and track patterns of seclusion and restraint use. NASMHPD also encourages facilities to conduct the following internal reviews: (1) quality assurance reviews to identify trends in seclusion and restraint use within the facility, improve the quality of care and patient outcomes, and help reduce the use of seclusion and restraint; (2) clinical reviews of individual cases in which these interventions are used; and (3) extensive root cause analyses in the event of a death or serious injury related to seclusion and restraint. To encourage frank and complete assessments and to ensure the individual's confidentiality, these internal reviews should be protected from disclosure.

NASMHPD is committed to achieving its goals of safely preventing, reducing, and ultimately eliminating the use of seclusion and restraint by: (1) encouraging the development of policies and facility guidelines on the use of seclusion and restraint; (2) continuing to involve consumers, families, treatment professionals, facility staff, and advocacy groups in collaborative efforts; (3) supporting technical assistance, staff training, and consumer/peer-delivered training and involvement to effectively improve and/or implement policies and guidelines; (4) promoting and facilitating research regarding seclusion and restraint; and (5) identifying and disseminating information on "best practices" and model programs. In addition, NASMHPD supports further review and clarification of developmental considerations (e.g., youthful and aging populations) that may impact clinical and policy issues related to these interventions.

Sine Qua Non for Public Health

Susan Salasin, Director, Trauma and Trauma-Informed Care Programs, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

In the late 1970s, the World Federation for Mental Health sponsored a scientific committee with a broad charter to determine whether the range of survivor responses to personal violence (e.g., war and captivity, civil violence, domestic violence, and sexual assault) could be understood best by developing a singular concept of generic posttraumatic response to violence, rather than using a series of “syndromes” such as “wartime captivity,” “rape trauma,” “combat veteran,” or other violence-specific descriptors representing distinct types of posttraumatic experiences. Representatives of government agencies, national and international associations, scholars, and activists from many countries served as committee members. They concluded that the concept of a generic posttraumatic response to violence fitted, in a summary fashion, the common types of personal violence. This generic response was termed the “traumatic stress syndrome”—the common psychological, emotional, physiological, and spiritual responses that occur in the wake of different types of personal violence.

The WFMH’s work built upon and was informed by the work of a contemporaneous American Psychiatric Association committee on traumatic stress that proposed the adoption of a formal psychiatric diagnosis encompassing a specified range of symptoms entitled “Post-Traumatic Stress Disorder.” In 1980, the American Psychiatric Association formalized this recommendation in the Diagnostic and Statistical Manual of Mental Disorders-III. The PTSD diagnosis provided a lens through which some of trauma’s main mental and physical aftereffects could be identified, treated, and studied more precisely. It also established a basis for third-party reimbursement of trauma treatment. While PTSD is not inclusive of the entire range of trauma’s effects, it does remain a central focal point for beginning discussions.

TRAUMA AS A PUBLIC HEALTH CHALLENGE

Since PTSD’s designation as a mental disorder, the experience of violence and trauma has been acknowledged as universal, pervasive, and potentially very damaging — both psychologically and developmentally — and is marked by shame, humiliation, and guilt. We have learned, given the numbers of

trauma survivors and their often debilitating post-traumatic responses, that this constitutes a public health challenge of the first magnitude. We have also learned that violence and trauma can be experienced, identified, interpreted, and healed in a variety of ways, and that even the language used to describe trauma varies between groups, and over the lifespan. The pressure of the public health challenge itself, and the increasing multiplicity of treatment and services available — though often under- or over-utilized — has stimulated an increasingly fine-tuned understanding of the range, intensity, and longevity of trauma’s effects, and of some of the possible elements and roads to recovery.

FIRST GENERATION APPROACHES TO TRAUMA HEALING AND RECOVERY

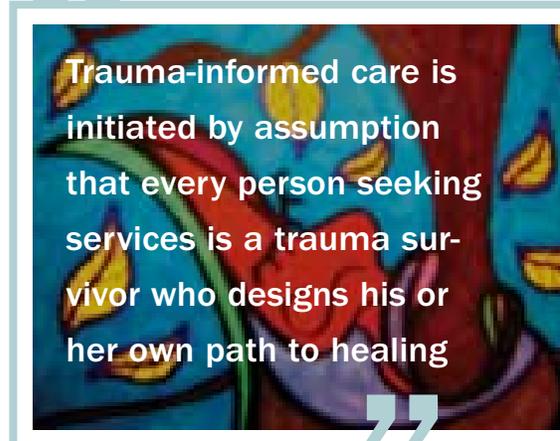
The first generation approaches to trauma healing and recovery focused on individual and clinical interventions to address PTSD symptoms and moved toward integration of trauma effects into ongoing life activities. The rapidly developing recognition of additional groups with violence and trauma histories — beyond those with war and captivity experiences (e.g., survivors of natural disasters and terrorism, refugees and immigrants fleeing homeland violence and persecution) — presented issues and needs that incited a second generation of approaches to trauma healing and recovery.

SECOND GENERATION APPROACHES TO TRAUMA HEALING AND RECOVERY

The second generation approaches focused on psychosocial education and empowerment models designed to tap into self-healing forces to energize personal and social movement. These approaches often are based on group and peer support models, and provide both support and education on the management of trauma and its affects. These approaches are not designed to be exclusive of clinical or alternative therapies; rather, they provide a social context for care.

Concurrent to the development of psychosocial educational empowerment approaches, we also learned that if the approaches are not implemented in organizations or programs that are trauma-

Sharon Wise



informed, they will not take root and may lose effectiveness.

TRAUMA-INFORMED CARE: A NEW PARADIGM FOR PUBLIC HEALTH SERVICES

Trauma-informed care is a new paradigm for organizing public mental health and human services. Trauma-informed care changes the opening question for those seeking services from “what is wrong with you?” (patient or consumer) to “what has happened to you?” (survivor). Trauma-informed care is initiated by assumption that every person seeking services is a trauma survivor who designs his or her own path to healing, facilitated by support and mentoring from the service provider.

In a trauma-informed environment, survivors are empowered to proactively set goals and to manage progress toward those goals. For most existing organizations or programs, that requires movement from a traditional “top down” hierarchical clinical model to a psychosocial empowerment partnership that embraces all possible tools and paths to healing. In a pluralistic public health system with many levels and types of services and treatment, this is coming to be accepted as a “sine qua non” or “without which not” for humane, dignified, cost-effective, and genuinely person-centered support and assistance in moving forward.

Susan Salasin is the Director, Trauma and Trauma-Informed Care Programs with Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services. For the past three decades, Susan Salasin served in federal government positions at the National Institute of Mental Health and at the CMHS at SAMHSA. CMHS program responsibilities currently involve the creation and implementation of initiatives to facilitate the development, implementation, and evaluation of trauma-informed systems and services for victims of violence and trauma.



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Virtual Veteran to Help Grad Students Learn

The computer simulation under development will be another tool for teaching students of military social work at USC how to interact with military personnel and identify the signs of post-traumatic stress disorder.

March 27, 2011 | By Alexandra Zavis, Times Staff Writer

Los Angeles Times

Petty Officer Sarax shifts in his seat as a therapist asks him about the wartime experiences that are causing strain with his wife.

"There are some things that I just don't want to talk about with her and she keeps pushing," he says. "...I lost a couple of friends over there. It was bad."

Sarax could be one of many veterans who are struggling to cope with the stress and trauma of war. But he is in fact a computer simulation.

Researchers at USC hope that virtual clients like Sarax will help social workers learn to interact with military personnel and identify the signs of post-traumatic stress disorder. It is one of the ways that the university's School of Social Work is harnessing technology to improve care for returning veterans and help head off a looming crisis. Since Sept. 11, 2001, more than 2 million U.S. troops have deployed to Iraq and Afghanistan. Nearly a third report symptoms of PTSD, severe depression or traumatic brain injury when they return, according to a 2008 study by Rand Corp.

"This, as everybody knows, exceeds the capacity of the existing institutions or the existing professional workforce" in both military and civilian settings, said Marilyn Flynn, dean of the USC School of Social Work.

The school was the first in the nation to offer a graduate specialization in military social work. The program, unveiled in 2008, is now available to students across the country through the school's new Virtual Academic Center. Schools of social work have tended to shy away from distance education because students need to learn clinical skills, said Vice Dean R. Paul Maiden. But, he said, technology now allows for live interaction between students and teachers.

For a recent class, assistant professor Dorian Traube emailed her students two cases involving abusive parents that were ripped from news headlines. She then logged onto the Virtual Academic Center's teaching platform from her office computer.

As students dialed in, their faces appeared in boxes on her screen like in the TV show "Hollywood Squares." Traube spoke to them using a headset and webcam, then moved them into break-out groups, where they practiced interviewing a client by acting out the cases.

Dana O'Dell, 39, who left the Army after suffering a spinal injury during the Persian Gulf War, joined the class from Fort Wayne, Ind. She is finding her sessions at the Virtual Academic Center even more engaging than ones at the brick-and-mortar institution where she obtained her bachelor's degree.

"All the distractions are gone," she said — and there is no hiding at the back of the classroom. Left untreated, war's invisible wounds can have far-reaching consequences. They can disrupt relationships with spouses and children and cause problems at work. Afflicted people are more likely to abuse drugs and alcohol, become homeless or attempt suicide.

The departments of Veterans Affairs and Defense have promised unprecedented amounts of mental health screening and counseling for returning veterans and their families. But they need more providers, particularly in remote locations. The Army says about 12% of its behavioral health posts — which include psychologists, psychiatrists, psychiatric nurses, social workers and others — are vacant. In the Navy, which also provides services for the Marine Corps, the figure is about 13%. The Air Force is at full strength in most fields, but needs psychologists.

The staffing shortages are aggravated by high burnout rates among providers who work with military personnel, Maiden said.

Brock McNabb, 34, who attends the Virtual Academic Center from Cupertino in the Bay Area, deployed twice to Iraq as an Army medic. During his second tour in 2006-07, the Army did not have enough mental health technicians, so he found himself working under a psychologist at Baghdad aid station.

"I didn't know anything about mental health," he said.

The three-member team was responsible for about 20,000 soldiers. They included men who had seen their buddies burn horribly to death in roadside bombings, and men who put out the fires and collected the remains.

"I was working 12- to 15-hour days, every day. There was no break," McNabb said. One day, it became too much.

"I remember, I had in mind: I'm going to blow my head off," he said. "I'm going to eat my 9-mm and lights out."

What saved him, he said, was habit. As on every other day, he walked back to his room at the end of his shift,

dropped his gun on a shelf near the door and collapsed onto his bed. He was lying there when he realized: "Oh, crap. I forgot to kill myself."

Too exhausted to get up again, he fell asleep. When he woke up, he said, the suicidal urge was gone.

Even when help is available, the providers are often unfamiliar with military culture or how to address combat-related issues such as PTSD, Maiden said.

One veteran abandoned counseling for a year after confiding in a therapist about the day his friend was killed by a rocket-propelled grenade, McNabb said. The therapist thought he was talking about a small car.

Social workers are often the first providers to interact with veterans like these and can get them the services they need, said Anthony Hassan, a retired Air Force officer who heads the USC school's Center for Innovation and Research on Veterans and Military Families.

His center is collaborating with the Institute for Creative Technologies at USC to develop virtual military clients like Sarax. Instructors can manipulate their uniform, rank, gender, ethnicity and responses, Hassan said. Prototypes are also being developed with voice recognition capabilities, so students can practice on their own, he said.

About 85 students are enrolled in the school's military social work specialization, which includes classes about PTSD and military culture. Others are taking the classes as electives. Later this year, the school plans to start offering a certificate course for experienced therapists who want to learn about working with the military community.

Hoping to draw more veterans and family members into the profession, the School of Social Work opened a campus in San Diego in 2009 and enlisted a former Marine master gunnery sergeant to help recruit students. The Virtual Academic Center, which opened in the fall, is accredited in 38 states, an advantage for military families who move frequently.

McNabb fits classes into a busy schedule doing outreach for the Department of Veterans Affairs. When he completes a master's degree in social work, he wants to continue working for the VA or go back into the military.

"There is such a huge need," he said. "With that MSW, I can go out and instill a lot of hope."



The Invisible Suffering of War

Jason Schiffman, MD, MA, MBA, Chief Medical Officer, Alorad, and Resident Physician, UCLA Department of Psychiatry and Biobehavioral Sciences

Mr. C. had been doing fine 20 minutes ago. In fact, we had just discussed how much he had improved since his admission and were planning for his discharge. He had been admitted to the 2 West AB psychiatric ward at the West Los Angeles VA two weeks ago after an unsuccessful suicide attempt via medication overdose, his third attempt since returning from Iraq a year and a half ago.

With some changes in his medications and a few family meetings with his parents and wife, his anxiety and hopelessness had come down quite a bit, and this morning the nursing staff had even noted he had been joking around with some of the other patients. Now I was being paged with a nursing report that Mr. C. had just had a seizure and was non-responsive.

I ran back to the ward and found him rigid on his bed, surrounded by nurses and staring blankly into the distance. He was a physically fit 25-year-old who had been a star football player in high school. His mother told me that before deployment, he had been an outgoing, happy kid who loved surfing and going to concerts with friends. That was not who he was anymore. Looking at him now, I could tell he hadn't suffered a seizure. If that was the case, it's likely he would have bitten his tongue or urinated on himself.

One of the nurses handed me a scrap of paper that read, "Blood Pressure: 160/98. Heart Rate: 106." This was good news. His heart was beating and his blood pressure was high enough to get blood to his brain. In fact, his pulse and blood pressure were abnormally high, making me wonder if this was the same thing he had described to me upon his admission as "panic attacks," during which he would feel that he was leaving his body and after which he would have no recollection of what had happened.

I moved closer to him and said his name loudly into his ear. No response. I pressed hard on one of his thumbnails (which is harmless but very painful). No response.

"What happened?" I asked one of the nurses. "He got into an argument with one of the other patients," the nurse replied, "and then all of a sudden, just fell to the floor and started shaking."

I looked back at Mr. C. The muscles of his arms and legs were twitching; his eyes were vacant. I thought about what the nurse had just told me — he was having an argument with another patient and then just fell to the floor. "What were they arguing about?" I asked the nurse.

"I'm not sure," he said, "but whatever it was, he was getting really angry. I was on my way over to break it up when he started having a seizure and fell down."

I was becoming more confident that Mr. C.'s "seizure" was psychiatric in nature and was, in fact, yet another unfortunate manifestation of posttraumatic stress disorder — the diagnosis that had transformed his once happy young life into the purgatory in which he now lived.

"My panic attacks happen when I get upset or angry," he had told me. "I don't remember anything about what I'm doing, but my wife says I start shaking and I won't answer her."

It turned out that what Mr. C. was calling "panic attacks" were actually dissociative episodes triggered by severe emotional stress. This explained the incident that had just taken place on the ward. Dissociation is a disruption of one's consciousness, memory, identity, or perception that can occur in a number of different psychiatric



Shelley Netzer "Idol and Eyes"

Most are unaware of the boundless human suffering of the veterans with PTSD walking among us. This is invisible suffering and it feeds the more distant, secondary consequences of war — divorce, alcoholism, homelessness, and suicides.

disorders. It can also be associated with motor abnormalities or paralysis, as was in Mr. C.'s case.

Some researchers have noticed similarities between this type of dissociative episode with paralysis in human beings and the phenomenon of *thanatosis* or "playing dead" seen in many animals. According to this view, dissociative states with muscular rigidity like the one Mr. C. had just experienced are the body's natural response to overwhelming threats that cannot be escaped.

What might seem puzzling is that Mr. C.'s dissociative episode had been triggered by what anyone else would consider to be a relatively minor stressor — a disagreement over the TV remote control. How could something so minor lead to such overwhelming stress that Mr. C.'s brain and body shut down? The problem was that for Mr. C. there was no such thing as minor disagreements anymore. He had PTSD, and like many other veterans with this condition, his brain and body had permanently entered the "fight or flight" state. In this state, the parts of the brain involved in the higher level processing necessary to distinguish the more subtle aspects of social situations become subordinate to the evolutionarily, older parts of the brain that view the world as either safe or dangerous.

At some point in the argument over the TV remote control, Mr. C.'s brain decided the situation had changed from safe to dangerous. The meaning of "dangerous" varies for each of us, depending upon our expectations of what bad things may happen, which in turn depends upon what bad things have happened in our past. For veterans with PTSD who, like Mr. C., have survived life-threatening situations and witnessed the death and dismemberment of their friends, "dangerous" can mean something horrific. To Mr. C., it meant something so horrific that he literally froze with fear.

After the administration of a tranquilizer, this young man began to return to his normal state and within another two days was well enough to go home. Before he left, he was given an outpatient follow up appointment, but like many patients with PTSD, he never showed up. The drive to avoid reminders of trauma is exceptionally strong in PTSD, and because starting treatment is a reminder, those who need treatment the most are often least likely to get it.

When speaking of the consequences of going to war, we tend to consider the visible tragedies — the deaths, physical injuries, and grief. Most are unaware of the boundless human suffering of the veterans with PTSD walking among us. This is invisible suffering and it feeds the more distant, secondary consequences of war — divorce, alcoholism, homelessness, and suicides — but the public does not connect these tragedies to the root cause. When I think of the soldiers and civilians in Iraq and Afghanistan today who will experience traumas that may change them forever, like Mr. C., I wonder how things might be different if their suffering were more visible.

Dr. Schiffman is a psychiatrist with the UCLA Anxiety Disorders Program and is the editor-in-chief and medical director of www.Anxiety.org. He is also the chief medical officer of Alorad, Inc. and the president of the healthcare brands division of that company. He is a graduate of the MD/MBA program at the University of Southern California where he specialized in health systems management and web-based healthcare delivery.

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Margaret O'Brien "Canyon Sundown"



Gayle Bluebird, RN, Peer Services Director,
Delaware Psychiatric Center

Art “therapy” is gone, self-directed expression is here. Creativity and the arts can lead us to the answers we seek, heal our wounds, and help transform us into the persons we want to be.

Art has become widely accepted for its power to heal and transform lives, as a means for peers to express themselves and tell their stories, and, increasingly for some, as a means of self-sufficiency.

Many peers with traumatic life experiences report the importance of art and creativity as integral to recovery. The arts can be broadly defined as any form of creative endeavor: writing, music, painting, dance, sculpture, storytelling, performance, and journaling. All of these activities can also serve as a conduit for expressing parts of ourselves we are unable to express in any other way. Art is a powerful healing tool to explore deep emotions, sorrows, inner and outer struggles, and joys. Art is a safe way for trauma survivors to express themselves without judgment or censor. Art is flourishing as it involves the discovery of things and self as if it were new. And alternative healing practices are also coming to be considered as artistic exploration.

Art offers us the ability to transform ourselves, to recover and heal, by awakening and freeing parts of ourselves from the effects of traumatic experiences and memories. Peers beginning their own artistic journey may reveal parts of themselves that they hadn't expected. Through artwork, people develop their own personal vocabularies for achieving a fuller identity. Images on paper, or words in poetry, reflect back at us — as mirrors of ourselves — providing new insights.

The audience is important, too. We are our first audience, self-critic, and self-analyst. We make deci-

sions whether to share our work with others. Some of us destroy our art, afraid of memories we have discovered or because we devalue our own self-expressions. Valuing our own art is another step in our healing. Letting ourselves speak, permitting ourselves to continue, and sharing our work with others are each separate, but equally important, challenges.

The consumer movement has done much to bring consumers out of isolation. It has allowed us to find each other in peer-run organizations such as drop-in centers, wellness centers, and in some states, peer-run arts programs. National conferences also offer a way for artistic exposure by sponsoring talent shows and art exhibits. These places and events have given us opportunities to meet each other and support one another. We discuss our art over cups of coffee, in support groups, and at workshops. We give each other confidence.

Many consumer artists have begun to earn a living from their art. Prominent among them is Jerome Lawrence who has painted a series of beautifully combined colors to present flowers and scenes of nature; he has received attention from Rosalynn Carter and now sells his works for substantial sums. Musician Mike Skinner writes songs about his recovery from childhood sexual abuse, attracting a large following. Meghan Caughey created a name for herself by producing contrasting artwork — some done while extremely depressed and then later as she was “coming out of the mud.” One of her works,

“Strip Searched on the Inpatient Unit,” was inspired by reading Pema Chodrin who said that we should “take full measure of joy in juicy, spicy, and brilliant craziness and confusion.”

Art is leading the way for an immense culture change in mental health settings. Physical environments are changing, and comfort rooms are being created; paintings on walls are done by clients and credited by the use of their full names. Art “therapy” is gone, self-directed expression is here. Creativity and the arts can lead us to the answers we seek, heal our wounds, and help transform us into the persons we want to be.

Enjoying the process of creating is a perfect antidote to unpleasant symptoms and memories. When we engage in a personal creative effort we do not have time to ruminate or reminisce; we are just there.

*Gayle Bluebird, RN, has been active in the consumer/survivor movement since the early 1970s. She works at the Delaware Psychiatric Center as Peer Services Director. She has produced and edited the technical report/guidebook *Paving New Ground: Peers Working in Inpatient Settings* and the accompanying DVD, *A Dialogue with Peers and Family Members*. She also produced a video for SAMHSA titled, *Leaving the Door Open: Alternatives to Seclusion and Restraint*. In addition, Bluebird often speaks at national conferences on subjects of the arts and developing peer roles in inpatient settings. She is the co-coordinator of *Altered States of the Arts*, a national network of artists, writers and performers. In 2010, she received one of the prestigious VOICE Awards honoring consumers who have made contributions toward positive change in the mental health system.*



When I Dream, I Dream in Color

Sharon D. Wise

My name is Sharon Denise Wise, but my family called me Angel. I was diagnosed with a mental illness at a very young age.

As a little girl, I was resilient and creative. I knew early on that there was something in my artwork that made people feel both happy and sad at the same time. I would draw pictures in an attempt to share with the rest of the world what my world looked like.

The abuse I experience led to terrible, vivid black and white dreams that I translated into art in the daytime. It appeared my artwork was trying to tell me something. Art was something I ran to for help adapting to the pain of abuse, violence, and neglect I experienced in my home and community.

The visual and performing arts were outlets I used so that I would not harm myself. When I would get locked up, I'd volunteer in the arts and craft program. Although I was not physically, mentally, or spiritually strong, creating and assisting others in creating colorful images gave me a sense of peace and hope. Touching the paint grounded me and helped me feel connected to something that was coming out of my own soul.

Once I began to heal and recover, my art went from black and white to vibrant colors. Everyone responds differently to what they see in my artwork. Some think it's beautiful, and some weep as they try to understand what happened to me.

The performing and visual arts saved my life. My

Sharon D. Wise



vibrant colored self-portraits illustrate my traumatic experiences and journey. I also use the butterfly to tell my story, coming on stage draped in a cocoon, struggling to break free from the confines. When I come out of the cocoon, I spread my wings and become a beautiful butterfly. My love for the arts has helped me recover and survive on my journey to peace.

Greater than My Diagnosis

Based on an exclusive interview for
National Council Magazine with Beth Filson

Beth Filson "I am the Dreamer"



Trauma can render you speechless. "It's an experience so huge, that it is often unspeakable — at the very least in how it is felt by the body and mind. Often, we simply do not have the words for it," says Beth Filson, a Massachusetts artist, writer, and trainer in trauma-informed peer support. After her typewriter was whisked away during her first hospitalization (because it was electric), Beth used what was available — some butcher block paper and chalk pastels.

"Art allowed me to hold on to myself, who I knew I was and what I knew my story to be," she says, "during a time when the focus on psychiatric labeling threatened to replace my sense of self. Art was how I survived." Trauma often gives rise to a loss of autonomy and imposed coercion; Beth adds, "There is no vocabulary that can talk about that. So art became the language I used to speak the truth of my experience." Not to dissect its representation of the past or its meaning — for Beth, art is not a tool. It's not healing. It's self preservation.

Beth was excited to see the trees, the rivers, and the mountains again, after she moved back to the East Coast. A huge flock of Canadian geese flying overhead stirred deeply intense feelings. Unable to assign any words or language that would accurately and completely capture her sense of coming home, Beth created an etching. "I felt profoundly at peace because the etching said what I could not put into words," she says. Art is not always about the darkness. It's about the mystery, too. Art is one of many avenues that can be used to explore different ways of expression.

"It's necessary for each of us to be alone in some form or fashion — art of any kind demands its time. Sadly, in mental health, this need for aloneness is too quickly pathologized," Beth explains. As others took an interest in what Beth was doing, art allowed her to participate in a very different way in her community. "As my etchings got attention, my community began to see me as something greater than a mental health diagnosis. Art is what we do as a society and a community. It's there to be witnessed," adds Beth. Years later, art has become a whole lot of other things. But the simplest tool stroke on clay board continues to speak volumes when mere words fail to capture the largeness of Beth's experience in the world.

"Healing is to come to know some completeness, some wholeness. That is what completing an etching is for me. Art is my wholeness," Beth explains. "Art is about maintaining and experimenting with healing, and figuring out more about my capacity for experiencing the world. There are some of us who create art as a means of survival that serves no other purpose. It's an assertion of identity.



When Disaster Disrupts

Linda Ligenza, Trauma-informed Care Consultant, National Council for Community Behavioral Healthcare

It was 5:41 pm on a Sunday evening when the residents of Joplin, Missouri heard the familiar tornado warning siren — a sound they had come to ignore because of so many false alarms. With only 20 minutes before it hit, and with most people at home at that time, residents crowded into bathtubs, children tucked under their parents. They were completely unprepared for the 200 mph winds that would destroy an area 12 by 3 miles wide in just seconds. 158 people died. Houses, schools, a hospital, senior housing, group homes for the disabled, stores, and restaurants were destroyed. The stories of loss were tragic and horrifying. A high school student sat next to his dad as they drove home from his graduation ceremony and the tornado ripped him out of the vehicle through the closed sunroof, while his father struggled to hold on to his foot — his body wasn't recovered for a week.

According to Dr. Fran Norris of the National Center for Post-Traumatic Stress Disorder, a disaster is defined as “a sudden event that has the potential to terrify, horrify, or engender substantial losses for many people simultaneously.”

The stress and grief that follow disaster trauma are normal reactions to an abnormal event— it's important for clinicians to understand this while assessing and working with disaster survivors. Typically, a period of shock and disbelief may last longer in catastrophic events like the Joplin tornado, and a myriad reactions may follow — sadness, anger, disillusionment with the pace of rebuilding, and finally recovery.

It is important not to pathologize, but to educate, empower, and teach skills to disaster survivors. Another important factor to keep in mind is that most survivors will not seek treatment. These individuals are not typical consumers of mental health services and are often independent and used to taking care of themselves. This is why outreach approaches immediately following a disaster are critical to successful response and recovery efforts. Disaster literature and expert consensus guidelines teach that there are five key elements helpful in any response: safety, a sense of calm, self-advocacy, connecting to others, and hope.

Typical reactions fall into four categories: emotional (e.g., fear, anger, worry, sadness, grief); physical (e.g., headaches, stomachaches, fatigue);



It is important to remember that most people will not develop PTSD after a disaster or traumatic event, though many may experience symptoms of stress and some may have symptoms of distress.

behavioral (e.g., crying, increased substance use, agitation); and cognitive (e.g., forgetfulness, confusion).

The closer an individual is to an event's epicenter, the more severe the impact. The injured, families of the deceased or injured, those with pre-existing trauma, and first responders are most at risk for adverse reactions.

Immediately following a disaster, survivors' most important needs include being in a safe place, feeling calm, and having their basic needs met. Therefore, providing practical assistance is essential. Having the resources to begin rebuilding one's life is also central to recovery; clinicians must know the community's available resources (e.g., FEMA Disaster Recovery Services, Lutheran Social Services, American Red Cross) so appropriate connections can be made.

Psychological First Aid was developed to replace group "debriefing" models due to its lack of effectiveness with the general population. Typically, PFA is used in the early days and weeks after a disaster. These interventions keep many from needing mental health services.

People affected by disasters will most likely require a mental health evaluation and treatment when their reactions or symptoms signal distress, which can be identified by such signs as inability to carry out daily functions; trouble with relationships, prolonged mourning of losses, diminished ability to cope or problem solve, isolating behaviors, hopelessness,

health problems, and uncertainty about the future. In children, one may see regression to earlier developmental stages, poor school performance, isolation, 'acting out' behavior, and physical complaints. Clinicians can help parents by teaching them how to talk with their children about the disaster. It is important to remember that most people will not develop PTSD after a disaster or traumatic event, though many may experience symptoms of stress and some may have symptoms of distress.

Following several catastrophic events, SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch of the Center for Mental Health Services worked closely with researchers from the National Center for PTSD and the National Child Traumatic Stress Network to develop a set of evidence-informed interventions that could be used during the recovery phase to promote resilience. This model, which utilizes cognitive behavioral approaches, is called Skills for Psychological Recovery.

SKILLS FOR PSYCHOLOGICAL RECOVERY

Clinicians should engage, empower, and educate survivors to do the following:

Problem-solve

Plan more positive and meaningful activities

Manage stress and reactions to the disaster

Engage in more helpful thinking

Build healthy social connections

For those who continue to feel distressed and do not respond to these interventions, cognitive behavioral therapy or other modalities may be indicated to treat PTSD, anxiety, or depressive disorders.

Self-care is also an important component of trauma work. Clinicians and others working with trauma survivors are at risk for developing "secondary traumatic stress," experiencing symptoms of trauma such as anxiety, guilt, and stress as a direct result of working

with survivors. This is also referred to as "compassion fatigue" and "vicarious traumatization." To prevent these symptoms, clinicians should follow a self-care plan that includes connecting with support systems, such as co-workers, family, friends, and maintaining a healthy lifestyle that includes eating and sleeping well, getting regular exercise, avoiding alcohol and other harmful substances, engaging in pleasurable activities, and not working excessive hours.

Joplin residents continue to recover from this tremendous tragedy, and local professionals, paraprofessionals, and nonprofessionals continue to provide crisis counseling services to individuals and their communities – and receive support to do so through programs such as the FEMA Crisis Counseling Assistance and Training Program. These individuals demonstrate the enthusiasm, skills, and hearts necessary to effectively reach out to residents and help them recover from such a devastating event.

Important Disaster Trauma Resources include:

- >> SAMHSA Tip Sheets: www.samhsa.gov
- >> SAMHSA Disaster Technical Assistance Center: www.samhsa.gov/dtac/resources.asp
- >> Federal Emergency Management Agency: www.fema.gov
- >> National Center for Post-Traumatic Stress Disorder: www.ptsd.va.gov/public/pages/fslist-natural-disasters.asp
- >> National Child Traumatic Stress Network: www.nctsn.org

Linda Ligenza is a licensed clinical social worker who has worked in behavioral health for more than 30 years. Her 20-year tenure at the New York State Office of Mental Health included service as coordinator of NYC mental health response for families affected by 9/11. She worked for SAMHSA's Traumatic Stress Services Branch as the disaster trauma special expert and team lead for the Crisis Counseling Program, a national program funded by FEMA and monitored by SAMHSA to promote resiliency and recovery in disaster survivors. Ligenza worked closely with FEMA officials and other federal agencies, provided expert testimony to legislators, and was an advisor to SAMHSA Administrator, US Surgeon General, and HHS Secretary on issues related to the Gulf Coast Oil Spill. In September 2010, she left federal service to become an independent consultant, trainer, and part-time psychotherapist.

PSYCHOLOGICAL FIRST AID CORE COMPONENTS

Contact and safety

Safety and comfort

Stabilization

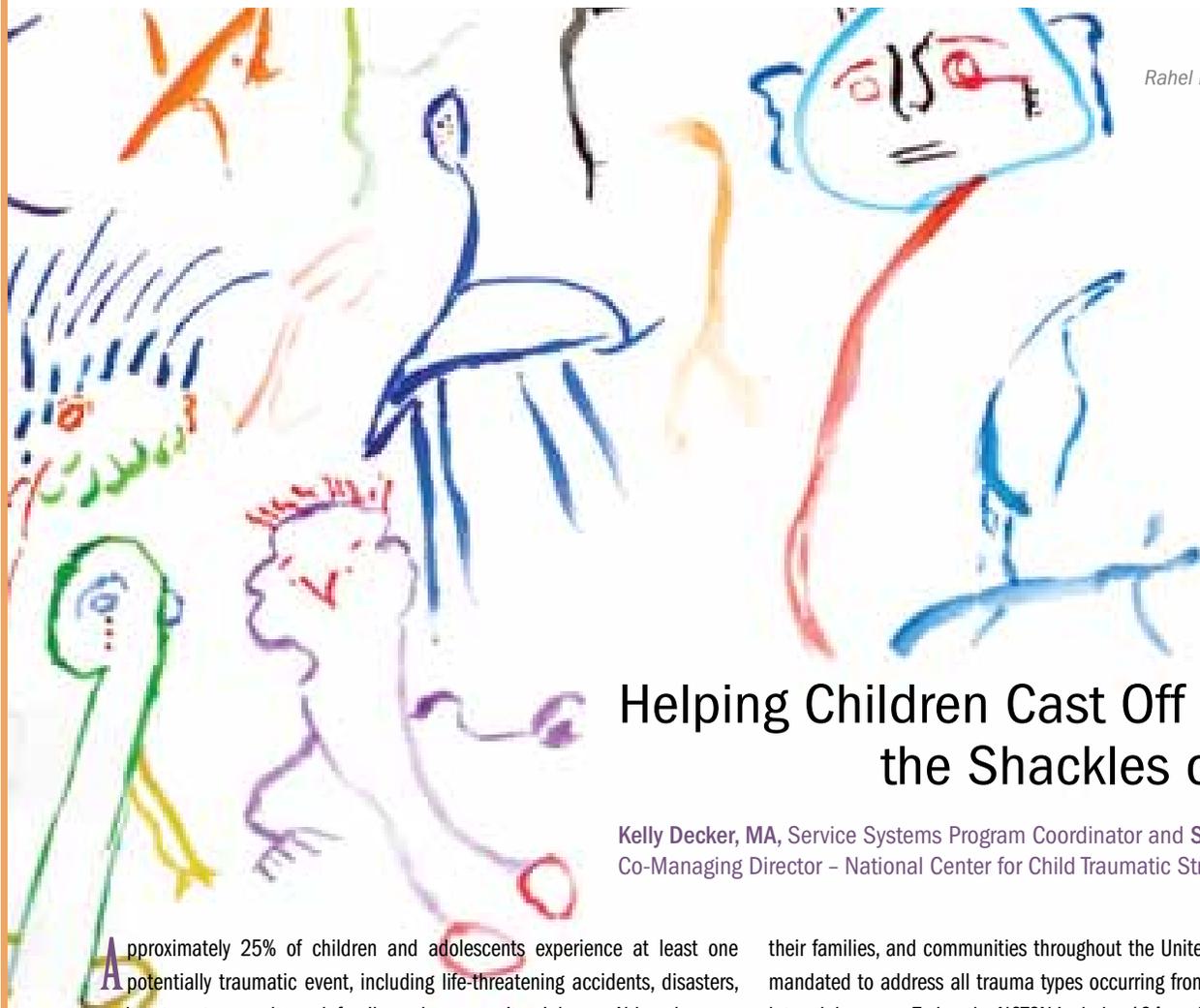
Information gathering re needs and current concerns

Practical assistance

Connection with social supports

Information on coping

Linkage with local services



Rahel Polgreen "Imagination II"

Helping Children Cast Off the Shackles of Trauma

Kelly Decker, MA, Service Systems Program Coordinator and Susan Ko, PhD, Co-Managing Director – National Center for Child Traumatic Stress

Approximately 25% of children and adolescents experience at least one potentially traumatic event, including life-threatening accidents, disasters, maltreatment, assault, and family and community violence. Although some may recover quickly after traumatic events, others experience disruptions in psychobiological, academic, and social development, with profound long-term consequences.

Traumatic stress is also associated with increased use of medical, mental health, and other child-serving systems, such as primary care and schools, where children are most likely to access mental health services. Three-fourths of children under age 12 see pediatricians at least once per year, whereas only 4% see mental health professionals. Similarly, a longitudinal study of children found that the education system most often provides mental health services.

Child-serving agencies (i.e., healthcare, mental health, education, child welfare, first responders, and juvenile justice) are charged with providing a safe and healthy environment for children and adolescents. However, while many youth enter these systems with significant psychological trauma, historically there has been no systematic approach to developing evidence-based services to address the impact of trauma on these youth.

In recognition of the immense and systemic needs of children and families exposed to trauma, in 2001 the Substance Abuse and Mental Health Services Administration funded the National Child Traumatic Stress Network with the explicit mission to use state-of-the-art, empirically-supported strategies to raise the standard of care and improve access to services for traumatized children,

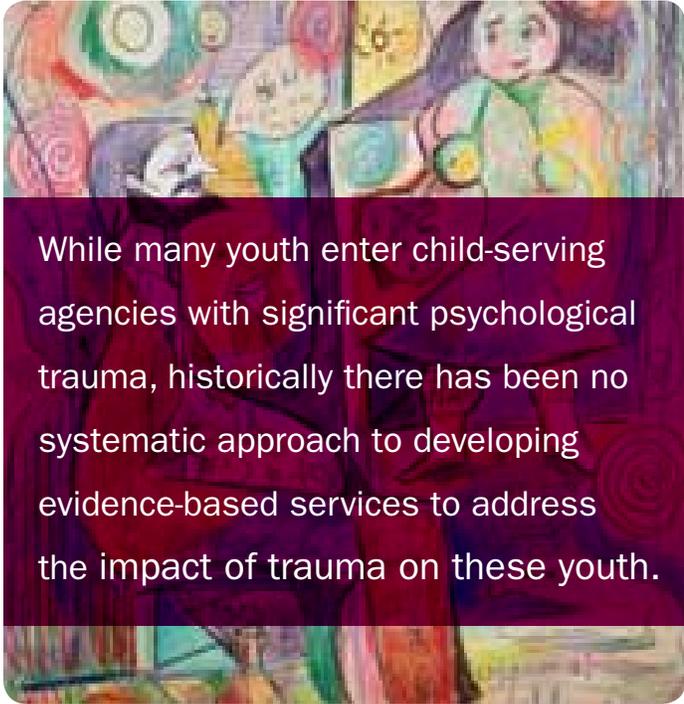
their families, and communities throughout the United States. The NCTSN was mandated to address all trauma types occurring from early childhood through late adolescence. Today, the NCTSN includes 134 medical universities, academic-based research facilities, and community service agencies that share the visions of creating trauma-informed systems nationwide, as well as providing all youth ready access to effective trauma-informed screening, assessment, intervention, and clinical support services.

CREATING TRAUMA-INFORMED SYSTEMS

Creating trauma-informed child-serving systems is one of the most important ways the NCTSN serves SAMHSA's mandate. In schools, child welfare agencies, community mental health clinics, hospitals, juvenile residences, and dependency and delinquency courts, the NCTSN has increased awareness of the impact of child traumatic stress, provided education and training, and developed resources to enhance the knowledge and skills of behavioral health staff.

Child-serving systems approach trauma differently, have different levels of knowledge and skills, vary in appreciation of trauma-informed care, and may have alternative criteria for meeting children's needs. As the goal of systems is to maintain excellent standards of care and improve outcomes for children, they must address the impact of traumatic stress.

Creating and sustaining trauma-informed systems requires a knowledgeable, committed, and skilled workforce. However, some service systems are neither ready to train their clinicians in trauma-informed, evidence-based interventions, nor certain how such training is relevant for all staff. The NCTSN addresses



While many youth enter child-serving agencies with significant psychological trauma, historically there has been no systematic approach to developing evidence-based services to address the impact of trauma on these youth.

Colin Lacey "Abstract Cartoon"

such concerns with system administrators, assisting in facilitating trauma-informed organizational change.

RECOMMENDATIONS FOR CREATING TRAUMA-INFORMED SYSTEMS

- >> **Look for opportunities to integrate trauma-focused practices throughout behavioral health and other service sectors.** Practitioners find that such efforts may address common service-sector concerns such as accurate risk detection and case identification; triage of clients to appropriate interventions; continuity of care among providers; and facilitation of staged, multi-systemic, or flexible interventions for high-risk, treatment-refractory, or culturally diverse populations.
- >> **Understand the impact of traumatic stress on the populations being served.** Develop partnerships to implement trauma-informed practice changes to address outcome improvements. For example, practitioners in the Los Angeles Unified School District, an NCTSN site, have collected data that supports the effectiveness of the Cognitive Behavioral Intervention for Trauma in Schools in improving grade point averages.
- >> **Rigorously evaluate the benefits of implementing trauma-informed care.** Collaborate with child-serving systems to bring clinical and research skills to projects that demonstrate benefits to children, families, and the system. Successfully enhancing services or reducing costs can help sustain trauma-informed services, leading to possible funding for wider dissemination. The Adverse Childhood Experiences research initiative, the largest study (N=17,337) to examine the cumulative impact of childhood trauma found a robust and profound relationship between early experiences of trauma and development of health and social outcomes across the lifespan.

- >> **Make education and training trauma-informed.** Expert clinicians can infuse traumatic stress knowledge and trauma-informed practice skills into core educational experiences for psychology, mental health, social work, and other human/child-service professions. The NCTSN has implemented a trauma-focused, problem-based learning method in the core curricula of over 20 graduate schools.
- >> **Provide trauma-informed care and traumatic stress interventions early and strategically.** Professionals in child-serving systems need not be specialists in traumatic stress, but they must be sufficiently trauma-informed to identify and help traumatized youths and families understand traumatic stress and gain access to trauma specialists.
- >> **Replicate specialized evaluation, assessment, and treatment services provided by programs within the NCTSN.** Explicitly include funding requests for evidence-based services for traumatized children and families in initiatives enhancing community-based mental health and healthcare services, faith-based programs, community policing and violence prevention programs, individualized educational programs, and juvenile justice programs. For example, practitioners in Delaware have used Cops, Kids and Domestic Violence in statewide trainings, resulting in state funding to hire clinicians trained in trauma treatment.
- >> **Emphasize interdisciplinary collaboration and relationship building.** Cross-training and cross-disciplinary integration among multiple systems (e.g., mental health practitioners, frontline workers, and administrators in other child- and family-serving systems) allows for seamless provision of services, a continuum of care for children, and reduces the risk of re-exposure to trauma through retelling their story upon entering each new system. The NCTSN has addressed gaps between the mental health and child welfare systems by adapting the Learning Collaborative and Breakthrough Series Collaborative models, a quality improvement methodology, developed by the Institute for Healthcare Improvement.

In summary, trauma-focused, child-serving systems require trauma-informed knowledge; skills for identifying and triaging traumatized children; resources and training of staff and administrators; and cross system collaboration. Creating trauma-informed child-serving systems is one of the most powerful strategies for raising the standard of care and improving access to services for traumatized children and adolescents.

Kelly Decker, MA, is the service systems program coordinator at the National Center for Child Traumatic Stress. She has consulted with the National Center since 2003 and provided training on the co-occurrence of adolescent substance abuse and trauma as well as the impact of child traumatic stress on the child welfare population. Decker is a doctoral candidate in clinical psychology at Fordham University. The focus of her dissertation research is on the mediating role of attachment on the relationship between childhood neglect and the development of self-injury in adulthood. Kelly has received clinical training in child, adult, and family psychology.

Susan Ko, PhD, is the co-managing director at the National Center for Child Traumatic Stress. In addition to administrative and managerial responsibilities, she oversees the Service Systems Program, which is dedicated to developing resources and increasing knowledge about the impact of child traumatic stress among a diverse array of service systems, as well as the general public. She is also responsible for overseeing and directing initiatives that address the intersection of culture and trauma. Her prior work includes an emphasis on evaluating the use of mental health assessments in juvenile justice settings.



Culture Shock

Colin Lacey "Abstract on Stage"

Roger D. Fallot, PhD; Director of Research and Evaluation and
Maxine Harris, PhD, Co-founder and CEO for Clinical Affairs – Community Connections

“Trauma-informed care” is a hot topic these days. In contrast, just over ten years ago, we were told by a group of editors that we could not title a monograph, *A Trauma-Informed Approach to Human Services* because “no one will know what that is.” Thus, Jossey-Bass published our *Using Trauma Theory to Design Service Systems (2001)*, a collection of chapters indicating the key changes involved in implementing the paradigm shift to trauma-informed care. In the intervening years, while trauma-informed approaches have moved from the margins to the center of many discussions of behavioral health care, there is still a great deal of ambiguity about the meaning of this concept.

There is growing agreement that being “trauma-informed” can occur in virtually any setting – even communities are beginning to refer to themselves in this way – as long as the setting takes into account what we know about trauma, including its prevalence, its broad and deep impact on survivors, and the complex and diverse ways in which people recover and heal from trauma. In contrast, “trauma-specific” services focus directly on the sequelae of trauma and facilitate recovery. We have developed and implemented, in a wide range of human service settings in numerous states, a model called, “Creating Cultures of Trauma-Informed Care.” This brief article offers an overview of this model.

First, we understand that any change in organizational – or larger system or

community – culture is built on values-based changes in both understanding and practice. We start with the key values of an organization because these are essential elements in shaping a culture; values tell us what matters most and where we should put our energy. Safety, trustworthiness, choice, collaboration, and empowerment are the core values of a trauma-informed culture of care. They stand as antidotes to the toxic impact of trauma, especially of traumatic violence, in people’s lives. If an organization can honestly state that every contact, every activity, every relationship, and every physical setting reflects these values, then it is a trauma-informed culture.

Understanding trauma, trauma survivors, the nature of services, and the service relationship in a way that changes fundamental questions is a first step. For instance, providers who ask people seeking services “What has happened to you?” are adopting a much more inviting stance than asking, implicitly or explicitly, “What is your problem?” or “What is wrong with you?” Following up with a question like “And how have you tried to deal or cope with it?” communicates an openness to learning from survivors what has been helpful (and not so helpful) in their recovery so far.

Finally, adopting a collaborative position by asking “How can you and I work together to further your goals for healing and recovery?” reflects a more positive



position than the more traditional “Here is what I can do to fix you” statement. As trauma moves from the periphery of our understanding of human behavior to the center, we put in place a “trauma lens” so that everything we see is shaped and infused by our knowledge of trauma.

Of course, such shifts in understanding are valuable only to the extent that they become part of routine, everyday relationships and practice. So in “Creating Cultures of Trauma-Informed Care” we have developed a Self-Assessment and Planning Protocol for agencies and larger organizations to use in their culture change. We first form representative workgroups from the organization to work with us on implementing its culture change. By representative we mean that every stakeholder in the organization needs to have a voice in this group. Not only the CEO but other senior administrators, supervisors, direct service staff, support staff, and people receiving services all need to be engaged fully in order for a meaningful change in culture to occur. Of particular importance is the unique perspective of people with lived experiences of trauma in this group; their voices have a definitive role to play in deciding the priorities for organizational change. In our experience, the other group that is frequently ignored in such initiatives are members of the support staff – receptionist, maintenance, accounting, transportation staff are just a few of those whose roles with people in recovery are essential in a trauma-informed culture.

Once this workgroup is formed, we ask them to focus first on the five core values in the experiences of people receiving services at the agency. How can organizational *safety* become a top priority, physically and emotionally? (How safe is the physical setting? The initial contact(s)?). How can *trustworthiness* be maximized? (Are the relationships open, transparent, and consistent? Do they maintain appropriate boundaries? Do people do what they say they are going to do when they say they are going to do it?). How can the organization strengthen consumers’ experiences of *choice* – not only in crises but in everyday practice? How can the culture enhance *collaboration*, the meaningful offer to share power and decision-making? Finally, how can the agency’s culture maximize *empowerment*, that sense of one’s strengths being recognized and validated and of developing needed skills?

Initially, this phase of our work focused almost exclusively on the people receiving services through an organization. We have come to see, in the past several years, that the experiences of staff members are equally important in these domains. We’ve learned a basic lesson: that it is possible for staff members to create a culture of safety, trustworthiness, choice, collaboration, and empowerment only when they experience these factors in their working environment and in their relationships with supervisors, administrators, and colleagues. In other words, a culture change needs to be thorough and not focused on changes in one group or another. So, after addressing the questions above for consumers, we ask the workgroup, drawing on input from the entire organization, to review the same questions for staff.

Ways of implementing a trauma-informed culture are as diverse as the organizations involved. Some have begun by emphasizing the safety and welcoming qualities of their physical environment – by removing love seats from waiting areas after consumers registered concerns about physical contact with strangers; by replacing intimidating signs with more welcoming ones; or by adding lights to the parking lots. Others have emphasized issues of choice – by ensuring that each new consumer has been asked about their preferences for responding to a crisis or that each staff member has an option about their work schedule. Each of these efforts shares an expected time frame for accomplishing the change and a responsible party to oversee the change. Our Services Implementation Plan form then asks the workgroup to assess the status of the change effort at the appropriate time and to note any lessons learned.

Our approach thus applies the five core values to each aspect of the organization’s usual, informal way of doing things. The other service-level domains involved in the Planning Protocol are the formal policies and procedures and the practices around trauma screening, assessment, recovery planning, and trauma-specific services. At the systems level, we address the need for full administrative support for culture change, staff trauma training and education, and human resources practices.

Finally, we discuss with organizations way to sustain and build on a trauma-informed culture of care. Many agencies have incorporated this approach into their ongoing staff training, quality improvement activities, and hiring and promotion practices, among others. In creating a culture of trauma-informed care, then, these organizations have made it possible for all to experience a safe and trustworthy setting, one where, in the words of one trauma survivor, she was to bring “her whole self” through the door for the first time.



Danny Welch

Roger D. Fallot, PhD, is a clinical psychologist and director of research and evaluation at Community Connections. He consults widely on the implementation of trauma-informed services. A founding board member of the SAMHSA Advisory Council for Women’s Services, Fallot was principal investigator on the DC Trauma Collaboration Study, a SAMHSA-funded research project examining the effectiveness of integrated services for women trauma survivors with mental health and substance abuse problems (1998-2004). He and a group of clinicians at Community Connections have developed a men’s version (M-TREM) of the Trauma Recovery and Empowerment Model (TREM), a manualized group intervention for working with survivors of physical and sexual abuse.

Maxine Harris is CEO for clinical affairs and co-founder of Community Connections. She is also the executive director of The National Capital Center for Trauma Recovery and Empowerment. Harris has served as principal investigator or co-principal investigator on numerous federally funded grant projects including: A Randomized Controlled Study of the Trauma Recovery and Empowerment Model (TREM) & PTSD (funded by National Institutes of Mental Health), the DC Trauma Collaboration Study under the Women, Co-Occurring Disorders and Violence Study funded by SAMHSA, and several other federally funded grants. She is the author of numerous articles and books.

The Rest of the Story

Anthony Salerno, PhD, Technical Assistance Specialist, SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Community Behavioral Healthcare

What is trauma-informed care? What does it mean when an organization says that they are committed to becoming a trauma-informed organization? Some behavioral healthcare providers may only tangentially recognized the role of adverse life experiences in the wide array of mental health, substance use, and physical health difficulties facing clients. They may believe that trauma-informed care means the provision of trauma-specific services for clients with

specific trauma histories delivered by professionals with specialized competencies. Undoubtedly, the presence of trauma-specific services is one important dimension of trauma-informed care, but that is just a part of the story.

The rest of the story tells us that an organization committed to integrating the philosophy, principles, and practices of trauma-informed care takes on the challenging task of examining its core processes, routine practices, well established policies, and basic organizational habits that challenge the organization's equilibrium set point. As our knowledge and experience of trauma-informed care increases, we face the challenge of integrating this knowledge into the policies, practices, training programs, and day-to-day operations of a healthcare organization.

The view of trauma-informed care as a comprehensive organizational change process reflects a compilation of perspectives emerging from consumer advocacy organizations, research informed findings, government initiated national reports, and recovery focused and person centered values. What are the key dimensions or domains that describe a trauma-informed organization? How can these domains inform and guide an organization in making practical and concrete changes that align with the principles and practices of a trauma-informed organization?

The seven domains of a trauma-informed care organization

- 1. Client Involvement:** The perspectives of clients with trauma histories, their choices and preferences play a central role in the organization's policies, practices and environment. In order to accomplish this, clients are in roles and positions to directly influence organizational decisions and have opportunities to shape the delivery of services.
- 2. Early Screening and Assessment:** There is a system in place to respectfully and sensitively offer all clients an opportunity to communicate about past and current trauma-related experiences. Organizational policies, intake and ongoing assessment procedures, and documentation guide and direct the exploration and identification of relevant client information that includes past and present trauma-related experiences.
- 3. Workforce Awareness and Knowledge:** All professional, paraprofessional, peer counselors, and support staff have a basic understanding of what it means to be part of a trauma-informed organization and can identify their role in supporting trauma-informed care. Supervision, performance expectations, employee orientation, and ongoing training support each employee as they increase their knowledge and engage in behaviors that support the organization's trauma-informed care mission.

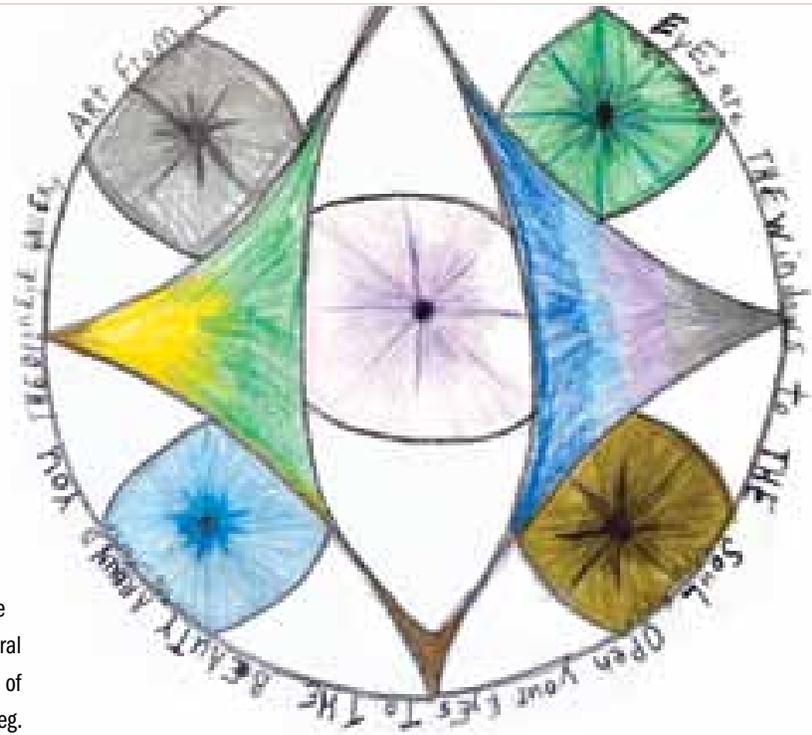
The rest of the story tells us that an organization committed to trauma-informed care takes on the challenging task of examining its core processes, routine practices, well established policies, and basic organizational habits.



Warren Heffner "Magical Sea and Sky"



With all the services, treatments, and/or programs clients may experience in our healthcare and social service system environments, what truly matters is their experience of the relationship with all the other humans in that environment.



Shelley Netzer "Five Eyes"

4. **Trauma-Informed Care Practice Guidelines:** The provision of medical, mental health, substance use, care management, and basic living assistance includes exploration and support of the emotional, cognitive, and behavioral difficulties associated with trauma-related experiences. The importance of trauma-informed care is reflected in the organization's core services – eg. evidence-based trauma-specific individual and group interventions; meetings with counselors routinely include inviting clients to discuss distressing adverse life experiences; and communication modalities and opportunities to educate clients and staff on the connection between traumatic life experiences and physical, mental, and substance use difficulties.
5. **Avoiding Recurrence/Retraumatization of Clients:** The organization has a transparent system in place to identify and correct policies, practices, activities, distressing incidences, and environmental conditions that increase stigma and decrease physical and emotional safety and security.
6. **Prevention and Creation of Alternatives to Seclusion and Physical and Chemical Restraint:** There is a clear understanding that behaviors that have in the past led to seclusion and restraint are actually adaptations or coping mechanisms that a client developed to manage the extreme discomfort adverse life events may have caused. Opportunities to develop new behaviors are at the core of services that empower clients to decide what will work for them rather than the retraumatizing effects of seclusion and restraint.
7. **Community Outreach:** The organization recognizes that clients function within larger residential, medical, mental health, substance use, legal, social service, and other community systems. The organization reaches out to and plays a leadership role in 1) establishing community partnerships and 2) providing education and information about trauma-informed care to a host of community organizations that likely interact with their clients.

The healing relationship: the cornerstone of a trauma-informed care system

Making progress on each of the seven domains has merit only by virtue of its association with facilitating, guiding, and reinforcing ongoing healing relationships – the cornerstone of a trauma-informed care system.

The healing relationship is something we all encounter in our lives. These are the friends, family members, colleagues, healthcare providers, and significant others who bring out the best in us. We don't need to conduct in depth examination of the scientific literature or gather the perspective of experts to understand the nature of a healing relationship – we experience it when we are with people who treat us with respect, who don't impose their preferences on us, who don't punish or reject our ideas and values, who recognize our worth even when we are at our lowest point, who believe in us, who understand that many of the negative actions a person takes may be a way of coping with distress, burdens, and challenges. People who establish healing relationships hardly ever say, "Hey, what's wrong with you?" Rather, they are more likely to say, "Hey, what's happened or happening to you? How can I help?"

With all the services, treatments, and/or programs clients may experience in our healthcare and social service system environments, what truly matters is their experience of the relationship with all the other humans in that environment. The seven domains of trauma-informed care are the organizational systems that create an environment in which healing relationships are nourished and strengthened.

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Anthony Salerno is a NYS licensed psychologist with 25 years of public mental health experience in inpatient and outpatient settings. He has extensive experience in designing rehabilitation programs; working closely with families and consumer advocacy organizations; training multi-disciplinary staff in the principles and practices of psychiatric rehabilitation; presenting at major professional conferences, and providing organizational consultation and training services to mental health agencies. In addition to clinical leadership activities, Salerno has helped organizations apply Continuous Quality Improvement methods to improve the quality of mental health services. He is currently involved in developing system-wide strategies to promote evidence-based practices in mental health, with a particular emphasis on wellness self-management and family psychoeducation.

Promises to Keep

INTERVIEW WITH ANN JENNINGS, PHD, FOUNDER AND EXECUTIVE DIRECTOR, ANNA INSTITUTE

Interview by Linda Ligenza for National Council Magazine

Ann Jennings is a pioneer in the field of trauma-informed care. She is the founder and executive director of the Anna Institute, named after her daughter, which provides guidance, resources, and information to support trauma-informed care. She also manages the national "SPSCOT" listserv and has worked in the trauma field as an educator, administrator, advocate, consultant, and author for over 30 years.

How did you get involved in the field of trauma-informed care?

It was through personal experience that I became aware that traumatic events, particularly in childhood, play a causal role in the development of emotional disorders. I was working in the field of mental health when I learned about my daughter Anna's history of early childhood sexual abuse. This was in 1979. She was 19 years old and had been in mental health facilities for 4 years when in a group session she heard other patients' stories and realized she was not the only person in the world to have been sexually abused as a child. It was then that she was able to disclose to me and others what had happened to her. Her disclosure made sense of so many of her behaviors and feelings that I hoped I might finally find her the kind of help she needed. Hope was quickly informed by reality, however, in this quest for help.

For the 17 years that Anna was in mental health services and psychiatric hospitals, she was never assessed or helped with the impacts of what happened to her — even though she herself asked for such help. No one had trauma training. The focus was on identifying what was wrong with her, counting symptoms, diagnosing her, and then medicating her. For 17 years no psychiatric treatments, mental health services, or medications helped her. In fact, many such treatments retraumatized her. As many sexual abuse survivors do, she felt defective, deficient, unworthy, bad, different from others — yet was never given the opportunity to share this burden, or to be understood and responded to. She finally lost hope and in 1992 at the age of 32, took her life.

Her story is similar to the stories of many others in our service systems. We must give all children and adults in our services the opportunity to share their stories and to be listened to and believed, understood, and helped. Needless suffering is caused by lack of knowledge of trauma and its centrality to mental health, addictions, and health problems. We need to understand this connection and ask about the person's life experiences, rather than assuming their problems to be solely genetic or biological.

How would you describe trauma-informed care?

I think Roger Fallot has described this best so in part I'll quote from his recent

work: "A trauma-informed service system or organization is one that thoroughly incorporates, in all aspects of service delivery and in all staff, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to put "safety first" and to avoid retraumatizing those who come seeking assistance."

The culture of a trauma-informed organization is built on core values of safety, trustworthiness, choice, collaboration, and empowerment. When a program can say that its culture reflects each of these values in every contact, physical setting, relationship, and activity, and *that this culture is evident in the experiences of staff as well as consumers*, then the program's culture is trauma-informed. This kind of environment is capable of supporting and sustaining the positive effects of "trauma-specific" services, which are designed to directly address sequelae of trauma.

What advances have you witnessed in the field of trauma-informed care?

Thinking about the advances made in this field over the past 25-30 years, in the public sector where I have been most involved, a few things stand out for me: advances in scientific research reflecting a paradigm shift in how we think about mental illness and addictions; growth in public and professional awareness of the prevalence and impacts of trauma over the lifespan; development of trauma-specific treatment models and trauma-informed approaches; focus on creating trauma-informed cultures in service settings and communities; increase in personal disclosures of traumatic experiences and the impact, and multiple paths to healing.

Advances in scientific research. Recognition of the impact of trauma on the development of mental illness and addiction was rare in the early 1980s. Now in 2011, 30 years later, science is catching up with what we know from many consumers; that trauma from overwhelmingly stressful childhood and/or adult experiences is a core causal factor—and that mental illness and substance abuse are not rooted exclusively in biology or genetics. Two examples of such research follow.

A 2008 comprehensive review of research literature on schizophrenia and



psychosis — *Child Maltreatment and Psychosis: A Return to a Genuinely Integrated Bio-Psycho-Social Model* —illustrates, and I quote, “for several decades the conceptualization and treatment of mental health problems, including psychosis, have been dominated by a rather narrow focus on genes and brain functions. Psychosocial factors have been relegated to mere triggers or exacerbators of a supposed genetic predisposition. This paper advocates a return to the original stress vulnerability model proposed by Joseph Zubin and Bonnie Spring in 1977, in which heightened vulnerability to stress is not, as often wrongly assumed, necessarily genetically inherited, but can be acquired via adverse life events. There is now a large body of research demonstrating that child abuse and neglect are significant causal factors for psychosis.”

The Adverse Childhood Experiences, or ACE Study, is another critical body of knowledge challenging long held models of thinking in the fields of health and behavioral health. Conducted by the Centers for Disease Control and Kaiser Permanente’s Department of Preventive Medicine, the study involved over 17,000 Kaiser patients. Its findings provide irrefutable evidence of

- A high prevalence of childhood adverse experiences in a middle class population, and
- A strongly proportionate and significant relationship between traumatic stress in childhood and leading causes of morbidity, mortality, and disability in the U.S.

Study participants received an “ACE Score” between 0 and 10 based on their responses to yes or no questions on 10 categories of adverse childhood experiences (age birth to 18). Each participant’s ACE score was then compared with his/her comprehensive health records. The findings were stunning. Repeatedly, in every analysis, the data revealed the higher an individual’s ACE score, the greater the likelihood in adulthood of

- Behavioral health and health risk problems such as alcoholism, smoking, obesity, depression, IV drug abuse, suicide attempts, and hallucinations
- Social problems such as revictimization by rape or domestic violence, homelessness, prostitution, teen and unwanted pregnancy, and inability to sustain employment, and
- Health problems including liver disease, COPD, autoimmune disease, and coronary artery disease — even after controlling for risk factors such as smoking.

Early death is also associated with childhood trauma, as the study found persons with an ACE score of 6 or higher die almost 20 years sooner than those with an ACE score of 0.

Growth of public and professional awareness of trauma. What was anomalous is becoming expected. This is one of the signs of a paradigm shift. When I first entered the field, childhood traumas such as physical or sexual abuse were considered rare, if considered at all. Now, both the general public and human service systems from federal to local levels are significantly more aware of the prevalence and impacts of violence and trauma in childhood.

Beth Filson “How to Grieve”



I am also keeping a promise to my daughter Anna... telling the story of her childhood and her years in institutions... Then, I want to tell the story of my own life as honestly as I can, and leave that legacy behind for my children, grandchildren, and great grandchildren who might be curious about me and perhaps learn something of use from my story. ”

Ann Jennings

Development of trauma-specific treatment models and trauma-informed approaches. Whereas in the early 1990s there were few if any models for trauma-specific treatments and trauma-informed care, now there is a plethora of such approaches available.

Focus on creating trauma-informed organizational cultures and communities. Numerous federal and state systems and behavioral health organizations are exploring and implementing ways of becoming trauma-informed. A model trauma-informed community, *Peace4Tarpon*, is evolving in Tarpon Springs, Florida.

Its stated mission is “to provide everyone in our community with information on the causes and consequences of trauma” and to support “public and provider education, resource assistance, and advocacy for appropriate prevention and intervention services.” *Peace4Tarpon* includes virtually every group and civic organization in the city – the mayor’s office and city council, the city manager’s office, the police and fire departments, the housing authority, the school system, health and human services, the business community, the faith-based community, and the local college, art museum and library. These disparate groups are working together with a common mission – to make Tarpon Springs a safe, healthy, healing, and productive community.

Increase in personal disclosures and advocacy. Consumers are increasingly speaking out about their histories of childhood trauma and advocating for services that facilitate healing and do not retraumatize, adding trauma on top of trauma. Prior to this, people understood consumers as ill or having a disease. This perception can be extremely stigmatizing and ignores the context of an individual’s life. As one consumer responded when asked what was different for her now that the mental health agency she went to for services had become trauma-informed, she said, “Well before, I brought a part of myself through the [agency] door. Now I bring my whole self through the door.”

What direction would you like to see the field go?

Basically, we have an epidemic of trauma in our society. The prevalence and impacts of childhood trauma and violence in this country represent a public health crisis of enormous proportions. Like AIDs—this epidemic has continued to grow and spread, in large part because it has been denied, ignored, or minimized for so long – or simply because we lack the will to do anything about it.

My hope is that we will soon come to recognize childhood trauma as the major public health crisis it is, underlying many of our most pressing and costly problems, and that the necessary fiscal and policy structures will be put in place to support programs that teach parents about trauma and its impacts, and help us learn how to heal ourselves, and how to protect and nurture our children and build their natural resilience.

One important issue that needs addressing is the imbalance of research, in the U.S. especially, with research into biological causes outweighing social causes by about fifteen to one. For example, of 1,284 publications about childhood schizophrenia only five relate to child abuse and eight to poverty.

Finally, I agree with John Briere that “If child abuse and neglect were to disappear today – the Diagnostic and Statistical Manual would shrink to the size of a pamphlet in 2 generations, and the prisons would empty.”

What direction is your work going?

I love much of the work I am already engaged in and will continue it. My interest at this time, however, increasingly centers on primary prevention of childhood trauma. I probably focus on this because of my experience as a mother

– wishing I had known more about how to raise my children, watching how my daughters, mothers themselves, and my sons, too, learn their parenting not just from their experience as children with me and their dad, but also from parenting programs and peer self-help. Because of this, they are breaking the intergenerational cycle of trauma in our family system.

I am also keeping a promise to my daughter Anna to finish and publish a book she and I wrote together, telling the story of her childhood and titled *A Child’s Path to Mental Illness*. A second book will be about her years in institutions and will include much of her artwork – which is hauntingly beautiful. Then, I want to tell the story of my own life as honestly as I can, and leave that legacy behind for my children, grandchildren, and great grandchildren who might be curious about me and perhaps learn something of use from my story.

What can child and adult serving organizations do to help?

Short term, this depends on what they are charged with doing now, and what funding exists. What they can do, now and in the long term, is to continually work on becoming trauma-informed – so that everything they are presently doing and everything that is realistically possible for them to do, and is infused with the values of trauma-informed care.

Management can set the tone. Organizational leadership and involvement is key to achieving this kind of transformative change. Advocates for trauma-informed care working as staff or as clients within organizations can make a significant difference by continually bringing up the issue of trauma in multiple settings within the organization, and using a variety of strategies to educate and raise awareness of other staff.

What can clinicians do to help?

Clinicians can also work as trauma advocates within their organizations and in the community as well. They can apply trauma-informed principles to their own practice and influence others in numerous ways: shifting from a “we/they” approach and from seeing people as “well/ill” to understanding the whole person within the context of their lived experience; deepening their knowledge and understanding of trauma and multiple paths to healing, and sharing what they know with others. They can refuse to adopt an authoritarian “expert” stance, conveying they know more about a person seeking help than that person knows about him or herself. They can become more transparent in recognizing and revealing the impact on their lives of their own traumatic childhood experiences and how much they share in common with the people they are committed to helping.

As Dan Gottlieb says in *Nobody Gets to See the Wizard*, “We are all part of the human family; each of our lives travels along the continuum of human experience, facing the same basic existential issues as we go. We have the capacity to really hear and understand each other, and on common ground, we can learn from each other and help each other to heal.”



A Community Safety Net to Prevent Youth Suicide

Maureen Underwood, LCSW, CGP

One of the most tragic events a community can face is the death of one of its youth by suicide. Whatever the circumstances, youth suicides bring disbelief, blame, and often, finger-pointing that assigns guilt to everyone and everything in the community that ‘should have seen this coming and done something to prevent it.’ Because young people spend the majority of their time in school, schools are often the targets of scapegoating. Parents, too, may be castigated and blamed: how could they have let this happen to their child?

There is never one, simple reason to explain why a youth would choose to end his/her life. While understandable, blaming in the aftermath of a suicide death can further fracture a grieving community and complicate the process of healing.

There is good news: communities that proactively address youth suicide are in a better position to identify those who might be at risk and refer them for effective treatment, and, in the regrettable circumstances of a completed suicide, manage the aftermath in a way that facilitates community healing.

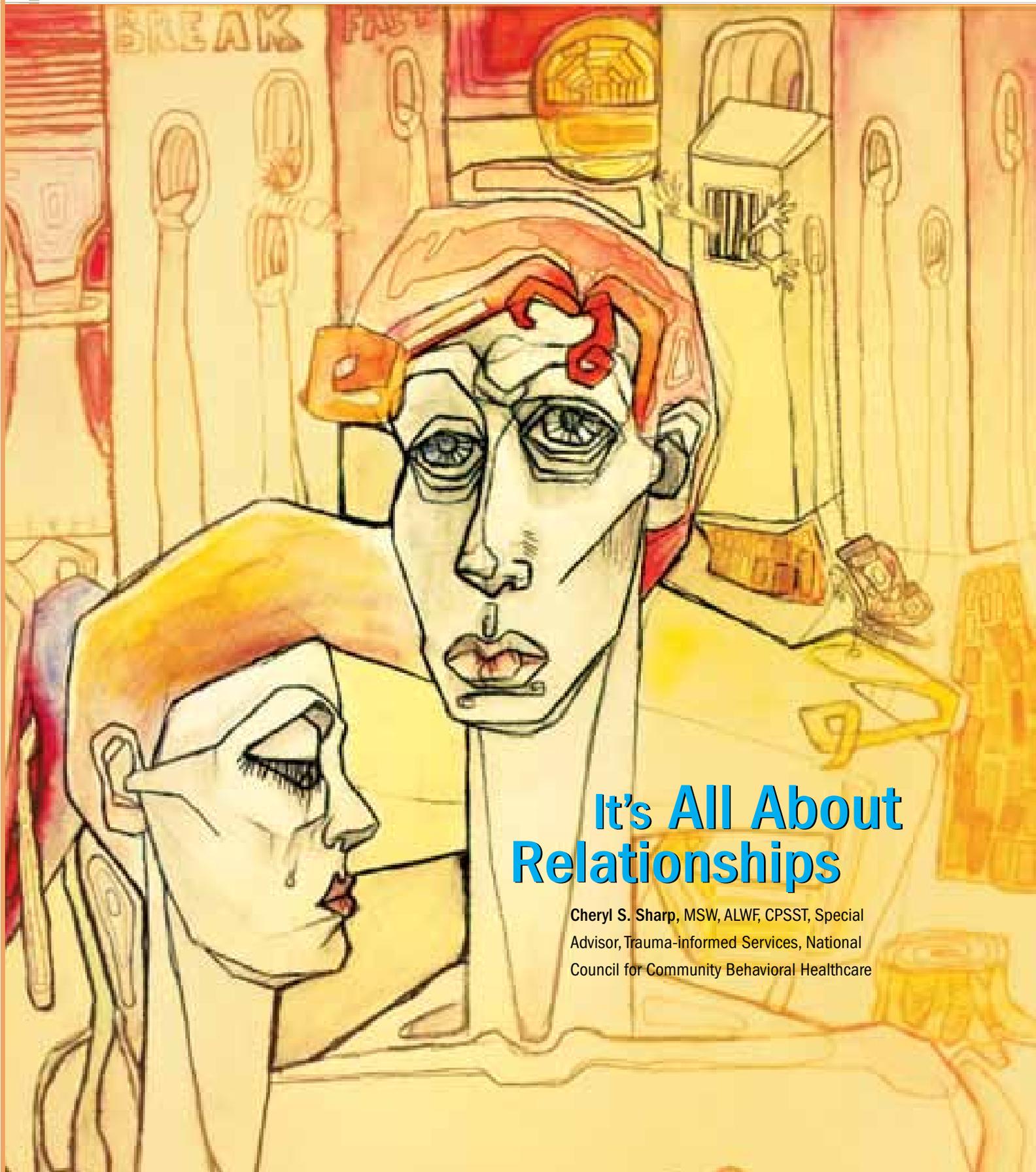
Susan Tellone-McCoy, the crisis team leader in a New Jersey high school that experienced a spate of suicides that experts call a ‘cluster,’ speaks from experience. “We really had no plan,” Tellone- McCoy said. “We had never had a suicide before. We had crisis plans for lots of other things, just not suicide.” After the fourth suicide death in less than eight months, she tells of a community shocked and outraged and of a stunned school struggling to maintain its focus on student education. Well-intentioned local mental health professionals offered advice and suggestions but Tellone-McCoy, a psychiatric nurse experienced in crisis intervention, recognized the need for interventions that were grounded in best practice or evidence-based research and tailored to the practical realities of the school. She teamed with clinical staff from the Society for the Prevention of Teen Suicide, a national organization that conceives of suicide prevention in the context of a ‘competent community.’ Their model, which asserts that everyone in the community has a responsibility to recognize when a community member is in need and knows where and how to access help, appealed to Tellone-McCoy’s understanding of the crisis in her community. “We needed to make sure everyone was on board with the prevention message in a way that didn’t stigmatize suicide or make it difficult for kids to ask for help. We also knew we wanted a program that engaged students and gave them an active part of the solution.”

There is never one, simple reason to explain why a youth would choose to end his/her life. While understandable, blaming in the aftermath of a suicide death can further fracture a grieving community and complicate the process of healing.

While several evidence-based programs exist, Tellone-McCoy’s school chose the *Lifelines* program, because it incorporated the principles of that competent prevention community. “For us,” she says, “it did everything we needed it to do. It included policy guidelines, presentations for faculty, staff, and parents, and a substantive curriculum for students.” She explained how the school, once blamed as the source for the suicides, was able to engage other significant segments of the community including clergy, law enforcement, and mental health in developing community activities to support the prevention effort. “Yes, we started in the school, but the ability to get so many aspects of the community involved in creating a safety net for our kids and their families is what effective youth suicide prevention is really all about.”

Hazelden Publishing, the leading publisher of evidence-based programs for prevention, treatment, behavioral health and corrections, publishes and distributes the *Lifelines Trilogy*. The components of this comprehensive suicide awareness and responsiveness program for youth include *Lifelines Prevention*, *Lifelines Intervention*, and *Lifelines Postvention*.

Maureen is a licensed clinical social worker and certified group psychotherapist with over 30 years of experience in mental health and crisis intervention. With a practice specialty in suicide, grief, trauma, and crisis resolution for children and families, she has developed numerous programs and published extensively on these and other related topics. From 1985 to 2000, she was the coordinator of the New Jersey Adolescent Suicide Prevention Project. In this role, she initiated collaborative relationships between mental health and educational systems statewide, providing in-service training, consultation on policy development, and assistance in the implementation of procedures for school-based crisis management. She has been providing clinical training in suicide assessment for emergency room mental health screeners for the past seven years and has coauthored a book chapter on the assessment of suicide risk in out-patient settings and the LIFELINES School-Based Youth Suicide Response Program



It's All About Relationships

Cheryl S. Sharp, MSW, ALWF, CPSST, Special Advisor, Trauma-informed Services, National Council for Community Behavioral Healthcare

Christian McCarroll "Europa"



When we experience trauma, our trust in the world, our relationships, and our selves are often broken. We heal in community and in relationship with others — and it is community behavioral healthcare that can serve as the link that so many of us need to begin healing.



How many of us choose a profession based on our life experiences? A *New York Times* article “Expert on Mental Illness Reveals Her Own Fight,” by Benedict Carey on June 23, 2011, (see reprint in this issue of National Council Magazine, page 42) tells the courageous story of Dr. Marsha Linehan, PhD, of the University of Washington, who, at the age of 68, shared her struggle with mental illness and profound self-injury, detailing how she turned her personal tragedy into a life’s work of helping others. Linehan developed the evidence-based model for Dialectical Behavioral Therapy, which has offered hope and a new way of life for many trauma survivors labeled with such dire diagnoses as borderline personality disorder.

As I travel the country providing trainings for the National Council for Community Behavioral Healthcare’s contract with SAMHSA-NASMHPD Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices and the SAMHSA-sponsored Trauma-Informed Practices Learning Community, I am struck by the number of human services providers who approach me to share their own experiences. Many of these people fear that if they speak of their experiences, they will lose their jobs or will somehow stray from ethical practice — perhaps fears Dr. Linehan may have shared for many years.

In a call to arms, National Council President and CEO Linda Rosenberg wrote of trauma’s prevalence and the urgency to make a difference in the lives of all who have suffered its impact. Trauma has a direct correlation to mental illness and substance use. However, we cannot designate trauma as exclusive to those with severe mental illnesses and substance abuse diagnoses. There is no “scarlet letter” on the faces of trauma survivors. Trauma knows no socioeconomic group, class, or culture. It is all of us.

Given the prevalence and lasting impact of trauma, it is heartening to note the increasing attention to trauma-informed care in the behavioral health and human services communities. The response to the National Council’s commitment to adopt trauma-informed practices and partner with its members to “shine the light on trauma” has been inspirational. I have been asked on numerous occasions, “Why this much interest?” I believe it is because trauma is so personal to so many of us. I also believe that the principles of trauma-informed care take us back to the reasons we decided to go into helping professions in the first place. The principles are steeped in compassion and caring, and they are at the forefront of creating cultures of wellness and recovery. Trauma-informed care is truly based on relationships and connections.

When we experience trauma, our trust in the world, our relationships, and our selves are often broken. We heal in community and in relationship with others — and it is community behavioral healthcare that can serve as the link that so many of us need to begin healing.

When I attended Shery Mead’s Intentional Peer Support Training, the phrase “listening for the untold story” stood out as the one thing that had been life changing in my own healing, as well as in what others often reported as they worked through recovering from traumatic experiences. Gently exploring “what happened,” rather than “what’s wrong,” offers a way to enter into relationships that are non-blaming, non-judgmental, and hope-based — relationships that embrace the fact that we are not inherently flawed.

Healing relationships can be forged in many environments. Mark Patterson, warden of the Women’s Community Correctional Center in Kailua, Hawaii, led the charge of turning a prison from a place of hopelessness into a place of “healing and forgiveness.” The small community of Tarpon Springs, Florida had the vision and courage to make the entire town a trauma-informed environment. San Mateo, California created the Peninsula Trauma-Informed Learning Collaborative to ensure all human services organizations work from the same set of guiding principles so that individuals accessing services from various settings receive appropriate and effective care. The National Council’s 21 Trauma-Informed Practices Learning Community grantees are also early adopters who share this passion, commitment, and enthusiasm to practice trauma-informed care. Each of these organizations has gone through a thorough assessment of what they have been doing and what they would like to do better; they now focus on specific areas of improvement, as well as on plans for continued progress after the learning community concludes.

There have been many champions who have worked tirelessly to create safe and supportive environments for persons who have experienced trauma. SAMHSA has led this charge through its support of NASMHPD’s Promoting Alternatives to Seclusion and Restraint through Trauma-Informed Practices Center and the National Center for Trauma Informed Care. You will read about many other champions, survivors, and experts in this issue, those who are shining a bright light on the issue of trauma-informed care. The National Council hopes to inspire, encourage, and ask you to think about what you can do to promote trauma-informed practices. We would also like you to tell us what you need to create environments of “healing and forgiveness” for consumers, staff, and the community as a whole. Please feel free to connect with me by email at CherylS@thenationalcouncil.org.

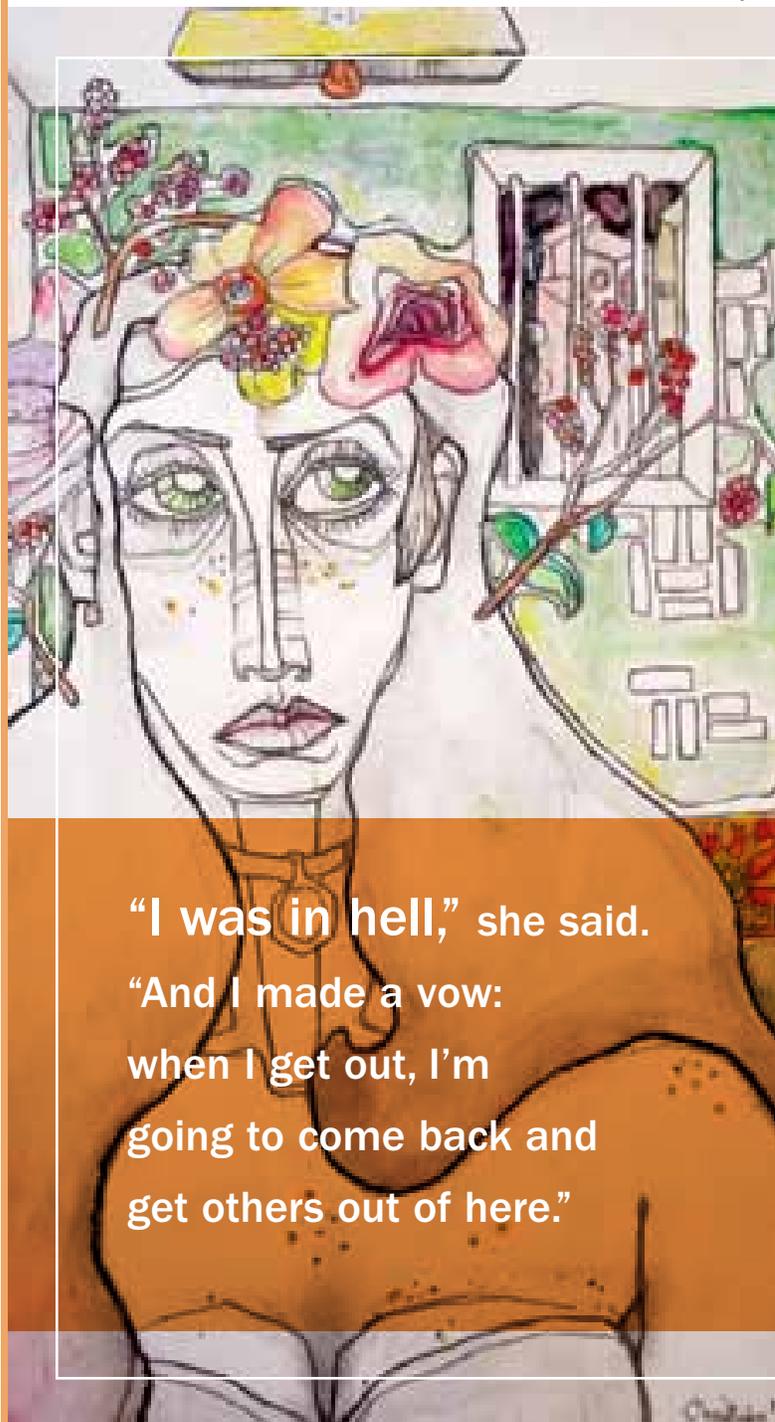
Cheryl Sharp is the special advisor for trauma-informed services at the National Council for Community Behavioral Healthcare. She holds the unique perspective of a person with lived experience as a consumer and family member, as well as a provider of services. As a consultant to the NASMHPD/SAMHSA’s Promotion of Alternatives to Seclusion and Restraint, Cheryl trains and speaks nationally on trauma-informed care. She is an advanced level WRAP facilitator, a Mental Health First Aid USA instructor, and a trainer of Intentional Peer Support. Sharp practices as a life coach/mentor and is an ordained minister. She has worked as a hospice/medical social worker and as a director of social services for a skilled nursing facility. She received the Lou Ann Townsend Courage Award for her contributions to persons with psychiatric disabilities.

Are You One of Us?

From “Expert on Mental Illness Reveals Her Own Fight” by Benedict Carey in the *New York Times*, June 23, 2011

This article is the first in “Lives Restored: A Therapist’s Demons,” a series of profiles about people who are functioning normally despite severe mental illness and have chosen to speak out about their struggles.

Christian McCarroll “Jacklyn”



**“I was in hell,” she said.
“And I made a vow:
when I get out, I’m
going to come back and
get others out of here.”**

“ARE YOU ONE OF US?”

The patient wanted to know, and her therapist — Marsha M. Linehan of the University of Washington, creator of a treatment used worldwide for severely suicidal people — had a ready answer. It was the one she always used to cut the question short, whether a patient asked it hopefully, accusingly or knowingly, having glimpsed the macramé of faded burns, cuts, and welts on Dr. Linehan’s arms:

“You mean, have I suffered?”

“No, Marsha,” the patient replied, in an encounter last spring. “I mean one of us. Like us. Because if you were, it would give all of us so much hope.”

“That did it,” said Dr. Linehan, 68, who told her story in public for the first time last week before an audience of friends, family and doctors at the Institute of Living, the Hartford clinic where she was first treated for extreme social withdrawal at age 17. “So many people have begged me to come forward, and I just thought — well, I have to do this. I owe it to them. I cannot die a coward.”

No one knows how many people with severe mental illness live what appear to be normal, successful lives, because such people are not in the habit of announcing themselves. They are too busy juggling responsibilities, paying the bills, studying, raising families — all while weathering gusts of dark emotions or delusions that would quickly overwhelm almost anyone else.

Now, an increasing number of them are risking exposure of their secret, saying that the time is right. The nation’s mental health system is a shambles, they say, criminalizing many patients and warehousing some of the most severe in nursing and group homes where they receive care from workers with minimal qualifications.

Moreover, the enduring stigma of mental illness teaches people with such a diagnosis to think of themselves as victims, snuffing out the one thing that can motivate them to find treatment: hope.

“There’s a tremendous need to implode the myths of mental illness, to put a face on it, to show people that a diagnosis does not have to lead to a painful and oblique life,” said Elyn R. Saks, a professor at the University of Southern California School of Law who chronicles her own struggles with schizophrenia in “The Center Cannot Hold: My Journey Through Madness.” “We who struggle



with these disorders can lead full, happy, productive lives, if we have the right resources.”

These include medication (usually), therapy (often), a measure of good luck (always) – and, most of all, the inner strength to manage one’s demons, if not banish them. That strength can come from any number of places, these former patients say: love, forgiveness, faith in God, a lifelong friendship.

But Dr. Linehan’s case shows there is no recipe. She was driven by a mission to rescue people who are chronically suicidal, often as a result of borderline personality disorder, an enigmatic condition characterized in part by self-destructive urges.

“I honestly didn’t realize at the time that I was dealing with myself,” she said. “But I suppose it’s true that I developed a therapy that provides the things I needed for so many years and never got.”

‘I WAS IN HELL’

She learned the central tragedy of severe mental illness the hard way, banging her head against the wall of a locked room.

Marsha Linehan arrived at the Institute of Living on March 9, 1961, at age 17, and quickly became the sole occupant of the seclusion room on the unit known as Thompson Two, for the most severely ill patients. The staff saw no alternative: The girl attacked herself habitually, burning her wrists with cigarettes, slashing her arms, her legs, her midsection, using any sharp object she could get her hands on.

The seclusion room, a small cell with a bed, a chair and a tiny, barred window, had no such weapon. Yet her urge to die only deepened. So she did the only thing that made any sense to her at the time: banged her head against the wall and, later, the floor. Hard.

“My whole experience of these episodes was that someone else was doing it; it was like ‘I know this is coming, I’m out of control, somebody help me; where are you, God?’” she said. “I felt totally empty, like the Tin Man; I had no way to communicate what was going on, no way to understand it.”

Her childhood, in Tulsa, Okla., provided few clues. An excellent student from early on, a natural on the piano, she was the third of six children of an oilman and his wife, an outgoing woman who juggled child care with the Junior League and Tulsa social events.

People who knew the Linehans at that time remember that their precocious third child was often in trouble at home, and Dr. Linehan recalls feeling deeply inadequate compared with her attractive and accomplished siblings. But whatever currents of distress ran under the surface, no one took much notice until she was bedridden with headaches in her senior year of high school.

Her younger sister, Aline Haynes, said: “This was Tulsa in the 1960s, and I don’t think my parents had any idea what to do with Marsha. No one really knew what mental illness was.”

Soon, a local psychiatrist recommended a stay at the Institute of Living, to get to the bottom of the problem. There, doctors gave her a diagnosis of schizophrenia; dosed her with Thorazine, Librium and other powerful drugs, as well as hours of Freudian analysis; and strapped her down for electroshock treatments, 14 shocks the first time through and 16 the second, according to her medical records. Nothing changed, and soon enough the patient was back in seclusion on the locked ward.

“Everyone was terrified of ending up in there,” said Sebern Fisher, a fellow patient who became a close friend. But whatever her surroundings, Ms. Fisher added, “Marsha was capable of caring a great deal about another person; her passion was as deep as her loneliness.”

A discharge summary, dated May 31, 1963, noted that “during 26 months of hospitalization, Miss Linehan was, for a considerable part of this time, one of the most disturbed patients in the hospital.”

A verse the troubled girl wrote at the time reads:

They put me in a four-walled room

But left me really out

My soul was tossed somewhere askew

My limbs were tossed here about

Bang her head where she would, the tragedy remained: no one knew what was happening to her, and as a result medical care only made it worse. Any real treatment would have to be based not on some theory, she later concluded, but on facts: which precise emotion led to which thought led to the latest gruesome act. It would have to break that chain – and teach a new behavior.

“I was in hell,” she said. “And I made a vow: when I get out, I’m going to come back and get others out of here.”

RADICAL ACCEPTANCE

She sensed the power of another principle while praying in a small chapel in Chicago.

It was 1967, several years after she left the institute as a desperate 20-year-old whom doctors gave little chance of surviving outside the hospital. Survive she did, barely: there was at least one suicide attempt in Tulsa, when she first arrived home; and another episode after she moved to a Y.M.C.A. in Chicago to start over.

She was hospitalized again and emerged confused, lonely and more committed than ever to her Catholic faith. She moved into another Y, found a job as a clerk in an insurance company, started taking night classes at Loyola University – and prayed, often, at a chapel in the Cenacle Retreat Center.

“One night I was kneeling in there, looking up at the cross, and the whole place became gold – and suddenly I felt something coming toward me,” she said. “It was this shimmering experience, and I just ran back to my room and said, ‘I love myself.’ It was the first time I remember talking to myself in the first person. I felt transformed.”

The high lasted about a year, before the feelings of devastation returned in the wake of a romance that ended. But something was different. She could now weather her emotional storms without cutting or harming herself.

What had changed?

It took years of study in psychology – she earned a Ph.D. at Loyola in 1971 – before she found an answer. On the surface, it seemed obvious: She had accepted herself as she was. She had tried to kill herself so many times because the gulf between the person she wanted to be and the person she was left her desperate, hopeless, deeply homesick for a life she would never know. That gulf was real, and unbridgeable.

That basic idea — radical acceptance, she now calls it — became increasingly important as she began working with patients, first at a suicide clinic in Buffalo and later as a researcher. Yes, real change was possible. The emerging discipline of behaviorism taught that people could learn new behaviors — and that acting differently can in time alter underlying emotions from the top down.

But deeply suicidal people have tried to change a million times and failed. The only way to get through to them was to acknowledge that their behavior made sense: Thoughts of death were sweet release given what they were suffering.

“She was very creative with people. I saw that right away,” said Gerald C. Davison, who in 1972 admitted Dr. Linehan into a postdoctoral program in behavioral therapy at Stony Brook University. (He is now a psychologist at the University of Southern California.) “She could get people off center, challenge them with things they didn’t want to hear without making them feel put down.”

No therapist could promise a quick transformation or even sudden “insight,” much less a shimmering religious vision. But now Dr. Linehan was closing in on two seemingly opposed principles that could form the basis of a treatment: acceptance of life as it is, not as it is supposed to be; and the need to change, despite that reality and because of it. The only way to know for sure whether she had something more than a theory was to test it scientifically in the real world — and there was never any doubt where to start.

GETTING THROUGH THE DAY

“I decided to get supersuicidal people, the very worst cases, because I figured these are the most miserable people in the world — they think they’re evil, that they’re bad, bad, bad — and I understood that they weren’t,” she said. “I understood their suffering because I’d been there, in hell, with no idea how to get out.”

In particular she chose to treat people with a diagnosis that she would have given her young self: borderline personality disorder, a poorly understood condition characterized by neediness, outbursts and self-destructive urges, often leading to cutting or burning. In therapy, borderline patients can be terrors — manipulative, hostile, sometimes ominously mute, and notorious for storming out threatening suicide.

Dr. Linehan found that the tension of acceptance could at least keep people in the room: patients accept who they are, that they feel the mental squalls of rage, emptiness and anxiety far more intensely than most people do. In turn, the therapist accepts that given all this, cutting, burning and suicide attempts make some sense.

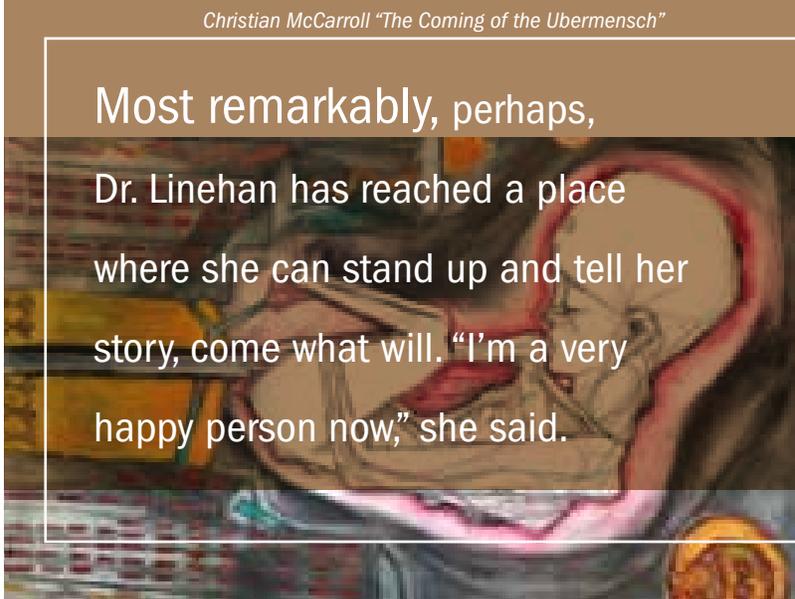
Finally, the therapist elicits a commitment from the patient to change his or her behavior, a verbal pledge in exchange for a chance to live: “Therapy does not work for people who are dead” is one way she puts it.

Yet even as she climbed the academic ladder, moving from the Catholic University of America to the University of Washington in 1977, she understood from her own experience that acceptance and change were hardly enough. During those first years in Seattle she sometimes felt suicidal while driving to work; even today, she can feel rushes of panic, most recently while driving through tunnels. She relied on therapists herself, off and on over the years, for support and guidance (she does not remember taking medication after leaving the institute).

Dr. Linehan’s own emerging approach to treatment — now called dialectical

behavior therapy, or D.B.T. — would also have to include day-to-day skills. A commitment means very little, after all, if people do not have the tools to carry it out. She borrowed some of these from other behavioral therapies and added elements, like opposite action, in which patients act opposite to the way they feel when an emotion is inappropriate; and mindfulness meditation, a Zen technique in which people focus on their breath and observe their emotions come and go without acting on them. (Mindfulness is now a staple of many kinds of psychotherapy.)

Christian McCarroll “The Coming of the Ubermensch”



Most remarkably, perhaps, Dr. Linehan has reached a place where she can stand up and tell her story, come what will. “I’m a very happy person now,” she said.

In studies in the 1980s and ‘90s, researchers at the University of Washington and elsewhere tracked the progress of hundreds of borderline patients at high risk of suicide who attended weekly dialectical therapy sessions. Compared with similar patients who got other experts’ treatments, those who learned Dr. Linehan’s approach made far fewer suicide attempts, landed in the hospital less often and were much more likely to stay in treatment. D.B.T. is now widely used for a variety of stubborn clients, including juvenile offenders, people with eating disorders and those with drug addictions.

“I think the reason D.B.T. has made such a splash is that it addresses something that couldn’t be treated before; people were just at a loss when it came to borderline,” said Lisa Onken, chief of the behavioral and integrative treatment branch of the National Institutes of Health. “But I think the reason it has resonated so much with community therapists has a lot to do with Marsha Linehan’s charisma, her ability to connect with clinical people as well as a scientific audience.”

Most remarkably, perhaps, Dr. Linehan has reached a place where she can stand up and tell her story, come what will. “I’m a very happy person now,” she said in an interview at her house near campus, where she lives with her adopted daughter, Geraldine, and Geraldine’s husband, Nate. “I still have ups and downs, of course, but I think no more than anyone else.”

After her coming-out speech last week, she visited the seclusion room, which has since been converted to a small office. “Well, look at that, they changed the windows,” she said, holding her palms up. “There’s so much more light.”



ADVERTORIAL

OptumHealthSM

Optimizing Health and Well-Being™

Mobile Integrated Health Clinic Drives Recovery

Ample evidence suggests that people with severe mental illnesses also have higher-than-normal incidences of chronic medical conditions including diabetes, cardiovascular disease and obesity. People with mental health challenges often face barriers to receiving primary care services including access, coverage, transportation and stigma. A whole health approach to care supports the integration of all health services in order to promote chronic illness management, foster physical and mental well-being and enhance recovery.

In March 2011, OptumHealth, in partnership with MultiCare Good Samaritan hospital, began to offer a person-centered health care home for people in Pierce County, WA with Serious Mental Illness (SMI) who have moderate-to-high physical health complexity. “The foundation of this program is all based upon relationships,” says Tim Holmes, vice president of MultiCare Health System. “Relationships with consumers, with providers, and with payers. All with the common goal of providing better health to an underserved and vulnerable population.”

The goals for this program are to: enhance consumer access to comprehensive health care; facilitate an ongoing relationship between the consumer, mental health provider and primary care provider; increase consumer engagement and adherence to treatment; increase consumer understanding and use of prescribed medications; increase consumer interest and focus on health-related behaviors; and provide more fully integrated care across the health care system. In its first year, the project is expected to serve 900 consumers.

The 38-foot travelling van is equipped with two functional treatment rooms, provides primary health care services and is called the Mobile Integrated Healthcare Clinic. The van is staffed by an advanced registered nurse practitioner, a nursing coordinator and a wellness peer support specialist coach. Medical services are supervised by an off-site physician at the MultiCare Good Samaritan Hospital. According to Dr. Doug Smathers, medical director for MultiCare Good Samaritan East Pierce County clinics and direct supervisor to the van’s medical provider, “the Mobile Integrated Health Clinic reaches out to a vulnerable population for whom the simple act of going to the doctor can be an insurmountable burden.”

The van travels weekly to four mental health agency sites. Typically, appointments are scheduled for a 60-minute physical assessment and then additional time with the RN and Wellness Manager to begin to develop a whole health wellness treatment plan. The mobile clinic provides screening and initial primary care services including blood pressure monitoring, blood glucose and lipid profile screening, and body mass indexing. Mental Health Case Managers attend all appointments, and follow-up includes scheduling additional appointments based on presenting health issues.

Wellness Groups are offered at all sites weekly, and focus on improving health-related behaviors and strengthening resiliency skills using ten healthy lifestyle domains: healthy eating, physical activity, restful sleep, stress management, service to others, support network, optimism, cognitive skills to avoid negative thinking, spiritual beliefs and practices, and building a sense of purpose and meaning. Sandie Johnson, the project’s peer specialist says, “This is all about building trust with the client while also empowering them. We are providing wellness classes which will give them the tools and support that will help them to help themselves do better at self care.”

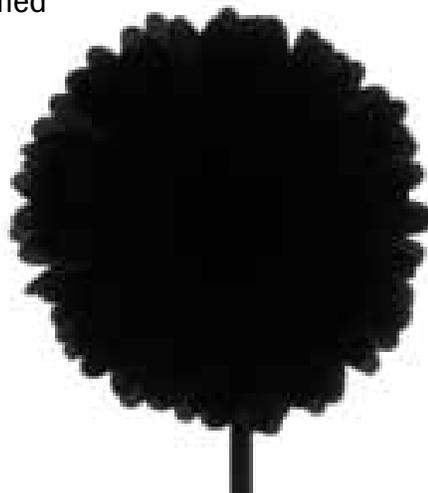
OptumHealth also acknowledges the importance of this unique and innovative collaboration. “We support this partnership to provide primary care services to people with serious mental illness so that they can receive medical services in a setting that is convenient, and helps overcome barriers to receiving essential medical care,” says Cheri Dolezal, executive director, OptumHealth Pierce Regional Support Network. “By getting the services they need to promote health and avoid serious complications from chronic illnesses, a whole health recovery approach is promoted.” OptumHealth is also externally evaluating the program and anticipates the dissemination of results as they are available.

For Additional Information Contact: Brad Lotterman at brad.lotterman@optumhealth.com

A whole health approach to care supports the integration of all health services in order to promote chronic illness management, foster physical and mental well-being and enhance recovery.

Trauma-informed Care From the Field: Stories of Change

Mental health and addiction treatment providers across the USA share their struggles and successes in implementing trauma-informed behavioral healthcare.



Anchorage Builds the Case for Change

Jerry A. Jenkins, MEd, MAC, Executive Director, Anchorage Community Mental Health Services, Anchorage, Alaska / jjenkins@acmhs.com

A member of the National Child Traumatic Stress Network, the Alaska Child Trauma Center at Anchorage Community Mental Services serves children 12 years and younger in the child protective services system who have been affected by complex trauma.

The ACTC relied on two data sources to support its 2005 SAMHSA funding proposal. First was the Anchorage Community Mental Services/Alaska Office of Children's Services Joint Assessment Project. Established in 2000, this collaboration served 100–200 children per year through mental health assessments and case consultation. A telling pattern developed during assessments: all the children had experienced traumatic and/or adverse events.

Similar data was noted through the "Bring the Kids Home" initiative. Spearheaded by the Alaska Mental Health Trust Authority and the Alaska Division of Behavioral Health, BTKH aimed to reduce the number of Alaska children in out-of-state residential psychiatric treatment centers. Between 1998 and 2004, the number had increased from 83 to 749, with a corresponding Medicaid expenditure increase of over 1,300%. According to the initiative's third year report: "Alaska Native children were over-represented: 49 percent of children in state custody and 22 percent of non-custody children in out-of-state placements were Alaska Native while only 16 percent of the general population is Alaska Native."

Anchorage providers began staffing "hard to return" cases in August 2003, and a picture began to take shape by 2004. The average length of stay was 489 days with a range of 142–1094 days. In other words, stays ranged from nearly 5 months to 3 years. Average age at time of staffing was 13 years, 5 months. The majority of youth presented with initial diagnoses that included oppositional defiant disorder, bipolar disorder, and major depression, followed by PTSD, conduct disorder, reactive detachment disorder, ADHD, and dysthymia.

During case presentations, participants began to ask, "What happened to this child? Why is he or she presenting with this disorder or behavior at such a young age?" Once complete bio-psycho-social histories were obtained, the history made sense of the symptoms. Over 70% had numerous adverse/traumatic events in their lives including neglect, physical abuse, sexual abuse, and witnessing violence.



In April 2005, SAMHSA solicited proposals for Category III sites for the NCTSN – community treatment and services centers that “implement and evaluate effective treatment and services in community settings and youth-serving service systems and collaborate with other Network centers on clinical issues, service approaches, policy, financing, and training issues.”

With two sources indicating adverse events and/or psychological trauma were indeed affecting Alaskan children, ACMHS Director of Child and Family Services Dee Foster proposed to evaluate the effectiveness of the ARC (Attachment, Self-Regulation and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth) Model for children 12 years and younger.

ACTC’s implementation of ARC and subsequent findings indicated ARC effectively decreased trauma symptomology in American Indian/Alaska Native, Caucasian, African American, Native Hawaiian/Pacific Islanders, and Asian children in community-based clinics. The Child Behavioral Checklist/Achenbach indicated children entering services had an overall CBCL T-Score in the 84 to 87 percentile. Upon completion of the intervention, scores placed them just below the 50 percentile.

The ACTC leadership team began advocating for inclusion of a trauma assessment in the Alaska Screening Tool. The Alaska Division of Behavioral Health uses the AST to screen all consumers entering DBH-funded services for substance abuse, mental illness, co-occurring substance use and mental illness, traumatic brain injury, and fetal alcohol spectrum disorders. In October 2010, the results were implemented statewide, adding a new section investigating adverse experiences...based on the Adverse Childhood Experiences study.

The initial results between October 1, 2011 and March 31, 2011 found 72% of respondents (n=2,326) reported adverse events/trauma, with 48% reporting three or more events. These results covered the life span (under 12 = 8.4%; 12-17 = 14%; 18-54 = 70.7%; 55+ = 6.9%).

So, should behavioral health providers be concerned about trauma and adverse events? The data from the ACTC, and now from the Alaska Screening Tool, consistently support the need to assess for and, when identified, treat trauma. The implications are far reaching as recovery-oriented providers help consumers understand the link between behaviors/thought processes and their life experiences. Real change can occur when you deal with the history and the results.”

Healing the Healers

INTERVIEW WITH RAUL ALMAZAR, PRESIDENT, ALMAZAR CONSULTING, BARRINGTON, ILLINOIS / Almazarconsulting@yahoo.com

“Organizations get traumatized, workers get traumatized, but what are we doing about it?” That’s how I became focused on ‘healing the healer,” says Raul Almazar, RN, MA, president of Almazar Consulting, and faculty member with SAMHSA’s Promoting Alternatives to Seclusion and Restraints through Trauma Informed Practices. Almazar does onsite visits and consultations with organizations for a wide variety of reasons ranging from preventing use of seclusion and restraints, high rates of staff injuries to labor and management conflicts, and some common threads begin to emerge, including: staff morale, staff issues, and leaderships’ failure to address workforce support issues.

Organizations are adopting effective practices in seclusion and restraint prevention, and bringing in evidence-based practices and trauma-informed care. “But often it is clear something’s not taking,” says Almazar, “And when I start talking about staff trauma, there’s an immediate connection. You have the walking wounded taking care of other people here.” For instance, while staff training is always a good thing, it’s not a panacea. You have to explain to employees beforehand how this will make their jobs better and easier, Almazar explains. Otherwise, the word “training” becomes synonymous with lost hours on the job and working double time to catch up upon return. “This creates stress for the staff, and when you have a chronically stressed workforce, they disengage,” Raul explains.

What employees want is recognition, appreciation, and leaders who listen and bring them to the table together to iron out problems, says Almazar. One of the first things leaders can do is to adopt a “we’re all in this together” attitude. “One of the things we know about people who are traumatized, is that a supportive family and a sense of community lessen the impact of the trauma,” Almazar explains. It’s the same for staff. Solid work relationships can heal. Almazar asks leaders how they promote relationships and a sense of community in their organizations. Organizations that are trying to deal with staff trauma need to be empathic, compassionate, and flexible.

Almazar helps leaders focus on staff appreciation and staff support, and how to emphasize where employees are doing the right thing. Attach any changes needed to the strength of the organization, rather than implying that what they are doing is wrong, Almazar cautions. Employees need to be able to identify with the need for change. Otherwise, they start thinking...why are you fixing something that isn’t broken? Almazar says, “One thing I tell organizations – and people in behavioral health can relate to this – is that they need to be healing organizations. Healing is an adjective, but it is also a verb. An organization not only helps others to get well, but it must continually restore its own health.”

A New Leaf Sheds All Restraints

Dan Oakes, MEd, LPC, Clinical Director of Youth Services, A New Leaf, Mesa, Arizona / doakes@turnanewleaf.org

Decades ago, an unusual program – A New Leaf – demonstrated the humanity and compassion missing so often from mental health programs that do not embrace trauma-informed care. In the 1990s, the program was a Level I residential facility, the highest level of residential care licensed by the Office of Behavioral Health Licensure in Arizona. Even then, before any push for trauma-informed care, A New Leaf had made a conscious decision to remain an unlocked facility. It also made it a policy to avoid seclusion and restraint, a “privilege” afforded any Level 1 residential facility in the state. It took some time to realize the philosophical underpinnings of these choices. The founders, board, and executive team had roots in education. They were determined to create intensive, human, and restorative programs, imparting wisdoms such as, “during the process of change, we should expect symptomatic acting out” and “all behavior has positive intent...we have to help our clients find that positive intent.” This kind of understanding differed from many other programs where the safety trainings focused on coercion and control, and it emphasized A New Leaf’s mission of “Helping families...changing lives.”

A New Leaf also recognized that any level of care that had rotating staff structures would inherently develop an institutional flavor that was counterproductive to the change process. This could retraumatize clients, and often did. The goal, then, was to constantly combat institutional tendencies. This was accomplished through maintaining awareness of the treatment milieu and culture, inclusion of clients in decision making, willingness to look at staff weaknesses and limitations, and recognition that the work would affect both clients and staff emotionally.

A New Leaf strived to remain a hands-on program. While other agencies adopted policies to avoid touching clients out of fear of accusations, A New Leaf taught and practiced appropriate touch. This allowed for the kind of attachment between clients and staff that is necessary for trauma reduction. Rather than merely working with behaviors, the program identified clients that could not connect emotionally. In standard institutional care, assessing the ability to attach goes unknown, so the focus remains on outward behavior. This is a critical institutional flaw. Many of the clients abreact hyperactively due to lack of connections and historical attachment disruptions, while others demonstrate a hypoactive system and shut down behaviorally, thereby appearing compliant. Allen Shore, Dan Siegel, Bruce Perry, Brian Post, and many other professionals are now demonstrating how crucial attachment is and how the unattached “body-system” responds autonomically with dysregulation.

This model had some striking behavioral effects on the milieu over the years at A New Leaf. The program’s need for physical restraint has almost disappeared and the need for seclusion is nonexistent. Staff consciously evaluates intakes for safety and the potential to respond to a restorative model and regularly reject admissions that demonstrate a high need for seclusion and restraint. Despite this, the number of critical incidents requiring physical intervention has diminished to almost zero, with recordable incidents only occurring every several years.

Over the years, A New Leaf has developed the practice of observing a child’s ability to attach and has concluded that traumatic histories of insecure attachment and cumulative life stressors can be mitigated with new healthy attachments. The focus is not only “trauma work” but work toward a combined goal of trauma reduction, attachment enhancement and bonding, and family and community transition of the attachment skill.

A New Leaf’s model evolved over many years. Now, decades after this model’s inception, it is inspiring to see trauma-informed care emerging as the standard in community behavioral health agencies, as well as to see a collective movement toward a standard that enhances the care and compassion for clients, helps families, and changes lives with a trauma-informed care model.

Beech Brook Moves from Staff Reticence to Improved Patient Outcomes

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Beech Brook, a behavioral health agency serving youth, scans vigilantly for emerging trends to better help disadvantaged populations. More than 6 years ago, Beech Brook leadership introduced one of these trends to the agency, introducing a new phrase: “trauma-informed care.” The term sounded good until everyone realized it implied transformational change – such as a drastic reduction or elimination of seclusions and restraints, a therapeutic tool long considered essential.

Soon after introducing the concept of trauma-informed care, Beech Brook benefited from a state-sponsored training provided by the National Technical Assistance Center for State Mental Health Agencies/National Association of State Mental Health Program Directors. Following the training, agency leadership chartered an internal trauma-informed care team to transform how staff thought about, screened for, assessed, and treated trauma. Utilizing NTAC’s Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool©, a potent change process was afoot despite initial reticence.



By new policy, the use of seclusion was eliminated agency-wide, followed by efforts to dramatically reduce restraint use. For example, the agency eliminated restraints in all community-based programs, keeping use available only in the highest levels of care. The agency revamped staff orientation and ongoing trainings, infusing them with trauma-informed care concepts and practices. Even non-clinical staff was required to receive a comprehensive seminar on Adverse Childhood Experiences and Complex Trauma.

Concurrently, the agency introduced new evidence-based clinical models endorsed by the National Child Traumatic Stress Network. Over time, Beech Brook added Trauma-Focused Cognitive Behavioral Therapy, Integrative Treatment of Complex Trauma, Parent-Child Interaction Therapy, and Caring for Children Who Have Experienced Trauma.

The agency received support for its trauma-informed efforts through participation in national, state, and local initiatives, including the:

- >> 2008 SAMHSA Learning Community on Integrative Treatment of Complex Trauma
- >> 2011 Adoption of Trauma-Informed Practices Learning Community sponsored by SAMHSA and the National Council
- >> Ohio Department of Mental Health Task Force on Childhood Trauma
- >> Ohio Department of Mental Health/Ohio Association of Child Caring Organization's Learning Community for Trauma-Informed Care
- >> Cuyahoga County Addictions and Trauma Collaborative

Agency efforts to date have culminated in measurable improvements. Beech Brook has seen an increase in the identification and treatment of trauma-related disorders, as well as statistically significant improvements in clients' symptoms and adaptive behaviors, exceeding state benchmarks. Client and customer satisfaction have remained high. Seclusions have been eliminated and the use of restraints dramatically reduced.

Implementing trauma-informed care comes with challenges. Employing evidence-based practices produces added expenses for training and consultation. Additionally, keeping an "eye on the trauma-informed care ball" takes energy and commitment, largely because of competing obligations (e.g., productivity, record compliance).

Regardless of the challenges, trauma-informed care is well worth it for clients and staff alike. For agencies considering a trauma-informed care approach for better outcomes, three main suggestions include:

- >> Ensuring that top leadership is committed to the vision.
- >> Taking advantage of external consultation, training, and available tools.
- >> Creating an internal trauma-informed care team with diverse representation and led by a "vision champion."

Bridges to Recovery Addresses Trauma's Ripple Effect

Trevor Small, PsyD, Clinical Director, Bridges to Recovery, Pacific Palisades, California / wiederhornh@yahoo.com

Trauma, like a pebble falling into still water, can create ripples throughout a person's life. A challenging aspect of working with trauma patients is sifting through the complex ripples of psychological symptoms and physical complaints that bring patients into residential care. At Bridges to Recovery, trauma services were implemented after recognizing that patients presenting with chronic, treatment-resistant diagnoses also identified traumas that were unaddressed in previous treatment but created overall functioning difficulties. To address this challenge, the residential treatment program integrated a holistic approach that filters out symptoms to uncover and treat underlying trauma in a peaceful, small therapeutic milieu.

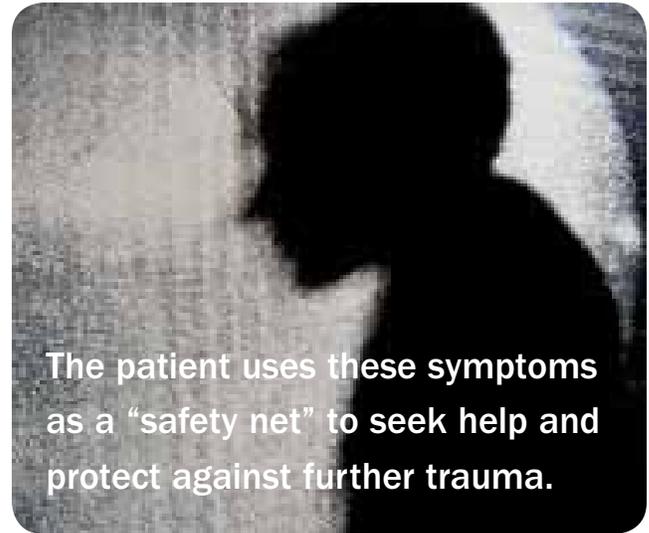
In initial stages of treatment, Bridges to Recovery obtains extensive collateral information to determine an accurate treatment plan. An individual's therapist helps each patient understand trauma's impact by shedding light on symptoms, and explaining how the patient uses these symptoms as a "safety net" to seek help and protect against further trauma. A detailed psychiatric evaluation then considers medications to guide the patient toward recovery, while assessing organic or substance abuse issues possibly complicating treatment. When the individual uses drugs and alcohol to manage overwhelming feelings, a substance abuse recovery plan – along with a careful medication approach – is required.

Individuals experiencing guilt and shame may not verbalize traumatic experiences, thereby complicating trauma work. In these cases, patients may develop maladaptive symptoms, including social withdrawal, aggression, and poor impulse control, to manage feelings and actions. As validation from others can support an individual's move toward growth, Bridges to Recovery implements group psychotherapy to explore trauma in a supportive, empathetic environment. Anger management, grief and loss, and dialectical behavior therapy are also used to holistically approach trauma. Family therapy is another important element of trauma work; relatives are often critical members of the treatment team that supports individuals after they leave residential treatment.

Somatic and eye movement desensitization reprocessing therapy teaches how aspects of trauma “store” within the body, often existing in individuals with unexplained and complex physical complaints. Somatic and Eye Movement Desensitization and Reprocessing therapists complement psychotherapy by seeking to uncover stored information that may prove valuable for individual growth.

Bridges to Recovery’s holistic approach has proven to be a highly effective trauma model to help individuals return to high functioning levels. While outcomes are often complicated to study, patients have decreased the use of psychiatric medications and increased their ability to emerge from old behavior patterns following discharge from this type of program.

Providers looking to implement trauma-informed care may want to follow a treatment-focused program that includes individual and group psychotherapy, and ensures a similar holistic approach to help individuals move toward full potential. Patients can then transition back to a still, quiet place without the ripples of disruption they struggled with prior to admission.



Leis of Love

INTERVIEW WITH MARK PATTERSON, WARDEN, WOMEN’S COMMUNITY CORRECTIONAL CENTER IN KAILUA, HAWAII

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After arriving at the Women’s Community Correctional Center in Kailua, Hawaii four-years ago, Warden Mark Patterson was ready to roll up his sleeves. “I spent 20 years working at the men’s facility, and I had always thought about what I would do differently if I had the opportunity,” says Mark. Many of the women at WCCC were non-violent offenders with myriad mental health issues, addiction, and trauma. “I thought – this is not a prison. It’s a treatment center that’s being run like a prison,” says Mark. So, he focused on trauma and how to develop programs to help deal with it. With little to no funding, Mark started small, and then enlisted community and volunteer support to tackle larger projects. Aging gray walls were covered with light blue paint, and decorated with Hawaiian flowers the female corrections officers dubbed “leis of love”...for the women with mental health issues.

Working the ample acreage surrounding the WCCC came next. Gardening allows the women to mimic the matriarchal spirit that embraces Hawaiian culture. “Hawaiian women do things together like cooking or weaving, in a circle. It’s instinctual,” says Mark. A mental health counselor accompanies the women out to the gardens, and before you know it, conversations naturally begin to emerge. “The land touches you. It has a positive effect. If you work it and bring life to it, you bring life back to yourself as well,” Mark explains.

“By the time many women come to the WCCC, they’ve already been through other programs in the system [like drug courts],” Mark explains. But there’s something about the realization that they’re in prison that sows the seeds for true change to blossom. Volunteers and community mental health professionals help facilitate innovative programs like the creative writing class that gave birth to the “Prison Monologues,” an annually published collection of life stories that are cathartic for the women to write and provides a community outreach component as well. Picnics lay fertile ground for reconnecting with children and participation in positive parenting classes – experiences Mark hopes will help reduce the intergenerational prison rate.

The WCCC women also help plan and put forth cultural celebrations each year honoring King Kamehameha and Dr. Martin Luther King, Jr. Hula mounds and additional greenery might one day replace the courtyard asphalt. “There’s a philosophy to the hula, a belief to it. Lots of the women here have hula experience,” says Mark. The more they can practice and share, they more they feel acceptance and self-confident. Mark is also ready to launch a peer assisted orientation process. “If we can find out what their issues are when they come into prison, we can better direct them toward programs,” he explains, adding however, that his visions for WCCC aren’t quite there yet. There’s still a long field to plow.

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Central Washington Raises the Bar for Effective Care

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Long considered a local expert in trauma, Central Washington Comprehensive Mental Health accepted what its leadership viewed as an ethical and clinical responsibility and took the necessary steps in 2006 to become a formal trauma-informed provider. In this effort to better serve Central Washington's diverse community, Comprehensive introduced four evidence-based practices: Parent Child Interaction Training (serves ages 3-7), Trauma Focused Cognitive Behavioral Therapy (serves ages 6-17), Cognitive Processing Therapy (serves older teens and adults), and EMDR (serves all age). The agency also implemented an annual training that emphasizes the importance of a trauma-informed mentality among clinical and non-clinical staff.

Staff reticence posed the initial challenge to introducing these evidence-based practices into Comprehensive's clinical practice. Long-time clinicians were hesitant to incorporate them into their daily practice; many felt the practices were "too much like a cookbook" and were "not individualized enough." As each supervisor began providing the evidence-based services themselves, and as Comprehensive developed a consultation program, the resistance began to decrease.

The clinical outcomes were undeniable and fully support the shift to provide these evidence-based practices, reinforcing the overall trauma-informed mentality agency staff needed in order to provide the best care possible to the consumers it serves.

Having overcome staff resistance, Comprehensive now focuses its efforts on achieving program fidelity, understanding that the models are most effective when they meet the fidelity standards set by the developers and/or researchers. Namely, the staff understands that it must designate the necessary clinical time slots each week to achieve fidelity.

As it instituted the new practices, the agency learned that establishing training standards and obtaining training from nationally recognized trainers were critical. In addition, the agency found that it achieved the best outcomes by designating one to two clinicians as the lead consultant(s) for each new practice and by requiring consultation groups to meet at least twice monthly until clinicians demonstrate adherence to fidelity standards, and then on a monthly basis thereafter.

Comprehensive now sees children and adults diagnosed with PTSD complete treatment within two to three sessions of those required by fidelity standards, enabling them to achieve better health and wellness through trauma-informed care.

Community Care Goes Back to School with Trauma-informed Care

Jeffrey Blau, LCSW, Director of Care Management; Judith Dogin, MD, Director of Care Management – Community Care Behavioral Health, Pittsburgh, Pennsylvania / blauji@ccbh.com

In order to better serve young people and their families in school, home, and community settings, Community Care Behavioral Health Organization, a non-profit behavioral health managed care organization, developed School-Based Behavioral Health Team Service, a Medicaid-funded clinical home model that emphasizes trauma-informed interventions. The SBBH model, developed in collaboration with education and other stakeholders, integrates comprehensive clinical service into the school environment.

SBBH's core clinical foundations include resilience and trauma informed care, family systems interventions, identification of co-occurring disorders, and positive behavioral supports. The SBBH teams use a biopsychosocial clinical assessment and formulation with a focus on critical events that influence family functioning. Program components include clinical services for youth and families, crisis intervention, case management, and consultation to school staff and other systems serving children. Services are provided by a team of licensed clinicians and experienced professionals.

One unique and critical feature of the model is the development of an SBBH Learning Collaborative, a community that partakes in small and large group training, team coaching, and case consultations. Program training addresses the challenge of expanding the team's clinical capabilities and advancing continued professional development. Training also equips individuals to apply theory using practical family-focused tools. Core principles of the trainings include helping young people and their families harness personal strength in the face of adversity, appreciating the impact of trauma's psychobiology on everyday interactions, and positively aligning with families to avoid re-enactments. Training also provides a greater awareness of the ACE study, helping SBBH teams in thoroughly assess and identify high-risk youth and families and develop treatment plans that promote emotional, psychological, and physical safety.



An example of a SBBH team's application of trauma-informed care involved a 11-year-old girl who was experiencing serious anxiety symptoms. The team was confronted by what they perceived as "interference" from an adult family member. When the team therapeutically slowed its efforts to address the symptoms and increased its focus on hearing the family story, they uncovered a history of domestic violence, serious physical illness, and abandonment. The team then understood the "interference" as "protectiveness" and was able to respect the family's painful life experiences, strengths, and perseverance – resulting in improved therapeutic alliance, trust, and partnership.

The implementation of the SBBH model has been successful largely because of a system-wide commitment to open communication, collaboration, respect, and safe problem solving – all vital elements of trauma-informed care. For enrolled youth, SBBH has improved family relationships and school performance.



Program training addresses the challenge of expanding the team's clinical capabilities and advancing continued professional development. Training also equips individuals to apply theory using practical family-focused tools. ”

Congreso Sees Cultural Sensitivity in a New Light

Jennifer Atlas, Manager of Primary Care Projects, Health Promotion and Wellness; **Claudia Garcia-Leeds**, Clinical Director; **Waleska Maldonado**, Vice-President of Health & Primary Care; and **Lorett Matus**, Director of Esfuerzo (HIV/AIDS) Program – Congreso de Latinos Unidos, Philadelphia, Pennsylvania / waleskam@congreso.net

In North Eastern Philadelphia, trauma is more than an abstract buzzword – it is an all-encompassing concept that defines what many in the community experience daily. Located in the most vulnerable census tract in Pennsylvania, the community faces high levels of domestic violence, violent crime, and drug activity.

With 80% of clients suffering with symptoms of PTSD, providing trauma-informed care is paramount. This spring, Congreso was awarded a technical assistance grant through the National Council's Adoption of Trauma-Informed Practices Learning Community and a 3-year grant from Pennsylvania's Department of Behavioral Health to institute the nationally renowned Sanctuary Model, an evidence-supported approach that help create a trauma-informed organizational culture. Over the next 3 years, Congreso aims to educate all personnel on trauma theory and how they can contribute to an environment in which staff members support one another and members of the community who have experienced trauma. The agency will begin by piloting the model within the health division and with all front desk and security staff.

One of the main challenges Congreso faces is the need to consider the range of programs and the varying staff roles across the organization, and how this model will be implemented in the more than 50 programs and among 200 staff members. Additionally, there is a cultural context to consider. Fewer than one in 11 Latinos with mental health disorders contact mental health specialists. Stigma, cost, and a dearth of culturally competent services all help perpetuate generational community trauma, which directly affects the agency's work.

Despite these challenges, Congreso has seen change. The agency has built collaborations with other organizations that have already implemented the Sanctuary Model. Staff has expressed a desire to be involved prior to an official launch. Within the interdisciplinary team implementing this initiative, there has been greater awareness of what comprises trauma and how to best adopt the Sanctuary Model.

Though there is much to learn, Congreso advises creating a diverse team, one that includes senior management staff and community members. This diversity of backgrounds has already contributed positively to plans for the project's expansion.

Congreso's diverse staff – combined with the resiliency and vibrancy of the community that the agency serves—presents a unique opportunity for tremendous impact both inside and outside of the agency's walls. Congreso looks forward to continuing this process and to someday serving as a model to the community and to other organizations nationwide. ¡Si se puede – we can do it!

Grafton's Caregivers Put Themselves in the Patients' Shoes

Shweta Adyanthaya, Director of Communication, Grafton Integrated Health Network, Winchester, Virginia / sadyanthaya@grafton.org

Grafton Integrated Health Network's journey away from coercive and restrictive interventions and toward a trauma-informed treatment milieu involves many inter-linked components. First is the promotion of a philosophy and environment where clients are safe, valued, respected, and honored. This principle is paramount in a trauma-informed treatment model and critical to improving clients' quality of life and to treatment success.

At Grafton, professional caregivers have focused on comfort versus control. Creating such an environment requires caregivers to put themselves in the position of someone experiencing behavioral distress and let go of any perceived "upper hand." It challenges professionals to rise to their best when those they support are at their worst. It requires humility and the understanding that when a person is having difficulties, is not an opportune time to teach, place limits, or induce additional anxiety and distress. It requires professionals to be kind, courteous, and respectful, and to do whatever is needed to ensure that a person is safe, valued, respected, and honored.

Individuals who have experienced trauma have difficulty forming healthy, trusting relationships with others. At Grafton, the caregiver's role is to help "heal" the individual and build a safe, comforting, and trustworthy relationship, which is accomplished through the use of language that is supportive, encouraging, and nonthreatening.

Trauma-informed treatment also involves taking the time to evaluate a behavior's function and intent. All behavior, both positive and problematic, has meaning. Caregivers at Grafton know they must determine and understand why individuals do what they do and teach "socially acceptable" replacement behaviors.

Appreciating the pervasiveness of trauma, committing to early identification, and understanding the connection between symptoms of behaviors and past traumatic history are all pivotal to trauma-informed treatment as we've discovered at Grafton.

Grafton's trauma-informed treatment model has transformed the lives of those served and led to positive and sustainable outcomes, including a 97% reduction in the use of physical restraints; 41% reduction in employee injuries; and \$7.5 million in savings to-date.

Creating such an environment requires caregivers to put themselves in the position of someone experiencing behavioral distress and let go of any perceived "upper hand."

The Guidance Center Leads Community to Invest in the Future

Laura Huot, Director of Children's Community Mental Health and Deborah Willis, Director of Research and Evaluation, The Guidance Center, Wayne County, Michigan / dwillis@iamtgc.net

Creating a trauma-informed system of care requires cross-system collaboration around information collection and sharing, training, a common vision across public and private systems, and the ability to blend funding in a way that creates a seamless system. It also requires leadership. The Guidance Center has served as a leader in community's effort to create such a system for children.

The Kid's Talk Child Advocacy Center began in 2001 as a forensic interview program for children under age 13 alleged to have experienced sexual abuse. The program worked in partnership with the Wayne County Prosecutor's office, Children Protective Services, and county police. Eight years later, the Guidance Center decided to expand the effort to a full-service children's advocacy center. It was then, in 2009, that the Kid's Talk CAC grew to include advocacy and mental health services. With guidance from its advisory board, CAC began developing a vision to create a full-service center that provided leadership in the development of prevention, intervention, and cross-system training, as well as medical examinations in partnership with the Children's Hospital of Michigan to children who had been abused. The Kid's Talk CAC expanded its partnership with the Department of Human Services, increased cooperation with partnering law enforcement agencies, established a partnership with the Merrill Palmer Skillman Institute at Wayne State University to seek funding for research and program evaluation, and moved into a larger facility capable of housing all the new services and collaborations.

As the Kids Talk CAC expanded, the Detroit-Wayne County Community Mental Health Agency also began to send children's therapists and supervisors employed by private CMH agencies contracted by DWCCMHA to trainings in Trauma-Focused Cognitive Behavioral Therapy. Concurrently, workers in other systems began receiving training by the Virtual Center for Excellence, a training center for CMH workers, on how to mitigate trauma.



Collaboratives, multiple funding streams, information sharing are all important, but it is the ability to align visions across varying systems and programs that transforms a group of linked services into a system. Once visions align, individual outcomes merge into group and community outcomes—and real change occurs. Behind this progress is leadership, a person or group that steps up and issues a call to gather and share, and then supports the necessary dialogues to maintain momentum and fruitful collaboration.

When the Kid's Talk CAC receives full accreditation in March 2012, Wayne County will have a designated organization and established leader to continue the charge of building a system of care that is trauma-informed across all children's services.

Institute for Health and Recovery Knows Healing is All-Encompassing

Norma Finkelstein, PhD, Executive Director, and **Laurie S. Markoff, PhD**, Director of Trauma Integration Services, Institute for Health and Recovery, Cambridge, Massachusetts / lauriemarkoff@healthrecovery.org

In 1998, the Institute for Health and Recovery was chosen as a site for SAMHSA's Women, Co-Occurring Disorders and Violence Study, a 5-year project that explored the interrelation between violence, trauma, and co-occurring mental health and substance abuse disorders among women. During the study, IHR worked with three large behavioral health treatment agencies to enhance their ability to provide trauma-informed care. When the study's positive outcomes were published, IHR received numerous requests for training and technical assistance; it now has experience not only implementing trauma-informed services inside its organization, but also doing so with state agencies and service organizations — in Massachusetts and nationally. Various organizations fund IHR's systems transformation work as part of quality improvement or workforce development efforts; it also receives state and federal support.

The major challenge to implementing trauma-informed services is the comprehensive nature of the change required. Many organizations did not have structures in place to support long-term system change efforts. Organizations must make a serious administrative commitment to providing trauma-informed services and institutionalize this commitment by including trauma-informed care in a mission or policy statement.

The next step is to create a trauma integration committee comprised of staff members who represent different programs, as well as different roles, across the organization (e.g., administrators, supervisors, direct care staff, clinicians, administrative support). In addition, it is vital that organizations include representatives of the people the agency serves and their families. Preparation must be done so that all members feel safe expressing opinions and can value the input of everyone else at the table. This is critical because changes that are understood and embraced by everyone affected, and that are implemented in ways that have been developed collaboratively, have the best chance of actually being implemented as intended.

The trauma integration committee receives trauma training and then develops a trauma integration strategic plan. Goals usually include ongoing training of all staff; reviewing policies, procedures, and services through a trauma-informed lens; implementing trauma screening; locating/developing trauma-specific services; providing information and supports to address secondary trauma and self-care for staff; providing psycho-education on trauma for people being served, expanding peer services, and providing education and resources on emotional regulation for all. Implementation of the trauma strategic plan proceeds at a pace determined by the organization's needs and resources.

The positive impact transformation has on both staff and people being served often surprises organizations. Staff members feel more empowered and effective in their work. Those served are more hopeful, more connected, and more empowered. Working collaboratively toward the goal of providing an environment that fosters healing from trauma becomes a source of connection and inspiration for everyone involved.



The major challenge to implementing trauma-informed services is the comprehensive nature of the change required.



Kentucky River Says Never Give Up

Brenda Hughes, PhD, Director of Trauma Services, Kentucky River Community Care, Hazard, Kentucky / Brenda.Hughes@krccnet.com

It was Robert Kennedy who said, “Few will have the greatness to bend history itself; but each of us can work to change a small portion of events.” It was such a desire for positive change in one of the poorest areas in the nation that resulted in the implementation of trauma-informed care at Kentucky River Community Care, Inc., a Southeastern Kentucky community behavioral health center serving. It was the desire – the “vision” – to bring healing to a region that had long suffered generational trauma.

A Violence Risk Index compiled by David Mathews, PhD, provided statistical data that substantiated that the Kentucky River Region had the most extreme mental health needs in the state, as well as the most severe incidences of family violence. It was at this point that KRCC’s new “Trauma Services” division was born.

There were no state or federal mandates requiring the development of trauma-informed care, but rather a belief in change for the future that motivated the movement within KRCC to better address the needs of the community it serves.

KRCC formed collaborative partnerships with other agencies to secure funding from state and federal sources. The grants that they secured then allowed for the creation of trauma-specific programs. One such program resulted in a nationally recognized model, The Appalachian Violence Outreach Network. Another trauma-specific program, involving intensive treatment for women who experience trauma and substance abuse, has now expanded from one to six sites.

Agency-wide training on trauma targets KRCC’s 650 employees and infuses the “culture of trauma-informed care” throughout all aspects of the agency – from the phone message service announcing trauma services to the website’s description of trauma-specific program offerings. For KRCC, the success of its trauma-informed care can be attributed to never giving up on a “vision” to create meaningful change.

There were no state or federal mandates requiring the development of trauma-informed care, but rather a belief in change for the future that motivated the movement within KRCC to better address the needs of the community it serves.

King County Nurtures Recovery through Broad Community Outreach

Shirley Havenga, MA, MPA, Chief Executive Officer, Community Psychiatric Clinic, Seattle, WA / shavenga@cpcwa.org

Trauma is an almost universal experience of public mental health and substance abuse consumers; the need to address it has become essential for the growth and recovery of trauma survivors. In that vein, SAMHSA awarded a 5-year service grant to the King County Mental Health, Chemical Dependency Services Division – which has primary responsibility for King County, Washington’s delivery of publicly-funded behavioral health services – to implement trauma-informed care as a framework for mental health service delivery and to improve the mental health system’s awareness of and ability to address the needs of trauma survivors.

KCMHCSD selected three community mental health agencies – Community Psychiatric Clinic, Valley Cities Counseling and Consultation, and Asian Counseling and Referrals Services – to introduce a trauma-informed system of care through delivery of nationally recognized models, the Sidran Institute’s *Risking Connection*® and the *Essence of Being Real*. Under the grant project, the agencies provide services to adults living with, or at risk of, serious mental illness, including veterans of the U.S. military and their families. KCMHCSD chose ACRS to provide cultural-related feedback on implementation; both VCCC and CPC were selected to designate clinical teams to implement trauma-informed care and serve in the evaluation process.

The project aims to support the recovery and healing process of adults served in the King County community mental health system through services that recognize trauma as a pivotal force in people’s lives, and to empower people to manage their path to wellness and recovery. The project includes comprehensive screening for and assessment of trauma history; assessment of need for specialized treatment interventions resulting in referral for and/or provision of appropriate treatment interventions; trauma-informed treatment delivered by clinical teams, including peer support specialists who are trained in the application of the *Risking Connection*



model; a peer facilitated group intervention utilizing the *Essence of Being Real* curriculum; and the Copeland Center's Wellness Recovery Action Plan training and support.

The project will serve 600 individuals in the first year and roughly 50 more each subsequent year, peaking at 200 in the fifth year; in total, the project will serve 800 over 5 years. Trauma screening of clients and staff training will expand to the other 14 King County mental health providers in the grant's second phase.

Grant funding became available in October 2010, and services began by April 1, 2011. Therefore, significant results have not yet been identified. However, KCMHCDSO will conduct comprehensive process and outcome evaluations, which will assess progress on system culture transformation, impact on clinical service providers, impact on individuals' trauma symptoms and mental health recovery outcomes, and impact on client satisfaction.

Livingston County Cares for the "Community Child"

Elizabeth Stahl, LMSW LACASA, Supervisor, Kim Batsche-McKenzie, LMSW Wraparound Service Coordinator, and Lindsay A. Beaudry, MSW Community Collaborative Planner; Livingston County Human Services Collaborative Body, Howell, Michigan / lbeaudry@cmhliv.org

In recent years, Livingston County, Michigan has reinvented its response to trauma. The impact of trauma has long lurked in courtrooms, psychiatric emergency rooms, in classrooms with behavior concerns, and in substance treatment facilities. These venues have acted as holding tanks, addressing symptoms of trauma while unintentionally ignoring the overarching systemic theme and its costs. Livingston health and human service partners have shifted away from looking at children's behaviors and needs in silos and mounted a broader approach focusing on the "community child."

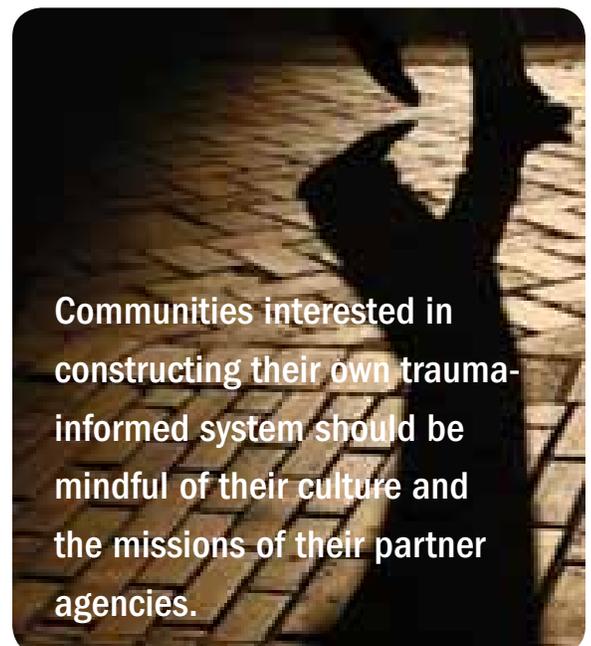
Powered by a SAMHSA grant, Western Michigan University's Child Trauma Assessment Center approached Livingston in 2007 proposing technical assistance for communities interested in replicating a trauma assessment concept. CTAC provided a model for performing multidisciplinary trauma assessments on children, clinical instruction on trauma-informed evidence-based practices like Trauma-Focused Cognitive Behavioral Therapy; and training for professionals on topics like secondary trauma. This multitiered model was well received by the Livingston community.

Livingston's Trauma-Informed System of Care was piloted using flexible, blended local funding to offset host agency expenses and stipends for private practice practitioners. The system receives support via in-kind donations from social workers, occupational therapists, and speech pathologists from local school districts and community mental health centers. The multidisciplinary team is trained to perform assessments using evidence-based tools that inset a trauma "lens" specific to their skill set. Assessments are intended for children with severe emotional disturbances who are at risk of out of home placements. Team leadership is provided by Livingston's domestic violence, sexual assault, and child abuse agency staff with oversight from a community multidisciplinary trauma steering team.

More 20 assessments have been conducted since 2009, saving the community thousands of dollars. Local capacity has eliminated waiting periods for costly out of county assessments that lack community perspective. Children assessed are now more likely to remain in their community instead of moving to residential placements, and children already placed outside their family home have seen fewer placement disruptions. System partners better understand the physical, mental, and psychological implications of trauma, leading them to react more productively, instead of punitively, to challenging behaviors – resulting in more appropriate services.

Livingston learned that assessment capacity alone is not enough to transform the community landscape. Transformation also requires a welcoming community and a rich network of trauma-informed services to carry out recommendations drawn from assessments. Maintenance and ongoing training in trauma-focused practices is essential to the sustainability of the Livingston model. Additional challenges included maintaining community momentum and product consistency, which donated staff time can address.

Communities interested in constructing their own trauma-informed system should be mindful of their culture and the missions of their partner agencies. When seeking out allies it is best to identify a common philosophy around the "community child" and unite around combating the costs of trauma. Expanding existing programming and generating system buy-in at all levels is essential to the success of any system transformation.



Communities interested in constructing their own trauma-informed system should be mindful of their culture and the missions of their partner agencies.

Mental Health Center of Denver is Where Women Come Home

Eric Brody, Grants Development Manager, Mental Health Center of Denver, Denver, Colorado / Eric.Brody@mhcd.org

The Mental Health Center of Denver's longstanding commitment to providing trauma-informed care took a major step forward in 2006 when, with funding from SAMHSA, it launched the Growth and Recovery Opportunities for Women program. GROW provides specialized treatment to 40 homeless women who have experienced trauma and suffer from co-occurring serious mental illness and substance abuse disorders.

The program was developed as a collaboration between multiple community stakeholders, including local homeless shelters, community indigent medical treatment clinics, MHCD clinicians, and mental health consumers. Together, from their varying perspectives, the members of this collaboration identified the needs of Denver's female homeless population living with co-occurring mental health and substance abuse disorders. The foremost concern was the expectation that a traumatic background had largely contributed to the consumer's homelessness and symptoms of mental illness. This concern led to the adoption of Trauma Recovery and Empowerment Model, an evidence-based practice tailored for those with a traumatic background and stress-related mental illness. Other evidence-based practices integrated into the program include Assertive Community Treatment, Integrated Dual Disorders Treatment, and Motivational Interviewing/Stages of Change.

In addition to the project director and program manager, the project staff includes one full-time case manager, two full-time clinical case managers, a part-time psychiatrist, and a part-time psychiatric nurse. The project also receives support from a cultural competency consultant and research and evaluation personnel.

The main challenge of delivering trauma-informed care is to achieve and sustain a level of trust with consumers whose experiences have made them wary of strangers. Recognition of this challenge prompted the adoption of one of the program's innovative hallmarks: treatment of women by women. All treatment providers are women, mirroring the group served and enhancing the effective delivery of services.

Another challenge is providing the appropriate training and ongoing supervision necessary to ensure that all personnel — clinical and non-clinical — interact with every consumer in a trauma-informed manner. This can present a financial and administrative challenge as most new staff have neither received previous training in a trauma-informed treatment paradigm nor even been informed about it.

The GROW women have exhibited remarkable progress. A standardized assessment taken at intake and discharge shows a 187% improvement in abstinence from alcohol and illegal drugs, a 41% improvement in employment and education, and a 42% improvement with regard to health, behavioral, or social consequences of alcohol or drug use. MHCD also assists its consumers with housing, and the percentage of women who achieved stable housing through their GROW experience increased a staggering 4,700%. In 2009, SAMHSA recognized this innovative, highly successful program with its Science and Service Award.

Other providers can certainly replicate this kind of success with trauma-informed care. To increase their chances for success, providers should make sure that all staff members who interact with consumers — including community partners — bring a trauma-informed sensibility to their work and treat every consumer as a potential victim of trauma.



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One of the program's innovative hallmarks is treatment of Women by Women.”



Mental Health Connection Moves from Tragedy to System Change

Patsy Thomas, President, Mental Health Connection, and Molly Lopez, PhD, University of Texas at Austin, School of Social Work, Austin, Texas
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On September 16, 1999, a man with a mental illness entered the Wedgwood Baptist Church in Fort Worth, Texas and opened fire on a group of students and advisors. Seven young people were killed, seven others were critically injured. More than 150 adolescents were in attendance that evening.

As part of the community's response to this tragic event, Fort Worth Mayor Kenneth Barr formed a taskforce of local leaders and practitioners to address gaps in mental health services, forming a community collaboration called Mental Health Connection of Tarrant County. MHC was tasked with transforming the mental healthcare system and creating an accessible, coordinated array of effective services and supports. The taskforce represents a vital partnership of public, private, city, and state agencies.

In 2007, MHC began an initiative to dramatically reduce the noted research-practice gap. Six learning communities, each focused on a different system area, were formed that spent the next several months examining relevant research. After completing the research review, the Trauma Learning Community followed with a recommendation that the community implement a standard trauma screening protocol and Trauma Focused Cognitive Behavioral Therapy. Implementation was supported through Texas' SAMHSA-funded Mental Health Transformation Grant. Fifty-four therapists from 13 agencies received training in TF-CBT and participated in 9 months of coaching.

MHC noted several challenges to delivering trauma-informed care, including the complexity of incorporating a standard screening protocol across all participating agencies, the lack of systematic referral processes, limited experience with trauma assessment tools, and the need to develop a method for therapist peer support.

The team continues to explore opportunities to train additional practitioners and ways to improve treatment fidelity.

In Prison We Care

INTERVIEW OF LYNN BISSENETTE, SUPERINTENDENT, MASSACHUSETTS CORRECTIONAL INSTITUTION, FRAMINGHAM, MASSACHUSETTS
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Changes in the way the Massachusetts Correctional Institution, MCI Framingham, viewed trauma were propelled by multilateral avenues and the collective action of administrators and staff members who wanted to learn more about trauma-informed care. "The road to becoming more trauma-informed was a long time coming," says Lynn Bissonnette, superintendent of MCI Framingham, a medium-security women's correctional facility in Framingham, MA dating back to 2004 when a governor's commission on corrections reform launched an independent female offender panel to explore problematic issues in the system. "One of the topics reviewed was becoming more trauma informed," explains Lynn. After noticing an extreme spike in self-injurious behavior 2 years ago, Lynn did additional research to figure out why and to draft a proposal for a Bureau of Justice Assistance grant to really get the trauma-informed care ball rolling despite looming budget struggles and cuts. As part of the grant, Lynn was able to invite Joan Gillece to do onsite training with corrections staff on the impact of trauma on behavior.

Lynn also wanted to get peer support off the ground and train inmates and clinicians in coaching and mentoring skills. Most of the women in the state wind up at MCI Farmington. The inmates are very diverse and the turnover is huge, explains Lynn. About 30 female inmates were initially trained and word

spread throughout the facility. Applicants, many of them long-termers, came pouring in. "Because of the women's histories, they are experts in trauma, and they've been able to survive. If you have the experience you can be a listening ear for another woman," says Lynn. Potential applicants were screened by mental health professionals. These women have been doing peer mentoring on an informal basis for years, and now they're coming out of the woodwork to volunteer.

Women are different from men, explains Lynn. Female offenders are more challenging. "They don't take the initiative to speak up and advocate for themselves in a productive way. Now the women offer suggestions and create presentations. I've been here for 28 years and it's really opened my eyes to how much talent we have here," Lynn says, "I've always known this, and now it really shows." MCI Framingham has recently launched an inmate orientation program that helps new women acclimate (a lot of stress comes from adjusting to the facility). A wellness program includes yoga classes taught by a volunteer instructor. And a group of staff and inmates are developing a participant module program that will include everything from stress management to how to best use your time...with an emphasis on self-awareness. "We're hoping to be ready for full rollout by September," Lynn adds.

Eighty-six youths and caregivers were enrolled in the evaluation study. Participants ranged from age 8 to 17, were predominately female (61%) and ethnically diverse (32% Hispanic, 25% Black, 43% White). Participants received an average of 13.5 TF-CBT sessions; outcomes were measured by self-reporting by parents and youths at study entry, end of treatment, and 12-month follow-up. Parents and youth both reported reductions in trauma-related symptoms at the end of treatment, and maintained improvements at the 12-month follow-up assessment. Improvements were also seen in internalizing and externalizing symptoms. The size of the effects ranged from medium to large and were similar to those reported in efficacy studies of TF-CBT using the same outcome measures. Improvement in youth resilience was documented, as were reductions in caregiver distress. At study conclusion, therapists indicated they were very likely to continue using TF-CBT.

In addition to pure perseverance, the success of MHC's initiative to expand trauma-informed care in Fort Worth was due to the time invested in developing a shared vision, the collaboration and support provided by agency leadership and participating therapists, and the partnerships with treatment developers and academic researchers. The MHC team also benefited greatly from the resources developed through the National Child Traumatic Stress Network.

Peace4Tarpon Knows It Takes a Village

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"There is no trauma-free zone," reads a poster announcing Peace4Tarpon, a community-wide effort to introduce trauma-informed principles in Tarpon Springs, Florida. The mission of Peace4Tarpon is "to provide *everyone* in our community with information on the causes and consequences of trauma" and to support "public and provider education, resource assistance, and advocacy for appropriate prevention and intervention services." Peace4Tarpon includes virtually every group and civic organization in the city—the mayor's office and city council, the city manager's office, the police and fire departments, the housing authority, the school system, health and human services, the business community, the faith-based community, and the local college, art museum, and library. These disparate groups work together with a common mission – to make Tarpon Springs a safe, healthy, healing, and productive community.

Peace4Tarpon was the inspiration of the city's vice-mayor, Robin Saenger, a passionate advocate experienced in local politics. But it also grew directly out of a mounting national movement. When the vice-mayor was first introduced to the concept of trauma-informed care, she immediately saw its potential for community development. She didn't have far to go to find knowledge and expertise – the National Center on Trauma-Informed Care had been training the Florida behavioral health and justice systems for several years, and there were people nearby to provide advice and support. After preliminary discussions with community leaders, Saenger arranged for short presentations on trauma-informed care to be made to the city council and to a group of community stakeholders. Both groups were profoundly moved by data showing the relationship between "adverse childhood experiences" and health and social problems. The framework of trauma-informed care seemed relevant to everyone: business leaders started discussing implications for the workforce; the mayor wrote an editorial about the importance of human capital in community development; and the chief of police commented, "This we can understand and get behind. We deal with the consequences of violence every day."

A steering committee with open membership was formed, and all members signed a Memorandum of Understanding. Membership continues to expand – a mark of growing community interest. While there is no external funding for the initiative, members have been very creative in accessing resources. During its

Because the impetus for **Peace4Tarpon** came from the community, the initial focus was on **public education.**



first year, Peace4Tarpon received a \$1,000 grant from the Rotary Club, was named the "North County site" in a countywide children's initiative, and received \$18,000 for public education from the Juvenile Welfare Board. In addition, the library purchased a collection of books on trauma for children and adults, the local art museum partnered with a nearby college to offer art therapy sessions for traumatized children, and other organizations and individuals contributed time, expertise, and in-kind resources.

Because the impetus for Peace4Tarpon came from the community, the initial focus was on public education. The premise was that many trauma survivors could be helped, and many harmful interactions avoided, if ordinary citizens understood trauma, knew what to look for, and were familiar with some fundamental do's and don'ts. Almost 300 people attended a Saturday training event that formally launched the initiative. Discussions at steering committee meetings have since demonstrated how an understanding of trauma can change people's assumptions and behaviors.

One woman described how after the training, she was able to intervene in a situation in which her neighbor was being unintentionally retraumatized by first responders who didn't know her trauma history. In the past few months, a social marketing subcommittee has made plans to reach broadly into the community using posters, t-shirts, storefront signs, local media, and Facebook. A trauma survivor from a nearby community has offered to help organize the peer voice, and a youth summit, teacher education event, and trainings for first responders have been planned.



Most agencies represented on the steering committee have also expressed their desire to become trauma-informed. The community mental health center has played a key role in demonstrating the depth of that undertaking. After extensive staff training and a complete revision of assessment instruments, the agency director asked a friend with a trauma history to enroll as a client, unknown to staff, and to report on her experience. Much to the director's chagrin, the agency failed the test completely – the woman experienced the intake process and environment as inconsistent with basic principles of trauma-informed care. To the agency's credit, they took the feedback seriously and have since made major changes, providing a wonderful model to other agencies.

Peace4Tarpon will soon begin a pilot project in one elementary school as part of an overall focus on schoolchildren. The project will identify high risk children and families, use trusted community members to broker relationships, draw on all

relevant agencies to meet identified needs of the child and the family, and use a "time bank" (a pool for trading skills and resources) to give families an opportunity to give back to the community.

There has recently been a re-emergence of local community organizing as a viable strategy for change. Grassroots efforts to develop resilient and sustainable approaches to the environment and the economy have been springing up across the country and across the globe. Peace4Tarpon is a similar effort, focusing on social and behavioral resilience. Clearly, the health and social welfare of a community and the people who live there are as important to long-term sustainability as the environment and the economy. Tarpon Springs has made trauma-informed care mainstream, and other communities are already considering similar efforts. National Council members are in a prized position to provide the inspiration and local leadership to make it happen.

Out of Shame Comes Sharing

INTERVIEW WITH ELLEN GOLDSTEIN, ASSISTANT DIRECTOR, REDWOOD HOUSE AT CAMINAR, SAN MATEO, CALIFORNIA

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Back in October 2008, eight mental health professionals and one consumer united through their vision of San Mateo County, CA as a trauma-informed system of care. Each one had realized the need for an understanding of the prevalence and impact of trauma on people's lives. So, they came together as change agents and formed the Trauma Learning Collaborative, an innovative, self-organized group, and began working together to provide trauma training known as Trauma 101. One of TLC's members, Ellen Goldstein is the assistant director at the Redwood House at Caminar, a crisis facility in San Mateo County. "We are a group that recognized the need for trauma-informed services and we are each passionate about training others," says Ellen. "Trauma 101 seeks to reduce stigma and shame by asking the question, 'How can I understand this person?' rather than, 'How can I understand this problem or symptom?'" Ellen explains.

Group members attribute the Co-Occurring Initiative that began in 2006 as the springboard that helped open some vital doors and made the formation of a collaborative such as TLC feasible. Trauma 101 develops a common framework for working with people whose lives have been affected by trauma, and helps service providers from a diversity of specialties and clinical care backgrounds to increase their recognition of the effects of trauma. The key to TLC's success lies in its collaborative spirit and adherence to a consistent message that embraces each TLC member as an integral and complementary part of the collaborative team.

Instead of making trauma-informed training something extra for agencies and providers, the Collaborative focuses on integrating a trauma-informed culture

into the existing infrastructure. "We have not met any real obstacles because we are joining the system to improve services for those we serve," says Ellen. An online search of existing efforts in trauma-informed care gave the Collaborative its starting point for developing a PowerPoint that is adaptable to any service provision population. "TLC is offering a zero cost solution for how to become trauma-informed," Ellen adds. TLC has trained over 500 providers within the system to date, and for the past 3 years TLC has organized yearly grant-funded events such as the first and second Annual Trauma Conferences to help educate providers and consumers about working with the effects of trauma. Last May, TLC hosted two days of training at the National Center for Trauma and Justice and performed onsite visits to the county's level 14 facility for adolescents, juvenile justice program and outpatient mental health for youth and adult. Providers are hungry for this. TLC's spirit of service and possibility is rippling throughout the system and drawing an increasing number of requests for Trauma 101 trainings.

The Trauma Learning Collaborative consists of a diverse representation of providers and a consumer spanning nine distinct, yet complementary areas within the San Mateo County's system of care, including: Chauncey Chatman, MFT Case Manager for Alcohol and Other Drug Services BHRS, Ziomara Ochoa, MFT Program Specialist for South/Central Youth Team BHRS, Ellen Goldstein, MFT, Charlotte Ormond, PhD. Program Coordinator for Outpatient Women's Trauma and Substance Recovery Program WEC StarVista, Mary Taylor Fullerton, MFT Program Specialist for the Co-Occurring Initiative BHRS, Kristin Dempsey, MFT Director of Workforce Development BHRS, Nancy Wilson, Mental Health and Substance Abuse Recovery Commission, Toni de Marco, MFT Clinical Services Manager for Juvenile Probation, Child Welfare and Prenatal to Three Behavioral Health and Recovery Services Teams BHRS, and Noelle Bruton, MFT Mental Health Program Specialist Prenatal to Three Program BHRS.

Seminole's Success Stories Inspire Patients and Providers

James P. Berko, MSW, ACSW, President and CEO, Seminole Behavioral Healthcare, Fern Park, Florida / cmorton@cbrpr.com

For Seminole Behavioral Healthcare, trauma-informed care is more than a philosophy, it is a crucial part of the organization's treatment program and its implementation of evidenced-based practices.

Recently, a 4-year-old boy visited the private, nonprofit organization in Seminole County, Florida. He was having temper tantrums and had been kicked out of day care. Now, some might chalk this up to him being a "bad boy." However, there was more to the story, and Seminole Behavioral staff knew to ask, "What happened to him?"

His therapist learned that the boy was adopted and suffering because of significant neglect experienced during infancy. Trauma was behind his temper. Once the child's family shifted its thinking and saw his temper as fear-based and not anger-based, they were more equipped to respond in a helpful, loving way. Most parents and providers who are uneducated in trauma might have merely disciplined the child for bad behavior. However, Seminole Behavioral was able to teach the family how trauma affects behavior and provide them with a more informed way of understanding the boy's behavior.

Area residents seeking treatment from Seminole Behavioral often carry a deep-rooted seed of trauma. For this reason, the organization strives to look further into an individual's past to discover trauma and its role in an individual's life.

Funded through public and private partnerships, Seminole Behavioral's program has solicited client input for its policy decisions and staff training right from the start. In the future, the organization plans to incorporate client input via online

networks. For example, client volunteers will post success stories on Seminole Behavioral's Facebook page.

The nonprofit also has made many changes ranging from the facility's look to involving patients in their own treatment, and has received encouraging feedback from clients. From the moment an individual walks through the door, he or she experiences a warm and welcoming environment, not a sterile one that is too common in the industry. And, it's working.

One of the greatest challenges with implementing trauma-informed care is involving every member of the organization, including support staff that have not traditionally been involved in direct client care. What's more, successful implementation of trauma-informed care requires client engagement, critical evaluation of the organization, and manageable and realistic goals.

One of the greatest challenges with implementing trauma-informed care is involving every member of the organization,

The National Council for Community Behavioral Healthcare selected Seminole Behavioral to join forces with 21 organizations nationwide to share strategies via a Learning Community. The nonprofit will provide training to community-based organizations throughout Florida upon completion of the Learning Community. And since the organization is heavily involved in the Central Florida Trauma-Informed Care Task Force, it will share what it learns with those organizations as well.

By weaving trauma-informed care into treatment, Seminole Behavioral is improving the care its clients receive — looking beyond the surface of an individual's problem and delving deeper into the root of it, asking, "What has happened to you?"

Spectrum Advocates for Understanding the Unspoken

Susan Moitozo, Vice President of Clinical and Women's Services, Spectrum Health Systems Inc, Worcester, Massachusetts
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As a national non-profit organization specializing in the treatment of drug and alcohol addiction, Spectrum Health Systems, Inc. has long embraced the concepts of gender responsive services. The organization also recognizes trauma as an underlying and interacting component of many clients' substance use disorders. With this understanding, Spectrum began an initiative to evaluate gender responsive and trauma-informed practices across its continuum of services to better design its program to better meet the needs of individuals with histories of trauma.

The organization surveyed clients and staff in its 80-bed, long-term, co-ed residential treatment program, revealing some dissatisfaction around key areas relating to gender and trauma. Both men and women expressed a desire for same gender forums to discuss personal and sensitive topics, as well as the designation of separate and personal space geared to each gender's needs. The survey feedback prompted many changes in the physical layout of space and environmental design, the creation of gender specific treatment tracks, and the introduction of trauma treatment programs.



As Spectrum implemented these environmental and clinical design changes, the organization collaborated with the Institute for Health and Recovery to embark on a comprehensive training process to ensure all staff members were trained in trauma-informed care.

Using self-assessment tools, Spectrum evaluated its progress toward trauma integration; over the past 4 years, the organization has continued to evaluate policies, procedures, and program materials. These efforts have resulted in heightened recognition among staff of trauma's symptoms and triggers, environmental adjustments that minimize re-traumatization, and the delivery of helpful support to clients whose experiences affect their ability to respond within the program's treatment environments.

For Spectrum, adoption of trauma-informed care has resulted in better screening practices for detecting potential trauma needs, improved curricula to foster necessary coping skills among clients with histories of trauma, and integrated interventions that address trauma and substance abuse earlier in treatment.

Guided and informed by evidence-based knowledge and practice, Spectrum strives to ensure that its policies, practices, training, curricula, and service delivery systems recognize and incorporate the principles of trauma-informed services. Women may report trauma more frequently, but the numbers of men willing to self-disclose trauma is growing. Spectrum infuses staff and clients with one fundamental principle: a client should not have to disclose trauma to receive trauma-informed care.

Spectrum's program completion rates and client satisfaction scores have each increased 20% since instituting these changes.

Gender-responsive Programs at Miramar

INTERVIEW WITH DEBORAH BELL, TECHNICAL DIRECTOR, NAVAL CONSOLIDATED BRIG MIRAMAR, SAN DIEGO, CALIFORNIA

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Aboard the Naval Consolidated Brig Miramar, a military prison operated by the U.S. Navy at Marine Corps Air Station Miramar in San Diego, California, the focus has been on trauma, and how trauma affects women offenders. The level 2 co-ed facility houses males with sentences of 5 years or less and Department of Defense female offenders from pre-trial to life sentences. "Our newly opened women's facility uses trauma-informed principles in its design to create an atmosphere that is conducive to the women's sense of safety and security, so they can focus on their rehabilitation," explains Miramar's Technical Director, Deborah L. Bell. Men act differently and think differently, even when they commit crimes. To address their different issues they separated the men and women in treatment groups, and even changed the flow of prisoner movements to provide more privacy. "They each have equity in treatment," says Debbie, "It's just...different."

Walls in the women's facility are covered in warm southwest colors and the acoustics were dimmed by covering concrete floors with carpet. Harsh lighting was replaced with softer natural light and wooden doors replaced steel to mimic a more natural living environment, while still providing needed security. Dropping the ceilings a few inches with a barrier to hide harsh HVAC pipes allows them to speak in more natural tones without having to raise their voices, so the brain isn't reminded of a former trauma that might have involved loud, harsh sounds, Debbie explains. The blend of gender-responsive programs and design creates a promising setting for these military prisoners to return to civilian life as productive citizens.

The setting is neutral and calm, and provides a feeling of safety and concern that helps to begin to trust the process of healing. Women participate in programming, work, physical fitness, and recreation activities, and in town hall group meetings that foster a sense of community. The overall environment encourages the women to open up. Civilian and military teams work with them, and they have responded by speaking up more, and trusting a bit more, says Debbie. But in the corrections setting, and in the military overall, there's a fine line to walk when voicing your opinions. "We're telling the women to speak up, but on the other hand the message in corrections is 'do as your told and don't argue,'" Deborah explains. But even in everyday settings, having your voice heard does not always mean that your input must be accepted, she adds.

Developing these skills takes practice, and there are lots of steps backward as well as forward. There a process behind using assertiveness versus aggressiveness or silence in expressing one's needs, says Debbie. "I respect these women. They've somehow gotten themselves out of a negative situation in their background by joining the military and serving their country. That's a step forward," Debbie insists. But there's a sense of overwhelming loss as well. They chose the military as their career and now it's gone. What's safe for them and best for them is getting back on solid footing, recognizing the negative influences, and making good choices that will continue once they get out. "This is empowering in and of itself," says Deborah.

Star View Gives Youth in Residential Care A New Outlook

Gary Crouppen, PhD, Clinical Program Consultant, Karyn Dresser, PhD, Director, Research and Program Practices, Peter Zucker, PhD, President and CEO, Stars Behavioral Health Group; Natalie Spiteri, PsyD, Administrator, Star View Adolescent Center, Oakland, California / kdresser@starsinc.com

Youth participating in the Star View Adolescent Center residential treatment program regularly achieve their treatment goals within a year. However, the program's clinical leadership recently perceived an opportunity to accomplish even more with the young residents.

The opportunity emerged after a shift to serving a predominately child welfare population. While clinical leaders already understood the complex developmental trauma prevalent in the new service population – and senior clinicians effectively address associated symptoms – the agency lacked an integrative model with sufficient nuance to map what youth really need given their difficult life stories, as well as plainness of language and guidelines to shape and sustain the work of all 200 staff members across the various departments – counseling, dietary, facilities, nursing, residence, social work, and schooling.

After some review, SVAC leadership determined the Attachment, Self-Regulation and Competency model fit the center's objectives. They engaged ARC co-developer Margaret Blaustein, PhD, and commenced a multi-year implementation process – now nearing mid-point – sustained and overseen by varied funders and regulators.

Implementation challenges relate primarily to unifying staff around a common understanding of trauma's impacts and the optimal ways – in light of the varying staff roles and educational/training levels – to work with young residents. Through consultation with ARC developers, SVAC leadership learned the importance of sustained emphasis on key ARC lessons, consistent use of language, and attention to staff's vicarious trauma. The program has reconfigured some aspects of

Veteran Connections

INTERVIEW WITH LISA PETERSON, LMHC/LCDP, PROGRAM MANAGER, OUTPATIENT BEHAVIORAL HEALTH SERVICES, THE KENT CENTER, WARWICK, RHODE ISLAND / lpeterson@thekentcenter.org

Stigma is one of the biggest hurdles for veterans to clear when seeking help for mental illness and trauma endured in combat. "TAMAR, Trauma, Addiction, Mental Health and Recovery, is a starting point to address this," says Lisa Peterson, LMHC/LCDP, program manager of outpatient behavioral health services at The Kent Center for Human and Organizational Development in Warwick, RI. "Hopefully we can take away some of the stigma and fear and improve their functioning and overall quality of life." The veteran-centric TAMAR classes that are being piloted at The Kent Center were developed by the National Center for Trauma Informed Care, and a veteran's format was created as part of this grant. "Everyone, from the front desk staff to the outpatient therapists, is trained to be mindful that people's experiences shape their interactions with us, and we want to be respectful in how we respond," says Lisa.

Every aspect of the programming is configured to trauma-informed care principles, and staff members learn to recognize that even subtle things can serve as barriers to seeking out and receiving treatment. For one, how many times do consumers have to tell their story? Lisa explains. The Kent Center streamlines its intake process and trains clinicians to document records that can flow efficiently between treatment providers. "And we provide consumer-centered care. Treatment is really a collaborative process that focuses on what the consumer

wants to work on," says Lisa, "They drive the bus because they are the experts on themselves and what they've experienced. Consumers are also educated about which services they may participate in, and why," she explains, adding that they need to understand why what has happened to them has not allowed them to ease back in to the lives they had before the trauma.

The Kent Center TAMAR classes emphasize coping skills, symptom reduction, and programming that help reduce criminal recidivism, particularly when the crimes appear to be linked to trauma, says Lisa. This can be especially problematic when the individuals themselves don't recognize that the behaviors that are getting them into trouble might be linked to the trauma. "Or that their difficulties might be a result of the combat mindset that doesn't just shut off when they come home," explains Lisa. This obliviousness to the trauma connection keeps them from working on things they need to. "The most powerful aspect of TAMAR is the connection and bonding that occurs," says Lisa, "Being in the classes together helps them to see other veterans who are feeling the same way. They establish a connection and natural support with one another so they can talk about the things their families just won't understand, or are so horrific they simply cannot share it with them." The men figure out that it's okay to lean on one another because of their shared experiences.



program structure (e.g., creating unit teams) and, along with formal training, engaged in teambuilding activities to encourage staff buy-in. Leadership set about to help staff experience what it feels like to be supported, using fun and novel approaches like gratitude logs and “wellness week” activities.

The emphasis on empathic care taking – modeled by management for staff – proves critical, as staff must in turn provide such care to each young resident to best facilitate healing and wellness. This is an especially important counter-balance for both staff and clients in a highly regulated service context characterized by many rules for congregate living, treatment, and education. In intensive residential trauma treatment, staff members must hear about what they can do, positively and proactively, to take care of themselves, as well as the clients.

Is the program working? So far, data are promising. Overall facility incidents are down nearly 50% (from 424 in the first quarter to 249 in the second, 2011); use of restrictive interventions are trending down (30 in April, 25 in May, and 18 in June); and average daily school attendance improved markedly (77% last year to 95% end of this school year). Notably, staff creativity has also exploded – they are introducing many new, integrative sensory-motor curricula such as dance, yoga, meditation, and psychodrama into group services. The new activities are well liked and attended by the youth, marking another great harbinger of youths’ recovery and future wellness.

Tri-County Knows Trauma-Informed Care is the “Right Thing to Do”

Catherine R. Ryder, LCPC, ACS, Executive Director, Tri-County Mental Health Services, Lewiston, Maine / cryder@tcmhs.org

Tri-County Mental Health Services implemented trauma-informed services because it was the right thing to do. In the initial stages of implementation, the process required active executive level support and participation, followed by the initiation of focus groups representing a cross section of agency staff, consumers, and stakeholders within the community. These focus groups allowed for critical discussion of current service delivery and recommended strategies for change.

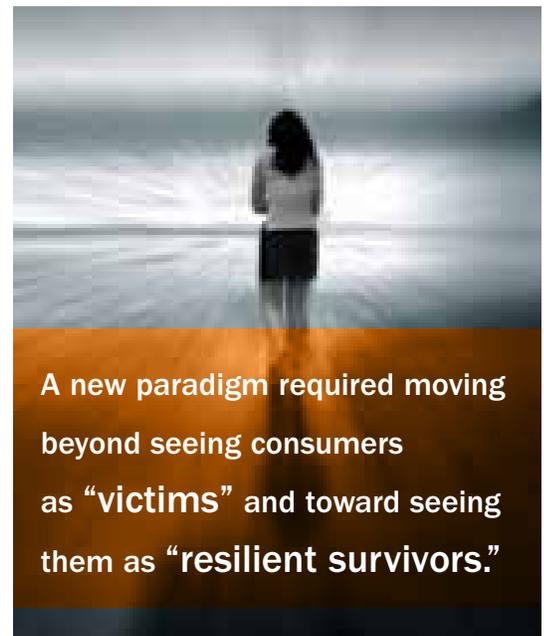
During the focus group process, it became clear that agency staff did not fully understand the role violence and victimization play in communities, and more importantly, how it shapes consumers’ lives. This recognition, and a new paradigm, required moving beyond seeing consumers as “victims” and toward seeing them as “resilient survivors.”

The concepts of hope and recovery were vital to launching trauma-informed services. Hope allows for an understanding that there is life beyond illness or a traumatic event, and the recognition that people are more than the symptoms of their illness. Recovery is not linear and therefore can create challenges that result in despair. The agency’s work was to find a way to support consumers in holding on to hope during the most challenging of times. This included designing and implementing services that respond to the unique needs, vulnerabilities, and strengths of trauma survivors and offering services in a way that facilitates the collaborative participation of consumers/survivors in their own service provision. Key elements included recovery and skill building values; universal trauma screening, assessment, and service planning; privacy and confidentiality; group interventions; privacy of space; crisis management; and clinician care.

Two years after implementation, program evaluation results support the effectiveness of trauma-informed programming in enhancing consumers’ overall daily functioning; reducing mental health symptoms and physical health concerns; strengthening consumer safety; and decreasing the use of intensive services such as inpatient hospitalization and crisis interventions. Consumers report, in both qualitative and quantitative surveys, very high levels of satisfaction with the overall program, and specifically, with the trauma-informed changes in service delivery.

As a result of Tri-County Mental Health Services’ new understanding and application, consumer roles within the agency shifted. Consumer advisory teams were created to develop and inform practice standards and agency policies; peer employment opportunities were developed and staffed, consumers assumed a stronger presence on the board of directors, and support and training for consumers interested in participating in state workgroups became the norm.

Additional application of the agency’s trauma-informed position is evident in its interview and hiring process. All new staff members attend a weeklong orientation during which they receive an inoculation to trauma-informed service delivery, and then receive ‘booster shots’ throughout their tenure. This standard is now a constant in supervisions and case reviews. As a commitment to trauma-informed services, the Tri-County Board of Directors adopted the following statement: “We unanimously endorse the agency taking a recovery based trauma-informed approach to service delivery.”



Truman Shines a Light on Trauma in the Primary Care Milieu

Tara Gunther, PsyD, Section Chief/ Psychology, Truman Medical Center Behavioral Health, Kansas City, Missouri / tara.gunther@tmcmcd.org

Located in Kansas City's urban core, Truman Medical Centers is widely known as a Level 1 Trauma Treatment Center. The prevalence rates of trauma are extremely high, prompting TMC's recent move to create a trauma-informed culture and internal paradigm shift. Given the all too common opinion that patients are confrontational or violent when in the primary care settings and yet not violent or confrontational in the behavioral health setting, TMC decided to implement trauma-informed care across the entire hospital spectrum – including primary, specialty, and behavioral health care.

To date, TMC's emphasis has been to educate staff about trauma and its impact, as well as to promote sensitive practices. Alternating staff members conducted the education sessions, eliminating the need for additional funding; TMC hired a clinical psychologist skilled in evidence-based treatments for PTSD in order to improve treatment for those who need this level of service. TMC also sought grant funding to help support the uninsured and underinsured people that it serves.

Each department has experienced its own paradigm shift after participating in trauma-informed educational sessions. After the sessions, there is clear recognition that the difficult-to-engage patient who presents as angry, hostile, withdrawn, or tearful may have something else in their history affecting how they respond to treatment interventions. Staff report increased awareness while interacting with patients about procedures, successful use of task specific inquiry, and a better-informed view of no shows and cancellations. While too early in the journey to realize marked differences in patient outcomes, TMC expects to see improved patient satisfaction, increased compliance with treatment, and greater patient involvement in developing care plans.

TMC's other efforts include corporate-wide, open house information sharing at monthly management meetings, inclusion of trauma in TMC's patient-centered care initiative, information sharing with community organizations, collaboration with the local school of medicine to include trauma in curriculum, and education at nursing orientations.

Critical to TMC's trauma-informed culture is an increased capacity to provide PTSD services. The newly hired clinical psychologist provided training to 18 additional staff members in Prolonged Exposure Therapy and plans to offer Cognitive Processing Therapy in the future, as well as other therapies such as Seeking Safety, psycho-education groups, and emotional regulation groups.

TMC identified five key components in its yearlong journey toward a trauma-informed culture:

- >> Involve primary care providers and other medical caregivers in creating trauma-informed cultures.
- >> Take the time to chart a course toward implementing trauma-informed care. Once one understands the scope of the issue and the changes



The prevalence rates of trauma are extremely high, prompting TMC's recent move to create a trauma-informed culture and internal paradigm shift.



trauma-informed care can bring, there is a real desire to “do something,” but one of TMC's smartest moves was involving its organizational development department in the National Council Learning Collaborative to ensure trauma-informed policies, procedures, and hiring practices.

- >> Identify champions willing to lead the change.
- >> Engage trauma survivors.
- >> Develop a communications and marketing plan.

TMC's greatest challenge is the scope of work it carved out. TMC has more than 4,000 staff, faculty, and students. It is located on several campuses with diverse patient and staff populations. While leadership realized the scope was great and the work challenging, it understood the greatest risk was never to change at all. The next major challenge to implementation is capacity: the clinical need for trauma-specific care exceeds capacity to provide such services. Staff members remind themselves daily that people with histories of trauma have lived with these experiences for many years without adequate treatment – they are courageous and resilient – and together with consumers, staff will make a positive difference in the quality of care and the lives of those they serve.

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National Council

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“ PEOPLE WILL FORGET
WHAT YOU DID,
BUT PEOPLE WILL
NEVER FORGET HOW
YOU MADE THEM FEEL. ”

MAYA ANGELOU

The National Council for Community Behavioral Healthcare honors the best and brightest in mental health and addictions services through its Awards of Excellence. Each year, outstanding organizations, staff and board leaders, and programs are recognized for being the change – for promoting recovery and having a lasting impact on children, adults, and families.

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The Reintegration Awards, brought to you by the National Council and supported by Eli Lilly and Company, celebrate the achievements of those in the community who dedicate themselves to improving the lives of individuals with serious mental illnesses, and the achievements of those living with schizophrenia or bipolar disorder who battle tremendous odds to improve their own lives and the lives of their peers.

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- Artistic Contribution
- Mentorship
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Nominations open November 2011
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Intentional and Informed Connections

Beth Filson "In Restraints We All Sound the Same"

Beth Filson, CPS, MFA, Trauma-Informed Peer Support Consultant, NCTIC/NASMHPD, National Center for Trauma Informed Care; Shery Mead, Shery Mead Consulting

Peer support is a well-established mental health practice used in informal settings, as well as in hospitals, clinics, and other settings. Trauma-informed intentional peer support has distinct features and practice implications. But what does it take to make peer relationships trauma informed?

WHAT DOES IT MEAN TO BE TRAUMA-INFORMED?

To be trauma-informed is to assume that most people (both in and out of the mental health system) have histories of trauma. Though each person's experience with trauma differs, there are common elements that make it exceptionally difficult to have trusting, honest, and mutual relationships. Some of these factors include secrecy, shame, feelings of powerlessness, and coercion. When we have experienced multiple traumas across our lives, these factors become

essential to the stories we tell ourselves (e.g., 'I'm bad,' 'it must have been my fault,' 'I can't,' or 'you need to decide for me') Yet, much of the time, we look good, we act fine, we appear strong, and we seem independent. This is where intentional peer support comes in.

Intentional peer support assumes that people make sense of their experience through a process of enculturation. In other words, whatever cultural and personal messages I received about my experience became my reality and my source of knowing, or "knowledge." When most people in our lives have supported that knowledge, we take it for granted. Take trauma-informed care, intentional peer support must always start from the perspective that our knowledge has been constructed and we participate in peer support meetings because they provide an environment in which knowledge can be examined without judgment or interpretation and new ways of knowing can then be made possible. We provide this environment by using three principles and four basic practices.



THREE PRINCIPLES

1. LEARNING VS. HELP

If peers are not trauma informed, we might see our role as that of a “helper,” as if we are there to fix other people’s problems. This gets us into a pathological framework where we make assumptions about what’s wrong versus coming to understand what happened. Helping that originates out of assumptions can lead to coercion and compliance, rather than collaboration and dialogue.

Instead, most people hope that we’ll learn more about them and how they’ve learned to make sense of their experience, learn about the cultural conditions that maintain their reality, and most importantly, what their ideas are about what might make a difference. Then, and only then, are they willing to understand or listen to where we’re coming from. Learning together takes time; it’s about building relationships where new information and new knowledge can emerge.

2. FOCUSING ON THE RELATIONSHIP VS. FOCUSING ON THE INDIVIDUAL

One of the essential principles of trauma-informed care is collaboration. This principle is supported by a focus on what the relationship needs rather than on what just one of us needs.

When the focus is on one individual, I may feel that I’ve done my job only when s/he makes changes based on my perception of the problem. For example, if a you come to me and says, ‘I’m depressed,’ and I respond by telling you to take your medication, I may miss an opportunity to learn something about the dynamics of our relationship (e.g. that you and I both have something to offer the other).

If my focus is on the relationship I may say, “for me, depression just doesn’t describe the grief and the overwhelm I sometimes feel. Could you tell me more about what you mean when you say you are depressed?” This flow of increased mutual understanding, as well as the generation of a new meaning, is the goal of intentional peer support.

3. RESPONDING OUT OF HOPE VS. REACTING OUT OF FEAR

When we see risk and safety as inseparable, we tend to react out of fear. We see our role as controlling the safety of the other person. So, when we do feel afraid, we may jump in and create a situation that ultimately recreates traumatic event such as coercion.

This is where the idea of hope comes in. In order to sit with the discomfort of a difficult situation we must have some hope that something interesting or even positive will come out of going right through the middle of it. We may not know what that is (trying to control the outcome would be a fear based response), but gradually begin to trust that there is learning in our discomfort. This learning then creates new ways of being in a relationship, leading ultimately to very different outcomes than if our goal was merely to get through a frightening time. For trauma survivors, this may be the first time they’ve been allowed to be uncomfortable in the context of a “safe” relationship, which can lead to greater trust and a sense of self-efficacy.



By focusing on learning rather than helping, the relationship vs. the individual, responding out of hope, rather than reacting out of fear, we make room for people to emerge out of the shadows of their trauma.



FOUR PRACTICES

Connection: The first practice is connecting. It is about creating that space each person can “see” each other. It means being vulnerable, open, and willing to change, as well as solid, authentic, and fully present. Connection is facilitated by acknowledging the mystery of each other—the fact that when we put aside assumptions about one another and what the other needs, we make room for really seeing, and really hearing, each other. Validation is often key in building connection.

Worldview: The second practice is about being curious and interested in how we’ve “come to know what we know.” In other words, we ask each other questions that open up the larger story (what’s happened) and are interested in how we see ourselves and our role. From a trauma-informed perspective, a focus on worldview provides opportunity for story and for re-connecting a person to his or her context, the events that have shaped and informed how s/he lives in the world.

Mutuality: This is the process we use to bring our awareness and ourselves to the table. Mutuality is significant to trauma-informed peer support because it allows us to stay away from the “helper/helpee” roles and instead build relationships that are mutually responsible.

Moving Towards: This process is the culmination of the other three practices. It is about creating new ways of seeing and doing that go beyond mere “problem-solving.”

These principles and practices offer a respectful stance on interacting with people in a trauma-informed way. By focusing on learning rather than helping, the relationship vs. the individual, responding out of hope, rather than reacting out of fear, we make room for people to emerge out of the shadows of their trauma — all while building relationships that keep us both evolving.

Beth Filson is a nationally recognized trainer and curriculum developer in trauma informed peer support and peer workforce development and certification since 2002. She is co-author of Engaging Women Trauma Survivors in Peer Support—A Guidebook—a joint project of the Substance Abuse and Mental Health Services Administration and the National Center for Trauma-Informed Care. Beth co-facilitates Intentional Peer Support and is also working with The Transformation Center and the Massachusetts Department of Mental Health to pilot trauma-informed guidelines for engaging men and women who use self-inflicted violence.

Shery Mead is a consultant offering a broad range of training in intentional trauma-informed peer support, warmline skills, peer run crisis alternatives, co-supervision, facilitator training and training for professionals in recovery-based practice. She has written two books with Mary Ellen Copeland and one on her own. Mead speaks at many conferences and trains locally, nationally and internationally.

Peer Support Guides the Way

Darby Penney, Senior Research Associate, Advocates for Human Potential, Inc.

Women with histories of trauma often find peer support immensely helpful in coming to terms with trauma's impact on their lives and in healing from its effects. However, just like program administrators, clinicians, and other staff, peer supporters need information about the effects of trauma and trauma-informed approaches to practice peer support in a way that best supports women and avoids retraumatizing them. In the final stages of development, a new SAMHSA guidebook focuses specifically on women and trauma, and the trauma-informed peer support services for them.

Informed by an advisory group, the manual will serve as a resource for peer supporters working in behavioral health settings or other human service systems who want to integrate trauma-informed principles into their relationships with women they support or peer support groups to which they belong. The guide aims to provide peer supporters with the understanding, tools, and resources needed to engage in culturally competent, trauma-informed peer support relationships with women who are trauma survivors; it also targets administrators, policymakers, and non-peer staff who work in settings alongside peer supporters, as well as those interested in adding trauma-informed peer support to their organizations' services.



Sharon Wise

Women are more likely to experience violence at the hands of people they know and trust, while men usually experience violence from strangers... Women's experiences have historically been invisible, ignored, or discounted.

The advisory board focused the manual specifically on women because they saw a need for gender-specific materials to address their unique needs. Men and women often experience different kinds of violence. For example, women are more likely to experience violence at the hands of people they know and trust, while men usually experience violence from strangers. These differences create a profound difference in the way women and men understand trauma experiences, and therefore, affect peer support relationships. In addition, women's experiences have historically been invisible, ignored, or discounted. Awareness of these issues helps peer supporters understand the women with whom they work better.

The manual is organized in two sections: Fundamentals and Moving into Action. The first section provides basic information on topics related to trauma and its impact on women; trauma-informed services and supports; peer support principles and practices; and the social and cultural issues that affect women who are trauma survivors. The second section focuses on concrete ways peer supporters can bring their understanding of these issues into active peer support relationships with women. Both sections offer exercises, examples, and resource lists that point readers to books, articles, and websites that explore each topic more deeply.

The guide also presents peer supporters with critical information to help them work successfully within organizations that have not yet implemented trauma-informed care or are not knowledgeable about peer support's role and function. It also explores issues such as self-harm, the role of religion and spirituality, and the impact of trauma across the lifespan. The guide concludes with a discussion of how trauma survivors can become involved in social action and reclaim their power by working for positive change as part of the healing process.

According to SAMHSA Project Officer Mary Blake, this guide is the first step in the agency's effort to include and expand the peer voice in trauma materials. She envisions future documents on these issues, including gender-specific material related to men who are trauma survivors.

Darby Penney is a long-time activist in the human rights movement for people with psychiatric labels. As a senior research associate with Advocates for Human Potential, Inc., she works for the SAMHSA-funded National Center on Trauma-Informed Care, and is a co-author of Engaging Women Trauma Survivors in Peer Support: A Guidebook. Penney was previously director of recipient affairs at the New York State Office of Mental Health, where she was responsible for bringing the perspectives of people with psychiatric histories into the policymaking process. She is co-author with Peter Stastny of The Lives They Left Behind: Suitcases from a State Hospital Attic and a companion website and traveling exhibit of the same name.



MENTAL
HEALTH
FIRST AID

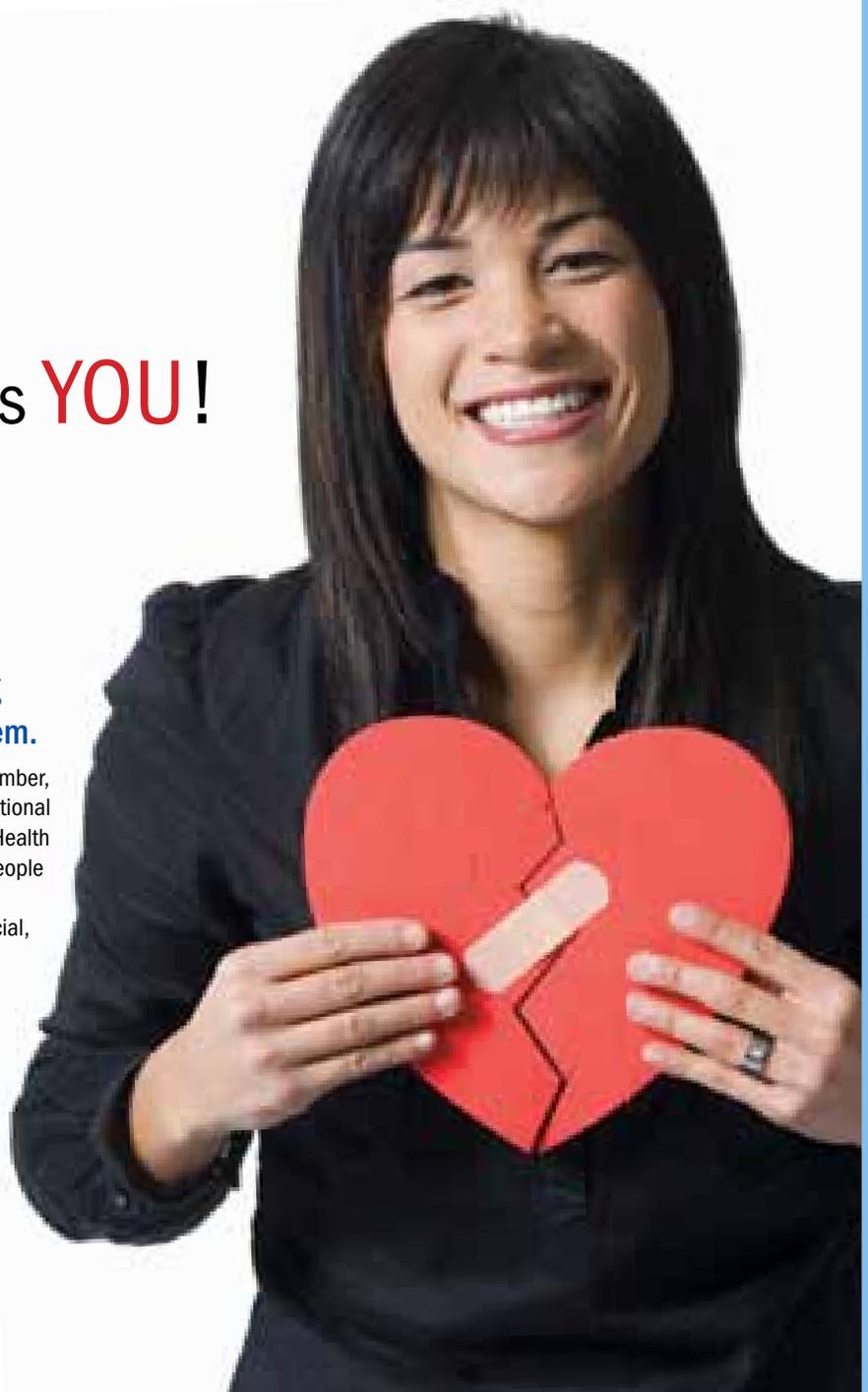
Sometimes, first aid isn't
a **bandage**,
or **CPR**,
or the **Heimlich**,
or calling **911**.

Sometimes, first aid is **YOU!**

Someone you know could be experiencing
a mental illness or crisis. **You can help them.**

You are more likely to encounter someone – friend, family member, coworker, neighbor, or member of the community – in an emotional or mental crisis than someone having a heart attack. Mental Health First Aid teaches a 5-step action plan to offer initial help to people with the signs and symptoms of a mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self help care. Anyone can take the 12-hour Mental Health First Aid course – first responders, students, teachers, leaders of faith communities, human resources professionals, and caring citizens.

Sometimes, the best first aid is you.
Take the course, save a life, strengthen
your community.



*Take the Mental Health First Aid course. Sometimes, the best first aid is **YOU**.*

For more information or to find a Mental Health First Aid course in your community, visit
www.MentalHealthFirstAid.org

And *That's* How They Do It In Brooklyn

Jo Ann Ferdinand, Acting Justice, New York State Supreme Court and Presiding Judge, Brooklyn Treatment Court

When the Brooklyn Treatment Court opened in 1996 as the first drug court in New York City, the conventional wisdom was that women drug abusers fared worse than men in treatment. Without questioning the treatment approach administered, it was simply concluded that women were harder to engage and more likely to relapse. BTC tested those conclusions by designing a system to identify the unique challenges faced by women participants and provide them with the services required to succeed.

The mission of drug courts is to reduce drug abuse and related criminal activity by offering substance abuse treatment to nonviolent offenders with addictions and providing continuous judicial supervision to ensure compliance with the treatment mandate. Research has shown that women who use drugs have fewer resources to support them through treatment. These women often have histories of physical and sexual abuse, fear losing their children if they admit drug use, feel pressure from a live-in partner whose lifestyle supports drug use, and have low self-esteem and little self-confidence. Moreover, these women are more likely to have a co-occurring mental health condition. With this in mind, we created a protocol to ensure that women, who enrolled in court supervised treatment and complied with their court mandate, would receive assistance in resolving their many issues including childcare, employment, housing, medical care, and mental healthcare. To achieve this goal, we sought partnerships with community-based agencies to provide the services our women needed to get their lives back on track. Along the way, we found that many of our assumptions about the needs of drug-addicted women were wrong.

We assumed that women would need to bring their children to their meetings with case managers and the judge, so we planned to open a childcare center in the courthouse. However, it quickly became apparent that this facility was unnecessary because many of our women had already lost custody of their children. Instead, we formed a partnership with the family court. They inform us if any of the women in BTC have pending parental rights cases and, in exchange, we give them access to our records to confirm that these women continue treatment and are drug free. To ensure that BTC participants are knowledgeable about their parental rights, we created a civil legal needs initiative through which a law student from Brooklyn Law School advises the women under the supervision of a South Brooklyn Legal Services attorney.

In order to place participants in programs quickly – the single greatest predictor of treatment success – we require a birth certificate, proof of eligibility for government health benefits, a recent TB test, and up-to-date medical records. Since most of the women had neither a stable living environment nor a primary care doctor, getting them into treatment posed a challenge. We addressed this issue by again finding partners in the community to deliver the

necessary services. Since 1998, we have operated a certified healthcare clinic in the courthouse, under the auspices and license of a local hospital, to provide preliminary medical screenings and TB tests. In addition, the Human Resources Administration has trained BTC case managers to enroll individuals eligible for healthcare benefits, and the Department of Health expedites our requests for birth certificates. As a result of these efforts, BTC participants are referred to treatment with minimal delay.

BTC case managers conduct a bio-psycho-social assessment of all potential participants to determine eligibility for drug court, severity of addiction, and required level of care. Early on, we became aware that many of the women referred to our court exhibited symptoms of mental health problems and/or reported a history of mental illness. Through funds received from the Center for Substance Abuse Treatment, we were able to enhance the mental health component of our assessment tool to identify participants requiring special treatment needs in their placement. Under an agreement with the Kings County Hospital Psychiatric Department, a forensic psychiatrist trained in the eligibility criteria and treatment capabilities of our court evaluates candidates and provides a diagnosis and recommendation. When the diagnosis rules out a serious and persistent mental illness, rapid placement is possible. If the psychiatrist recommends medication, we ensure that the medical staff at the local prison places the candidate on such medication; once she is stable, we find placement with a treatment provider able to provide the necessary psychiatric care.

The psychiatric evaluations made us aware that a large number of women with addictions have experienced trauma. If not appropriately addressed with specialized treatment by trained staff, the prospects for long-term recovery are diminished. A trauma-informed approach in substance abuse treatment programs is essential in effectively addressing trauma survivors' multiple and unique needs. We learned from research that a history of childhood abuse, as well as other forms of trauma, is especially likely for people in the criminal justice system who struggle with mental health problems. Alcohol and other substances are used for "self-medicating" by traumatized people to "numb-out" or escape from intrusive thoughts and emotional pain.

To ensure our women receive appropriate care, BTC collaborated with Palladia, a residential substance abuse treatment provider, to create a comprehensive program for both mental health and addiction. Participants in this program receive specialized services from an interdisciplinary team; this collaboration has greatly affected the rates of retention for women in treatment.

BTC, like all drug courts, uses sanctions and rewards to change drug-using behaviors and teach consequential thinking. The staff assumed that the same sanctions and rewards would work for all participants. For instance, as a judge,



I may send recalcitrant participants to jail for a few days to teach the lesson that if they continue to use drugs they will spend more time in jail. Afterward, they generally realize that the court expects them to keep their commitment to get clean and that they have to take their part seriously. Trauma survivors must be taught how to draw this connection between their negative behavior and the court-imposed, painful response in order to change their behavior.

Jail sanctions may unintentionally confirm these women's belief that they are failures. Many of them already feel shame for the things they did to get drugs, and especially feel tremendous guilt for neglecting their children. They feel that they are unworthy, and often lack the confidence to change. Therefore, when the court imposes a sanction for their behavior by sending them to jail for a few days, they believe the judge correctly sees them for who they are and knows that jail is where they belong. They often return to court saying, "Just sentence me. It's too hard. I would rather do my time."

To overcome this obstacle to recovery, the court must use a strength-based approach in which positive reinforcements are used much more frequently than negative ones. For example, I make a point of recognizing every effort a participant makes to do the right thing, acknowledging all small steps such as progress keeping appointments, showing up on time, dressing well, admitting to urges, choosing to stay in treatment even after a rule breaking, accepting punishment for misconduct and taking responsibility for poor choices. By rewarding every accomplishment, I teach them that negative behaviors are not who they are but what they did, and I demonstrate my belief in their ability to do the right thing. Women in particular thrive on these positive interactions and, upon finishing treatment, often say to me, "You saw something in me I didn't see in myself. You had faith in me." One graduate told me that she got the message from BTC that we were going to hold onto her and put good things back into her life until she was ready to do it for herself. She began to want to make me proud of her, to show me that she was the person I saw her as.

We developed new rewards that are particularly meaningful to our women. Picture Your Recovery is used as both an incentive and a motivational intervention. With the support of case managers, participants take photographs using a disposable camera provided by the court and create photo journals that catalog people, places, and objects that symbolize their strengths and inspirations. It offers a creative and expressive outlet to tell one's stories visually. The photo journal becomes a strength in itself, a tangible object that represents positive achievement and behavior, and the cooperative process of assembling the journal fosters the relationship between participants and case managers.

Because it is very difficult for mothers to participate in their children's lives during separation, BTC developed a restorative program that provides residential participants an opportunity to connect with their children. Parents With A Story allows parents to play an active role in their children's lives by selecting a book donated to the court and filming them reading the story aloud. The recorded DVD and corresponding book are sent home to the child who is then able to repeatedly view the DVD and read along with his or her parent. This can minimize the distance between parent and child and provide an opportunity for positive communication. When



Colin Lacey

Women in particular thrive on these positive interactions and, upon finishing treatment, often say to me,

“You saw something in me I didn't see in myself. You had faith in me.”

parents are able to be a constructive part of their children's lives, they develop nurturing skills, such as reading to their children, which they can continue after completion of treatment. This program also assists in the development of reading skills and promotes reading as a positive activity.

To further enhance the services our participants receive from treatment providers, BTC partnered with the National Center for Trauma Informed Care to sponsor training on Creating Trauma-Informed Systems of Care for Substance Abuse Settings. We invited local treatment providers to join us at a two-day trauma workshop conducted by the National Coordinating Center for the Seclusion and Restraint Reduction Initiative. Treatment providers sent their agency's in-house trainers to learn the skills necessary to more fully engage trauma surviving drug court participants. Our goal is to ensure that all women participating in BTC are sent to programs that are trauma-informed.

Jo Ann Ferdinand is currently an acting justice of the New York State Supreme Court and has been a judge since 1986. She was involved in the establishment 15 years ago of the Brooklyn Treatment Court, the first drug court in the city of New York, and remains its presiding judge. The Court provides treatment, regular drug testing, and continuous judicial supervision to non-violent adult defendants with substance use in order to reduce drug abuse and the attendant criminal behavior. Over 4,500 defendants have been referred to substance abuse programs; 2,500 have successfully completed the court mandate. Judge Ferdinand was a founding member and former president of the New York Association of Drug Treatment Court Professionals, served on the NYS Commission on Drugs and the Courts, and testified before the Commission on Sentencing Reforms, which lead to creation of judicial diversion courts in New York.

The Healing WRAP

Matthew Federici, Executive Director, Copeland Center for Wellness and Recovery; Cheryl S. Sharp, MSW, ALWF, CPSST, Special Advisor, Trauma-informed Services, National Council for Community Behavioral Healthcare

One formidable difficulty facing people who have experienced traumatic events is a deep loss of personal power. Frequently, we develop coping strategies that only compound trauma, leaving us with a profound sense of hopelessness that we are doomed to live out a life that moves from one traumatic experience to the next. Many of us have found new and creative ways to address these issues using WRAP (Wellness Recovery Action Plan).

The experiences of Mary Ellen Copeland, PhD, with mental health challenges led her, along with many of her peers, to develop WRAP. Copeland's mother, Kathryn Strouse Copeland (1912-1994), was for years committed to a state psychiatric hospital. While told that Kathryn "was incurably insane and would never get well," the Copeland family never gave up and continued visiting their matron, even though at times she did not recognize them – and Kathryn began to improve despite the dire predictions. She eventually returned home and became a respected and loved member of her community. Later, when Mary Ellen Copeland's own treatment with available medications at the time was life threatening, she began asking her psychiatrist, "How do people get well?" At the time, the response was, "they don't." She persisted in asking the question and began asking it of others facing similar struggles.

The responses she received became WRAP's five key concepts of recovery:

- >> Hope
- >> Personal Responsibility
- >> Education
- >> Self Advocacy
- >> Support

With humble grassroots beginnings, WRAP is now a cornerstone for people who struggle toward recovery from mental and emotional issues. The thousands of us who have used WRAP as part of our recovery have found that we can apply it to any area of life in which we struggled, including substance use, smoking cessation, weight loss, diabetes, gaining and sustaining employment, fibromyalgia, and healing from trauma.

Difficult feelings and behaviors are seen as normal responses to traumatic circumstances and in the context of what is happening and not as symptoms or a diagnosis.

The WRAP program includes:

- >> **Developing a Wellness Toolbox:** Finding simple, safe, and free ways to promote our wellness
- >> **Daily Maintenance Plan:** Addressing 1) 'What I am like when I am well'; 2) 'Things I must do every day to stay well'; and 3) 'Things I might need to do or could do'
- >> **Triggers and Action Plan:** Identifying things that make me uncomfortable, and taking action to stay well
- >> **Early Warning Signs and Action Plan:** Understanding the subtle signs that indicate I may not be as well as I could be, and taking appropriate action
- >> **When Things are Breaking Down and Action Plan:** Planning ways to take immediate and assertive action in order to prevent a crisis
- >> **Crisis Plan:** Maintaining control of oneself even if others have to act on our behalf (similar to a mental health advance directive)
- >> **Post Crisis Plan:** Developing a timetable for resuming activities

As an evidence-based practice, peers provide WRAP classes. Making a connection based on shared experience offers participants the greatest amount of hope, as they learn what has worked for the facilitator, a person who has similar life experiences. However, neither patient identities nor illness define a "peer" in a WRAP workshop. An essential value of WRAP facilitation is that "difficult feelings and behaviors are seen as normal responses to traumatic circumstances and in the context of what is happening and not as symptoms or a diagnosis." In addition, facilitators as a practice avoid clinical, medical, and diagnostic language. Practicing these values and ethics in facilitation is critical to ensure that WRAP is a tool for recovery and healing from trauma. Regardless of identifying as a peer or a person in trauma recovery, WRAP is for anyone who may find quality of life benefits in taking a class.

Matthew Federici is the executive director of the Copeland Center for Wellness and Recovery. He is an advanced level Mental Health Recovery Educator and WRAP facilitator. He brings a blended perspective as family member, experienced provider of recovery services and from his own journey in wellness recovery. His career has focused on independent living services, supported employment, advanced directives, WRAP® and Peer Support services. Federici was awarded Distinguished Advocate Award in 2002 and Distinguished Career Award in 2009 from the Pennsylvania Association of Psychosocial Rehabilitation Services.

Cheryl Sharp is the special advisor for trauma-informed services at the National Council for Community Behavioral Healthcare. She holds the unique perspective of a person with lived experience as a consumer and family member, as well as a provider of services. As a consultant to the NASMHPD/SAMHSA's Promotion of Alternatives to Seclusion and Restraint, Cheryl trains and speaks nationally on trauma-informed care. She is an advanced level WRAP facilitator, a Mental Health First Aid USA instructor, and a trainer of Intentional Peer Support. Sharp practices as a life coach/mentor and is an ordained minister. She received the Lou Ann Townsend Courage Award for her contributions to persons with psychiatric disabilities.

Danny Welch



“WRAP”ped Up in Service

Based on an interview with Walter Hudson

Danny Welch

Driving in the rain, or the smell of wet, sandy earth, was enough to drag Walter B. Hudson back in time. “If you see it, hear it, or feel it, it triggers something in your brain,” he explains. The “it” is whatever mimics the environment or circumstances surrounding a previous trauma...the car accident, the death of a fellow Army officer, or the critical head injury from a sailboat accident that extinguished Walter’s ability to complete his graduate thesis. “I couldn’t put together multisyllabic words,” he says, “I couldn’t even read a book.” Walter, a former Army Ranger and now a senior project manager in Ohio, was also diagnosed with bipolar disorder and weathered months-long bouts of severe depression. He started using WRAP® (Wellness Recovery Action Plan) while in recovery as a veteran with service connected PTSD.

“Imagine what you do every day just to feel well,” Walter explains, “Healthy things. We call those ‘wellness tools.’ It can be anything as mundane as polishing your shoes, or paying a bill.” Anything can be a wellness tool. You learn these things when you start writing them down, he adds. A WRAP addresses everything from daily and long-term maintenance tools that help you stay well, to signs and symptoms that you’re approaching critical mass.

“Let’s say I’m homeless,” Walter explains, “I have only two things on my daily list—find food and shelter. If I do that, I get through the day.” The signs are important. If you recognize them early enough you might be able to prevent a disaster. You’re not sleeping well, says Walter. You go to work, you’re irritable... you yell at someone and you get fired. You might have been able to save yourself some grief if you (or someone else) had recognized the signs a few days earlier. WRAP is like an advanced directive (of sorts) that also includes a list of people who will recognize these signs and take over for you until you get back to wellness. “Water your plants, check on your pets,” explains Walter, “everyone has a different support role.”

Walter explains that “People who’ve had brain injuries or strokes get frustrated and irritated because we can remember what we were able to do before the injury.” Writing a WRAP is like writing your own owner’s manual, or do-it-yourself cognitive behavioral therapy, he says. “When I used to get triggered, I suffered. Now, I have a favorite meal instead. Or go to a movie, or call someone.” And it works. SAMHSA’s National Registry for Evidence-Based Programs and Practices recently listed WRAP. Walter helps facilitate WRAP workshops specifically designed to help other veterans. “I discovered that the more I helped others, the more I was able to recover,” adds Walter.

“**People who’ve had brain injuries** or strokes get frustrated and irritated because we can remember what we were able to do before the injury.

”

Seeking Safety: Coping Skills

Lisa M. Najavits, PhD, Lecturer, Harvard Medical School, and Clinical Associate, McLean Hospital

Seeking Safety is a widely used, evidence-based model developed in 2002. Originally designed for co-occurring posttraumatic stress disorder and substance use disorder, it has since been applied more broadly to other populations (e.g., subthreshold, trauma history only, other addictions). The title of the treatment – Seeking Safety – expresses its central idea: when a person has trauma and/or substance use problems, establishing safety is the most urgent clinical need. Safety is an umbrella term that signifies various elements, including safety from addictive behavior, from dangerous relationships, and from extreme symptoms such as violence to self or others.

Seeking Safety is a cognitive behavioral therapy that can be used from the start of treatment. It was designed for males and females, any type of trauma, any type of substance, any level of care, any clinician, and any individual or group modality. It encourages patients to explore the link between trauma and substance abuse, but without delving into details of the past that could destabilize a person. It is present-focused, offering psychoeducation and safe coping skills in an integrated fashion, focusing equally on trauma and addiction. It is highly flexible to adapt to different settings, and has been used successfully with numerous populations including adolescents, military and veterans, homeless, domestic violence, criminal justice, racially diverse, traumatic brain injury, serious and persistent mental illness, illiterate clients, and others. It embodies a compassionate tone that honors what patients have survived and respects their strengths. It is also one of the lowest-cost models to implement and thus, from a public health perspective provides few barriers to entry.

Seeking Safety offers 25 topics; each is independent of the others, allowing the clinician to conduct as few or as many as time permits. Each topic represents a safe coping skill that focuses on cognitive, behavioral, interpersonal, or case management domains. The topics include: PTSD: Taking Back Your Power; Compassion; When Substances Control You; Creating Meaning; Discovery; Integrating the Split Self; Recovery Thinking; Taking Good Care of Yourself; Commitment; Respecting Your Time; Coping with Triggers; Self-Nurturing; Red and Green Flags; Detaching from Emotional Pain (Grounding); Honesty; Asking for Help; Setting Boundaries in Relationships; Getting Others to Support Your Recovery; Healthy Relationships; Healing from Anger; Community Resources; Introduction/Case Management; Safety; Life Choices; and Termination.

Thus far, Seeking Safety is the only model for PTSD and substance use disorder that meets standard criteria as an effective treatment in the field. The evidence base of published studies represents a broad range of investigators and populations and includes seven pilot studies, six randomized controlled trials; one controlled nonrandomized trial; two multisite controlled trials, and one dissemination study. Usually the patient samples represented severe and chronic PTSD and substance abuse, and had relatively high minority representation. Overall, all studies found positive outcomes; in the controlled and/or randomized controlled trials, Seeking Safety typically outperformed the comparison condition; treatment satisfaction was high in all studies.

For further information on Seeking Safety, visit www.seekingsafety.org. The site provides downloadable articles, all of the outcome studies, information and training and resources, and other details.

Lisa M. Najavits, PhD, is professor of psychiatry, Boston University School of Medicine; Lecturer, Harvard Medical School; research psychologist at VA Boston and VA Bedford; and clinical associate, McLean Hospital. She is author of the books Seeking Safety: A Treatment Manual for PTSD and Substance Abuse; A Woman's Addiction; and over 135 professional publications. She has received various awards, including the 1997 Young Professional Award of the International Society for Traumatic Stress Studies; the 1998 Early Career Contribution Award of the Society for Psychotherapy Research; the 2004 Emerging Leadership Award of the American Psychological Association Committee on Women; and the 2009 Betty Ford Award of the Addiction Medical Education and Research Association. She is chair of the upcoming SAMHSA Treatment Improvement Protocol on Trauma and Substance Abuse.



Kat Hoffman "Timothy's Garden"

Seeking Safety

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A Matter of Faith

Andrea Blanch, PhD, President, Center for Religious Tolerance

Chances are good that many people who come to you or your agency for help have an active spiritual life. According to the Pew Foundation, 87% of people in the United States define themselves as “religious,” 57% regularly attend a worship service, and a growing number describe themselves as “spiritual but not religious.” Clients who have experienced severe trauma may be searching for answers to deep religious or spiritual questions. They may wonder how God could allow such a thing to happen, or they may seek to restore their sense of a meaningful world. As Laura Mancuso, an interfaith chaplain and mental health professional states, “Spirituality touches the very core of the suffering that results from trauma...It reminds us that we are whole, no matter what happened, and can help restore our sense of safety.”

Yet, why are so many clinicians uncomfortable talking about religion or spirituality with clients? There are several factors at play, according to Roger Fallot, PhD, a psychologist who works to integrate spirituality into trauma treatment. Fallot notes that many people erroneously believe that the “separation clause” of the First Amendment to the Constitution prohibits discussion of these issues in a therapeutic setting. Reverend Mancuso agrees that this misconception has been a barrier: “The time has come to stop hiding behind a generalized fear of violating the separation of church and state and to instead become informed about what that actually means.”

Dr. Fallot believes that many people are also personally uncomfortable with these issues: “For some people, religious or spiritual experiences are too close for comfort to psychotic process or to irrational thinking. Many people simply don’t know what to do when their clients tell them they talk to God.” Fallot gives the example of a woman applying for a housing subsidy who was asked what she would do in an emergency. When she replied that she would pray, she was denied the subsidy – presumably because the agency fear she had poor judgment and coping skills. “It’s noteworthy that the decision was so quick,” Fallot adds. “Almost any other answer would have elicited follow-up questions like ‘What would you do next?’ or ‘What else would you do?’”

Many of the “coping strategies” that trauma survivors already use as part of their healing journey have roots in religious or spiritual systems.

Despite the reluctance of many clinicians to address religious or spiritual issues, many trauma survivors talk about recovery as a deeply spiritual process. To begin a discussion of these issues, SAMHSA’s National Center on Trauma Informed Care convened a two-day “listening session” in 2009 that included religious leaders, behavioral health practitioners, and trauma survivors. Thirty-eight people participated, reflecting 26 different faith traditions. The meeting’s focus was on identifying ways in which a religious or spiritual framework can assist people in responding to and healing from trauma and violence.

Several themes emerged from the discussion. Churches and clergy are often on the frontlines of a crisis, and many people turn first to faith leaders for help. The world’s religions clearly have deep wisdom to offer people who have experienced violence or trauma. From the Jewish celebration of the Passover Seder to Christian beliefs about the Resurrection and the Buddha’s teachings about nonattachment, religious texts and practices offer ways to understand and cope with human suffering. Many of the “coping strategies” that trauma survivors already use as part of their healing journey have roots in religious or spiritual systems: yoga, meditation, breath work, retreats in nature, chanting, even some forms of dance and music were originally associated with accessing the divine.

Mancuso points out that many of these practices are effective in building resiliency, as well as in trauma healing. “No one is immune from the possibility of experiencing trauma. Daily spiritual practices are a good way to prepare for the traumas that will inevitably come our way. It’s a method of building resiliency during calmer times that will serve us well when the unexpected happens – enhancing our capacity to survive and thrive despite the traumatic events of our lives.”

Another issue that arose during the discussion concerned the potential negative impact of religion or

spirituality on trauma healing. For some people, religion may have been a source of profound trauma, as in clergy abuse, and for others, it may have been a source of constriction or punishment. While trauma-informed practice requires the clinician to be vigilant about potential retraumatization, both Fallot and Mancuso believe that we have an obligation to address this domain. Spiritual competence, the capacity to understand and work within the framework of other people’s religious or spiritual realities, is as important as other forms of cultural competence. In fact, a recent survey of California County behavioral health directors concerning mental health and spirituality found the highest level of survey respondents agreed, “Spirituality is an important element of multicultural competency for mental health providers.”

“All trauma interventions should offer – not require – spiritual support...People recovering from trauma deserve to have every possible resource made available to them. We must gather the courage to stop excluding spirituality as an essential resource for trauma healing,” according to Mancuso. Fallot concurs: “Professionals sometimes feel like they are walking through a minefield when these issues come up, but not addressing religion and spirituality excludes an entire sphere of people’s existence. Really, it’s like any other issue – all you have to do is ask.”

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Andrea Blanch, PhD, the president and director of the Center for Religious Tolerance, has worked for more than 30 years as a social change agent. A former state mental health commissioner, she was founding director of the Collaborative on Conflict Management in Mental Health and the National Trauma Consortium. Blanch has published widely on women’s mental health, trauma, and social change, consults nationally and internationally, and has done grassroots organizing in the Balkans and the Middle East. She was a 2009 fellow in the Women, Religion and Globalization program at Yale University. Blanch was awarded the 2010 annual Duisberg Peace Award by the Southwest Coalition on Peace and Justice.

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A Sanctuary for Change

Sandra L. Bloom, MD, Associate Professor of Health Management and Policy, School of Public Health, and Co-director, Center for Nonviolence and Social Justice – Drexel University

The Sanctuary Model is an evidence-supported organizational approach for creating trauma-informed systems of care. Regardless of whether services delivered are to children, adults, or families, organizational barriers present the greatest challenge to the sustained and significant changes involved in becoming truly “trauma-informed.” The Sanctuary Model maintains that systems of care have become “trauma-organized” and as a result, organizations as a whole may become engaged in problematic behaviors that parallel the very problems for which clients seek help. Organizations in chronic crisis are in a poor position to make the significant changes in behavior, thought, and underlying assumptions necessary for a system to become truly trauma-informed.

The Sanctuary Model seeks to provide a cohesive context within which healing from psychological and social traumatic experiences can be addressed. It challenges organizations to reexamine basic assumptions concerning the extent to which social service environments promote safety and nonviolence across physical, psychological, social, and moral domains for everyone involved – clients, family members, staff, and administrators. This requires an active process of breaking down institutional, societal, professional,

and communication barriers that isolate these members from each other. Simultaneously, the rebuilding process involves consciously learning new ways to relate as interdependent community members; creating and modeling healthy, emotionally intelligent, and supportive relationships between individuals; and developing an atmosphere of hope and nonviolence. The intervention aims to strengthen the therapeutic community environment, lay the building blocks for “learning organizations,” and empower people to influence positively their own lives and communities.

Sanctuary Model implementation begins with attendance at the Sanctuary Institute, a five-day intensive training experience. Teams of five to eight people, from various levels of the organization, including executive leadership, come together to learn from faculty that consists of colleagues from other organizations implementing the model. These teams become the Sanctuary Steering Committee for their organization. Together they are introduced to the practices of the Sanctuary Model and take home the Sanctuary Implementation Manual, Direct Care Staff Training Manual, Indirect Care Staff Training Manual, and S.E.L.F. Psychoeducational manuals.

A Sanctuary Steering Committee returns to its organization and creates a Core Team – a larger, representative, multidisciplinary team – to support implementation across the organization. Ongoing consultation and technical assistance from Sanctuary faculty guides organizations through the implementation process, which extends over three years and leads to Sanctuary certification, after a peer-reviewed evaluation process. Recertification occurs every three years.

Once an organization commits to adopting the Sanctuary Model by attending the Sanctuary Institute five-

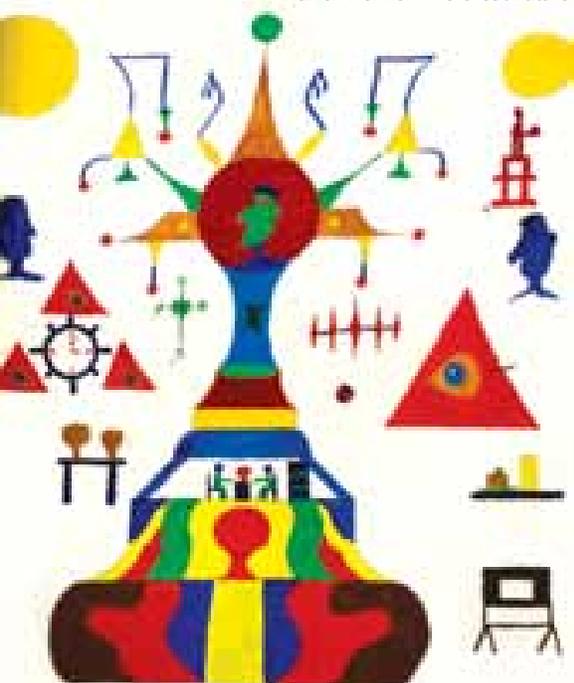
day training, the organization becomes a part of the Sanctuary Network, a learning community that includes more than 200 mental health, educational, and social service organizations around the nation world committed to the development of trauma-informed services.

The desired outcomes for the Sanctuary Model are complex and, to some extent, must be decided by each organization since Sanctuary targets such a wide variety of programs. At a minimum Sanctuary aims to eliminate interpersonal violence in all forms and all coercive forms of treatment. Sanctuary looks for outcomes through measures easily accessed by the organization, including decreases in workmen’s compensation claims, staff and patient injuries, staff turnover, and use of coercive measures like seclusion, restraint, and medication coercion. Sanctuary also aims for substantial changes in staff and administrative attitudes toward clients and each other, more clinical sophistication, better assessment and case formulation, and significant increases in application of complex strategies for change. If implementation progresses well, Sanctuary expects increased clinical commitment to employing trauma-specific forms of treatment by well-trained and supervised staff, better responses to vicarious trauma, and less staff burnout.

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Dr. Sandra L. Bloom is a board-certified psychiatrist, associate professor of health management and policy at the School of Public Health of Drexel University in Philadelphia, co-director of the Center for Nonviolence and Social Justice at Drexel University, distinguished fellow of the Andrus Children’s Center in Yonkers, NY, and a past president of the International Society for Traumatic Stress Studies. She is the author of Creating Sanctuary: Toward the Evolution of Sane Societies and co-author of Destroying Sanctuary: The Crisis in Human Service Delivery Systems and Restoring Sanctuary: A New Operating System for Organizations.

“ The Sanctuary Model maintains that organizations in chronic crisis are in a poor position to make the significant changes in behavior, thought, and underlying assumptions necessary for a system to become truly trauma-informed. ”

Warren Heffner “The Great Future”



Trauma-informed Care Training Resources

Compiled by **Cheryl S. Sharp, MSW, ALWF, CPSST**, Special Advisor, Trauma-informed Services, National Council for Community Behavioral Healthcare

Behavioral healthcare has come a long way from a general awareness of the impact of trauma to understanding that we must change our policies and practices to trauma-informed systems of care. We do that through our practice improvements and implementation of trauma-informed care. We must provide trauma-specific services. So what does it all mean?

We need to be very clear that an organization can't just look at a checklist and decide, "Yes, we are a trauma-informed organization, we've checked the boxes." There is no "Good Housekeeping" seal of approval.

I have had organizations ask me, "How will I know when my organization is considered trauma-informed?" If this is the question, the organization is not there yet. There is only the journey of becoming more, doing greater work, being open to new ideas, trying new things and constantly evaluating whether or not the people we serve are getting better, moving forward in their lives and that

your staff is more satisfied in their work and staying because they feel safe, energized and motivated due to the positive outcomes they are seeing personally and professionally.

There are many valuable resources available, practices that are evidence-based and new practices are emerging constantly. Below is a resource list taken from **Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services** prepared by Ann Jennings, PhD. This entire report is available at <http://annafoundation.org/TIC-RESOURCES.html> and will be very useful as your organization moves forward on its journey.

The National Council for Community Behavioral Healthcare looks forward to working with all of our members and partners to create safe and secure environments that are able to address the needs of those we serve.

TRAINING IN DEVELOPING TRAUMA-INFORMED SERVICE SYSTEMS AND ORGANIZATIONS FOR ADULTS		
TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
Creating Cultures of Trauma-Informed Care Models: pgs 11-13	Developed by Roger Fallot, PhD, and Maxine Harris, PhD, Community Connections DC	Rebecca Wolfson Berley, MSW 202-608-4735 / rwolfson@ccdc1.org www.ccdc1.org
Creating Trauma Informed Systems of Care: Facilitating Recovery in Mental Health Service Settings Models: pgs 13-14	Kevin Huckshorn, National Association of State Mental Health Program Directors	National Technical Assistance Center, National Center for Trauma Informed Care 703-739-9333 or 301- 634-1785 NCTIC@nasmhpd.org www.mentalhealth.samhsa.gov/nctic
Developing Trauma-Informed Organizations: A Tool Kit Models: pg 14	MA State Leadership Council of the WCDVS Women Embracing Life and Living Project of the Institute for Health and Recovery	Marissa Daley / 617-661-3991 marissadaley@healthrecovery.org www.healthrecovery.org
National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings Models: pgs 14-15	Kevin Huckshorn, National Association of Mental Health Program Directors	Joan Gillece Director, NASMHPD 703-739-9333 extension 140 www.nasmhpd.org/ntac2010.cfm
Risking Connection®: A Training Curriculum for Working with Survivors of Childhood Abuse Models: pgs 15-16	Sidran Institute	Esther Giller, Sidran Institute 410-825-8888, ext. 207 esther.giller@sidran.org www.sidran.org
Risking Connection® in Faith Communities: A Training Curriculum for Faith Leaders Supporting Trauma Survivors Models: pgs 16-17	Sidran Institute	Esther Giller, Sidran Institute 410-825-8888, ext. 207 / esther.giller@sidran.org www.sidran.org
The Sanctuary Model Models: pgs 17-19	Sandra Bloom, MD	Sandra L. Bloom, MD, CommunityWorks 215-248-5357 / sbloom@sanctuaryweb.com www.sanctuaryweb.com
Women and Addiction: A Gender-Responsive Approach Models: pgs 20-21	Stephanie S. Covington, PhD, LCSW	Stephanie S. Covington, PhD, LCSW 858-454-8528 / sscird@aol.com www.stephaniecovington.com www.centerforgenderandjustice.org



TRAINING IN TRAUMA-SPECIFIC SERVICE MODELS FOR ADULTS

TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
Addictions and Trauma Recovery Integration Model (ATRIUM) Models: pg 29	Dusty Miller, EdD, and Laurie Guidry, PsyD	Dusty Miller 413-584-8404 / dustymi@aol.com www.dustymiller.org
The Associative Skills Model: Taking Charge of Change; The Trouble with Feelings; and Boundaries, Precious Boundaries Models: pgs 30-31	Elizabeth Power, MEd	Esther Giller, Sidran Institute 410-825-8888 ext. 207 esther.giller@sidran.org
Beyond Trauma: A Healing Journey for Women Models: pgs 31-32	Stephanie S. Covington, PhD, LCSW	Stephanie S. Covington, PhD, LCSW, 858-454-8528 / sscird@aol.com www.stephaniecovington.com
Cognitive-Behavioral Treatment for PTSD Among People with Severe Mental Illness Models: pgs 32-33	B. Christopher Frueh, PhD et al	B. Christopher Frueh, PhD Menninger Clinic and Baylor College of Medicine frueh@hawaii.edu
Eye Movement Desensitization and Reprocessing Models: pgs 32 - 33	Francine Shapiro	Esther Giller, Sidran Institute 410-825-8888 ext. 207 / esther.giller@sidran.org www.sidran.org/gbs
Growing Beyond Survival: A Self Help Toolkit for Managing Traumatic Stress Models: pg 34	Elizabeth Vermilyea, MD, and Sidran Institute	Stephanie S. Covington, PhD, LCSW 858-454-8528 / sscird@aol.com www.stephaniecovington.com
Helping Women Recover: A Program for Treating Addiction Models: pgs 34-36	Stephanie S. Covington, PhD, LCSW	Stephanie S. Covington, PhD, LCSW 858-454-8528 / sscird@aol.com www.stephaniecovington.com
Integrated Substance Abuse, Mental Health and Trauma Treatment with women: A case study workbook for staff training Models: pgs 37-38	Boston Consortium of Services for Families in Recovery), Boston Public Health Commission and Institute on Urban Health Research at Northeastern University	Dr. Hortensia Amaro / h.amaro@neu.edu Rita Nieves, RN, MPH / Rita_Nieves@bphc.org
Managing Traumatic Stress through Art: Drawing from the Center Models: pgs 38-39	Art Therapists Barry M. Cohen, Mary-Michola Barnes, and Anita B. Rankin	Esther Giller, Sidran Institute 410-825-8888 ext. 207 / esther.giller@sidran.org
Prolonged Exposure Therapy Models: pgs 39-40	Edna B. Foa, PhD, Center for the Treatment and Study of Anxiety	Dr. Edna Foa or Dr. Elizabeth Hembree Center for the Treatment and Study of Anxiety 215-746-3327 / ctsa@mail.med.upenn.edu
Seeking Safety Models: pgs 41-42	Lisa M. Najavits, PhD Harvard Medical/McLean Hospital	Lisa M. Najavits, PhD 617-299-1620 / info@seekingsafety.org www.seekingsafety.org
Spirituality in Trauma Recovery Group Models: pg 43	D.C. Trauma Collaboration Study at Community Connections, a Women, Co-Occurring Disorders, and Violence Study sites	Kate Boucek, MSW 202-608-4784 / kboucek@ccdc1.org www.ccdc1.org
Trauma Affect Regulation: Guide for Education and Treatment (TARGET©) Models: pg 45-46	Julian Ford, PhD	Judith Ford 860-751-9072 / Judy@advancedtrauma.com
Trauma, Addictions, Mental health And Recovery Trauma Treatment Group Model Models: pgs 46-47	Part of the SAMHSA Women, Co-Occurring Disorders and Violence Study	Marian Bland, LCSW-C 410-724-3242 / blandm@dhmh.state.md.us
Trauma Recovery and Empowerment Model Models: pgs 47 - 49	Maxine Harris, PhD, and the Community Connections Trauma Work Group	Rebecca Wolfson Berley, MSW Director of Trauma Training 202-608-4735 / rwolfson@ccdc1.org
Trauma Resiliency Model Veterans Resiliency Model Models: pgs 50-51	Trauma Resource Institute Co-founders Elaine Miller-Karas, MSW, and Laurie Leitch, PhD	Elaine Miller-Karas / Elainemk27@mac.com www.traumaresourceinstitute.com
TRIAD Women's Group Model Models: pg 52	A SAMHSA Women Co-Occurring Disorders and Violence Study sites	Colleen Clark, PhD 813-974-9022 / cclark@fmhi.usf.edu

TRAINING IN ADAPTATIONS OF TRAUMA-SPECIFIC SERVICE MODELS FOR ADULTS

TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
Cultural and Linguistic Adaptation and Expansion of Trauma Recovery and Empowerment Model: Spanish Models: pgs 55-56	Boston Consortium of Services for Families in Recovery, Boston Public Health Commission	Dr. Hortensia Amaro / h.amaro@neu.edu Rita Nieves, RN, MPH / Rita_Nieves@bphc.org
An Introduction to Trauma Issues for Women on Inpatient or Short-Stay Units Models: pg 56	Maxine Harris, PhD, Bronwen Millet, PhD, Lori Beyer, MSW, Jerri Anglin, MSW, Rebecca Wolfson, MSW	Kate Boucek, MSW 202-608-4784 kboucek@ccdc1.org www.ccdc1.org
Men's Trauma Recovery and Empowerment Model: A Clinician's Guide to Working with Male Trauma Survivors in Groups Models: pgs 56-57	Community Connections with Roger D. Fallot, PhD et al	Rebecca Wolfson Berley, MSW Director of Trauma Training 202-608-4735 rwolfson@ccdc1.org

TRAINING IN DEVELOPING TRAUMA-INFORMED SERVICE SYSTEMS AND ORGANIZATIONS FOR CHILDREN

TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
Child Adult Relationship Enhancement Models: pgs 59-60	Trauma Treatment Training Center and Cincinnati Children's Hospital Medical Center	Lacey Thieken Mayerson Center for Safe & Healthy Children 513-636-0042 / Lacey.Thieken@cchmc.org
Child Development Community Policing Program Models: pgs 60-61	Developed by the Yale Child Study Center and the New Haven Department of Police Service	Steven R. Marans, PhD National Center for Children Exposed to Violence 203-785-3377 Email: steven.marans@yale.edu
Stewards of Children: Adults Protecting Children from Abuse Models: pg 63	Darkness To Light	Pat Patrick, LISW 843-954-5444 / ppatrick@d2l.org www.darknesstolight.org
Trauma Informed Organizational Self Assessment Models: pgs 64-65	National Center on Family Homelessness	Kathleen Guarino, LMHC National Center on Family Homelessness 617-964-6841 Kathleen.guarino@familyhomelessness.org www.familyhomelessness.org
Trauma Systems Therapy Models: pgs 65-66	Glenn Saxe	Glenn Saxe Children's Hospital Boston/Harvard Medical School 617-919-4676 Glenn.saxe@childrens.harvard.edu

TRAINING IN TRAUMA-SPECIFIC MODELS FOR PARENTING

TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
Nurturing Program for Families in Substance Abuse Treatment and Recovery, 2nd edition Models: pg 67-68	Institute for Health and Recovery	Marissa Daley 617-661-3991 marissadaley@healthrecovery.org www.healthrecovery.org
Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Program Models: pgs 69-70	Marilyn Steele, PhD, in collaboration with Marilyn Marigna, Jerry Tello, and Ronald Johnson	Marilyn Steele, PhD Parenting Across Cultures 323-936-0343 dr_mls@earthlink.net, www.parentingacrosscultures.com



TRAINING IN TRAUMA-SPECIFIC SERVICE MODELS FOR CHILDREN AND FAMILY/PARENTS/CAREGIVERS

TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
Alternatives for Families—A Cognitive-Behavioral Therapy Models: pgs 72-74	David J. Kolko, PhD	David J. Kolko, PhD kolkodj@upmc.edu
Child-Parent Psychotherapy Models: pgs 74-75	Alicia F. Lieberman, PhD, and Patricia Van Horn, JD, PhD	Chandra Ghosh Ippen, PhD Child Trauma Research Project 415-206-5312 / chandra.ghosh@ucsf.edu
Combined Parent-Child Cognitive Behavioral Therapy: Empowering Families At-Risk for Physical Abuse to Develop Healthy Outlooks and Positive Environments Models: pgs 75-76	Melissa K. Runyon, PhD, in collaboration with Esther Deblinger, PhD	Melissa K. Runyon, PhD Associate Professor of Psychiatry runyonmk@umdnj.edu
International Family Adult and Child Enhancement Services: A Comprehensive Service Model for Refugee Children Models: pgs 76-77	International Family, Adult and Child Enhancement Services of the Heartland Alliance for Human Needs & Human Rights	Terri Bogage 617-661-3991 / terribogage@healthrecovery.org www.healthrecovery.org
Parent-Child Interaction Therapy Models: pgs 77-79	Sheila Eyberg, PhD	Dr. Sheila Eyberg University of Florida / www.pcit.org University of California Davis CAARE Center www.pcit.tv
Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART) Models: pgs 79-80	Kennedy Krieger Institute Family Center	Betsy Offermann, LCSW-C 443-923-5907 Offermann@kennedykrieger.org
Trauma Focused Cognitive Behavioral Therapy for Children and Parents; Cognitive Behavioral Therapy for Childhood Traumatic Grief; Combined TF-CBT and Sertraline for Children Models: pgs 80-81	Judith A. Cohen, MD, Anthony P. Mannarino, PhD, and Esther Deblinger, PhD	www.musc.edu/tfcbt www.pittsburghchildtrauma.org Jan Markiewicz / jmarkiewicz@psych.duhs.duke.edu Judith Cohen / jcohen1@wpahs.org
Trauma Systems Therapy Models: pgs 81-82	Glenn Saxe, MD	Glenn Saxe, MD, Children's Hospital Boston/Harvard Medical School 617 919 4676 / Glenn.saxe@childrens.harvard.edu
Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model Models: pgs 84-85	Chadwick Center for Children & Families at Rady Children's Hospital in San Diego	Lisa Conradi, PsyD, NCTSN Project Manager 858-576-1700 ext. 6008 lconradi@rchsd.org
Cognitive Behavioral Therapy for Childhood Traumatic Grief Models: pgs 85-87	David J. Kolko, PhD, Judith A. Cohen, MD, Anthony P. Mannarino, PhD, Esther Deblinger, PhD, and Elissa J. Brown, PhD	Elissa J. Brown, PhD St. John's University 718-990-2355
Culturally Modified Trauma-Focused Treatment Models: pgs 87-88	Based on Trauma-Focused Cognitive Behavior Therapy (Cohen, Mannarino, & Deblinger, 2006)	Michael de Arellano, PhD National Crime Victims Research & Treatment Center (843) 792-2945 / dearellma@musc.edu www.musc.edu/ncvc
Group Intervention for Children of Mothers with Co-occurring Mental Health and Substance Abuse Disorders and Histories of Interpersonal Violence Models: pg 88	SAMHSA Women, Co-Occurring Disorders and Violence Children's Subset Study.	www.nationaltraumaconsortium.org
Integrative Treatment of Complex Trauma for Children and Adolescents Models: pgs 88-89	Cheryl Lanktree, PhD, and John Briere, PhD	Cheryl Lanktree, PhD / clanktree@memorial.org John Briere, PhD / 562 933-0590 www.johnbriere.com
Love and Life: Trauma Recovery and Empowerment for Adolescent Girls and Young Women Ages 12-18: A Clinician's Guide for Working with Adolescent Girls in Groups Models: pg 90	Community Connections DC with Sasha Bruce Youthwork, Inc and District of Columbia's Department of Mental Health School Mental Health Program	Rebecca Wolfson Berley, MSW 202-608-4735 rwolfson@ccdc1.org

TRAINING IN TRAUMA-SPECIFIC SERVICE MODELS FOR CHILDREN AND FAMILY/PARENTS/CAREGIVERS <i>continued</i>		
TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
Real Life Heroes Models: pgs 91-93	Richard Kagan, PhD	Richard Kagan, PhD richardkagan@nycap.rr.com
Sanctuary Model for Children in Residential Settings Model: pgs 93-95	Sandra Bloom, MD	Sarah Yanosy Andrus Children's Center 914-965-3700 x1117 / syanosy@jdam.org www.andruschildren.org
Seeking Safety Models: pgs 95-96	Lisa M. Najavits, PhD Harvard Medical/McLean Hospital	Lisa M. Najavits, PhD 617-731-1501 / info@seekingsafety.org www.seekingsafety.org
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) Models: pgs 96-97	Draws from Dialectical Behavior Therapy, Trauma Affect Regulation, and Trauma and Grief Component Therapy	Mandy Habib, PsyD Division of Trauma Psychiatry 516-562-3276 / mhabib@nshs.edu
Trauma Affect Regulation: Guide for Education and Treatment (TARGET®) Models: pgs 97-98	Developed by Julian Ford, PhD	Judith Ford 860-751-9072 Judy@advancedtrauma.com
Trauma and Grief Component Therapy Models: pgs 98-100	Developed by Christopher M. Layne, PhD, William R. Saltzman, PhD, and Robert S. Pynoos, MD, MPH	Christopher Layne, PhD UCLA - National Center for Child Traumatic Stress 310-235-2633 ext. 223 cmlayne@mednet.ucla.edu
Voices: A Program of Self-Discovery and Empowerment for Girls Models: pg 100	Stephanie S. Covington, PhD, LCSW	Stephanie S. Covington, PhD, LCSW, 858-454-8528 sscird@aol.com

TRAUMA-SPECIFIC PEER SUPPORT AND SELF HELP MODELS		
TRAUMA TRAINING	DEVELOPED BY	CONTACT INFORMATION
The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma Models: pg 104	Sidran Institute and consumer advocates of the TAMAR Project, the MD WCDVS Study	Sidran Institute 410-825-8888 ext. 207 esther.giller@sidran.org www.sidran.org/gbs
Women's Leadership Training Institute: "For and By Women in Recovery from Addiction, Mental Illness, and Trauma," Instituto de Entrenamiento para Mujeres Lideres en Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion Models: pg 107	Boston Consortium of Services for Families in Recovery, Boston Public Health Commission, the Institute on Urban Health Research, Northeastern University and Dorrington, Saunders and Associates	Dr. Hortensia Amaro h.amaro@neu.edu Rita Nieves, RN, MPH Rita_Nieves@bphc.org
A Woman's Way through the Twelve Steps Models: pg 108	Stephanie S. Covington, PhD, LCSW	Stephanie S. Covington, PhD, LCSW 858-454-8528 / sscird@aol.com www.stephaniecovington.com www.centerforgenderandjustice.org
Your Surviving Spirit: A Spiritual Workbook for Coping With Trauma Models: pg 108	Dusty Miller, EdD	Dusty Miller 413-584-8404 / dustymi@aol.com www.dustymiller.org

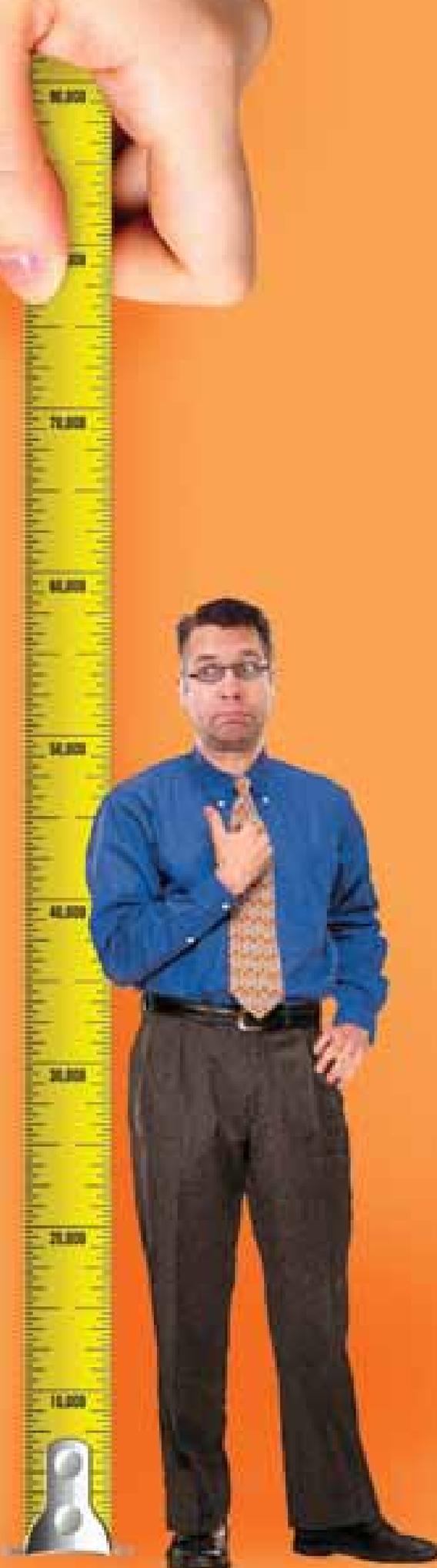
This resource list is based on information from: SAMHSA's National Center for Trauma Informed Care's Models for Developing Trauma-Informed Behavioral Health Systems and Trauma Specific Services, 2008 Update

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For Mental Health and Addictions Treatment Providers

STARTLING STATISTICS

- In the 10 years since 2001, **more than 2 million U.S. troops** have deployed to Iraq and Afghanistan.
- The Department of Defense reports **more than 6,000 deaths and 43,000 injuries** in our two conflicts.
- Many of those who have been injured return home with **posttraumatic stress disorder, depression, traumatic brain injury, and substance use**, and far too many die from **suicide**.
- **Mental health disorders caused more hospitalizations** among U.S. troops in 2009 than any other reason.
- Cumulative lengths of deployments are associated with **more emotional difficulties among military children, and more mental health problems among U.S. Army wives**.
- **More than 75,000 veterans are homeless**.
- Between 2005 and 2009, **one member of the Armed Forces took his or her life every 36 hours**.
- The suicide rate among active duty soldiers dropped slightly in 2010, but the number of **suicides** in the **National Guard and Reserves increased by 55 percent**.

AN UNMET NEED

Increasingly, civilian practitioners are treating returning veterans and their families. Unfortunately, many of these mental health and addictions treatment providers are not properly trained or prepared to serve returning veterans. Few clinicians understand the military orientation—a culture of its own—and therefore, do not understand how to provide culturally competent and clinically sound services to veterans and their families.

That's why the National Council for Community Behavioral Healthcare has partnered with the U.S. Department of Defense Center for Deployment Psychology (CDP) and Essential Learning to launch **Serving Our Veterans: Behavioral Health Certificate in September 2011**.

SERVING OUR VETERANS: BEHAVIORAL HEALTH CERTIFICATE 14 self-directed, self-paced online courses earning up to 22 hours for only \$350

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- Epidemiology of PTSD in Military Personnel and Veterans
- Fundamentals of Traumatic Brain Injury
- Improving Substance Abuse Treatment Compliance
- Meeting the Behavioral Health Needs of Returning Veterans
- Military Cultural Competence
- Overview of Suicide Prevention
- Prolonged Exposure Therapy for PTSD for Veterans and Military Service Personnel
- Provider Resiliency and Self-Care: An Ethical Issue
- PTSD Then and Now, There and Here
- The Impact of Deployment and Combat Stress on Families and Children:
 - Part I: Understanding Military Families and the Deployment Cycle
 - Part II: Enhancing the Resilience of Military Families
- Working with the Homeless: An Overview

To earn the certificate, individuals must complete the entire suite of courses and successfully pass a post-test on each course.

For more information about the Certificate, or to learn more about the National Council's support for our returning veterans, contact Jeannie Campbell, Executive Vice President, at 202-684-7457 or jeanniec@thenationalcouncil.org.

