

# Creating Trauma Informed Systems of Care for Human Service Settings

## *An Overview of Fundamental Concepts*

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# Trauma Informed Care

## Outline

- Defining Trauma & Trauma Informed Care
- Prevalence in Persons with Psychiatric Disorders
- Trauma Informed & Trauma Insensitive Systems
- T&TA for Implementing TIC Systems of Care

# What is Trauma?

- Definition (*NASMHPD, 2006*)
  - The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters
- DSM IV-TR (*APA, 2000*)
  - Person's response involves intense fear, horror and helplessness
  - Extreme stress that overwhelms the person's capacity to cope

# Definition of Trauma Informed Care

- Mental Health Treatment that incorporates:
  - An appreciation for the high prevalence of traumatic experiences in persons who receive mental health services
  - A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual

*(Jennings, 2004)*

# Prevalence of Trauma

## Mental Health Population – United States

- 90% of public mental health clients in have been exposed to trauma

*(Mueser et al., in press, Mueser et al., 1998)*

- 51-98% of public mental health clients in have been exposed to trauma

*(Goodman et al., 1997, Mueser et al., 1998)*

- Most have multiple experiences of trauma

*(Mueser et al., in press, Mueser et al., 1998)*

- 97% of homeless women with SMI have experienced severe physical & sexual abuse – 87% experience this abuse both in childhood and adulthood

*(Goodman et al., 1997)*

# Prevalence of Trauma

Sydney, AUSTRALIA

- *Lifetime prevalence among homeless individuals*

- At least 1 traumatic event
  - 100% of women (n=38)
  - 90% of men (n=119)
- 58% suffered serious physical assault
- 55% witnessed injury or murder
- 50% women - history of rape
- 10% men – history of rape

- Nearly universal in population – closely associated w/PTSD & Depression

*(Buhrich & Hodder, 2000)*

# Prevalence of Trauma

## Child Mental Health/Youth Detention Population - U.S.

- Canadian study of 187 adolescents reported 42% had PTSD
- American study of 100 adolescent inpatients; 93% had trauma histories and 32% had PTSD
- 70-90% incarcerated girls – sexual, physical, emotional abuse

*(DOC, 1998, Chesney & Sheldon, 1991)*

# Prevalence of Trauma Addictions Population – U.S.

- Up to two-thirds of men and women in SA treatment report childhood abuse & neglect  
(SAMSHA CSAT, 2000)
- Study of male veterans in SA inpatient unit
  - 77% exposed to severe childhood trauma
  - 58% history of lifetime PTSD (Triffleman et al., 1995)
- 50% of women in SA treatment have history of rape or incest  
(Governor's Commission on Sexual and Domestic Violence, Commonwealth of MA, 2006)

# Other Critical Trauma Correlates: The Relationship of Childhood Trauma to Adult Health

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

# What does the prevalence data tell us?

- The majority of adults and children in psychiatric treatment settings have trauma histories
- A sizable percentage of people with substance use disorders have traumatic stress symptoms that interfere with achieving or maintaining sobriety
- A sizable percentage of adults and children in the prison or juvenile justice system have trauma histories

*(Hodas, 2004, Cusack et al., Mueser et al., 1998, Lipschitz et al., 1999, NASMHPD, 1998)*

# What does the prevalence data tell us?

- Growing body of research on the relationship between victimization and later offending
- Many people with trauma histories have overlapping problems with mental health, addictions, physical health, and are victims or perpetrators of crime
- **Victims of trauma are found across all systems of care**

*(Hodas, 2004, Cusack et al., Mueser et al., 1998, Lipschitz et al., 1999, NASMHPD, 1998)*

# Therefore.....

We need to presume the clients we serve have a history of traumatic stress and exercise “universal precautions” by creating systems of care that are *trauma-informed*

(Hodas, 2005)

# Trauma Informed Care Systems

# Trauma Informed Care Systems

## Key Principles

- Are based on current literature
- Are informed by research and evidence of effective practice
- Recognize that coercive interventions cause traumatization and re-traumatization and are to be avoided

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

# Trauma Informed vs. Non Trauma Informed Care

- What do trauma informed care (TIC) systems look like?
- How are they different from care systems that are not informed by trauma (NTIC)?

## Trauma Informed

- Recognition of high prevalence of trauma
- Recognition of primary and co-occurring trauma diagnoses
- Assess for traumatic histories & symptoms
- Recognition of culture and practices that are re-traumatizing

## Non Trauma Informed

- Lack of education on trauma prevalence & “universal” precautions
- Over-diagnosis of Schizophrenia & Bipolar D., Conduct D. & singular addictions
- cursory or no trauma assessment
- “Tradition of Toughness” valued as best care approach

# Trauma Informed      Non Trauma Informed

- Power/control minimized - constant attention to culture
- Caregivers/supporters – *collaboration*
- Address training needs of staff to improve knowledge & sensitivity
- Keys, security uniforms, staff demeanor, tone of voice
- Rule enforcers – *compliance*
- “Patient-blaming” as *fallback* position without training

## Trauma Informed

- Staff understand function of behavior (rage, repetition-compulsion, self-injury)
- Objective, neutral language
- Transparent systems open to outside parties

## Non Trauma Informed

- Behavior seen as intentionally provocative
- Labeling language: manipulative, needy, “attention-seeking”
- Closed system – advocates discouraged

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

## Trauma Informed

## Non Trauma Informed

### *Language*

- Asking people how they prefer to be addressed
- Quietly making rounds and informing people of schedule
- “Let’s talk and find you something to do”
- “May I help you?”
- Calling people by first name without permission or last name w/out title
- Yelling “lunch” or “medications”
- “If I have to tell you one more time ....”
- “Step away from the desk”

# TIC and Transformation

- Developing and implementing trauma informed systems of care is one of the first steps toward becoming *Recovery Oriented*.
- Systems of care based on control, coercion, disrespect, insidious discrimination, are violent, or use practices that shame or traumatize, greatly delay, or halt the recovery process.

# Trauma informed T&TA

- Half-day, full-day, or 1.5 day training curricula available
- Target audience: senior and middle management; direct care staff
- Mental health, addictions, homelessness providers, DJJ, criminal justice, MRDD, foster care systems
- Includes training materials; CEU ready

# Trauma informed T&TA

- Individual onsite consultations for state mental health agency staff to develop system-wide implementation plan, including statewide policy statement, facility policy and procedures, development of an implementation plan etc.

# Trauma informed T&TA

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