

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Understanding and Addressing Trauma among People Receiving Services in Criminal Justice and Behavioral Health Settings

Joan B. Gillece, Ph.D.

Sharon Wise, M.H.S.

Shairi Turner, M.D., M.P.H..



Agenda

- 1:00 Welcome: **Ken Robertson**, Team Leader-Criminal Justice Grants, SAMHSA
- 1:05 Logistics: **Pam Rainer**, LMSW, Advocates for Human Potential, Inc.
- 1:10 Introductions: **Holly K. Rogers**, Public Health Advisor, SAMHSA
- 1:15 **Joan B. Gillece**, Ph.D., Project Director, NASMHPD
- 1:35 **Sharon Wise**, M.H.S., The House of Sharon
- 1:55 **Shairi Turner**, M.D., M.P.H., Deputy Secretary for Health and Director, Office of Minority Health Florida Department of Health
- 2:15 Q & A
- 2:30 Conclude Webinar

Q & A | Manage |

<Type a question for the presenter>

Ask

No questions have been answered yet.



Webinar Objectives

- Define trauma-informed care, providing concrete examples of systems that have made this cultural change.
- Provide an overview of findings from the Adverse Childhood Events (ACE) study, drawing a clear connection between childhood trauma and a range of adverse physical and behavioral health outcomes in adulthood.
- Discuss how a trauma-informed approach to service delivery prevents re-traumatization and may prevent adverse outcomes of trauma.

Joan B. Gillece, Ph.D.

Joan B. Gillece, Ph.D.

**Director of Trauma Informed Care and Alternatives to Seclusion and Restraint,
National Association of State Mental Health Program Directors, Alexandria, VA**

Dr. Gillece has thirty years of experience working in the behavioral health field with fifteen dedicated to trauma and six in prevention of seclusion and restraint. Working cross agencies with a focus on adult and juvenile justice, Dr. Gillece has recently published in American Correctional Association, Corrections Today an article on developing trauma informed services in Correctional Settings.

As project director for two SAMHSA Trauma Centers, the National Center for Trauma-Informed Care (NCTIC) and the National Technical Assistance Center to Promote Trauma-Informed Practices and Alternatives to Seclusion and Restraint (CTIP), Dr. Gillece has championed the cause of full consumer integration and development of Culturally Competent programs. Utilizing survivors in all aspects of trauma work, Dr. Gillece has coordinated technical assistance, conference presentations, and consultations with experts in the field. Commitment to strength based support by implementing trauma informed values with the overreaching theme of recovery has been her focus.



Joan B. Gillece, Ph.D., (Bio cont'd)

Relevant interagency training, technical assistance and collaboration include agencies serving individuals with HIV/AIDS, substance abuse, homelessness, older persons, juvenile justice, and developmental disabilities. Prior to joining the National Association of State Mental Health Program Directors (NASMHPD) six years ago, Dr. Gillece served as Director of Special Populations for Maryland's Mental Hygiene Administration where her responsibilities included all aspects of state mental health planning and delivery of services as well as development of collaboration across agencies serving individuals with psychiatric diagnoses.



What is Trauma and Why Must We Address It?

Joan Gillece, Ph.D.



What is Trauma?

Definition of Trauma

- 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 (NASMHPD, 2006).
- Person's response involves intense fear, horror, and helplessness (APA, 2000).
- Trauma produces extreme stress that overwhelms the person's capacity to cope (APA, 2000).

Trauma-Informed Care

Trauma-informed care is defined as mental health treatment that incorporates:

- An appreciation for the high prevalence of traumatic experiences in persons who receive mental health services and/or behavioral 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

Population of Individuals in the Child Mental Health/Youth Detention System

- Canadian study of 187 adolescents reported 42% had Post Traumatic Stress Disorder (PTSD).
- American study of 100 adolescent inpatients; 93% had trauma histories and 32% had PTSD.
- 70-90% of incarcerated girls reported experiencing sexual, physical, and/or emotional abuse (DOC, 1998; Chesney & Sheldon, 1991).

Prevalence of Trauma

Population of Individuals with Substance Abuse Disorders

- Up to two-thirds of men and women in substance abuse (SA) treatment report childhood abuse and 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 a 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, substance abuse, self harm, and sexual promiscuity;
- Severe medical conditions: heart disease, pulmonary disease, liver disease, STDs, GYN cancer; and
- Early death (Felitti et al., 1998)

Adverse Childhood Events

ACE's operational definition of Trauma

- Recurrent and severe physical abuse
- Recurrent and severe emotional abuse
- Sexual abuse

Growing up in household with:

- Alcohol or drug user;
- Member being imprisoned;
- Mentally ill, chronically depressed, or institutionalized member;
- Mother being treated violently;
- Both biological parents absent; and
- Emotional or physical abuse

ACE Study

“Male child with an ACE score of 6 has a 4600% increase in likelihood of later becoming an IV drug user when compared to a male child with an ACE score of 0. Might heroin be used for the relief of profound anguish dating back to childhood experiences? Might it be the best coping device that an individual can find?”

(Felitti et al, 1998)

ACE Study

“Is drug abuse self-destructive or is it a desperate attempt at self-healing, albeit while accepting a significant future risk?” (Felitti, et al, 1998).

“Addiction is best viewed as an understandable, unconscious, compulsive use of psychoactive materials in response to abnormal, prior life experiences, most of which are concealed by shame, secrecy, and social taboo” (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., Muesar 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

- 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

- Power/control minimized
- constant attention to culture.
- Caregivers/supporters – ***collaboration.***
- Address training needs of staff to improve knowledge & sensitivity.

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

Non Trauma-Informed

- 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

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

Non Trauma-Informed

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

Contact Information

Joan Gillece, Ph.D.

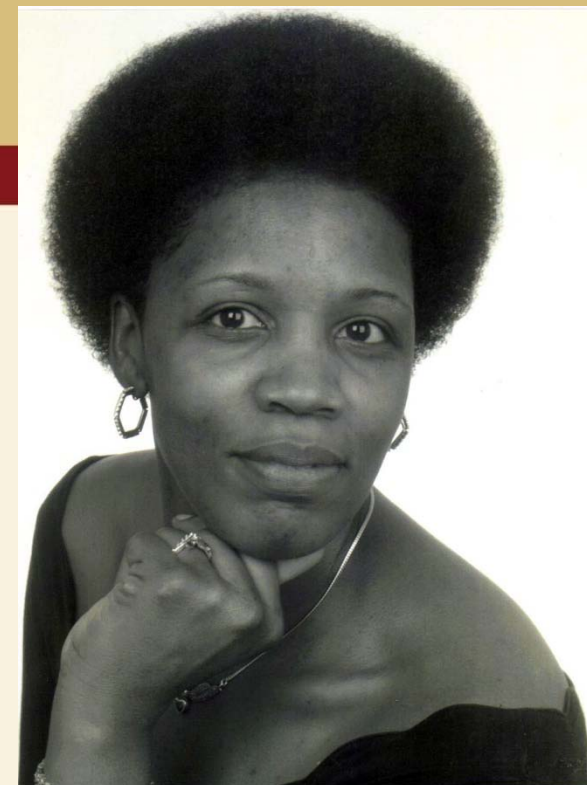
Joan.gillece@nasmhpd.org

703-739-9333

Sharon Wise, M.H.S

Sharon Wise was diagnosed with a mental illness at a young age and hospitalized for the first time at the age of nine. Following over thirty institutions and hospitalizations, many of them by force, including being secluded and restrained, she has learned to use the trauma she suffered as learning and teaching tools. She is now an advocate for others who've had similar experiences.

Sharon goes around the country teaching and training peers, government officials and the community about Trauma informed care, sharing her experience, strength and hope. She also is an independent filmmaker and documentarian.



Sharon Wise, M.H.S

Sharon is an outstanding artist and uses her art to create vibrant colored self-portraits that illustrate her traumatic experiences and African American heritage. As a performing artist she uses the butterfly to tell her story and is also an excellent motivational and keynote speaker.

Most recently she received a national VOICE Award in Los Angeles taking her place with movie stars and others recognized for their contributions in trauma informed care and mental health. In addition to her advocacy she designed a social inclusion booklet for her peers that display options of 'free places' to go for entertainment, training and relaxation.

Sharon not only teaches on Trauma Informed Care and Substance Abuse Prevention, she is also a mental health educator, gifted event planner, Researcher and Documentarian.



Trauma & Recovery

Sharon Wise, M.H.S.



- **When I experienced trauma early in my life, it was in the form of direct emotional, physical and psychological abuse that mentally stressed me and shattered my sense of security.**
- **It made me feel helpless and vulnerable in the world around me.**

Trauma & Recovery

The personal traumatic experiences often involved a threat to my life or safety, but in ALL situations, I felt overwhelmed and alone.

Trauma & Recovery

It's wasn't the objective facts that determined whether the events were traumatic, but my *subjective emotional experience of the events. The more frightened and helpless I felt, the more likely I was to be traumatized.*

Trauma & Recovery

My trauma happened unexpectedly. I was not prepared for it. I felt powerless to prevent it. It happened repeatedly. Someone was intentionally cruel and abusive. It happened in my childhood, as a youth and as an adult.

Trauma & Recovery

Today my recovery is moving forward in a positive way. It took years to heal and recover from my trauma. One of my most profound tools, outside of therapy, is using the performing and visual arts. Paramount was Motivational Peer Support & Engagement.



Trauma & Recovery

The trauma I suffered led to lasting emotional and psychological damage. But I know now that recovery is possible. Some people recover quickly from the most tragic and shocking experiences. Others are devastated by experiences that, on the surface, appear to be less upsetting. But in any case, *WE DO RECOVER FROM OUR TRAUMA* with support and trauma specific treatment, Peer Support & other types of services.



Trauma & Recovery

Recovery Tips That May Be Helpful

1. Don't isolate.
2. Ask for support
3. Establish a daily routine
4. Take care of your Emotional, Spiritual & Physical health
5. Find Activities you enjoy

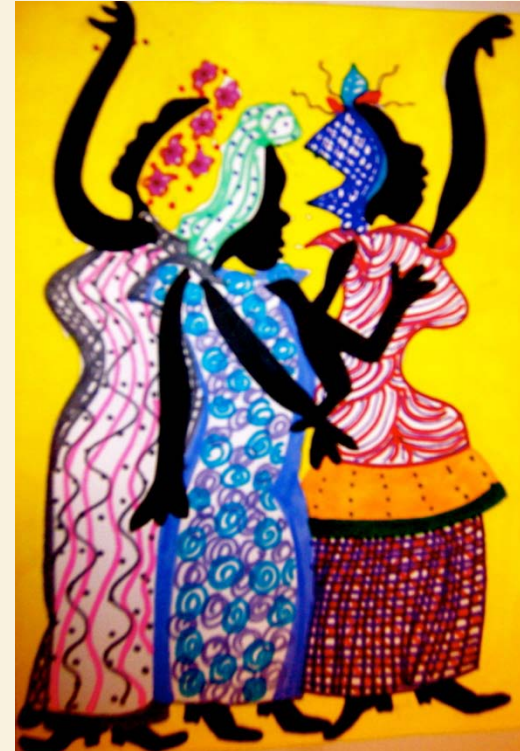


Contact Information

Sharon D. Wise, M.H.S.
The House of Sharon
Artist/Documentarian/Designer/Survivor

2859 Denver Street S.E.
Suite 4
Washington, D.C. 20020
202-460-2753

thehouseofsharon@msn.com



Shairi Turner, M.D., M.P.H.

Dr. Shairi Turner is an Internist and a Pediatrician. In September 2009 she was appointed as the Deputy Secretary for Health and the Director of the Office of Minority Health for the Florida Department of Health. In these positions she supervises the Divisions of Family Health Services, Disease Control, Environmental Health, Emergency Medical Operations, the Bureau of Laboratories, the Bureau of Statewide Pharmaceutical Services, the Bureau of Health Statistics and Assessments, the Office of Public Health Nursing, 67 County Health Departments and the Office of Minority Health.

In 2005, she was named as the first Chief Medical Director in the eleven-year history of the Florida Department of Juvenile Justice. During these four years, Dr. Turner established and directed the Office of Health Services. The Office was responsible for assisting the Department with the provision and oversight of quality medical, mental health, substance abuse and developmental disability services.



Shairi Turner, M.D., M.P.H. (Bio cont'd)

During her tenure with the Department of Juvenile Justice, Dr. Turner's focus also included the impact of childhood trauma (physical, sexual and emotional abuse) on youth involved in the juvenile justice system, as well as the importance of gender specific services designed to meet the unique needs of girls in the system. She has given numerous presentations on issues relating to health/mental health care in the juvenile justice setting. Most recently, she became a faculty member with the National Association of State Mental Health Program Directors, providing technical assistance to other states regarding the biopsychosocial impact of trauma in childhood.



Neurobiology of Trauma

Shairi Turner, M.D., M.P.H.



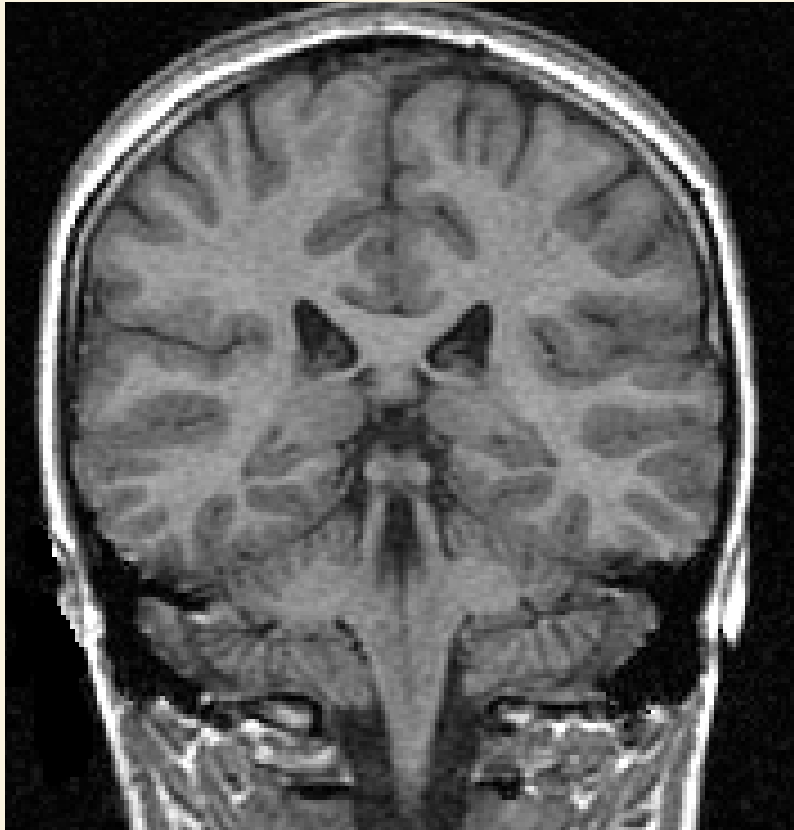
What is Trauma?

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.

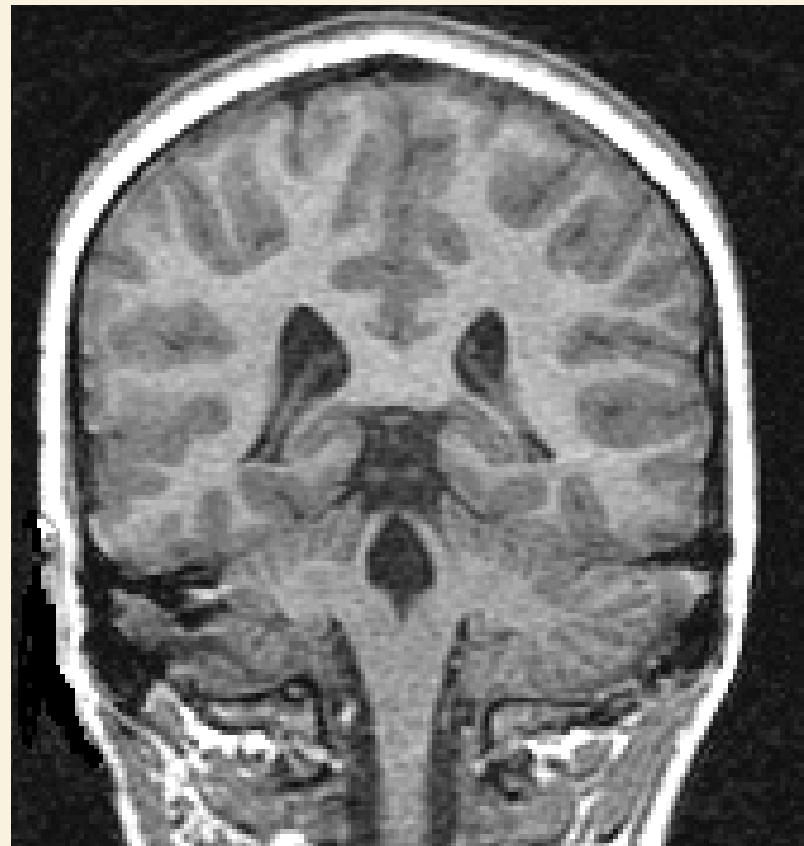
(National Association of State Mental Health Program Directors, 2006)

Trauma and the Developing Brain

- De Bellis et al., 1999



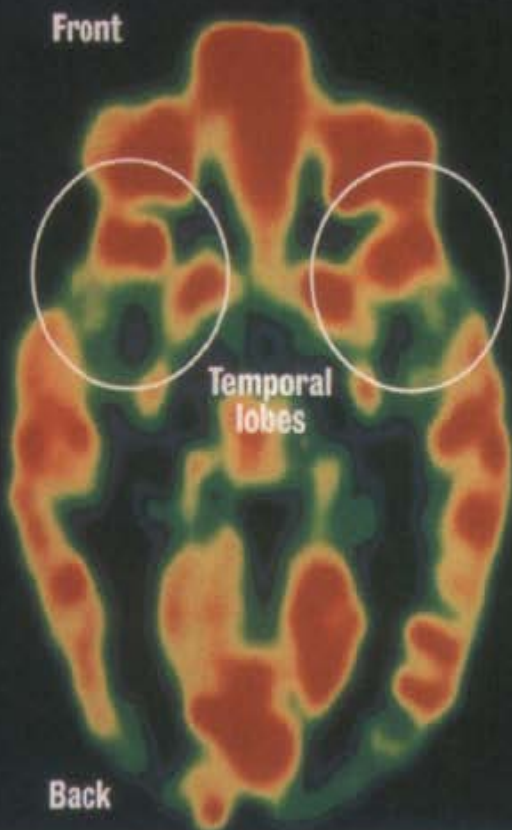
Normal 11 y.o. Male



Maltreated 11 y.o Male with PTSD

Healthy Brain

This PET scan of the brain of a normal child shows regions of high (red) and low (blue and black) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire the circuits.



Front



An Abused Brain

This PET scan of the brain of a Romanian orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.

MOST ACTIVE LEAST ACTIVE

A color scale legend for PET scan activity levels. It consists of five colored squares in a row: red, orange, green, blue, and black. The red square is labeled 'MOST ACTIVE' and the black square is labeled 'LEAST ACTIVE'.



*From Neurons to Neighborhoods:
The Science of Early Child
Development*

**REPORT FROM THE NATIONAL RESEARCH
COUNCIL
AND THE INSTITUTE OF MEDICINE**

JACK P. SHONKOFF AND DEBORAH A. PHILLIPS, EDITORS

Core Concepts of Development

1) The development of children unfolds along individual pathways whose trajectories are characterized by continuities and discontinuities, as well as by a series of significant transitions.

(Shonkoff & Phillips, 2000)

Core Concepts of Development

2) The growth of self-regulation is a cornerstone of early development that cuts across all behavioral domains.

(Shonkoff & Phillips, 2000)

State Change

22 year-old man with history of childhood physical abuse displayed aggressive behavior on the prison ward and was physically restrained.



State Change

12 year-old girl
with a history of
sexual abuse,
provoked by an
older male peer
while in school.

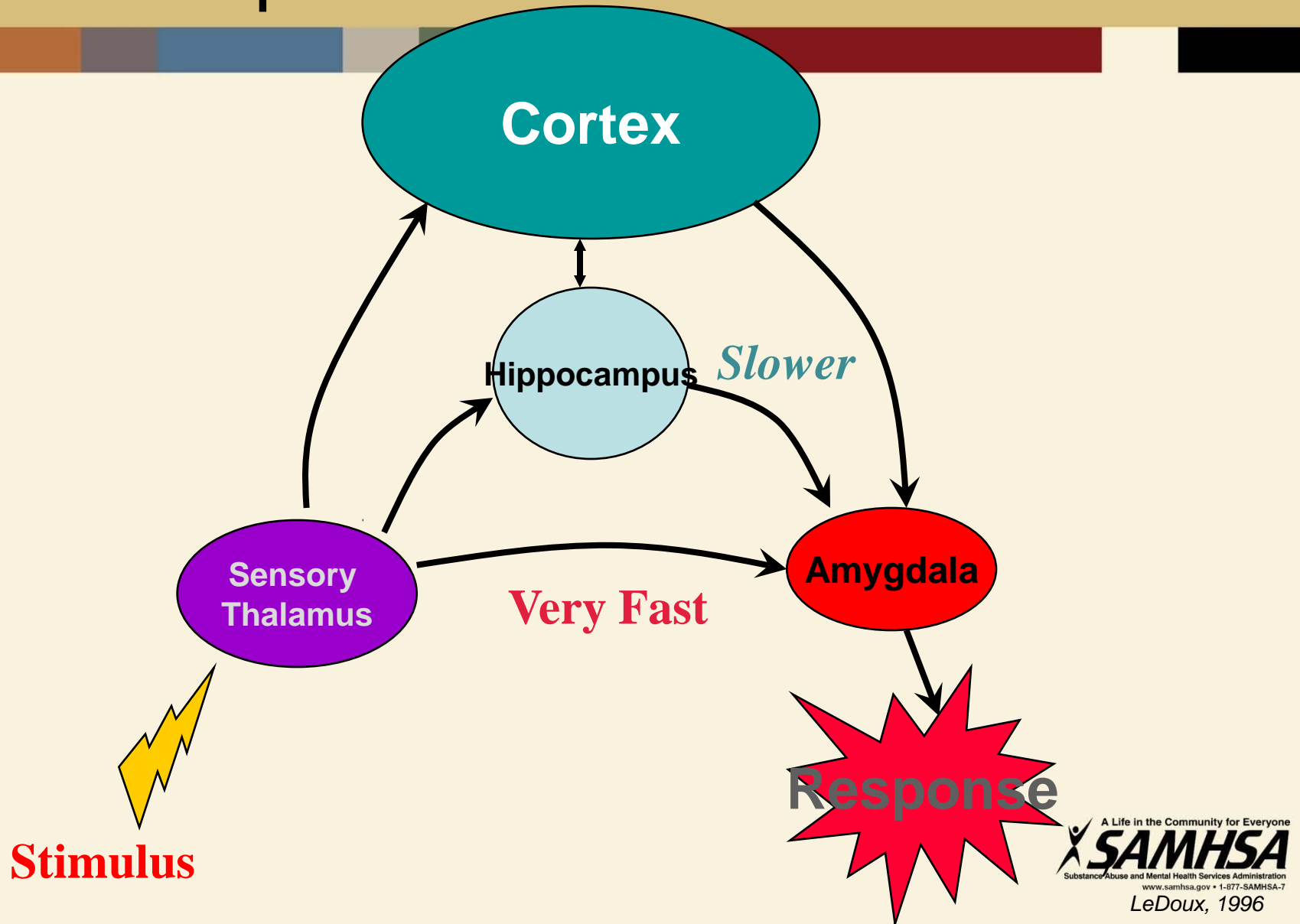


Core Concepts of Development

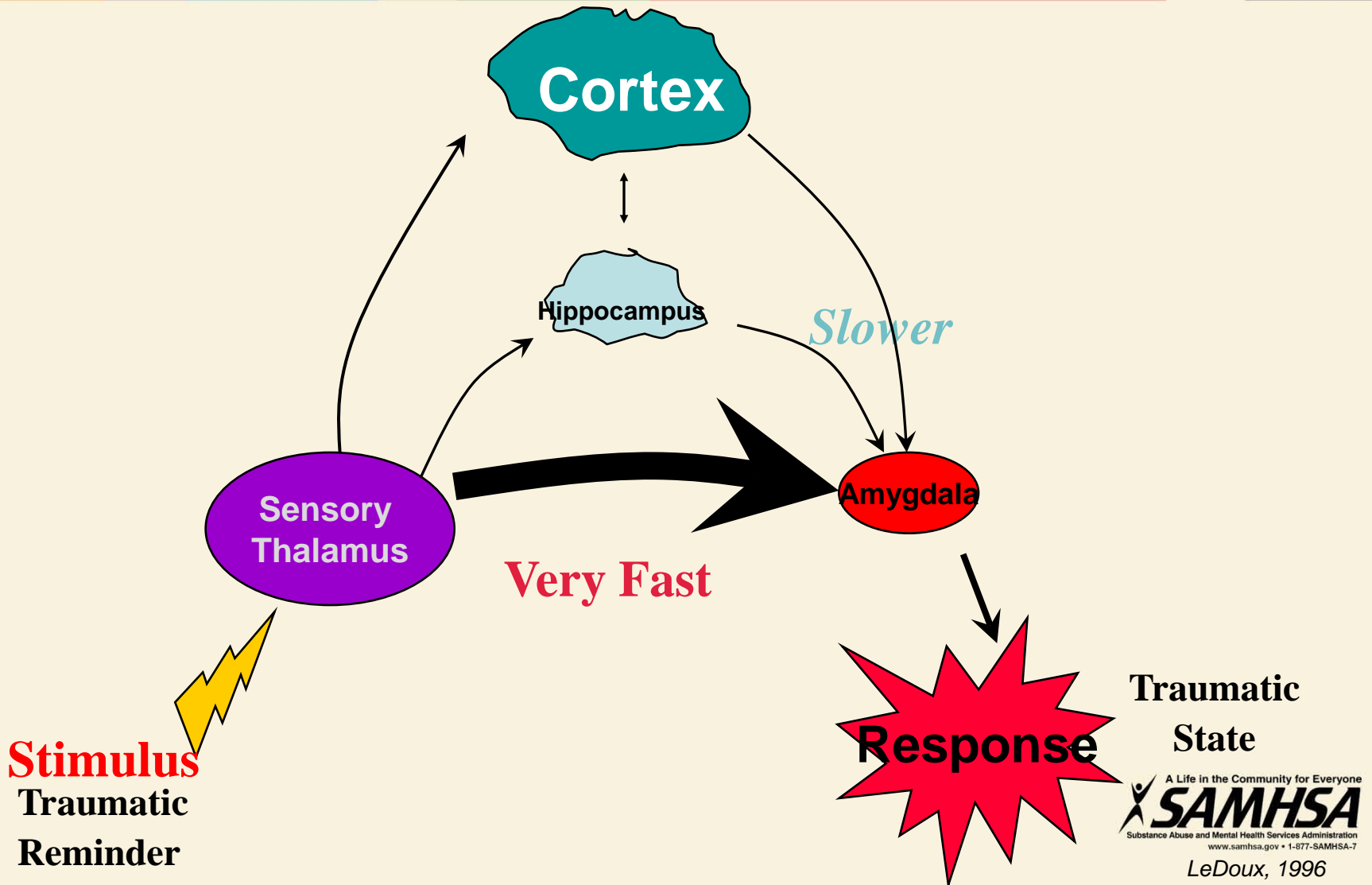
3) Human development is shaped by a dynamic and continuous interplay between biology and experience.

(Shonkoff & Phillips, 2000)

Transition Between Stimulus and Response : *The Normal Translation*



Transition Between Stimulus and Response : *Altered Form and Function*



Triggers

Seeing, feeling, hearing, smelling something that reminds us of past trauma



Activates the alarm system...



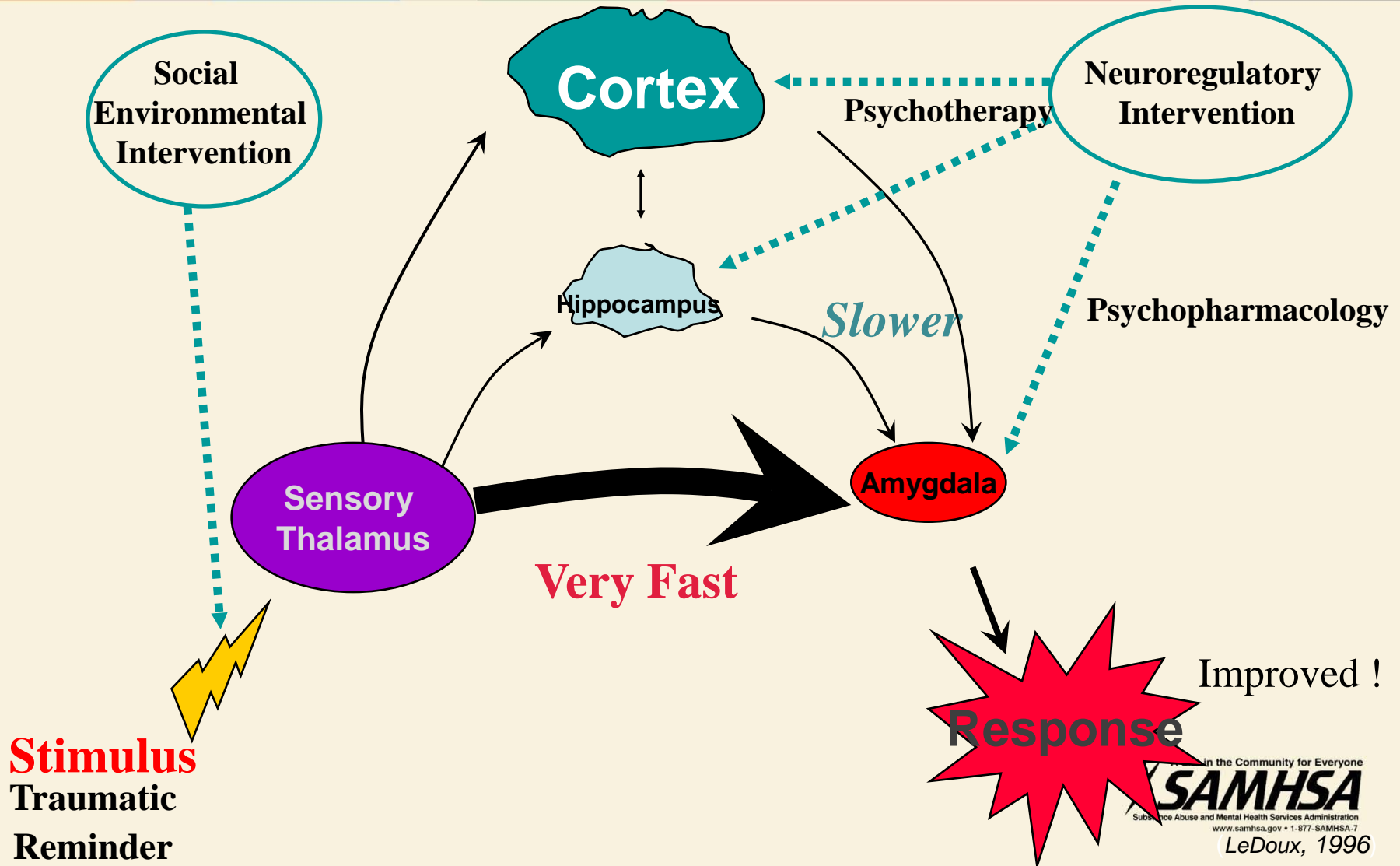
The response is as if there is current danger

Thinking brain automatically shuts off in the face of triggers

Past and present danger become confused

causing...

Transition Between Stimulus and Response: *Effective Interventions*



Improved !

Response

Stimulus
Traumatic
Reminder

Goal of Treatment

- Maintain Calm/Continuous/
Engaged State
- Prevent Discontinuous States
- Build Cognitive Structures
that allow choices

Core Concepts of Development

4) Human relationships, and the effects of relationships on relationships, are the building blocks of healthy development.

(Shonkoff & Phillips, 2000)

Attachment

- Earliest relationships are critical in developing the capacity to regulate emotional states.
- Neglectful and traumatic early relationships create a state of dysregulation that negatively impacts the interpersonal cues in future relationships.

Attachment & Relational Deficits

- Appear guarded & anxious
- Difficult to re-direct, reject support
- Highly emotionally reactive
- Hold on to grievances
- Do not take responsibility for behavior
- Make the same mistakes over and over
- Repetition compulsion / traumatic re-enactment

(Hodas, 2004)

Mastery of a Traumatic Environment

- Many adults have primarily experienced abusive and neglectful relationships.
- Extreme behaviors within relationships can be seen as defensive or self-protective.
- The *origin* of this behavior must be seen as an attempt to master extremely difficult environments.
- Traumatized adults respond to their trauma history in the present. The context has not changed.
- In this way, traumatized adults are “doing the best that they can”.

Core Concepts of Development

5) The course of development can be altered...by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes

(Shonkoff & Phillips, 2000)

CONCLUSIONS

- Response to traumatic stress is learned behavior, mediated by the brain & the social environment.
- Traumatic stress brings the past to the present.
- The survival response impacts the mind, body, behavior & speech “... *the amygdala leads a hostile takeover of consciousness by emotion.*”

(LeDoux, 2002)

Contact Information

Shairi R. Turner, M.D., M.P.H.

Shairi@TurnerDavis.com

Q & A | Manage |

<Type a question for the presenter>

Ask X 🙋

< >

No questions have been answered yet.



Q & A with the Presenters



Joan Gillece



Shairi Turner



Sharon Wise

Following the Webinar

- You may view an archive of today's presentation at:
<http://www.samhsa.gov/nctic/>
- For further information on technical assistance for CSAT Criminal Justice Grantees you may contact your Federal Project Officer.
- Please take a moment to complete the survey that will be sent to you following the webinar.

Thank you for participating in today's webinar!