HIV Quality Improvement Network

Trauma-informed care: evidence, resources, dialogue

Welcome webinar participants!

BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS

Overview

- **Overview of trauma-informed care**, Tim Wall
- **Experiences applying trauma-informed care**, Elaine Halsall
- **Directed questions**, Christina Clarke
- **Open questions and dialogue**, all participants
- **Closing**

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Trauma-informed

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“The past is never dead. It’s not even the past.”

– William Faulkner

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Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being.

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Events and circumstances may include the actual or extreme threat of physical or psychological harm or the withholding of material or relational resources essential to healthy development.

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The individual's *experience* of these events or circumstances helps to determine whether it is a traumatic event.

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Adverse effects of trauma include an individual’s inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; and to manage emotions, memory, attention, thinking, and behavior. In addition to these more visible effects, there may be an altering of one’s neuro-physiological make-up and ongoing health and well-being.

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Traumatic experiences may lead to a hyper-vigilante, constant state of arousal which eventually wears one down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the search for meaning.

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Research has highlighted the central role of trauma in mental and substance use disorders and the linkage between trauma experiences and other chronic physical diseases.

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Research identifies the interaction of genetic vulnerability with toxic environmental stress to produce neural, endocrine and immune system changes that become the hallmarks of both behavioral health disorders and a range of general health conditions that are undermining our health and well being.

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The Relationship of Adverse Childhood Experiences to Adult Health Status

A collaboration effort of Kaiser Permanente and The Centers for Disease Control

Vincent J. Felitti, M.D.

Robert F. Anda, M.D.

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The Adverse Childhood Experiences (ACE) Study is a retrospective and prospective analysis of the relationship between traumatic stress in childhood and the leading causes of morbidity, mortality and disability in the United States, including chronic medical diseases, mental illness, obesity, and substance abuse.

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There are strongly proportionate and significant relationships between ACE scores and a variety of mental health, health, behavioral and healthcare utilization measures, decades after the experience of adverse childhood events.

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Mental health indicators such as chronic depression, hallucinations, suicide attempts, and use of psychotropic medications are all strongly and significantly related to ACE scores, as are health risk behaviors such as smoking, alcohol use, IV drug use, and multiple sex partners.

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Very strong relationships are also reported between ACE scores and a host of biomedical conditions, including liver disease, autoimmune disease, chronic obstructive pulmonary disease and coronary artery disease – even after controlling for conventional risk factors such as smoking.

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According to most estimates, trauma is an almost universal experience among people who use public mental health, substance abuse and social services, as well as people who are justice-involved or homeless.

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Chronic and toxic stress affects the developing brain and body and causes dysregulation of the stress response.

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Chronic stress and trauma are associated with structural changes to the hippocampus, amygdala and pre-frontal cortex of the brain.

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Events that occur early in life have long-term effects on emotionality and stress responsiveness that can affect how people react to environmental challenges, predispose them to high risk behaviors, and increase the rate at which the brain and the body age.

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Allostasis is the process of maintaining equilibrium in the face of threat. It involves the production of hormones (adrenal steroids) that provoke the flight or fight response.

Prolonged exposure to these hormones is associated with neural and endocrine damage that can ultimately result in cognitive impairment, illness and death. Early experiences in life may prime the system to be overly responsive to environmental stress.

"The impact of trauma is felt throughout an individual's life in areas functioning that might seem far removed from the trauma, as well as in areas that are more obviously connected."

(Harris & Fallot, 2001)

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How Trauma Can Affect Relationships

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At it's core the injury of Trauma can damage our capacity to be self compassionate.

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Neurobiology of Trauma

“Who we are today is not who we need to be tomorrow” (Davidson, 2004)

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BASIC ASSUMPTIONS

The basis of normal human development is attachment

Anything that interferes with the attachment relationship of a child is experienced as traumatic and affects development

Traumatic experience at any time disrupts attachment

Disrupted attachment can interfere with every human capacity and that interference looks different in different people

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EFFECTS OF TOXIC STRESS ON BRAIN

Impairs connection of brain circuits and in extreme cases, results in smaller brain development

May cause development of low threshold for stress, resulting in over reactivity (chronic hyperarousal)

High levels of stress hormones, including conrtisol, can suppress body's immune response

Sustained high levels of cortisol can damage the hippocampus, responsible for learning and memory. Cognitive deficits can continue into adulthood.

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Making Sense of Trauma

- Trauma is not in the event (s)
- Trauma is in the nervous system

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Downstairs Brain

- The downstairs Brain includes the limbic region and the brain stem. It is the more primitive part of the brain and is responsible for:
  - Basic function (breathing, linking and heart rate, etc)
  - Innate reactions (fight, flight or freeze)
  - Strong emotions (i.e. anger or fear)

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Upstairs Brain

- Under Construction
  - Develops with the child – fully developed by mid 20’s)
- The upstairs Brain includes the cerebral cortex and is highly sophisticated
  - Thinking
  - Imagining
  - Planning
- Automatic Responses which we have no control over
- Alarm system is always on

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NINE FUNCTIONS OF AN INTEGRATED PREFONTAL CORTEX

1. Body awareness
2. Ability to attune to Others
3. Balanced Emotions
4. Ability to Calm Fears
5. Ability to Pause before Acting
6. Capable of Insight and Reflection
7. Ability to Feel Empathy
8. Capable of having a Sense of Morality, Fairness and the Common Good
9. Ability of Being intuitive

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FIVE MAJOR FUNCTIONS OF THE AMYGDALA

1. Flags what is Important
2. Motivates
3. Sorts Experiences into Memory
4. Interprets Sensations as Emotional Feedback (what fear feels like…)
5. Organizes Attachment (who one goes to when in need of reassurance)

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Flight

Fight

Freeze

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Relationships/Attachment

<u>We are biologically wired to attach (be in relationship).</u>

Ensures our survival.

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CHILDHOOD ADVERSITY AND OTHER FORMS OF TRAUMA ARE TO THE HUMAN OPERATING SYSTEM WHAT VIRUSES ARE TO THE COMPUTER BRAIN

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TRAUMA DISRUPTS ATTACHMENT

AND DISRUPTED ATTACHMENT WRECKS HAVOC WITH EVERYTHING ELSE

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INTERGENERATIONAL TRANSMISSION
THE WAY THE "VIRUS" SPREADS

- How to care for self and others
- How to manage emotions
- How to behave
- What should be expected or anticipated
- What to remember and what to forget

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Trauma trumps logic every time.

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WHAT IS TRAUMA INFORMED CARE?

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Trauma affected people frequently encounter services that mirror the power and control experienced in abusive relationships that caused past trauma.

Although trauma may be central to may people's difficulties and awareness of it pivotal to their recovery, in public mental health and social service settings their trauma is seldom identified or addressed.

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The symptoms that are the creative and necessary adaptations to the effects of trauma are often not recognized as associated with prior trauma by survivors or clinicians.

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A *trauma-informed approach* refers more broadly to how a program, agency, organization or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma; it refers to a change in the organizational culture.

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In this approach, all components of the organization incorporate a thorough understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal from trauma.

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A trauma-informed approach is designed to avoid re-traumatizing those who seek assistance, to focus on "safety first" and a commitment to "do no harm," and to facilitate participation and meaningful involvement of consumers and families, and trauma survivors in the planning of services and programs. (Harris and Fallot, 2001).

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A definition of trauma-informed incorporates three key elements:

1. *realizing* the prevalence of trauma;
2. *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and
3. *responding* by putting this knowledge into practice.

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A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.

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At its core the trauma informed model replaces the older notions of, "sickness" or "badness" with that of injury.

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Trauma informed systems, organizations, programs and services are based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience and that traditional service delivery approaches may exacerbate, so that these services and programs can support recovery, avoid re-traumatization and become more compassionate, effective and efficient.

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Trauma Informed Care provides the foundation for a basic understanding of the psychological, neurological, biological, social and spiritual impact that trauma and violence have on the individuals we serve.

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Core Principles of Trauma Informed Care

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- Universal Precautions
- Trauma as a defining and organizing experience that forms the core of a person's identity.
- Recognize safety as a core value.

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The four principles that are essential with people affected by trauma are: RICH(Risking Connection; Saakvitne, Gamble, Pearlman and Tabor Lev, 2000)

- Respect
- Information
- Connection
- Hope

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- Understanding the whole person and appreciating the context in which they are living.
- Recognizing the interconnectedness of body, mind and spirit.
- Treating the whole person

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- The goal is to return a sense of control and autonomy to the individual.

- A strength based approach.

- Recognizing that the core of the service relationship is open and genuine collaboration at all phases of service delivery.

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- Trust and safety, rather than being assumed, must be earned and nurtured over time. Consequently in initial meetings providers should limit the amount of client disclosure and risk taking.

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Compassion

At its root trauma is all about self compassion, it is enhancing people's ability to be self compassionate and therefore more able to be more compassionate to others.

Requirements for creating a trauma informed system of care.
(Harris & Fallot, 2001)

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1. Administrative Commitment to Change
2. Universal Screening
3. Supporting Staff Development and Wellness
4. Hiring Practices
5. Review Policies and Procedures
6. Creating a Safe and Supportive Environment
7. Clinical Supervision, Support and Consultation
8. A Commitment to Organizational Health and Healing

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9. Each person is encouraged to develop skills in the areas of:

- Self Knowledge
- Self Regulation
- Self Soothing
- Self Compassion
- Self Trust
- Limit Setting and Assertiveness
- Communicating Needs and Desires
- Accurate Perceptions of Others
- Appreciating Mutuality and Reciprocity

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- Adopt a universal assumption of inclusion,
- Adopt the credo “Above all else, do no harm” and “Be Kind”.

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Outcomes

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- Staff is better able to recognize that the people they serve have experienced trauma and are reacting in the present based on these past experiences
- Trauma related language is used more frequently
- Changes in attitude about traumatic stress and its impact on consumers

- Staff is asking for more trauma training
- The program finds ways to train new staff in trauma
- The program finds ways to provide on-going trauma education, whether in the form of in-person or on-line trainings or case discussions or consultants

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- There are more formal ways to support staff
- The program builds in self care
- The program uses more strengths-based language
- Staff wellness
- Increased integration and use of self-soothing and grounding techniques

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- Decreased use of restraints and intrusive procedures
- Increase in job satisfaction
- Increase in client satisfaction
- Decrease in client complaints
- Increase capacity for and demonstrations of compassion

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- Enhanced therapeutic relationships
  - decreased conflict and adversarial interactions
  - decreased risk of judgemental behaviour and assigning inaccurate meanings/interpretations to behaviour
  - increased authenticity in the client/staff relationship

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- Improved program efficiencies and cost savings
- Improved program effectiveness
- Enhanced access to care and services
- Improved job satisfaction

Questions and dialogue

Closing

Thank you to Tim Wall, Elaine Halsall, and all participants!

- Please complete the post-webinar survey: http://fluidsurveys.com/surveys/impactbc/trama-informed-care-webinar-survey/
- Data and narrative submissions deadline tomorrow
- Learning Session 5 on January 30th in Vancouver, make sure you're registered!