



**SAMHSA's Resource Center to Promote
A D S
Acceptance, Dignity and Social Inclusion
Associated with Mental Health**

Social Inclusion and Trauma-Informed Care

September 10, 2009



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

<http://www.promoteacceptance.samhsa.gov>



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The moderator for this call is Michelle Hicks.



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Disclaimer

The views expressed in this training event do not necessarily represent the views, policies, and positions of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.



Questions?

At the end of the speaker presentations, you will be able to ask questions. You may submit your question by pressing “*1” on your telephone keypad. You will enter a queue and be allowed to ask your question in the order in which it is received. On hearing the conference operator announce your name, you may proceed with your question.





Speakers

Helga Luest, President and Chief Executive Officer, Witness Justice

Helga Luest (M.A.) is a recognized expert in the field of trauma, including trauma-informed care, the healing process, and the navigation of the criminal justice process for victims and victim rights. She is a national keynote presenter and trainer, with a background in public relations and communications. As president/chief executive officer of Witness Justice (www.WitnessJustice.org), Ms. Luest leads advocacy, program development, and contract initiatives, including subcontracts to provide communication and outreach activities for numerous Federal technical assistance contracts. In her career, Ms. Luest has received many awards for exceptional social marketing campaigns, including two Telly Awards® for television public service campaigns, an International Association of Business Communicators Award for best campaign, and a 2009 Silver Addy® Award for conference materials. Ms. Luest is also a survivor of a random attempted murder that took place in Miami, FL, in 1993, and her personal experience drives her passion for this work and informs her approaches in advocacy, education, and programs.



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Speakers

Rhonda Elsey-Jones, Educator, Advocate, Trauma/Mental Wellness Trainer and Specialist, Holistic Practitioner

Rhonda Elsey-Jones is currently the program manager for Baltimore Rising Inc.'s Mentoring Children of Incarcerated Parents, a program providing mentors for children whose parents and/or close family members are incarcerated. A survivor of childhood trauma, Ms. Elsey-Jones overcame substance abuse and as such is familiar with the justice system. For nearly 20 years, she worked with individuals in the recovery process, offering assistance to people with issues related to substance abuse, trauma, mental health, and incarceration. In 2001, Ms. Elsey-Jones offered her services to the development of Tamar's Children, a pilot program for pregnant women who were incarcerated. Her personal interest and lived experiences led her to a workshop on the development of the Tamar's Children Project, ultimately working as their case manager and assistant director while pursuing undergraduate, graduate, and doctoral degrees. Ms. Elsey-Jones is a strong advocate for trauma survivors, individuals with mental health diagnoses, people who have been addicted, and people involved with the justice system and youth. She speaks throughout the Nation on a variety of trauma-related topics. Ms. Elsey-Jones is an active board member for the National Women's Prison Project (NWPP). She recently served as consumer co-lead with Helga Luest, developing a Situational Analysis and Marketing Plan for the Center for Mental Health Services' (CMHS') National Trauma Campaign.





Speakers

Joan B. Gillece, Ph.D., Project Director, National Coordinating Center for the Seclusion and Restraint Reduction Initiative

Joan B. Gillece, Ph.D., is the project director for the National Coordinating Center for the Seclusion and Restraint Reduction Initiative. She is also the project director and principle trainer and consultant to CMHS National Center for Trauma-Informed Care. Prior to coming to the National Association of State Mental Health Program Directors, Dr. Gillece was the director of special needs populations for Maryland's Mental Hygiene Administration. She was responsible for developing and sustaining services for Maryland citizens who have serious mental illnesses and may also be incarcerated in local detention centers, homeless, suffering from a co-occurring substance use disorder, or deaf. She has been successful in obtaining private, State, local, and Federal funding to create a patchwork of services for special needs populations. Dr. Gillece obtained funding to develop a program for pregnant, incarcerated women and their newborns. This program, called Tamar's Children, was designed to break the intergenerational cycle of despair, poverty, addiction, and criminality. She has spoken extensively on developing model systems of care through partnerships across agencies. Dr. Gillece has provided consultation to numerous States on developing innovative institutional and community-based systems of care for individuals involved in the justice system through the GAINS Center and the National Institute of Corrections. She has national experience in working with diverse service agencies on developing systems of care that are trauma-informed.



Social Inclusion and Trauma-Informed Care

*Social Change Through Public Outreach:
A National Awareness Campaign*

By Helga Luest

President and CEO, Witness Justice



Witness Justice™

Background

- Recognizing the interrelationship between trauma and mental health, CMHS funded the development of a Situational Analysis and Marketing Plan for a national trauma campaign.
- With an educational goal to increase understanding and improve social inclusion, an indepth look at the impact a campaign would have was explored.

Situational Analysis Findings

- Trauma is very common in the United States.
- Trauma is a universal experience for people living with mental health concerns and co-occurring disorders.
- People with mental health concerns are more likely to experience trauma that is interpersonal, intentional, prolonged/repeated, occurring in childhood and adolescence, and may extend over a lifetime.

Situational Analysis Findings (Cont'd)

- Many ethnic and racial groups have been negatively impacted by historical trauma as well as intergenerational cycles of violence and substance abuse.
- Trauma histories among mental health consumers largely go unaddressed.
- Left unaddressed, trauma poses dire consequences to the recovery and well-being of consumers and their families and communities.

Situational Analysis Findings (Cont'd)

- Trauma-informed interventions for people with mental health and substance use concerns are effective, but not readily available.
- While some research exists, attitudes and beliefs among the public, consumers, and providers about the link between trauma and mental health are largely unknown.
- Media interest in the link between trauma and mental health is significant.

Situational Analysis Findings (Cont'd)

- Many organizations are involved in trauma-response activities, but there has not yet been a national campaign that focuses on trauma and its link to mental health.

A Call for National Education

“It has become more clear than ever that psychological trauma is a primary—but often ignored or overlooked—factor of health (both physical and mental) with survivors of violent crime, abuse, disaster, terrorism, and war must contend ... A public education and awareness campaign is a necessary, and cost effective first step to help alleviate this crisis.”

—U.S. Congress, Addiction Treatment & Recovery Caucus,
Letter to the President of the United States, 9/29/06

Importance of Social Inclusion

What is social inclusion?

Social inclusion focuses on social relationships that adequately allow a person to feel “included.”

Social inclusion embraces the trauma-informed philosophy of equality and meeting people “where they are.” It’s based on relationships where trust and mutual caring transcend specific settings or contexts.

Importance of Social Inclusion

- Areas where social inclusion needs to occur:
 - Employment
 - Education
 - Housing
 - Social supports

Without Social Inclusion...

- Without social inclusion, stigma and discrimination will be impossible to overcome and total wellness for survivors and consumers will be difficult to achieve.

A Step in the Right Direction

- Public education
- Building understanding
- Increasing interest in and access to trauma-informed care
- Fostering healing relationships
- Understanding that education needs to happen beyond human services to reach the goal of social inclusion

A National Trauma Campaign: The Marketing Plan

- Potential audience: Families
 - Inner city
 - Rural
 - Military

Strategies To Consider

- A campaign that leads to social inclusion has to start at a grassroots-level and in the community.
- Look at activities that build understanding, break through stigma, and lessen discrimination.
- Develop a “trauma-informed” campaign with survivor and consumer leadership in implementation.

Telling the Story

- There's nothing more compelling than hearing someone's story of survival, healing, and resilience. Include real-life stories that demonstrate how social inclusion can be achieved.

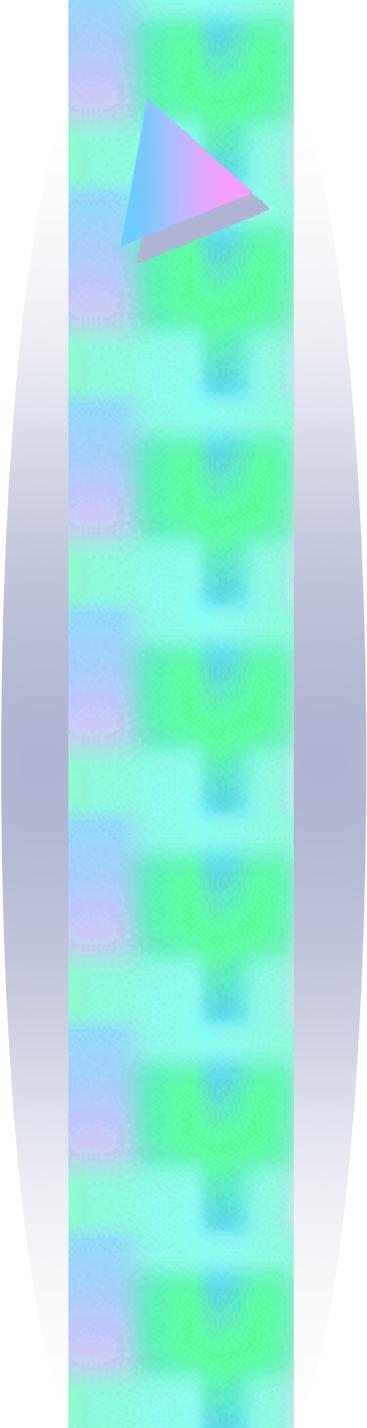
Contact Information

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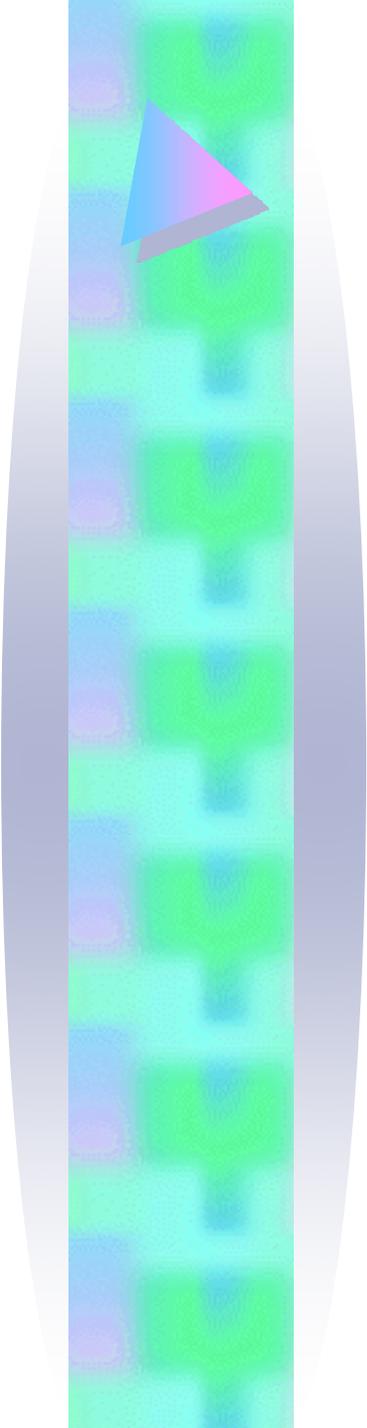
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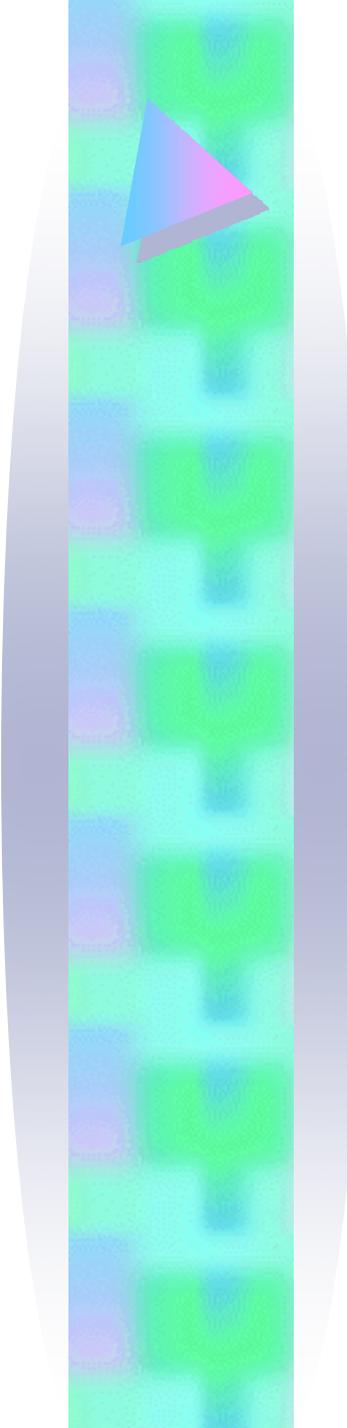
**Social Inclusion
and
Trauma-Informed Care:
A Personal Perspective**

Rhonda Elsey-Jones

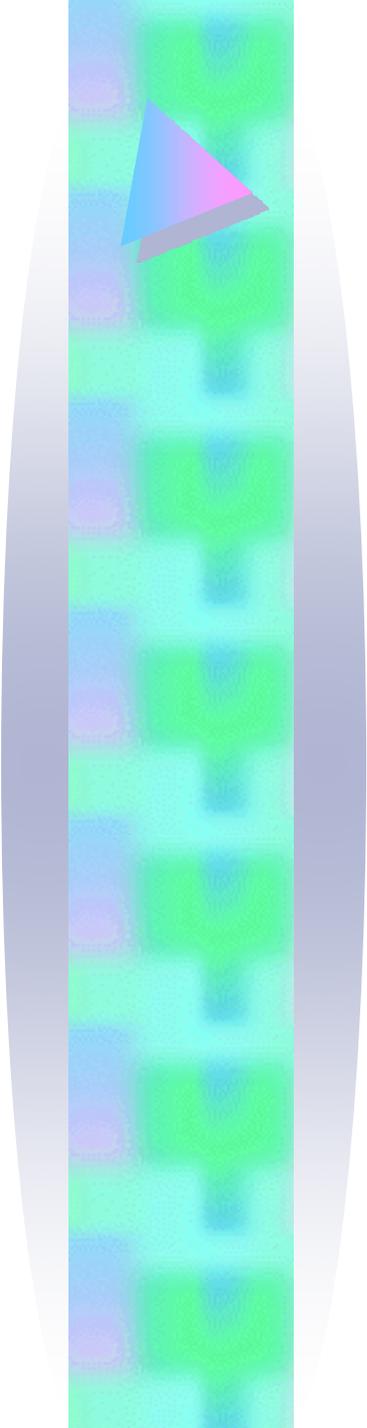


The healthy social life is found
When in the mirror of each human soul
The whole community finds its
reflection
And when in the community
The virtue of each one is living

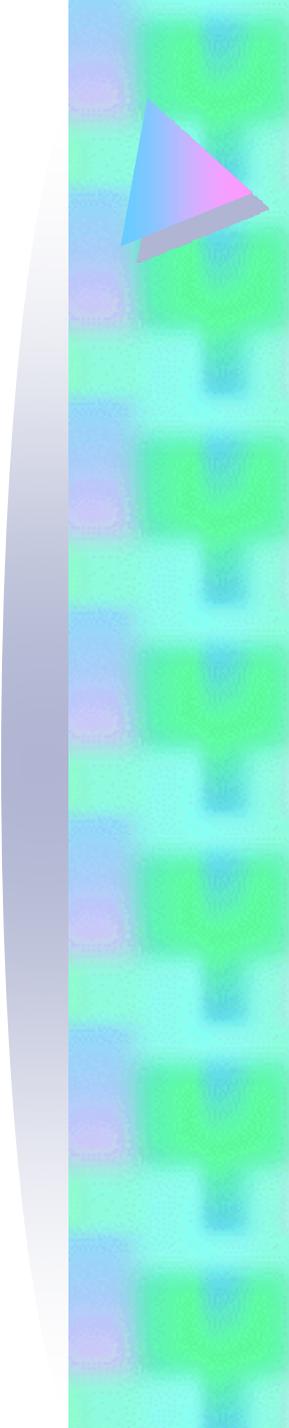
Rudolf Steiner –The Soul Motto

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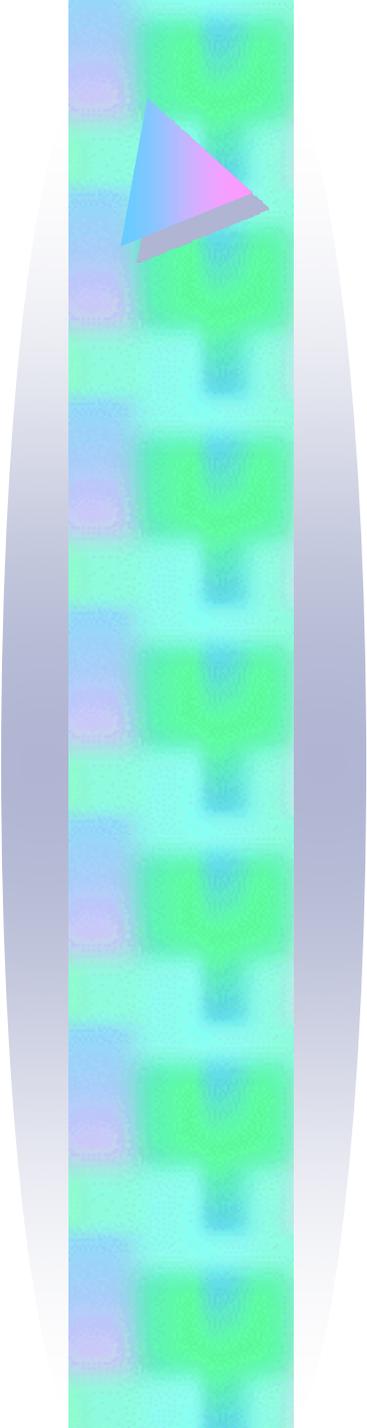
Social exclusion means that people or groups of people are excluded from various parts of society or have their access to society or services impeded.

A decorative vertical bar on the left side of the slide, featuring a colorful triangle at the top left and a blurred background of green, blue, and purple squares. The text is centered on the right side of the slide.

Social exclusion occurs when people suffer from a series of problems such as unemployment, discrimination, poor skills, low income, poor housing, high crime, family breakdown, and ill mental and physical health.



Individuals who have experienced trauma and have been diagnosed with mental illnesses are also excluded from their families and society because of the secrets they have to keep, the experiences they have had, their feelings of fear, isolation, shame, guilt, blame, unworthiness, etc.



Trauma



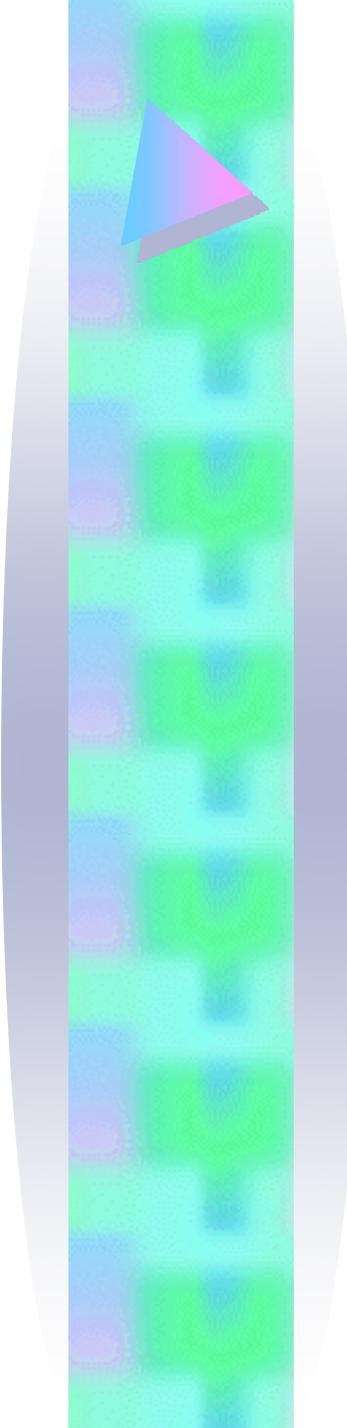
Isolation



Mental Illness



Physical Illness

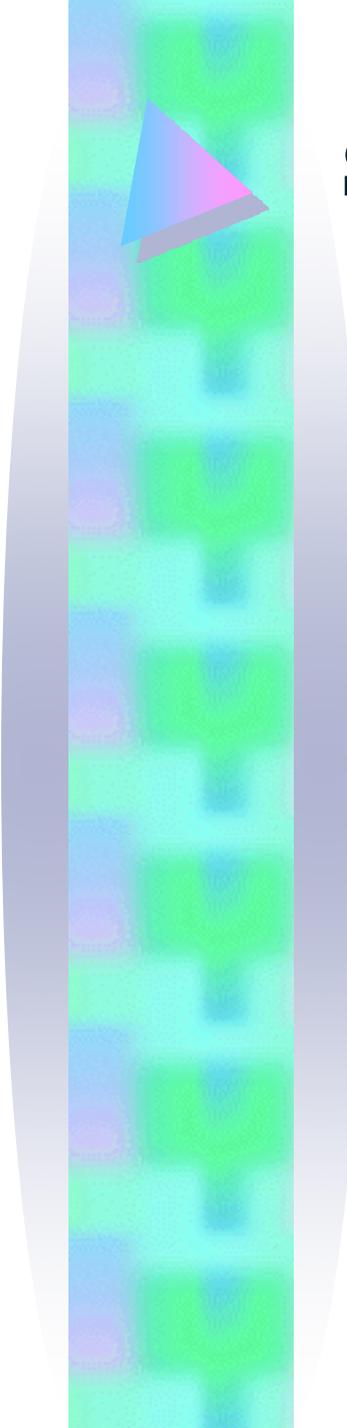


Women and Trauma

Women with abuse and trauma histories face a range of mental health issues including;

- ✓ Anxiety
- ✓ Panic attacks
- ✓ Major depression
- ✓ Substance abuse
- ✓ Personality disorders
- ✓ Dissociate identity disorders
- ✓ Psychotic disorders
- ✓ Somatization
- ✓ Eating disorders
- ✓ Post-traumatic stress disorders

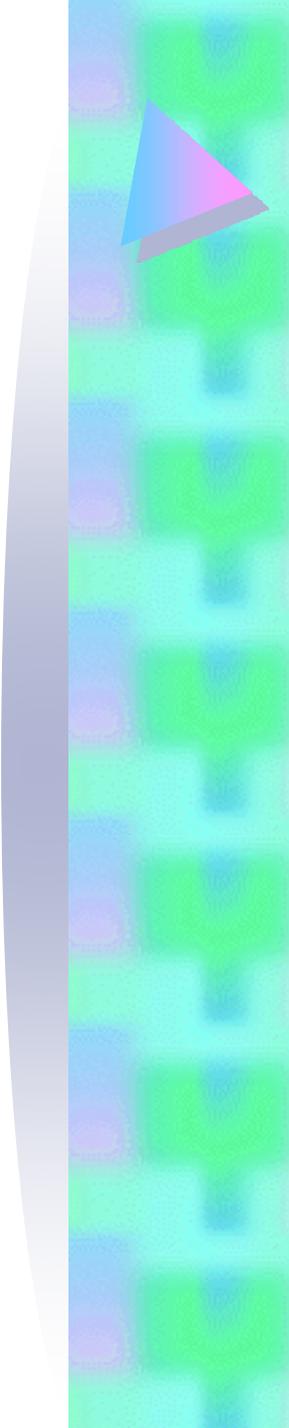
Women, Co-Occurring Disorders & Violence Study



Social Inclusion and Trauma-Informed Care

Social inclusion is based on the belief that we all fare better when no one is left to fall too far behind and the economy works for everyone.

Social inclusion simultaneously incorporates multiple dimensions of well-being.

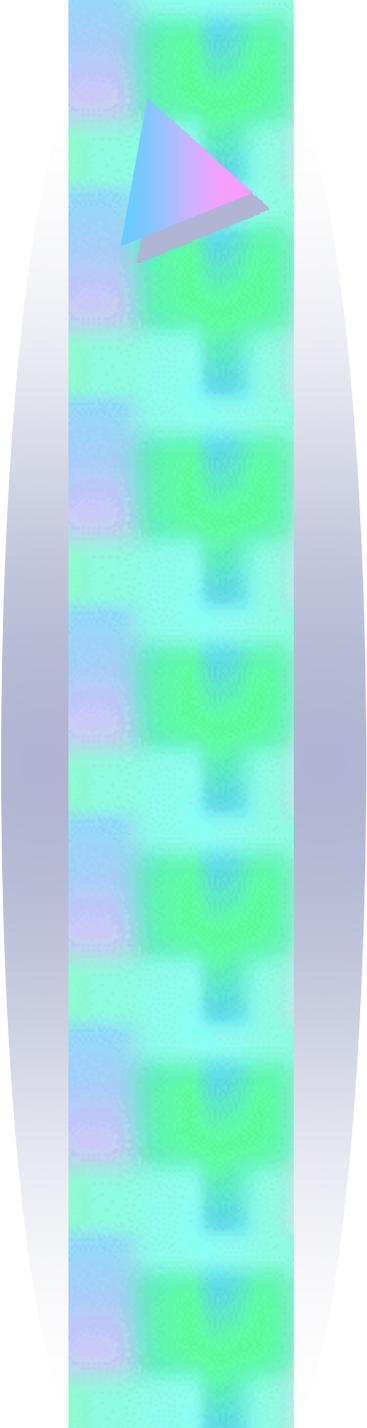


Social Inclusion and Trauma-Informed Care

Social inclusion occurs when individuals are educated, empowered, nurtured, learn to advocate for themselves, and begin to advocate for others.

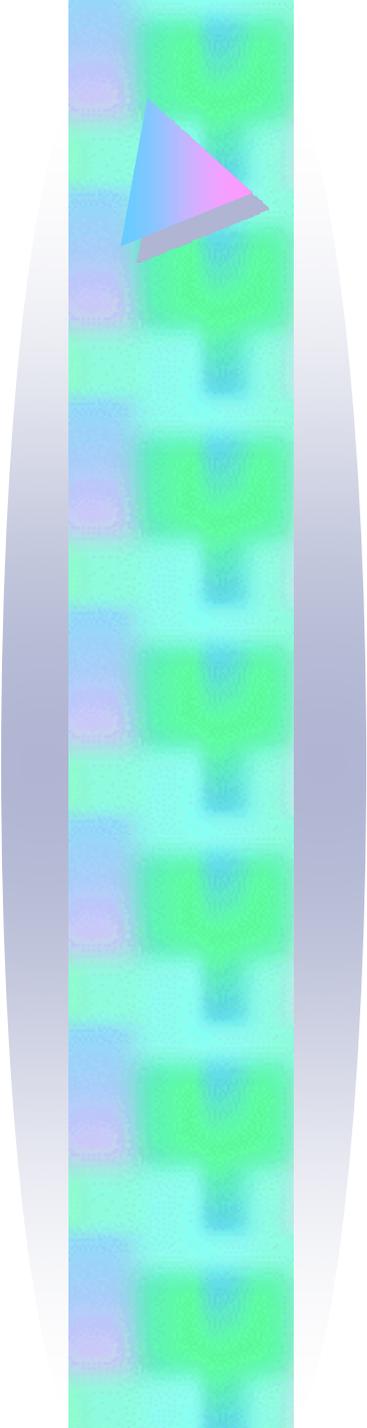
This cycle of wholeness and wellness continues.

“As I heal, I assist others in healing.”



What Trauma-Informed Services Are Not!

- ✓ Agency-centered/focused
- ✓ Break them down to build them up
 - ✓ Condescending
 - ✓ Demeaning
 - ✓ Forced treatment
- ✓ No consumer involvement



What Trauma-Informed Services Are Not! (Cont'd)

- ✓ A power struggle
 - ✓ Punitive
 - ✓ Quantitative
 - ✓ Reformative
- ✓ Shaming and blaming

Trauma-Informed Services Are:

 **Consumer-driven**

 **Informative**

 **Hopeful**

 **Safe**

 **Nurturing**

 **Trust-building**

Trauma-Informed Services Are:

(Cont'd)

 **Respectful**

 **Empowering**

 **Based on secure attachments**

 **Person-centered**

 **Individualized**

 **Flexible**

Trauma-Informed Services Are: (Cont'd)

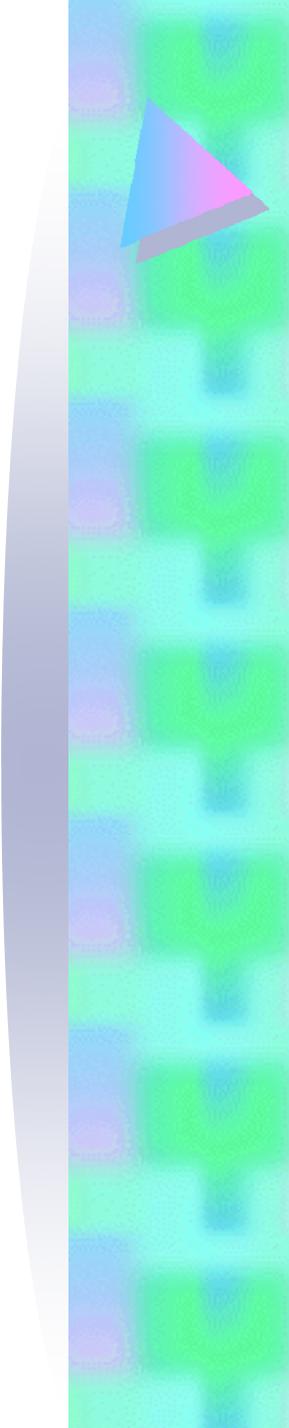
 **No power struggles**

 **No mandates or absolutes**

 **Collaborations and consensus**

 **Building self-esteem**

 **The “whole truth”**



 *Consumers are the experts on their experiences.*

The professional is the expert who guides the consumer using concepts, theories, and techniques.

It is our hope that together they will form a roadmap for change in the trauma, mental wellness, social inclusion system.

Creating Trauma-Informed Systems of Care for Human Service Settings

Trauma-Informed Care

*An Overview
of Fundamental Concepts*

Joan Gillece, Ph.D.

*National Center for
Trauma-Informed Care*

Definition of Trauma-Informed Care

■ Treatment that incorporates:

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- 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.
- The care addresses these effects, and is collaborative, supportive, and skill-based.

(Jennings, 2004)

Prevalence of Trauma and Implications

Prevalence of Trauma Mental Health Population

- 90 percent of public mental health clients have been exposed. *(Mueser et al., 2004; Mueser et al., 1998)*
- Most have multiple experiences of trauma. *(Ibid)*
- 34–53 percent report childhood sexual or physical abuse. *(Kessler et al., 1995; MHA NY & NYOMH, 1995)*
- 43–81 percent report some type of victimization. *(Ibid)*

Prevalence of Trauma Mental Health Population

- 97 percent of homeless women with SMI have experienced severe physical and sexual abuse—87 percent experience this abuse both as child and adult. *(Goodman et al., 1997)*
- Current rates of PTSD in people with SMI range from 29–43 percent. *(CMHS/HRANE, 1995; Jennings & Ralph, 1997)*
- Epidemic exists among population in public mental health system. *(Ibid)*

Trauma and Psychiatric Disorders Among Children in Mental Health Settings

- A Canadian study of 187 adolescents reported that 42 percent had PTSD.

(Kotlek, et al., 1998)

- American study of 100 adolescent inpatients reported that 93 percent had a history of trauma and 32 percent had “severe” symptoms of PTSD.

(Lipschitz et al., 1999)

- Children with PTSD have twice as many comorbid psychiatric disorders and score higher on depression, dissociation, and suicidal scales.

(Ibid)

Experience of Trauma in Youth Involved in the Justice System

- Childhood abuse or neglect increases the likelihood of arrest as a juvenile by 53 percent and as a young adult by 38 percent—the likelihood of arrest for a violent crime also increases by 38 percent.
(NASMHPD/NTAC, 2004)
- Prevalence of PTSD in DJJ populations is eight times as high as a community sample of similar peers.
(Wolpaw & Ford, 2004)
- Among a sample of juvenile detainees more males (93 percent) than females (84 percent) reported experiencing trauma; however, more females met PTSD criteria (18 percent females vs. 11 percent males).
(Abram et al., 2004)

National Child Traumatic Stress Network (NCTSN)

NCTSN's Subcommittee on Juvenile Justice working group reported the following:

- Boys in the juvenile justice system report trauma in the form of witnessing violence—girls are likely to report being the victim of violence. *(Steiner et al., 1997)*
- 74 percent of juvenile justice–involved females report being hurt or in danger of being hurt; 60 percent reported being raped or in danger of being raped; 76 percent reported witnessing someone being severely injured or killed. *(Cauffman et al., 1998)*
- Childhood abuse and/or neglect increases the risk of promiscuity, prostitution, and pregnancy. *(Wisdon & Kuhns, 1996)*

Prevalence of Trauma

- A majority of adult and children in inpatient psychiatric treatment settings have trauma histories.

(Cusack et al.; Mueser et al., 1998; Lipschitz et. al, 1999, NASMHPD, 1998)

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

(Hodas, 2004)

Impact of Trauma Over the Life Span

- Effects are neurological, biological, psychological, and social in nature, including:
 - Changes in brain neurobiology
 - Social, emotional, and cognitive impairment
 - Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self harm, sexual promiscuity, violence)
 - Severe and persistent behavioral health, health and social problems, and early death

Adverse Childhood Experiences (ACE) Study

The ACE study identifies adverse childhood experiences as growing up (prior to 18 years of age) in a household with: recurrent physical abuse; recurrent emotional and/or sexual abuse; an alcohol abuser; an incarcerated household member; someone who is chronically depressed, suicidal, institutionalized, or mentally ill; mother being treated violently; one or no parents; emotional or physical neglect.

(Felitti et al., 1998)

Trauma-Informed Care Systems

Trauma-Informed Care Systems

Key Principles

- Integrate philosophies of care that guide all clinical interventions.
- Are based on current literature.
- Are inclusive of the survivor's perspective.
- Are informed by research and evidence of effective practice.
- Recognize that coercive interventions cause traumatization and retraumatization and are to be avoided.

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

Trauma-Informed Care Systems

Key Features

- Recognition of the high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults with SMI/SED
- Early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness

(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al.)

Trauma-Informed Care Systems

Key Features (Cont'd)

- Recognition that service environments are often traumatizing, both overtly and covertly
- Recognition that the majority of staff are uninformed about trauma and its sequelae, do not recognize it, and do not treat it

Trauma-Informed Care Systems

Key Features (Cont'd)

- Valuing the individual in all aspects of care
- Neutral, objective, and supportive language
- Individually flexible plans and approaches
- Avoid shaming or humiliation at all times

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

Trauma-Informed Care Systems

Key Features (Cont'd)

- Awareness/training on retraumatizing practices
- Institutions that are open to outside parties: advocacy and clinical consultants
- Training and supervision in assessment and treatment of people with trauma histories

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

Trauma-Informed Care Systems

Key Features (Cont'd)

- Focusing on what happened to you in place of what is wrong with you *(Bloom, 2002)*
- Asking questions about current abuse
 - Addressing the current risk and developing a safety plan for discharge
- One person sensitively asking the questions
- Noting that people who are psychotic and delusional can respond reliably to trauma assessments if questions are asked appropriately *(Rosenburg, et al., 2001)*

Universal Precautions as a Core Trauma-Informed Concept

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

Recognizing Care Systems That Lack Trauma Sensitivity

Systems Without Trauma Sensitivity

- Individuals are labeled and pathologized as manipulative, needy, attention-seeking
- Misuse or overuse of displays of power—keys, security, demeanor
- Culture of secrecy—no advocates, poor monitoring of staff
- Staff believe key role is as rule enforcers

Systems Without Trauma Sensitivity (Cont'd)

- Little use of least restrictive alternatives other than medication
- Institutions that emphasize “compliance” rather than collaboration
- Institutions that disempower and devalue staff who then “pass on” that disrespect to service recipients

(Fallot & Harris, 2002)

Systems Without Trauma Sensitivity-Related Characteristics

- High rates of staff and recipient assault and injury
- Lower treatment adherence
- High rates of adult, child/family complaints
- Higher rates of staff turnover and low morale
- Longer lengths of stay/increase in recidivism

(Fallot & Harris, 2002; Massachusetts DMH, 2001; Huckshorn, 2001)

Organizational Commitment to Trauma-Informed Care

Organizational Commitment to Trauma-Informed Care

- Adoption of a trauma-informed policy to include:
 - Commitment to appropriately assess trauma
 - Avoidance of re-traumatizing practices
- Key administrators getting on board
- Resources available for system modifications and performance improvement processes
- Education of staff prioritized

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

Organizational Commitment to Trauma-Informed Care (Cont'd)

- Unit staff can access expert trauma consultation.
- Unit staff can access trauma-specific treatment if indicated.

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

Organizational Commitment to Trauma-Informed Care (Cont'd)

- Assessment data informs treatment planning in daily clinical work.
- Advance directives, safety plans, and de-escalation preferences are communicated and used.
- Power and control are minimized by attending constantly to unit culture.

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

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More information

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Resources

CMHS's National Center for Trauma-Informed Care
<http://mentalhealth.samhsa.gov/nctic/default.asp>

Trauma-Informed Care Overview
<http://mentalhealth.samhsa.gov/nctic/trauma.asp>

The Science of Trauma
http://download.ncadi.samhsa.gov/ken/pdf/NCTIC/The_Science_of_Trauma.pdf

Sidran Institute
<http://www.sidran.org/index.cfm>

Witness Justice
<http://www.witnessjustice.org>



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Survey

We value your suggestions. Within 24 hours of this teleconference, you will receive an email request to participate in a short, anonymous online survey about today's training material. Survey results will be used to determine what resources and topic areas need to be addressed by future training events. The survey will take approximately 5 minutes to complete.

Survey participation requests will be sent to all registered event participants who provided email addresses at the time of their registration. Each request message will contain a Web link to our survey tool. Please call **1-800-540-0320** if you have any difficulties filling out the survey online. Thank you for your feedback and cooperation.

Written comments may be sent to the Substance Abuse and Mental Health Services Administration (SAMHSA) ADS Center via email at promoteacceptance@samhsa.hhs.gov.

