Trauma Informed Approach and the SAMSHA Research Project THRIVE

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Today's Agenda

- Review trauma-informed principles and the difference between the trauma-informed approach and trauma specific services.
- Explore research findings regarding the complex relationship between trauma, mental health, physical health and recovery.
- Discuss how Maine DHHS and Thrive are working to promote, achieve and sustain a trauma-informed system of care through continuous quality improvement.

History and Background:
Maine's Trauma-informed System of Care

History and Background

- Six years ago Maine was awarded a six year grant by the Federal Substance Abuse and Mental Health Services Administration to develop and implement a System of Care for Children that would be:
  - Trauma-Informed
  - Family Driven
  - Youth Guided
  - Culturally and Linguistically Competent

Systems of Care

A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations so services and supports are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and throughout life.

Gary Blau, Child, Adolescent and Family Branch, CMHS, SAMHSA

Why Develop a *Trauma-Informed* System of Care?

- Data collected and analyzed by Dr. Jay Yoe, Ph.D. of DHHS showed clearly that compared to others, children and youth trauma survivors in Maine:
  - Were at greater risk of significant harm;
  - Were likely to experience co-occurring challenges physically, developmentally and with substances;
  - Had significantly greater challenges in the areas of child/youth and parent/caregiver acceptance and engagement with service providers;
  - Were more likely to use mental health services and high-end services for greater periods of time; and
  - Had 73% higher mental health service expenditures and 51% higher overall treatment expenditures.

What is Trauma?

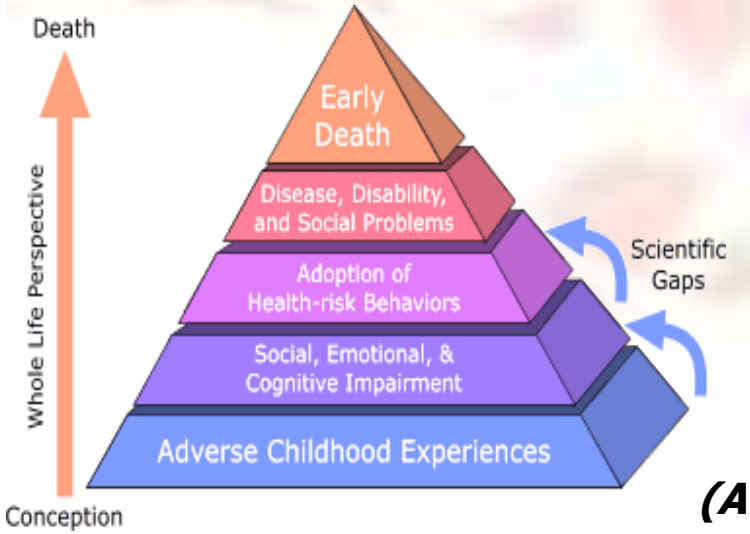
- The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism and/or disasters. NASMHPD, 2004
- A trauma is a psychologically distressing event that is outside the range of usual human experience. Trauma often involves a sense of intense fear, terror, and helplessness.
- Trauma should not be confused with stress. Stress is an inevitable component of everyone's life. Trauma is an experience that induces an abnormally intense and prolonged stress response.
- Child Traumatic Stress is when children and adolescents are exposed to traumatic events or situations, and that exposure overwhelms their ability to cope.

Why Does it Matter?

- Trauma is pervasive
- Trauma's impact is broad and diverse
- Trauma's impact is deep and life-shaping
- Trauma is often self-perpetuating and differentially affects the more vulnerable
- Trauma affects how people approach services
- The service system has often been re-traumatizing

Adverse Childhood Experience Study

- A high number of traumatic experiences during childhood leads to higher risk of health and social problems.
  - Substance abuse, mental health and depression, chronic disease, and partner/domestic violence.



(ACES; Felitti et al, 1998)

A Systemic Approach

- A Trauma-informed system includes:
  - Universal trauma screening, assessments and service planning – integrating all components;
  - Focus on recovery, resiliency, strengths-based, and skill building;
  - General awareness and understandings of all stakeholders of trauma, its effects and potential triggers;
  - Changes in policy and practice to support a trauma sensitive approach throughout the system and participating agencies to reduce incidences of re-traumatization; and
  - Crisis Management from a trauma informed perspective.

Trauma-Informed Approach versus Trauma-Specific Treatment

Trauma-Informed In a Nutshell

If you remember nothing else, remember this!

Instead of asking "what is *wrong* with you?"
a trauma-informed approach asks
"what *has happened* to you?"

Roger Fallot and Maxine Harris (eds.), Using Trauma Theory to Design Services Systems

What is Trauma-Informed Approach

- Means understanding the role that violence and victimization play in the lives of large numbers of children and families
- Providing services and supports in a manner that is welcoming, respectful and appropriate to trauma survivors
- A trauma informed organization makes every effort to avoid re-traumatizing individuals

Trauma-informed vs. Trauma-specific

Trauma-informed

- An approach to service delivery that acknowledges and understands the effects of trauma

Trauma-specific

- Evidenced based treatment models that have been proven to facilitate recovery from trauma

Trauma Experiences vs. Trauma Diagnosis

- Children and youth react to trauma differently than adults.

- Children and youth who experience trauma are <u>less likely</u> to receive a formal PTSD diagnosis than adults
  - Common diagnoses are: separation anxiety disorder, oppositional defiance disorder, phobic disorders, and ADHD.

(Ford et al, 2000; Husain, Allwood, Bell, 2008; Daud & Rydelius, 2009)

The Trauma-Informed Domains

1. Safety
2. Trustworthiness
3. Choice
4. Collaboration
5. Empowerment
6. Language Access and Cultural Competency

Thrive Evaluation Findings

Thrive Evaluation Overview

Cross-Sectional Descriptive Study

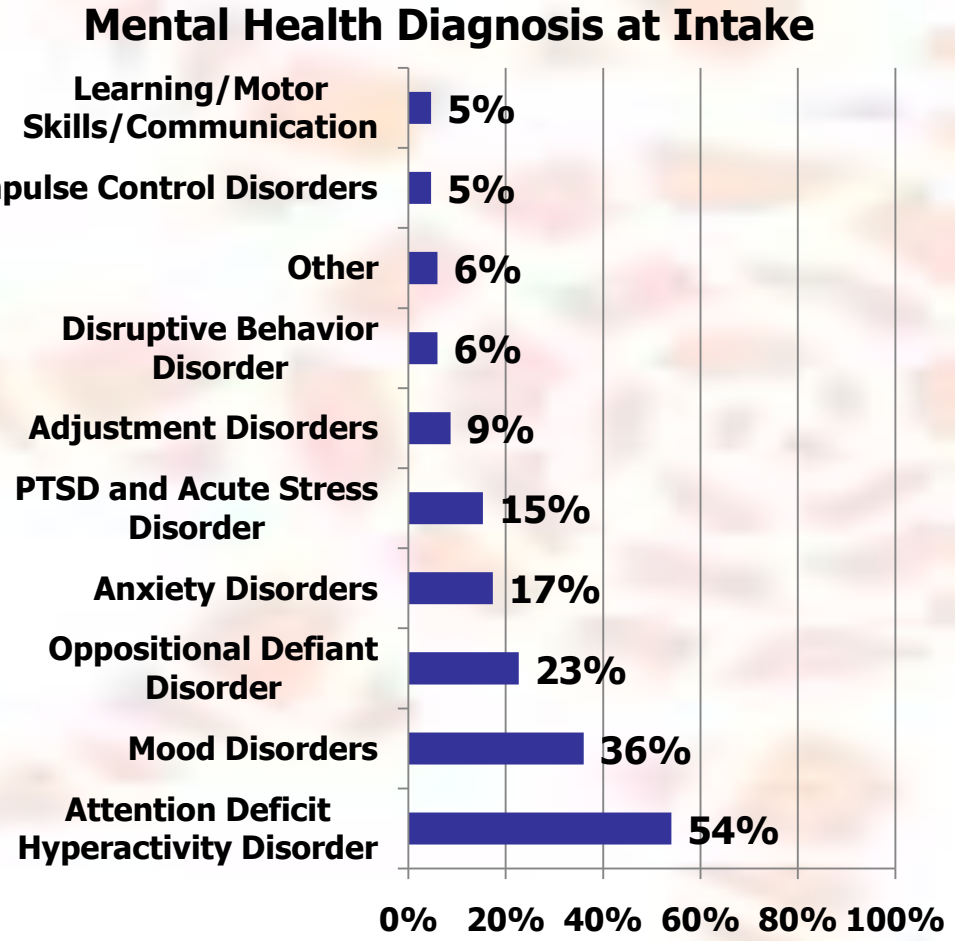
- Who are the children and families served and what are their characteristics?
- Collected of all children/youth whose family is working with Family Support Partner (FSP)

Longitudinal Child and Family Outcome Study

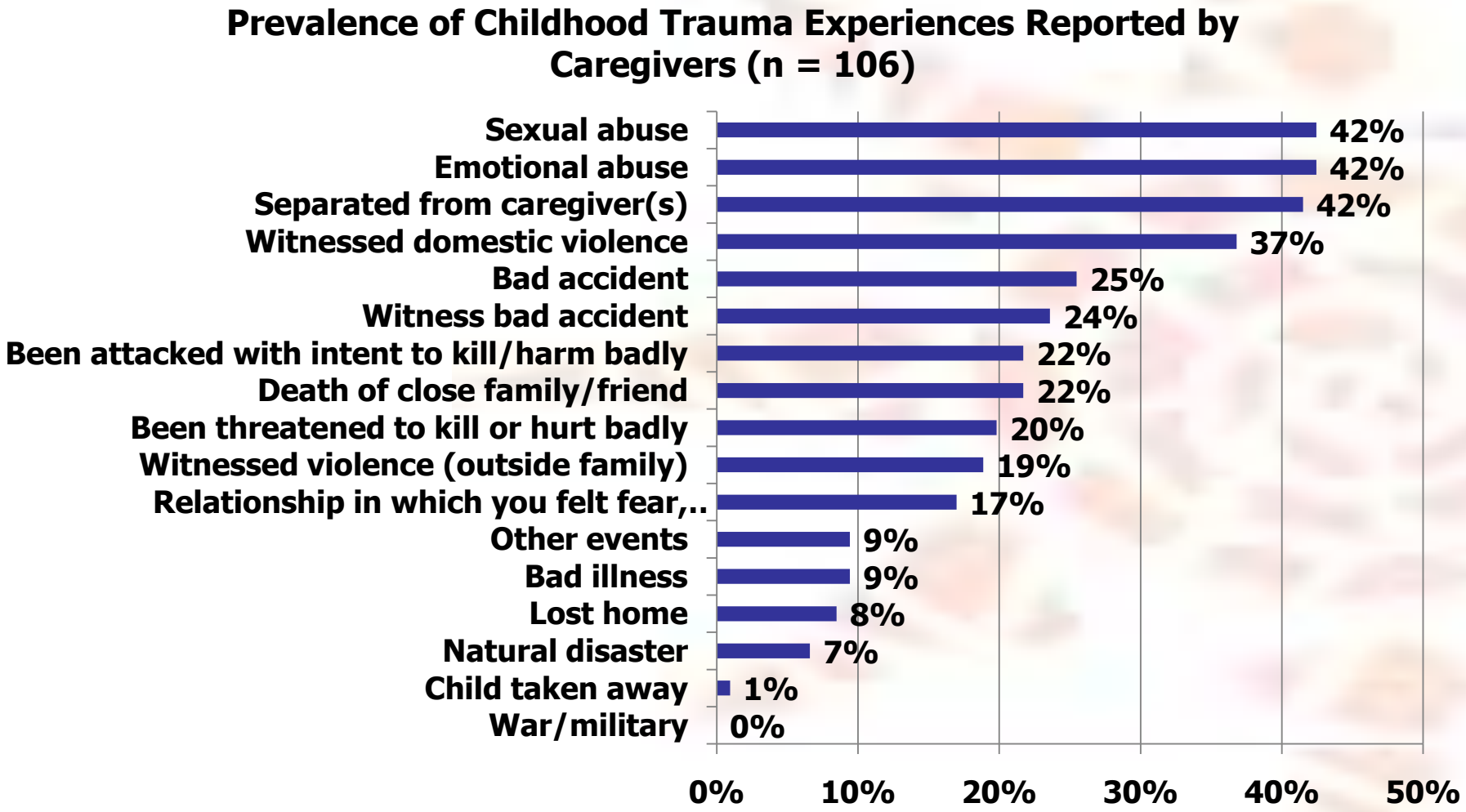
- To what extent do child and family outcomes improve over time?
- Interview conducted with most families within 30 days of FSP intake and then every 6 months for up to 36 months

Thrive Evaluation Population

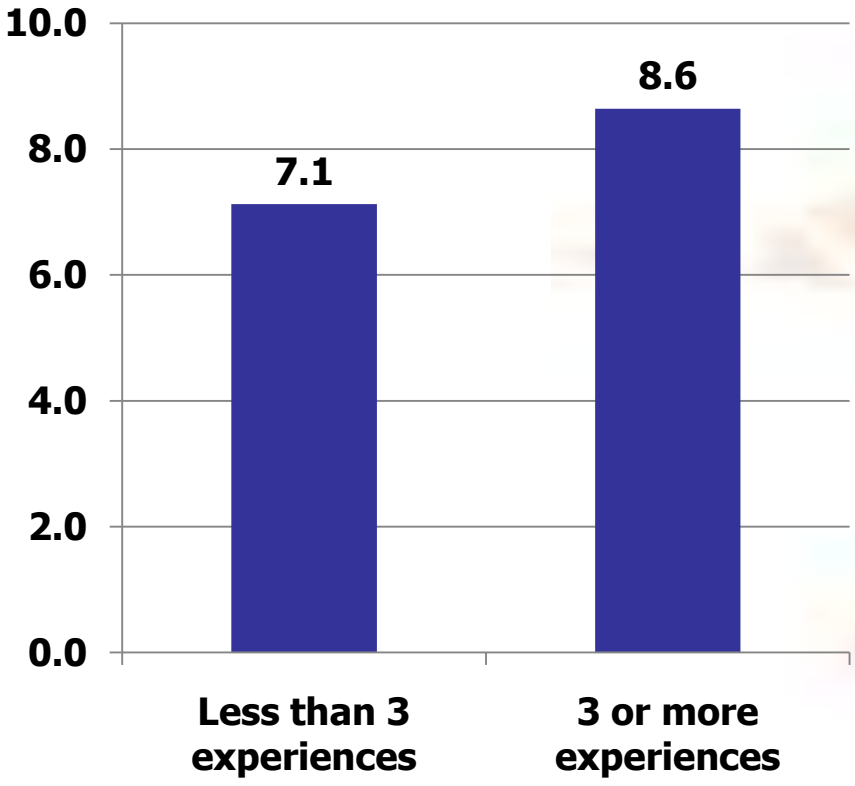
- Children and Youth:
  - Average age = 10
  - 65% boys (35% girls)
  - 91% lived at home, 79% with at least one biological parent.
- Caregivers:
  - Female, early 40's
  - Biological parent
  - High school graduates
  - 70% earn less than $25K per year

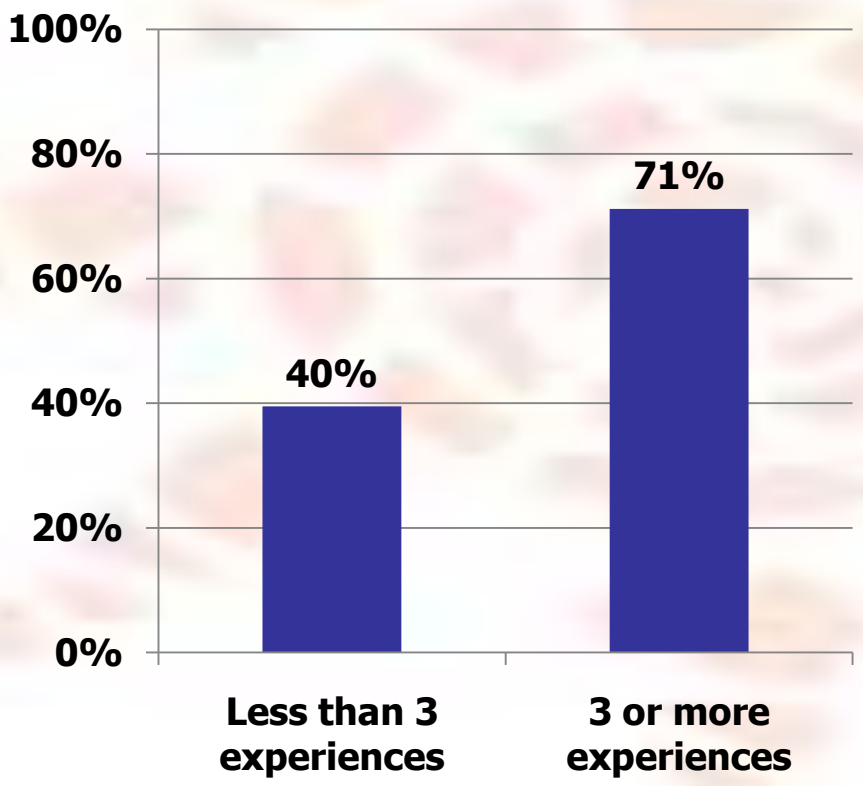


Trauma Experiences of Caregivers



Effects of Trauma on Caregivers





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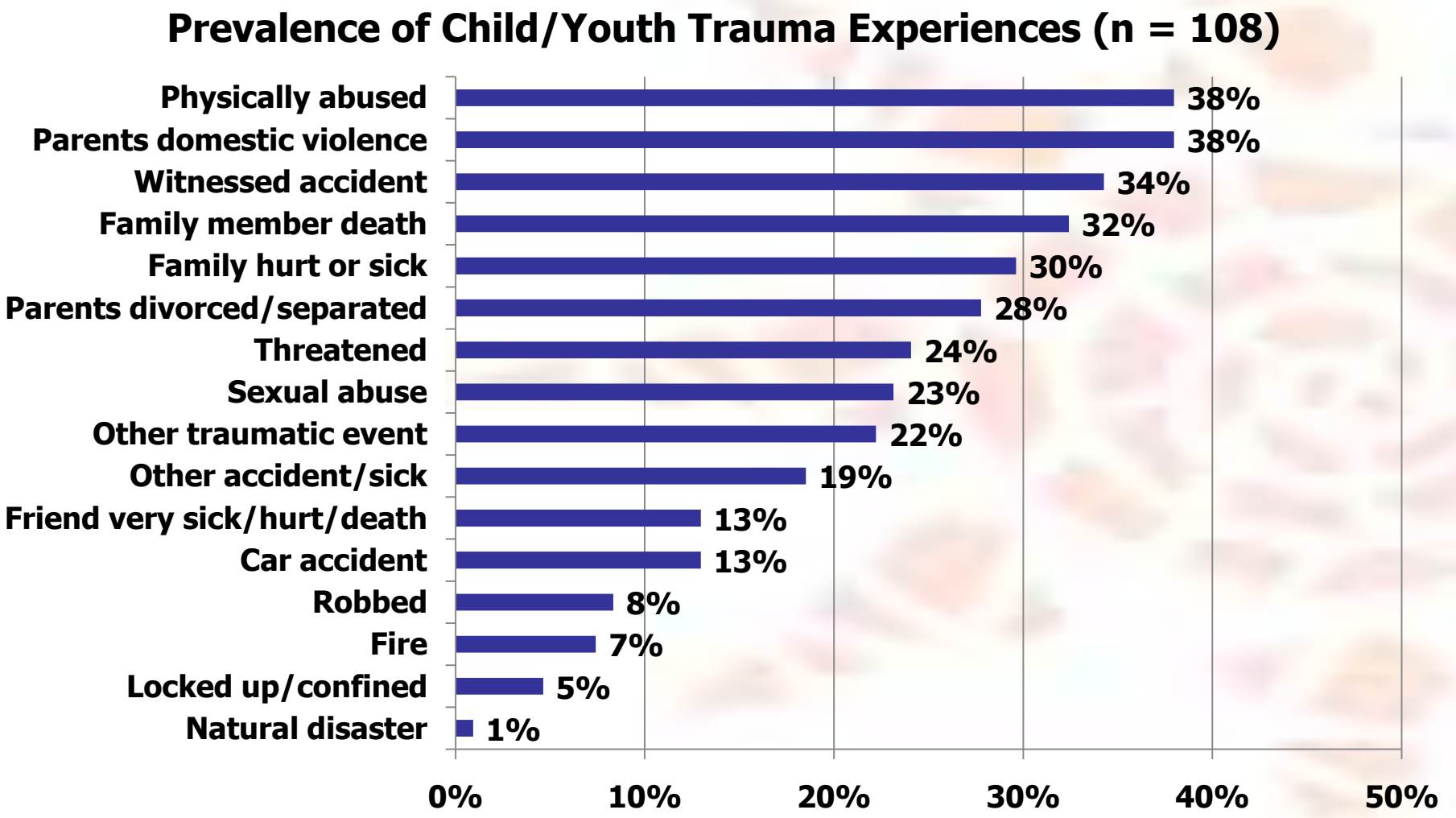
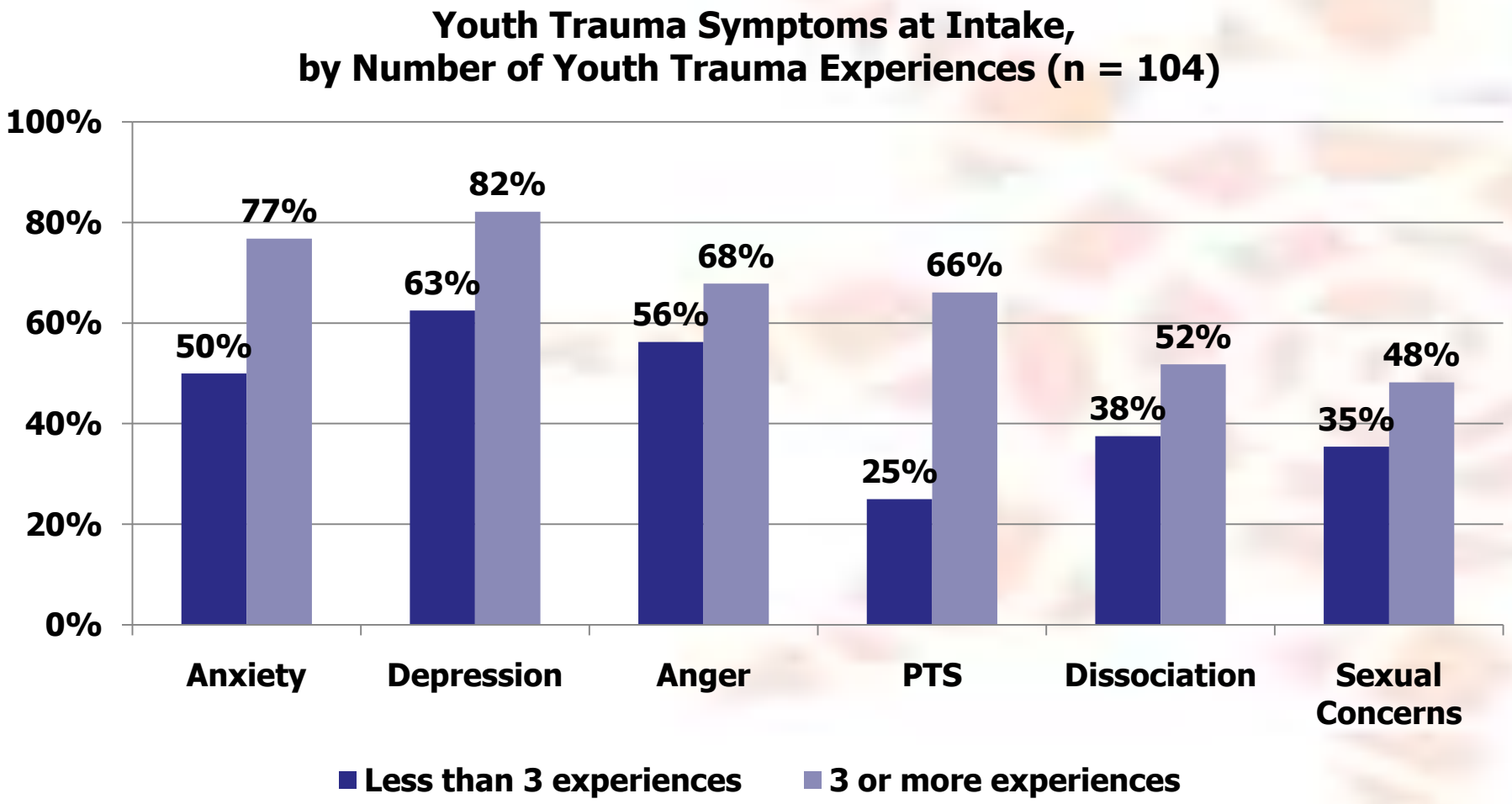
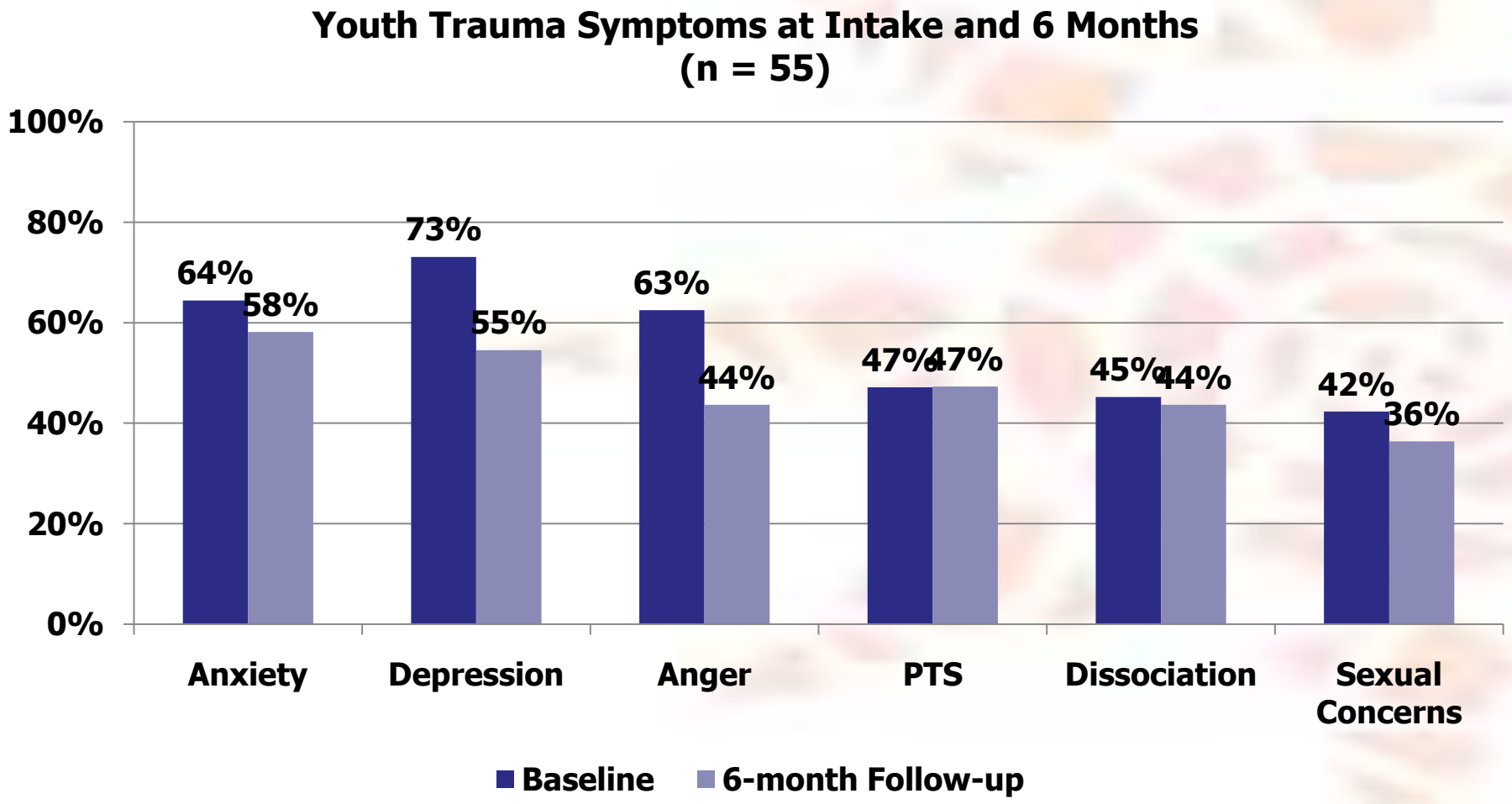
Child and Youth Trauma Experiences



Trauma Symptoms at Intake



Trauma Symptoms After 6 Months



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Conclusions and Implications

- Children and youth who experience trauma and experience trauma-related symptoms often do not have a PTSD diagnosis

- Trauma experiences of parents and/or primary caregivers, particularly childhood events, appear to effect family functioning and youth symptoms

- Trauma-informed approach to services appears to have positive effect on trauma symptoms

Assessing and Sustaining the Trauma-informed Approach

Why Assess?

- To begin a CQI process that will improve the entire mental health system for youth and families.

- To identify areas where agencies are doing well, and to guide next steps for making the system even more trauma-informed.

Development Phases

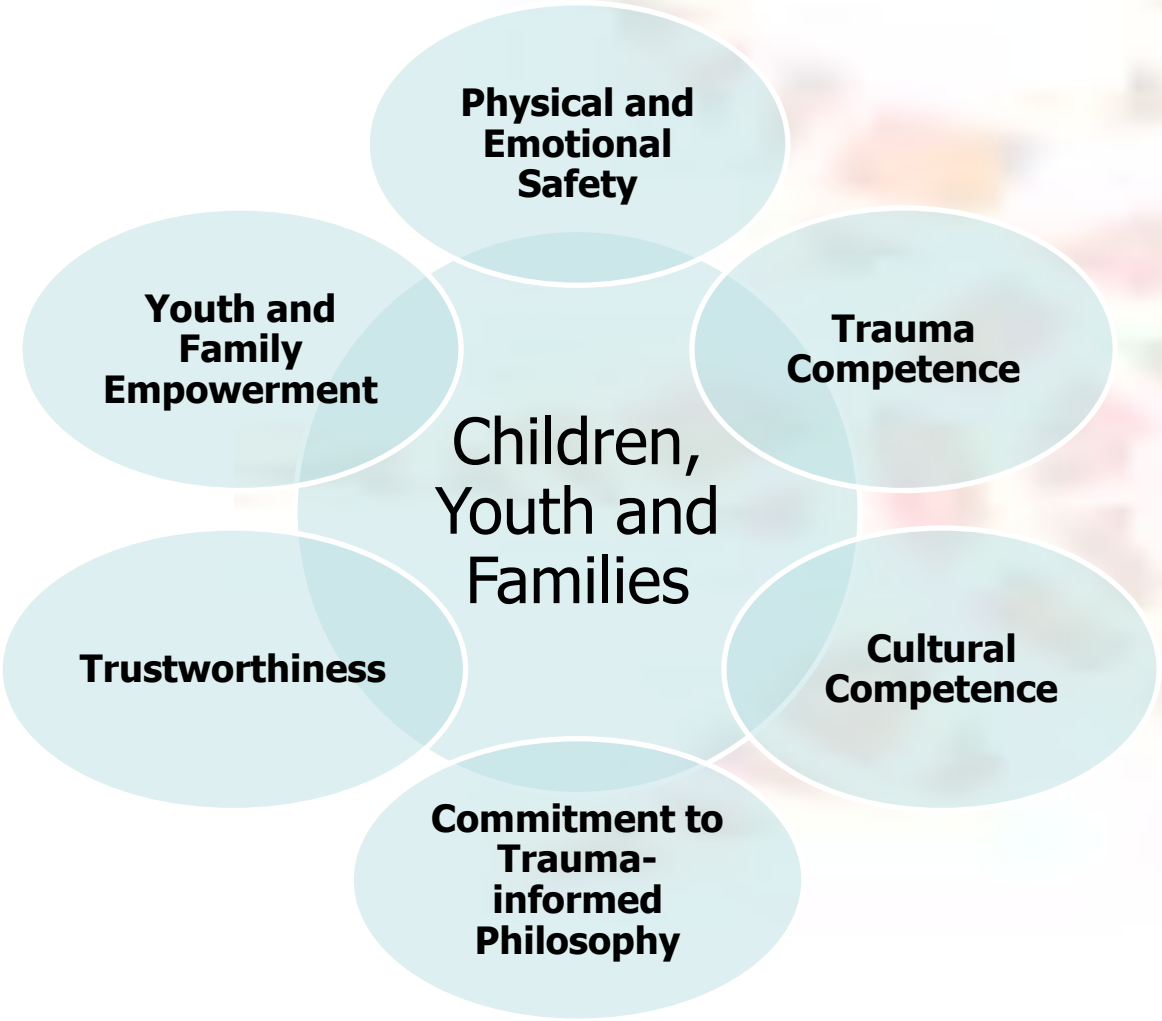
- Planning: created conceptual framework, method for data collection, involved key stakeholders
- Pilot Testing: implemented pilot tests, made revisions based on results
- Implementing: statewide assessment and response monitoring

Trauma-informed Agency Assessment

- A two-pronged assessment: measures 6 key trauma elements across multiple perspectives

- Three tools developed to gauge the level of trauma-informed approach to services
  - Agency Staff Self-Assessment
  - Family Questionnaire
  - Youth Questionnaire

The Domains


Physical and Emotional Safety
Youth and Family Empowerment
Trauma Competence
Children, Youth and Families
Trustworthiness
Cultural Competence
Commitment to Trauma-informed Philosophy

Tool Validation

- Cronbach's Alpha
  - Tests on the domains fall within acceptable ranges
- Exploratory Factor Analysis
  - Groupings make sense
  - Each question contributes meaningfully to domain results

Internal Consistency & Reliability

Sustaining the Trauma-informed Approach

- Statewide Assessment
  - Contractual Obligation
  - Biennial Administration
- Continuous Quality Improvement (CQI)
  - CQI Plan Required
  - Ongoing Technical Assistance and Training

The Contract Language: Systems of Care

System of Care Principles:

17. The goal of DHHS is that Providers of Children's Behavioral Health Services are integrated in a **Trauma Informed System of Care**. Providers will promote the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) System of Care Principles of 1) Family Driven, 2) Youth Guided, and 3) Culturally and Linguistically Competent care. These three System of Care Principles are described at http://systemsofcare.samhsa.gov/.

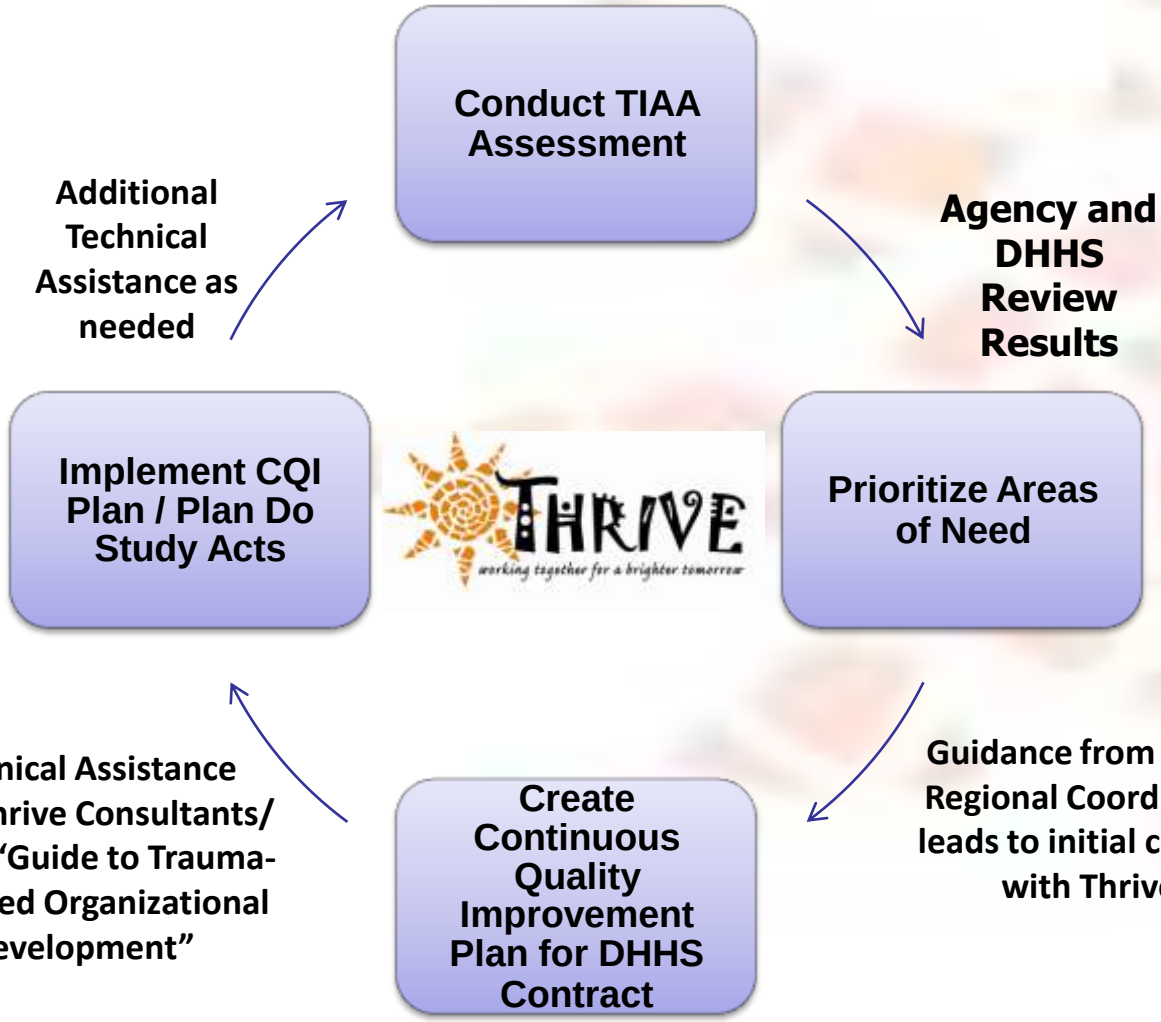
18. An additional principle for a Maine's Children's Behavioral Health System of Care is that it is **Trauma Informed**.

19. By January 1, 2010, the Provider shall administer a system of care self **Assessment Tool** approved by the Department that addresses the principles referenced in paragraphs 18 and 19 herein.

20. By January 1, 2011, Provider, in collaboration with Children's Behavioral Health Services, will include in its **Quality Improvement Plan** developed under Rider "A" areas of need identified by the Assessment Tool and plans to meet those needs

www.maine.gov/dhhs/purchased-services/contract-2010/rider-e/RIDER-E-CS.pdf

Statewide CQI Plan for Systems of Care



The Contract Language: Co-Occurring

Co-Occurring Principles:

22. The goal of DHHS is that **all Providers become Co-occurring Disorder (COD) Capable** (COD-C). This expectation is reflected in DHHS policy and it is expected that all Providers achieve this by June 30, 2011. A COD capable program "is organized to welcome, identify, engage and serve individuals with co-occurring substance abuse and mental health disorders and to incorporate attention to these issues in all aspects of program content and documentation. Such programs provide services that incorporate understanding of and approaches to substance abuse problems as they relate to and affect the mental health disorder."

23.The Provider shall make available to all staff to consumers and the Program Administrator a formal statement of commitment to implementing COD-C programs, referring to the principles stated in paragraph 22.

24.To assist Providers in the development of COD Capability, CBHS requires Providers to take the following steps towards COD competence and provide documentation to the Program Administrator on or before June 30, 2011:

a. Perform an organizational self-assessment using either the Maine DDCAT or the COMPASS EZ and develop a Continuous Quality Improvement process for COD-C development with measurable goals, action steps and a system to track measurable progress;

b. Demonstrate written protocols or policies that describes its service approach to people who have experienced co-occurring mental illness and substance abuse or other co-occurring conditions; and

c. Document implementation of a training plan for staff in the interrelationship of mental illness and mood altering substances, the identification of available resources, and the referral and treatment process.

Additional information regarding the Co-Occurring State Integration Initiative is available at http://www.maine.gov/dhhs/cosii/index.shtml.

Screening:

31. The Provider shall utilize the **AC-OK** Adolescent Screening Tool or other Department approved tool for identifying people who have experienced **co-occurring disorders, trauma and mental health** issues

Comments? Questions?

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