Addressing Trauma in Mental Health and Substance Use Treatment

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Abstract

Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by public mental health and substance abuse service systems. The greater the trauma, the greater the risk for alcoholism and alcohol abuse, depression, illicit drug use, suicide attempts, and other negative outcomes. Clearly, we cannot begin to address the totality of an individual's healthcare, or focus on promoting health and preventing disease, unless we address trauma. Trauma-informed care is now the expectation, not the exception, in behavioral health treatment systems.

Introduction

Individuals with histories of sexual assault, domestic violence, child abuse and neglect, and witnessing interpersonal violence from childhood onward make up the majority of clients served by public mental health and substance abuse service systems. The greater the trauma, the greater the risk for alcoholism and alcohol abuse, depression, illicit drug use, suicide attempts, and other negative outcomes. Clearly, we cannot begin to address the totality of an individual's health care or focus on promoting health and preventing disease, unless we address trauma. Trauma-informed care is now the expectation, not the exception, in behavioral health treatment systems.

It is important that we shift our focus from asking the people who seek our help what is wrong with them to asking what happened to them. Our success in helping to improve their health, the health of our organizations, and the health of the nation depends on it.

Why Is a Focus on Trauma Important?

First, we know that violence is pervasive Ninety percent of public mental health clients have been exposed to, and most have actually experienced, multiple exposures of trauma[1], while 75% of women and men in substance abuse treatment report abuse and trauma histories[2].

Second, we know the physical and psychological consequences of violence are highly disabling The Adverse Childhood Experiences (ACE) study, a general population study conducted by the

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Centers for Disease Control and Prevention and Kaiser Permanente, is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. Almost two-thirds of the study participants reported at least one adverse childhood experience of physical or sexual abuse, neglect, or family dysfunction, and more than one in five reported three or more such experiences[3].

ACE researchers discovered that the greater the number of adverse experiences, the greater the risk for negative outcomes. Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempts; a 2- to 4-fold increase in smoking, poor self-rated health, and sexually transmitted disease; and 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The ACE study found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults[4].

We cannot begin to address the totality of an individual's health care, or focus on promoting health and preventing disease, both tenets of health care reform, unless we address the trauma that precipitates many chronic diseases. Nor can we begin to bring down the spiraling costs of health care. The economic expenditures of untreated trauma-related alcohol and drug abuse alone were estimated at $160.7 billion in 2000[5]. The human costs are incalculable.

Third, we know that trauma is shrouded in secrecy and denial and is often ignored Nobody wants to talk about interpersonal violence. Both women and men who have been physically or sexually assaulted are afraid to talk about their experiences for fear they will be mislabeled, mistreated, or simply not believed. In some cases, their fears are well founded.

We do not talk about trauma because often we are not prepared to hear it or address it. But when we do not ask, we do harm. We may pathologize an abuse survivor's coping mechanisms. Or worse, we may unintentionally re-create the abuse by the use of forced medication, seclusion, or restraints. We must offer trauma-informed services and supports.

What Does It Mean to Be Trauma-Informed?

There is emerging evidence that trauma treatment is effective. As part of the US Substance Abuse and Mental Health Services Administration's (SAMHSA) Women, Co-Occurring Disorders, and Violence study, several clinical approaches have been manualized and guidelines have been developed. These include the Trauma Recovery and Empowerment Model developed by the National Council for Community Behavioral Healthcare (National Council) member Community Connections in Washington, D.C., which has become one of the major trauma recovery interventions for women. A good resource for learning about trauma-specific services is the report *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services*[6].

Trauma-specific interventions are one piece of the puzzle, but we must examine this from a larger perspective. We must adopt a *systemic approach*, which ensures all people who come into contact with the behavioral health system will receive services that are sensitive to the impact of trauma. People must be able to receive such services regardless of which "door" they enter or whether they ever find their way to a trauma-specific treatment program.

We can begin by recognizing the primacy of trauma as an overarching principle. Being trauma-informed means realizing the vast majority of people we come in contact have trauma histories. Trauma must be seen as the expectation, not the exception, in behavioral health treatment systems.

Trauma-informed care means that regardless of the reasons an individual comes to our door, clinical staff asks them about their trauma history. We must ask respectfully, and we must be prepared to listen.

In a trauma-informed system, services are designed to accommodate the needs of trauma survivors. In a trauma-informed human services system, the following applies:

1. Repeated trauma is viewed as a core life event around which subsequent development organizes. Symptoms are understood not merely as complaints but as attempts to cope and survive.
2. Treatment for individuals who have been traumatized recognizes both their vulnerabilities and their strengths. By the very fact that people we serve have experienced violence or the threat of violence and have come out on the other side, they are survivors, not victims.
3. Services for trauma survivors are based on the principles of safety, voice, and choice as defined by the people we serve. Our primary goals as helpers and healers must be the individual's empowerment and recovery. The consumer must be an active planner and participant in services. Peer support can be lifesaving.
4. Trauma services are ethnically, racially, and spirituality relevant to the individual and gender-specific. Cultural competence is more than the latest buzzword in our field. It is the best way to ensure that the people we serve receive treatment that is meaningful to them.
5. Finally, trauma treatment is coordinated across multiple service systems. The problems engendered by violence cut across emergency services, mental health care, primary health care, substance abuse treatment, and domestic violence. But all too often trauma survivors cycle in and out of these various systems without ever receiving appropriate services. We cannot let that continue.

How Can Behavioral Health Organizations Do More?

Here are some things we can do, beginning today, to make mental health and addictions treatment services and systems more trauma informed:

1. Engage leadership at the top. You must have top–down recognition of the importance of trauma for it to become embedded in the system.
2. Make trauma recovery consumer-driven. The voice and participation of consumer/survivors should be at the core of all activities, from service development and delivery to evaluation.
3. Emphasize early screening. Make early screening for trauma, assessment of the impact of trauma, and referral for integrated trauma services common practice.
4. Develop your workforce. Create workforce orientation, training, support, competencies, and job standards related to trauma. Do not just train clinical staff, but train and educate everyone who comes into contact with consumers, from the receptionist to the maintenance staff.
5. Institute practice guidelines. Centralize clinical practice guidelines for working with people with trauma histories. Develop rules, regulations, and standards to support access to evidence-based and emerging best practices in trauma treatment.
6. Avoid recurrence. Implement procedures to avoid re-traumatization and reduce impacts of trauma.

In May 2011, the *National Council* launched a Learning Community for Adoption of Trauma-Informed Practices[7]. The learning community is a group of health care organizations committed to creating environments and services that address the needs of individuals who have experienced significant trauma. The learning community is supported by an award from the SAMHSA and is

the first of many initiatives planned by the National Council to enhance trauma-informed behavioral health services.

References

1. Goodman L, Rosenberg S, Mueser K, et al. Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin*. 1997;23:685–696.
2. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Substance abuse treatment for persons with child abuse and neglect issues. *Treatment improvement protocol (TIP) series*. 2000; Number 36. DHHS Publication No. (SMA) 00–335. Washington DC: U.S. Printing Office.
3. Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACE) Study, Major Findings. Accessed at http://www.cdc.gov/ace/findings.htm on July 21, 2011.
4. Felitti VJ, Anda RF, Norenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine* 1998;14:245–258.
5. The Economic Costs of Drug Abuse in the United States 1992–1998. Report prepared by The Lewin Group.
6. Center for Mental Health Services National Center for Trauma Informed Care. Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services, 2008 Update. Accessed at http://www.annafoundation.org/Models%20for%20Developing%20Traums-Report%201-09-09%20_FINAL_.pdf on July 21, 2011.
7. Press Releases: The National Council Selects 21 Organizations to Participate in Trauma-informed Practices Learning Community. Accessed at http://www.thenationalcouncil.org/cs/the_national_council_selects_21_organizations_to_participate_in_traumainformed_practices_learning_community on July 21, 2011.