

**From:** Linda Rosenberg, National Council President & CEO  
**Date sent:** 02/24/2011 04:02:55 am  
**Subject:** Asking what happened to you, not what's wrong with you

[Print This](#) 

If you have difficulty viewing this message please [click here](#).

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

# National Council

NOTES FROM LINDA, PRESIDENT & CEO



Mental Health and Addictions Policy and Practice Excellence



## Trauma-informed Care: A Call to Arms

*"During every incarceration, every institutionalization, every court-ordered drug treatment program, it was always the same: I was always treated like a hopeless case. All people could see was the way I looked or the way I smelled. It wasn't until I finally entered a recovery-oriented, trauma-informed treatment program a little more than four years ago, where I felt safe and respected, that I could begin to heal...Someone finally asked me 'What happened to you?' instead of 'What's wrong with you?'"*

Tonier Cain

Tonier Cain is a success story. Today, she is a team leader with SAMHSA's National Center for Trauma Informed Care and was a featured "In My Own Words" speaker at the 2010 National Council Conference. But for every Tonier Cain, there are hundreds of thousands of women and men who pass through our programs every day with painful histories of personal trauma — including sexual assault, domestic violence, child abuse and neglect, and witnessing interpersonal violence — that we all too often ignore. The good news is that people with behavioral health conditions and trauma histories can and do recover. Your work is testament to that fact. But we can and must do more.

*This letter is a call to arms.* I'd like to begin by telling you why I think it's so 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.* In the United States, a woman is beaten every 15 seconds; a forcible rape occurs every 6 minutes. Trauma is now considered to be a near universal experience of individuals with behavioral health problems. According to the U.S. Department of Health and Human Services Office on Women's Health, from 55 to 99 percent of women in substance use treatment and from 85 to 95 percent of women in the public mental health system report a history of trauma,

with the abuse most commonly having occurred in childhood. More than 92 percent of women who are homeless have experienced severe physical and/or sexual abuse during their lifetime. Significant numbers of women in the criminal justice system report physical and sexual abuse, and national surveys suggest that as many as one-third of women veterans have experienced rape during their military service.

*Second, we know the physical and psychological consequences of violence are highly disabling. The Adverse Childhood Experiences study*, a general population study conducted by the 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 wellbeing. 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 of five reported three or more such experiences.

ACE researchers discovered that the greater the number of adverse experiences, the greater the risk for negative outcomes. These include alcoholism and alcohol abuse, depression, illicit drug use, risk for intimate partner violence, sexually transmitted diseases, suicide attempts, and unintended pregnancies. Heart disease, liver disease, and chronic obstructive pulmonary disease are also affected by adverse childhood experiences.

We can't begin to address the totality of an individual's healthcare, or focus on promoting health and preventing disease — both tenets of healthcare reform — unless we address the trauma that precipitates many chronic diseases. Nor can we begin to bring down the spiraling costs of healthcare. The ACE Study revealed that the economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at \$161 billion in 2000. *The human costs are incalculable.*

*Finally, 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 that they will be mislabeled, mistreated, or simply not believed. In some cases, their fears are well founded.

We don't talk about trauma because often we aren't prepared to hear it or address it. But when we don't ask, we do harm. We may pathologize an abuse survivor's coping mechanisms. Or worse, we may unintentionally recreate 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 SAMHSA's 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 (TREM) developed by National Council member Community Connections in Washington, DC, 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*.

Trauma-specific interventions are one piece of the puzzle, but I am talking about something much broader. We must adopt a systemic approach which ensures that all people who come into contact with the behavioral health system will receive services that are sensitive to the impact of trauma. They 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 that

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. Roger Fallot, clinical psychologist and Director of Research and Evaluation at Community Connections, tells us that trauma-informed services:

- Incorporate knowledge about trauma in all aspects of service delivery.
- Are hospitable and engaging for survivors.
- Minimize revictimization.
- Facilitate recovery.

As Roger and others have noted, in a trauma-informed human services system:

- 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.
- Treatment for individuals who have been traumatized recognizes both their vulnerabilities and their strengths. By the very fact that the people we serve have experienced violence or the threat of violence and have come out on the other side, they are survivors, not victims.
- 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.
- 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.*
- Finally, trauma treatment is coordinated across multiple service systems. The problems engendered by violence cut across emergency services, mental health care, primary healthcare, 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 can't let that continue.

#### **How can National Council members do more?**

The Kent Center, a National Council member in Warwick, RI, has been working to increase awareness about the impact of trauma throughout Rhode Island. They are partners with the state in a SAMHSA grant to develop the Jail Diversion and Trauma Recovery Program, which aims to create trauma-informed criminal justice and behavioral health care systems. As President and CEO David Lauterbach points out, "Becoming trauma informed is an ongoing process. We are all in the process of becoming more trauma informed each day, if we work at it."

Many of you are already far down the road in offering trauma-informed services and others are starting to think about how you step up. Here are some things you can do, beginning today, to make your services and systems more trauma informed:

- **Engage leadership at the top.** You must have top-down recognition of the importance of trauma for it to become embedded in the system.

- **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.
- **Emphasize early screening.** Make early screening for trauma, assessment of the impact of trauma, and referral for integrated trauma services common practice.
- **Develop your workforce.** Create workforce orientation, training, support, competencies, and job standards related to trauma. Don't just train clinical staff — train and educate everyone who comes into contact with consumers, from the receptionist to the maintenance staff.
- **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.
- **Avoid recurrence.** Implement procedures to avoid retraumatization and reduce impacts of trauma.

#### How will the National Council support you?

We believe we have much to contribute to leadership in the area of trauma-informed care and will work with you to raise awareness, educate our members and the general public, and, ultimately, improve client outcomes. We are starting by:

- Developing a Learning Collaborative, with funding from SAMSHA. This competitive program will allow 15 providers to participate in a year-long, high-intensity collaborative learning process that involves virtual and face-to-face meetings, online communities, webinars, consultation with experts, and sharing of lessons learned.
- Offering a robust array of workshops on trauma-informed care at the National Council Conference, May 2-4, 2011 in San Diego, CA along with a full-day preconference university, "Shining Light on the Secret: Bringing Trauma-Informed Care to Behavioral Health" on May 1, offered in collaboration with the SAMHSA-funded National Center for Trauma-informed Care.

Thank you for taking the time to read this important letter and to think about how you can take trauma-informed care in your organizations and systems to a new level.

Please share with us your successes and challenges in implementing trauma-informed care. We are especially looking for stories of lives you've touched and transformed, simply by asking those you serve "What happened to you?" not "What's wrong with you." We would like to share your case studies and stories through the National Council media and marketing channels so the world knows how you are making a difference. Please send your stories to our Vice President, Marketing and Communications, Meena Dayak at [MeenaD@thenationalcouncil.org](mailto:MeenaD@thenationalcouncil.org).

As always, I look forward to hearing from you at [LindaR@thenationalcouncil.org](mailto:LindaR@thenationalcouncil.org) or at 202.684.7457.

Best Regards,  
Linda Rosenberg, MSW  
President and CEO  
National Council for Community Behavioral Healthcare  
[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)



Follow the National Council on

