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Assessment #4

Medical Directors' Recommendations on Trauma-informed Care for Persons with Serious Mental Illness

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Fourth in a Series of Ten Briefs Addressing: Bold Approaches for Better Mental Health Outcomes across the Continuum of Care

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Medical Directors' Recommendations on Trauma-informed Care for Persons with Serious Mental Illness

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Executive Summary

The National Association of State Mental Health Program Directors (NASMHPD) Medical Director Council has made seven recommendations for trauma-informed interventions for people with Serious Mental Illness (SMI). The council's recommendations are motivated by the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) vision to make trauma-informed, whole-person health care the expectation in all systems[1] of care for people with SMI. In its December 2017 Report to Congress, ISMICC highlights that adverse childhood experiences and trauma play an immense role in the development of SMI and that experts increasingly recognize trauma-informed treatment as crucial to recovery. It also states that Trauma-Informed Care (TIC) is a critical element in closing the gap between what works and what clinicians and organizations offer people with SMI.

Over four percent of the United States population has an SMI. Individuals with SMI are more vulnerable to suicide, poverty, and arrest. Nearly 25 percent of people with SMI live below the poverty rate, and the suicide rate for people with mood disorders is 25 times higher than that of the general population. Each year, approximately two million people with SMI are put in jail. Roughly 66 percent of people with mental illness in jail or prison do not receive treatment.[2]

The NASMHPD Medical Director Council stresses that people with SMI often have a tenuous relationship with their community. They may have a thread of support that holds them to it, such as a housing subsidy, case manager, therapist, or family member. When this connection is severed, people with SMI end up in an unsheltered homeless or decompensated status—visible to the community but without a large political constituency.[3]

They are also more likely to experience hospital readmission. In 2011, readmissions for people with schizophrenia (and other psychotic disorders) and mood disorders were comparable with diabetes for the highest readmission rates within 30-days of a previous admission. With this increased vulnerability in mind, below are the council's recommendations for trauma-informed interventions for people with SMI:

1. All treatment providers for individuals with SMI should become trauma-informed and fully implement trauma-informed practices throughout their organizations/practices.
2. All individuals with SMI should be screened for traumatic experiences that might have occurred throughout their life, from childhood to present.

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[1] Meaning federal departments and the systems they represent.

[2] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). T*he Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://store.samhsa.gov/shin/content/PEP17-ISMICC-RTC/PEP17-ISMICC-RTC.pdf.

[3] Interview with Katherine Warburton, M.D., Medical Director at California Department of State Hospitals, on July 6, 2018.

3. All treatment for individuals with SMI should consider trauma history and its effect on symptom course, treatment adherence, and response.
4. Individuals with SMI and a history of traumatic experiences should receive trauma interventions that are evidence-based and specific to SMI as part of their comprehensive treatment plan.
5. Organizations/practices treating individuals with SMI should establish specific approaches to decrease the likelihood of victimization and retraumatization and respond promptly to address victimization/retraumatization and improve patient safety when it occurs.
6. All treatment providers for individuals with SMI should make serious efforts to decrease seclusion, restraint, and other coercive interventions that contribute to retraumatization within their organizations and practices, with the goal of total elimination of these interventions.
7. For maximum impact, these recommendations should be implemented in all areas of the treatment continuum accessed by individuals with SMI, inclusive of general medical settings.

Trauma-Informed Care is a high priority for NASMHPD, which advocates for TIC within and across systems. Under the leadership of Joan Gillece, Ph.D., NASMHPD has administered SAMHSA's Center for Mental Health Services National Center for Trauma-Informed Care (NCTIC) and has provided on-site training and technical assistance to nearly every state in the country to develop and improve trauma-informed environments across the spectrum of public health programs.

In the report *Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes*, NASMHPD has proposed seven bold goals to produce breakthroughs for people living with mental illness. Each goal is measurable, achievable, and would improve the lives of countless children, adolescents, and adults. The first bold-goal listed in the report is 100 percent early screening, identification, and timely response after the onset of mental illness symptoms in youth and adults. The authors discuss how pediatricians and schools are increasingly screening patients for mental illness and trauma.[4] For the goal to be achieved, it must be comprehensive and integrated throughout the community. The same is true for trauma-informed approaches. NASMHPD expects that the Medical Director Council recommendations will increase implementation and understanding of the importance of TIC in the health care system and its effectiveness for consumers with SMI. That said, for maximum impact, trauma-informed approaches must include the entire public health field, social services, law enforcement, and the community as a whole.

[4] Pinals, D. A., & Fuller, D. A. (2018). *Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes.* Alexandria, VA: National Association of State Mental Health Program Directors.

Introduction

Childhood trauma is a serious issue throughout the United States. According to the 2011-2012 National Survey of Children's Health, close to 35 million children between birth and age 17 experienced one or more Adverse Childhood Experiences[5] (ACEs). That number is nearly 50 percent of children. The Data Resource Center for Child and Adolescent Health highlights that 25.3 percent of children surveyed experienced one adverse family experience and 22 percent experienced two or more.[6] The Centers for Disease Control and Prevention reported that nearly two-thirds of surveyed adults said they experienced one or more ACEs and more than one-in-five reported having experienced three or more. These experiences have a detrimental impact on mental health and physical morbidity. People with four or more ACEs are at higher risk for depression, suicide, alcoholism, drug abuse, smoking, obesity, heart disease, cancer, lung disease, and liver disease.[7] As a person's number of ACEs increase so does his or her risk for lower educational completion and unemployment.

Trauma in adulthood is also detrimental and, in the case of SMI, can be a more important predictor of outcomes than ACEs. Kaiser Permanente researchers Scott P. Stumbo *et al.* compared the effects of ACEs and adverse adult experiences on recovery from SMI, finding that adverse adult experiences were even more important predictors of outcomes than ACEs. The research team interviewed and administered questionnaires to 177 participants who had a diagnosis of bipolar disorder, affective psychosis, schizophrenia, or schizoaffective disorder. What researchers discovered is that child and adult exposure to adverse experiences were extremely high. More than 90 percent of participants experienced ACEs, and 82 percent experienced adult adverse experiences. Ninety-four percent of participants experienced cumulative lifetime exposure to adverse experiences; meaning, adverse childhood *and* adult experiences. In linear regression analysis, the research team found that adverse adult experiences are associated with lower recovery scores, quality of life, and mental, physical, and social functioning and broader psychiatric symptoms.[8] The takeaway is that clinical attention should focus on *both* childhood and adult adverse experiences.

The University of California's Trauma Recovery Center (UC TRC) Model in San Francisco is the best quantitative illustration on how the right combination of identification, TIC support, and TIC services can reduce avoidable psychiatric

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[5] Adverse Childhood Experiences include physical, sexual, or emotional abuse, physical or emotional neglect, or witnessing domestic violence. They also include growing up with alcohol or other substance abuse, mental illness, parental discord, loss of a parent, or crime in the home.

[6] Data Resource Center for Child and Adolescent Health. (n.d.). 2011/12 National Survey of Children's Health. Retrieved from http://www.childhealthdata.org/browse/survey/results?q=2614&r=1

[7] Felitti, V. J., Anda, R. F., Nordenberg, D. *et al.* (1998). 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*, 14(4), 245-258. Retrieved from https://www.ajpmonline.org/article/S0749-3797(98)00017-8/pdf.

[8] Stumbo, S.P., Yarborough, B.J., Paulson, R. *et al.* (2015) The impact of adverse child and adult experiences on recovery from serious mental illness. *Psychiatr Rehabil J.*, 38 (4): 320-7. doi: 10.1037/prj0000141

hospitalization.[9] Alicia Boccellari, Ph.D., founded the center after overhearing her colleague state, "We can sew them up, but we can't make them well." Dr. Bill Schechter, former Chief of Surgery at Zuckerberg San Francisco General and Trauma Center (SFGH), lamented that while he and his team could use their lifesaving skills to help a person survive a violent trauma physically, patients were not receiving comprehensive care to address psychological trauma, factors that may have contributed to their vulnerability, and challenges they would experience in recovery.

Participants in the UC TRC have been affected by interpersonal violence, having experienced it themselves or as a direct family member of someone who did. That is part of what makes the UC TRC Model ideal for examining. Many people with SMI are victims of interpersonal crime, having higher rates of physical and sexual abuse than those in the general population.[10] This detrimentally impacts outcomes. For example, adolescents with treatment-resistant depression and histories of physical or sexual abuse had a poorer response to 12 weeks of combined treatment (Cognitive-Behavioral Therapy and medication) compared to those with the same diagnosis who did not report abuse.

GGNet Mental Health Care Centre researcher Maria W. Mauritz and her colleagues found that the prevalence of interpersonal trauma exposure and Post-Traumatic Stress Disorder (PTSD) in SMI patients is significantly higher than in the general population. Mauritz *et al.* state what is concerning is that staff often overlook both interpersonal trauma exposure and PTSD in the treatment of SMI patients. In part, this is because of symptom overlap; for example, psychotic symptoms and dissociation can be signs of both schizophrenia and PTSD. Clinicians may also ignore traumatic experiences because they believe this could lead to further impairment and stress, although there is no evidence that it would. What is known is that the course of a person's SMI is adversely affected by interpersonal trauma exposure and trauma-related disorders.[11] For instance, adults with Major Depressive Disorder (MDD) who, in one study, reported childhood interpersonal violation—physical, emotional, and sexual abuse—before the age of seven had a poorer response to antidepressant medication than those with the same diagnosis who did not.[12] Trauma negatively impacts the course of illness and clinical features in people with SMI.

It is important to highlight that it is not just childhood and adult traumas that are of concern, but also those that come with being institutionalized. Until recently, clinicians did not examine whether the state hospital experience contributed to trauma. According to Katherine Warburton, M.D., Medical Director at California Department of State Hospitals, it is state hospitals, particularly forensic state hospitals, where people end up after they have been in environments that detrimentally impact mental health, such as

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[9] Stephanie Hepburn. (2017). *TA Coalition Assessment Working Papers: Quantitative Benefits of Trauma-Informed Car*e. Retrieved from https://www.nasmhpd.org/content/ta-coalition-assessment-working-papers-quantitative-benefits-trauma-informed-care.

[10] Mauritz, M.W., Goossens, P.J.J. & Draijer, N. *et al.* (2013) Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology,* 4:1, 19985. doi: 10.3402/ejpt.v4i0.19985

[11] *Ibid*.

[12] Williams, L.M., Debattista, C. & Duchemin, A-M. *et al.* (2016) Childhood trauma predicts antidepressant response in adults with major depression: data from the randomized international study to predict optimized treatment for depression. *Translational Psychiatry,* 6, e799; doi:10.1038/ tp.2016.61

homelessness, arrest, or incarceration. Institutionalization is also a traumatic life event but rarely examined as a focus of treatment.[13]

The UC TRC Model fosters a "trauma-informed compassion culture"; it is comprehensive and integrated across the myriad of services patients need. The culture includes collective hope, vision, and leadership, paying careful attention to social justice and health disparities. Meaning, the center works to eliminate inequality. As a result, participants experienced a reduction in disparities, even if they were homeless when they entered the program, young, and had less formal education. Participants' workforce participation increased and alcohol and drug use, a risk factor for rehospitalization, decreased.[14] (Read more about the UC TRC and inclusiveness in the section *Trauma-informed Approaches Across Treatment Continuum*.)

Recommendations

Over the past six years, Dr. Warburton has witnessed changes in patients admitted to California forensic hospitals. Nearly half are unsheltered and homeless at the time of arrest, an incredibly vulnerable status. The percentage of individuals with SMI entering forensic hospitals with previous arrests has increased from 15 percent to roughly 45 percent over the past six years. Exactly what has changed is unknown. Patients are coming into the hospitals with more criminogenic behavior and thinking, which is not a symptom of SMI. Dr. Warburton and her team are examining the detrimental social pathways that impact patients before they enter forensic hospitals, identifying not only childhood and adult trauma, but also that of living with an SMI, homelessness, or hospitalization.

People with SMI are more likely to have experienced physical and sexual abuse compared to the general population. GGNet Mental Health Care Centre researcher Maria W. Mauritz and her colleagues found that the mean prevalence rates in SMI were as follows: 47 percent of participants had been physically abused (compared to 21 percent in the general population) and 37 percent had been sexually abused (compared to 23 percent in the general population). Women with a schizophrenia spectrum disorder, bipolar disorder, or mixed SMI had a higher prevalence of sexual abuse than similarly diagnosed men. The researchers also found that PTSD prevalence was significantly higher in those with SMI than in the general population of adult Americans—30 percent compared to 7 percent.[15]

The prevalence of trauma in people with SMI highlights the importance of formal trauma assessment in such patients to minimize underreporting and improve treatment. This is why the NASMHPD Medical Director Council recommends *all treatment providers for individuals with SMI should become trauma-informed and fully implement trauma-informed practices throughout their organizations/practices*.

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[13] Interview with Katherine Warburton, M.D.

[14] Stephanie Hepburn. (2017).

[15] Mauritz, M.W., Goossens, P.J.J. & Draijer, N., *et al*. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology,* 4:1, 19985. doi: 10.3402/ejpt.v4i0.19985.

Trauma-informed approaches allow clinicians to understand better what is driving a person's behavior. People are usually admitted to a forensic setting because they behaved violently. It could be that their actions are prompted by a history of homelessness, exposure to unsafe situations, or time in a correctional environment where they learned or had to adapt using specific behaviors. These experiences may impact their behavior. The trauma of having an SMI, a person losing life as he or she once knew it, and facing rejection from family may also contribute to the behavior. Dr. Warburton states that forensic units are active places where people exhibit a lot of behaviors that are disruptive, and it is these behaviors that make integrating into the community difficult. The majority of violent episodes in forensic hospitals are impulsive and not necessarily driven by the symptoms of a person's mental illness. By not addressing people's trauma, clinicians are missing an essential focus of treatment, one that may be the most important for some of these individuals. Screenings are necessary to identify trauma, which is why the NASMHPD Medical Director Council recommends *all individuals with SMI be screened for traumatic experiences that might have occurred throughout their life, from childhood to present.*

The objective is to identify trauma and reach people with SMI where they are, making it essential to screen for trauma throughout a person's *entire* biographical timeline. An ACEs assessment and a Subjective Units of Distress Scale (SUDS) assessment give clinicians information about the consumer's overall health and whether he or she is at-risk for mental health and physical morbidities such as diabetes or suicide. It is also critical to obtain information on his or her socio-economic status and daily environment; this will help determine the scope of services he or she may need at present or when reintegrating into the community. These measures help clinicians understand the challenges the person with SMI faces and allow them to track the person's progress, making alterations to treatment where and when needed. Understanding a person's past-to-present gives providers the knowledge they need to meet consumers where they are and know what triggers could retraumatize them.[16] It also enables providers to address the trauma people with SMI experienced, and help them build resiliency.

Not only is it vital to look at a consumer's current circumstance through the lens of past trauma, but also to ask questions to determine whether his or her current environment is safe or whether it could exacerbate or trigger symptoms.[17] A person who was abused in childhood and is currently in an abusive situation will be symptomatic and more likely to have psychotic symptoms, making it less probable that he or she will adhere to a medication regimen or other forms of treatment.

Trauma History and Symptom Course

Traumatic experiences can impact onset, persistence, recurrence, symptom severity, and treatment response in people with SMI. Patients with Borderline Personality Disorder (BPD) who experienced childhood maltreatment[18] have greater severity of mania,

[16] Interview with Mark Hurst, M.D.

[17] *Ibid.*

[18] Physical, sexual, or emotional abuse, neglect, or family conflict.

depression, and psychosis than patients with BPD who did not. These patients also have greater comorbidity with PTSD, anxiety disorders, and alcohol use disorders. Additionally, they experience an earlier age of onset, a higher number of manic episodes, and a higher risk of suicide attempts.[19]

Early life stress[20] is associated with the onset and severity of psychiatric disorders. Researchers Clara Passmann Carr *et al.* reviewed 44 studies and found that: (1) emotional abuse is most closely associated with personality disorders and schizophrenia; (2) physical neglect with personality disorders; and (3) physical abuse, sexual abuse, and unspecified neglect with mood and anxiety disorders.[21]

There is also a strong association between rape and auditory verbal hallucinations. Researchers Richard Bentall *et al.* found that people who were raped before the age of 16 were approximately six times more likely to experience hallucinations. Bentall and his team also discovered that those who were brought up in institutional care were roughly 11 times more likely to experience paranoia than those who were not. In 2015, researchers Inga Schalinski *et al.* examined the timing of ACEs and their impact on SMI. She and her team found that, in patients with schizophrenia spectrum disorder, the severity of shutdown dissociation[22] was related to childhood traumatic events, with emotional neglect followed by various types of emotional abuse as the most robust associations. The peak age of vulnerability was at 13-14 years of age.[23]

In one study, adults with Major Depressive Disorder (MDD) who reported childhood interpersonal violation (physical, emotional, and sexual abuse) before the age of seven had a poorer response to antidepressant medication than those with major depression who did not have that adverse experience.[24] The implication is that childhood trauma adversely affects the course of illness and clinical features in people with SMI. As Maria W. Mauritz and her colleagues state, assessing trauma in persons with SMI can alter outcomes by both reducing underreporting and increasing treatment. To address trauma's impact on outcomes, the NASMHPD Medical Director Council recommends *all treatment for individuals with SMI should consider trauma history and its effect on symptom course, treatment adherence, and response.*

It's vital that those working with people with SMI realize that screenings do not always capture all trauma. This is not necessarily a deficit on the part of the screening; trauma

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[19] Agnew-Blais, J. & Danese, A. (2016). Childhood maltreatment and unfavourable clinical outcomes in bipolar disorder: a systematic review and meta-analysis. *The Lancet Psychiatry*, 3(4), 342–349. doi: 10.1016/S2215-0366(15)00544-1

[20] Sexual abuse, physical abuse, emotional abuse, physical neglect, and emotional neglect

[21] Passmann Carr, C.P., Martins, C.M.S. & Stingel, A.M. *et al.* (2013). The role of early life stress in adult psychiatric disorders. A systematic review according to childhood trauma subtypes. *J Nerv Ment Dis; 201*: 1007Y1020.

[22] The shutting down of sensory, motor, and speech systems

[23] Schalinski, I. & Teicher, M.H. (2015). Type and timing of childhood maltreatment and severity of shutdown dissociation in patients with schizophrenia spectrum disorder. *PLoS ONE 10(5)*: e0127151.doi:10.1371/journal.pone.0127151.

[24] Williams, L.M., Debattista, C. & Duchemin, A-M. *et al.* (2016) Childhood trauma predicts antidepressant response in adults with major depression: data from the randomized international study to predict optimized treatment for depression. *Translational Psychiatry,* 6, e799; doi:10.1038/ tp.2016.61

can happen in utero, when a person is preverbal, or at a time he or she may not remember. It may present itself through later behavior. For example, a patient may be fearful of a syringe, have a strong behavioral reaction, and refuse medication because the experience triggered an unidentified trauma. When trauma is triggered, the person experiences it emotionally rather than processing it cognitively. The challenge is that unidentified trauma can negatively affect symptom course.

In the circumstances mentioned previously, the patient may not know why he reacted strongly, only that the needle scared him. With a trauma-informed approach, the question is not what is wrong with the person but what happened to the person. Even if that cannot be entirely answered or identified, examining the behavior and turning to a mutuality of decision-making can help. Often, people who experienced trauma have had people they trusted violate their trust and harm them. That's why it is essential that patients have a voice. Mark Hurst, M.D., Medical Director Ohio Department of Mental Health and Addiction Services (OhioMHAS), states that by giving consumers a voice and engaging them to be part of decision-making, they are more apt to adhere to treatments, improving future outcomes.

This represents a shift from a paternalistic medical approach to shared decision-making and discussion. Instead of the clinician making a diagnosis and assigning a treatment plan, the clinician and consumer talk through treatment options.[25] It is not without hurdles, but building rapport helps consumers to become actively involved in treatment and to feel as if they have a say and are not being coerced or victimized.

The clinician's objective is to work with patient preferences as much as possible, while informing the person that, without adherence to the prescribed treatment regimen, he or she will have more symptoms and life challenges. For instance, to help a patient with SMI achieve adherence, a clinician could inform the patient on options, such as home delivery of medications on a daily basis, dissolvable or liquid, or long-acting injections. The idea is to highlight that doing a treatment is essential and there is a vast array of effective options from which to choose. It is critical that while working with a person with SMI to understand why they have difficulty with adherence, clinicians are also helping them meet their needs and life goals effectively. The clinician should always examine a patient's reasons and reactions through a trauma-informed lens.

Medication is a component of treatment, but trauma-informed interventions are holistic and examine the entirety of the person. Clinicians work to determine what is imperative to patients, helping them achieve their goals, as opposed to telling patients what is right for them and what they need to do. For example, a patient may want to live independently. If she wants to live on her own, her team assists her to obtain benefits so she can afford a safe residence. Helping patients achieve their goals results in improved treatment adherence, fostering the patient to become an essential part of the team working to improve his or her outcomes.

[25] Interview with Mark Hurst, M.D.

Evidence-Based Trauma Interventions

There are numerous treatments for traumatic experiences, but only a handful are evidence-based and demonstrate efficacy in individuals with SMI. Clinicians need to work with what is proven, not just what sounds good. That's why the NASMHPD Medical Director Council recommends that *individuals with SMI and a history of traumatic experiences should receive trauma interventions that are evidence-based and specific to SMI as part of their comprehensive treatment plan.*

Among treatments that are both evidence-based and demonstrate efficacy in people with SMI are Recovery-Oriented Cognitive Therapy (CT-R), CBT for PTSD for People with SMI, Dialectical Behavior Therapy (DBT), and Mindfulness-Based Cognitive Therapy (MBCT).

Recovery-Oriented Cognitive Therapy (CT-R)

This treatment is designed specifically for people with schizophrenia. It is based on the cognitive model and is an empirically supported process for helping people with schizophrenia realize recovery. Like other treatments for traumatic experiences, the CT-R approach meets people where they are, accesses people's adaptive mode, and helps them develop aspirations and steps toward attaining those aspirations. This approach also works to help individuals strengthen positive beliefs and weaken negative ones, and build resilience to stress and challenges. Clinicians can use CT-R in an array of therapies, such as individual therapy, group therapy, and as part of a team-based approach. It can be applied to people across the full range of severity of schizophrenia, from individuals recently diagnosed with schizophrenia to those who have been chronically institutionalized for decades.

Dr. Paul Grant and Dr. Aaron Beck developed CT-R. They examined whether a cognitive approach to help create experiences that address low motivation and negative attitudes in persons with schizophrenia might make those individuals feel better. It turns out, the method worked.

The Aaron T. Beck Psychopathology Research Center (ATB-PRC) at the University of Pennsylvania conducts ongoing research on CT-R. In 2017, Dr. Beck told *Practicing Recovery*, SAMHSA's quarterly newsletter, that the treatment focus in the CT-R approach is on the person's strengths and building on those strengths to restore "a sense of hope, adequacy, and belonging." He states this allows the treatment team to provide clients with opportunities to transform their positive attributes into adaptation into the community, resulting "in a rewarding and meaningful life."

When Dr. Beck speaks with psychiatrists and other providers accustomed to a disease-centric approach to medicine, he uses the analogy of appropriate treatment for Type 2 diabetes where the focus is on motivating the person to acquire healthy behaviors as opposed to the disease. This same approach is at the core of CT-R for schizophrenia.

CBT for PTSD for People with Severe Mental Illness (SMI)

The CBT for PTSD for People with SMI therapy relies on the principles of cognitive restructuring. It is individual, time-limited, and therapists typically work with clients on their PTSD over a three- to six-month period. The treatment must be comprehensive and integrated. In *A Cognitive-Behavioral Treatment Program for Posttraumatic Stress Disorder in Persons with Severe Mental Illness*, Kim T. Mueser, Ph.D. *et al.* state that PTSD is just one of a bevy of potential problems clients with SMI face, and that for clinicians to effectively treat it, there must be ongoing communication between the therapist and members of the client's treatment team. This is particularly true for the case manager who coordinates numerous facets of the client's treatment and can make the therapist aware of critical issues the client is experiencing. It also allows the case manager to support and reinforce the therapist's CBT teachings. To facilitate a holistic approach, Dr. Mueser and his team have created guidelines to establish and maintain ongoing contact between the client's therapist and case manager.

Dialectical Behavior Therapy (DBT)

DBT was developed in the late 1980s by Marsha M. Linehan, Ph.D., ABPP, to treat chronic suicidality and self-injury in people with Borderline Personality Disorder (BPD). It has also been used to treat depression, PTSD, substance use, and eating disorders. It consists of four components (although a clinician can personalize it for each client): Skill training group therapy, DBT individual therapy, DBT phone coaching, and a DBT therapist consultation team. The psychotherapy teaches clients skills such as mindfulness and observation, prompting clients to pay attention and notice what is in front of them and what they are thinking and feeling. It also teaches clients distress tolerance, emotion regulation, interpersonal effectiveness skills, and how to balance acceptance and change. Dr. Linehan describes it as teaching people how to climb a ladder.

Mindfulness-Based Cognitive Therapy (MBCT)

Developed by psychologists Zindel Segal, Mark Williams, and John Teasdale, Mindfulness-Based Cognitive Therapy is for adults with recurrent Major Depressive Disorder (MDD). It integrates components from Dr. Jon Kabat-Zinn's Mindfulness-Based Stress Reduction and CBT therapy for depression, teaching clients to move their mental focus away from negative thought patterns. Dr. Segal, Dr. Williams, and Dr. Teasdale wanted to prevent relapse in clients experiencing depression by halting the pathological influence of risk factors and triggers. The team stood back and looked at sadness and mood-dependent memory, where moods and thoughts come together and influence each other. They created a therapy that uses mindfulness meditation and cognitive methods to give clients the tools to interrupt these automatic processes by disarming negative moods with positive thoughts.

Decreasing Victimization and Retraumatization

Staff must examine the person's current living scenario to reduce the likelihood of victimization and retraumatization, which can derail treatment, hindering outcomes. For example, they must determine whether the person is living in a dangerous situation where there is a high risk of victimization or where he or she experienced harm. Safety- and stabilization-related TIC interventions are crucial, such as making sure clients have access to safe housing, clothing, medication, transportation, financial entitlements, and legal advocacy. Simply put, people with SMI or otherwise, cannot work on trauma if they are in survival mode. SMI clients must be helped to build skills to address the trauma they experience or experienced. The NASMHPD Medical Director Council recommends that *organizations/practices treating individuals with SMI should establish specific approaches to decrease the likelihood of victimization and retraumatization and respond promptly to address victimization/retraumatization and improve patient safety when it occurs*.

It is not always clear why a person with trauma behaves a certain way. The person may be responding to acute stress and in "fight, flight, or freeze" mode, and unable to verbalize what is wrong. Trauma-informed approaches examine a person's history to anticipate what could traumatize or retraumatize clients, but sometimes that involves a bit of detective work. For example, Bob Oglesbee, a veteran with Lived Experience, was a resident of Ohio Veterans Homes and refused to shower in the communal bathroom. The staff could not understand why, so they contacted Kim Kehl, Trauma-Informed Care Project Coordinator at OhioMHAS. Oglesbee shared with Kehl his history of sexual abuse—he was sexually abused by a family member when he was a young boy and raped by his superior in the military.[26] Kehl advised staff to put a deadlock on the bathroom door, and because he felt safe, Oglesbee began showering.

Staff at the residence could have assumed that Oglesbee had poor hygiene; that his behavior was an indicator that he was not doing well and needed a medication adjustment. Instead, the staff took the time to determine *why* he did not want to shower, and the solution they discovered ended up being quite simple—a deadlock. It allowed Oglesbee to be safe and feel safe, which are not always the same.

In the case of SMI, Dr. Hurst states that staff sometimes assume a person's trauma is a delusion. It is essential to look into it and not assume; if it is a delusion, it is important to remember that the experience is real to the client and that the clinician needs to consider this when addressing the trauma.[27]

Decrease Seclusion, Restraint, and Coercive Intervention

Trauma-informed approaches allow staff to understand clients' behavior, focusing on what happened to them. This understanding breaks the cycle of retraumatization and gives clients a better sense of safety, security, and equality. It also decreases the need for

[26] Stephanie Hepburn. (2017).

[27] Interview with Mark Hurst, M.D.

seclusion, restraint, and avoidable hospitalization, allowing staff to recognize a potential crisis early on. The NASMHPD Medical Director Council recommends that all *treatment providers for individuals with SMI should make serious efforts to decrease seclusion, restraint, and other coercive interventions that contribute to retraumatization within their organizations and practices, with the goal of total elimination of these interventions.*

Some providers and organizations believe the best way to avoid restraint is to have physically-intimidating enforcers on the unit. The result is intimidation, making treatment facilities similar to an incarcerate setting and not conducive to patient healing and recovery. Environments like prisons are not known for safety, nor do they give patients a sense of security. This negatively affects clients and staff. Dr. Hurst states that there is a strong association between staff putting hands on patients and staff injuries. If trauma-informed interventions are done effectively, staff do not place hands on patients to redirect or restrain them. The result is that there are fewer staff injuries.

According to Dr. Hurst, skeptics argue that treatment facilities will never be able to eliminate seclusion or restraints. However, some organizations *have* eliminated coercive interventions over time with a thoughtful quality improvement approach. Dr. Hurst states it is essential to treat each incident of seclusion and restraint as an adverse event and evaluate what happened before, during, and after, so that the facility can learn from the experience and try to avoid future comparable situations leading to a similar outcome. He states that, just as the acceptable number of suicides is zero, the acceptable amount of seclusion and restraint episodes is also none. "Until we reach zero, we still have work to do."

Trauma-Informed Approaches Across the Treatment Continuum

People with SMI often experience numerous, ongoing challenges, including health problems, substance use disorders, and marginalization, resulting in the need for assistance in accessing housing, employment, and education.[28] Shifting to a trauma-informed approach must be comprehensive and holistic, not only including the public health field, but also social services, law enforcement, and the community as a whole. Fortunately, in states that have begun to adopt a trauma-informed approach in behavioral health, those in areas that work closely with them are following suit. Dr. Warburton dove into trauma-informed approaches with a sense of urgency because she became acutely aware that state hospitals were doing a grave disservice to their patients by not creating a trauma-informed culture during treatment. As a result, Dr. Warburton and her team quickly put together trauma-informed care trainings, inviting not only people in behavioral health but also those in numerous connected fields, such as hospital attorneys and assistant chief counsel who have become trauma champions. Dr. Warburton states that people do not need to treat patients to be trauma-informed.

In Ohio, Dr. Hurst states it is law enforcement that has been reaching out and wanting to know more about becoming trauma-informed. He says it is, in part, because of the secondary trauma they witness and experience, but also so they can improve their

[28] Interdepartmental Serious Mental Illness Coordinating Committee. (2017).

understanding of the trauma clients have. Thus far, in partnership with the Department of Developmental Disabilities on Ohio's interactive Trauma-Informed Care Initiative, the Ohio Department of Mental Health and Addiction Services has trained more than 36,000 police officers. Among trainees are first responders, caregivers, and service providers. The first day of training focuses on the trauma clients bring with them when they access services, and the second day targets vicarious trauma and workforce resilience.

Integration of trauma-informed approaches allows clients to feel stable and safe, improving their participation and outcomes. That's why the NASMHPD Medical Director Council states the recommendations *should be implemented in all areas of the treatment continuum accessed by individuals with SMI, inclusive of general medical settings.* The reason for this recommendation is: Integration works. In 2005, Joseph Morrissey *et al.* found that housing stability increased in an integrated, family-focused TIC outreach and care coordination program for homeless mothers in Massachusetts. At 18 months of TIC, 88 percent of families in the study remained in Section 8 housing or moved to permanent housing.[29] Five years later, Elizabeth K. Hopper, Ph.D. reported that TIC reduces demand for crisis services, including hospitalization and crisis intervention.[30]

Like Dr. Hopper, Dr. Boccellari at UC TRC has found that trauma-informed approaches can reduce avoidable psychiatric hospitalizations.[31] The trauma-informed model has experienced incredible success because the program is integrative *and* focuses on inequality. Dr. Boccellari and her team found the right combination of identification and trauma-informed support and services. Understanding that trauma survivors need complex care, she set up a system that gives comprehensive services to people who have experienced interpersonal, violent trauma. This includes, but is not limited to, victims of rape, domestic violence, and assault. The UC TRC also supports victims' family members. Many of the center's participants are marginalized, having experienced trauma, violence, and poverty. Similar to people with SMI, participants at the center had immediate, practical requirements the team needed to address before or concurrent with mental health interventions such as safe housing, financial entitlements, transportation, and legal advocacy.

California legislation mandated a randomized trial, resulting in a longitudinal study of 541 violent trauma participants. The TRC Model was far more successful in engaging participants in mental health services than community care *and* it proved more cost-effective. The vast majority (77 percent) of participants receiving TRC services engaged in mental health treatment compared to 36 percent of those receiving community care. Clinicians who were part of the TRC network found that 78 percent of patients illustrated

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[29] Morrissey, J. P., Jackson, E. W. & Ellis, A. R. *et al.* (2005). Twelve-Month Outcomes of Trauma-Informed Interventions for Women With Co-occurring Disorders. *Psychiatric Services*, 56(10), 1213–1222. https://doi.org/10.1176/appi.ps.56.10.1213

[30] Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. *The Open Health Services and Policy Journal*, *3*, 80-100. Retrieved from http://www.homelesshub.ca/sites/default/files/cenfdthy.pdf

[31] Stephanie Hepburn. (2017).

improved mental health functioning and 69 percent showed better role functioning like parenting or working.[32]

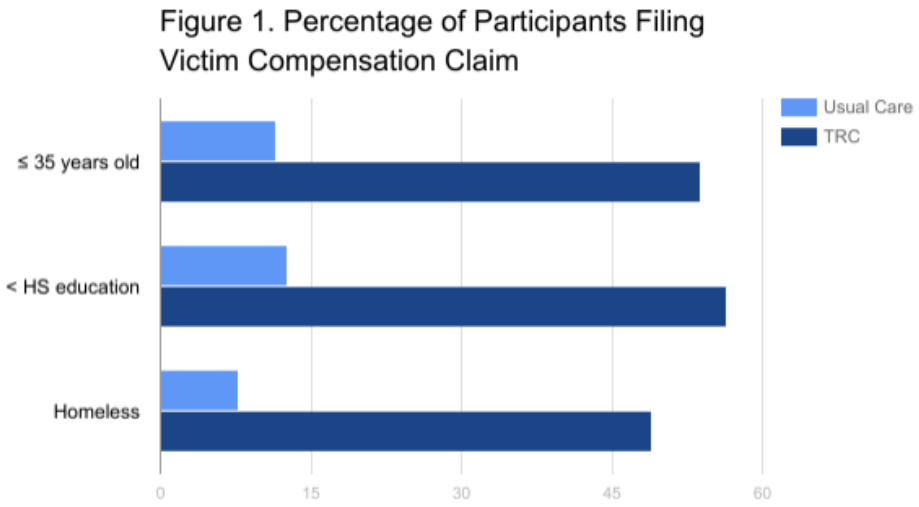
The TRC Model was also more successful in helping participants apply for and access compensation benefits—56 percent of TRC participants submitted applications compared to 23 percent of those receiving usual care. The cost per hour of TRC services was 34 percent less than traditional services, making the model more effective and less expensive.[33]

In California, state-level victim compensation funds are available to help victims of violent crimes recover physically, financially, and psychologically, but application rates for compensation are low. This is particularly true for physical assault survivors who are male, young, or of an ethnic minority. Dr. Boccellari found that the TRC Model was more effective at helping this population to file for victim compensation than usual care. Her study, published in 2008, included 407 males (294 were Black, Latino, or Mixed/Other) who were, on average, 37 years old and had 12 years of education. Many of the men were unemployed and uninsured, and more than 40 percent were homeless. Significantly, more members of these vulnerable groups filed a victim compensation claim when receiving trauma-informed TRC services than did those getting usual care, illustrating *marginalized* trauma survivors' need for comprehensive, complex care. Over half of men receiving TRC services who were 35 and younger, or with less than a high school education, applied for victim compensation, and nearly half of men receiving TRC services who were homeless applied.[34] (*See Figure 1.*)

[32] San Francisco Trauma Recovery Center Report to the Legislature, May 2004. Prepared by California Victim Compensation and Government Claims Board. Retrieved May 25, 2017 from www.vcgcb.ca.gov/docs/reports/UCSFTRCreport.pdf

[33] *Ibid.*

[34] *Ibid.*



Populations	Usual Care	TRC
≤ 35 years old	11.5	53.8
< HS education	12.7	56.5
Homeless	7.8	49

Source: Journal of Public Health[35]

The TRC data affirms that integrative, trauma-informed approaches serve at-risk populations by reducing disparities and increasing consumer engagement in their treatment. The model also cuts alcohol and drug use,[36] which is essential because substance use increases the risk for trauma, future injury, and rehospitalization.[37] Among participants with significant substance use problems, 56 percent decreased or stopped drinking, 54 percent reduced or terminated using drugs, and 89 percent reported improvement.[38]

Trauma-informed approaches appear to, at least during participation, decrease participant marginalization while increasing resilience.

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[35] Alvidrez, J., Shumway & M., Boccellari, A., *et al.* (2008). Reduction of state victim compensation disparities in disadvantaged crime victims through active outreach and assistance: A randomized trial. *American Journal of Public Health, 98, 882-888*. Retrieved May 20, 2017 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2374813/.

[36] San Francisco Trauma Recovery Center Report to the Legislature, May 2004.

[37] Rivara F.P., Koepsell T.D. & Jurkovich G.J. (1993). The effects of alcohol abuse on readmission for trauma. *Journal of the American Medical Association*, 270:1962–1964. Retrieved May 25, 2017 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3947745.

[38] San Francisco Trauma Recovery Center Report to the Legislature, May 2004.

Conclusion

The NASMHPD Medical Director Council has made seven recommendations for trauma-informed interventions for a particularly vulnerable population, people with SMI. People with SMI often have a tenuous relationship with their community, and when it is severed, they frequently end up in an unsheltered homeless or decompensated status. They also experience more interpersonal trauma exposure than the general population.

Early life stressors have been found to be associated with the onset and severity of mental illness. For instance, physical abuse, sexual abuse, and unspecified neglect are most closely associated with mood and anxiety disorders, while emotional abuse is most associated with personality disorders and schizophrenia, and physical neglect with personality disorders. This impacts onset, persistence, recurrence, symptom severity, and treatment response. As Dr. Warburton states, clinicians must not only identify and address childhood and adult trauma in people with SMI, but also trauma that can arise from institutionalization, incarceration, or just living with an SMI.

Trauma-informed approaches allow clinicians and organizations to identify trauma and reach people with SMI where they are, determining whether the person is at-risk for mental health and physical morbidities like diabetes and suicide, and also collecting information on the person's daily environment and socio-economic status. This comprehensive approach gives clinicians and organizations a holistic snapshot of the patient's challenges, offering a greater understanding of the scope of services the person may need immediately and in the future. It also helps to identify triggers that can cause retraumatization and what to address to build patient resiliency.

A comprehensive trauma-informed approach fosters trust and allows patients mutual decision-making. Not only is it crucial for people who experienced trauma to have a voice because people they trusted violated their trust, but it also makes them more apt to participate in treatment, working collaboratively to improve their outcomes.

The UC TRC Model illustrates there are significant benefits when marginalized trauma survivors receive comprehensive, complex trauma-informed care integrated across the numerous services they need—care that addresses inequality and instills resiliency, hope, and leadership. The trauma-informed model has been shown to be significantly better at engaging participants in mental health services (77 percent) than community care (36 percent). Participants experience a reduction in disparities, substance use, and increased mental health and role functioning, such as working or parenting.

Elizabeth K. Hopper, Ph.D., writes in *Shelter from the storm: Trauma-informed care in homelessness services settings* that trauma-informed care has a positive impact on housing stability, decreasing demand for crisis services, including hospitalization and crisis intervention. It is also more cost-effective, because not only is it less costly than traditional treatment, it increases consumer participation, which improves outcomes and means practices and organizations are not losing out on millions of dollars[39] from missed appointments.

[39] Singh, N., Barber, J., & Van Sant, S. (2016). *Handbook of Recovery in Inpatient Psychiatry*. doi:10.1007/978-3-319-40537-7

The NASMHPD Medical Director Council recommendations are designed to increase implementation and understanding of the importance of trauma-informed approaches in the health care system and beyond, and its effectiveness for consumers with SMI. Trauma-informed approaches have a positive impact all around, improving outcomes for patients and their families and improving the bottom line of treating organizations, culturally and financially.