



# Enhancing the Capacity of a System of Care to Deliver Trauma-Informed Treatment for Substance Use Disorders: The Massachusetts Trauma-Informed Practice Change Initiative

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Norma Finkelstein, Ph.D.

Laurie Markoff, Ph.D.

**Institute for Health and Recovery**

*normafinkelstein@healthrecovery.org*

*lauriemarkoff@healthrecovery.org*

**NIATx Annual Summit/SAAS National Conference**

**July 12, 2011**

*Institute for Health and Recovery*



# Why Trauma Matters

- A significant proportion of men and women entering services for substance use disorders have histories of trauma

*(Brems, 2004; Clark, 2001; Farley, 2004; Medrano, 1999; Moncrieff, 1996; Rice, 2001)*

- Women in community samples report a lifetime history of physical & sexual abuse ranging from 36-51%, while women with substance abuse problems report a lifetime history ranging from 55-99%

*(Najavits et al., 1997)*



# Perpetrators

- Estimates of alcohol use among perpetrators of sexual assault range from 34-74%
- 50% of batterers have an alcohol use disorder and 33% have a drug use disorder *(Stuart et al., 2003)*
- Sample of 2,000 American couples found rates of domestic violence almost 15x higher if husband is described as “frequently” as opposed to “never” drunk *(Collins and Messerschmidt, 1993)*
- 94% of calls to police, perpetrator has used alcohol or alcohol and other drugs within 6 hours of assault *(Brookhoff, et al., 1997)*



# ACE Study

- Sample of 17,000 Kaiser Permanente middle class American adults of diverse ethnicity
- Scoring system used: one point for each category of Adverse Childhood Experiences (ACE) before 18
- ACEs not only common, but effects were cumulative
- Compared to persons with ACE score of 0, those with ACE score of 4 or more were 2x more likely to be smokers, 12x more likely to have attempted suicide, 2x more likely to be alcoholic and 10x more likely to have injected street drugs



# ACE Study

Recurrent & severe physical abuse	11%
Recurrent & severe emotional abuse	11%
Contact sexual abuse	22%
Growing up in a household with:	
Alcoholic or drug-user	25%
Member being imprisoned	3%
Mentally ill, chronically depressed, or institutionalized member	19%
The mother being treated violently	12%
Both biological parents NOT present	22%

*(Felitti, 2003)*



# Adverse Childhood Events Study

## **Controlling for other adverse childhood events:**

- Men with a history of childhood sexual abuse were 30% more likely to have alcohol problems and 60% more likely to have used illegal drugs
- Women with a history of childhood sexual abuse were 60% more likely to have alcohol problems and 70% more likely to have used illegal drugs

*(Dube et al. 2005)*



# Failure to Understand & Address Trauma Can Lead to:

1. Failure to engage in treatment services *(Farley, 2004)*
2. Increase in symptoms (eating disorders, self-harm)
3. Increase in management problems
4. Retraumatization *(Harris and Fallot, 2001)*
5. Increase in relapse
6. Withdrawal from service relationship
7. Poor treatment outcomes *(Easton et al 2000; Ouimette et al 1999)*



# Trauma-Informed Services

- Trauma-informed services are based on an understanding of the impact of violence and victimization
- All treatment for substance use/co-occurring disorders should be trauma-informed



# Assumption 1: Trauma is Central and Pervasive

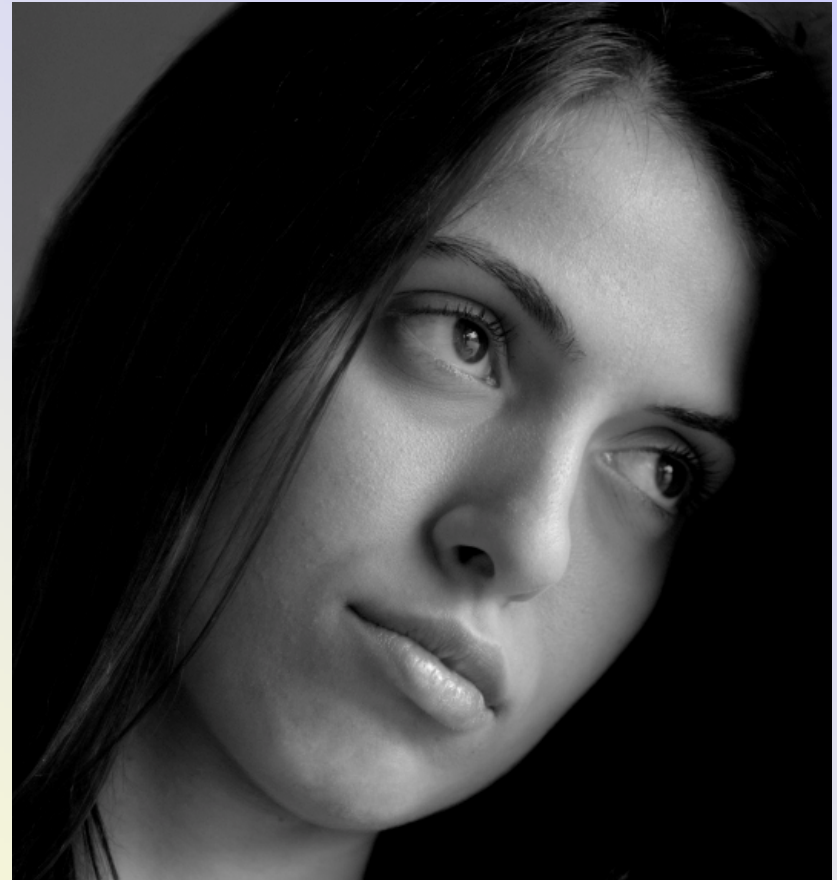


- Central to the development of mental health, addiction, and behavior problems
- Impacts *many* aspects of a person's life



## Principle 2: Universal Precautions

A client should not have to disclose trauma to receive trauma-informed services—treat everyone as a potential trauma survivor.





# Assumption 3: Symptoms and Behaviors

Are often attempts to cope with the trauma





## **Assumption 4: Goal of Services**

**Is to return a sense of autonomy and control  
to the victim**





# **SAMHSA'S Women, Co-occurring Disorders and Violence Study (WCDVS) 1998 – 2004**

## *Phase 1*

- 2 years, 14 sites
- Design of new Trauma-Integrated Service System
- Selection of most promising trauma interventions
- Development of cross-site protocols

## *Phase 2*

- 3 years, 9 sites
- Implementation of cross-site study comparing integrated trauma-informed and trauma-specific services to services as usual



# Six-Month Outcomes

- All women improved on all 4 major outcomes (alcohol/drug use, mental health, trauma symptoms)
- On 2 of 4 measures (post-traumatic symptoms and drug use severity), women in the intervention programs showed significantly greater improvement than those in usual care
- On mental health status, differences almost reach significance
- Effect sizes are small, but present
- Women in integrated condition did better than women in usual care when provided with integrated counseling

*(Morrissey, J.P. et al., 2005)*



# Twelve-Month Outcomes

- Effect sizes for mental health and post-traumatic symptoms showed statistically significant improvements for women in the intervention condition relative to those in the comparison condition
- The 2 substance use severity outcomes show no additional improvement, but 6-month outcomes were maintained

*(Morrissey, J.P. et al., 2005)*



# WCDVS

- Can address trauma within substance use & mental health disorder treatment from the beginning—does not hurt, but helps, the recovery process
- Showed the importance of developing trauma-specific treatment models that address substance use & co-occurring disorders



# **CREATING TRAUMA-INFORMED ORGANIZATIONS**



# 5 Strategies for Creating a Trauma-Informed, Service-Providing Organization

- Empowering/Relational Environment
- Administrative Commitment
- Training
- Hiring and Human Resources Practices
- Review of Provision of Services and Policies

*(Community Connections, 2003)*



# **Empowering/ Relational Environment**

- **Build connection at multiple levels of organization with information flowing between levels**
  - Administrators, middle management, direct care staff, peer leaders
- **Bring together diverse constituencies affected by proposed changes**
  - Direct care staff, participants, peer leaders



# **Empowering/ Relational Environment**

Openly and respectfully discuss differences from the outset:

- Identify sources of disagreement and tension prior to collaborative work – address in planning process
- Build on areas of agreement and shared goals
- Use relational skills to develop solutions that take all points of view into account
- All members have input into group decisions



# Administrative Commitment

- Administrative leadership supports a long-term commitment to providing trauma-informed services
- Top managers draft and issue a policy statement and/or amendment to organization's mission statement
- Form sub-committee of diverse staff and participants
  - Provide feedback integrated into policy statement
  - Develop plan for moving toward trauma-informed services



# Training

- Select or develop basic training curricula
- Conduct training on basic curricula for all staff
- Include training by those who have experienced trauma
- Incorporate training into new staff orientation on an ongoing basis



# Hiring and Human Resource Practices

- Hire new staff with knowledge/ understanding/ experience of trauma
- Hire those who have experienced trauma in professional and peer positions
- Recognize and reduce impact of secondary traumatization on staff



# Review of Provision of Services and Policies

- Review current policies and practices and evaluate for potential replication of trauma dynamics
- Develop a system for review of future policies in terms of trauma sensitivity
- Review agency policy and procedures with regard to development of trauma services



# Department of Public Health/ Bureau of Substance Abuse Services (DPH/BSAS)

**Goal:** All substance abuse treatment programs in MA will provide trauma-informed care.

- 2002: Provision of trauma-informed care included in terms and conditions of all contracts
- 2003: Presented results of WCDVS in multiple venues across state
- 2004-2006:
  - Twice yearly statewide trainings
  - Needs assessment among SUD programs
  - On-site training available upon request at SUD programs



# 2007

**Goal:** Ensure that training and TA resulted in practice changes.

- Program creates Trauma Integration Team
- Conducts Trauma Integration Self-Assessment
- Training is provided for all staff
- May request additional training and TA to support plan implementation
- Co-facilitation of trauma-specific groups in train-the-trainer model
- Program repeats assessment at end of consultation period



# Outcomes

- 22 items scored as 1 (rarely implemented) to 5 (consistently implemented) resulting in scores ranging from 22 to 110
- 15 programs completed
- Post Assessment scores range from 70-110, with an average of 95.2
- Change scores range from 1-48, with an average of 15.5



## 2011: Current Observations

- Waiting list of 6 programs
- Participants at statewide training at different stages of change
- Programs in pre-contemplation do not apply for the training and TA
- Staff attending statewide trainings cannot implement if program is not interested
- Do not know if practice change is sustained



# Proposed Plans for 2011

- Statewide or regional training at multiple levels
- BSAS will review and prioritize waiting list
- BSAS licensing division will recommend programs that, in their evaluation, need to enhance their ability to provide trauma-informed treatment
- Focus on Supervisors: IHR developing a supervision guide that will be used in future supervisor trainings
- Will conduct staff level anonymous survey at a designated interval after program receives training and TA as additional measure of practice change