Welcome! Introductions!!
Icebreaker!!!
Thank yous!

• Ann Williamson, Director, Utah Department of Human Services
• Doug Thomas, Director, Utah State Division of Substance Abuse and Mental Health
• Brent Kelsey, Assistant Director, Utah State Division of Substance Abuse and Mental Health
• Becky King, LCSW, Program Administrator, Utah State Division of Substance Abuse and Mental Health
• Carmen Lloyd, Administrative Support, Utah State Division of Substance Abuse and Mental Health
• Kimberlie Raymond, Administrative Team Leader, Utah State Division of Substance Abuse and Mental Health
• Jeff Marrott, Public Information Officer, Utah State Division of Substance Abuse and Mental Health
• Jose Herrerra, Event Manager, Davis Conference Center
• Deb Comstock, volunteer extraordinaire and Davis County Domestic Coalition

Guest speakers

• Damon Polk, CADC II, Cultural Director, Red Circle Lodge
• Lane Shepard, Clinical Director, Red Circle Lodge
• Katherine P. Supiano, PhD, LCSW, F-GSA, FT, Director
• Kara Patin, LCSW
• Lindsey Terry, yoga instructor
• Guest Speaker: Brian Miller, Ph.D
• Karen Gardner, EMDR Utah
• Massimiliano Frani, Edoardo Guerra, Ben Christiansen, Ph.D
• Jason Smith, DC, DABCN, FABVR, FACFN
• Laura Thompson, JD, CWLS, Office of the Utah Attorney General
• Terri Flint, LCSW
• Gordon Bruin, InnerGold and Summit Wellness
Beginnings

• Idea:
  – Have a weeklong intensive for people to get a strong handle on trauma-informed transformation
  – Offer spots only to motivated and engaged people
  – Create a feedback loop with homework assignments

• Genesis of the Utah Trauma Academy
  – DoJ Victim Academy (Now OVC Victim Assistance Academy)
  – Utah’s commitment to trauma-informed services
  – Becky King’s quiet persuasion
  – 2016 Utah Trauma Academy 100 people

2016 Lessons

• Very high attendee approval of the Utah Trauma Academy
• Audience made up of primarily clinically focus
• People often returned home due to life and work requirements so after social or optional activates had low attendance
• Post-conference follow up or specific reporting back would be better to see how the Academy took life
• Have plans for next trauma academy to build on momentum
Introducing your team

• Gabriella Grant, Director, California Center of Excellence for Trauma Informed Care
• Rebecca King, Division of Substance Abuse and Mental Health
• Deb Comstock, volunteer extraordinaire
• Each one of you are a part of this team!

Ice-breaker:
Introduce yourself to your neighbors!

• Name, agency, city
• Your favorite ice cream flavor (or similar)
• How you are going to survive a 5-day Academy?
5 agreements Don Miguel Ruiz (and son)

1. **Be Impeccable with your Word**: Speak with integrity. Say only what you mean. Avoid using the Word to speak against yourself or to gossip about others. Use the power of your Word in the direction of truth and love.

2. **Don’t Take Anything Personally**: Nothing others do is because of you. What others say and do is a projection of their own reality, their own dream. When you are immune to the opinions and actions of others, you won’t be the victim of needless suffering.

3. **Don’t Make Assumptions**: Find the courage to ask questions and to express what you really want. Communicate with others as clearly as you can to avoid misunderstandings, sadness and drama. With just this one agreement, you can completely transform your life.

4. **Always Do Your Best**: Your best is going to change from moment to moment; it will be different when you are healthy as opposed to sick. Under any circumstance, simply do your best, and you will avoid self-judgment, self-abuse, and regret.

5. **Be skeptical. But learn to listen**: Don’t believe yourself or anybody else. Use the power of doubt to question everything you hear. Is it the truth? Listen to the intent behind the words and you will understand the real message. *(With his son.)*
What about the agency level?

- Our entire chain of command literally reaching up to the governor and our legislature all express focus and dedication to improving our responsiveness to the traumas that have brought people into contact with our agency.
- I do not know of any plans the agency has to implement trauma-informed transformation.
- Being more trauma informed is part of our 5 year plan.
- Trauma-informed is not a buzz word here, it is a commitment to those we serve.
- The owner of my agency has gone through this training, he told me about it and is strongly encouraging it.
- The agency I am currently employed with recognizes the impact of trauma in tribal communities and has demonstrated that recognition by providing me with full support.

When did you first hear “trauma informed”?

- I immediately felt like I wanted to shout it from the rooftops of every substance abuse program I’d every encountered.
- I work in a setting where trauma happens every day, to both patient and caregivers. This year alone my caregivers have tried to save the lives of officer involved shootings, pediatric and teen suicides and more. I have only recently become familiar with the phrase “trauma informed practices”. Only recently has my organization created processes and policies where when these events happen, we get emotional support.
- I first heard it in the US Army when I was receiving training in 2005 to deploy to Iraq as a Mental Health Specialist assigned to a Combat Stress Control detachment. It changed the way that I looked at troop leadership. I began to recognize that much of what might originally have been perceived as maladaptive or malingering behavior may have found its etiology in trauma and thus needed to be addressed with trauma informed leadership practices.
Historical threads in many fields and movements

1950s-1970s  Modern mental health consumer/survivor movement rises in the wake of a radical restructuring of the asylum system and the civil rights and nonviolent peace protest movements
1992  *Trauma and Recovery* written by Dr. Judith Herman published
1990s  “Decade of the Brain” declared by President George Bush
1990s-2000s  “Adverse Childhood Experiences Study” conducted by Kaiser Permanente
1998-2004  “Women with Co-occurring Disorders and Violence Study” funded by SAMHSA
2000  National Child Traumatic Stress Network (NCTSN) founded
2001  *Using Trauma Theory to Design Service Systems* by Harris and Fallot
2005  *Helping Children in the Child Welfare System Heal from Trauma* published by NCTSN
2005  SAMHSA issues Blue Print to reduce and eliminate seclusion and restraint
2010  Federal Partners on Women and Trauma started
2013  Trauma Informed Schools (Walla Walla, WA and Cherokee Point, San Diego), ACEConnection and many local efforts begin activating
2018  U.S. House H.R. 443 on adverse childhoods passed unanimously
2018  *SUPPORT for Patients and Communities Act* passed by Congress with extensive trauma-related legislation; more legislation currently in committee.

Utah timeline

2011  National Conference on Adult and Juvenile Female Offenders featuring Dr. Stephanie Covington
2012  Utah Foster Care Symposium with Dr. Bruce Perry
2013  Utah Department of Human Services brought Dr. Stephanie Covington to speak on trauma informed care
2013  Seeking Safety training offered (also in 2014, 2015, 2016, 2018)
2013  Trauma Informed Care Network founded
2014  Health and Resiliency Symposium: Building a Trauma Informed Community,
2015  Utah Governor issues a decree on trauma ???
2017  Utah legislature passed H.C.R. 10 in 2017
2018  H.B. 177 Trauma Informed Justice Provisions signed by Governor
2019  Utah Lt. Gov. Spencer Cox charges Resilient Utah with making Utah a trauma-informed state
Step One: Use a common definition of trauma

COMMON DEFINITION

Write down....

• Write down how you would define trauma – a way to explain it to someone else?
Defining trauma

Individual trauma results from exposure to an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

SAMHSA (Substance Abuse Mental Health Services Administration)

http://www.integration.samhsa.gov/clinical-practice/trauma

Compare Grief and Trauma

Grief
• Generalized reaction is SADNESS
• Grief reaction stand alone
• Grief reactions are generally known to the public and the professional
• In grief, most can generally talk about what happened
• In grief, pain is the acknowledgement of the loss
• In grief, anger is generally non-destructive and non-assaultive
• In grief, child says "I wish I would/would not have..."
• Grief generally does not attack nor "disfigure" our self image
• In grief, dreams tend to be of the deceased
• Grief generally does not involve trauma reactions like flashbacks, startle reactions, hypervigilance, numbing, etc.

Trauma
• Generalized reaction is TERROR
• Trauma reactions generally include grief reactions
• Trauma reactions, especially in children, are largely unknown to the public and professionals
• In trauma, most do not want to talk about what happened
• In trauma, pain triggers tremendous terror and an overwhelming sense of powerlessness and loss of safety
• In trauma, anger often becomes assaultive even after non-violent trauma
• Trauma guilt says, "It was my fault. I could have prevented it."
• Trauma generally attacks, distorts and "disfigures" our self image
• In trauma, dreams are about self and potential victim
• Trauma involves grief reactions in addition to trauma specific reactions

Gallagher (no date), adapted from What Parents Need to Know, by William Steele, TLC Institute, 1997
Identifying trauma

To join the UBI Pilot Study, email traumainformedcalifornia@gmail.com
Subject line: UBI

![Diagram showing the relationship between Conception, Death, Early Death, Disease, Disability, and Social Problems, Adoption of Health-risk Behaviors, Social, Emotional, and Cognitive Impairment, Disrupted Neurodevelopment, and Adverse Childhood Experiences.]

Anda et al., 2009

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
Treatment is neurobiological

ACE Study compared to City of Berkeley Interns

**ACE Study findings**
- Emotional abuse: 11%
- Physical abuse: 28%
- Sexual abuse: 22%
- Emotional neglect: 15%
- Physical neglect: 10%
- One or no bio parents: 23%
- Mother treated violently: 13%
- Substance abuser in home: 27%
- Mentally ill person in home: 17%
- Household member in prison: 5%
- No ACEs reported: 33%

**Utah Sub Abuse Conference 2014 (n=115)**
- Emotional abuse: 49%
- Physical abuse: 33%
- Sexual abuse: 37%
- Emotional neglect: 48%
- Physical neglect: 17%
- One or no bio parents: 30%
- Mother treated violently: 18%
- Substance abuser in home: 26%
- Mentally ill person in home: 59%
- Household member in prison: 5%
- No ACEs reported: 17%

Compiled anonymously and voluntarily by attendees of trainings provided by CCE-TIC
Compiled by the California Center of Excellence for Trauma Informed Care
Professionals higher exposure

ACEs in General Population (n=17337) Compared to Health Professionals (n=2351)

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PTSD video
Complex trauma

Unsafe homebase

Feels safe and accepting

“I am bad”

Help sux

Step Two: Use universal precautions around trauma

UNIVERSAL PRECAUTIONS
Q&A

• Define universal precautions:

A. Thinking that everyone has trauma.
B. Treating and protecting everyone equally.
C. Taking a thorough assessment of trauma history with everyone.
D. Requirement to disclose to know for sure.

Universal precautions

• The ACE study showed 67% of the general public have at least 1 ACE (Felitti and Anda, 2005).
• Trauma exposure is universal in child welfare (Finklehor, 2011).
• Over 70% of people with disabilities reported they had been victims of abuse (Spectrum Institute, 2013).
• Over 92% of mothers who are homeless reported severe physical and/or sexual abuse during their lifetime (Goodman, et al., 2006).
• Among SMI clients in public mental health, average of 7 types of traumatic events over lifetime (Lu, et al., 2013).
• 89% of women with MH/sub abuse reported either physical or sexual abuse and 58% reported both (Newmann and Salmann, 2004).
• Members of the military have higher rates of trauma before entering the military than the general public (Blosnich 2014).
• Over 66% of men seeking treatment for substance use disorder report one or more traumatic life events and 33% meet PTSD diagnosis (Back et al., 2000).
Universal precautions

- We ask, they do NOT have to tell – informed consent
- If no specific information, think trauma first!
- Notice if thinking trauma provides more solutions, compassion and optimism
  - rather than finding blame, feeling overwhelmed, becoming triggered, struggling to know what to say.
- If disclosure, recognize the bravery and ask what the person would like you to do.
- Then, ask how this still affects client today - redirect to the present.
- Know mandated reporting laws and speak to supervisor after any disclosure.
- Avoid unilateral decision-making, if possible.

- Among patients with high rates of trauma load, treatment retention level increased from 29% to 80% when education about alcohol and trauma was added to treatment as usual. (Dore, 2012)
Step Three: Apply the public health model of prevention, intervention and treatment

PUBLIC HEALTH MODEL

SAMHSA ~ 2014

“Trauma is a widespread, harmful and costly public health problem....It is an almost universal experience of people with mental and substance use disorders....Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early intervention, and effective, trauma-specific assessment and treatment.”
Public Health

- Public health refers to all organized measures to prevent disease, promote health and prolong life among the population as a whole.
- Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.
- Thus, public health is concerned with the total system and not only the eradication of a particular disease.

- World Health Organization

Trauma-informed ➔ Safety

**TRAUMA-INFORMED:** a culture that acknowledges the impact of trauma and strives to increase physical and emotional safety — **public health**

**TRAUMA-SPECIFIC:** interventions whose primary task is to address the impact of trauma and to facilitate trauma recovery — **individualized treatment**

All publicly funded programs benefit from becoming trauma informed and can also choose to also become trauma-specific.
TIP 57

A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

- **Realizes** the widespread impact of trauma and understands potential paths for recovery
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices
- **Seeks to actively resist re-traumatization**

Trauma informed values and skills

- **Core values**
  1. Safety (physical and emotional)
  2. Trustworthiness and Transparency
  3. Peer Support
  4. Collaboration and Mutuality
  5. Empowerment, Voice and Choice
  6. Cultural, Historical, and Gender Issues

- **Trauma recovery skills**
  1. Build safe actions
  2. Become more transparent; become known to someone
  3. Identify and build safe connections
  4. Work on something you care about with others who care about the same thing
  5. Develop personal power: ability to speak and act autonomously
  6. Hear the messages and pull out the parts that help; disregard those that hurt

Grant, 2015

SAMHSA, 2014
6 Foundational Steps

1. Adopt a common definition of trauma (see SAMHSA)
2. Practice universal precautions around trauma
3. Apply the public health approach of prevention
4. Distinguish between physical and emotional safety
5. Be a safe connection
6. Use objective measures
End of Day Ritual

• Homework:
  – Write about how a common definition of trauma can help your clients/students/etc. Any concerns?

• Reading:
  – Harris and Fallot – Safety

Thank you!

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