The Johns Hopkins Office of the Provost and the Urban Health Institute present
The Fourth Annual Symposium on the Social Determinants of Health

Healing Together: Community-Level Trauma Its Causes, Consequences and Solutions

IN BRIEF 4:
Trauma-Informed Health Services

Trauma exposure is linked to physiological, behavioral and emotional health problems, both immediately and across the lifespan. Ultimately, at some point during their lifetime, individuals with traumatic life experiences will interact with health services, either through a trauma-specific treatment center, a mental or behavioral health facility, in a primary care setting, or in a hospital or urgent care center. Whether the traumatic event is the reason for a patient's interaction with health services, i.e. the individual sustained a gunshot wound, or the individual has experienced trauma unrelated to an appointment or treatment, health care professionals should understand how these experiences affect the patient's health and well-being. A trauma-informed model of care allows health care professionals to provide care that reduces symptoms of trauma exposure; identifies individuals and families that are most at risk for health problems associated with trauma exposure; and avoids depersonalizing and stressful interactions that can themselves be traumatizing for patients.

This brief will discuss three different settings in which health care services can benefit from a trauma-informed approach to care; however, these examples are not exhaustive.

Mental Health and Behavioral Health Settings

Being a trauma-informed facility or having trauma-informed practices is very different from being a trauma-specific treatment center. Although trauma-specific treatment centers are important for addressing specific disorders that are trauma-related, such as PTSD, it is important that other facilities that interact with patients also be trauma-informed in their services. These facilities include substance abuse centers, child and adolescent behavioral health facilities (such as group homes and acute units) and psychiatric inpatient and outpatient facilities. Just because these facilities deliver trauma-focused or trauma-based therapies (such as trauma-focused cognitive behavioral therapy), it does not automatically follow that they are "trauma-informed." To be trauma-informed, in addition to ensuring that effective trauma-focused treatment is available, the facility should raise awareness and understanding of trauma among all staff, including, but not limited to the behavioral health providers, intake professionals, administrative staff

ABOUT THIS SERIES

The Fourth Annual Social Determinants of Health Symposium, "Healing Together: Community-Level Trauma – Its Causes, Consequences and Solutions," was convened on **April 20, 2015**. This symposium brought together professionals, community leaders and experts to discuss efforts to support Baltimore in becoming a "trauma-informed" city. To provide a common language and knowledge-base for this discussion, the Johns Hopkins Urban Health Institute developed a series of briefs on trauma-informed care.

Briefs in this series include:

Brief 1: Introduction to "Trauma-Informed" Care: Important Components and Key Resources

Brief 2: Creating a Trauma-Informed Criminal Justice System: Success Stories, Challenges and Potential Solutions

Brief 3: Trauma-Informed Schools

Brief 4: Trauma-Informed Health Services

BRIEF 4:

- Trauma-informed care in:
  - Mental health and behavioral health services
  - Primary care settings and
  - Hospitals or emergency care facilities
- Suggested components of trauma-informed care in health services
- Resources

and referral services. In addition, the facilities should integrate knowledge of the connection between trauma and a host of symptoms into policies, procedures and practices while seeking to resist re-traumatization by avoiding practices such as seclusion or restraint.[1] The goal of trauma-informed services in not to treat the specific symptoms associated with trauma exposure, but to help the individual in a way that is respectful and sensitive.

Some examples of trauma-specific interventions that are often used in behavioral health services include: Addiction and Trauma Recovery Integration; Risking Connection; Sanctuary Model; Seeking Safety; Trauma, Addiction, Mental Health, and Recovery (TAMAR); and Trauma Recovery and Empowerment Model (TREM and M-TREM).

More information can be found on the Substance Abuse and Mental Health Services Administration website.[2]

Primary Care Settings

We know that trauma exposure, especially in early childhood, has adverse effects on long-term health and well-being. Although many primary care physicians see patients with trauma exposure, Green et al[3] noted that doctors found traumatized patients difficult to work with and that they felt unprepared and unsure of their ability to care for them adequately.[3] This uncertainty could lead to trauma symptoms left untreated with adverse health consequences for patients. Incorporating trauma-informed training in professional education for doctors, nurses and other medical practitioners would help alleviate this problem. Some key competencies that could be incorporated into professional training to enhance preparedness include: skill building and practice of effective communication styles to be used when discussing trauma histories, identification and diagnosis of mental health and trauma issues, and trauma referral strategies. Moving away from a focus solely on diagnosis and treatment of symptoms is a key strategy for prevention of retraumatization and would allow primary care physicians to provide better care for their patients.

Success has been shown in the primary care setting in two separate, randomized, controlled studies of communication training with primary care providers (PCPs). Helitzer et al[4] used an approach intended to improve understanding of traumatic life experiences and communication of health risks. PCPs learned how to identify and discuss adverse childhood events with patients.[4] They were able to demonstrate that after a brief training session, PCPs showed improvements in patient-centered communication, communication skills and discussion of adverse childhood experiences. These improvements were sustained for a period of 24 months.[4]

"It is our experience working with traumatized patients that the traumatic life events of the patient must be a central focus of clinical thinking. This entails considering the effects of the patient's trauma story on the medical history, physical examination and laboratory studies."

Mollica 2001, p. 1213. [5]

"The depersonalizing and stressful hospital atmosphere that exposes patients to incessant loud noises, a lack of privacy, awakenings in the middle of the night, and examinations by strangers who fail to identify themselves may be an important contributing cause of transient vulnerability that has been characterized as "post-hospital syndrome."

Detzky & Krumholz, 2014.[6]

In a more recent randomized study by Green et al,[7] a program was developed to "focus on maximizing the understanding and healing power of interactions between trauma survivors and providers so that other activities like asking about trauma or symptoms, or making mental health referrals, can be done in the most trauma-informed way possible, with the best chance of trust, honesty, and follow-through."[7] This training approach, adapted from Risking Connection, not only included modules to help PCPs understand trauma's effects on patients, but also addressed physicians' self-awareness, second-hand trauma exposure and understanding of their own trauma histories. This approach was effective for improving patient-centered interactions.

Hospitals and Urgent Care Settings

Medical settings can themselves be traumatic for patients. We know that the number one goal in emergency care settings is to treat severe injury and prevent death. As a result, often little time is spent focusing on the effects of injuries and illness on an individual's emotional well-being and quality of life. It has been shown that three months after discharge from a medical-surgical intensive care unit, 16% of patients had PTSD symptoms and 31% had depressive symptoms.[8] Some recommendations for reducing traumatization in hospital settings include: structuring environments to reduce stress, disruptions and surprises; training personnel to promote more personal, sensitive and respectful care; eliminating unnecessary tests and procedures; decreasing random medication alterations; encouraging activity and providing a post-discharge safety net.[7]

Examples of successful models include: Cincinnati Children's Hospital; Family Informed Trauma Treatment Center at the University of Maryland School of Medicine and the Philadelphia Children's Hospital. A helpful acronym was developed by The Children's Hospital of Philadelphia to help medical professionals follow a patient-sensitive strategy that avoids re-traumatization called the ***D-E-F*** protocol (**distress - emotional support - family**). This resource can be found on The Children's Hospital of Philadelphia website.[9]

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The goals of the ***D-E-F*** model are:

D – Reduce distress

- Assess and manage pain
- Ask about fears and worries
- Consider grief and loss

E – Promote emotional support

- Ask: Who and what does the patient need right now?
- Identify barriers to mobilizing existing support

F – Remember the family

- Assess family members distress
- Gauge family stressors and resources
- Address needs beyond medical

Suggested Components of Trauma-Informed Care

The following are suggestions for providing trauma-informed care:

- Conduct clinical assessments of trauma in the primary care setting.
  - Examples include the Hopkins systems checklist-25 and the Harvard Trauma Questionnaire.
- Provide trauma-informed training in primary care programs, including training to improve clinician-patient communication, as well as clinician understanding and responsiveness to the impact of trauma. SAMHSA[2] recommends the following for providers:
  - Work with the client to learn the cues he or she associates with past trauma.
  - Obtain a good history.
  - Maintain a supportive, empathetic and collaborative relationship.
  - Encourage ongoing dialogue.
  - Provide a clear message of availability and accessibility throughout treatment.
- Take appropriate measures after someone has a traumatic injury or accident to reduce stress and address needs beyond immediate medical care.
- Avoid institutional policies such as seclusion and restraint that are likely to re-traumatize individuals who have trauma histories.
- Provide a safe and secure environment.
- Advocate for appropriate coordination among services.

TOOLS

- Trauma toolbox for primary care: a six-part series designted to educate PCPs about trauma https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx
- Example of a primary care behavioral screener http://www.integration.samhsa.gov/clinical-practice/PCBHS_Screener_-_User_Guide.pdf
- Top 10 checklist for behavioral health organizations http://www.integration.samhsa.gov/clinical-practice/TIC_Flyer_web_2013_new.pdf
- SAMHSA's TIP: Information on building a trauma-informed medical workforce http://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf
- Handbook on sensitive practice for health care professionals http://www.integration.samhsa.gov/clinical-practice/handbook-sensitivve-practices4healthcare.pdf

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