Utilizing Trauma-Informed Practices to Reduce Restraint & Seclusion

Presented by Jack Nowicki, LCSW for the Texas Behavioral Health Institute Conference

NATIONAL SURVEY OF CHILDREN’S EXPOSURE TO VIOLENCE

- Phone surveys
- 4549 youth 7* - 17
- 2 Groups:
  - Rep Sample of 3053, and
  - Oversample of 1496 (70% minority or low income)

60% of youth responding exposed to violence in past year!
Providing care that
• Does no harm
• Avoids re-traumatizing
• Helps the person heal

Providing services that have all been reconsidered based on the role violence plays in lives of people.

Providing care that
• Addresses complex trauma-related issues
• Keeps people safe

Providing services that
• Assess damage
• Provide specialized treatment protocols
• Treat clinical symptoms
• Evaluate progress

* Sometimes called “Trauma-based”

THE STRESS ~ CRISIS ~ TRAUMA CONTINUUM

Think of stress in relational, systemic terms, as co-constructed by the person and the event

- Disruption of equilibrium
- Breakdown of coping
- “Triggered” memories of traumatic events

- Major Terrorist Disaster
- Death of Spouse
- Sexual Assault
- Torture or Physical Attack
- Divorce or Breakup
- Auto Accident
- Loss of Job or Home

➢ Perspective on Event
➢ Personal, material, social resources
➢ Life experiences
➢ Self esteem
➢ Stage of development
➢ Personality
➢ Physical health
PERSONAL, MATERIAL, & SOCIAL RESOURCES

How people respond to traumatic events depends upon their resiliency & their personal, material, and social resources.

TRAUMA INFORMED CARE & PTSD: DSM DIAGNOSES

“...clinically significant distress or impairment...”

Acute Stress Disorder:
- Starts 3 to 30 days post event
- Usually remit naturally in shorter time period (to re-establish “coping”)
- Emphasis on dissociative symptoms

PTSD:
- Starts 4 weeks post event &
- Lasts longer than 4 weeks
- Reactions “triggered” by cues
- Dissociative symptoms “set aside”
- Prevalence of PTSD is about 7.8%
- “roughly 50 to 60% of the U.S. population is exposed to traumatic stress (and) only 5% - 10% develop PTSD”
BUILDING TRAUMA INFORMED COMMUNITY PROGRAMS

Trauma-informed public health prevention services have three forms: Primary, Secondary, and Tertiary, including the following:

- Creating a culture of care.
- Training staff in T.I.C.
- Ensuring policy reflects T.I.C. practices.
- Assessing trauma history.
- Developing safety plans.
- Using de-escalation skills.
- Debriefing after interventions.
- Doing nothing that might re-traumatize!

KEY COMPONENTS OF TRAUMA INFORMED CARE (TIC)

These components of developing a trauma-informed culture from Gordon Hodas were developed for residential programs and have been used in other community-based programs as well.

Understanding
- The impact of trauma & how it may define the person’s identity
- Being in a relationship with the person underneath the trauma
- The services we can & cannot give the person
- That all the services are given within the context of a relationship that may inspire the youth to trust and compromise

Relationship, as perceived by the client, plus involvement = positive outcomes
**KEY COMPONENTS CONTINUED**

Youthworkers are the vehicle from which the youth learn about trust and safety... achieved through... partnership...

**Education & Training**

**Values**

Trauma-informed care operates with a different set of values:

1) Focus is on empowerment, not management and control.
2) Staff & Agency are responsible for engaging youth & families about trauma-informed care.
3) The Goal of trauma-informed agencies and their staff is for youth to remain “safe” while they work towards their own stated goals.
4) Language is the mode of communication and staff respond to youth’s ideas of the meanings of our communications.

**KEY COMPONENTS CONTINUED**

Trauma-informed systems (agencies) require sustained administrative & organizational effort, including:

**Administrative Commitment**

1) Adding trauma-informed to the mission statement, and objectives of the agency
2) Screening all youth for past history of violence and victimization
3) Training all staff about the impact of trauma & implementing trauma-informed care
4) Identifying staff who can become “trauma champions” based on their background in trauma-informed or trauma-based care
5) Reviewing and updating policies & procedures to ensure they are consistent with trauma-informed care
THREE BEST PRACTICE STRATEGIES

Trauma Assessment

- Open conversation about past history of trauma?
- Any current danger to self or others?
- Simple trauma assessment instrument
- Exploring “triggers”

More about Triggers

- Youth’s conflicts with parents, running away, truancy, substance abuse, school difficulties, MAY be crisis-related or trauma-related.
- In counseling we can assess their level of crisis and/or conduct a trauma assessment to identify any relationship between the “presenting problem” & past trauma.
- Events & Emotions may “trigger” youth’s behavior... so asking about antecedents to behavior is a good idea.

THREE BEST PRACTICE STRATEGIES

Safety Planning

- Necessary for all youth in residential services!
- May be useful for youth in counseling when we assess a link between past trauma or crisis and problem behavior.
- May be useful as an antidote for youth in substance abuse recovery.

De-escalation Skills

- Totally Necessary for all staff in residential services!
- Helpful for counseling staff to know for emergency situations that occur.
- Can be helpful to teach youth in other counseling programs how to self-de-escalate, chill out, etc.
REFERENCES