Chapter Title	Section #		Subject #
Clinical	C		312
Subject Title **Trauma Informed Care**	Adopted 8/28/17	Last Revised 8/26/19	Reviewed 7/23/18; 8/26/19; 8/24/20; 7/26/21; 5/23/22; 5/22/23

POLICY

Application

This policy shall apply to the programmatic supports and services of The Right Door for Hope, Recovery and Wellness.

1.0 Purpose

To define the guidelines that The Right Door for Hope, Recovery and Wellness will follow to address trauma in the lives of the people served and to ensure that Mid-State Health Network (MSHN) and The Right Door for Hope, Recovery and Wellness, as one of its affiliate members, maintains consistent trauma-informed care philosophies across its network of care. More specifically, this policy outlines the steps that The Right Door for Hope, Recovery and Wellness will take to promote an understanding of trauma and its impact, to ensure the development of a trauma-informed system of care, and to make available trauma-specific services for all populations served.

2.0 Definitions

2.1 Trauma: “An individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” [Substance Abuse Mental Health Services Administration (SAMHSA)].

The term “trauma” generally relates to experiences or situations that are emotionally painful and distressing, and that may overwhelm an individual’s ability to cope. Exposure to trauma is very common within the general population. For individuals with diagnoses of serious mental illness, rates of traumatic exposure, particularly violent victimization, are even higher (i.e., 34-53% report child abuse, 43-81% report lifetime victimization) (Mueser et at., 1998). Thus, trauma must be considered part of the common human experience.

Forms of potentially traumatizing events include diagnostically defined events such as serious injury, assault, and sexual violence (APA, 2013), as well as additional aversive experiences such as discrimination, racism, oppression, and poverty. These chaotic life conditions are often directly related to chronic fear and anxiety and can have serious long-term effects on mental and/or physical health

Chapter Title	Section #		Subject #
Clinical	C		312
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and other life outcomes. In fact, many individuals with trauma histories have comorbid mental health (e.g., depression, other anxiety disorders, etc.), substance abuse, and physical health difficulties. It should also be noted that secondary trauma, which relates to the emotional distress that results when an individual hears about the firsthand trauma experiences of another, can also be experienced by individuals. Compassion fatigue can occur when a provider is repeatedly exposed to secondary traumatization.

Examples of traumatic events include (but are not limited to):

- War, battles, combat (death, explosions, gunfire, etc.)
- Natural disasters (floods, tornados, fires, etc.)
- Catastrophe (harmful/fatal accidents, terrorism, etc.)
- Violent attack (animal attack, assault with or without a weapon, battery and domestic violence, rape, threats of bodily harm with or without a weapon, etc.)
- Abuse (physical, sexual, mental and/or verbal)
- Suicide and attempted suicide
- Adverse childhood events (all types of abuse, neglect and other potentially traumatic experiences that occur to people under the age of 18)

2.2 Post Traumatic stress disorder (PTSD) is one such difficulty that can develop after exposure to an event in which an individual is exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (APA, 2013). Individuals with PTSD may remain highly distressed or frightened even when they are no longer in danger. Individuals can develop PTSD through direct exposure to potentially traumatic events (PTE's), through the witnessing of PTE's, or through indirect exposure (e.g., learning of the sudden, unexpected loss of a loved one, working in a position that requires repeated exposure to aversive events – for example, a first responder, etc.). PTSD can occur in people of any age, including children and adolescents. While PTSD is often associated with combat trauma in veterans exposed to war, PTSD can occur in civilians

Chapter Title	Section #		Subject #
Clinical	C		312
Subject Title **Trauma Informed Care**	Adopted 8/28/17	Last Revised 8/26/19	Reviewed 7/23/18; 8/26/19; 8/24/20; 7/26/21; 5/23/22; 5/22/23

exposed to a variety of potentially traumatic events including assault, rape, torture, kidnapping, child abuse, car accidents, bombings, natural disasters, etc.

To receive a diagnosis of PTSD, an individual must experience symptoms within the following domains and must experience functional impairments secondary to these symptoms:

2.2.1 Intrusion: the traumatic event is persistently re-experienced (e.g., nightmares, intrusive thoughts, flashbacks, etc.)

2.2.2 Avoidance: persistent effortful avoidance of distressing trauma-related stimuli after the event

2.2.3 Negative Alterations in Cognitions and Mood: changes in thoughts and/or mood that began or worsened after the traumatic event (e.g., lack of interest in previously enjoyed activities, constricted affect, feelings of guilt or self-blame, pulling away from others, etc.)

2.2.4 Alterations in Arousal and Reactivity: changes in arousal and reactivity that began or worsened after the traumatic event (e.g., irritability, trouble sleeping, concentration difficulties, exaggerated startle response, etc.)

2.3 Trauma-Informed Services refers to services that are designed to specifically avoid re-traumatization of those who are seeking assistance, as well as staff working in those service settings. These services seek safety first and commit themselves to doing no harm (nonmaleficence). It is an approach that appreciates that healing is possible, trauma-informed care engages people with histories of trauma, recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. This approach seeks to shift the paradigm from one that asks “What’s wrong with you?” to one that asks “What has happened to you?” Every part of a trauma-informed system’s organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.

3.0 Agency Trauma Informed Care Practices

Because individuals with trauma histories are found across all systems of care, we need to presume that individuals served by The Right Door for Hope, Recovery and Wellness may have been exposed to traumatic or aversive life experiences, and we must provide

Chapter Title	Section #		Subject #
Clinical	C		312
Subject Title **Trauma Informed Care**	Adopted 8/28/17	Last Revised 8/26/19	Reviewed 7/23/18; 8/26/19; 8/24/20; 7/26/21; 5/23/22; 5/22/23

a trauma-informed system of care to facilitate a welcoming and safe environment throughout the course of treatment. It is critical to understand that our most vulnerable individuals with intellectual and/or developmental disorders have experienced a variety of traumas. Those with serious mental illness and co-occurring substance-use disorders who also have a significant trauma history may not initially respond to traditional treatments. The providers of care must have the training and sensitivity to respond with compassion and effective strategies to those they serve as well as have strategies to cope with their own compassion fatigue.

3.1 To ensure consistency with a trauma-informed culture of care, The Right Door for Hope, Recovery and Wellness staff will create and maintain a safe, calm, and secure environment with supportive care, a system-wide understanding of trauma prevalence and the impact of aversive life experiences, recovery and trauma specific services, and recovery-focused, person served-driven services. This will be done by identifying and treating trauma-related issues, and by providing ongoing trauma education/training to all staff.

3.2 The Right Door for Hope, Recovery and Wellness providers will emphasize the following Core Values of Trauma-Informed Care:

3.2.1 Safety: Ensuring physical and emotional safety

3.2.2 Trustworthiness: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries

3.2.3 Choice: Prioritizing person served choice and control

3.2.4 Collaboration: Maximizing collaboration and sharing of power with persons served

3.3 The Right Door for Hope, Recovery and Wellness providers will emphasize the following core components of a Trauma Informed Systems of Care:

3.3.1 Recognition of the high prevalence of trauma

3.3.2 Recognition of primary and co-occurring trauma diagnoses

3.3.3 Assessment for traumatic histories and symptoms

3.3.4 Utilization of evidence-based practices

Chapter Title	Section #		Subject #
Clinical	C		312
Subject Title **Trauma Informed Care**	Adopted 8/28/17	Last Revised 8/26/19	Reviewed 7/23/18; 8/26/19; 8/24/20; 7/26/21; 5/23/22; 5/22/23

3.3.5 Professionals who understand the function of behavior (rage, repetition-compulsion, self-injury, etc.)

3.3.6 Use of objective, neutral language

3.3.7 Recognition and constant attention to culture and practices that can be re-traumatizing

3.3.8 Collaboration with caregivers and the individual's support system

3.3.9 Collaboration and transparency in the engagement in community outreach and partnership building such as engaging and educating community partners (e.g. courts, police, emergency services, hospitals, the public, etc.) about trauma-informed care. The Right Door for Hope, Recovery and Wellness engages with external partners in the care of individual persons served, with the individual's permission and involvement, to promote and ensure system-wide trauma informed care.

3.3.10 Addressing training needs of staff to improve knowledge, understanding, and sensitivity

3.4 The Right Door for Hope, Recovery and Wellness will emphasize the provision of trauma-specific services. Such services are designed to specifically address the consequences of trauma in the individual and to facilitate healing by recognizing the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery, the interrelation between trauma and symptoms of trauma, and the need to work collaboratively with survivors, family, and friends of the survivor and other human services agencies.

3.5 Training in and adoption of trauma-informed values and principles, as well as the development of a trauma-informed system of care ensuring safety and preventing re-traumatization

3.6 Ongoing organizational self-assessment of trauma-informed care

3.7 Adoption of approaches that address secondary trauma of staff

3.8 Screening for trauma exposure and related symptoms for all populations in the service system

Chapter Title	Section #		Subject #
Clinical	C		312
Subject Title **Trauma Informed Care**	Adopted 8/28/17	Last Revised 8/26/19	Reviewed 7/23/18; 8/26/19; 8/24/20; 7/26/21; 5/23/22; 5/22/23

3.9 Ongoing assessment for trauma issues for all populations

3.10 Trauma-specific services for all populations using evidence-based practices (EBP) or promising practices when and where EBPs are not available

3.11 Collaboration with other community organizations to support the development of a trauma-informed community that promotes behavioral health and reduces the likelihood of mental health and substance use disorders

4.0 Principles adopted by The Right Door for Hope, Recovery and Wellness

The following principles shall be upheld for all populations in the adoption of trauma-specific services:

4.1 Providing a safe, calm, and secure treatment environment to ensure safety

4.2 Developing a system-wide understanding of trauma prevalence, impact, and trauma-informed care

4.3 Understanding and embracing cultural competence and diversity

4.4 Providing person served choice and control

4.5 Ensuring recovery-focused, person served-driven, and trauma-specific services

4.6 Developing healing, hopeful, honest, and trusting relationships where there is shared power

References

MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY17 Attachment C6.9.9.1

Deborah McPeek-McFadden, Board Chairperson	Date		