



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

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# **Developing Trauma-Informed Behavioral Health Systems**

**2003**

**Report from NTAC's National Experts Meeting  
on Trauma and Violence  
August 5-6, 2002  
Alexandria, VA**

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Services Administration (SAMHSA),  
U.S. Department of Health and Human Services (HHS)

This report was produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) and is supported under a Contract between the Division of State and Community Systems Development, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Association of State Mental Health Program Directors. Its content is solely the responsibility of the author(s) and does not necessarily represent the position of SAMHSA or its centers.

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## Acknowledgments

The National Technical Assistance Center for State Mental Health Planning (NTAC) within the National Association of State Mental Health Program Directors (NASMHPD) gratefully acknowledges the many individuals and organizations that contributed to the development of this report and the meeting on which it is based. In particular, we would like to thank Gail P. Hutchings, M.P.A.; Joyce T. Berry, Ph.D., J.D.; Susan Salasin; and Michael J. English, J.D., of the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) for their time and effort and for continuing to demonstrate their commitment to this issue.

Meeting participants (*Editor's note: See Appendix A*), who included federal officials, state mental health agency commissioners and medical directors, other national and state policy makers, researchers, providers, family members, and trauma survivors, provided invaluable insight and expertise to the process. They discussed with candor both the progress that has been made in the field since the last NTAC trauma experts meeting and the areas where progress has not occurred. They reviewed and revised a set of “essential elements” that should be in place in public mental health systems to ensure that people who have experienced violence and trauma in their lives receive effective services. The participants developed a specific set of recommendations for next steps, and they reviewed and commented on an earlier draft of this report. Andrea Blanch, Ph.D., prepared the first draft and assisted in the editorial process of this document.

NTAC wishes especially to thank the consumer/survivor/recovering persons who attended the meeting, as well as those whose voices were represented, for their courage, competence and persistence in raising these issues and working on these solutions.

Finally, acknowledgments and thanks go to Bruce D. Emery, M.S.W., who facilitated the meeting, and to the NTAC staff members who helped produce and publish this report, including Rebecca Crocker, former media/meeting coordinator; Ieshia Haynie, program associate; Robert Hennessy, editor and publications coordinator; and Catherine Q. Huynh, M.S.W, former assistant director.

—Kevin Ann Huckshorn, R.N., M.S.N., I.C.A.D.C., Director,  
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## Introduction and Background

This document summarizes the proceedings of the National Experts Meeting on Trauma and Violence held on August 5-6, 2002, in Alexandria, VA. The meeting, which was sponsored by the National Technical Assistance Center (NTAC) and the National Association of State Mental Health Program Directors (NASMHPD) and funded by the Center for Mental Health Services (CMHS), was convened for several reasons.

First, several years have passed since the initial NTAC experts meeting on the issue of trauma was held on April 2-3, 1998. At that time, the role of violence and trauma in the lives of people served by the public mental health system was not widely recognized. During the intervening years, a number of state mental health systems have made significant investments in developing trauma-specific treatment services and trauma-informed systems of care. This progress needs to be recognized and shared.

Second, findings are beginning to become available from SAMHSA's *Women, Co-Occurring Disorders, and Violence* national research program. Research results are currently being analyzed, and initial results look promising. Numerous scholarly papers and presentations will follow as the data are mined for important implications for the field. We now have an emerging understanding about what works and what doesn't work in responding to the needs of trauma survivors in our public system of care. It is time to begin implementing what we have learned.

Finally, the events of the past several years, including terrorist attacks, war, and other forms of unprecedented social violence, have heightened public awareness of the scope and impact of trauma on us as individuals, on our communities, and on our society. These tragic events have made it imperative that our behavioral health systems be knowledgeable about—and prepared to respond to—violence and its aftermath.

The experts meeting was planned by a committee (*Editor's note: See Appendix B*) including a wide variety of stakeholders, and the meeting itself included individuals with a range of different perspectives and experience. It was designed to accomplish several goals: 1) to review and assess progress made in the states since the first national experts meeting, identifying major successes and remaining challenges; 2) to identify and re-energize leadership in the states on this issue; 3) to ensure coordination of trauma initiatives with other related NASMHPD priorities; 4) to consider the new opportunities that have emerged in the environment since the events of 9/11/01; and 5) to make specific recommendations to NASMHPD, the states, and other organizations and groups concerning next steps in creating trauma-informed systems of care.

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## Historical Context

Although the current emphasis on trauma and violence in behavioral health is relatively new, the historical roots of this work can be traced back more than 30 years.<sup>1</sup> In the 1970s, the emergence of feminism and the domestic violence movement focused public attention on the needs of survivors. At the same time, widespread interest in public health led to significant efforts in primary prevention and early intervention. However, few of these efforts touched the public mental health system, which at the time was largely institutionally based. As attention focused on the problem of violence, the intergenerational cycle of abuse became evident, and it became clear that without accurate diagnosis and intervention, people would continue to cycle in and out of different service systems.

In the 1980s, publicly supported efforts shifted toward empirical research, while the mental health field began to focus on recovery and self-help, pushed by a growing consumer/survivor movement. While state mental health systems worked hard to develop community-based programs, consumer/survivors increasingly emphasized the relationship between the experience of violence and coercion and the development of severe psychiatric conditions, substance abuse, and a wide variety of other social problems.

In the 1990s, SAMHSA developed a specific agenda on women's issues and gender-specific treatment, and work continued on Posttraumatic Stress Disorder (PTSD), particularly as it pertained to veterans. In 1994, the landmark national conference *Dare to Vision* brought together more than 350 consumer/survivors, practitioners and policymakers in a forum designed for sharing and discussing problems and potential solutions. For the first time, the incidence and prevalence of trauma among consumers of public mental health and substance abuse services became clear, as did the importance of developing effective treatment models. It also became clear that complex PTSD manifests differently in women than in men, and that it is critical to tailor programs and services to the different needs of women and men. Major themes emerging from the conference also included the need for mental health and substance abuse service integration, the damaging impact of seclusion and restraint, and the critical importance of consumer/survivor leadership in all aspects of design, delivery and evaluation of services. *Dare to Vision* created a national momentum on trauma and violence, led to the creation of an ongoing national "technical advisory group" on trauma, and stimulated the development and testing of innovative approaches at the local, state, and federal levels.

At the federal level, CMHS (in partnership with the Center for Substance Abuse Treatment [CSAT] and the Center for Substance Abuse Prevention [CSAP]) launched a national research program to develop and evaluate integrated service approaches for women with trauma histories and co-occurring mental health and substance abuse disorders, as well as for their children. The research program also called for full

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<sup>1</sup> Historical review provided by Susan Salasin from the Center for Mental Health Services and A. Kathryn Power, Mental Health and Substance Abuse Commissioner from Rhode Island.

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participation of consumer/survivors. The first two years of this program were devoted to developing and documenting innovative systems of care, with the following three years designated for an outcome evaluation including both cross-site and individual site data.

In December 1997, a plenary panel on trauma and violence was held at the bi-annual NASMHPD commissioners meeting, with five states participating (MA, NY, ME, PA, and RI). The response to this panel was strong and immediate. During the following year, NASMHPD held the first national trauma experts meeting, created an annotated bibliography on trauma and mental health, and declared NASMHPD to have a strategic role in keeping trauma at the forefront of a national mental health agenda. In December 1998, the commissioners unanimously adopted a position paper on trauma and violence<sup>2</sup>.

During the period between 1998 and 2001, significant progress was made. Published in 1999, the Surgeon General's Report<sup>3</sup> on mental health mentioned trauma briefly; about a dozen states formed a network to share ideas and support the development of trauma-informed systems of care (State Public Systems Coalition on Trauma, SPSCOT); and several individual states and localities forged ahead, developing and testing innovative service approaches, hosting statewide and regional trauma conferences, and developing procedures to obtain client trauma histories. Researchers began to look at the effectiveness of various interventions and at the cost of leaving trauma untreated. At the same time, NASMHPD and the states began to focus on several of the issues that had surfaced during *Dare to Vision*—in particular, the use of seclusion and restraint in psychiatric hospitals.

By 2001, findings were also emerging from SAMHSA's *Women, Co-Occurring Disorders, and Violence* project. It had taken considerable effort to fully integrate consumer/survivor/recovering women, but the effort was beginning to bear fruit, with truly collaborative models emerging. Several innovative service models had been developed, documented and manualized, and a number of comprehensive training programs were available. The project had also been successful in stimulating interest in the academic research community, and scholarly work on the topic was increasing.

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<sup>2</sup> The NASMHPD Position Statement on Services and Supports to Trauma Survivors is online at [www.nasmhpd.org/posstmb.htm](http://www.nasmhpd.org/posstmb.htm)

<sup>3</sup> U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

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## Summary of Progress to Date

In the time between 1994's *Dare to Vision* conference and the 2002 NTAC trauma experts meeting, substantial progress was made. Some of the resulting beliefs of this progress are listed below.

- ◆ It is widely recognized that abuse and violence—particularly childhood sexual abuse—play a significant role in the development of severe psychiatric symptomatology, substance abuse disorders, and a host of other social problems.
- ◆ We have an emerging understanding about what works and what doesn't work in the treatment of trauma-related behavioral health problems. In particular, it is critical to integrate mental health and substance abuse treatment services within an overall framework that keeps the trauma issue in the forefront.
- ◆ The costs of *not* treating trauma are high. Trauma survivors are often “high end users,” cycling in and out of the most expensive services. Untreated trauma takes a huge toll on people's lives.
- ◆ State mental health systems can provide effective leadership in addressing the needs of survivors, despite serious political, financial, and other challenges.
- ◆ We know something about the factors that lead to successful integration of consumer/survivor/recovering persons in trauma services and research, and about factors that hinder such efforts.
- ◆ Mental health and substance abuse treatment systems across the country have experimented with developing trauma-specific services and trauma-informed systems of care, have experienced some success, and are ready to expand and refine their efforts.
- ◆ Advocacy for trauma response and treatment has grown, and now reflects a coalition of interests with the voice of consumer/survivor/recovering individuals at its core.

However, substantial challenges remain, particularly in implementation of the knowledge and experience gained so far. Some of these challenges are listed below.

- ◆ Resources and supports for the integration of consumer/survivor/recovering persons need to be increased, more attention should be paid to gender issues, and a new language should be developed which fully incorporates the experience of survivors.
- ◆ More effective strategies are needed for ensuring that services reflect the reality of people of color, ethnic and religious minorities, people living with disabilities,

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and people living in poverty. Real inclusion will not occur until we are working with and through the organizations and associations that shape people's lives.

- ◆ A lifespan perspective needs to be developed and implemented, with special attention to children, families, and the elderly. New research on the developmental effects of trauma on the brain are compelling and require that we take a new look at the mental health needs of children who experience a wide range of traumas. It also needs to be recognized that supports for children and supports for parents are different, and both are critical.
- ◆ The “science to services” cycle needs attention. The current mental health workforce is, in general, unprepared to provide trauma-sensitive services or supports, and too few clinicians are trained in trauma treatment techniques.

Evidence of the progress made since *Dare to Vision* is being collected in *The Damaging Consequences of Violence and Trauma: A Two-Part Report on a Key Public Health Issue*, now in development by NTAC/NASMHPD. The first part of the document, “Facts and Recommendations for Behavioral Health Systems,” makes a compelling case that trauma and violence underlie many of our most difficult behavioral health and human service issues, while offering strategic recommendations to policymakers based on the evidence. The second part, entitled “Trauma Services Implementation Toolkit for State Mental Health Agencies,” is a list of resources available from states that have already made progress on developing trauma-informed systems.

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## What We Learned from 9/11/01

The events of September 11, 2001, and the following months are said to have “changed our world forever.” Certainly these events have put the issue of violence and trauma into the forefront of public consciousness. This shift in public awareness has provided an opportunity to create a new understanding about the relationship between violence and severe behavioral health problems and to emphasize the need for adequate services and supports. However, there is also a danger that the dramatic impact of terrorism and random acts of social violence may overshadow the endemic issues of interpersonal and family violence—childhood physical and sexual abuse, rape, and domestic violence—that affect so many lives on a daily basis.

A careful examination of what happened after the events of 9/11 yields relevant lessons and helpful guidance to mental health systems<sup>4</sup>. It has become very clear that isolation can exacerbate the effects of trauma; that both severity of the experience and repetition affect the impact of trauma; and that trusted friends and acquaintances are an important factor in recovery. It is also true that some people, for reasons we don’t fully understand, appear to be quite “resilient,” coming through even very traumatic experiences without severe consequences. Although many of these perspectives are not new, the events of 9/11 have made it clear exactly how important it is for public mental health systems to address these issues.

### **1. Trauma and violence are public health issues.**

The impact of violence is *never* restricted to individuals; it *always* affects groups and communities. Concepts of risk, resilience, and prevention are important and should be the platform on which interventions are built. The cumulative impact of traumatic events and experiences needs to be acknowledged and measured, rather than having each event or manifestation treated separately. Consequences for physical and mental health should always be considered simultaneously.

### **2. Disasters and other forms of social violence have a particularly damaging impact on people with trauma histories.**

People with previous unaddressed or unresolved trauma histories are the most likely to develop severe symptoms of PTSD after a disaster, and often have a delayed response to events. Acute symptoms (e.g., self-injury) may be exacerbated, and for some, an ongoing recovery process may be interrupted. For example, after 9/11 many women who were in the process of leaving abusive situations chose instead to remain. Most communities are completely unprepared to handle people with very severe trauma reactions, particularly if the response is delayed until after the disaster response teams have gone home. As a result, many people with trauma histories—even those who have not been previously

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<sup>4</sup> This section is drawn from a presentation by Andrea Blanch, Ph.D., summarizing major points from a series of conference calls and e-mail discussions involving more than two dozen trauma experts directly or indirectly involved in post-9/11 response.

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diagnosed and those for whom hospitalization is not the best solution—may end up being admitted to psychiatric hospitals.

**3. Peer support is the *most natural and the most effective response to trauma.***

After 9/11, people instinctively gathered into groups and networks to help each other cope, particularly women who focused immediately on the needs of their children. The community response was unequivocal public support—an outpouring of emotion for the ways in which human beings care for each other in times of crisis. This reaction was in contrast to the skepticism with which peer support has sometimes been viewed in professional behavioral health systems, where self-help may be seen as an intervention to be used only as an adjunct to professional care. It needs to be widely recognized that individuals who have experienced trauma in their lives, and who have learned the skills necessary to manage their lives and their emotions, can be tremendous resources to others who are experiencing the consequences of trauma.

**4. Effective responses to trauma occur in natural community associations.**

Multiple community groups, agencies, neighborhood organizations, and ad hoc groups were involved in the response to 9/11, and it was this upsurge of community involvement that seemed to make the difference. Community response is particularly helpful because 1) people are comfortable with familiar organizations, 2) they feel less stigmatized in asking for help in their natural environment, and 3) they are more able to give as well as to receive, a critical factor in recovery. In addition, unlike many professional helping services, communities naturally consider and treat families as a unit, since that is how they know each other.

**5. Spirituality and faith-based approaches are critical.**

For many people, religious organizations, churches, and spiritual groups are primary social support systems. For some racial and ethnic groups, religious leaders are the first line of response. In addition, when dealing with trauma, questions about the meaning of life, good and evil, loss of faith, and forgiveness are often central concerns. Building effective bridges between behavioral health and spiritual communities and being prepared to support discussion of spiritual issues are both essential to effective trauma response.

**6. Linguistic access and cultural competence are *primary, not secondary* concerns.**

Effective trauma response must be *immediate* and it must be *relevant* to people's lives and experience. Linguistic and cultural competence is therefore essential. In addition, cultural and religious norms affect people's response to violence. Immigrants and refugees fleeing oppression or violence are particularly at risk for serious reactions to social violence, and are most likely to encounter linguistic and cultural barriers.

**7. Linkage between disaster response and mental health trauma treatment is key.**

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The fields of disaster response and behavioral health have different origins, use different languages and conceptual models, and have developed along different trajectories. Often the fields are quite removed from each other. Disaster response teams are often unprepared to deal with interpersonal violence and are usually geared toward relatively short-term interventions. On the other hand, mental health personnel may find it difficult to mobilize quickly. Trauma response would benefit greatly from ongoing structural connections between the fields, cross-training, clarification of roles, and mutual decisions about the most effective use of resources.

**8. A model of transformation or transcendence may be more appropriate than a model of recovery.**

People who experience severe trauma do not ever “recover” from it fully, at least in the sense of going back to the pre-trauma state. People and lives are changed unalterably by their experiences, particularly if the trauma is prolonged or repeated. However, people are sometimes able to transcend their experience and become deeper and stronger than they were before the trauma. Factors that appear critical to this process include finding safety and support; developing empowering relationships and valued social roles; developing the skills necessary to manage physical, psychological, and spiritual needs and to maintain wellness; and ultimately, reconceptualizing the trauma experience and using it as a source of energy for personal and interpersonal social growth and activism.

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## Essential Elements in Trauma-Informed Systems

Substantial progress has been made over the past few years in developing and testing model approaches to trauma treatment—what the field has begun to refer to as “trauma-specific services.” A few states and localities have also attempted to develop “trauma-informed systems”—i.e., to integrate an understanding about trauma throughout their systems of care.

This systemic approach is critical for several reasons. First, it ensures that all people who come into contact with the mental health system will receive services that are sensitive to the impact of trauma, regardless of which “door” they enter or whether they ever find their way to a trauma-specific treatment program. Second, structural change endures; it is less likely that changing political, social, or economic forces will reverse the new direction if it has been embedded throughout the system. Finally, trauma-informed systems recognize the primacy of trauma as an overarching principle, and will communicate this fact to other individuals and organizations. Attention to the behavioral health consequences of trauma and violence will therefore naturally diffuse to other human service systems.

The following list outlines 15 essential elements in a trauma-informed system. This list is not exclusive or exhaustive. However, it provides a basic “checklist” for determining the extent that sensitivity to trauma has been embedded throughout a mental health system.

- 1. State trauma policy or position paper.** A written statewide policy or position statement should be adopted and endorsed. This document should include a definition of trauma, make a clear statement about the relationship between trauma and recovery, and publicly declare trauma to be a priority issue. Ideally, the position statement should commit the state to meeting the essential elements of a trauma-informed system. The *NASMHPD Position Statement on Services and Supports to Trauma Survivors* serves as a model of such a position paper.
- 2. Trauma screening and assessment.** All people who enter the system of care, regardless of which “door” they enter, should receive a trauma assessment and screening at admission. This assessment should be an integral part of the clinical picture, to be revisited periodically and to be used as a part of all treatment, rehabilitation, and discharge planning. Trauma assessments should include questions about previous experiences with seclusion and restraint and other traumatizing practices as well as questions about interpersonal and social violence.
- 3. Clinical practice guidelines and treatment approaches.** There is emerging evidence that trauma treatment is effective. As part of SAMHSA’s *Women, Co-Occurring Disorders, and Violence* study, several clinical approaches have been manualized and guidelines have been developed. Clinical approaches to trauma treatment should clearly identify trauma as the issue being treated, promote

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recovery, allow for survivors to tell their stories, include trauma-sensitive training and supervision, and be experienced as empowering by consumer/survivors.

- 4. Specialized trauma programs with integrated mental health and substance abuse services.** Programs designed specifically for trauma survivors should be available in adequate numbers to serve the population. Although program models may vary widely, all should be recovery-oriented, emphasize voice and choice, and be fully trauma-informed. In addition, because of the numbers of trauma survivors with co-occurring disorders, trauma treatment programs should provide integrated mental health and substance abuse services.
- 5. Procedures to avoid retraumatization.** A statewide effort should be made to reduce or eliminate any potentially retraumatizing practices such as seclusion and restraint, involuntary medication, etc. Specific policies should be in place to acknowledge and minimize the potential for retraumatization, assess relevant history, respect gender differences, and provide immediate intervention to mitigate effects should violence occur in care settings.
- 6. Staff trauma awareness, training, competencies, and job standards.** All human resource development activities should reflect sensitivity to issues of violence, trauma and coercion; incorporate relevant skill sets and job standards; and address risk management and liability issues from the perspective of a trauma model. Particular care should be taken in the selection of violence prevention training models and vendors.
- 7. Linkages with higher education.** Formal, ongoing efforts should be made to collaborate with institutions of higher education to revise curricula, include consumer/survivors as trainers, and incorporate trauma and violence as a core part of the training of all future behavioral health care workers in all disciplines.
- 8. Regulations addressing trauma.** Licensing, regulations, certification, and contracting mechanisms should all reflect a consistent focus on trauma.
- 9. Research, needs assessment, quality improvement data regarding trauma.** Data on incidence and prevalence, person-centered outcomes, and satisfaction with trauma services should be regularly collected and should be used as part of ongoing quality improvement and planning processes.
- 10. Financing mechanisms.** Funding strategies for trauma-specific services should be clearly identified, and existing exclusions and barriers to reimbursement eliminated. Although new funds are not necessarily critical to developing a trauma-informed system, attention to reimbursement and funding issues is key to a successful change strategy.
- 11. Consumer/survivor/recovering person involvement and rights.** The voice and participation of consumer/survivors should be at the core of all systems activities,

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from policy to financing. Special attention should also be paid to the rights of people with trauma histories and to the ways in which these rights may be systematically violated.

- 12. Trauma policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, and physical disability.** A commitment to all forms of diversity should be the bedrock on which trauma-informed systems of care are built.
- 13. Systems integration, including life-span perspective.** Because trauma may result in multiple vulnerabilities and affect many aspects of a survivor's life, coordination across systems is essential. Integration of mental health and substance abuse is absolutely critical. Systems integration should also include the health care system, criminal justice, and social services.
- 14. Trauma-informed disaster and terrorism response.** Mental health and disaster response workers should work as a coordinated team in designated emergency support and in ongoing interventions in the aftermath of disasters. A clear communication plan should exist, and all workers should be knowledgeable about mental health trauma issues from the initial assessment through the intervention process.
- 15. Trauma function and focus in state mental health department.** A single, high-level, clearly identified point of responsibility for trauma-related activities should exist within the state administrative structure. This could be a task force, a unit or office within the department, or ongoing, high-visibility leadership on the part of the agency director.

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## **Next Steps: Issues and Recommendations for NASMHPD**

Taking the next steps in developing trauma-informed systems of care will require strong political leadership and commitment to systems change at all levels. Despite their notoriously short average tenure, state mental health agency (SMHA) commissioners are key to influencing their own systems, their sister state agencies, and the private sector. NASMHPD has a significant national role to play with such organizations as the *Joint Commission on the Accreditation of Healthcare Organizations* (JCAHO) and the *National Association of Psychiatric Health Systems* (NAPHS).

Much of the resistance to developing and implementing a trauma approach results from denial and/or fear of confronting violence. In other cases, it is the path of least resistance. It is simply easier to exclude (from the research) people who self-injure than it is to include them. It is easier to medicate people who are in great pain than it is to stay with them as they work through it. It is easier to move whole programs and staff unchanged from the institution to the community than it is to change the nature of the interaction between staff and clients. Champions are needed at all levels of the organization to make trauma and violence an explicit focus and to do the very difficult work of supporting real organizational change.

NASMHPD has already played a major leadership role in acknowledging this issue and making it a priority. The following six recommendations are offered as concrete next steps that could be taken to continue to make progress in this area.

### **Recommendation #1: Develop and Support Political Leadership**

- ◆ Invite the National Association of State/Alcohol Drug Abuse Directors (NASADAD) to co-sponsor a policy statement on trauma and violence, and to work as partners in systems change efforts whenever possible.
- ◆ Adopt a resolution encouraging states to implement the essential elements of a trauma-informed system, and assist by convening state and regional summits to share information and expertise. NTAC should provide a “trauma script” to support emerging leadership as change agents.
- ◆ Work to influence other national organizations, including the National Governors Association (NGA), the Federal Emergency Management Agency (FEMA), JCAHO, NAPHS, etc.

### **Recommendation #2: Continue Focus on Seclusion and Restraint**

- ◆ Issue a statement encouraging states to completely eliminate the use of seclusion and restraint and all other forms of coercion, and ensure that an examination of

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trauma and violence is a key part of all efforts to reduce the use of coercive measures.

- ◆ Spearhead an effort to examine and respond to the use of restraint and seclusion in all child-serving agencies, including schools.

### **Recommendation #3: Play an Active Role in Information Dissemination**

- ◆ Develop and support a clearinghouse of trauma information, which would include 1) ongoing revisions and regular updates to NTAC's forthcoming publication, *The Damaging Consequences of Violence and Trauma: A Two-Part Report on a Key Public Health Issue*, and 2) a Web page on trauma as part of the NASMHPD Web site at [www.nasmhpd.org](http://www.nasmhpd.org)
- ◆ Support the development of additional targeted educational materials, including 1) a toolkit of resources developed by consumer/survivors, 2) information designed for families, 3) information about the role of spirituality in trauma recovery, and 4) information for communities about normal responses to trauma and about how to respond in a trauma-sensitive manner in times of disaster.
- ◆ Prevention and public education efforts should be re-invigorated with an emphasis on helping people to understand that what appear to be bizarre symptoms may be legitimate efforts to cope with overwhelming trauma.

### **Recommendation #4: Build Research and Data Capacity**

- ◆ Conduct a survey of the states to determine what states have done to date, the barriers that they have encountered, and which supports they need to move forward in implementing the essential elements. This information should be used to expand the Toolkit section within NTAC's *The Damaging Consequences of Violence and Trauma: A Two-Part Report on a Key Public Health Issue* and also to guide technical assistance activities.
- ◆ Develop performance indicators on trauma, and coordinate with disaster response groups to share data and encourage cooperation in the field.

### **Recommendation #5: Work to Establish and Promulgate Legal Standards of Care**

- ◆ Work to establish new legal standards of care for assessment and treatment of trauma survivors, both in hospitals and communities, building on legal precedents established to date.
- ◆ Work to establish new legal standards of care for people who self-injure—making it clear that self-injury is not an adequate or compelling reason to use seclusion and restraint—to admit someone involuntarily, or to discharge someone against their wishes.

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- ◆ Develop a strategy for working with judges and mental health courts to educate them about trauma and to reduce the use of all forms of coercion.

**Recommendation #6: Emphasize Workforce and Training Issues**

- ◆ In cooperation with CMHS, articulate a new skill set for mental health staff based on the lessons learned from 9/11, and implement human resource development strategies, including partnerships with higher education, in support of this new vision.
- ◆ Focus new initiatives on capacity building for natural communities and families.
- ◆ Provide technical assistance to states in supporting staff in dealing with their own trauma experience, as a way of managing systems change.
- ◆ Develop mechanisms to help states involve non-mental health professionals in their trauma work, including professionals in conflict management and disaster management.

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## Appendix A

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**National Technical Assistance Center  
for State Mental Health Planning**

**National Experts Meeting on Trauma and Violence  
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August 5-6, 2002  
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