ACCEPT
Addiction & **C**o-morbid **C**onditions: **E**nhancing **P**revention & **T**herapeutics

Agenda

Zoom link to join from PC, Mac, iOS or Android: https://echo.zoom.us/j/156261634

Joining by phone ONLY: +1 646 558 8656 or +1 669 900 6833 (US Toll)
Zoom Meeting ID: 156 261 634

For attendance, purposes please text the following code: NOXFOQ to 608-260-7097

Session Date: Friday January 17, 2020

Didactic Topic and Presenter:
Trauma Informed Patient Care
Lindsey Peterson, MS, CRC - UW Project ECHO ACCEPT Rehabilitation Counselor

Content Experts:
Ritu Bhatnagar, MD and Susan Mindock, CSAC; and Sheila Weix, MSN, RN, CARN

- 12:30 PM: Attendance text-in – Introductions

- 12:45 PM: History of ECHO and the Future

- 1:10 PM: Didactic Presentation
    - Presenter: Lindsey Peterson, MS, CRC

- 1:30 PM End of Session

ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2018-2020

Trauma Informed Patient Care
Friday January 17, 2020
Lindsey Peterson, MS, CRC - UW Project ECHO ACCEPT Rehabilitation Counselor

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:
1. Review appropriate opioid prescribing and monitoring practices.
2. Participate in office-based management of substance use disorders.
3. Seek, with greater frequency, overdose prevention education.
4. Identify the role of medication-assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of substance use disorders.

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It is the policy of the University of Wisconsin-Madison ICEP that the faculty, authors, planners, and other persons who may influence content of this CE activity disclose all relevant financial relationships with commercial interests* in order to allow CE staff to identify and resolve any potential conflicts of interest. Faculty must also disclose any planned discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). For this educational activity, all conflicts of interest have been resolved and detailed disclosures are listed below.

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Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	N/A
Randy Brown, RSS Chair	No relevant financial relationships to disclose	Yes
Paul Hutson, Content Expert, Pharmacy	Consultant for Projections Research Inc.	Yes
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	N/A
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse	No relevant financial relationships to disclose	No
Lindsey Peterson, MS, CRC, Content Expert	No relevant financial relationships to disclose	No
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

CONTINUING EUDCATION INFORMATION:

Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by the University of Wisconsin–Madison ICEP and the Wisconsin Department of Health Services, Division of Care and Treatment

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...nade possible by 435200-G-18-11448-285932-880 from Wisconsin Department of Health Services. The views expressed in written ...cations and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government or the State of Wisconsin.

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Credit Designation Statements
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The University of Wisconsin-Madison ICEP designates this live activity for a maximum of 1 hour of knowledge-based CE credit. Credit can be earned by successfully completing this live activity. Pharmacists and Pharmacy Technicians should claim only the credit commensurate with the extent of their participation in the activity. CE credit information, based on verification of live attendance, will be provided to NABP within 60 days after the activity completion.

Pharmacists and Pharmacy Technicians must enter their NABP number in their profile in order to receive credit.

2020 Universal Activity Number (UAN)
JA0000358-9999-20-005-L04-P

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Detailed disclosures will be available prior to the start of the activity.

History of UW ECHO and Future Directions

Randall Brown MD, PhD, DFASAM

Associate Professor, UW SMPH Dept. of Family Medicine & Community Health

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Project ECHO Overview

▶ University New Mexico
- Launched in 2003
- Initiative to expand Hepatitis C care for patients and provider education via case-based learning and mentorship.

The NEW ENGLAND JOURNAL of MEDICINE

Principles of the

A Amplification - Use **Technology** to leverage scarce resources

B Share **Best practices** to reduce disparity.

When all the principles are applied, a
All Teach and A
comes toge

ORIGINAL ARTICLE

Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers

Sanjeev Arora, M.D., Karla Thornton, M.D., Glen Murata, M.D.,
Paulina Deming, Pharm.D., Summers Kalishman, Ph.D., Denise Dion, Ph.D.,
Brooke Parish, M.D., Thomas Burke, B.S., Wesley Pak, M.B.A.,
Jeffrey Dunkelberg, M.D., Martin Kistin, M.D., John Brown, M.A.,
Steven Jenkusky, M.D., Miriam Komaromy, M.D., and Clifford Qualls, Ph.D.

ABSTRACT

BACKGROUND

The Extension for Community Healthcare Outcomes (ECHO) model was developed to improve access to care for underserved populations with complex health problems such as hepatitis C virus (HCV) infection. With the use of video-conferencing technology, the ECHO program trains primary care providers to treat complex diseases.

Project ECHO®
University of Wisconsin

Project ECHO in Wisconsin

WI Opioid Project ECHO

▸ **Launched:** May 2018

▸ **Goal**: connect clinical experts with primary care providers, and medication assisted treatment prescribers across Wisconsin in an effort to reduce opioid-related complications.

▸ **Funding:** WI Dept. Health Services Grant
  ◦ SAMHSA Opioid State Target Response
  ◦ HOPE Agenda

Project ECHO ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

▸ **Launched:** May 2019

▸ **Goal:** Provide facilitated training, through case-based learning, and mentoring support for providers regarding substance-related issues.

▸ Funding: WI Dept. Health Services Grant
  ◦ Similar to WI Opioid ECHO funding
  ◦ Expansion to be inclusive of all substances

Project ECHO ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

▸ **Project Goals and Objectives:**

1. Increase provider engagement in the management of patients with Substance Use Disorders (SUDs)and related co-morbidities through outreach to primary care settings to improve knowledge of Substance-related issues
   1. ECHO
   2. Addiction Consultation Provider Hotline
   3. Educational outreach

2. Enhance provider satisfaction in caring for patients with Substance Use Disorders.

3. Improve substance use outcomes and reduce substance use impact for WI residents, families, and communities

Project Data

Attendance
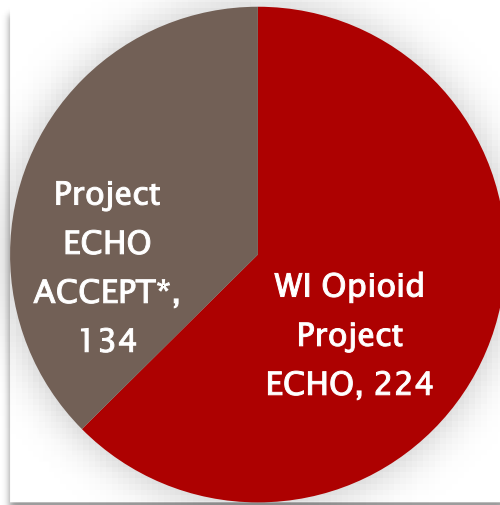
- WI Opioid Project ECHO: 11 Sessions (5/2018–4/2019)

- Project ECHO ACCEPT: 7 sessions as of November 2019.

Reocurring Attendees

* ECHO ACCEPT Data is through November 2019

Attendance per Session

Figure 3: Participant Credentials per Series Year
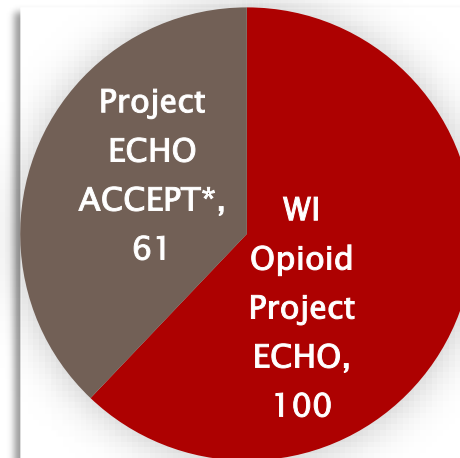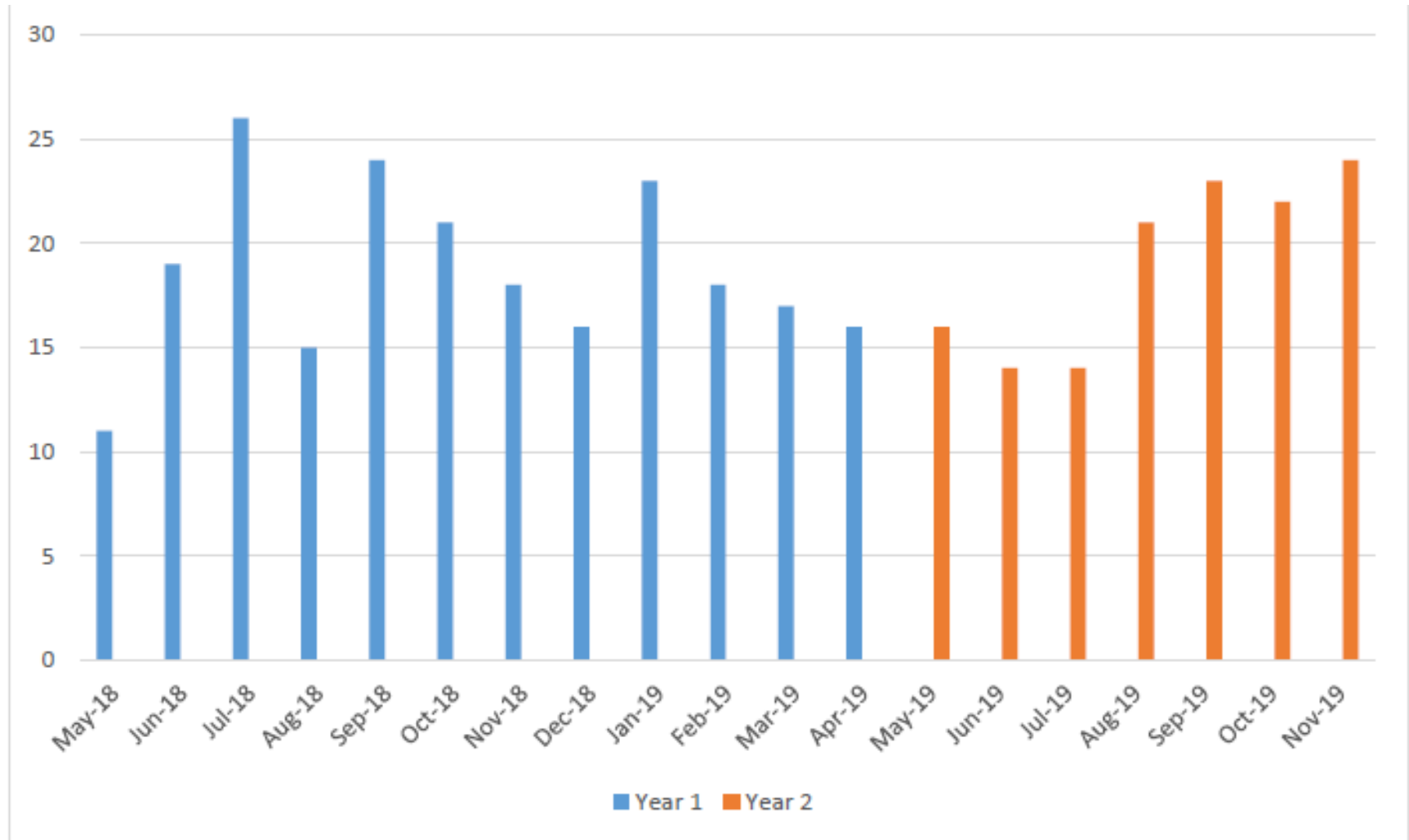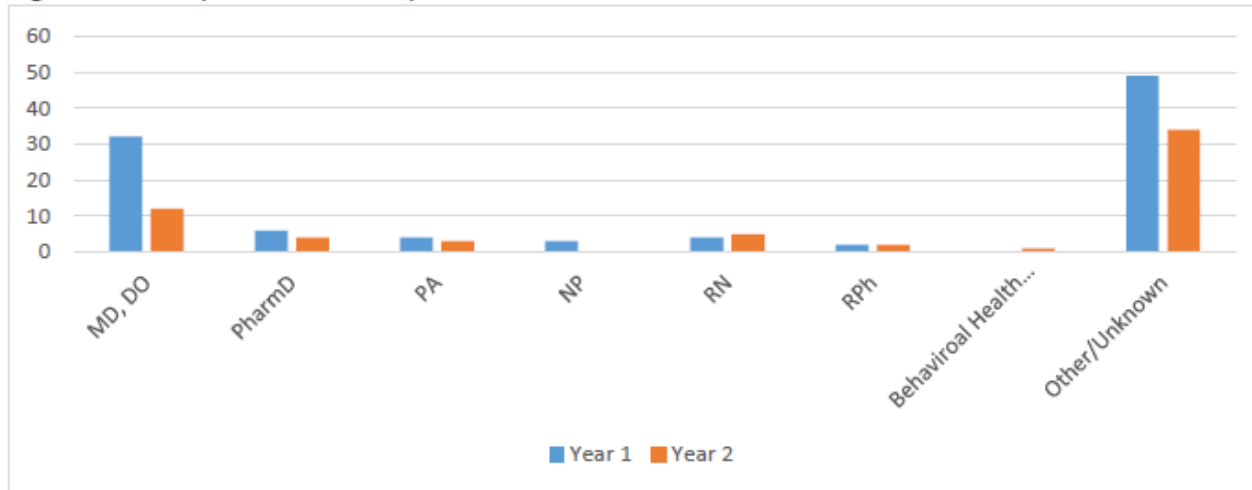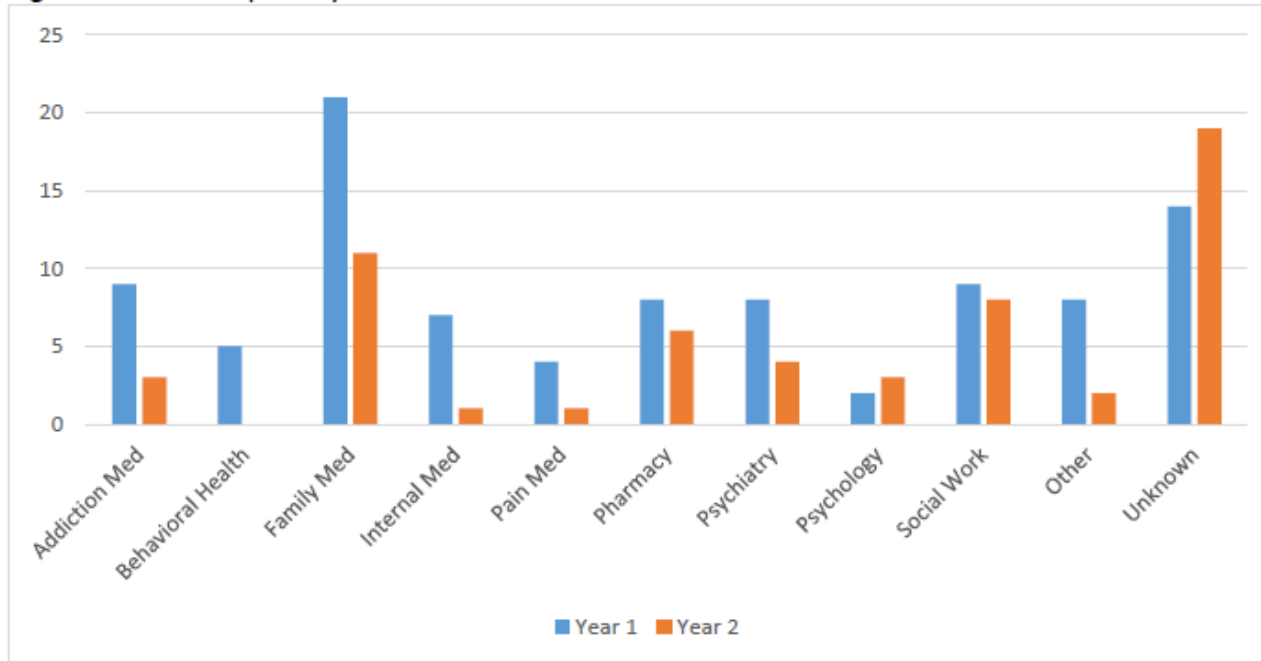

Figure 4: Provider Specialty

Attendance by Organization/Health System

Most Frequent:

- Access Community Health
- Ascension
- Center for Urban Pop. Health-Milwaukee
- WI DHS
- Hospital Sisters Health System (HSHS)
- Lakeland Care Inc.
- Marshfield
- Metastar
- Mile Bluff Medical Center
- My Choice Family Care
- Prevea
- SSM Health
- UnityPoint Health – Meriter
- UW/UW SMPH
- UW Health
- Village Pharmacy
- Wheaton Franscian Healthcare
- VA

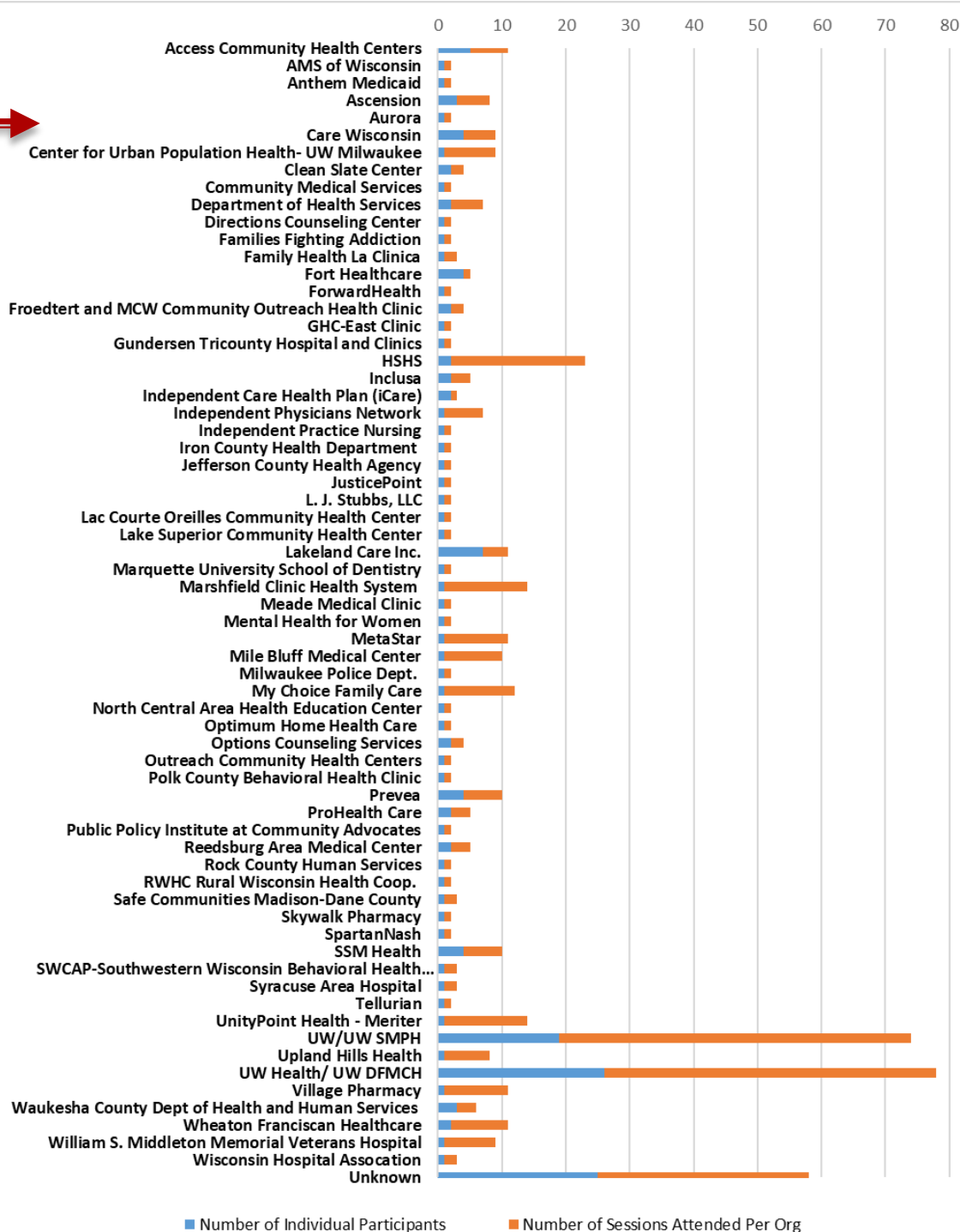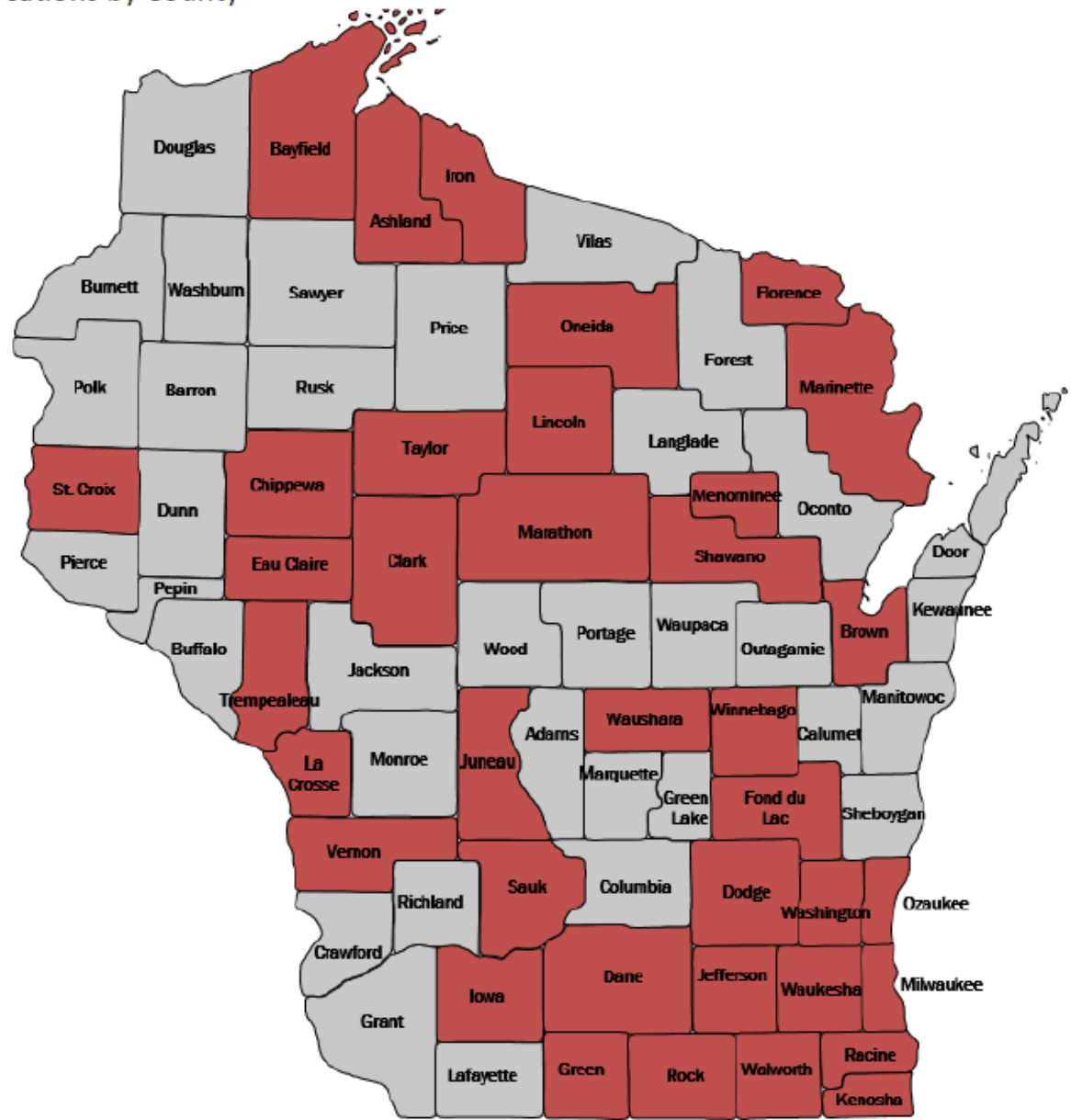Bar chart: Attendance by Organization/Health System. Legend: ■ Number of Individual Participants ■ Number of Sessions Attended Per Org

Organizations listed: Access Community Health Centers, AMS of Wisconsin, Anthem Medicaid, Ascension, Aurora, Care Wisconsin, Center for Urban Population Health- UW Milwaukee, Clean Slate Center, Community Medical Services, Department of Health Services, Directions Counseling Center, Families Fighting Addiction, Family Health La Clinica, Fort Healthcare, ForwardHealth, Froedtert and MCW Community Outreach Health Clinic, GHC-East Clinic, Gundersen Tricounty Hospital and Clinics, HSHS, Inclusa, Independent Care Health Plan (iCare), Independent Physicians Network, Independent Practice Nursing, Iron County Health Department, Jefferson County Health Agency, JusticePoint, L. J. Stubbs, LLC, Lac Courte Oreilles Community Health Center, Lake Superior Community Health Center, Lakeland Care Inc., Marquette University School of Dentistry, Marshfield Clinic Health System, Meade Medical Clinic, Mental Health for Women, MetaStar, Mile Bluff Medical Center, Milwaukee Police Dept., My Choice Family Care, North Central Area Health Education Center, Optimum Home Health Care, Options Counseling Services, Outreach Community Health Centers, Polk County Behavioral Health Clinic, Prevea, ProHealth Care, Public Policy Institute at Community Advocates, Reedsburg Area Medical Center, Rock County Human Services, RWHC Rural Wisconsin Health Coop., Safe Communities Madison-Dane County, Skywalk Pharmacy, SpartanNash, SSM Health, SWCAP-Southwestern Wisconsin Behavioral Health..., Syracuse Area Hospital, Tellurian, UnityPoint Health - Meriter, UW/UW SMPH, Upland Hills Health, UW Health/ UW DFMCH, Village Pharmacy, Waukesha County Dept of Health and Human Services, Wheaton Franciscan Healthcare, William S. Middleton Memorial Veterans Hospital, Wisconsin Hospital Assocation, Unknown

Figure 6: Participant Locations by County

Provider Locations

Out-of-State:
- Indiana
- Nebraska
- Illinois

Last Revised: 12/18/2019

Past Topics

Date	Topic	Presenter
Friday, May 18, 2018	Quantity Guidelines in Prescribing Opioids	Paul Hutson, PharmD, BCOP
Friday, June 15, 2018	Alcohol Misuse in the Setting of Daily Prescription Opioid Use or MAT	Chris Nicholas, PhD
Friday, July 20, 2018	Interpretation of Urine Drug Testing	David Galbis-Reig, MD
Friday, August 17, 2018	Counseling Strategies in Primary Care	Lindsey Peterson, MS, CRC
Friday, September 21, 2018	Clinic Flow for Office Based Opioid Treatment	Elise Wessol, DO
Friday, October 19, 2018	Transition of Methadone to Buprenorphine	Ritu Bhatnagar, MD
Friday, November 16, 2018	Pain Management in the Setting of MAT	Ritu Bhatnagar, MD
Friday, December 21, 2018	Management of Opioid Use Disorders in Pregnancy	Sreevalli Atluru, MD
Friday, January 18, 2019	Anxiety and Depression and OUD	Dean Krahn, MD
Friday, February 15, 2019	Cannabis Use and Chronic Pain	Peggy Kim, MD
Friday, March 15, 2019	Buprenorphine and Managing Diversion Risk	Elise Wessol, DO
Friday, April 19, 2019	Buprenorphine and home induction	Randy Brown, MD, PhD
Friday, May 17, 2019 (new series year)	Addictions and Substance Use Disorders: Definitions and Concepts	Dean Krahn, MD
Friday, June 21, 2019	Interview Advice and tips regarding Co-Morbidity Pt. 1	Dean Krahn, MD
Friday, July 19, 2019	Alcohol Withdrawal	Randy Brown, MD, PhD
Friday, August 16, 2019	An Overview of Fetal Alcohol Spectrum Disorders in the Adult Population	Lindsey Peterson, MS, CRC
Friday, September 20, 2019	Alcohol Use Disorder and Liver Transplant: The role of Behavioral Health Therapist	Susan Mindock, LPC, CSAC
Friday, October 18, 2019	Interview Advice and tips regarding Co-Morbidity Pt. 2	Dean Krahn, MD
Friday, November 15, 2019	Trauma in Women with Substane Use Disorder	Lindsey Peterson, MS, CRC
Friday, December 20, 2019	Substance Use Issues in Older Adults	Randy Brown, MD, PhD
Friday, January 17, 2020	Trauma-Informed Care Treatment	Lindsey Peterson, MS, CRC
Friday, February 21, 2020*	Opioid withdrawal & intoxication	TBD
Friday, March 20, 2020*	Opioid agonist Tx (OBOT)	TBD
Friday, April 17, 2020	Youth perceptions of opioid safety, knowledge gaps, and preferences for education in high schools	Olufunmilola Abraham, PhD, MS, BPharm
Friday, May 15, 2020*	Opioid antagonist Tx	TBD
Friday, June 19 ,2020*	Opioid Treatment Programs (OTPs)	TBD

Most Views of Recorded Sessions

1. 1,057 views - "From Methadone to Buprenorphine" - Ritu Bhatnagar, MD

2. 141 views - "Opioid Antagonist Therapy for OUD" - Randy Brown, MD

3. 132 views - "Office-based Opioid Agonist Treatment - Elise Wessol, DO

Future Topics

- Emerging Treatments for OUD
- Mindful Awareness in Body-Orientated Therapy
- Culturally Specific Treatment Needs of minority populations
- Alternative to Jail: Evidence Behind Drug Courts
- Motivational Interview: Adolescents and Marijuana
- Psychotherapy in MAT
- Rural Perspectives of SUD treatment and Prevention
- Supporting Providers through Patient Overdose
- 211 Helpline Program Overview
- Wisconsin Voices for Recovery Program Overview
- Management of Care for Undocumented Populations
- E-Cig/Vaping – pharmacotherapy to assist w/ quitting
- Ethics of stopping agonist care
- Future of Telehealth and SUD
- TX of Methamphetamine Addiction
- Use of CAM for Addictive Disorders
- Ongoing support and education for CHCS around MAT
- Best Continuums of Care
- Lucemyra
- Stimulant use in opioid users

- Facilitating MAT in ER and "hand-offs"
- Long acting Buprenorphine Formulations
- Effective empathy, ethics of treating pts w/ SUD differently than those w/o
- How to handle the "difficult" patient (not following treatment plan)?
- How to ensure insurances will pay for treatment
- Corrections and Criminal Justice Involvement in SUDS

Discussion

Trauma-Informed Patient Care Treatment

Lindsey Peterson, MS, CRC

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Overview

- What is Trauma-Informed Care (TIC)?
- Why is TIC important?
- What are some key principles and themes of TIC?
- What are some strategies to implement TIC with clients? Within an organization or system as a whole?
- Moving from trauma-informed to trauma-responsive

What is Trauma-Informed Care?

- Commitment to building competence among staff and establishing clinical standards and guidelines that support delivery of trauma-sensitive services (SAMHSA TIP 57, 2014)

- Grounded in: person-centered approach, recovery-oriented practices, and empowerment strategies (Kelly et al., 2014)

- Accommodates vulnerabilities of trauma survivors, avoids inadvertent retraumatization, and facilitates consumer participation in treatment and healing (Jennings, 2004)

What is Trauma-Informed Care?

- Reflects the centrality of the relationship of traumatic experiences to mental health symptoms and substance use disorders (Kelly et al., 2014)

- Does not need to be focused on treating symptoms of trauma

  ◦ Whether mission is to deliver primary care, mental health, addiction, or housing services, the goal is to provide services that are welcoming and appropriate to the needs of those affected by trauma (Harris & Fallot, 2001)

Why is TIC Important?

- Those who have experienced trauma are at risk of being retraumatized in every social service and health care setting

- People affected by trauma from abusive relationships will frequently encounter services that mirror the power and control they experienced in those relationships (The Trauma Toolkit, 2013)

- Traditional service delivery models of care can trigger survivors and exacerbate their symptoms (Kelly et al., 2014)

What are Common Themes of TIC?

- **Trauma awareness**: providers need to understand trauma and how mental or physical symptoms and behaviors can be adaptations to traumatic experiences
- **Emphasis on safety**: many survivors feel unsafe and have experienced boundary violations and abuses of power
  - TIC should support clients to build physical and emotional safety
  - Both provider and client should be aware of potential triggers
  - Roles and boundaries should be established through collaborative decision-making (Hopper, Bassuk, & Olivet, 2010; Jennings, 2004)

What are Common Themes of TIC?

- **Opportunity to rebuild control**: loss of control in previous traumatic experiences often affects responses to subsequent trauma
  - Being encouraged to make choices and experience a predictable environment helps clients rebuild a sense of self-efficacy and personal control
- **Strengths-based approach**: consistent with recovery-oriented models; helps patients identify their strengths and build upon them (Hopper, Bassuk, & Olivet, 2010; Jennings, 2004)

Seven Core TIC Principles

- Acknowledgement (*recognizing that trauma is pervasive*)
- Safety
- Trust
- Choice and control
- Compassion
- Collaboration
- Strengths-based (The Trauma Toolkit, 2013)

Seven Core TIC Principles

▶ When systems and organizations are committed to integrating these principles at every level, they should consider:
  ◦ Power and control (*Whose needs are being served? Do policies empower those being served or those providing the services?*)
  ◦ Doing with and not doing to
  ◦ Explaining what, why and how
  ◦ Offering real choices
  ◦ Flexibility
  ◦ Understanding and identifying fight, flight, freeze and fawn responses
  ◦ Focusing on strengths, not deficits
  ◦ Examining power issues within the organization and promoting democratic principles (Poole, 2013)

Key Elements in a Trauma-Informed Approach

- Three key elements:
  - Realizing the prevalence of trauma
  - Recognizing how trauma affects all individuals in the organization, including its own workforce
  - Responding by putting this knowledge into practice (SAMHSA, 2012)
- Begins with the first contact a person has with an agency
- Requires <u>all</u> staff members (*receptionists, providers, board members*) to recognize a traumatic experience can influence a client's:
  - Engagement with services
  - Interactions with staff and other clients
  - Responsiveness to program guidelines and practices
- Builds a supportive environment by redesigning organizational practices (*with consumer participation*) to prevent retraumatization
  (Harris & Fallot, 2001; Hopper et al., 2010)

Key Elements in a Trauma–Informed Approach

- Trauma-informed organizations prioritize teaching skills:
  - Self-soothing
  - Self-trust
  - Self-compassion
  - Self-regulation
  - Limit setting
  - Communicating needs and desires
  - Accurate perception of others

- Creating a climate of hope and resilience:
  - Acknowledge the client's abilities to survive and even grow from adversity
  - Acknowledge the strength it takes to get to where the client currently is
  - Communicate that the client is more than what has happened to them
  - Let the client decide what their path to healing consists of (The Trauma Toolkit, 2013)

Seven Commitments for Trauma-Informed Organizations

1. **Non-violence**: building safety skills and commitment to a purpose
2. **Emotional intelligence**: teaching emotional management skills
3. **Social learning**: building cognitive skills
4. **Open communication**: overcoming barriers to healthy communication, conflict management, and appropriate boundaries
5. **Social responsibility**: building social connection skills, establishing healthy attachments
6. **Democracy**: creating civic skills of fairness and compassion
7. **Growth and change**: working through loss and preparing for the future (Sandra Bloom, The Sanctuary Model)

How Do I Build a Trauma-Informed Organization?

- Meet the client's needs in a safe, collaborative, and compassionate manner
- Prevent treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services
- Build on the strengths and resilience of clients in the context of their environments and communities
- Endorse trauma-informed principles through support, consultation, and supervision of staff (SAMHSA TIP 57, 2014)

How Do I Build a Trauma-Informed Organization?

▸ Workplaces and organizations have a responsibility to create a psychologically safe workplace

▸ This includes an environment that promotes trauma-informed principles not just for those receiving services, but also for those providing services (Bloom, 2003)

Accept stressors as real and legitimate, impacting organization as a whole	Work in a team-based structure	Create a culture to counteract the effects of trauma	Establish a clear value system within your organization
Be clear about job tasks and personnel guidelines	Obtain supervisory and management support	Maximize collegiality	Encourage a democratic process in decision making and conflict resolution
Emphasize a levelled hierarchy	View issues as affecting the whole group, not just an individual	Use the approach of seeking solutions, not assigning blame	Address the avoidance of health boundaries
Communicate openly and ensure transparency	Expect a high degree of cohesion	Expect considerable flexibility of roles	Eliminate any subculture of violence or abuse

Organizational Checklist from The Trauma Toolkit

Does your organization…

- ❑ Have a position statement that includes a commitment to trauma-informed practices?
- ❑ Allow staff time or money to focus on implementing trauma-informed services?
- ❑ Encourage clients to provide suggestions, feedback, and ideas?
- ❑ Emphasize transparency in communication practices?
- ❑ Provide training opportunities on vicarious or secondary trauma?

- ❑ Implement policies to minimize the risk of retraumatization?
- ❑ Provide strengths-based supervision?
- ❑ Encourage the discussion of ethical concerns?
- ❑ Provide opportunities for peer support and consultation?
- ❑ Conduct universal screening for traumatic experiences?
- ❑ Give clients choice or flexibility in what services they receive?
- ❑ Include trauma survivors in the creation and evaluation of policy?

Concrete Strategies to Provide TIC

▸ Aim to prioritize client choice and control in common tasks and everyday interactions (*in addition to major life decisions or treatment planning*)

▸ Try asking your clients some of the following questions:
  ◦ What information would be helpful for us to know about what happened to you?
  ◦ Where/when would you like us to call you?
  ◦ How would you like to be addressed?
  ◦ Of the services I've described, which seem to match your present concerns and needs?
  ◦ From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions? (SAMHSA TIP 57, 2014)

Providing Choices

‣ Ensure that the client feels comfortable during invasive assessments and procedures, and make adjustments when needed

‣ Where possible, give the client choices about referrals

‣ Allow the client to set the pace, slow down or take breaks

‣ Continually inform the client of what is happening during healthcare encounters (Havig, 2008)

‣ Write things down for clients who may dissociate during sessions (The Trauma Toolkit, 2013)

Providing Choices

- Understand the meaning the client gives to the trauma from their own perspective

- Understand what healing means to the client within their cultural context

- Be open to referring clients to non-traditional or alternative healing services (Brokenleg, 2008)

- Encourage clients to make informed choices by:
  - Providing educational materials
  - Discuss the benefits, limitations and objectives to various service options (The Trauma Toolkit, 2013)

Establishing a Safe Environment

- Anticipate that various environmental stimuli may generate strong emotions and reactions in a trauma survivor
  - Can include: triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual/auditory/olfactory stimuli (SAMHSA TIP 57, 2014)
- Work toward consistency in provider-client interactions and treatment processes
- Help the client regulate difficult emotions before focusing on recovery
- Follow through with what has been reviewed or agreed upon in prior sessions or meetings (SAMHSA TIP 57, 2014)

Minimizing Risk of Retraumatization

- Clients with histories of trauma may experience some treatment procedures as negative or retraumatizing
    - Reminiscent of specific characteristics of past trauma or abuse
- They may feel that past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas
- Clients may express feelings of powerlessness or being trapped if not actively involved in treatment decisions
- If treatment processes or providers mirror specific behavior from the clients' past experiences with trauma, they may become distressed or respond in the same way they did to the original trauma (SAMHSA TIP 57, 2014)

Minimizing Risk of Retraumatization

- Some examples of potentially retraumatizing elements of treatment:
    - Seclusion or isolation of clients
    - Mislabeling client symptoms as personality or other mental disorders rather than traumatic stress reactions
    - Interactions that command authority
    - Treatment assignments that could humiliate clients
    - Confronting clients as resistant
    - Presenting treatment as conditional upon conformity to the provider's beliefs or definitions of issues (SAMHSA TIP 57, 2014)

Conclusions

- Not every client who has experienced trauma wants or sees the need for trauma-informed treatment
  - Some may feel they've already dealt with their experiences
  - Some may display avoidant behavior to reduce feelings of distress, fear, or overwhelm (SAMHSA TIP 57, 2014)
- You can't always predict what may or may not be upsetting or retraumatizing to clients
  - Maintain vigilance and curiosity with clients (SAMHSA TIP 57, 2014)
- Consider philosophies and behaviors conveyed to staff members by administrative practices
  - If staff members do not feel empowered, it may be hard for them to value the need for client empowerment (SAMHSA TIP 57, 2014)

Conclusions

- Embrace the belief that trauma-related reactions are adaptive
  - This communicates that responses to trauma reflect creativity, self-preservation, and determination
- When working with people who have experienced trauma, be mindful of the temptation to highlight pathology or illness
  - This can give the impression that there is something wrong with the client, rather than something wrong was done to them (Elliot et al., 2005)
- When providers position themselves as experts in relation to their clients, it can replicate power dynamics present in traumatic experiences
  - You are not the expert of your client's life, and you must be willing to learn from them (The Trauma Toolkit, 2013)

Conclusions

- Even if a client does not meet diagnostic criteria for trauma-related disorders, it is still important to recognize that trauma may still affect their life in significant ways
  - This includes culturally expressed symptoms of trauma, e.g. psychological stress expressed through physical concerns
- Don't worry about getting it right all of the time
  - Focus on how consistently you handle situations where feelings of vulnerability or safety are present
- View the client's response to trauma as adaptive, even when you believe their methods are ultimately detrimental
  - This projects the message that clients possess valuable expertise and knowledge about their own concerns
  - Shifts the viewpoint from "Providers know best" to "Together, we can find solutions" (SAMHSA TIP 57, 2014)

Resources

- Advice to Administrators: Self-Assessment for Trauma-Informed Systems by NCTIC. (NCTIC, Center for Mental Health Services, 2007)
- Center for Substance Abuse Treatment. Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2014. Treatment Improvement Protocol (TIP) Series, No. 57.
- Trauma-Informed: The Trauma Toolkit, Second Edition, 2013
  - https://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf
- Moving from Trauma-Informed to Trauma-Responsive: A Training Program for Organizational Change. Covington S. and Bloom S., 2018.
- Trauma Informed Care in Medicine. Raja et. al., 2015.
  - https://www.ingentaconnect.com/content/wk/fch/2015/00000038/00000003/art00003
- Wisconsin Department of Health Services: Trauma-Informed Care Principles
  - https://www.dhs.wisconsin.gov/tic/principles.htm
- SAMHSA-HRSA Center for Integrated Health Solutions
  - https://www.integration.samhsa.gov/clinical-practice/trauma-informed
- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
  - https://store.samhsa.gov/system/files/sma14-4884.pdf

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2–3 = mild
4–5 = moderate
≥ 6 = severe