Webinar: How the Trauma Informed Approach can help treat Substance Use Disorder

March 28 @ 11:00 am - 12:00 pm

>> Good morning everyone, this is Marghie Giuliano. I am the regional lead for our medication safety work at the Quality Improvement Organization. On behalf of the New England QIN-QIO, and our partners at the New England Rural Health Association, I'd like to thank you for joining us for today's session.

>> Before we get started I'm going to quickly review a few housekeeping items. This call will be recorded for training purposes. The recorded presentation will be available within a few business days after the webinar on our website.

>> The phone lines will be the one mute during the presentation but we will unmute the lines after the presentation for questions. I will give instructions at that time.

>> We want to have you actively participate during the session by using the chat function. My colleague, Stephanie, will be monitoring the chat window and responding to your comments in real time. Do not be shy. We'd love to hear your thoughts about what our speaker is saying and how you are addressing medication safety in your own practice.

>> Substance use disorders have a significant cost. The cost is not only to our people but also to our economy. According to the national survey on drug use and health, 19.7 million American adults battled a substance use disorder in 2017. Astonishingly, more than 1 million were 65 or older. In 2017, about 978,000 had an alcohol use disorder. Importantly, two thirds of this population developed this disorder before the age of 65.

>> Drug abuse and addiction costs American society more than $740 billion annually in lost work place productivity, healthcare expenses and crime related costs. The misuse of prescription opioids and use of heroin is one of the most significant public health issues in the United States. Opioid abuse claims more lives than motor vehicle crashes and is far reaching. The statistics listed on this slide are staggering. Providing access to effective care may prevent misuse and the consequences such as overdose.

>> As most of us are aware, in the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to opioid pain relievers and healthcare providers began to prescribe them at greater rates. Increased prescription of opioid medications led to widespread misuse of both prescription and nonprescription opioids before it became clear that these medications could indeed be highly addictive.

>> In 2017, HHS declared a public health emergency and announced a five-point strategy to combat the opioid crisis. Better addiction prevention, treatment and recovery services are paramount. We've seen

that many states have implemented limitations on prescribing and increased referral services. We need better data to track trends. Recently, we've seen there's been an uptick in Fentanyl overdoses. We have to ensure that clinicians are effectively managing pain – as we know this can be a fine balance. We want to ensure access to life-saving reversal agents and we need more research.

>> Researchers believe that genetics may account for up to 60% of a person's risk of addiction, but note that environmental factors including life experiences, education and family also impact risk. People who experience trauma, especially adverse childhood experiences are at an elevated risk for substance use disorders, mental illness and physical disorders.

>> Trauma informed care is an evidence-based approach to deliver healthcare in a way that recognizes and responds to the long-term health effects of the experience of trauma. In 2014, treatment improvement protocol 57, the Substance Abuse and Mental Health Services Administration, SAMHSA, addressed trauma related prevention, screening, assessment, intervention, and treatment issues and strategies providing a framework for organizations that wanted to take a trauma informed approach. So upon completion of this event, you should be able to explain the connection between adverse childhood experiences and substance use disorders, describe promising practices for implementing the trauma informed care approach and consider how trauma informed care might work in your organization.

>> Today's speaker has no relevant conflicts of interest to disclose. I want to highlight that individuals wishing to receive ACPE credits must participate in the full session and complete the session evaluation. Details, including the ACPE code, will only be provided at the conclusion of this session.

>> As I shared, during this call we want you to use the chat feature so we can hear from you. So please chat in with questions and comments on the presentation, your experiences as well as what you might need some assistance with. Let's start by seeing who is on the call. Please type in your name and role, organization and your state.

>> Now I will introduce today's speaker. Jennifer McCarthy is a Senior Program Coordinator for care transitions at Healthcentric Advisors. Ms. McCarthy brings a wealth of knowledge with integrated and trauma-informed behavioral health care and is an innovative educator and quality improvement facilitator.

>> She has been recognized for developing cross component relationships and served as a subject matter expert for the National Council for Behavioral Health. Jennifer has a Bachelor's degree in geography, a Master's degree in education and counseling and is currently working towards a doctorate of health professions education.

>> In addition to being Lean Six Sigma certified, she is a licensed clinical professional counselor. Prior to joining Healthcentric advisors, she worked as a practice facilitator helping Maine physicians achieve their quality improvement goals. In 2016, she received the behavioral health excellence award from the Maine primary care Association and in 2006, was a master of change recipient from North Shore Community College. Please join me in welcoming Jennifer McCarthy.

>> Thanks very much, Marghie. That was a great introduction, and I am thrilled! I was looking at the chat; we have a real wide variety of participants. I'm thrilled to be here and hopefully you will get some good information out of this time together.

>> Marghie reviewed the objectives for today, so the first thing is talking about the connection between adverse childhood experiences and substance use disorders. I thought I would start with this quote, because it is powerful. Edward Machtinger is a leader in trauma-informed care, trying to get primary care organizations on board with this type of approach. He coined this phrase: “Trauma is the original gateway drug opening the pathway to depression, anxiety, substance use, and early death.” If I did nothing else but present you with this slide, I feel like this is the essence of trauma informed care and how it relates to chronic health conditions and specifically, substance use disorders.

>> When I’ve been doing this talk, and when I worked with patients prior to joining Healthcentric Advisors and being a practice facilitator, I was the behavioral health consultant at an FQHC here in Maine, and when we were becoming trauma informed we were making assumptions that everybody knew about what trauma was. I was talking with a patient and I said, “can you tell me about your trauma history?” She said, “well I wasn’t in any car accidents and I have no previous injuries.” And that’s when it dawned on me that I made a lot of assumptions thinking that people understand what trauma is. If you can take a moment, type in how you think you would define trauma and that will lead us into a discussion.

>> What do you think of when you hear the word "trauma?"

>> We have a good group here. Life altering experience. Excellent. I’m preaching to the choir today, good. People are understanding that it is not necessarily an accident or a traumatic injury to the brain; it is something that is an event that has had a lasting effect. Excellent! Thank you for participating.

>> So SAMHSA, they are the ones that define trauma, and basically its the Three E's. So, just a little side note, I like to affectionately call this “Tic-Toc,” so as we move through you’re going to hear my references for different ways to remember these. So trauma is an event of actual extreme threats or harm which an individual experiences that is traumatic, and causes long lasting effects. I like to tell the story – if I experience something that is traumatic, my coworker may not view that in the same way so we cannot make assumptions just because something was upsetting to me it's going to affect my coworker the same way. Trauma and experiences are individual, it depends on the type of environment someone has grown up in, and any kind of predisposition. Try to remember that, it is unique to the person experiencing the trauma.

>> Here we are talking about the opioid epidemic, you can’t take two steps without hearing about this crisis that we have on our hands. And I like the campaign for trauma informed policy and practice, they came together to try to address the opioid epidemic, and their stance is that in order to combat this epidemic and help people who have substance use disorders, it is to get to the root cause, which is trauma – adverse childhood experiences. This is their position statement saying in order for us to tackle the epidemic you need to acknowledge that trauma is part of a person's history, and that we need to take a trauma informed approach.

>> ACEs, this is the second thing (adverse childhood events). I know I'm talking to a group of people who have a good sense of ACEs but its worth repeating. Back in 1995-97, the CDC and Kaiser did a large study where they asked 17,000 people 10 questions and these 10 questions were based on the type of trauma. Here are the results: one in four people were exposed to two or more categories of ACEs. So if there are 10 questions, 10 categories, there are 10 types of ACEs. One in four people scored more than two types of ACEs, one in 16 had four or more – somebody who had maybe neglect, abuse, natural disaster, any kind of trauma that they were exposed to counted on this questionnaire. I really want you to take away the fact that back to that 1 in 16 exposed to four or more categories, it can take 20 years off of somebody's life. That is profound. We are dealing with people on a daily basis who maybe had one ACE or two, but when you move to four categories or more, they really need help and they need sensitivity. I'm glad we're talking about this today because as we move forward you will see how we will be able help these folks.

>> This is a famous pyramid about ACEs. I want to say too that it is not necessarily just kids who have experienced adverse childhood experiences, you can be an adult, a young adult, older adult, and experienced a traumatic event. But this is sort of where the study came from and the depiction of ACEs and how they affect people. As you can see, if somebody is exposed to an adverse event, they can disrupt the development and it can impair functioning, as you get older, you start to feel the pain and the aches of being traumatized, isolation, and what you want to do, you want to numb it, hide that, so you start to develop risky behaviors such as smoking, drinking, gambling, and these things can lead to chronic disease and eventually an early death. I hate to be depressive about this but this is the reality of somebody who has been experienced adverse events.

>> I just found this recently, its called "The Pair of ACEs," what it does is, it hones in on the fact that not only if somebody has experienced adverse events, but if they are coming from an adverse environment, imagine how profound the affects will be. As you can see, if somebody has been exposed to emotional abuse, substance abuse, domestic violence, and they are living in an environment where there is poor housing, or lack of access to care, a lot of violence, you can see that it's going to set somebody up to be stressed out and triggering chronic disease and other types of health risk behaviors. This is a powerful slide, the pair of ACEs.

>> Here are two different studies. If the ACE pyramid, the ACE Questionnaire and the "Pair of ACEs" wasn't enough for you to believe that there is a link, I've got some good evidence for you here and some research. So Quinn, et al in 2016 it did a study where they saw that adults reported five or more ACEs were three times more likely to misuse pain medications and five times more likely to engage in injection drug use. That is staggering! The next study, in 2009, found that over 80% of the patients seeking treatment for an opioid use disorder had experienced at least one form of childhood trauma. This is real, the link is real, the connection is real, and I'm glad that we are here talking about it. This will be the way that we will help tackle this opioid crisis.

>> What we just did is establish that there is a connection so now you're thinking, "what do I do?" You can become trauma informed. I've been traveling around New England talking about becoming trauma informed, and oftentimes when I present it, people get overwhelmed, where do I start?

>> It doesn't look as bad as the eight steps I have listed, it is trying to do a few steps and trying to engage your leadership team, and your staff in understanding that trauma informed care is a way of thinking about how we do business not that is a stop and start. Its that this is the way it we care for people. It is very similar to being in a patient centered manner, it is similar to addressing social determinants of health, its very similar to health equity, so this is just another way for folks to package how to treat patients. But really, I don't want you to be overwhelmed and frightened by the process of becoming trauma informed. I do want to say that folks in the behavioral health world have been trauma informed for some time. Primary care is following suit, and I'm working on long-term care facilities, I hope to get into hospitals as well, because everywhere we go, the trauma informed approach is really beneficial.

>> There are communities, school systems, even trauma informed states. Oregon and Wisconsin are fully trauma informed and I believe Utah is working on it. So this is powerful stuff and we are really at a good time when we could be learning what to do to become trauma informed. Just because of the brief time that was have together, I cannot go through each step, but it is my way of saying I can come out and visit with you and help you and provide some technical assistance. But it's really not that hard, we will talk about how to do an organizational self-assessment in a minute, but this is the crux of trauma informed care.

>> If you have somebody who comes to you with any chronic condition, but we're talking about substance use disorder today, if you go on into the judgment zone, taking the stance of what is wrong with you, why are you here? What is going on? Why are you doing what you are doing? That is hurtful and it makes people go on the defense.

>> People who have experienced trauma, or adverse events have had their trust broken, and it's been a power differential, meaning that whoever was perpetrating the adverse event, had more power over the person who experienced the event. So for folks who have adverse events, and substance use disorders, these folks have been marginalized, stigmatized, they've burnt bridges because of the behaviors they've exhibited, so how are they supposed to gain access to care if they already feel like they will be judged as soon as they open the door.

>> So instead, we want to shift our thinking and say, what helps? What happened to you? Doesn't that already feel better? Some days if I come in and I feel tired, someone says, what is wrong with you? Why do you look so tired? That doesn't feel so good. But if they say, wow, you must be going through a lot. What can I do to help? That takes me off the defensive, and makes me want to be more open and engaged with the individual.

>> I have heard people say, my mom passed away a long time ago, I think I was getting teary one day and somebody said to me, "well, aren't you over that yet?" That is so hurtful. What they could have said was, "what a profound loss you had, is there anything I can do?" That is the essence of trauma informed care – what happened to you versus what is wrong with you.

>> Where does this start? You can do an organizational self-assessment, and I've included this in an attachment for our webinar today. It is a few pages, it is done by domain, you take your team and you

may already have the quality improvement team that does some innovative planning at your organization, you would all take the assessment and the gaps form the implementation plan. If you have most of the things on the list, you are further along than you thought, which leads me to my next slide.

>> The Missouri Department of Mental Health, they were smart in how they were thinking about becoming trauma informed. It can be overwhelming as I said. You saw the eight steps, and you might think, “wow, where do I start?” But if you think about it from a developmental stage, and most of us in behavioral health in medicine we get how things mature. But we want to see where you are at. If you are trauma aware, the organization is aware of the fact that trauma is prevalent and there might be some effect on the people you serve or your staff. If you are trauma sensitive, you are starting to explore the principles and getting ready to integrate into your policies and practices. If you are trauma responsive, you have done a lot of the work to integrate and are starting to make this a regular way of your practice. If you are trauma informed, this is your standard, this is how you do business.

>> Can you take a minute and type in where you think your organization is. Aware, sensitive, responsive or informed.

>> This is fantastic. We have a really good foundation going. This is fabulous and really warms my heart. We’ve got a lot of trauma informed. Keep typing in but we will keep on going.

>> Those of you who are trauma informed, you are aware of the core principles, and they form how you do your business. Let me take a minute and say it is important not only are we trying to become trauma informed to help the client, the patients, residents, whoever we do business with, but it is also for our staff. It is important. We know as caregivers we have to take care of ourselves first before we can take care of others. It is really important for an organization to have this environment where people feel safe, they can trust what is going on, trust their supervisors, trust the processes, decisions, they have some sort of choice and control over what they do, and of course we love collaboration and empowerment.

>> If the staff feels like they have an interaction with the patient, resident or client, and they do not feel like it went well, they need to feel like it is safe enough to go to the supervisor and have a conversation. For instance, “Please can we debrief? I just had an incident it does not feel good; how can I do things differently?” That's important. Often times people do not feel comfortable to go to the supervisor.

>> How about clinicians or medical providers who do not feel comfortable sharing the fact they need to know a piece of information but they are too afraid to admit they do not know it. If you’ve set up an environment where people feel comfortable to share and say, “you know what, I don’t know that but let me go ask someone,” that is how you will build a healthy environment and organization and you take those qualities and you welcome people who have experienced adverse events and you can translate that into the care and they will feel safe and nurtured, and not judged will want to engage in care.

>> Continuing on these guiding principles, universal precautions. I work in a quality improvement organization, I learn more and more about hospital work, nursing home work, your standard precautions, this is similar. We have the universal precautions; we assume everyone has experienced some type of event. If we just set up the system so that we assume everybody had some sort of

experience, you do not feel like you have to make all these different types of accommodations, this is the way we do what we do.

>> Trauma informed the lens is just another word for empathy, everybody who works has empathy. The ability to take yourself and while you talk with somebody who's experienced an adverse event, and they are sharing about that, you can walk in their shoes for the moment, you can be as close to their feelings without having experienced them yourself, so you use that lens to care for the people that you work with and others you interact with.

>> We have talked about the connection of adverse childhood experiences and substance use disorders, and what it would be like to be trauma informed, and now we will talk about what it looks like.

>> I was at an FQHC who became trauma informed back in 2016. It took us a little bit of time but what we did, we had an implementation team, people from all across our organization, we had an HR representative, the medical director, the behavioral health director, myself, care coordinators, and we had a patient, that was to me the most important member. H weighed in, and it just so happened that he had a trauma history. It ended up working out well, he could tell us from his perspective what it would be like to access care in a trauma informed organization.

>> The 4R's. Remember back what we had previously, but now we have The 4R's. The first one is we *realize* there is a widespread impact of trauma. We want to set up an environment. We started a medication treatment program. We wanted the folks who walked through the door, to feel comfortable from the start, feel like this was a safe place for them to come and get their care and not to feel judged. It is about the approach, everybody is trained from the front desk, all the way up through leadership, the board of directors. When we held trainings, our facilities manager was one of the best participants, so we cannot overlook that just because somebody isn't having direct contact with the patient that they won't be a great contributor to the process. We wanted to provide a safe environment. Next – recognizes. We *recognize* that there are signs and symptoms of trauma in the people we work with, and also our colleagues. We will talk about that. You want to prescreen and screen and when I conducted the prescreening appointments for our medication assisted treatment program, we used the opioid risk tool. This is prior to us being trauma-informed. It had a question, "have you had a history of pre-adolescent sexual abuse?" People were taken aback by it, but it gave me the opportunity for the first time, to help them understand that there was a relationship between adverse childhood experiences and substance use disorders, and a light went off. They felt so relieved, like for the first time someone was helping them understand why they did what they did, how they could get on a path to recovery and how they can get hope. So as we became trauma informed and rolled more of the principles into our MAT program, it was a beautiful thing to see.

>> We want to go onto the next one which is *response*. What we did, you want to make sure that when you're being trauma informed you have these practices throughout your policies, procedures and practices so I want to highlight one. We had a monthly meeting called the patient action review committee, where we would talk about high risk patients, high utilizers, maybe people who hadn't engaged in a while; it was my job to make sure that as we were trying to come up with the

multidisciplinary approach, I reminded everybody that maybe there is a trauma history, maybe something we don't know about. Oftentimes, I would end up calling the patient and scheduling the appointment, and help to do more of a further explanation into their history, so I could help them understand this is probably why you feel the way you do. That made them feel good and so supported.

>> The last one, *resist*, is a tricky one. I did retraumatize a patient one time. You know, I'm a seasoned counselor doing this 25 years, and in my fervor, I wanted to help some to get the care they needed, I pushed them too far and did not listen to them. I did retraumatize them. And when I say that I retraumatized them I mean that I triggered them enough that they needed to take to their bed for two days and I was horrified I did that, but my heart was so in the right place. It was well-meaning; I really just wanted this person to get the care that they needed but instead I retraumatized her. So what could I have done differently? Well, I probably could've listened to her. I wanted her to see a psychiatrist and she said no. She said no, that she wasn't ready, and I didn't listen. I pushed a little further. Our hearts are in the right place but make sure we use motivational interviewing skills and partnering with patients, particularly with substance use disorders, making sure we are not alienating them, and singling them out or making them feel stigmatized. We want them to be able to connect with us.

>> Just a quick thing about prescreening and screening. Back to the patient that we had as part of our group – we were ready to go and give the full screening tool, either the ACE questionnaire or the life events checklist, but he said to slow down and pump the brakes on that one. While we were watching some webinars as part of being in the trauma informed care collaborative, we came across Dr. Shauna Grady who came up with a couple of questions - one, have you had an experience so upsetting that it changed you spiritually, physically or behaviorally? And then, do those problems bother you now? I also do a 2a, do you want to discuss them right now? Somebody can say yes to number one, and number two, but no to 2a, meaning they don't want to talk. That goes back to the motivational interviewing – respecting and partnering with the patient. If the person wanted to learn more about the connection between adverse experiences and substance use disorders or their chronic conditions, you could administer one of the evidence-based screening tools.

>> On the left-hand side is the ACE, the original questionnaire that was given during the research. And then there is the life of its checklist on the right-hand side, and we chose the life of its checklist, versus the ACE questionnaire, and that patient we had as part of the group backed us on this decision, because the ACE questionnaire can be graphic. Even looking at question 3, if you can see it on your screen, is very graphic. We thought that would be too much, we are trying to help people engage and we will ask them questions three. So we went to the life events checklist. We like this one because it has 17 types of trauma and not only did it happen to you but did you witness it; did you learn about it? Adverse experiences do not have to happen directly to you. It could be that you saw something. Maybe you saw something on the news. I have several patients who were very upset by the 2016 election. I'm not getting political; I'm just stating the fact that a few people that I worked with were traumatized. I had to work with them to de-escalate and come up with a safety plan because they were so stressed out by the result. I really like the life events checklist because it gets to the different types of trauma that somebody can experience.

>> So a little bit about the workflow, how to do things in an efficient manner – this is how we did it. We had the medical assistant or the care manager ask the prescreening questions; they did this as part of the physical exam, the annual wellness, and the new patient visit. We thought it would be the most normalizing way to ask these questions. If they got a positive response, they would tell the medical provider and the medical provider would bring me in as the behavioral health professional, I would have a chat with the patient and we would decide whether they wanted to do the full screening tool or if they were saying, I am okay, I'm just trying to learn a little bit about it, or maybe they were ready for some treatment. So that it just something else I can come out and help you with, is the workflow.

>> Now that we have people engaged, they feel comfortable, we've got them screened, you think what will I do with them now? If you're fortunate enough to have on site mental health like we did, great, you can make a referral. If you do not, I can see that there are a lot of behavioral health organizations on with us, I know that there are many accessible behavioral health organizations across, Maine, New Hampshire, Rhode Island, Massachusetts. So, these are some of the types of treatments that they are practicing. I'll go through them quickly.

>> Sanctuary model isn't a treatment, its more of an in-depth way of doing trauma informed care, Dr. Sandra Bloom is the one who coined that model, the rest of them are treatments, so seeking safety, Dr. Lisa Najavits from Boston University, that's about trying to help patients feel safe in everything they do, because again, the trust was broken so they need to feel safe and secure in the relationships they are developing.

>> We know about cognitive behavior therapy – looking at your feelings, behaviors and actions. It has a trauma focused slant, helping someone adjust to how they focus their trauma, and we try to reduce the negative behaviors that come from traumatic experiences.

>> Trauma recovery and empowerment model, eye movement, desensitization reprocessing, fantastic type of reprocessing. I had a session and it helps and you can do that by tapping your hand or by using a light machine, it re-processes your memory for experiencing a traumatic event.

>> One of my favorites is somatic experiencing by Peter Levine, folks who have experienced adverse events, are often disconnected or often disassociate anything they can do to survive, so somatic experiencing is helping people get connected back into their body and environment. You sit in a chair and you help the patient look around the room and try to point out three things, maybe tell me the time, what is on the bookshelf, your feet are planted firmly on the ground, and then you put your hand on your stomach, you say I'm grounded, I'm centered, here I am. That is just a snippet of some treatment types, there's also prolonged exposure. I could do a whole show on that but that's just a start for you. All the links are in my references for you.

>> SAMHSA, of course, does a wonderful job with their tips, I'm sure you have seen them. You can go to their website and download these packets, they are great, TIP 57 is all about trauma informed care, TIP 63, it is about opioid use disorder and has trauma informed care approaches throughout the booklet.

>> Here is my TIC Talk. When I went to college I had pneumonic devices and catchy ways to remember things. What is the ACE? How many ACEs do you have? You can talk about The Three E's, what happened to you? The 4R's, and the core principles. Sounds like a lot, but you know, it isn't. Its just good care.

>> This is what a trauma-informed care organization looks like, these are organizations right now, I want to reiterate that, you do not have to scrap everything you have done and start from scratch. We are constantly trying to care for the caregivers and increase the quality of the services. This helps us to take a step back, have a more compassionate way of doing things and making sure we check in with our staff and providers, because they can get burned out from dealing with people who have had adverse experiences.

>> Last one, "Trauma informed care is not a destination, it is a process and a way of doing business." It is not a start and stop. This is the way you run your business. We can use a trauma informed lens to make sure we have empathy and make the environment safe and nurturing for people, that we partner with the people we work with, you can take in the changes one step at a time. Margie McLaughlin, one of our consultant here, she developed a nifty slogan, "Hear with your heart." On the left side is, "Shift your perspective." That's the State of Wisconsin's nifty slogan. Maybe your organization can come up with something clever to say.

>> The reason I like Heart with your heart or Shift your perspective is, we're all about when we're working with people with substance use disorders, and people with chronic conditions, I really want to reiterate that, I am talking about substance use disorders today but this is good care for everyone. If you're at the nurse's station and you hear someone say, "oh he is a drug seeker." Instead of saying to that person, "you shouldn't be saying that," you could say, "are you hearing with your heart? Do you hear what you're saying Is this how we want to treat our patients?" It's a great way to latch on so people can do some self-correcting without feeling their own trauma or stigma from saying something that maybe wasn't correct.

>> And finally, I came across this quote, "hurt people, hurt people." You have to know that people who have experienced adverse events are hurt and they turn around and hurt people. So we are trying to help them understand that if they can see the link between adverse experiences and why they do what they do, they will not hurt people anymore and they will have their hearts open to get help and we can engage with them more, because they will not have that wall up. Hurt people hurt people. That is really powerful. I see in the chat, "Compassion first." Fantastic. We've got something to add.

>> I am here if you have any questions or if you want to talk more about this topic. I am very passionate about this. Just about everything I'm doing right now has to do with trauma-informed care; its my project in school. Contact me and we can talk.

>> Here are the references. Any questions?

>> Thanks so much Jen for that wonderful presentation. Let's jump in and join Jen with questions and comments. Nayara, can you remind people how to unmute themselves to ask questions over the phone?

>> Sure, if you'd like to ask a question over the phone, you can just press pound six two unmute yourself.

>> Stephanie, do we have any questions in chat at this time?

>> We do not, Marghie.

>> Ok, so I'm going to take the prerogative to ask a question, if that's okay. Jennifer, obviously, I would assume that becoming more trauma informed, comes with a cost. How do you justify the time, the cost and the effort to become a trauma informed organization? What are the additional costs?

>> Well, you asked a great question, and I was doing some preparation for that. I was having a conversation today with some colleagues about that Believe it or not, there's not a lot of data to show the cost-benefit analysis of being trauma informed. I looked. But what I can say, it is similar in being sensitive to social determinants of health, health equity, being patient-centered. It may be a while before we can see the lasting effects of being trauma informed, but we know it is good care. We know that, I think it was 60% of adults who present themselves to primary care has had an adverse experience. That's more than half the people who walk through the door. If we're trying to help them understand the connection between their experiences and conditions, we can imagine that it will help reduce readmissions and high utilization and it will increase engagement which would eventually increase self-management and which would reduce the burden on the health care system. So I think that that is to be continued. It is too early on to see anything quantifiable. But I am hopeful and I know it is good care.

>> Great, thank you. Steph is there anything in chat?

>> Can I jump in? This is Lisa Freeman. I missed the first part of the presentation, so I apologize if this has already been said. I don't have professional experience with regard to this but I have personal experience with a very close family member in my immediate family.

>> A couple of things I have seen, this person had to go through substance use inpatient treatment four times before it took. In talking to many of the others there who were there because we had a lot of conversations. What I became aware of, is that virtually all of them had suffered a very significant personal loss. That was either a split family, where it was not acrimonious, a suicide, an untimely death, things of that nature. I think that the approach of recognizing that something significant has happened in these people's lives, it is hard for them to talk about. That's why they turn that inside themselves. That's why it is important for the treatment to be effective, which leads to the fact that there's always a comorbidity that I've seen which substantiates that these 28 day cycles of bring them in, give them support and push them back out, it doesn't work. The last thing is of course, that with substance use

disorders, it's not until the person themselves finally realizes they need support, they need the treatment and what they are doing is not the way they want to live – Until that happens, it's not going to click with them completely.

>> I was talking to people, when I said, yeah, we went through it four times and they said that's okay we went through that 12 times before it took. Almost everyone in the program has been through it multiple times. We have to recognize it is truly a journey, this is approach is 100% on target but it needs to be modified to understand the depth of the issues.

>> Wow, thank you. That was great.

>> This is Stephanie – we do have a couple of questions in chat. One from Carol, "have healthcare providers been compared to the general population on ACE scores?" She's wondering how many caregivers have trauma history.

>> Hm, that's a good one. Let me just scroll up and see that one again. Are you asking, Carol, if providers have checked their own ACEs? I'm sure tons. I don't have numbers, but I can tell you, from personal experience, we had a medical provider at our organization who was triggered, she had her own trauma history who was triggered by a patient. It wasn't handled well at all, either from her or from leadership, even though we were trauma informed. You're raising an important point. We are human, we interact with people all day long who have their own experiences, we need to keep ourselves in check. I do not have numbers but that is a great question, when we talk about the trauma informed approach from an organizational standpoint, we look at each other, all the staff as well as whoever we are serving. Thank you for bringing that up.

>> We have more in chat, one from Peter. He mentioned that for their medication assisted treatment program, they have to demand compliance while being compassionate, and helping without enabling, which can be tough. And from Carol, trauma informed systems have a possible transgenerational benefit. And we do have a question from Susan, "Do you recommend assigning a diagnosis on the patient chart when you recognize trauma?"

>> Great question, Susan. I would think so. In my role as behavioral health consultant, I did not formally diagnose, I left that to the medical provider. I think it would be helpful. Oftentimes they would get a diagnosis of PTSD. Just so that in case they seek treatment, it would be covered by insurance. Sorry to be so businesslike, but it's the truth. Also, so that patients can start to own and acknowledge what they have experienced so they can start to make sense of what has happened and how they can move forward. Excellent question; I would definitely recommend a diagnosis.

>>Nayara, anybody on the phone with questions?

>>I have a question. I typed it in. Can you hear me? I typed it in but its not well written. My question is how the principles of trauma informed care can be relevant either to concepts like harm reduction among various populations? Whether its injection drug users or survivors of commercial sex, or at the

other extreme, is there any attempt to incorporate trauma informed care principles in the way that certain, very traumatizing, agencies or departments of government can work? I had in mind maybe the Department of Corrections or DCYF? Any attempt to modify how they do their work?

>> Absolutely, that is great. Let me do the second part first. Which is yes, there are social justice movements, and organizations are trying to become trauma informed, so police have gone through training, first responders, Department of Corrections, so yes. What you can do after this, is type in trauma informed care and you will see a lot of resources and references. Its sort of a buzz. You will see some of the work that the criminal justice system has done to help become more trauma informed. And regarding harm reduction, that is what we practice, and it was quite a shift for all of us, again, because we were in that mindset that people are abusing the system, abusing themselves. So, we alongside becoming trauma informed, embraced the harm reduction philosophy; I think they go together nicely. SAMHSA has a definition of recovery. I don't know it off the top of my head but its 4 parts. Really, what its based on is hope, health, and it is based on the fact that patients get to decide what their recovery journey looks like. I am not going to sit there and tell them that they need to be abstinent, or do this or do that, I am not partnering with them, I am not appreciating their history (that way), I am telling them what to do. So harm reduction goes so nicely with trauma informed approaches. Thank you for raising that. Does that help?

>> Can I ask one follow up question to that, which is, "Has there been an attempt to speak to various twelve-step organizations about whether they may be retraumatizing people who come into their communities who are, for example, on medication assisted recovery, and they are often told, "well, you're not on recovery because you're on methadone." To me that seems retraumatizing.

>> I don't know if I feel comfortable answering that question, I am pretty passionate about trauma informed care and harm reduction so I think it is better for me to just say I am passionate about this versus going down that road. I really do believe that a person who is in recovery should be able to go anywhere they want to seek support, so I think I'll just be politically correct and leave it like that.

>> Thank you for a great discussion. Just so you know, if you have a question in chat, we will be following up with you. I hate to end such a great discussion but we are almost at the top of the hour and I want to be respectful of the time. For those of you who are looking for ACPE credits, the code is trauma informed.

>> If anyone is looking for connections with the QIO, you want to learn more in your state, here's our contact information. We also have Jen's email as well in our chat. I will now turn over for final wrap up. Thank you, everyone.

>> Thank you for joining us today. This is just a reminder that we are on social media. Please connect with us. We also have many videos on YouTube. We appreciate your attendance and great discussion. We will be following up with an email with resources, and please fill out the webinar evaluation. Thank you.

>> [Event concluded]