

TRANSCRIPT OF WEBINAR:

IMPROVING HEALTH THROUGH TRAUMA-INFORMED CARE 7-28-15

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BEGIN TRANSCRIPT:

MODERATOR: Good afternoon everyone! And good morning to those of you who are joining us from the West Coast. Welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webcast titled “Improving Health through Trauma-Informed Care.” My name is Karen Johnson. I’m the director of Trauma-Informed Care Services at the National Council for Behavioral Health. And I’m your moderator for today’s webinar.

As you may know, SAMHSA-HRSA CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.

In addition to national webinars designed to help providers integrate care, the center is continually posting practical tools and resources to the CIHS website, providing direct phone consultation to providers and stakeholder groups, and directly working with SAMHSA primary and behavioral health care, integration grantees, and HRSA-funded health centers.

So before we get started, a couple of housekeeping items. To download the presentation slides, please click the download menu labeled “Event Resources” on the bottom left of your screen. Slides are also available on the CIHS National Council website at “About Us Webinars.”
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[During these] (ph) presentations, your slides will automatically be synchronized with the audio, so you don’t need to worry at all about flipping slides to follow along. You can listen to the audio through your computer speakers or please insure they are on and the volume is up. (pause) You can also insure (pause) your system is prepared to host this webinar by clicking on the question mark button in the upper right corner of your player and clicking “Test My System Now.”

You may submit questions from speakers at any time during the presentation by typing a question into the “Ask a Question” box in the lower left portion of your player. We will have two sessions for question and answers, so hopefully we will be able to address most of the questions that you have.

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So today’s webinar—we’ll walk through what a trauma-informed clinic looks like and simple steps you can take to insure your services and clinic environment are trauma-informed.

After this webinar, you will be able to identify characteristics of a trauma-informed primary care clinic, recognize specific steps to educate the staff and patients on trauma’s effects, and to modify daily clinic routines to become trauma-informed. And you will be able to, um, obtain practical resources for moving forward and implementing trauma-informed care within a primary care clinic.

So we’re really excited to have a strong, um, group of presenters today. We are joined by Alex Ross, Leah Harris, Mary Blake, and Eddie Machtinger. As each person comes up in the webinar, I will introduce them and, um, share a little more information about them. But first, for today’s welcome for this webinar, I want to turn, um—turn the microphone over to Alex Ross from HRSA. Thank you, Alex. [00:04:13]

ALEX ROSS: Yes, thank you, Karen. Um, good morning—good afternoon to all those on today’s webinar from the Health Resources and Services Administration, and on behalf of the Substance Abuse Mental Health Services Administration, and the whole team at the SAMHSA-HRSA Center for Integrated Health Solutions. I want to welcome you to today’s webinar on developing trauma-informed primary care practice in an integrated care setting.

While we know that people who experience physically or emotionally harmful or life-threatening events can have lasting adverse mental health and physical health effects, we also know that a trauma-informed approach to care can improve patient-engagement with providers and support positive health outcomes.

Provider organizations that recognize the widespread impact of trauma can actively resist re-traumatization of the people they serve. Today’s webinar—our speakers—will answer the question of how you can embed trauma-informed approaches into everyday practice. By the end of the webinar, you will obtain practical resources for implementing trauma-informed care in primary care clinic settings. And everything we do through the SAMHSA-HRSA Center is about practical information to help you work more effectively in your practice.

Topics that you’ll hear about today include governance and leadership, screening and assessment, the physical environment, training and workforce development, financing, progress monitoring, and quality assurance—just to name a few of the key concepts that will be touched upon. [00:05:50]

HRSA has a strong interest in this topic and a number of our programs greatly benefit from a trauma-informed approach. These include in our Maternal and Child Health Bureau, our Home-Visiting Program, and our Healthy Start program—in our HIV and AIDS Bureau, our community-based provider programs, our Office of Rural Health, and of course our community health center programs. All are, uh—benefit from a trauma-informed approach to care.

We are going to hear from some terrific experts in the field. Um, Leah Harris is going to touch on what it means to be trauma-informed in primary care settings. Mary Blake, my colleague from SAMHSA, will discuss “Creating the Foundation – Defining Trauma-Informed Care Principles and Domains.” And Eddie Machtinger, um, a professor of medicine and director of the Women’s HIV Program at the University of California in San Francisco will be talking about building a trauma-informed clinic—where to begin in the trauma-informed care transformation.

Karen Johnson will facilitate the question and answer sessions. And at the end, there’ll be a slide or two on those practical resources that I mentioned before.

Um, I want to just finish by promoting and encouraging you to go to the SAMHSA-HRSA Center for Integrated Health Solutions website after this webinar—not only for the useful information on trauma-informed care but for the wide range of resources that are provided on integrated care topics such as Models of Integration, Financing, Workforce, and Clinical Practice.

I want to thank today’s speakers for taking time to participate. And I want to thank especially our audience for your interest in this topic. With that, I’ll turn it back to Karen. (telephone rings)

MODERATOR: Thank you so much, Alex. So, we want to move forward in our webinar by bringing our first presenter, Leah Harris. She’s a mother, advocate, and story-teller who shares her (inaudible at 00:07:48) experiences of trauma, serious mental health challenges, addiction and recovery with the [birth] (ph) audiences. She’s a trainer for the National Center for Trauma-Informed Care, and trauma-informed care specialist, coordinator of Consumer Affairs with the National Association of State Mental Health Program Directors. Leah? [00:08:06]

LEAH HARRIS: Hi. Thank you so much, Karen. Um, I’m really honored to be here, and I’m so excited about this growing movement to incorporate trauma-informed approaches into primary care. As we know, trauma affects us mind, body, and spirit, so it’s particularly important not only to integrate mental and physical health care but also an understanding of the impact of trauma and the pathways to healing. And I understand that’s a lot of integration but it’s definitely worth it.

So I’m just going to give a really basic overview to set the stage for what Mary and Eddie will be sharing with you.

So the impact of trauma—um, I can say that I, myself, as a trauma survivor, this is not theoretical. I definitely experienced a lot of these different kinds of impacts myself in my life,

and I'm lucky that I've found many resources to help me cope with them. But I just kind of wanted to share some of the basic impacts.

There's a huge body of in-depth research on the neurobiology of trauma that unfortunately there is not time to go into today. But I definitely would refer you to the Adverse Childhood Experience's study, which Mary will be touching on a bit more in her presentation. I'd also like to refer you to an excellent new book that has just come out. I hear it's the number one seller in psychiatry by Bethel Vanderkolk—K-O-L-K—uh, "The Body Keeps the Score." That really kind of goes in-depth into the different and various impacts of trauma.

Um, but suffice it to say that the—you know, the changes in brain neurobiology affect, you know, the social, emotional, and cognitive abilities. They lead to all kinds of health risk behaviors that are really—we need to understand them as ways to cope with traumatic experience—which, of course, lead to really serious, you know—they can lead to serious behavioral health, physical health, and social problems, and particularly early mortality.

[00:10:18]

So I think it's—this is just a sampling of the ways that your patients might be affected by trauma. And I just want to emphasize on this slide—and I know there's a lot of text here—that we cannot assume that the person's trauma has been in the past. We've got to also consider the fact that this individual might currently be unsafe who's in the office. There's some research that shows conservatively that 14 to 35 percent of adult, female patients in emergency departments, and 12 to 23 percent in family medicine, reported experiencing some form of interpersonal violence in the previous year. So I think that that's really critical to keep in mind that, yes, adverse childhood experiences have a tremendous effect on mind, body, and spirit, but that people may be experiencing current trauma, as well.

And I think it's really critical to note that not only does trauma affect the body and the brain and the health outcomes, it also affects engagement with health care itself. So if you have patients who are repeatedly missing or canceling their appointments—you know, not sort of following through with preventative care recommendations or other medical recommendations—they may have anxiety about certain medical procedures or chronic unexplained pain or autoimmune disorders, as well, that we're learning more and more about how those can be traced to a traumatic experience. [00:12:00]

And just a quick anecdote—you know, I know we're talking about primary care here, but I just need to say that, you know, my current dentist is really getting it right. Um, I explained to my dentist and hygienist at the first visit about how having fingers and instruments in my mouth causes me a lot of distress and anxiety. And it's only because of all this work I've done in trauma-informed care that I can even voice that. So many people probably really struggle to even voice something like that. And they were so kind. They were non-judgmental when I brought this up. They, you know, suggested I—they provided me with headphones and, you know, suggested I listened to some soothing music. And that really helped tremendously. And as a result of just that really kind of simple intervention, I really have kept up with my appointments when in the past I would repeatedly cancel and reschedule. So, this is just—you know, it's not

primary care, again, but it's just the example of how when a care provider responds in a non-judgmental, supportive way, it can really make all the difference. And I have a lot fewer cavities.

Um, so why is a trauma-informed approach important for primary care settings. So as we mentioned, you know, they have a direct impact in how patient's—not only on their health—but how they engage in health care. And that—there may be a situation where a patient voluntarily discloses current or past trauma and how do we respond without further traumatizing that person. And then knowing about the impact of trauma can really improve patient outcome. So, because of my dentist, I'm showing up to my appointments and my teeth are and my mouth is healthier.

And understanding trauma can better help you manage risks. And I think that's critical in a world where risk management is increasingly important in the health care field. [00:13:55]

Oh, and one thing I just wanted to say about this slide is that, you know, the person—very often, the patient showing up is not necessarily going to tie past trauma to the current health issues that they're going through. So they might not always even be able to articulate it. Sometimes they will, but you can't always count on that.

So these are just, you know, some of the ways that medical care can be experienced as re-traumatizing. Certainly, you know, invasive procedures, removal of clothing—you're in a vulnerable position—physical touch, particularly when the provider is not explaining where they're touching and why. Um, personal questions. And I think, you know, the power dynamics of the relationship are not to be discounted. And I've even heard medical providers talk about the experience of being a patient and how—how vulnerable—inherently vulnerable that experience can be—even for someone who is, themselves, a provider. Um, certainly the gender of the health care provider can affect things. Um, and then, you know, the loss and lack of privacy. So, you know, we just understand that all of these things can be going on for your patients maybe simultaneously when they're in your office, and they may not be voicing that in any way whatsoever.

So, I just, you know, wanted to share a couple of experiences from my own life as a trauma survivor in primary care—one good and one not so good. So I'll start off with the bad.

So, um, I have an A-score of 7, which is, uh—it's pretty high. They say any A-score over 4 is kind of at that tipping point where people really start to experience challenging physical, mental, and behavioral health problems. [00:15:50]

So in this primary care office—which I should say was, um, a holistic, integrated care facility—the kind of place where you pay out of pocket and get reimbursed. It was—they really went out of their way to make the environment really soothing and really peaceful. There were like waterfalls and beautiful colors on the wall and, you know, it just had that feel when you walked into it like, “Oh, this is a health care oasis.”

I was being seen for a routine physical and there were some—you know, we talked about my risk factors for breast cancer, um, and talked about the BRCA genetic testing—which I hadn't had, yet—and, you know, we were going through this whole conversation. And then very sort of

abruptly, the doctor sort of said, “You know, you really need to consider a prophylactic double mastectomy.” —you know, kind of in this like really brusque kind of, “I’m telling you what’s best for you kind of tone.” And I started to ask some questions about it, and he’s like, “Oh, you know. Our time is up. Um, reschedule for some additional questions you might have.” And I just felt—first of all, someone bringing up that as a possibility is quite scary, you know, and I felt really shut down, um, by this provider. And I bring up this whole example to show that, you know, you can have the most soothing and beautiful environment in the world—and that is important in terms of making people feel comfortable from the moment they walk in the door—but it’s not enough when the practice itself is not trauma-informed. Nobody, you know, asked me about trauma. There was really no screening—not even in a written form—when I became a patient there. And so, I think that this is just a good example. And I never went back to this practice. And talk about having trouble following up with health care treatments, you know, it took me several months to even get back into a practitioner, uh, to schedule the BRCA test. Um, and good news—I don’t have the gene, but it was a very scary experience. [00:17:52]

The second experience, uh, was so much more positive. As I said, I’ve been really personally affected by traumatic experience in terms of my chronic pain history, which started for me in my mid-20’s—which is very young. I’d show up at the primary care office with severe and chronic low-back pain that was disabling, really struggling with eating disorders, obesity. I was told I was a candidate for back surgery. And this was through Kaiser Permanente, and they actually had a complementary and alternative medicine program that I would be able to participate in. And, um, this—I would say this—when you walked in this office, it didn’t look particularly soothing and it was fairly sterile as, you know, a lot of the general primary care clinics can be. But this clinician—she was so wonderful. I mean, she took so much time to get to know me. She asked me a lot of questions about myself, you know—really—you know, she asked me about my history of trauma. And she took a really holistic kind of approach to what was going on with me and my chronic pain and my trauma history—and just had all these community resources to refer me to.

So, as a result of working with her, you know, I lost weight—you know, I had a remission of my symptoms. And it was a really positive, positive health outcome for me. And I feel really, really lucky that I found her. You know, and a lot of times finding practitioners like this can be a bit of a needle in a haystack experience, but that is changing. You know, this was longer ago than I would like to admit, so I don’t share my age. But— (laughs) but, um—you know, I know that that is changing and it’s tremendously exciting that it is.

So, I’m just going to wrap up here, um, and just—obviously Mary and Eddie are going to go much more in-depth into the “how’s” of this: How do you create a trauma-informed practice? But these are just some of my thoughts. [00:19:57]

Um, as we know, trauma disconnects. It disconnects a person not only from themselves but from others, from their community, perhaps from their family. And really, what I want to emphasize is that any approach to trauma-informed care should really proceed to create a sense of safety, relationship, connection—including connection to trauma-informed community resources like I mentioned with the previous provider.

So I think really, you know, looking at the total approach—and this is from the 30,000-foot view—you know, creating a soothing physical environment is great. It's not a one-and-done kind of thing. There's much more to be done. Um, it's really about training all staff. And not just direct-care providers; we're talking about the person sitting at the front desk—anyone—you know, the person who's walking you into the office—anybody who is working with someone who has the potential to be a trauma survivor.

Um, and then—you know, I know that this can be very difficult in terms of the time constraints that providers face in the primary care setting, so I don't say this naively, but to the extent that we can take time to get to know the patient—even a little bit at a time—create a sense of safety, respectful relationship, um—you know, that is really critical to adopting a trauma-informed practice. And then, you know, that goes hand-in-hand with adopting collaborative and person-centered approaches. So, offering choices, offering options—don't say, (laughs) “You need to take your breasts off,” and not talk about other options (laughs) with the client. You know, that's just one example, you know.

But it's really about minimizing the patient's sense of control because ultimately trauma is so much about a loss of control and a loss of power. And whatever we can do to help people to regain that sense of empowerment, you know, so that they can better care for themselves, for their health, for their families, and hopefully achieve the kinds of health outcomes that we all want to see. [00:21:58]

Um, so I want to thank you so much for listening. And I will turn it back over to Karen!

MODERATOR: Thank you so much, Leah, for that very valuable information you shared related to trauma-informed care and how you tied it back to your personal experiences. Thank you so much. And now we want to move on to a presentation by Mary Blake.

Mary is a public health advisor in SAMHSA's Center for Mental Health Services. She serves as CMHS lead for Adult Trauma and Trauma-Informed Care, and oversees SAMHSA's National Center for Trauma-Informed Care and Alternatives to Restraint and Seclusion. Also, Mary brings her expertise in trauma and trauma-informed care to a number of SAMHSA and broader federal committees and work groups. Thank you so much for joining us here today, Mary!

MARY BLAKE: Thank you very much, Karen, and hello to everybody on the line. I'm delighted to be here and able to talk with you all about this important—uh, about this important subject. I want to say a thank you to Karen Johnson and Rose Philippe for organizing the webinar. A special thanks to Alex Ross at HRSA for your leadership in bringing trauma-informed approaches forward with the federally qualified health centers and other activities at HRSA. And also an acknowledgment of [Timly Biggs] (ph) [00:23:31] at SAMHSA who, along with Alex, provides federal leadership for The Center for Integrated Health Solutions.

I'm honored to be presenting today with my colleagues Leah Harris and Eddie Machtinger, with whom I've had the privilege of working on a number of projects and initiatives. And I would also like to acknowledge my colleague here at SAMHSA, Larke Huang, who is the director of SAMHSA's Office of Behavioral Health Equity, the agency lead for SAMHSA's Strategic

Initiative on Trauma and Justice, and the co-lead with me on SAMHSA's General Adult Trauma Screening and Brief Response in Primary Care Initiative. Thank you very much. [00:24:10]

Um, as Leah had mentioned, the issue of trauma and the impact of violence, abuse, and adverse experiences—it plays a central role in the fabric of life for individuals, families, and communities in the United States, um, and truly constitutes a public health crisis. And this is gaining greater and greater attention across multiple facets of our lives. We're seeing many different efforts to address trauma in schools and social services and work places and communities and in health care. So I'm really glad that we're talking about this today as it relates to primary care.

Leah had mentioned the Adverse Childhood Experiences Study, also known as the A-study. I see we had a question about that. Um, the Adverse Childhood Experiences Study was a collaborative effort between Kaiser Permanente Health Care in California and the US Centers for Disease Control really looking at, um, overall health status of individuals served under Kaiser Permanente and also correlating their current health status with ten categories of adversity in childhood. I'm not going to spend a lot of time going over the study for today's call, but if you Google the Adverse Childhood Experiences Study, you'll be able to find detailed information. [00:25:51]

What's important about the A-study is that it showed a, um—a direct and correlated effect between adversity in childhood and adult disease. And this graphic really provides a good, um, picture of what we're looking at. We're looking at disrupted neurodevelopment, social/emotional cognitive impairment, health risk behaviors, disease and disability, and early mortality, as Leah had mentioned.

When you talk to trauma survivors, a lot of them use this particular line, which I think is very salient. "The issues are in the tissues." The experience and violence in abuse has profound impact for people in—in their bodies, in their health. And that's why this is so important. Trauma not only impacts people in the current moment, it impacts them over the lifespan. So abuse in childhood puts an individual at greater risk for abuse in adulthood. Indeed, emerging research in the epidemiological realm shows that trauma also has ripple effects that impact families and communities.

SAMHSA has [taken on effort] (ph) [00:27:11] to respond using its own comprehensive public health approach to trauma. Um, our comprehensive health approach focuses on integrating and hardwiring and understanding of trauma—and then, uh, developing strategies to implement trauma-informed approach across our programs, our work, in collaboration with our federal partners, and also with other public service sectors.

Um, our goals are to, one—reduce the impact of trauma in the lives of individuals, families, and communities; two—to develop and implement trauma-informed approaches across systems and work places; three—to make trauma-informed screening, early intervention and treatment a part of business as usual; and four—to promote the recovery, well-being, and resilience of individuals and families and communities. [00:28:10]

We have a number of activities that [we are] working on to achieve these objectives. And today I'm going to talk about two in particular. The first being SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach; and the second really is our General Adult Trauma Screening and Brief Response in Primary and Other Health Care Settings Initiative.

In October of 2014, SAMHSA released its paper—it's Concept of Trauma and Guidance for a Trauma-Informed Approach. This paper was developed over a period of time looking at best practices and evidence for implementation [in the field], (ph) convening in experts' panel, gathering comments from technical experts on an initial draft paper, posting the draft paper on SAMHSA's website for public comment, and soliciting comments for our federal partners and colleagues.

The purpose of this paper is several-fold. We seek to gain—uh, gain shared understanding of what SAMHSA means by trauma in a trauma-informed approach, to obtain agreement, and enable discussions of trauma across different service sectors, to provide a basis for measurement, and to provide the basis for training and technical assistance.

I should say that when we posted the initial draft for comment, we received over 20,000 comments or endorsements from the field. Today, this paper is the most downloaded document from SAMHSA's website, and we know that the work in the paper has resonated across multiple systems and service sectors, including health care. [00:29:50]

I wanted to quickly highlight, um—highlight our concept of trauma. We know that sometimes people focus on events of effects, but SAMHSA's concept of trauma really provides a deeper and more nuanced understanding of how trauma unfolds and how it impacts a person. We call our concept of trauma "The Three E's." The individual trauma results from an event, a series of events, or a set of circumstances that are experienced by an individual as physically or emotionally harmful or life-threatening, and that have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. This is very important, and I would urge you to download a copy of our paper to get a closer look at, um, how these "Three E's" matter in the evolution and impact of trauma.

In our paper, SAMHSA also provided a definition of what we mean by a trauma-informed approach. And because we're just very picky at SAMHSA, we decided to go with "The Four R's." So we have "The Three E's" of trauma and "The Four R's" of a trauma-informed approach.

In a trauma-informed approach, all people at all levels of the organization or system have a basic realization about trauma and how it can affect families, individuals, groups, organizations, and communities. As a result, people in the organization or system are able to recognize the signs of trauma. And they may be gender, age, or setting-specific. And they may manifest by individuals seeing or providing services. Trauma is the great equalizer. It impacts the workforce in the same way that it impacts the patient population. [00:32:00]

The program, organization, or system responds by applying the principles of a trauma-informed approach to all areas of functioning. Staff in every part of the organization—from the person

who greets the patient at the door to the executives in the governance board—have changed their language, behaviors, and policies to take into consideration the experiences of trauma among children and adult users of services, as well as among the staff providing the services. A trauma-informed approach seeks to resist re-traumatizing the clients, as well as the staff.

Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. And Leah, when she spoke gave a wonderful explanation of that—of that fact.

A trauma-informed approach does not simply raise awareness of the issue of trauma, it fundamentally changes an organization or system's culture, behavior, actions, or responses. In this approach, all components of the organization incorporate a thorough understanding of the prevalence and impact of trauma, the role it plays, and the complex and varied paths in which people recover and heal.

A trauma-informed approach can be implemented in any type of service setting or organization. And it is distinct from a trauma-specific intervention. Um, and I think that's really important to point out. (computer sound)

Um, I want to talk to you very quickly about some guiding principles, um, that really underlie—um, underlie a trauma-informed approach. And how they look and practice may vary from sector to sector, or setting to setting. But the principles really are the basis for how the organization—um, how the organization operates. [00:34:06]

A trauma-informed approach reflects adherence to these six principles rather than a prescribed set of practices or procedures. The principles may be [generalizable] (ph) across multiple settings, even though the terminology and the application may be specific to a particular setting. These principles underlie the values, beliefs, and attitudes of individuals and organizations offering a trauma-informed approach.

And I wanted to point out that these principles are consistent with current trends in health care more broadly. When you think about efforts to focus on patient-centered care, collaborative decision-making, self-management of chronic disease, or enhanced patient-doctor communication strategies, the principles really do a nice crosswalk with some of these current things going on in the area of health care.

Developing a trauma-informed approach requires change at multiple levels of an organization, and a systematic alignment with the key principles I just described. Um, and this—so SAMHSA provided these domains as guidance to help an organization think about how it might get started in developing a trauma-informed approach. The guidance can assist in the development of a changed strategy, can help identify organizational strengths and weaknesses, provide milestones to measure progress, and prevent the occurrence of re-traumatization.

While the list of domains is similar to what one might find in any basic organization change model, it is the infusion of the six key principles that make it trauma-informed. Even though no

checklist can cover every situation, this general set of guidance can be useful as a starting point. [00:36:05]

What I'm going to do next is I'm going to pull out a couple of these domains and, um—and I'm going to show you the kinds of questions that a primary care setting might want to ask itself as it looks to implement a trauma-informed approach.

In the area of policy, a primary care setting may want to look at how it's agency's written policies and procedures look at focusing on trauma and issues of safety and confidentiality. What are the policies around patient privacy, for instance. Um, what are the policies in terms of how a person is seen when they come in and whether they have opportunities for private time with the doctor without their spouse. Um, what are the policies around screening, and how do they recognize the pervasiveness of trauma in the lives of the people, um, coming into the primary care setting? Also, how do Human Resource policies attend to the impact of the, uh, physicians and other staff working with people who have trauma in their own lives and also working with patients who have their own issues.

We can also take a look at engagement and involvement. So, how do patients—what opportunities do patients have to provide feedback in terms of the office's engagement practices and services received? How are—how are staff members fully informing patients of their rights, of their policies and rules and activities and schedules? Um, how is transparency and trust among staff and clients promoted? [00:38:00]

Another domain is in the area of training and workforce. How is the agency, um, addressing the emotional stress within their own workforce when dealing with individuals who've have traumatic experiences? What are ongoing workforce development activities provided to the staff in the primary care setting, and how do they integrate trauma knowledge into, um—into their opportunities? What training is provided to whom?

Um, these are some of the questions that a primary care setting can ask itself as it's looking to implement a trauma-informed approach. More details about each of the domains and the types of questions a primary care setting might want to ask are provided in SAMHSA's concept paper. And I know Eddie is going to go into greater detail to walk through, um—to walk through what this looks like in the work that he's been doing.

The next thing I want to quickly touch on is SAMHSA's General Adult Trauma Screening and Brief Response Initiative—um, which is really building a framework for screening and brief response for trauma across the lifespan in primary care and other health—and public health settings. So really, how do we integrate, uh, within the context of primary care, screening for trauma across the lifespan, and the capacity to respond or to refer out?

This is an initiative that SAMHSA's been engaged in for over a year. We're working with a technical experts group, both comprised of federal colleagues as well as experts out in the field. Eddie and Leah are two of the experts that we're working with.

Some of the key questions that we're asking in the context of what we call our [Gatsper] (ph) Initiative: Why would you screen in primary care? And what would you do with the information? What models, tools, and resources currently exist? What needs to be in place before moving forward? What workforce development and training is needed? And how do we get buy-in, uh, from primary care settings? [00:40:17]

We've engaged in a number of activities in this particular initiative. We've launched the initiative with a face-to-face experts' meeting last year. We then engaged in a series of, uh, what has now been four virtual discussion groups. Um, the first two—one focused on screening and one focused on brief response—and each one of those virtual discussion groups met three times, um, to help us frame our thinking and think about how we might provide some guidance and support to the field around these issues of screening and brief response.

We then have started in developing a toolkit for primary care and other health care settings. And we continued to engage with our federal and field experts. Um, and you can see who some of our partners [are]. [00:41:10]

Here is what we have accomplished today. First and foremost, our experts have told us that what's most essential when you think about screening for trauma across the lifespan is that the setting really addressed becoming trauma-informed as the first step, and then, to figure out how would we respond when we ask questions?—and then to think about how might we identify ways to solicit information or engage in screening?

Through our project, we've identified a trauma-screening framework for both providers and patients. This is not a screening tool but more guidance on things to think about if you were to go forward with screening. [00:41:59]

We've developed a description or definition of brief response to trauma in primary care and other public healthcare settings. We created a matrix with five categories for brief response and key questions that should be considered. Um, we identified elements for our toolkit. We have now completed a first draft of our first product and sent it to our experts and stakeholders for comment.

Our toolkit will include three elements: An infographic and introduction that's really focused on, "Why should you care about trauma in [a] primary care setting?" — followed by a fact sheet: "How does understanding trauma change your medical practice?" And then the third piece is an implementation brief that we're calling, "Getting into Action," which is how to get started.

So that is our [Gatsper] (ph) [00:42:53] Initiative in a very quick nutshell. And, um, I thank you very much and, uh, look forward to any questions you may have. I'll pass it back to Karen.

MODERATOR: (computer sound) Thank you so much, Mary, for all that important and relevant information related to the work that SAMHSA's been doing in this area.

We do—we want to take a short break here for—to try and answer some questions that have been asked, um, and then we'll continue on with Eddie after this brief pause. (computer sound)

So one question perhaps for Mary or Leah: “How or in what ways is brain neurobiology changed by traumatic experiences?”

MARY BLAKE: So this is Mary. Uh, can you hear me?

MODERATOR: Yes, go ahead, Mary. Thank you. [00:43:50]

MARY BLAKE: Great. Um, so if you think about it in the bas—the nuts and bolts of the impact of trauma, it really has a profound effect on the central nervous system. And really all the way down to the amygdala and kind of triggering this fight, flight, or freeze response. As a result, um, we start to see alterations in the workings of the biological stress response systems. Um, some of the particular impacts we can see are overactive stress hormones released—altered neuroendocrine system. Um, there’s some research that shows some impact on brain volume including reduced hippocampus volume. Um, and there are many other impacts that can arise as a result of people being in a chronic state of hyper-arousal and hyper-vigilance.

So those are just some of ways that the, uh, neurodevelopment is affected.

MODERATOR: Excellent. Thank you so much, Mary. I’ll do—we’ll do one more question and then we’re going to proceed. Um, so this question may be for both of you—if you have any thoughts, perhaps, on how you help a person that has not realized they are traumatized by the behavior they display, and there’s knowledge that that person was abused as a child. So, um, “What do you do when a person fits into every category of displayed behaviors but things they are doing and—doing well and treating people in a way that is very normal?” Any thoughts on that?

MARY BLAKE: (pause) Okay, so—I don’t know, Leah, if you want to run with this or would you like me to? [00:45:46]

LEAH HARRIS: Yeah, I was—I was thinking about it. Yes, it’s a—it’s a tough question! It is not an easy question. I guess, you know, what I would just say is that (sigh) it’s not only that we share the information, but it’s how we share the information about trauma. And I think just to say that—you know, I don’t know what the behaviors are in particular, but to say not—maybe put it on the person directly—but to say, “You know, in my experience, I’ve seen that a lot of people who have, you know, a history of trauma struggle with the following things.” You know, and the person may say, “Oh, that resonates.” Or they may say, “That absolutely doesn’t resonate.” But I think the key is just continuing to create a sense of safety, you know, because so often people don’t feel comfortable to discuss this until that sense of safety is present. Um, so I think that kind of would be my answer off the top of my head, Mary. I don’t know if you have anything to add to that.

MARY BLAKE: I do. I mean, I think in the first place, it’s not unusual that people don’t connect their experiences to their current behavior. I think that’s pretty common. The one thing that you can do to help is, as a primary care doctor, to be aware of how trauma can impact how people react, how people behave, and to—and to be sensitive to ways in which how you practice can avoid re-traumatizing, and to really kind of work with the person around their stated reason for

being there. If it's an issue with obesity, perhaps understanding that the obesity may actually arise in the context of prior abuse. And so you may tailor how you work with that person on their obesity issues just a little bit differently.

So I think that, um, part of the answer is maybe you don't help them specifically with their trauma, but you can change your practice in a way that they are more engaged with you as a primary care doctor, which can give rise to opportunities for their other experiences to come on the table and for you to take the next step with the patient. [00:48:04]

MODERATOR: Thank you so much both Mary and Leah for those answers to what it was a tricky question and a hard one. Thank you very much. And—and one very short one, Mary, um, before we move on. “What is the timeline for the toolkit package to be available?”

MARY BLAKE: Well, right now what we're doing is we are finishing up each of the toolkit products. We hope to have drafts completed, uh, within the next three months. And then—um, and then they'll have to go through SAMHSA's clearance process. And anybody who knows how the clearance process is with federal products can go—it can take a little bit of time. We would hope to see them released, uh, next fiscal year, but I can't tell you exactly when—perhaps maybe sometime in the spring or summer of next year. But, uh, that'll depend on a number of factors.

MODERATOR: Thank you so much! Okay. Now we're going to move forward into, um, the second half of our webinar—or the last portion. And, for this portion, we are privileged to have Eddie Machtinger, M.D., who is a professor of medicine and director of Women's HIV Program at the University of California, San Francisco. Eddie has been published many times, um, on the topic of trauma. He is a leading national advocate to transform the Ryan White Primary Care System for low-income people living with HIV into a realized system of trauma-informed primary care. Eddie? [00:49:53]

EDDIE MACHTINGER: Thanks so much, um. Good afternoon or good morning. It's an honor to be included on this webinar with each of you and talking today. So, I'll just dive in. Um, the Women's HIV Program where I work—um, WHP, is partially supported by congressional Ryan White funding for clinics caring for underserved and low-income people with HIV. And it's a national network that cares for about 600,000 people with HIV across the country. And like all Ryan White clinics, our clinic, WHP, provides on-site, interdisciplinary services, which include primary medical care, gynecology and obstetrics, a pharmacist, a social worker, case managers, therapy, psychiatry, linkages to substance abuse treatment, and an (inaudible at 00:50:48) breakfast.

Um, in our program, over 85 percent of the women are on HIV medications. And of those, over 85 percent have undetectable viral loads. And both of these are higher—much higher than national averages.

And I—I say this not to claim that our clinic, or the Ryan White system in general, is trauma-informed—or that it takes optimal care of patients—because both of these are totally untrue. At our program, for example, despite receiving optimal federal monitoring reports and being

considered a national model of care for this population, if you scratch just a little beneath the surface, you find out that 40 percent of our patients are using hard drugs like crack cocaine, methamphetamine, or heroine. 50 percent report being depressed. Very few are out about their HIV status or histories of trauma, which makes it really hard for them to make friends and form supportive relationships. Many are living with abusive partners. Very few are working. And far too many are dying. [00:51:55]

Um, so my focus on trauma came from an epiphany that we had studying why so many of our patients were dying despite access to interdisciplinary services that are probably far more robust or broader than what you have in your clinics or what you have where you receive care. And, what we found was at WHP, of the women living with HIV who die, only 16 percent die from HIV/AIDS. And nationally, only 25 percent of deaths among women living with HIV, um, are due to HIV/AIDS.

And so, most women—if you dig deeper—living with HIV who are dying, are dying from violence, suicide, addiction, and other diseases known to be associated with childhood and adult trauma. And so our epiphany was that HIV, um, like other diseases, including like heart, lung, and liver disease, obesity, and diabetes, depression, and substance abuse, and many others, is a symptom of a far larger problem, which is widespread, unaddressed trauma. And these diseases are often stubbornly refractory to treatment, which is probably familiar to you and why you struggle treating substance abuse or depression—in part because we're not addressing the trauma and post-traumatic stress disorder that underlie and perpetuate them.

So, the impact of trauma, um, to me is most [convividly] (ph) [00:53:40] illustrated by describing to you the most recent deaths in our clinic. And these are actual.

So, of the ten recent deaths, two were from murder; three were from suicide; three were related to addiction; one was from pancreatic cancer; and one, um, was a 22-year-old woman infected at birth, who we knew since she was a little girl and loved tremendously, who stopped taking her antiretroviral medications due to hopelessness, and died from a completely preventable opportunistic infection called PML. [00:54:13]

Um, we knew all these women really well. And, they were all really different. But their stories are all united in having life-long histories of trauma. Uh, that—and this trauma contributed to their being infected in the first place, and led to their deaths—literally in the case of Rose and Amy, and through substance abuse, depression, and hopelessness in most of the others. And it's important to note that all of these women were fully engaged in care at the time of their deaths.

So, after Rose was murdered by her husband, we convened a city-wide group of the many agencies who had worked with—and really loved Rose—to learn from what happened. And we concluded that our clinic—and really our whole San Francisco care system—was unprepared for the leth—for the lethality she faced, and had no services designed to help her recover from the serial abuse that she had sustained, or gained the self-efficacy or social support to leave this guy a long time ago. And at that time, we committed ourselves to changing our clinic to be more responsive to the actual needs of our patients. And to do that, we partnered with the Positive

Women's Network USA—which is the largest advocacy organization in the country led by and for women living with HIV.

Um, the PWN—they were also seeing the devastating impact that unaddressed trauma was having on their members and on themselves. And we looked for a way to address trauma in a primary care clinic setting and found that there was a lack of guidance at that time for a clinic director like me about the core components of a practical approach to trauma-informed primary care. [00:56:07]

And so, together, we convened a working group of 27 leading national policy-makers, trauma experts, advocates from the government, military, academia, clinics, community organizations—um, and it included Larke Huang from SAMHSA, and others, to identify evidence-based building blocks of a practical approach to trauma-informed primary care with a particular emphasis on addressing both intimate partner violence and lifelong abuse—not just intimate partner violence but both intimate partner violence and lifelong abuse, and that has a strong emphasis on provider well-being. And I'm going to very, very briefly describe each of the components.

And so, on the left, the model we developed has three core components and rests on a robust organizational foundation. And for me, this really was the guidance I was seeking years ago when Rose died, uh, when I first sought to develop a trauma-informed primary care clinic. And I think, uh, this information hopefully dovetails and builds on the concepts just presented by Mary.

And so, just looking at the graphic, the first component is a trauma-informed environment that is calm, safe, and empowering for both patients and staff. Um, in this type of environment, providers and staff from every discipline are educated about the impact of trauma on health, and just as importantly, skills to communicate with patients and with each other, um, that are more supportive and less triggering.

Um, often—just as an aside—often the environment in which we work mirrors the trauma experienced by patients. Like providers are reactive, tense, and can be defensive. And I've seen this education alone—um, skills-building and education about trauma—go a long way to changing this [vibe in-clinic]. (ph) [00:58:08]

Uh, the second core component is screening. And in a trauma-informed clinic, providers routinely inquire both about current trauma and lifelong abuse. And I'll just say as an aside, it doesn't have to be every provider, it could be the appropriate provider depending on your clinic as well as about the consequences of lifelong abuse, including complex PTSD, depression, and substance use. And all to say that although screening is routine in universal, disclosure is always led by the patients and guided by the respect for patient choices. And, one more thing, interventions can be offered without requiring the patient to disclose the details of lifelong abuse.

And finally, screening is directly linked to on-site or community-based interventions that address current and lifelong abuse. And so, for example, for recent trauma, someone discloses that they're currently being abused, um, or experiencing violence, immediate safety and autonomy

are prioritized, and interventions might include an algorithm for safety plans, danger assessments, and referrals to community-based, domestic violence organizations.

For the consequences of lifelong abuse, interventions are longer-term and ideally would include on-site or referrals to evidence-based group interventions. At least, any existing services in-clinic like social work, therapy, substance abuse counseling, medication adherence, or whatever you have in-clinic, can become trauma-informed and recognize a link between lifelong abuse and physical and behavioral health, and then integrate this understanding into their care and attitude that they have with patients. [00:59:55]

And lastly, these three components are dependent on a strong foundation. Um, some of which—some of us don't work in clinics that have this strong foundation. But ideally it would include a core set of trauma-informed values, robust partnerships with community-based organizations, clinic champions from each discipline, and an ongoing response to vicarious trauma among providers.

So, I say all this, um, but really want to say two more things about this approach. The first is that this model is aspirational. Most of us are not fully in control of our clinical environment. Even clinic directors are not in control. I'm not in control. This approach can and likely should be implemented incrementally. For example, you can start with a training about the impact of trauma for the entire staff. And from there, clinic champions can be identified and protocol can be made for screening responses and referrals. And it's not that this is easy, um, but it's doable. And there are now excellent resources from SAMHSA and many others about how to realize each of these steps depending on your clinic resources and population.

So, the second main point I'd like to make is while this model is a helpful tool, when I was asked to do this talk today about how to begin creating a trauma-informed clinic, I realized that the single guiding principle that helped me—me move towards becoming trauma-informed is reducing isolation for both patients and for us. People who have experienced significant trauma are often profoundly isolated and have never been provided with information about the impact that trauma has had on their health and behaviors—or provided with a safe space to either talk about their experiences or learn the skills to cope with them. Finding ways to help reduce that isolation is likely going to be the most important intervention we make. [01:02:06]

And—so similarly, it's preposterous to think that we as providers can help patients heal from trauma if we ourselves are working in highly stressful, chaotic, and unsupportive environments. For me, as a primary care provider, each successful step towards creating a trauma-informed clinic has included reducing my isolation and creating structures that increase the amount of support I receive from my colleagues in my clinic and in the community.

So, in the next few slides, I'd like to describe a few steps that I have taken towards reducing isolation and becoming more trauma-informed in my clinic that I hope you'll find helpful in your individual efforts. (pause)

Um, so within my clinic, I've come to appreciate the aspects of our existing care model that reduced the isolation of providers and provide an ideal foundation for becoming more trauma-

informed. So before each clinic, we have an interdisciplinary conference for 45 minutes to discuss each patient that is coming in that day. And that conference helps providers feel like they're not shouldering the entire care experience alone. Many of our patients are really, really complicated and really at high risk of death, and being isolated in their care is a tremendous burden. And being together helps unburden providers.

Often, I see patients together with our social worker, case manager, or pharmacist. We, um, have quarterly meetings to discuss those patients at highest risk of death—it's called a "Risk of Death Meeting,"—and those who are lost, to follow. Again, so that I'm not sitting with this information alone—and so I can know that everything possible is being done for my most vulnerable or triggering or chaotic patients. [01:03:56]

And the new thing is, you know, we've (inaudible) trauma-informed primary care. We've just recently contracted with a really amazing trainer. Um, she plans to close clinic for one-half day, four times over the next six months, to dive deeply into topics with our entire staff that I'm so excited to learn about. And the topics include basic principles about the impact of trauma and health, skills to communicate with patients and with each other—and then with topics that I'm so interested in and I think are so important like institutional racism and implicit bias.

So, um—I've also had a great experience forming new partnerships with individuals and organizations outside my clinic that have led to far more options for my patients and some of the best professional experiences of my career. These relationships have focused on organizations and individuals who work applies to any trauma-informed clinic. And these include peer support and political advocacy, sisterhood and storytelling, trauma specialists from other institutions, and researchers.

And I'd like to briefly describe the impact of four of these relationships. The focus of each of these partners isn't necessarily HIV specific and really can be a crucial ingredient to any trauma-informed clinic. So in other words, you can't do this all yourself. The depth of healing required by our patients requires sisterhood and catharsis that can't all be achieved in the clinic setting.

And so these are the types of examples of organizations to look for in your communities over time with whom to partner.

Um, the first is with an organization that provides peer support and political advocacy. I'd met Nana Cana, (ph) the director of the PWNUSA, Positive Women's Network USA, in 2012 at the International AIDS Conference. And we have since become formal institutional partners. And I have learned many things from Nana that have guided my efforts to build a legitimately trauma-informed clinic. [01:06:05]

I have received guidance at each step from people with lived experience of both HIV and trauma. Um, Nana introduced and mentored me about the power of political advocacy. Her organization provides our patients with access to sisterhood and leadership training. And [this relationships]—this relationship continues to result in a better care model that I'm developing—more influence in a relationship for me in this effort to advance trauma-informed primary care and peer support for patients.

So I've advanced my slides to the next one. That was Nana. Sorry about that. And, so the next person is with a community arts organization that facilitates sisterhood and storytelling.

Um, for over 25 years, Rodessa Jones has been the founder and director of the Madea Project Feeder for Incarcerated Women. And she developed a method in jails to bring women together and help them develop the skills and confidence to tell their stories publicly through feeder.

We met and applied for a collaborative grant that allowed her to work with our patients outside of jails. Her method held particular power because their stories [are] (ph) the stories of our patients include being HIV positive and having histories of trauma. And her work provides healing for patients that is just not possible in-clinic. And this partnership with Rodessa has led to incredibly fulfilling relationships—both with her and with my patients who participated, because I'd go to the practices and come to know them in a completely different light—and the process which is also so daring and inspirational. And from this experience, I learned that it is possible to heal from profound lifelong trauma but that it requires hard work and a deliberate method.

So I've just two more quick slides of examples and then just a simple conclusion. [01:07:57]

Um, the next category of relationship that has been so helpful is with trauma experts who've been at this work far longer than I have and have so much to share. I now have met many of them, but Lee Kimberg (ph) has been there the longest.

In my medical residency, she taught us how to screen for intimate partner violence and gave us all her cell phone number to support us if we ever encountered a situation with a patient that felt overwhelming. And from Lee, I get personal support and guidance for our trauma-informed care effort—advice about patients anytime. And she also taught me a framework called “The Four C's”—which I wish I had time to talk to you about and can post information about later—to engage patients who have experienced serious lifelong abuse. Lee inspired me to engage more deeply with patients who have experienced lifetime trauma now—even, um—(pause) even before we've created a full model for the whole clinic.

So I'm going to skip the [Four C] (ph) slide out of respect for time, and then just lastly mention, um, the fourth type of partnership that I think is so careful, and that's with researchers who can provide mentorship, knowledge, and skills. And for me, one such mentor has been Carol Dawson Rose, a professor of nursing, who shares trauma-informed values and a desire to see this work gain credibility. And as a result, she has co-led studies that guide our care model, has allowed us to evaluate and learn from what we're doing, helped us develop credibility, new relationships, and many more opportunities to fund this effort.

So, in conclusion, there are many steps you can take to begin building a trauma-informed clinic. And there is more guidance available now than ever before to do so. For me, the first step and guiding principle has been reducing isolation and building supportive relationships for both—really for both patients and for providers. [01:09:57]

This is crucial for patients to heal from the impact of trauma and providers to sustain the love, compassion, and presence to move from treatment to healing. And if you can, find people to collaborate with who you like, who support you, and who share trauma-informed values. And even now, before a larger system is in place, learn to engage traumatized patients. Doing this is really liberating because you realize that the point of each encounter is to form relationships and not necessarily to accomplish a series of tasks. And from there, clinic-wide transformation can begin. Thank you so much.

MODERATOR: Thank you very much, Eddie. Appreciate all that you have shared today and all that Mary and Leah also shared. So now, we are going to move into our question and answer portion. We do have a good amount of questions, so we'll try to move through these really quickly.

One classic question that I'd like to ask to whoever might respond is, "In a normal primary care visit, how could we have the time to do and address the trauma issue." So the time question. Someone could answer that.

EDDIE MACHTINGER: Um, I'll just take a quick stab at it. Um, (pause) you don't really—you don't really have to take a full trauma history on every patient that you encounter. We're mandated to screen for intimate partner violence, which is protocolized, and there's a lot of assistance in helping us do that. And it doesn't even have to be the provider who screens for intimate partner violence. It can be the medical assistant or the social worker or someone else in-clinic. Um, but in terms of lifetime abuse, it might not even really be appropriate to screen or talk about lifetime abuse with a patient who has just met you and with whom you only have a few moments—and who has been betrayed by so many people in their lives, um, previously, and might just be starting to trust you. [01:12:04]

And so my effort is less about screening for trauma and making interventions for trauma than giving people space to share with me who they are and what's really happening in their life. And also, I have a rule that I try to say something positive to a patient every visit—no matter if they're on crack or, you know, what state of mind or state of physical well-being they're in—just complimenting them or appreciating them for having made the effort to come into clinic that day.

And it's that openness, you know, and less of a focus on getting through a series of tasks like immunizations or checking their med list, or other things that actually leads me to tackle really what is their biggest risk for death—which actually isn't HIV—or oftentimes, the disease that they have, but instead addiction and violence and other very stigmatized conditions. That will only come up if you give them the space to bring it up.

MARY BLAKE: So, Karen, this is Mary. I just wanted to add a couple of other things to what Eddie said because this is an issue that's come up as a question in our Gatsper work, as well. Um, another way that, um—that clinics can use to have information available to patients and to staff is to have educational brochures in waiting rooms. And those kinds of—that kind of information—number one, signals that the organization is open to hearing about people's experiences if they feel like sharing them. It also, um, is a way to provide information to patients.

So maybe they have their own “Aha” moment about what’s happening—as well as for the staff to understand that. [01:13:52]

And ultimately, you know, one thing to consider is, um—instead of, “What are you going to specifically do to get at the root of trauma for your patients?” —is to take a universal precautions’ approach. You assume that there will have been some violence abuse or adversity in the person’s life and you reconsider how you approach people based on that knowledge. So, um, those are some other—some other things that, um, occur to me.

MODERATOR: Mm hmm. (pause) Thank you both very much. Moving to the, um, topic of culture, there’s two questions here, um—and I think I’ll just, um, try to combine them both. But would you offer any ideas that people should keep in mind related to working in multicultural settings with traumatized patients who come from countries all over the world, and you’re working with them in short-term care? Another question was focused on, you know, how—what do we need to consider related to the question of culture when we’re addressing trauma-informed care in a primary care setting?

MULTIPLE VOICES: (overlapping talking)

MULTIPLE VOICES: No, go ahead.

FEMALE VOICE: Go ahead, Eddie.

EDDIE MACHTINGER: Oh, I just wanted to just bring up humility. I, um—you know, I try to know what I don’t know, and I’m very humble about the life experiences of many of my patients that are very different than my own. And, um, part of our effort towards trauma-informed care is to get training in specifically—most of my clients are women of color—and I’m not a woman of color and I’ve not had the lived experience of a woman of color. And so I try to partner with organizations led by women of color—um, led by women who have lived experiences. And then the trainings that I’m most excited about are the ones about trauma in its broadest form in terms of structural violence like trans-phobia and racism—and then, un-implicit bias to understand how we’re possibly triggering, um, you know, more trauma for our patients by really not understanding their own—um, their own triggers. [01:16:13]

MARY BLAKE: Yeah, this is very—I wanted to go back to SAMHSA’s “Three E’s”—that middle E. So you have what has happened to the person, and then you have how they make meaning of it. And to understand that when people go through bad things, um, how they understand those things—and I don’t mean necessarily deliberately or consciously—but how they make meaning of what happens to them is driven in many ways by historical context, social context, cultural context, and all of that. So that, whereas we may assume that a person would feel a certain way or have a certain impact by something that happened, we need to recognize that, um—that people—how people talk about what happened to them and how they make meaning of it is very much, um, culturally influenced.

And so—going back to what Eddie was saying about humility—it’s to understand that the person may not describe their experiences in a way that would—would be a way that you would do it because maybe you come from different cultures.

The other thing that I would like to say is I would very much like to acknowledge the work of Dr. Richard Mollica at Har—at the Harvard Program on Refugee Trauma, who’s done some really beautiful work really on this cultural piece and his book, “Healing Invisible Wounds,” is very profound to really take a look at that cultural implication. [01:17:52]

MODERATOR: Thank you! Thank you, Mary and Eddie. A question related to vicarious trauma—can you speak to, um, how vicarious trauma plays out for witnesses of domestic abuse and assault? (long pause)

MARY BLAKE: Well this is Mary again. I feel like I’m dominating a little bit here. [And I don’t want to.] (ph)

EDDIE MACHTINGER: (laughs)

MARY BLAKE: I mean I think that it’s well-recognized that the witnessing of violence can be just as, um—just as impactful as the direct experience itself. I’m not quite sure I understand if there’s anything more to that question or not. Um—

MODERATOR: Mary? Mary, there isn’t. I think you touched on it that, um, it’s just a simple—it’s—as I noted, it’s a short question—but noting that witnessing violence perhaps is as traumatic—or can be as traumatic as being the direct victim.

MARY BLAKE: Right. I would also say that it’s probably more—more the case that it’s under-addressed in the context of kids growing up in an environment with domestic violence or other people in the household or the environment. So, it really—it really can have just as much of an impact as the direct experience, um, and should be considered as such.

MODERATOR: So, thank you on that, um, same topic related to how others are affected by the trauma around them. Um, there’s a question: How does trauma affect personnel within our clinics who are in prolonged stressful work places and are providing these services—and perhaps what to do about that? [01:19:53]

LEAH HARRIS: Um, yeah. This is Leah. You know, I think it’s not, “How does trauma affect personnel?” It does affect personnel, right—in multiple ways. Um, you know, I think so often people—you know, various service settings are understaffed. People are witnessing all kinds of really difficult situations. There’s often not enough support for staff. Not enough time to care for oneself. You know, and I think just being continually stressed and overworked, you know, comes out in the ways that Eddie mentioned earlier. You know, people can be shorter than they’d like to be with their patients or just feeling too hurried to take the time to really understand what’s going on for a person. So, I think—you know, critical is that, you know, in this process of becoming trauma-informed—but that part of it really is promoting really—actively promoting self-care for staff—you know, even in the face of budget difficulties that prevent optimal staffing levels. So I

think that's kind of how I would begin to answer that question and definitely defer to Mary or Eddie for further thoughts on that.

EDDIE MACHTINGER: I—I just have one thought. I—I think sometimes, um— (pause) a vicarious trauma becomes the norm. You know, I—I went into kind of a frontline, poverty, medicine clinic understanding that environment—these environments are really chaotic. And in some ways, because of my own background, I found that appealing. I thought that somehow that'd be exciting and, you know, helpful to me. And so many of us have our own trauma histories. And what I came to realize is that the norm, which is—you know, for most of these frontline, you know, Medicaid, poverty medicine clinics—is the opposite of what providers and patients really need. They need—instead of total chaos in the lobby and people, you know, building mountains of the breakfast food instead of eating it because they're high on crack or, you know, fighting with each other—they need like—they need a calm and safe environment. And we, as providers, need a calm and safe environment. [01:22:09]

And I don't—I think there's a culture that has been accepted in poverty medicine or chaos. And I think there is a bar that has been set far too low for patients, in terms of outcomes in poverty medicine clinics, where it's okay to have their [viral load] be undetectable, but we can just ignore the fact that they're using drugs, not working, not out, and with a decent relationship. And I think both of those things really need to change. And I think that's why trauma-informed care is so—so exciting to me because I think it can really change the primary care experience for providers and patients in frontline clinics. And hopefully, more people, more high quality medical students, more nurses, will go into frontline primary care instead of into Dermatology or, you know, ENT or Ophthalmology, because the clinics can be more healing.

MARY BLAKE: Thanks, Eddie. And this is Mary. I had one other thought to add to the great comments by Leah and Eddie. That is we often talk about vicarious or secondary trauma when we're talking about the work force. Um, and as Eddie touched on, I don't think we can forget the fact that the workforce is also composed of people with current and direct experience of trauma. And, um—and what we have found is that very often they are afraid to discuss it or get help for it. And—and that also is its own issue.

So, um—you know, for the primary care clinic to really recognize that trauma may be impacting everybody who walks through the doors and to be somewhat intentional about, um—about attending to that fact—whether it's by providing good referral information, resource information in the waiting room. [01:24:12]

Whether it's providing the educational materials for staff and patients alike—that shows them that these experiences are common and that people really can and do heal. I think that's another piece that I think is very important. We often look at trauma through a pathology lens, but many people who've experienced trauma—including myself—will say that it's really important to also use a strength-based, resiliency-focused approach, um, that shows people that people can and do recover and heal from their traumatic experiences. And the ways those experiences are spilling out in their physical health concerns.

MODERATOR: Thank you so much, everyone, for those excellent answers. We are almost out of time with questions [and will] do one more, however. And, thank you so much for all who have asked many questions. They're—they're really relevant. Um, unfortunately we won't be able to address all of them. I've tried to put them into topic categories. But one—one more question that seems come—that's come up more than once is: What recommendations would you have for someone—a client who is in a setting and finds the doctor, or whoever is in the room with them, to be dismissive related to their trauma and their trauma needs? Do you have any suggestions for how that client may share, um—may communicate with the providers in the room about their needs?

LEAH HARRIS: This is Leah. Um—well, my first suggestion would be [to] find another provider. But I understand that that is not always easy—particularly if you're on, you know, Medicaid. You know, it can be very difficult to change providers. Um, but that would be my first (chuckles) suggestion. [01:25:57]

Barring that, um, people have found it helpful to take an advocate with them into their appointments. Um, you know, I personally have benefited from that. I've been the advocate for other people. And to really, you know, rehearse and practice what you're going to say in the appointment. I think, in the moment, you know, people can be very intimidated by their providers and then sort of the questions go out the window. But having that—that (inaudible) support with you in the appointment, rehearsing what you're going to say in advance, um, I think can be very helpful. Um, those are my thoughts. Um, welcome other thoughts.

MODERATOR: Thank you so much, Leah. That's, um, very helpful feedback. Unfortunately we don't have time for any other, um, answers right now. So thank you for addressing that question.

Before we end today, we wanted to make sure that you, all of you on the webinar, are aware of our, uh—of some really helpful resources available to you. I would point you first to SAMHSA's website and all the many resources that Mary talked about specifically. Uh, they have a tip on trauma-informed care and behavioral health services, which can be very helpful for behavioral health professionals to understand the impact and consequences for those who've experienced trauma and how to—how to, um, do this work within that setting.

Secondly, we have CIHS's trauma-informed care resources. So we would point you to their website—features trauma screening tools that can be used to screen for the presence of adverse or trauma life experiences. On that website, you will also find information about, um, the national council's initiative with Kaiser Permanente, which is a—a learning community with [FQHC's] (ph) that, um—across the country in which we are striving to advance trauma-informed approaches within those clinics.

Thirdly, we would point you to the American Academy of Pediatrics Trauma Toolbox for Primary Care. Pediatric—the pediatric community maybe came to this first, perhaps, relate—in the primary care setting, this trauma work. And there is lots of wonderful information that you can find within this toolbox. [01:28:12]

For more information or resources, please be sure to visit our, um—our CIHS website in which you will find many resources and tools that can be valuable to your work as you move forward.

Thank you so much for all who have presented today. And on this slide you will see all of our contact information. And I'm—I'm sure everyone who was present is open to you reaching out to them with additional questions that may have come up for you in this webinar.

Thank you, again, Leah, Mary, and Eddie, and Alex, for all that you have shared today—a really valuable, informative webinar that has, um, covered so many important areas of a very relevant topic.

There is a survey at the end of this webinar as you'll find if you sign off. We please encourage everyone to fill out the survey so that we can, um, have information related to how you found this relevant, important, etc. [01:29:15]

(background sounds until 01:29:25)

MODERATOR: And one more piece of information. Just please know our slides and recording from this webinar will be available within 24 hours at, um, our CIHS website, which is integration.samhsa.gov. And you'll find it under—you'll find it about—under the “About Us Webinars” link.

Thank you so much, everyone! We hope you have a wonderful day.

[01:29:52]

END TRANSCRIPT