TRAUMA INFORMED CARE:

NEW INNOVATIONS IN MENTAL HEALTH CARE

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Abstract

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This paper examines the history of mental health care in America. It focuses on the social factors that have shaped the modern mental health care system. It further examines the need for trauma-informed care. This paper gives a brief overview of the significance of trauma-informed care and whether further reform is necessary.

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Chapter One: Introduction

The field of mental health is very expansive and continues to grow. For instance, since the year 2000, mental health disorders among active-duty troops have increased 65% (Ruiz, July12, 2012). In 2011, The Substance Abuse and Mental Health Services Administration (SAMHSA) released the results to their survey, which indicated forty-five million Americans suffer from some form of illness (Latham, 2011).

Recent studies indicate that up to 81% of men and women who are diagnosed with a mental illness have experienced some sort of sexual/physical trauma in their past. Sixty-seven percent of these men and women were abused as children (Kaufman & Zigler, 1987). Many psychiatric hospitals struggle with patients who have multiple psychiatric disorders that are compounded by the after effects of numerous traumas. Unlike traditional hospitals' patients, patients with mental illness can exhibit behavioral issues including sexual acting out, physical and verbal aggression and property damage.

Traumatic experiences for both adults and children can result from violence, abuse, natural disasters and neglect. Trauma creates a sense of fear, powerlessness, hopelessness, and a constant state of alert ("Substance abuse and,"). Until recently, treatment for patients who had experienced trauma was done similarly to treatment for non-traumatized patients. With the growth of evidence based practices, the practice of trauma informed care has expanded. Trauma-informed care engages patients' history with abuse and helps them acknowledge the effect of past abuse in their lives ("Substance abuse and,").

Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental

health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system ("National institute of,").

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of individuals seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization ("Substance abuse and,").

Previously psychiatric patients were often treated as if their symptomology was in fact in their control. Many hospitals refused to treat psychiatric patients, and those that did used leather restraints, padded rooms and shock treatment (Butler, 2011). The mentally ill were used for experiments and held against their will, sometimes for years.   The laws that govern commitments within the U.S. have changed as well. In the 1890s the legal standard of commitment merely required the presence of mental illness and a recommendation of treatment (Testa, 2010). More recently, both mental illness and dangerousness are required.

Trauma-informed care has been developed to reduce the amount of trauma a patient may have while hospitalized. It was developed to change the mind-set of providers and prompt staff to change the paradigm and instead of asking, "What's wrong with you?" ask, "What has happened to you?" ("Substance abuse and,")

Statement of the Problem

The problem to be addressed is how the treatment of mentally ill patients evolved into the movement toward trauma-informed care.

Definition of Terms

"Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives" ("Substance abuse and,")

"A Mental Disorder is a health condition characterized by significant dysfunction in an individual's cognitions, emotions, or behaviors that reflects a disturbance in the psychological, biological, or developmental processes underlying mental functioning. Some disorders may not be diagnosable until they have caused clinically significant distress or impairment of performance. A mental disorder is not merely an expectable or culturally sanctioned response to a specific event such as the death of a loved one. Neither culturally deviant behavior (e.g., political, religious, or sexual) nor a conflict that is primarily between the individual and society is a mental disorder unless the deviance or conflict results from a dysfunction in the individual, as described above" (American Psychiatric Association, 2000).

Delimitations of Research

The references used for the review of literature were collected over a period of 91 days using the resources of the Karrmann Library at the University of Wisconsin – Platteville and Wyllie Library at the University of Wisconsin – Parkside. The several search engines provided by EBSCOHOST were used. The key search terms were "Trauma informed care and mental

illness," "trauma informed care," "approaches of treatment of mental health disorders," and

"trauma of mental health disorders."

Method of Approach

      A brief review of the history of trauma informed care was conducted. The review of

literature relating to research and studies regarding the approach of trauma informed care in

working with both adults and children with mental health disorders was conducted. The findings

were summarized and synthesized, and recommendations made.

Chapter Two: Review of Related Literature

History of Mental Health Care

The history of the care of the mentally ill revolves around the reactions to societal-specific problems. Many interventions were developed due to societal issues in an attempt to better the lives of both the mentally ill and society as a whole. Each solution proposed flourished initially but eventually failed, only proven to be successful for acute or milder patients but not for traumatized patients (Morrissey & Goldman, 1986).

The first effort in the United States to improve the care of the mentally ill was the creation of the asylum. In the 1840's, state after state began to create public insane asylums for the furiously insane (Luchins, 1988).

> The bourgeoning of reformism in the 1830's and 1840's was the most remarkable phenomenon in the society history of that generation. Scarcely a field was left untouched…[the] reformers and their followers traveled far and wide, lectured and lobbied persistently, and were on the whole extraordinarily successful in arousing the people and legislators to provide institutions for care and education of the unfortunate at public expense (Baldwin, 1952, pp. 613-616).

Insane asylums were erected to prevent mentally ill people from going to jail, where there was little support. Reports were distributed detailing the conditions in which the "insane" live. This prompted states to develop a solution in the asylums.

Dr. Thomas Kirkbride (1809-1883) became the first superintendent and physician-in-chief at the Department for the Insane of Pennsylvania Hospital. He was known for being gentle, kind and considerate. He was one of the first physicians to regard mental illness as a disease. He combatted popular inclinations, which regarded mental illness as mysterious afflictions. He made statements indicating anyone with a brain is liable to insanity. Dr. Kirkbride also

developed trainings, which were unheard of, for attendants and his nursing staff, to better the care of the patients (Deutsch, 1949).

Dr. Kirkbride created an architectural design to enhance the therapeutic effects of the asylum. The Philadelphia Hospital for the Insane was the prototype to many. Advocates of the asylum believed the mentally insane could be transformed to productive members of society. There was a shared belief that if there was early intervention, mental illness could be cured (Deutsch, 1949).

At the time the asylums were developed, ill individuals only went to hospitals when they were near death. There was a push by advocates to make asylums attractive to caregivers of the mentally ill. The buildings were built with the hope to make them inviting. Each building and the grounds were designed to create a homelike setting, where families would feel comfortable leaving their loved ones (Deutsch, 1949).

Initially, the treatment of the mentally ill consisted of a system of incentives, rewards and punishments. This system was organized according the each patient's social status, class and mental abilities (Luchins, 1988). There were schedules in place from morning to night to create structure for patients. The schedules in place included things like activities of daily living, grooming, dining, and medication management, speaking with their physician, exercising, recreational and educational activities (Warner, 1986). This schedule progressed for each patient as they began to get better. The patient was considered to be cured when they were absent of all mental illness. The physicians kept in contact with each patient's family by letter. They often answered questions via mail to gain the trust of both the patient and the patient's family.

Initially, the patient's stay was a matter of months with only a few chronic mentally ill staying for years. As the population of America expanded so did the need for institutionalized care. The states began to build larger facilities to avoid overcrowding, however overcrowding became commonplace. Admissions began to increase drawing from immigrant groups and the incarcerated. Many of the new admission had the most advanced forms of mental illness and the chances of recovery began to decrease (Butler, 2011).

In the 1870's, it was proposed to have the insane stay in small cottages in a colony-like setting similar to that in a place called Gheel. In the 1300's the town of Gheel (Belgium) grew significantly when the mentally ill came for a cure during the Festival of St. Dymphna. "By 1532, a college of 10 clerics cared for the sick at Gheel…. A large number of lunatics settled in and around the town." (Luchins, 1988 pp. 477). The "shrine" was closed during the French Revolution.

Other suggestions included building separate asylums for chronically ill patients, but the harmless insane could live in the community. The critics of the asylum made reference to the fact that many mentally ill patients lived at home prior to their admission into the asylum. They recommended asylums should only be used for dangerously ill individuals. Many superintendents of hospitals believed that the mentally ill did not need the luxuries instituted by Dr. Kirkbride. They felt that a hospital could be built more cheaply to simply house the patients (Luchins, 1988).

As the debate regarding the asylum continued the asylums became more and more overcrowded. There was a sense of a two class system in place. Many state asylums housed the poorer people, while the wealthy sent their relatives to private hospitals. This, of course,

lowered the quality of care of the patients in the state hospitals significantly. In 1890, the New York State Care Act was established which required the states to assume full responsibility for the care of the mentally ill. This legislation was developed and integrated to remedy the quality of care deficiencies. This effort, however, created another problem. Many local almshouses began transferring patients with chronic and incurable mental health issues to the state asylum to alleviate fiscal burdens. Due to the financial benefits of having patients moved from local to state facilities, the number of patients in state mental hospitals increased by 240% between 1903 and 1950 (Morrissey & Goldman, 1986).

In contrast to the historical view of the asylum, the former patients of the asylum have another assessment. There were many wards that allowed card playing and theatrical presentations however, if there were any forms of insubordination, patients would be moved to a more restrictive unit. The daily schedules were often rigid, due to the number of patients (Dwyer, 1987). Many patients who were unable to care for themselves went wet and dirty throughout the night. There were also unsupervised times at night where patients were locked in their rooms until morning.

According to released patients, some asylum physicians conducted experiments on patients including draining fluid from patients' brains and filling their heads with air, frontal lobotomies and an abundance of electric shock therapy (electroshock therapy is still practiced to this day). There were also many hospitals that were plagued by the allegations of staff raping patients or engaging in other physical, sexual or emotional abuse. Because these patients were often left by their families, or were poor immigrants, there were not many investigations into these allegations (Dwyer, 1987).

The Deinstitutionalization of the Mentally Ill

World War II marked the next transition in mental health care. There were many soldiers requiring mental health treatment after the war. The psychiatrists returning from war began using psychotropic medication (a new development), psychotherapy and brief hospital stays. Asylums began opening outpatient clinics to serve previously discharged patients. Just as before, there was a promise that early interventions along with drug treatment would assist patients to become productive members of society (Grob, 1995).

As a result of the efforts of several mental health organizations including Mental Health America, there were several laws enacted promoting deinstitutionalization of the mentally ill. In 1946, the National Mental Health Act created the National Institute of Mental Health ("National institute of,"). The mission of the NIMH is to transform the understanding of treatment of mental illness through research ("National Institutes of,").

The next law was the Mental Health Study Act of 1955. This act created the Joint Commission of Mental Illness and Health. This organization evaluates the needs of the mentally ill and makes recommendations. The Commission also provides an accreditation to mental health facilities throughout the United States ("National Institutes of, "). In 1961, the Commission published a report indicating there was a need for community based mental health care. The other act that sharply changed the horizon of patient treatment was the Community Mental Health Centers Act of 1963. The act provided federal monies for the construction of community mental health centers to facilitate the early detection of symptoms and offer preventive treatment (Grob, 1995).

Community Mental Health Centers (CMHC) were well intended however they too fell short of their promise. The purpose of CMHCs was to have treatment without the deprivation of liberty. However, it created a non-supportive and non-medical system that turned into counseling centers which provided psychotherapy for less serious patients (Slovenko, 2003). In doing this the more severe patients were underserved. Due to the non-supportive nature of CMHCs many patients began to self-medicate with illicit drugs and alcohol. In 1968, there was legislation to expand the scope of treatment in CMHCs to include treatment of drug and alcohol abuse.

In the creation of CMHCs, one factor was overlooked. Higher functioning patients who lived within an asylum were often given jobs in laundry, farms, kitchens and housekeeping. These positions often gave the patients a sense of self-esteem and increased their quality of life as well as fostering a sense of community within the institution. When the patients were placed in the community, the higher functioning patients lost a sense of worth and belonging. Initially these patients were given less priority than was given to more acute patients at CMHCs. Once CMHCs became more prevalent, the higher functioning patients either went to live with family or became homeless.

In 1972, the Supplemental Security Income for the Aged, the Disabled and the Blind (SSI) came into law. With this new entitlement, states were pressured to release the mentally ill from inpatient care because they now had income. During the Reagan administration, there was a mass release of mental health patients. Funding was cut from mental health programming and essentially patients who had lived in housing for the mentally ill most of their lives were released to the streets. There was a sharp increase in homelessness among the mentally ill.

Overview of the Development of Trauma Informed Care

The Substance Abuse and Mental Health Services Administration ("Substance abuse and,") was developed in 1992. Under Congress' direction SAMHSA translates research related to individuals effected by substance abuse and mental health issues. ("Substance abuse and,"). The idea of trauma-informed care came from the creation of SAMHSA. Care throughout the United States has changed since its creation.

Though the idea of asylums is outdated, there are numerous psychiatric hospitals throughout the United States. These hospitals usually care for acute patients in need of medication management or adjustment. There are strict laws regarding holding patients against their will. In Wisconsin, Chapter 51 governs mental health commitments. When patients are brought in there is a probable cause hearing within 72 hours before a Court Commissioner. Probable cause is found if there is both evidence of mental illness and verbal or physical threat or danger to oneself or others ("State alcohol,").

Among the numerous tools psychiatric hospitals have to control the environment for acute patients are seclusion and restraints. These methods are used to manage self-harm and aggressive behaviors towards other patients and staff. Episodes of seclusion include the confinement of a patient in a locked or unlocked room. Restraint episodes include manual holds by staff, chemical restraints (which include the use of involuntary administration of medication), the use of ambulatory restraints, and full restraints (which include the use of a bed with restraints attached) (Hammer, Springer, Beck, Menditto & Coleman, 2010). The impact of restraint and seclusion upon traumatized patients was not considered.

Due to the overuse of chemical and physical restraints as well as research suggesting neurological changes that occur within a human brain in response to trauma, trauma informed care is gaining popularity, SAMSHA developed the concept of trauma-informed care. Trauma-informed care revolves around the idea that the experience of trauma can change one's perception of the world. Trauma informed-care involves a shift of thinking for human service providers. This shift takes into consideration the patient as a whole, including past trauma which can impact their human experience (Evans, 2014).

Trauma can be defined in many ways with respect to trauma informed care. There are more common examples which include: childhood and adult sexual assault, military post traumatic stress, and physical assault. Having a mental illness can be a traumatic experience as well. In some cultures there is stigma attached to mental illness. Being reminded that one is mentally ill by taking medications or seeing physician may be traumatic (Bloom, 2013).

The trauma-informed care model suggests episodes of seclusion or restraints with previously abused patients may result in re-traumatization due to similarities in the episode with previous abuse. Seclusion and restraints are a controversial topic due to the high rates of childhood physical and sexual abuse among psychiatric patients (Hammer, Springer, Beck, Menditto & Coleman, 2010). For example, a patient who has had a history of sexual abuse, and is placed in full restraints with several individuals are holding them down, may experience anxiety and possible flashbacks to the abuse. In contrast, a patient who is placed in seclusion who has a history of abandonment, may experience a great deal of reaction to being left alone for an extended period of time. This is not the intention of the staff, but it may trigger the patient to act more aggressively and harm themselves or staff.

There are also biological reasons why trauma informed care is imperative. With recent advances in medicine it is now possible to see the effects of trauma on the brain. With neuroimaging, it is possible to see that most of our brain activity is due to electrical and chemical responses in the brain. If there is a threat the feeling of fear is instinctual in most people. The stress response is a primal reaction within our brain. The brain controls heart rate and blood pressure during times of stress. Though in times of threat the brain is working to help us survive, it is supposed to return to baseline when the threat dissipates (Evan, 2014). For some returning to baseline is more difficult. They remain hypervigilant or become avoidant or even exhausted due to past trauma.

Though trauma-informed care is becoming more prevalent, there are many misconceptions of what it is. Trauma-informed care is not a specific therapeutic intervention. There are many models outlined on the SAMSHA website. Ultimately, the objective of all models is to reduce or eliminate the necessity for seclusion and restraints by using a series of de-escalation techniques ("Substance abuse and,").

Studies indicate trauma victims are more likely to experience episodes of seclusion or restraints than are patients who do not have a history of trauma. This may be due to their inability to regulate their emotions or their misinterpretation of others actions. Traumatic childhood abuse can affect normal development, particularly, emotional regulation and adaptive social functioning (Hammer, Springer, Beck, Menditto & Coleman, 2010).

The Adverse Childhood Experiences (ACE) Study was a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego. The study investigated the correlation between childhood maltreatment and its consequences for later-life health and well-being. The study's sample comprised over 17,000

Health Maintenance Organization (HMO) members who underwent comprehensive physical examinations. The study focused on information regarding childhood experiences of abuse, neglect and family dysfunction and how such experiences contributed to the current state of health and well-being of the subjects ("Adverse childhood experiences,").

The data from the ACE study indicates a substantial relationship between the participants' emotional experiences as children and their physical and mental health as adults. The study provided a score to each participant. The score was derived from how many traumas they had experienced. Examples of the scoring include: parental separation or divorce, incarcerated household member, one or no parents, emotional or physical abuse, and intimate partner violence against mother ("Adverse childhood experiences,").

After determining the ACE score of each participant, their current physical and mental state was taken into consideration. This included: alcoholism and abuse, depression, fetal death, illicit drug use, liver disease, risk of intimate partner violence, sexually transmitted diseases, adolescent pregnancy, suicide attempts and others. The study concluded there were definite correlations between early childhood traumas and problems later in life ("Adverse childhood experiences,").

The ACE study was used in determining how many trauma-informed care models were developed. There were over 50 additional studies conducted from the information obtained from the ACE study ("Adverse childhood experiences,"). In a study conducted in 1999, it was determined more than 94% of women incarcerated in a state prison reported some form of past traumatization. There are many prisons that are adapting trauma-informed care models to decrease the amount of violence within the prison system (Harner & Burgess, 2011).

Trauma-informed care takes into consideration the many ways someone may experience trauma and how past trauma may trigger certain responses. Pain, loss of control, inconsistency, sensory overload, and disrespect may be experienced by anyone in a psychiatric hospital. For individuals with past trauma, any of those things may cause them to act out aggressively (Fallot & Harris, 2002). The key is to assess the patient's level of agitation and use techniques to de-escalate without the use of restraints or seclusion.

The Mandt system is used by some hospitals to reduce restraints. One of the techniques outlined in the Mandt system is rephrasing questions. Instead of asking "What's wrong with you" ask "What has happened to you". As caregivers, staff must understand that patients are the experts on their lives. This includes active listening, avoiding lessening or devalue their feelings. Instead of clinicians creating goals and presenting to patients, give the patient the ability to be a part of treatment planning (Donovan, 2012).

Lastly, trauma-informed care also reaches out to the family or caregivers of the mentally ill. There are many resources for families who may need trainings on how to deal with their loved ones. There are also support groups to help families understand mental illness and long term issues that may or may not occur.

Chapter Three: Conclusions and Recommendations

In summary, his paper outlines the history of the treatment of mental illness. It also describes significant advances in the area of mental health and supports the need for trauma-informed care initiatives, including the need to deter institution for the overuse of seclusion and restraints.

The existing literature on the topic of trauma-informed care leads to the conclusion that it is necessary. With many reforms in the past and several to come, mental health is an ever expanding topic of interest. Trauma-informed care should be the minimum standard of care regarding how patients are treated, both in hospitals and in prisons.

There is much work to be done to adequately demonstrate the effects of trauma-informed care. There appears to be insufficient empirical data showing the effectiveness of trauma-informed care compared to traditional approaches. There is also little research on consumer preferences regarding trauma-informed care. This is data that is needed to understand the significance of trauma-informed care. There is currently research being performed at Drexel University through the Healing Hurt People Program of the Center for Nonviolence and Social Justice. The study includes patients receiving trauma-informed care through case management and weekly treatment groups. Measurements were done at baseline and will continue over the course of treatment. The research will examine the effects of trauma-informed care on symptoms of post-traumatic stress disorder, depression, exposure to community violence, and personal mastery (perceptions of how good one is at something). This research has not been concluded yet, but it will be the first to examine the effects of trauma-informed care ("National network,").

In the last one hundred years there have been drastic changes to the views on mental health and its treatment. Public perception of the mentally ill has changed as well The medical and legal professions have strived to make advances that preserve the rights and dignity of patients. Although there have been many improvements, more are needed. Trauma-informed care is new and not all hospitals and caregivers have been trained or are familiar with it. With more research supporting its use, trauma-informed care is likely to replace the status-quo.

Lastly, public perception is important to change. When the general public understands more about mental illness there will be change in the treatment of mentally ill patients. Many Americans do not have significant knowledge of mental illness and may believe mental illness is not a pressing issue. However, mental illness can affect anyone regardless of social status, gender or ethnicity. It is important that health care professionals treat all patients with dignity and respect. Trauma-informed care affords traumatized patients that dignity and respect.

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