Services Research
Knowledge/Questions for
Trauma-Informed Attention
to IPV in Health Care

Lessons from Behavioral
Health Care Settings

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Overview

- Implications for Screening/Assessment of IPV, given lessons learned from work on trauma in behavioral health settings [mental health (MH) and those focused on alcohol and other drugs (AOD)]—emphasizing larger system implications
- Emphasize complexity of patterns, Q’s and issues at various system levels & phases of interventions
- There is much experience, some evidence
- Many research questions
Patterns of Co-occurrence [IPV, AOD, MH, traumatic reactions]

- People likely at different levels of risk, problems, and phases of difficulties in different areas.
- Low risk factors on one, higher on others.
- Active problems in one or more.
- May have successfully changed on one or more, but need support to maintain & not recidivate.

Q’s: How ID screening & intervention implications of complex patterns of co-occurrence?
Links Between Screening and Brief Interventions

- Might some universal brief interventions be useful for all women?

- How ID those who’d benefit from selective or indicated preventive interventions for one or more of these co-occurring conditions?

- What approaches helpful to facilitate referrals to IPV assistance or treatment (e.g., AOD, trauma)?

- What useful for whom to support maintenance of positive changes for those who’ve made some?
Screening & Brief Interventions

- These exist for IPV, MH, AOD separately with some evidence of effectiveness
- Know much less about how to integrate these, how to ensure that those targeting MH & AOD are sensitive to IPV and active coercion
- Not been vetted for trauma-informed issues

How inter-relate these, maintain effectiveness & include trauma-informed principles?

Where & how to locate screening, brief intervns
Trauma-Informed Organizations and Systems

- Harris and Fallot coined the term trauma-informed services with organizational implications.

- Women Co-Occurring Disorders & Violence Study (WCDVS) and other efforts to implement and study these documented that only trauma-informed services/clinicians are NOT sufficient.

- The entire organization and aspects of larger environment must be trauma-informed, or will undermine other efforts, and interfere especially with initial contacts, retention, & minimizing harm.
Trauma-informed Services/Organizations

- Do not trigger trauma reactions or retraumatize,
- Are welcoming, empowering,
- Assist trauma survivors to participate
- Provide a healing and non-dangerous climate
- Have trauma-specific services
- Are accountable and collaborative with regular feedback mechanisms so that people with lived experience can provide feedback about what they experience as traumatic & disempowering
Trauma-informed principles important in all organization elements

- Participant/services level—all phases
- HR practices. Staff, training, supervision
- Leadership - Mission, values
- Organizational culture, practices, policies
- External collaborators, funders, regulators

Q’s: Need more tools to assess degree & effectiveness of “trauma-informedness”
Becoming trauma-informed is a process (e.g., innovation theory)

- At all levels, all components. Ensure one doesn’t undermine others. Need champions, those with lived experience, data regularly disseminated.

- Early phases—assess, assess, assess; educate, educate, educate. Pilot work, collaborations

- Middle phases—disseminate learnings, expand approaches that work, address resistance/barriers,

- Later—consolidate, train new people, make sure don’t undermine as other changes happen
Trauma-informed approaches challenge existing paradigms

- Is the case in all fields—not efficient, messy
- Requires change elements not always necessary
  - Trainings in multidisciplinary groups, including external collaborators
  - Cross disciplinary and functional teams
  - Provide data on successes, challenges.
  - Disseminate info, multiple forms & audiences
  - Develop and reward active champions, regular feedback and input from those most impacted
- Provide support/supervision related to trauma for everyone, even evaluators
Research Questions for Trauma-Informed Development Process and Phases

• How consider all aspects of the organization, and all personnel, not just direct services?
• Is there training and supervision of all staff focused on traumatic reactions?
• Adequate leadership for change? How working together?
• How are trauma-informed principles, policies, practices reflected in larger organizational environment/culture?
• What about relationships w environment, ext resources?
• Are process, fidelity, and outcome research & evaluations using trauma-informed practice principles?
System Capabilities in Referral to Treatment components of SBIRT

- Most IPV, AOD, MH, even trauma-specific treatment settings may not be trauma-informed.
- May retraumatize and make referrals difficult.
- Orgs have vastly different histories & paradigms, have difficulty addressing co-occurring issues.
- New models are emerging, but still uncommon.
- How assess and develop needed hybridity and trauma-informedness in referral partners?
Challenges in Measuring Costs Saved, Effectiveness, Critical Pathways

- For trauma-informed, coordinated, hybrid, or joint
- Are beginning to be examples and evidence, that these approaches improve access to health and other types of care, retention, and some outcomes
- Are examples of longer-term cost-savings, but research is difficult, more is needed.

- How measure cost-effectiveness & key elements w complex co-occurring issues, esp if randomized control designs may not be best or even possible?
References from WCDVS


Special issues of journals

- Vesey, B/ M. & Clark, C. (Eds) (2004) *Responding to Physical and Sexual Abuse in Women with Alcohol and Other Drug and Mental Disorders.* Haworth Press. Also volume 22 (3/4) of *Alcoholism Treatment Quarterly.* descriptions of what the 9 implementation projects were, how they approached services.

- The *Journal of Behavioral Health Services and Research, April/June 2005. Volume 32(2).* This is a mix of data-based papers and treatment issues papers.

- *Journal of Community Psychology, 2005, Vol.33, No.4.* This has another mix of data-based papers and papers that extract from the experience of conducting and integrating all the interventions.
More special issues, WCDVS


- *Journal of Substance Abuse Treatment* 2005, 28(2), March 05. introduction, 4 papers on study results, 2 commentaries on the 6-month outcomes from the Women, Co-Occurring Disorders and Violence Study., *ces*, 2005, 56 (10).

- *Psychiatric Services*, 2005, 56 (10). There are three papers in this issue reporting on overall design issues and 12 month outcome data..

Other single article data-based papers:


More WCDVS data-based papers


Some other system-level resources.

