Strategic Initiative #2: Trauma and Justice
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Issue Statement

Trauma is a widespread, harmful, and costly public health problem. Trauma occurs as a result of violence, abuse, neglect, disaster, war, and other emotionally destructive experiences. Trauma has no boundaries with regard to age, gender, economics, race, ethnicity, geography, or sexual orientation. Trauma is now understood to be an almost universal experience of people receiving treatment for mental and substance use disorders. The need to address trauma has become a fundamental obligation for effective behavioral health service delivery.

The effects of trauma place a heavy burden on individuals, families, and communities and create challenges for all public institutions and service systems. With appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without support. Unaddressed trauma significantly increases the risk of mental and substance use disorders, chronic physical diseases, and early death[13].

Traumatic victimization often results in negative behaviors that bring both youth and adults into the criminal justice system. Studies of people in jail and prison reveal high rates of mental and substance use disorders and personal histories of trauma. Preventing trauma is a promising avenue for reducing criminal justice involvement. Treatment is also a key strategy for improving outcomes for people in jail and prison who have mental and substance use disorders.

A better understanding of the needs of trauma survivors has emerged over the past decade. Behavioral health providers have implemented “trauma specific” services to directly address the impact of trauma on people’s lives as well as create service settings that are “trauma informed.” In a trauma-informed setting, providers and clients feel safe and the possibility of retraumatization is minimized.

While much of the focus on trauma is on individuals, some communities experience historical trauma that is transmitted from one generation to the next. For example, African Americans and American Indian and Alaska Native communities have suffered historical losses of land and identity and assaults on their culture and way of life that result in intergenerational trauma. The connection between historical trauma and the undermining of the economic and social fabric of the community with associated behavioral health problems and high risk behaviors is well documented.[14]

Another growing community exposed to trauma is military service members, veterans, and their families. Dealing with the losses, fears, and injuries associated with two ongoing wars, military families with trauma-associated symptoms and disorders are increasingly coming to the attention of behavioral health providers. Repeated deployments, relocations, military sexual trauma, and serious injuries exert an emotional toll on military families.

In recent years, man-made and natural disasters such as terrorist attacks, hurricanes, floods, and oil spills have received national attention as causes of death, physical injury, environmental damage, economic hardship, and emotional trauma. Research indicates that these disasters and their aftermath are likely to have an impact on the exposed population's behavioral health, resulting in an increase in mental and substance use disorders, along with a decline in perceived quality of life. With appropriate and early behavioral health services, trauma experienced by survivors of disasters can be mitigated and deleterious effects prevented.

Addressing individual, family, and community trauma requires a comprehensive, multi-prong public health approach. This includes increasing awareness of the harmful short- and long-term effects of trauma experiences across the age span; development and implementation of effective preventive, treatment, and recovery/resiliency support services that reflect the needs of diverse populations; strong partnerships and networks to facilitate knowledge exchange and systems development; training and tools to help systems effectively identify trauma and intervene early; and informed public policy that supports and guides these efforts.

The mission of this initiative has two related parts: 1) to create trauma-informed systems to implement prevention and treatment interventions to reduce the incidence of trauma and its impact on the behavioral health of individuals and communities; and 2) to better address the needs of people with mental and substance use disorders in the criminal justice system.

Background

SAMHSA is one of the leading agencies addressing the impact of trauma on individuals, families, and communities. SAMHSA has made contributions in key areas through a series of significant initiatives over the past decade. These contributions include the development and promotion of trauma-specific interventions, the expansion of trauma-informed care, and the consideration of trauma and its behavioral health effects across health and social service delivery systems.

The SAMHSA-funded National Child Traumatic Stress Network (NCTSN) has generated an array of evidence-supported screening, early interventions and treatments for

children, youth, and families. NCTSN has provided leadership in linking researchers and provider agencies to accelerate the development of field-based trauma interventions addressing various forms and severity of trauma. Over 300 products, including manualized effective trauma treatments, have been developed by the network.

The Women, Co-occurring Disorders and Violence study led to the development of gender-specific trauma treatments and highlighted the traumas experienced by women and girls. It also laid the foundation for the National Center for Trauma-Informed Care (NCTIC), a SAMHSA-funded technical assistance center that provides consultation and education to develop trauma-informed environments in publicly funded programs. Trauma-informed, gender-specific care represents a new paradigm of service delivery which recognizes that every aspect of the service system - organization, management, and staff - must have a basic understanding of how trauma and gender affect a person needing treatment for a mental or substance use disorder. Trauma-informed, gender-specific services are based on an understanding of the vulnerabilities and triggers of trauma survivors (which may differ for women and men) that may be exacerbated in traditional behavioral health care and lead to re-traumatization.

SAMHSA's work on preventing and reducing the use of seclusion and restraint in treatment settings also has led to major changes in the cultures of treatment environments. As a result of the Alternatives to Restraint and Seclusion State grants, mental health facilities successfully eliminated or reduced the use of coercive and often re-traumatizing practices; improved the safety and morale of both clients and staff; and facilitated resilience, recovery and consumer self-directed care.

These changes are not limited to behavioral health care. Jails, forensic treatment settings, and courts have implemented trauma-informed care and in some cases have seen reductions in recidivism, fewer staff injuries, and improved adherence to treatment and involvement in care. Child welfare systems can also benefit from a trauma informed approach.

SAMHSA and its partners have provided substantial "research and development" in the area of trauma services. However, this information has had limited reach in the field. Broader dissemination, training, and technical assistance is needed for better uptake and penetration of these practices into key systems: health, child welfare, behavioral health, public health and criminal and juvenile justice. Strategies for implementation, financing and workforce development are necessary to advance the trauma work.

Fast Facts

- Trauma is strongly associated with mental and substance use disorders.[15, 16]

- More than 6 in 10 US youth have been exposed to violence within the past year, including witnessing a violent act, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly 1 in 10 were injured.[17]
- An estimated 772,000 children were victims of maltreatment in 2008.[18]
- Adverse Childhood Experiences (e.g., physical, emotional, and sexual abuse, and family dysfunction) are associated with mental illness, suicidality, and substance abuse.[19]
- A lifetime history of sexual abuse among women in childhood or adulthood ranges from 15-25 percent and the prevalence of domestic violence among women in the United States ranges from 9 – 44 percent depending on definitions.[20]
- The cost of intimate partner violence, which disproportionately affects women and girls, was estimated to be $8.3 billion in 2003. This includes the costs of medical care, mental health services, and lost productivity.[21]
- In a 2008 study by RAND, 18.5 percent of returning veterans reported symptoms consistent with PTSD or depression.[22]
- More than half of all prison and jail inmates (People in State and Federal prisons and local jails), meet criteria for having mental health problems, 6 in 10 meet criteria for a substance use problem, and more than a third meet criteria for having both a substance abuse and mental health problem.[23]
- The use of seclusion and restraint on persons with mental and substance use disorders has resulted in deaths and serious physical injury and psychological trauma. In 1998, the Harvard Center for Risk Analysis estimated deaths due to such practices at 150 per annum across the Nation.[24]
- Racial incidents can be traumatic and have been linked to post traumatic stress symptoms among people of color.[25]
- Evidence suggests that some communities of color have higher rates of PTSD than the general population.[26,27]
- LGBT individuals experience violence and PTSD at higher rates than the general population.[28]
- 18.9 percent of men and 15.2 percent of women in the United States reported a lifetime experience of a natural disaster.[29]

Strategic Initiative 2 – Goals

Goal 2.1: Develop a comprehensive public health approach to trauma.
Goal 2.2: Make screening for trauma and early intervention and treatment common practice.
Goal 2.3: Reduce the impact of trauma and violence on children, youth and families.

Goal 2.4: Address the needs of people with mental and substance use disorders and with histories of trauma within the criminal and juvenile justice systems.

Goal 2.5: Reduce the impact of disasters on the behavioral health of individuals, families, and communities.

Goal 2.1: *Develop a comprehensive public health approach to trauma.*

Objective 2.1.1: Create a surveillance strategy for trauma and its association with behavioral health disorders.

Action Steps:

1. Build partnership between SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) and trauma research experts and providers to develop a standard definition and measures of individual and community trauma to be included in individual assessments and community and national surveillance systems.
2. Incorporate trauma measures into surveillance systems, e.g., NSDUH, Behavioral Risk Factor Surveillance System (BRFSS), National Health Interview Survey (NHIS), Youth Risk Behavior Survey (YRBS), etc., treatment and facility surveys, and performance measures for SAMHSA grant programs.
3. Work with SAMHSA's State, Territorial, and community epidemiological work groups to include trauma measures.
4. Develop criteria and measures for trauma-informed care that can be used with programs department-wide.

Objective 2.1.2: Build the public's awareness of the impact of trauma on health and behavioral health.

Action Steps:

1. Develop and implement a national public information, education and awareness campaign on trauma and its association to health and behavioral health. This will include targeted work with Tribes, Asian American and Pacific Islanders, African American, and immigrant/refugee communities.
2. Collaborate with other HHS Operating Divisions and other Federal partners to adopt trauma prevention messages and participate in the National Campaign.

3. Collaborate with the Indian Health Service and tribal communities to develop a specific information and awareness campaign on trauma and its sequelae (e.g., suicide, etc.) for American Indians and Alaska Natives.
4. Collaborate with SAMHSA's National Network to Eliminate Disparities in Behavioral Health (NNED) to develop and disseminate culturally relevant trauma information and materials to the diverse racial, ethnic and sexual minority communities in this Network.

Objective 2.1.3: Build a trauma informed behavioral health system.

Action Steps:

1. Coordinate the work of the NCTSN, NCTIC, Disaster Technical Assistance Center (DTAC) and the Seclusion and Restraint Coordinating Center, to streamline the availability of resource materials, training and technical assistance on trauma and trauma-informed care.
2. Engage SAMHSA grantees and technical assistance providers as well as Federal/State/Territorial/Tribal partners and stakeholders from the field, including trauma survivors, providers, and researchers, to develop and implement a national strategy for trauma-informed care.
3. Create core competencies for direct service professionals for screening, assessing and treating trauma among diverse populations. Create core competencies for administrators and managers for creating trauma-informed therapeutic environments.
4. Conduct trainings on trauma-informed care and alternatives to seclusion and restraint for behavioral health facilities in collaboration with HHS Regional Areas and SAMHSA regional staff, Addiction Technology Transfer Centers (ATTCs), the Center for the Application of Prevention Technologies (CAPT) and other technical assistance centers.
5. Provide training on trauma and trauma-informed care to SAMHSA staff and grantees.
6. Evaluate SAMHSA programs using a trauma-informed approach to determine effectiveness in reducing the incidence of trauma and its impact on the behavioral health of individuals and communities.

Objective 2.1.4: Address historical trauma through a place-based trauma project.

Action Steps:

1. Identify communities where historical trauma has contributed to intergenerational transmission of trauma and high rates of trauma, violence and incarceration.

2. Using a public health perspective, target funding streams to educate about trauma community-wide, provide screening and early intervention in multiple settings, and implement evidence-based, culturally congruent trauma interventions.

Goal 2.1 Measures:

Measures under development

Goal 2.2: *Make screening for trauma and early intervention and treatment common practice.*

Objective 2.2.1: Identify effective screening tools for trauma based on developmental age, nature of trauma exposure, culture and service context.

Action Steps:

1. Develop an annotated compendium of screening tools for trauma and a statement of principles, guidance and standard protocols for trauma screening in various settings.
2. Develop a strategy for incorporating trauma screening tools into standard practice in diverse settings (e.g., health centers, ERs, behavioral health, child welfare, criminal and juvenile justice, etc.) for diverse populations.

Objective 2.2.2: Develop a continuum of interventions that are appropriate to the severity of trauma and that are included in benefits and services addressed in Health Reform.

Action Steps:

1. Convene a Consultative Session (e.g., trauma experts, intervention developers, researchers, providers, consumers and families) to identify gaps in the continuum of trauma interventions, e.g., brief interventions, and develop a strategy to fill these gaps.
2. Work with HHS partners, e.g., NIH and CDC, to bring together trauma survivors, researchers, intervention developers, community-based practitioners and trainers from SAMHSA's technical assistance centers to develop and evaluate practice improvement tools for trauma.
3. Develop payment strategies in coordination with Affordable Care Act implementation and other funding streams to increase public awareness about trauma community-wide, provide screening and early intervention in multiple settings, and implement evidence-based trauma interventions.

Goal 2.2 Measures:

Measures under development

Goal 2.3: *Reduce the impact of trauma and violence on children, youth and families.*

Objective 2.3.1: Increase the use of programs/interventions that have been shown to prevent the behavioral health impacts (including trauma) of maltreatment and interpersonal and community violence in child serving settings.

Action Steps:

1. Reduce exposure to violence and risk factors for trauma through SAMHSA prevention programs for child serving settings, (e.g., Project LAUNCH, Prevention Prepared Communities, Safe Schools/Healthy Students, Suicide Prevention Programs, SAMHSA Block Grants and Drug Free Communities.)
2. Partner with the Administration for Children and Families (ACF) and State, Territorial, and local child welfare agencies to increase the reach of prevention programs for children in early child care, child welfare and foster care settings.
3. In the above action steps, ensure a focus on children of color who are disproportionately represented in out-of-home care in the child welfare system

Objective 2.3.2: Support programs to address trauma experienced in childhood, and its subsequent impact across the life span.

Action Steps:

1. Develop a dissemination, training, and technical assistance strategy through the National Trauma Coordinating Center to move established trauma-focused interventions beyond the NCTSN and more broadly into child-serving systems. Through this strategy, identify and address barriers to access for trauma specific treatments. Ensure that this strategy is inclusive of racial, ethnic, and sexual minorities.
2. Continue to raise the standard of care for sub-populations of children and families (i.e., those in child welfare) in need of trauma treatments through the development of specialized treatment interventions by the NCTSN. This includes the development of early intervention approaches for trauma in child-serving programs that promote the child's recovery and also help parents or caregivers address their own trauma histories.

3. Collaborate with ONDCP, HHS partners, (e.g., ACF, HRSA, CDC, IHS) and with the 12 agency Interagency Work Group on Youth Programs (Education, DOL, DOJ, USDA, etc) to promote understanding of the impact of trauma and the importance of intervening early and increasing access to trauma interventions and trauma-informed care in child serving settings such as pediatric care, home visiting, early childhood systems, and child welfare.
4. Identify and build on specific points of collaboration such as partnering with the Department of Education to create and disseminate materials related to bullying.

Objective 2.3.3: Improve policies to address the impact of trauma on children.

Action Steps:

1. Ensure that SAMHSA funded programs (discretionary and block grant) address trauma prevention and treatment for children, youth and families.
2. Collaborate with other programs and child serving systems such as Home Visiting Programs at HRSA, and Child Abuse Prevention and Child Welfare programs at ACF, to strengthen policy directives and program goals to include a trauma informed approach.
3. Develop financing models to support trauma efforts that include family-centered/multi-generational interventions and prevention efforts.

Goal 2.3: Measures:

Measures under development

Goal 2.4: *Address the needs of people with mental and substance use disorders and with histories of trauma within the criminal and juvenile justice systems.*

Objective 2.4.1: Expand alternative responses and/or diversion for people with behavioral health problems and trauma histories within the criminal and juvenile justice system.

Action Steps:

1. Partner with the Bureau of Justice Assistance and constituency groups to explore expanding beneficial behavioral health problem solving courts (e.g., alternative sanctions, links to social services, rigorous monitoring, etc.) to more people involved in the criminal and juvenile justice systems, including those served by more conventional courts.

2. Support State and Territorial planning efforts so that substance abuse, mental health and criminal justice planning are coordinated.
   a. Include language in SAMHSA justice-related grant solicitations that encourage State and Territorial Alcohol and Drug Abuse Agency, Mental Health Departments and State and Territorial Criminal Justice Agency involvement in the application process.
   b. Increase the frequency of contacts with State, Territorial and local governmental units, constituency groups, and Federal agencies to explore ways to increase State and Territorial government input into improving the State/Territorial-local coordination of grant applications.
3. Support training for judges, prosecutors, defense attorneys, probation offices, court managers, and other court staff about the complex issues of substance use, mental health disorders and trauma, and about the community context of crime to improve decision making and justice system approaches to serving the community.
   a. Collaborate with OJP, NIDA, and the National Judicial College to develop a strategy for implementing additional judicial training in this area.
   b. Initiate judicial training on behavioral health issues including trauma for State and Territorial Chief Judges and Presiding Judges.

Objective 2.4.2: Improve the ability of first responders to respond appropriately to people with mental health and substance use problems and histories of trauma.

Action Steps:

1. Partner with criminal justice and law enforcement groups, (e.g., International Association of Chiefs of Police (IACP), Associations of Sheriffs, the Office of Justice Programs (OJP), The National Association of Drug Court Professionals (NADCP), etc.) to expand the use of crisis intervention training and pre-booking diversion for people with behavioral health problems and histories of trauma.
2. Provide technical assistance and training tools such as web-based training, toolkits, and training of trainers to improve first responder preparedness for intervening with people with behavioral health crises and histories of trauma.

Objective 2.4.3: Improve the availability of trauma-informed care, screening and treatment in criminal and juvenile justice systems.

Action Steps:

1. Expand capacity of NCTIC and NCTSN to provide training and technical assistance on trauma-informed care, and trauma specific interventions

through partnerships with criminal and juvenile justice organizations, association, and agencies.

2. Work with HHS/The Office of the Assistance Secretary for Planning and Evaluation (ASPE)/The Administration on Children, Youth and Families (ACYF) to support intervention to children of incarcerated parents to address the range of trauma spectrum disorders experienced by the children.
3. Collaborate with DOJ/Office of Juvenile Justice and Delinquency Prevention (OJJDP) on their Children Exposed to Violence initiative.
4. Incorporate trauma-informed principles and practices into all criminal justice-based SAMHSA grants.
5. Collaborate with the Racial and Ethnic Disparities Issue Team of the Coordinating Council on Juvenile Justice and Delinquency Prevention to identify areas in which behavioral health issues contribute to disproportionate minority justice system contact (especially among Latino and African youth) and use SAMHSA's current grant portfolio to support services to reduce disproportionate minority involvement in the justice system.

Goal 2.4 Measures:

Measures under development

Goal 2.5: *Reduce the impact of disasters on the behavioral health of individuals, families, and communities.*

Objective 2.5.1: Ensure that behavioral health is a core element of Federal, State, Territorial, and local disaster response policies and practices.

Action Steps:

1. Convene the behavioral health experts from the IOM meeting on the Deepwater Horizon spill to identify areas requiring development in research, policies, and practice across the three phases of disaster (preparedness, response, and recovery).
2. Develop a "white paper" that collects the evidence that behavioral health is central to effective disaster response and recovery.
3. Develop a strategy to ensure that behavioral health surveillance systems are in place before, immediately after and in the recovery phase following a disaster.
4. Engage the State and Territorial Disaster Mental Health Coordinators to share training materials and resources with local disaster response personnel.

Objective 2.5.2: Build public awareness to ensure appropriate community response to disasters.

Action Steps:

1. Emphasize stress management, resilience building communications that make the link between traumatic events and health and behavioral health in public awareness materials.
2. Ensure that lessons learned from the crisis counseling program are shared broadly.

Objective 2.5.3: Enhance the approach to disasters across the three phases (preparedness, response, and recovery).

1. Connect communities to the national disaster behavioral health hotline after they experience disasters through the DTAC, the CCP program, and SAMHSA communications efforts.
2. Move lessons learned from the IOM committee white paper into appropriate SAMHSA programs such as the Crisis Counseling Program.

Goal 2.5 Measures:

Measures under development

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