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Megan: Hello, everyone, and welcome to today's Ask the Expert Webinar: The Value of Integrating Trauma Informed Care for the Healthy Start Community. I'm Megan Hiltner and I'm a coordinator for the Training and Technical Assistance with the Healthy Start EPIC Center, I'll be moderating the webinar today. We have 60 minutes set aside for this activity; we may not use that full time. But we hope that you are up for participating, we want you to use the chat box function in the bottom left-hand corner of your screen to ask questions. You don't need to save your questions until our presenter is done with her remarks, you can chat them at any point in time and we'll be breaking to ask those questions of the expert speaker during the webinar.

So now it is my great pleasure to introduce the expert for today's webinar. Michelle Hoersch is the Regional Women's Health Coordinator for Region V at the Office on Women's Health within the Department of Health and Human Services. She's been with the Office on Women's health for over 18 years. The Office on Women's Health's focus is to promote the health of women and girls across their lifespan, and one of Michelle's particular passions is working on the topic of trauma exposure and its impact on health.

In addition to having great expertise on this subject, she's a national lead on the Women and Partners Trauma Committee, which is a group of federal agencies and experts that have come together to better understand and address the impacts of trauma. So without further ado, I'm going to turn it over to you, Michelle, to move forward the presentation.

Michelle: Terrific. Well, thank you so much, Megan, it's always such a pleasure to collaborate with HRSA, Healthy Start, and JSI. Megan did a fabulous quick overview of the Office on Women's Health, so I won't spend much time on that. Also, I want to say that the conveners of this were a little nervous when I sent them this many slides, so I will be going over some of them very quickly. Don't hesitate to put up your hand or do something in the chat if you want me to go back to an issue, but I've been told that you'll have access to the slides. So if you, I've got a lot of the information in there just so you can go back to it as reference. And some of it is just a visual aspect of it, of seeing some of the rates that we'll go over. But back to my focus on trauma.

What I have envisioned, having worked in this area for 15 years, I would say, within the Office on Women's Health, is that it's just so critically important. I am a firm believer that exposures to traumatic events are really one of the greatest threats to public health in this country and, I would believe, globally.

So years ago, working with some work I did in the prison system, it became evident that trauma is really everywhere. And so from that grew my focus to equip health and social service providers and institutions with everything they need to know to be gender-responsive and trauma-informed so people can maximize the services and care provided to them. And so I feel like there's more and more I learn every single day. And at this point I feel like almost anything that is of a nature of ill health or problematic behavior or anything like that, I say we can get to a trauma history in two steps, typically. So it changes the whole way I watch the news and look at life around me.

So just to start, I think it's useful to have a functional definition of trauma. And that is when we're talking about trauma, we're not necessarily talking about car accidents. Though, in fact, a car accident can be truly traumatic. But what we're talking about are the experiences people have. So trauma occurs whenever an external threat overwhelms one's individual ability to cope.

So a few other concepts about trauma. It's not consensual, no one asks for the traumatic behavior. The individual who's the victim of trauma or the event is in discomfort, they fear, they feel intimidated, their bodily integrity or somebody else around them they feel is threatened.

So SAMHSA, or the Substance Abuse and Mental Health Services Administration, thank goodness for acronyms, right? In the Federal Government we have endless acronyms. Came up with the three Es, and I think this is very useful to keep in mind. Because a traumatic event, there's an event. A traumatic exposure, I should say, includes an event, the individual's experience of the event, and then some effect. And so while one thing may be truly traumatic to one individual, it may not be to another. And that could be for a great variety of reasons, and we'll get into that in a little bit.

Some of the effects of trauma you might expect: an inability to cope with the normal stress of a daily life, problems trusting, managing one's emotions, memory

or attention, some behavior changes. And also what we're finding now with the science is that there's some altered neurophysiology, particularly if there are multiple traumatic events that happen early in life when the brain is very, very, very plastic and malleable. And ultimately exposure to traumatic events can result in health impairment.

So how common are traumatic events? And I want to say, I want to ask you to stick with me. The good thing is you're on the phone, so I won't know if you have to take a break and walk away. But please don't, I ask that you hang in there because we're going to go over some tough material that I promise that we'll get through that and then move into some resolutions, some ideas of how we can make positive steps in these directions.

And so I first want to go over some of the prevalence issue, and this is never easy, it's never easy for me to talk about, and it's certainly not easy for people to hear, but do try to hang in there. But do also take care of yourself. Like I said, we're all in a webinar, so you can get up and stretch, you can walk out of the office, but don't be gone too long because I think this is interesting information.

So rape and sexual assault, I told you this wasn't going to be easy, but hang in there. Okay, rape and sexual assault. It was stunning for me to find out a number of years ago that one out of six American women has been either the victim of a rape or an attempted rape in her lifetime. So at that point, that was a number of years ago, that was at least 18,000,000 American women. Child abuse, certainly if there's anything that's underreported; it's the abuse of children in this country. Last year there were over 3,000,000 reports of child abuse that involved over 6,000,000 children. And the U.S. has one of the worst records among the Western nations, industrialized nations of child abuse, and we lose on average four to seven children every day to abuse and neglect.

So right now I'm talking about some of the different types of trauma so you understand what we're talking about when we talk about trauma. But remember, referring back to the three Es, almost anything that is negative where somebody feels threatened could be a traumatic experience. And I'll go over some of the other types briefly in a minute, but I wanted to go over some of the most common ones so you really start to understand that traumatic exposure is all around us.

With respect to intimate partner violence, nearly one in every three adult women experience physical assault by a partner during adulthood. Men who grow up with parents and there's violence in the home are twice as likely to abuse their own partners. Girls who grow up in abusive homes are far more likely to stay in an abusive relationship. And many batterers also abuse the children of their victim.

Childhood sexual assault. By the age of 13, two out of ten girls and one out of ten boys are sexually abused. And that clearly is one of the biggest kept secrets ever and it's by design. The abusers don't want the victims to talk, and so we know that this is probably even grossly underestimated.

Other types of trauma. Natural disasters and terrorism, terrorist events can be very, very traumatic. For example, the Sandy Hook Elementary School, any of us who have children, or even if you don't, can appreciate how traumatic that, even seeing that on TV could be a traumatic event. Hurricanes, tornadoes, so any kind of natural disaster. But natural disasters, interestingly enough, people don't have the same type of reaction to as when it is someone who actually perpetrates violence against you. So terrorism ends up having more traumatic impact than natural disasters, but that is not to say that natural disasters cannot be extremely traumatic for some people.

Other types of trauma would include a historical trauma, so American Indians and Alaskan natives and their whole experience culturally. The same could hold true for people who are immigrants and refugees, I mean particularly the refugee experience, with the detention centers and what they've gone through in order to get to this country. As well as the experience of African Americans and slavery, we can't discount that those experiences still have an effect.

You've probably all heard about toxic stress and trauma, I'll quickly go through this. Some stress is very good, it's the stress of, "I've got to get my daughter to school and I don't have much time." You get an increase in your heart rate and your stress hormones pump a little bit harder. That's a positive stress, it gets you to get something done. There's tolerable stresses that we've all experienced that you can tolerate because you've got social support. And so that serves a buffering effect, is having the social support. And knowing that you'll get through it and

knowing that whether it's work that you can leave and go home at the end of the day, or whatever the tolerable stress is.

But what creates trauma or a traumatic exposure is a toxic stress. And that's that prolonged activation of the stress response and it is exacerbated by the absence of productive relationships. And that's not to say you can't have protective relationships and very healthy relationships and still suffer toxic stress, by all means you can. Think about the life of many people who live in violent urban areas in the inner city where shootings are unfortunately common, other forms of violence are common. If you're in the military and you're in the active theater of military operations, that can be toxic stress. Even a work environment can be toxic. So those are types of stress that can turn into trauma.

So my whole reason for going through all those awful events is to drive home the point that trauma is very prevalent in our country and it's very common that any given individual have exposure to multiple traumatic events during their lifetime. And I also want to point out that the impact of trauma is dramatically underestimated. And we'll talk about that, that's where we're really going to focus most of our attention. Is that it is underestimated, the impact, but we also want to talk about what we can do.

So some of the long-term consequences of exposure to traumatic events include, not surprisingly: mental health issues; mental and substance abuse issues; physical health problems; behavioral health; and, in fact, early mortality. So what's the relationship, why is it and how is it that trauma is related to poor health outcomes?

I can't see hands, but when I do presentations and trainings live, I ask for a show of hands. So go ahead and do it, it's the physical interaction, the physical activity interaction. Raise your hand if you have heard of the Average Childhood Experience Study. Okay, I see a few virtual hands out there, that's good. That's so funny, I love it, I'm seeing "hand raised," that's hilarious. This is great, I didn't realize I could see that. So the Average Childhood Experience, or ACE Study, is an amazing study, and I would argue that it's really a sentinel study. And if you haven't heard of it, and I see not a whole lot of people have, I would like you to go take a look at it. I'll give you a really quick overview, but I'll definitely spend a little bit more time on this.

So it included over 17,000 individuals at Kaiser Permanente, that's a health plan out in California, based out of San Diego. And they volunteered to participate in this study. That's a lot of people, 17,000 is a considerable data set. And ultimately the study showed staggering proof of the health, social, and economic risks that result from childhood trauma.

So what is an ACE, or an adverse childhood experience, ACE for short? What they looked at , and a few minutes ago we talked about different types of traumatic exposure. Well, in the ACE Study what they did is they identified ten different vary common childhood experiences, unfortunately common. Five of them were personal, and you can see those five up there: physical abuse, verbal abuse, sexual abuse, as well as physical or emotional neglect, were the five personal. And then others were situational or relational. For example: having a parent who is an alcoholic or a drug abuser; a mother who is a victim of violence, we talked about that a little earlier; a family member who is incarcerated; someone diagnosed with an active mental illness; or the disappearance of a parent through divorce, death, or abandonment, so the complete loss of a biological parent, one or both.

So what did they find out of those over 17,000 individuals? They found that ACEs are extremely common, and those are just those ten. So keep in mind all the other things that can be a traumatic experience. Just looking at those ten, what they found is one in four people had one ACE, or adverse childhood experience, about 15 percent had two, one in ten people had three, and six percent had four. Now what's really stunning is one in nine people had five or more, and women are far more likely, 50 percent more likely to have an ACE score of five or more.

When you get to the point of four, that's what's called or described as complex trauma. You know the expression, "What doesn't kill you makes you stronger"? I don't use that anymore, I use to all the time. I thought it was fairly effective, a good way to think of things when I was in school or when my daughter is giving me a hard time or whatever. But what is more true, I'm realizing as I learn more and more about trauma, it's about the straw that broke the camel's back. It's that one additional traumatic event or stressor that just really put such a toll or an allostatic load, as you may have head that term, on your physiology and your neurobiology.

So look at that, one in nine people have five or more ACEs. So let's explore that a little bit further. So what do we know? That ACEs, or these traumatic exposures in childhood, are extremely predictive in a very graded stepwise dose-response fashion to adolescent health, or poor adolescent health, to likelihood of teen pregnancy, smoking, alcohol and drug abuse, risky sexual behavior, mental health challenges. Risk of re-victimization, and that's a conversation for another day. But yes, in fact if you were a victim as a child, you're more likely to be victimized as an adult. Difficulty with stability in relationships and performance in the workforce.

Now I want to stop for one second. Some of the most absolute functional, genius, productive individuals I know have high ACE scores. It is not a one to one relationship. When we talk about all these data that we're going to go through right now, it is, as you know, in the aggregate. It's all of the data put together and on average. So just because you have a high ACE score does not mean that this is necessarily "going to happen" type of thing. It doesn't mean that you're going to develop heart disease, it just means as a group we're at greater risk of it if we have a higher ACE score. I always want to point that out because it's really important to know that there are so many mitigating factors, there are so many things that can help reverse the impact of trauma. And so we'll talk about that in just a minute.

So here are some of the things that we've seen. So I'll go through these quickly because, if you're like me, you like visuals. And so what we see on the Y-axis is alcoholism. And you'll see that the condition is always going to be on the Y-axis and the ACE score is going to be on the X-axis. So here you see, as far as percentage of individuals who are alcoholic, only about three percent, if you have an ACE score of zero, there's only about a three percent likelihood that you're going to develop adult alcoholism. But then look, if you've got four or more ACEs, it's far closer to 16 percent or so. So that stepwise fashion, the more traumatic exposure as a child, the greater the risk behaviors. And we'll talk about risk behaviors in a few minutes.

Childhood experiences that may underlie depression, chronic depression as an adult. What's interesting here is not only the stepwise fashion where you see the greater exposure to trauma, greater risk of adult onset depression. But also, look how much more likely women are to be depressed, experience depression than

men. And I think that's very telling. Suicide attempts, same thing, greater likelihood, smoking. And again, I'm going to run through these because you have these slides, you can refer back if you're interested. Experience of later being raped, that is a dramatic jump from three to four. Experiencing four, more adverse childhood experiences. Heart disease. Now you're like, "Wait a minute, heart disease?" We'll talk about that in a bit.

Now when we talk about Healthy Start, I thought this was particularly useful. Looking at the relationship between an ACE score and teen sexual behaviors. Again, you go from left to right, the higher the Ace score, the greater likelihood of intercourse, early sex by age 15, teen pregnancy, and teen paternity.

IV drug use I think is also an interesting thing to look at, and this is not a typo. Where it says down here, "Male child with an ACE score of six or more has a 4,600 percent increased likelihood of becoming an IV drug user later in life." I mean that's stunning. Those are the types of statistics that people see once in career. The epidemiologists at CDC looked at that data and just couldn't believe it, but what they found are these kinds of relationships over and over and over. So to some degree we have to think, there is a huge causative factor here and we need to figure out, as health and social service providers, what we can do to not let that happen, how do we interrupt that cycle, that progression.

With respect to risky sexual behavior as it's quoted here, this is almost 14 years old, but I think it's worthy of noting, "That among individuals with a history of adverse childhood experiences, risky sexual behavior may represent their attempt to achieve intimate interpersonal connections." So it goes on further to say, "Having grown up in families unable to provide needed protection, such individuals may be unprepared to protect themselves and they underestimate their risk to achieve intimacy." So what they're doing is just trying to cope. And so we need to recognize that as a serious public health challenge.

So here's The ACE Pyramid, which I think is particularly useful. And you can really pick any kind of story about some traumatic experience in childhood. But let's just, for sake of illustration, you see at the bottom it says, "Adverse childhood experiences." So think of a girl, she might be, say, ten years old. And the night before, she's in school, but the night before she was up almost all night because her

mother's boyfriend or her father, whoever it would be, a male in the household, was beating her mother. Of course she couldn't protect her mother, and so she did what she could to try to get through the night. The next morning, by the grace of God, somehow she got to school.

And so what do you think is going to happen? I mean is this kid going to be on her game, ready to learn, ready to play with her friends, ready to be fully present both socially, emotionally, cognitively? I mean my guess is you're all saying, "No, no chance," right? She's going to be withdrawn, she may be tired and yawning, she may not be able to pay attention, she's not going to want to go play with her friends out on the blacktop at recess. It's just not going to happen for her.

So as a teacher, a teacher might see this girl and, not knowing what's going on at home, her first presumption, if this happens over and over, and we know that abuse happens repeatedly, she might think, "She's got ADD or she's lazy or she's just inattentive or she's not trying hard." Okay, well, you know what? When people have those expectations or perspectives about us, we know it, we can read their faces whether they say it or not. And chances are it's teachers, they're managing large classrooms, they're probably giving some cues, "Come on, Michelle, pay attention," whatever.

So what do we do? Okay, so we've had a terrible night listening to our mother get beaten, the girl has heard that. She goes to school and she's having a horrible time at school. And so after school someone offers her a drink because, you know what? We, as humans, are amazing at being able to achieve steady state. We can come back to grounded, we figure out ways to get grounded. And so in the literature, in public health we call that adoption of health risk behaviors. I call it coping, I think she's desperately trying to cope so she can go home, maybe take care of other siblings, or try to get some homework done, or do whatever she needs to do, make dinner, take care of her mother who may have developed a drinking problem because of the abuse, etc. You never know, you just start to see how it all adds up.

Okay, so this girl decides to take a drink or get high or smoke or have, what we would call, risky sex just to feel like somebody loved her and is taking care of her, right? Well, we know that down the road, that's going to set her up for disease, disability, social problems, you name it. And ultimately, with an ACE score of four

or more, 20 years of earlier death. So as public health professionals, we're thinking, "Wow, that's significant," right?

So back to this idea of high risk behavior, or is it coping? We are so, in public health, always thinking of high risk behavior, risky behavior. But what if we looked at that person, that individual and their habits as something that they're using to get by? Vince Felitti, Dr. Felitti was the Principal Investigator of the ACE Study, and he said this once and I thought it really resonated with me, that it's hard to give up something that almost works.

So if drinking pretty much helps you get by, it's obviously got its problems, but excessive drinking helps you get by, how easy is it going to be to give that up when your physician says you're getting cirrhosis of the liver? Give up smoking, if you've got emphysema? Stop eating high fat, high sugary, high salty foods when those are your comfort? Give up a lot of sex, if that's what brings you back to steady state? We know that sex does change the way our hormones, it changes our whole endocrine system and our neurotransmitters. And so it's really hard to give up.

You pick the risky behavior or coping mechanism and you'll see they're not easy to give up, no matter what the consequences are, because we live in the moment. And even if we see that down the road it's going to hurt us, the immediate satisfaction, the need to get by and cope is more important.

So what does the ACE Study say? Essentially the summary is it's that adverse childhood experiences are essential, basic, and long lasting determinants of health risk behavior that impact our mental health, our social functioning, our risk for disease and disability, death. And for administrators I always throw in healthcare cost because it's really, that's an important factor.

The thing is people who are survivors of childhood trauma, and adult trauma, have high utilization, are big users of medical services. Why? Because they don't feel well. Right? If you have kids, you know that that's one of the first things they'll say, is, "I don't feel well," when they don't want to go to school. Sometimes they don't feel well, other times it's just that somebody was bothering them at school or maybe they're getting bullied or maybe they're upset with their teacher or

whatever. So we know that emotional situations, what's bothering us, manifests itself in how we feel physically.

So you'd think that if people are going to get a lot of care because they're ending up in the ER or at their doctor's office because they don't feel well, that they would get their mammograms and their screenings and keep regular preventive dental appointments, etc. Not so. Trauma survivors are far less likely to do any of those things, and we'll talk about why in a minute.

What happens in many settings is called, it's known by many things: secondary victimization, second rape, re-traumatization. And that's what happens as not a direct result of the original criminal act or the traumatic experience, but the response of programs and institutions that aren't trauma-informed or trauma-sensitive. So what that results in is actually increases someone's symptoms and keeps them from benefiting fully from the care that they could get.

So with this knowledge, knowing how prevalent traumatic events are in our lives and in this country, and knowing the relationship, and knowing the relationship among traumatic events and poor health outcomes and poor behavioral health issues, or risky behavior, coping, what are we going to do? So what we're talking about know is trauma informed care. And I'm going to go through this rather quickly, but it's just to give you some ideas, some hooks to hang your hat on, if you will.

It's the idea that your words, your actions, the policies of your institution have a tremendous impact to either hurt or heal, and let's hope that it's towards healing. And there are things that are inadvertent, no one goes into the work that we're doing, clearly we don't go into it for the money, we go into it because we want to help people. But so often we don't realize that our behavior and our preconception really can translate into something very negative for those we serve.

So what is trauma-informed care? It's when every aspect of a service, from the front desk person to the individual who lays hands on as a healthcare provider or somebody who does home visiting or somebody who greet children at a Healthy Start, or a Head Start center. Anyone who interacts with individuals understand the impact, understand the prevalence of trauma, and understands how to provide trauma-informed care. It's so we prevent re-traumatization and we make people

feel as comfortable as possible with services so they can benefit as fully as possible.

So what are some of the basic principles of trauma-informed care? One, it takes trauma into account, it knows that there is a huge prevalence of trauma of all sorts out there. We don't need to know what the specific trauma is, we just should always assume that there's a trauma history. Because by and large most of us, many of us on this call have had some sort of trauma in our life. We should avoid triggering the trauma reaction and re-traumatizing the individual, and we'll talk about that a little bit more in a second. And we should adjust our own behavior and policies of the organization and procedures to support the individual. And that way we can allow survivors to manage their traumatic symptoms and benefit from our services.

So what we universal precautions is a basic tenant. Since we know that exposure to a trauma is everywhere, we assume that everyone has a trauma history. Therefore you're going to assume everyone has a trauma history and act accordingly. Why do you do that? Well, you're not going to hurt anybody if you assume they have a trauma history, it just leads to greater patient-centered or individual-centered care. But those who do have trauma a history, you're not going to re-traumatize them if you keep some of these things in mind.

So it's a real paradigm shift. It's going into a physician's office and knowing that your blood pressure is up, you've got diabetes, and you're smoking etc., and the doctor doesn't say, "You know you really need to quit smoking, drinking, and eating all that high fat food and get some exercise." So it's a paradigm shift from, "What's wrong with you, don't you know this?," which can be very stigmatizing and patient-blaming, to, "What happened to you?" And you don't even know what it is, but you can ask, "Okay, I see that you smoke. So what role does that serve for you, how does that help you get by?"

And understanding these things will help an individual be able to choose potentially. First they'll feel more understood and supported, but then they'll also be able to choose potentially better options. You build a better relationship in whatever kind of care you're providing, whether it's social service or physical

healthcare or dental care or even eye care. And then with that better relationship there are more options that you can provide.

So a colleague of mine, Dr. Sheela Raja, she's a clinical psychologist, she and I came up with this pyramid called The Trauma-Informed Care Pyramid, very much like The Ace Pyramid. And it starts with patient-centered communication. So it's a lot like motivational interviewing, understanding what is important to the patient and focusing on them, not focusing on yourself as a provider of whatever care and services. Understanding health effects of trauma, we talked about that a little earlier. And collaborating and understanding your professional role. The collaboration is with not only other providers to have resources for caring for your patients or those you serve, but also a collaboration with those you do serve. Understanding your own trauma history, recognizing that as human we also have trauma histories even though we are providers of one sort or another.

And then ultimately at the top of this pyramid is screening. But screening, the reason that it's so little and it's way up there, it's like you've got to master all of these and make sure that you know what to do, and only screen if there's something that you can genuinely offer. But most of trauma-informed cared focuses down here. It's down near the bottom, the more foundational aspects of focusing, having patient-centered communication, understanding the health effects of trauma, and knowing your history.

So one of the things that I'm working on is training healthcare providers via online clinical cases. And for any of you who are interested or know providers who may be interested, we're developing a number of cases, 16 to 20 over the next four years, to train healthcare providers. Because physicians are the most difficult to attract to training about things like this: one, they're busy; two, they don't know what can you possibly do; they're afraid of opening up a can of worms or that people will decompensate if trauma comes up in the context of a visit, etc.

So I just wanted to briefly mention that we are working on these trainings and can provide that information to any of you if you are interested in doing that. It's designed to increase their knowledge and skills. There's also a number of different resources, such as the National Center for Trauma-Informed Care, AceStudy.org, ACEs Too High, etc., you can look at those. And that's my contact information.

I want to say one additional thing about trauma. In the services you provide, if you think about what it's like- And let me go back here just a little bit, and then I will wrap up. Patient-centered communications. It's bigger than that, it's thinking through every aspect of what you do, how you interact with your clients or patients. And think about how you would do that if you knew the patient or the individual was a, say, a sexual assault survivor. Let me give an example.

Dentists are one of the things that incite fear in so many people. And why is that? And one of the things a very astute dentist found once and thought through this was that if you think about the dental situation, probably if somebody walks down the hall behind you and leads you or follows you to the chair, right? Having someone follow you down a hallway at a close distance can be very re-traumatizing and triggering. So what if you just led them and say, "Hey, when you're ready, please follow me"?

In the dentist chair, if you explain what you're going to do and say, "If at any time you need to have me stop and wait for a moment, please just raise your hand." Because think about it, now this person is having something done to them in a non-trauma-informed scenario. You've got somebody leaning over you, very close proximity, right in your face, you're unable to speak. So much of childhood sexual abuse happens orally, so pain inflicted by somebody who's got a power differential over you could be extremely triggering, not being able to use your voice.

So a very trauma-informed response would be explaining the procedure, saying, "If at any point you want to take a break, just raise your hand, we'll stop immediately." And then actually following through and stopping immediately rather than saying, "Oh, just hang in there, I'm almost done." Because what would that evoke? So you can all imagine that.

Talking to individuals you serve and explaining things. Valuing them, not being the receptionist who looks up as if somebody is interrupting them when they come for their appointment or come to ask something. But looking up with genuine interest and concern and a desire to help. There are so many small things that you can do. I wanted to just plant the seed, and then we have 23 minutes or so in order to answer questions. But if you just think through all the things that could potentially re-trigger, that will help you develop some trauma-informed practices.

And again, this is a very quick 30-minute plus overview of trauma-informed care just to lay the groundwork, but I'm happy to talk to anybody individually as we go on.

So with that I'd like to open it up for questions.

Megan: Thanks, Michelle, so much. Anyone that has any questions, feel free to put them into the chat box in the lower left-hand corner of your screen. Oh, we do have a question about the slides being available after the program. Yes, they will be. The slide were sent out with the registration information, but they also will be posted to the EPIC Center website along with the recording of this webinar. So you can get the slides that way.

Michelle: Megan, can I tell a story until there's another question, or do you have questions?

Megan: No, I say please continue, these are really great examples.

Michelle: Because the slides are one thing, and kind of the presentation is one thing, but it's the examples. Okay, think about if you're, I'll use two kind of extreme examples. If you are the receptionist at, or the person, the front counter, the front office staff, and somebody walks up. We've all been there, right? You walk up, you walk in for an appointment, and the person looks up like you're just really interrupted them. Are you going to feel welcome? Versus are you going to feel like this is an engaging environment, one that really could help your or cares about you? So it's the front desk staff that are central, they are the point people. And I always say that those are the key people. It's who answers the phone and who greets you sets the tone for how all these services are provided.

Let's look at another situation. An anesthesiologist, and you're like, "Well, we're not anesthesiologists." But I think this is important to think about. If you're an anesthesiologist and somebody has had a trauma history, right? And you just assume they do, but you can either try to put them under without talking to them and asking what their concerns are or anything like that. Or you can go, while they're fully clothed, go introduce yourself before they have the procedure that they're going to be put under for. Introduce yourself, introduce your whole team,

and tell them what's going to happen, tell them who's going to be in the room. Ask them if there's anything that could make them feel more comfortable.

All of the sudden you see blood pressures and pulse rates start dropping when people implement that kind of approach. Also you'll have to use less anesthesia because somebody, for example, imagine somebody who was date raped because they got a roofie in their drink in college or something, right? How comfortable will they feel being unconscious? Right?

You can use examples anywhere along the spectrum, but when you realize that people have these trauma histories, all the sudden it changes your, it changes the way you look at people and why they do what they do. If you start looking at behaviors that we've always called high risk as coping, that just totally changes the paradigm. People are doing something that's smart and trying to get by.

Okay. Are there any questions?

Megan: There is another question, Michelle. Do you know are there any evidence-based curriculums or practices that you would recommend to this Healthy Start audience?

Michelle: That's a really good question, there are good resources. We are on the cusp of having a huge sea change in how health and social services are provided, I believe with a huge focus on trauma-informed care. So we're really at the early stages. There's fledgling work that's been out there, there are people who totally get it and they have never heard the words" trauma-informed care," they're just so patient-centered or client-centered. Unfortunately those aren't the people who publish.

And so you've all met the great practitioners of one sort or another, but unfortunately there isn't a great deal. The best place to look though is called the ACEs Connection, it's in the resources. Let's see, let me change it back. ACEs Too High and the ACE Study. Oh, ACEs Connection is another one. But also the National Center for Trauma-Informed Care, every day they're adding new resources. So I can honestly say I am not familiar with anything, but that's why we're doing this work, is we're starting to raise the awareness. Wisconsin does amazing work related to trauma-informed care, and so you can also go to their

website, which I've listed here. They're the first state to have a trauma-informed care director for the whole state. Elizabeth Hudson, she's just amazing. So that might be another place to look.

But it's to participate in the trainings and to understand trauma-informed care is a fabulous first step. And typically when I do this training of this nature, it's usually 90 minutes, so I kind of burned through some of the other information. I want you to know that I am absolutely more than willing to provide in-person training where we can talk through a whole lot of different scenarios and give examples and get into much greater depth about how to deliver trauma-informed care and services, but it was just a little tough in this.

So do you have another question?

Megan: Yes, there is another question that just came in:

"What services do you suggest that we take advantage of for teens who suffer from complex trauma? As a 17-year-old, she suffers from major depression disorder, detachment, steals, risky sexual behavior, and so on. How do we help individuals such as this?"

Michelle: I don't have a quick answer, there's no magic wand, though I so wish there would be. I think eventually there will be because as more people understand the impact of trauma, they'll start to see it earlier and earlier, we'll start to recognize the symptoms. Because this individual will, somebody might have identified this early on because more than likely this individual has a huge trauma history. Because you don't engage in those types of behaviors unless you're trying to cope with something.

So what I would say is first adopting a trauma-informed approach, first recognize that she's probably reacting, or acting from a place of being a victim, being a trauma survivor. Recognizing that what she's doing is her efforts to cope, building a relationship and not blaming, and hopefully finding some great social workers or therapists that could work with her, and also just asking.

So if you know that she's engaged in risky sexual behavior, for example, asking, "So what role does having sex play in your life, why do you think that you do that so much, what role does it play, how does it help you? When you're stealing, what

is that doing for you?" And in a very nonjudgmental way. I mean I'm shooting from the cuff, I'm not a trained therapist, I don't want to suggest that you use that exact language. But just recognizing that she's doing that, any of her behaviors are from a place of trying to cope. And the more you look at her as an individual who has had probably a lot of trauma, and you don't even need to know what it is or ask what it is because unless you know how to respond when you get a positive response, don't do it.

Find different resources in the community, different services that she might be able to benefit from. And once you've developed a relationship, a non-judgmental relationship, and introduce the idea, these questions about, "So what does this do for you, how does this help you?," in a non-judgmental way, I think then you can start to help her be avail of those services.

Did that make any sense?

Megan: Oh, yes.

Michelle: Okay.

Megan: Well, I shouldn't answer on behalf of the person asking the question, but I think you gave great information.

Michelle: I hope that made sense. If not, you have my phone number, call me later and we can talk.

Megan: So there is another question, Michelle. "Is there a recommendation for when we should use the ACE questionnaire? Is it 60 days or 90 days?" This person asking says that they're trying to create a policy around this.

Michelle: Okay. If you go back to, let's see, can I pull this up? Go back to the ACE, oops, the trauma-informed care pyramid. I don't recommend screening unless everyone in the organization has had some basic trauma-informed care training. And I'm not talking about 30 minutes like this, I'm talking about at least a half a day to really talk through some of these concepts and these principles. I wouldn't screen unless everyone in the organization is well trained, unless you have practiced extensively what to do when you get a positive screen.

More importantly, why do you want the information? You have to ask yourself, "Why do you need to know?" And if there is no need to know, and very seldom is there because you can just build relationships and focus on the individual and be non-judgmental and non-stigmatizing and available to help connect with outside services without knowing what somebody's specific trauma history is, it really doesn't matter. So I air on the side of don't screen, just provide trauma-informed care. Do everything from patient-centered communication to understanding trauma, to collaboration and understanding your own history.

But only screen if there's an absolute reason that you need to know and if you've practiced the ability to respond to a positive screen and that you have services to provide specifically for any of the traumatic experiences that you can refer them to. You need really good substance abuse or intimate partner violence, you need to know all those resources in your community. I'd be really curious what the motivation is to screen, because I really advise not screening because you generally don't have to. You don't really need to know what the trauma was, you just need to know that there was trauma.

And again, you've got my phone number, we can call and talk about that extensively. Because there are people in both camps who say, "No screen?," but everybody agrees don't screen until you are well practiced at what it means if you get a positive response and what you're going to do for the individual as a result of finding out.

Okay, did you have another question?

Megan: There is another question. So I know you shared this training resource for healthcare providers, do you know or have a recommendation on where in-person training is available at this point in time?

Michelle: It varies. Again, this is just a really, very much of an emerging field. If you're in the Chicago area, I do in-person trainings whenever there's a need. I'm working with the CORE Center, which is an HIV/AIDS center, because individuals with HIV have a disproportionate trauma history, without a doubt.

No, I cannot tell you about live in-person trainings. You can get on lists such as ACEs Connections or ACEs Too High. ACEs Connections is particularly good

because they tell what's going on. I know that in Minnesota there's going to be a two-and-a-half-day training with absolutely one of my mentors, Dr. Stephanie Covington from the Center for Gender and Justice out of La Jolla, she's doing a two-and-a-half-day training. So those exist. I think it's got like 18 CEUs, so that's a good one if you're in the Bloomington, Minnesota area. You just kind of catch as catch can. There's no standing place where there's always ACE training, or trauma training. However, depending on the event or what you're doing, I am always happy to come train in person if it's feasible. So never hesitate to give me a call and ask.

Megan: Great. And on that same subject, do you know when the training in Bloomington, Minnesota is happening, Michelle? Or is there a website . . .

Michelle: I'm afraid if I go to my email it's going to jump on the screen. You know what? I'll send it to you and you can send it out.

Megan: Perfect.

Michelle: How's that?

Megan: Sounds great. Thank you, Michelle. And then there was a . . .

Michelle: Dr. Stephanie Covington is absolutely an amazing individual.

Megan: Great. There was a follow-up, Michelle, back to the screening question. This person said, "Thanks for clarifying around the screening. The motivation is that we're heating so much about ACEs, but very little about how and if we should be using ACEs in our practice." So just a comment about that.

Michelle: Okay. Can I just respond? Thank you, I'm glad that made sense. Sometimes when I'm speaking I know what I'm saying, but I don't articulate it well. So I'm very glad that it made sense, that there was some clarification there.

The value of ACEs in my opinion is, one, it says, "Wow, trauma is everywhere." Two, it puts in absolutely incontrovertible terms, in research terms solid data that you can't ignore, that says that, "Yes, in fact exposure to traumatic events, particularly during childhood, translates into health and social issues," okay? So that, I think, is super valuable. And it also helps people, it moved the needle on, the

ACE Study said, "Wow, we've got a big, huge trauma problem," but didn't say how to deal with it so much. So it spurred the whole field of trauma-informed care.

So yes, everybody should know the ACE Study. And then you take the ACE study and that's a body of knowledge, and then the quantum leap you take from there, or the logical next step, it's not even a quantum leap, is to learn more about trauma-informed care. And there's a whole lot out there on trauma-informed care that is emerging.

Megan: And another nice comment kind of in agreement with what you just said. This person just says, "I'm so glad to hear you say that screening is not necessary, I so agree with it. Thank you." And I just thought what we'll do about the training in Minnesota, and if we do by chance find other examples of training, we can post them to the discussion board of the EPIC Center website and share resources using that modality, as well.

Michelle: And I can see that Nikeva is talking about SAMHSA's National Center for Trauma-Informed Care, and you have a slide for that. Are you on the resources? You have a link. So that is, again, I'm so glad, Nikeva, that you are reinforcing that. The National Center for Trauma-Informed Care, every day there's new resources being posted there. So check these out, these are four of the best resources I'm aware of. But you never know, there's always more. And they'll lead you to more places.

Megan: Well, it looks like, group, we have about five more minutes left for Q and A. Does anyone else have any questions that you'd like to ask Michelle before we wrap things up?

Michelle: [Inaudible 00:54:47] . . .

Megan: Michelle?

Michelle: Oh, I'm sorry. Did you have a question?

Megan: No other questions, I was just going to say do you have any final remarks that you'd like to share with the Healthy Start community?

Michelle: If we've got five minutes, I'd love to give another example of trauma-informed care approach or principle. And then if you get another question, I'll stop.

So think about, it's simple things, it's all of the simple things. Asking before you touch someone, for example. Huge, huge, right? But we don't always think about. Not following behind somebody, but asking them to follow you.

We've been taught manners and we're taught that to be polite you say, "Please, after you." Well, that doesn't always do it for people, that can be very re-traumatizing. So you can very politely say, "When you're ready, if you'll follow me." Asking before you shut a door, say, "For privacy sake and to protect you so we can have a conversation, would you mind if I shut this door?" All of the sudden the simple maneuver- Not "maneuver," that sounds calculated and manipulative. The simple act of asking, asking someone's permission to shut a door, it changes the whole dynamic.

Because remember, the traumatic experience was never consensual. As soon as you start making things consensual, "Yes, it's okay if you shut the door." If you're a services provider, "May I touch you? Here's what I'm going to do." Those types of things are really critically important, it's asking permission to do a whole array of things. And just always assume the universal precautions, I can't emphasize that enough. So if you've taken anything away from today, please look up the ACE Study. Because it's one thing hearing me talk about it, but it's another one to go and read the statistics, it's stunning. Just assume, with the universal precautions.

So anyway, those are just a couple of thoughts.

Megan: Thank you so much, Michelle. And one of the attendees on the webinar today did just share another great resource, so we've chatted it out to all. The Kansas City Crittenton Children's Center has a program on trauma-informed care, so we just shared that with you all that this person had shared.

Michelle, thank you so much for your time and your expertise, your passion definitely comes clear in the information that you've shared today. Thank you to all of you for participating in the webinar today, and that will conclude the webinar, and thanks for participating. And our next webinar will be on February the 10th, and it will be an overview of the HUG Your Baby program. So if you haven't already registered for that, we hope that you will do so. All right, thanks again. Take care, everyone.