PERSON-CENTERED AND TRAUMA-INFORMED PRACTICE

Foundational Concepts & Elements of Transformation

NEW YORK STATE | Office of Alcoholism and Substance Abuse Services
mctac
CASA The National Center on Addiction and Substance Abuse

Core Elements

- The individual is the expert on his/her life
- Focuses on natural supports
- Maximizes self-determination and choice
- Maximizes community connections
- Identifies an individual's hopes, capacities, interests, preferences, needs, and abilities

Person-Centered Practice

- This is a philosophy, not a specific technique
- The beliefs of person-centered practice, when adopted, will come to infuse all aspects of an organization's functioning
- The centrality of the person as the locus of control in a web of services and supports/resources defines the essence of person-centered practice
- Practice is a collaborative process. The professional brings their experience and expertise. The individual brings their personal expertise.

What Does A Person-Centered Organization Look Like

- Individual choice is evident
- Client's voice is used in treatment plans – goals are in his/her own words
- Treatment decisions are made collaboratively
- Clinical and administrative processes that affect clients are transparent to all
- Families and natural supports are actively incorporated in treatment

What Does A Person-Centered Organization Look Like

- The structure of the organization is person driven not program driven
- A menu of services promotes choice and customization
- Nothing about us without us – transparency
- Efforts are made to retain and gain natural supports, connections, and integrations

Trauma-Informed Care

- Many of the features of person-centered practices are essential elements of an organization delivering care in a trauma-informed way.
- Safety, collaboration, trustworthiness/transparency, choice, and control and empowerment are shared elements between the two
- As part of the transformation process, organizations will integrate person-centered, trauma-informed, strength-based, recovery-oriented principles

Trauma-Informed vs. Non Trauma-Informed

Trauma-Informed

- Recognition of high prevalence of trauma
- Recognition of primary and co-occurring trauma diagnoses
- Assess for traumatic histories & symptoms
- Recognition of culture and practices that are re-traumatizing

Non Trauma-Informed

- Lack of education on trauma prevalence & “universal” precautions
- Over-diagnosis of serious mental illness
- Cursory or no trauma assessment
- “Tradition of Toughness” valued as best care approach

Trauma-Informed vs. Non Trauma-Informed

Trauma-Informed

- Caregivers/supporters – collaboration – constant attention to culture
- Address training needs of staff to improve knowledge & sensitivity

Non Trauma-Informed

- Rule enforcers – compliance – emphasis on power and control
- “Patient-blaming” as fallback position without training

Trauma-Informed vs. Non Trauma-Informed

Trauma-Informed

- Staff understand function of behavior (rage, repetition-compulsion, self-injury)
- Objective, neutral language
- Transparent systems open to outside support

Non Trauma-Informed

- Behavior seen as intentionally provocative
- Labeling language: manipulative, needy, “attention seeking”
- Closed system – outside support discouraged

(adapted from Fallot & Harris, 2002; Cook et al., 2002, Ford, 2003, Cusack et al., Jennings, 1998, Prescott, 2000)

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