

**Testimony by Julian Ford PhD In Support of House Bill No. 5821 “An Act Concerning Behavioral Health and Substance Abuse Services that are Gender-Specific and Trauma-Informed”**

I am Julian Ford, a clinical psychologist and Associate Professor of Psychiatry at the University of Connecticut School of Medicine. I conduct clinical research, training, and psychotherapy for children, adolescents, and adults who have experienced psychological trauma and have behavioral health and substance abuse problems. I have served as a consultant and provided training and technical assistance concerning trauma-informed services to the Department of Mental Health and Addiction Services and more than 25 DMHAS-affiliated or funded agencies, as well as the Co-Principal Investigator on a study conducted by the DMHAS Research Department which was the first scientific “clinical trial” of gender-specific and trauma-informed or trauma-specific group treatment for women and men in recovery from substance abuse and trauma disorders. I now serve as a consultant with colleagues from the UConn Department of Psychiatry providing training and technical assistance on gender-sensitive and trauma-informed services to the Court Support Services Division and Department of Children and Families and administrators, staff, and clinicians in the state’s juvenile justice detention centers and juvenile training school, public defenders’ offices, children’s psychiatric hospital and residential centers, child guidance clinics, and community organizations such as the Boys and Girls Clubs.

Since shortly after September 11<sup>th</sup> 2001 I have served as founding Director of the UConn/Yale/DMHAS/DCF joint Center for Trauma Response, Recovery, and Preparedness ([www.CTRP.org](http://www.CTRP.org)) which supports the efforts of hundreds of behavioral health providers serving the thousands of Connecticut families affected by the traumatic stress of terrorism and disaster. I also am a consultant and trainer for the National Association of State Mental Health Program Directors, the National Center for Women, Violence and Trauma, and the National Child Traumatic Stress Network regarding trauma-informed behavioral health and addiction services and state and national system reform issues. I am one of six founding members of the International Society for Traumatic Stress Studies President’s Special Committee on Complex Trauma and consult internationally on trauma services.

As a result of these experiences, I have observed first-hand in Connecticut, nationally and internationally the critical need for trauma-informed services for children, teens, adults, and families who receive, or are in need of, behavioral health or substance abuse services. Connecticut’s state agencies, DMHAS, CSSD and DCF, are considered leaders nationally in transforming systems of behavioral health care through innovative trauma initiatives. However, much work is yet to be done in order to ensure that no child, adult, or family with behavioral health or substance abuse and trauma issues is left behind--and that no behavioral health program or provider fails to sensitively addressing trauma issues. This requires a systematic cross-system approach that cannot be done piecemeal. Women’s services are an essential component, but greater attention needs to be paid to girls, boys, and men in the proposed plan for coordinating trauma-informed services. Efforts to make child welfare, children’s behavioral health, and juvenile justice services trauma-informed and gender specific are well underway—as they should be, given the profound lifelong impact of childhood trauma. Trauma-informed services for men also should not be an add-on, particularly when so many men are, or soon will be, returning home from war.

The statewide coordination plan thus should explicitly include expertise in recovery and prevention of psychological trauma for children, teens, and men as well as for women. Making all programs and all services trauma-informed for all consumers and families may seem like an unattainable or even unnecessary goal. The necessity is demonstrated by scientific findings showing that at least 80%, and often more than 95%, of persons of all ages, income and education levels, and ethnocultural backgrounds, and both genders, in behavioral health services have experienced psychological trauma—often repeatedly and including not only maltreatment and domestic and community violence, but also life threatening or life-altering disasters, accidents, illness, and loss of loved ones and homes.

In order to be attainable, the goal of universal trauma-informed behavioral health services must begin with an understanding of what it means for services to be “trauma informed” and how this not only enhances treatment and placement outcomes but also reduces costs. Services, providers, and programs are trauma-informed if they first protect recipients and providers from further exposure to trauma by ensuring physical and psychological safety, and second provide *an explanation* of how psychological trauma does—and does not—change people that is scientifically valid, meaningful to ordinary people, non-stigmatizing (that is, conveys authentic respect for survivors’ resilience and courage) and empowering (that is, shows how trauma’s after-effects, although never fully erased, can be recovered from in ways that make life worth living) and effective assistance in learning or accessing *skills* for transforming traumatic stress reactivity into ways of being self-regulated that enhance personal well-being, relationships, and participation as a citizen in society.

My colleagues in Connecticut and internationally and I teach professionals, scientists, and regular people of all ages that trauma sets in motion automatic changes in the body and brain that are a universal biological form of survival. These “alarm reactions” are healthy adaptive forms of self-protection that are familiar to all of us: they are an extreme version of the stress response that occurs when anyone is confronted by a situation that involves uncertainty or challenge. The stress response takes many forms depending on the person and situation, including being “revved up” by the “adrenaline rush,” angry, anxious, in pain, or “shut down” and emotionally or physically exhausted or depressed. In the rarer—but not uncommon, unfortunately—instance where stressors are traumas that threaten our very survival physically or emotionally, the problem is not the body’s alarm reaction but that none of us has been given a user’s manual that describes how to shut off this body’s alarm system. Remarkably, as terrible as trauma is, and as horrible as it is to suffer from post-traumatic stress reactions, the solution that trauma-informed programs and providers can teach is easily described: they need to show how the body and brain are protecting us after trauma, and teach us skills for re-setting this alarm when it has gone on “red alert” due to trauma. This puts trauma and traumatic stress into an entirely new light, and makes recovery from trauma less mystifying and daunting. Teaching kids and adults how to change their bodies’ adaptive survival reactions back to ordinary ways of being safe and dealing with stress is both a science and an art that requires knowledge of evidence-based approaches to education and therapy. Trauma-informed services take specialized training and continuing consultation well beyond that ordinarily available to behavioral health programs and providers, and this will require a concentrated fiscal and programmatic effort that must be sustained for years, not just for a year or two.

Thank you for the opportunity to speak about a subject of such great importance, and for your support for these crucial efforts to heal the wounds of trauma for the courageous adults and children whom I have been privileged to serve, and many others like them.