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The development of trauma-informed services challenges providers to think about the values and practice of case management in a new way.

Trauma-Informed Services and Case Management

David W. Freeman

The very label *case management* becomes an outmoded concept in a trauma-informed service delivery system. The language of "case" (as opposed to human being) and "management" (as opposed to help, education, facilitation, support, and encouragement) can be insensitive to many issues that are important to trauma-informed services.

To be trauma informed is to be aware of power, control, and interpersonal boundary issues in the clinical relationship. Although it is true that actual abuse happens in professional relationships, the subtler and more implicit abuses are the primary focus of this chapter. Trauma-informed service providers seek to be aware of the dynamics of abuse and to prevent those dynamics from being recreated in an otherwise helpful relationship.

Four clusters of values can differentiate traditional case management from trauma-informed services in an effective way: power and control, authority, goals, and language.

Power and Control

Trauma frequently entails experiences of powerlessness and loss of control. Consumer-survivors often bring specific sensitivities to the ways in which power and control dynamics are expressed in clinical relationships.

Management versus Empowerment. Power and control are vested in the staff in traditional case management. Case managers typically author the treatment plan, which governs access to clinical resources and requires the consumer's attendance at treatment appointments. Housing directors establish detailed residential rules that control, direct, and limit

everyday behavior. The representative payee controls the expenditure of even the smallest amounts of money. Psychiatric appointments are often scheduled with case manager and consumer together to improve communication, but at the expense of the consumer's privacy and her control over her own personal story.

Case management offers a risk-free life to people who accept its services. The representative payee pays rent and utilities, one's personal history is told by another to the psychiatrist, and compliance with house rules ensures trouble-free housing. Such risk-reducing management activities will be soothing to some. However, these management functions can be extremely burdensome to abuse survivors, recreating the controlling relationship that they first experienced at the hands of a perpetrator many years before. "Well-managed" case management services can also close off opportunities for learning through life's natural consequences. Some abuse survivors and professionals who have a history of avoiding risks are glad for the opportunity to take a chance in the supportive environment of a trauma-informed system.

In trauma-informed service systems, power and control are vested in the consumer. Thus, the process of consumer empowerment requires clinicians to yield some of their power to the consumer. Collaboration and cooperation are central concepts here. Service plans, housing arrangements, financial decisions, and medication orders are negotiated between professional and consumer. The consumer's voice, which has often been silenced, is nurtured and amplified so that it can be clearly heard. Clinicians find a new respect for consumers as the process of empowerment unfolds, and this respect facilitates a richer empowerment of the consumer.

Julie's story: At first I was worried about working in a trauma-informed system. I found myself taking personal and professional risks that I had never seriously entertained in the past. For example, I found that I could not hide behind a professional mask. I had to share much more of myself and become a real person in the eyes of the consumers around me. The empowerment of others requires me to yield some of my own power and control.

Problems and Disabilities versus Strengths. Traditional case management focuses on the problems and disabilities of consumers. Most treatment plans in this model start with a problem list that clarifies the nature and scope of treatment. This deficit orientation, which emphasizes the aspects of a person that are broken and dysfunctional, diminishes the power and authority of the individual who is being served and reinforces the need for an expert clinician to set things right.

The problem list approach to treatment planning and intervention generally blames the consumer. This blaming posture again reinforces the dynamics that many survivors of abuse first experienced in childhood. The notions of blame, problem, and incapacity also reassert the unequal power relationship between professional and consumer.

The trauma-informed system values a strengths-based approach to assessment and intervention that highlights the assets of the consumer.

Instead of being defined by his or her problems, the consumer is described as having capacities and abilities. All human beings have strengths, but strengths can be invisible or even undermined if they are not acknowledged and supported. A strengths-based perspective effectively facilitates the development of more skill and capacity in the individual, promoting a sense of well-being, competence, and self-esteem. The experience of a sense of competence sets in motion a further change process, helping consumers to appreciate their own abilities. It can be enormously beneficial to an individual to develop an inventory of her positive qualities, and a strengths-based perspective helps set this in motion.

John's story: When I facilitated my first trauma group, I was amazed at the intensity and power of the survivors in the group. I had previously thought that survivors were disabled and inarticulate. My main experience of people had been in the traditional medical model setting, where their voices could not be clearly heard. I will never again make the mistake of underestimating the strength of survivors.

Symptom Management and Reduction versus Skills Building. The traditional case management treatment plan calls for the reduction of problematic symptoms by a certain percentage. Such a plan will state that aggressive behavior, for example, or hallucinated voices will decrease by 10 percent in the next six months. The symptom is generally isolated from the consumer's life context and is rarely appreciated for the functions it serves.

This strategy of symptom management compartmentalizes and objectifies behavior and takes it out of its meaningful context. When the sense of a behavior's intention and purpose is lost, the person is devalued. The belief that one has behaved in a way that makes sense under adverse, abusive circumstances is also lost.

A trauma-informed approach emphasizes the skills that consumers could usefully acquire. The focus is on the future and the capacity for the development of new resources. A skills-building approach cultivates an environment of hopefulness, which contributes to the overall potential for recovery.

Authority and Responsibility

Trauma survivors are often especially attuned to possible abuses of authority and to practices that assign responsibility or blame inappropriately.

Expert Intervention versus Psychoeducation. In traditional case management, interventions are designed by experts with training in social work, psychology, psychiatry, or administration. They may give advice, direction, and orders to consumers, who are sometimes seen as being unaware of what is best for them. Explanations of behavior may be based in biological, psychodynamic, behavioral, or family systems models. In each case, the consumer cannot hope to know as much as the professional, who has devoted years to learning a clinical language and rationale.

Abusive relationships depend on unequal distribution of power in the relationship. The clinician as expert may unwittingly recreate the dynamics of the abusive relationship as expertise facilitates the exercise of power over another. When authority resides primarily in the clinician in the helping relationship, it becomes difficult for the consumer to trust herself enough to develop a voice of her own.

The sharing of information in a psychoeducational program that is both interactive and flexible enough to accommodate what the consumer thinks is important in a trauma-informed system. A psychoeducational program introduces consumers to the explanatory power of a trauma-informed clinical conceptualization. In such an educational program, past abuses are linked to current coping strategies, and current symptoms are reframed as attempts to cope with past abuses. Psychoeducational programs are most effective in group settings where consumers can learn from each other as well as staff, and staff can learn from the consumer's perspective. A group-based psychoeducational program also helps consumers trust their own perceptions of reality and receive validation for correct perceptions.

Allocation of Resources Driven by the System versus the Consumer. In a traditional case management program, the allocation of resources is often determined by a central clinical authority that is charged with the responsibility of keeping the gates and controlling who receives which service. These authorities often develop labyrinthine application procedures that require the practical assistance and advocacy of expert case managers. The average consumer can easily be made dependent on the system even for help in deciphering and interpreting the system's rules.

In a trauma-informed system, the allocation of resources is driven by consumer request. This demands a degree of flexibility in intervention planning that may be difficult to achieve in traditional systems. Consumers are empowered to direct their own lives in trauma-informed systems. At every opportunity, the consumer is brought into the decision-making process. Clinical services, housing arrangements, financial management strategies, and psychiatric services are all coordinated around the expressed needs of the consumer.

Goals

A trauma-informed approach encourages clinicians to rethink many traditional service goals.

Stabilization versus Growth and Change. Traditional case management values stabilization. Explosive behavior, the expression of intense affect, and withdrawal from interpersonal relationships are all understood as symptoms that require intervention. The clinician's goal in traditional case management is to ameliorate these symptoms, smoothing the path for the consumer's restabilization or return to the mainstream.

Survivors of abuse have legitimate protests about the use and abuse of power and control by professional systems. Yet professionals might interpret these protests as symptoms of a mental illness that require stabilization. In trauma-informed services, professionals can see these protests as an energetic and legitimate rejection of the status quo. Trauma-informed services value growth and change. The expression of powerful affect is understood as a reasonable effort to cope with difficult experiences. It is understood that intense feeling and self-expression have successfully protected the individual from past abuses. The goal now is to capitalize on the individual's underlying desire for a safer environment and a better life. Trauma-informed service providers help consumers develop their advocacy skills so that they can more effectively get what they want and help other trauma survivors as well.

Language

In trauma-informed systems, clinicians use language that communicates the values of consumer-survivor empowerment and recovery.

Clinical Language versus Everyday Language. Language provides support to those who are in power. "Doctors" and "professionals" are immediately thought of as having more power, knowledge, and authority than "patients." When "patients" are described as "chronically mentally ill (CMI)," there is an underlying suggestion that they are weak and deficient.

Wherever possible, trauma-informed providers talk about people and consumers rather than "patients" or "CMI adults." Daily language changes so that *plan of action* replaces *treatment plan, personal history* replaces *assessment,* and *narrative of events* replaces *progress notes* or *contact logs.* Changes in everyday language help clinicians become more aware of the stigma and power maintained by traditional discourse.

Chris's story: Change in the use of language takes time. I sometimes forget to use the new language, especially when I get nervous or upset. When I fall back on the traditional language, I often feel humiliated. I notice the impact of language all the time now. There is a consciousness raising that happens. I think people rally around a new way of describing and thinking about themselves. At the same time, I can see them wilt when they are described in the same old words.

Trauma-Informed Service Systems: Practical Applications

A greater awareness of trauma-related concerns can lead to particular modifications in a number of common clinical interventions.

Treatment Planning versus Service Contracts. Traditional treatment plans invoke the authority of scientific practice by articulating a diagnosis and problem list. This plan, however, may obscure the fact that there was and is a process of negotiation and uncertainty that accompanies clinical work and decision making.

Elaine's story: I always hated signing my treatment plan. The forms were long and confusing, and I usually ended up signing them without reading them.

The parts of the form that I did understand were insulting. I don't like talking about my problems with people I don't really know. Sometimes I had to sign the form after a long meeting with a lot of people: my psychiatrist, a social worker, some nurses—and the psych tech who put me in the quiet area last week! I never felt that I had much of a choice. And I knew that if I refused to sign, I would never get a job or an apartment—and those were the things I really wanted. They have to do these forms, I guess. Otherwise they couldn't get paid. But the forms don't do me any good.

The challenge for the trauma-informed service provider is to create a contract that helps bring the consumer's voice to life. This can be accomplished in several ways. The contract can be transparent about the process that helped produce the document. In trauma-informed work, this process involves negotiation of goals and strategic actions. If this process can be articulated, the voices of the consumer and the clinician, and the relationship between them, is brought out into the open. The contract can help empower consumers by focusing on consumer strengths, resources, and hopes rather than diagnoses and disabilities.

A pilot project at Community Connections has developed the Consumer Action and Support Plan (CASPAR) as an alternative to the traditional treatment plan. The CASPAR abandons problem lists as a starting point and focuses instead on consumer goals, the strengths and resources that the consumer brings to the table for achieving those goals, and the supports needed from staff to facilitate progress toward those goals. Additional skills that might enable the consumer to achieve these goals more easily are then described.

The second section of the CASPAR details the clinician's goals, the consumer's reaction to those goals, and the negotiated settlement. The agendas of the different parties—and their power relations—are always clearly stated in the CASPAR. The processes by which differences of opinion are resolved are made clear.

Darlene's story: I like it when people ask me what I want, particularly if I am taken seriously when I speak out. My old treatment team hated me. I argued with them all the time, and sometimes I got violent and threw things at them. The main problem was that we always disagreed, and I never got what I wanted. The old team reminded me of my family. They acted as if they knew what was best for me, but never asked how I felt or what I wanted. Believe me, I will fight tooth and nail against people who remind me of them. I care about being respected, and I demand to be taken seriously.

Crisis Planning and Response. Crisis intervention in traditional case management programs is focused on controlling the consumer and protecting the community. Sometimes force is used. Psychiatrists, psychologists, the courts, and the police can arrange for forced, involuntary hospitalization. Hospitals can keep people against their will. The potential for forceful imposition of authority and control (through commitment, restraint, and seclusion) is either active or threatened. The imposition of violent restraint techniques may even result in injury to the consumer.

A core feature of trauma is the experience of being overpowered by others. The ability to defend interpersonal boundaries is regularly threatened and breached in a traumatic relationship. Trauma survivors often report that the crisis intervention strategies of traditional case management programs are retraumatizing.

Barbara's story: I don't remember everything that happened before I was last hospitalized, but I do know I had a lot of problems. I was experimenting with a lower dose of medication because I didn't like the side effects, my boyfriend was beating me up, and my roommate had stolen my money. My case manager showed up with the police to take me to the hospital. I hate the hospital, and I hate the police. Basically I like to be in charge of myself.

In trauma-informed service systems, the consumer is invited to participate in crisis planning. Soothing activities are identified in advance, as are consumer choices about the specific interventions used to defuse a crisis. Skills in avoiding and deescalating crisis situations are identified and learned. Consumers are helped to take the opportunity to think into the future, plan for bad times, manage and protect their own boundaries, and take responsibility for making choices. All of these activities are empowering for the consumer.

Money Management. Money is often regarded as a necessary evil in traditional case management. There is almost never enough of it, and what little there is can easily become a battleground between case manager and consumer. It is not unusual for consumers to have only seventy dollars per month of discretionary money (after rent, utilities, food, and telephone) and for that money to be tightly controlled in small increments. This level of control is often introduced as a well-meaning attempt to protect the consumer against running out of money before the end of the month. In traditional case management, entitlement money is sometimes used as a reward for approved behaviors.

Money management occupies an intimate space in our lives. Many of our needs are met through the acquisition and expenditure of money. For another to have authority over this personal space can easily lead to boundary violations. Many trauma survivors have difficult experiences with people who assume positions of authority and then function in an over- or undercontrolling fashion. Peremptory, abrupt, or severe authority can be reminiscent of trauma experiences. Consumers who are hostile to the imposition of financial controls are sometimes criticized for their impulsivity, their anger management problems, or their noncompliance. In fact, they may simply be asserting authority over a medium of exchange with others.

Paula's story: Nothing is more important to me than my money. I don't trust anyone else to manage my money for me. I have friends who got ripped off by other agencies. One agency stole thousands of dollars from consumers. I know I don't always make the right decisions, but I would rather live with my own mistakes than have somebody else tell me what I can and can't have. My case manager used to give me ten dollars if I came to my appointment. To tell you the

truth, it was exactly like my old boyfriend. If I did what my boyfriend wanted, I'd get paid. And otherwise I'd get beaten up. Lots of times my boyfriend paid me for sex. I don't like anything that reminds me of those days.

In a trauma-informed system, the clinician uses the management of money as a tool to facilitate empowerment. Opportunities to use money management training to support the development of skills in dealing with interpersonal boundaries and responsibilities are legion.

As consumers assume increasing responsibility, clinicians begin to take greater risks. It is important that the clinician be actively involved in explaining the risks of financial decisions and increasing supports if consumers make bad decisions. As consumers learn more about the choice points in money management, they are empowered to shape their own lives more effectively.

Conclusion

Trauma-informed clinicians work in an environment that is traditional in its values and principles and must therefore be responsive to the concerns of the traditional mental health authorities. In fact, they must be able to operate in two worlds at the same time: the integrity of trauma services must be maintained, and the needs of the traditional system must be addressed. In addition, they must translate back and forth between the two worlds, explaining, for example, the importance of empowerment and strengths on the one hand, while helping the consumer maintain needed benefits on the other.

In order for clinicians to become trauma informed, they must immerse themselves in a new way of thinking about service delivery. Clinical formulations, relationships with consumers, the language of treatment planning, money management, and crisis intervention strategies—to name just a few domains—are different. The challenge of maintaining competence in the traditional system while developing skills in trauma-informed services is intellectually and emotionally challenging.

It is important for clinicians to work together with other professionals and with consumers to cultivate a support system that is adequate to meet these challenges. As clinicians bring trauma-informed values into the workplace, the rewards become obvious. The rejection of the old paradigm can be exciting. The cultivation of a new sense of purpose and mission is invigorating. And perhaps most important, consumers are gratified and inspired by the change in culture and the introduction of a new and compelling set of values and practices.

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This chapter provides pragmatic recommendations for creating partnerships with recipients of services who have traditionally been the most silent stakeholders in mental health system design and service delivery.

Defining the Role of Consumer-Survivors in Trauma-Informed Systems

Laura Prescott

Establishing the right to equal representation and participation, freedom from discrimination, and self-determination contributed heavily to the language of the consumer/survivor/ex-patient movement in the 1970s and Americans With Disabilities Act of 1990. Recent support for recovery and trauma-sensitive approaches emphasizing the principles of empowerment and self-determination in mental health coalesce with a number of other important social and economic shifts affecting the efforts of human service agencies to integrate consumer-survivors.

Managed care, privatization, blended funding streams, and emphasis on research-based outcomes have provided new opportunities for consumer-survivor involvement. Related emphasis on developing performance improvement measures and ensuring accountability can dramatically increase consumer-survivor involvement at all levels of policy and practice. Although many clinicians, administrators, and policymakers have embraced the principles of integration, they have struggled with defining what that means and how to proceed. Within this context, many human service agencies are challenged to stretch their vision beyond deficit-based approaches, search for new ways to operationalize the values of empowerment, and co-create cultures that foster sustainable partnerships with those receiving services.

Much of the material contained in this chapter is derived from L. Prescott, *Consumer/Survivor/Recovering Women: A Guide for New Partners in Collaboration.* Delmar, N.Y.: Women, Co-Occurring Disorders and Violence Coordinating Center, forthcoming.