

Nebraska Division of Behavioral Health  
OCA People's Council Meeting  
November 4, 2014 9:00 am -3:00pm  
Region V Large Conference Room  
1645 N Street Lincoln, Ne

**DRAFT Meeting Minutes**

**I. Call to order and roll call** **Jennifer Ihle**

Chairperson, Judie Moorehouse was not able to attend the meeting due to weather. The start of the meeting was delayed due to lack of a quorum. Once a quorum was established, the meeting was called to order by Jennifer Ihle at 9:50 am on November 4, 2014. Roll call was conducted and quorum determined.

**Council members present:** Nancy Rippen, Mary Thunker, Jennifer Ihle, Lisa Casullo, Phyllis Mc Caul, Candy Kennedy Goergen, and Scott Loder

**Not present:** Judie Moorehouse, Tammy Fiala, Jonathan Koley, and Ryan Kaufman

**DHHS Staff present:** Carol Coussons de Reyes, Cynthia Harris, & Lucy Flores

**II. Housekeeping and summary of agenda** **Jennifer Ihle**

Jennifer asked for approval of the agenda with any added or removed changes; Carol Coussons de Reyes suggested the agenda be changed on the removal of Hearing Voices Network Webinar Review and Conference Planning Committee Members CPSWS Reviewed unless someone would want to report on Judie Moorehouse absence of presenting, none reported wanting to cover these sections and these two sections of the agenda were removed. Carol stated that this agenda was missing indication that public comment was accepted throughout the meeting. Committee members indicated that this agenda and future agendas must indicate Public Comments taken throughout the meeting. A motioned to approve the agenda with these changes and the minutes with this change was made by Mary Thunker and seconded by Nancy Rippen. The motion was approved by unanimous vote.

**Handout A:** Agenda changes made to the draft agenda per housekeeping and summary of the agenda

**Handout B:** Past minutes for November 4, 2014

**Handout C:** Karen Harker handed out Appropriation & Spending Authority Process

**Handout D:** Carol Coussons de Reyes handed out THE NEW H5 MODEL  
Trauma and Recovery A Summary

**Handout E:** Carol Coussons de Reyes handed out Trauma Guide  
Healthy Foster Care America

**III. Approval of minutes** **Jennifer Ihle**

A motion to approve the minutes for August 5, 2014 was made by Mary Thunker and was seconded by Lisa Casullo. The motion was to correct the minutes that state only a few were interested in the Consumer and Family Involvement White Paper. Everyone stated interest in assisting with the white paper at the meeting. The motion was approved by unanimous vote.

**IV. Public comment** **No Public Comments**

There was no public comment.

## **V. Understanding DHHS Budget Cuts**

**Karen Harker**

Karen handed out **Handout C: Appropriation & Spending Authority Process**. Karen introduced the members to the language of Appropriation & Spending with Some Terms, Legislative Budgets Spending Authority. The State Budget is set for two years at a time with Biennium Budget. Karen further discussed the Administration Appropriate Process; legislative appropriate spending authority, CEO of DHHS allocates to Divisions, and the Behavioral Health Director allocates within Behavioral Health, including the office of Consumer Affairs. Members asked if pay of Regional Consumer Specialists was raised and Karen stated this pay rate is determined by the Regions. Members asked if leadership at the Lincoln Regional Center would fill vacant peer positions and Karen stated this was for the leadership at the Lincoln Regional Center to determine. It was asked if peer support was supported or window dressing. Karen stated that she believes peer support is supported. Members felt the presentation and discussion was very informative information and asked to have Karen come back to re-visit the next People's Council meeting. A motion was made by Candy Kennedy-Georgen that the committee draft a letter of Thank You for the support to Behavioral Health Office of Consumer Affairs. It was seconded by Mary Thunker. The motion was approved by unanimous vote.

## **VI. The Work of Partners in Recovery**

**Paige Namuth**

Paige Namuth introduced herself as a consumer and advocate for recovery. She organizes art shows for folks with a behavioral health diagnosis or traumatized persons. She believes in developing the artists beyond their art shows. She believes arts can overcome poverty. She displayed and talked about several art pieces that were made by artists at her center. She displayed and talked about her "Alcoholics are Angels" poster. She stated that it seems like someone killed your loved one and you have to live with the one who did it (referring to a person with active addiction and the relationship that the family has with the individual). Parents say that their loved one is turned into someone different and are really traumatized inside. Paige also said that each consumer is an angel that forgot their purpose. Members expressed interest in referring people to the arts program. Paige stated that she is having a renovation on the center, before she begins taking referrals. Paige reported she would let the members know when she was ready for referrals.

## **VII. Trauma 5H and NEW AAP Guide-Informing Health Care Providers on Peer Support** **Carol Coussons de Reyes**

Carol Handed Out; *Caring for Refugees and Other Highly Traumatized Person and Communities THE NEW H5 MODEL Trauma and Recovery A Summary*. The Author Richard F. Mollica MD. MAR Harvard Program in Refugee Traumas (HPRT). The NEW H5 Model is recognizing the urgent need to address the humanitarian care of those affected by human violence and aggression. The H5 model of understanding trauma stories focused on 5 key areas of the trauma story:

- **H.1 Human Rights** violations: All acts of violence are human right violations.
- **H.2 Humiliation**: Humiliation is the major instrument of violence used by perpetrators to create the state of humiliation in all violated persons.

- **H.3 Healing (self-care):** The remarkable realization that all persons affected by violence have a powerful, physical, mental, and social self-healing response is critical to facilitating the patients healing recovery.
- **H.4 Health Promotion :** The famous Adverse Child Events ( ACE) Demonstrate to mainstream American communities the impact of child abuse and past traumatic life experiences on the health and well –being of community members.
- **H.5 Habitat:** Many survivors not only live in psychologically oppressive environments but also in terrible housing situations.

Trauma Guide Healthy Foster Care America: Handout authored by American Academy of Pediatrics shared by Carol.

Helping Foster and Adoptive Families Cope with Trauma: A guide for Pediatricians the purpose of this guide is to support adoptive foster families by strengthening the abilities of pediatricians to identify traumatized children, educate families of early childhood trauma and to empower families to respond to their child’s behaviors in a manner that acknowledges past trauma, and promotes new learning to be more adaptive reactions to stress.

The Trauma Toolbox for Primary Care: 6 part series that was designed with the primary care practice in mind to understand Adverse Childhood Experiences (ACEs) and the process of asking families about exposure to ACEs or other traumatic events. The website link is: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx>

Carol stated that both trauma tools do not address the importance of peer support and that this was an excellent opportunity for peers to provide their doctors with resources related to trauma and information on peer support for trauma survivors. Members thanked Carol for the perspective and wanted to know more about how to make trauma assessments billable. Carol suggested Blaine Shaffer may be able to address the committee on this matter. Committee members asked Carol to invite Blaine to the next meeting in February.

### **VIII. Update on credentialing Steering Committee / Peer Support Implementation Plan**

Kate Speck of the UNL Public Policy Center will be working with the Office of Consumer Affairs to further develop regulations relating to peer support services and the training/certification of peer support specialists. Committee meetings with resume and an online offering will be made available for public comment.

### **IX. Consumer Involvement Whitepaper Workgroup Carol Coussons de Reyes**

This agenda item was tabled until the next meeting in hopes there would be a larger group of committee members present.

### **X. Alternatives Review**

Carol referred the committee to read the latest edition of the OCA Newsletter on Recovery Month & the Alternatives Conference in the interest of time, because at 1pm the quorum would be lost by one member leaving for another meeting.

**XI. Meeting Adjourned**

**Jennifer Ihle**

Motion was made to adjourn the meeting by Mary Thunker and seconded by Lisa Casullo. Meeting was adjourned at 12:50 pm on November 4, 2014

Next Meeting is scheduled for February 3, 2015 @ 9:00am – 3:00 pm Region V 1645“N” Street  
Lincoln , Ne 68508

*Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide only a general summary of the proceedings.*

11/4/2014 Meeting Minutes

**Office of Consumer Affairs**

People's Council

**DRAFT Agenda**

Region V 1645 N Street Lincoln, Nebraska 68508

First Floor Conference Room #1

November 4, 2014

9:00 AM – 3:00 PM

Judie Morehouse	Call To Order	9:00 am – 9:10 am
Karen Harker	Understanding DHHS Budget Cuts	9:10 am-9:40 am
Break		9:40 am -9:50 am
Paige Namuth	The Work of Partners in Recovery	9:50 am-10:20 am
Carol Coussons de Reyes	Trauma-5H and New AAP Guide-Informing Healthcare Providers on Peer Support	10:20 am-10:50am
Judie Moorehouse	Hearing Voices Network Webinar Review	10:50 am -11:20 am
Judie Moorehouse	Conference Planning Committee Members-CPSWS Conference Review	11:20 am-11:50 pm
Lunch		11:50 pm-1:00 pm
Carol Coussons de Reyes	Update on Credentialing Steering Committee/ Peer support Implementation Plan	1:00 pm-1:30 pm
Carol Coussons de Reyes	Consumer Involvement Whitepaper Workgroup	1:30 pm -2:00 pm
Break		2:00 pm -2:10 pm
Carol Coussons de Reyes & Cynthia Harris	Alternatives 2014 Review	2:10 pm 2:40 pm
Judie Moorehouse	Adjourn	2:40 pm-3:00 pm

If you have any questions and would like more information, please feel free to contact:

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Carol Coussons de Reyes, Administrator  
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Nebraska Division of Behavioral Health  
OCA People's Council Meeting  
August 5, 2014 9:00 am -3:00pm  
Region V Large Conference Room  
1645 N Street Lincoln, Ne

B-Handout

DRAFT Meeting Minutes

**I. Call to order and roll call** **Judie Moorehouse**

Chairperson, Judie Moorehouse called the meeting to order at 9:17 am on August 5, 2014. Roll call was conducted and quorum determined.

**Council members present:** Nancy Rippen, Mary Thunker, Jennifer Ihle, Judie Moorehouse, Tammy Fiala, Lisa Casullo, Jonathan Koley, Phyllis Mc Caul, Ryan Leiting, Ryan Kaufman, and Scott Loder

**DHHS Staff present:** Carol Coussons de Reyes, Cynthia Harris, & Lucy Flores

**II. Housekeeping and summary of agenda** **Judie Moorehouse**

Judie asked for approval of the agenda with any added or removed changes; a motioned to approve the agenda was made by Mary Thunker and seconded by Lisa Casullo. The motion was approved by unanimous vote.

**Handout A:** Agenda No changes were made to the draft agenda

**Handout B:** Past minutes for August 5, 2014

**Handout C:** Cynthia Harris handed out Draft Peer Support Implementation Plan- Office of Consumer Affairs

**Handout D:** Cynthia Harris handed out Draft Consumer and Family Involvement White Paper in Nebraska

**Handout E:** Kim Carpenter handed out Trauma-Informed Care Peer Support

**Handout F:** Carol Coussons de Reyes handed out Proposed OCA Budget for fiscal Year 2015

**Handout G:** Carol Coussons de Reyes handed out OCA Contracts

**Handout H:** Carol Coussons de Reyes handed out Mental Health First Aid

**Handout I:** Carol Coussons De Reyes handed out How do I get through the rough spots after I stop smoking?

**Handout J:** Joel Schneider handed out Understanding Peer support Services in Veterans Health Administration (VHA)

**Handout K:** Joel Schneider handed out How do you talk to a veteran? TALK TO ME,

**III. Approval of minutes** **Judie Moorehouse**

A motion to approve the minutes for May 6, 2014 was made by Mary Thunker and was seconded by Jennifer Ihle. With the corrections to the minutes on the name Amy Beacon to be removed and add BHECN. Adding the correct name to Jonathan Koley. The motion was approved by unanimous vote.

**IV. Public comment** **No Public Comments**

There was no public comment.

## **V. Peer Support Implementation Plan**

**Cynthia Harris**

Cynthia handed out **Handout C**; Draft Peer Support Implementation Plan – Office of Consumer Affairs Discussion by the members on several questions towards the peer support service and credentialing implementation plan. Lisa Casullo; A. Credentialing; asked about (a). Research of Trauma and Compassion Fatigue found in adults and family peer support workforce and action taken: Jonathan Koley – reviewed ii: Recommendations for Peer Support Credentialing Process January 2014? Jennifer Ihle- commented on training new Facilitators? There are 19 Facilitators and it gets pretty expensive to do the trainings, and not all of the 19 are active. Certification through formal regulatory process comments made: Recertification facilitators staying in tune, improve evaluations, talk about initiatives, and will meet facilitators training refresher and some recommendations **not all are active**.

## **VI. Consumer and Family Involvement White Paper**

**Cynthia Harris**

Cynthia Harris handed out DRAFT Consumer and Family Involvement in Nebraska. Topics for discussion were on Executive Summary, Nebraska Consumer and Family Movement History, Discussion of Consumer and Family Roles, Strategies for Optimizing and Family Involvement at Every Level, Recommendations and Definitions. Comments on the section history was made that perhaps it should reflect the history of involvement versus the history of the system. Further discussion on how other region specialists could voice other events that happened in Consumer and Family Movement's History and at other large advocating events. Phyllis McCaul said there used to be CAT Teams consumer liaisons voiced on regions. There is a lot of history to be captured. Lisa Casullo commented on resiliency to talk about how people became Advocates about recovery in individual things and experiences on how to do things differently, and on how people changed and touched each other was not focused on. Phyllis McCaul commented on where the legislation is now and the Mental Health Association. Judie Moorehouse recommended that more time was needed to review missing pieces on System of Care this would take time to read and come back to. Judie suggested to form a sub-committee to hold conference calls and report back. The sub-committee volunteers were Judie Moorehouse, Lisa Casullo, Mary Thunker, Jonathan Koley, Ryan Leiting, and Jenifer Ihle. Lisa Casullo commented on Recommendation for Providers – to focus on certain parts and break it down form a sub-committee from regions. Lisa Casullo suggested peer support training for providers will help them understand what Peer Supporters can do. Carol mentioned the website on Trauma and Peer Support is available ([www.dhhs.ne.gov/trauma](http://www.dhhs.ne.gov/trauma)). Carol mentioned the 2 hour OCA webinar 2010 on Recovery and Resiliency. Carol mentioned that the DRAFT version of the Consumer and Family Involvement Whitepaper is better suited to a subcommittee due to the amount of time involved. The OCA also intends to add System of Care information and recommendations that evolve from discussion around the state on the paper. The white paper will continue to evolve and will not be a static document.

## **VII. Consumer Involvement Discussion**

**Kim Carpenter**

Kim Carpenter handed out Trauma – Informed Care peer support and compassion Fatigue/ Vicarious Trauma. Opened up her presentation by giving us three educational training topics on Care Support Training, How to Train the Trainer, and on Compassion Peer Support. She began by asking what is most useful and meaningful to people in the developmental of vicarious and trauma 101 education?

## **VIII. Contracts and Budgets**

**Carol Coussons de Reyes**

Carol handed out two handouts on Proposed OCA Budget for Fiscal Year 2015 and OCA Contracts. The handouts were reviewed by Carol with the group. The group invited Karen

Harker to come to the meeting to further discuss the DHHS budget. The group also asked to hear more about our contract with Partners in Recovery.

**IX. Mental Health First Aid Carol Coussons de Reyes**

Carol handed out Handout on Mental Health First Aid: Research and Evidence Overview. The handout was reviewed by Carol. The group discussed the recent training offered to Instructors from BHECN. Overview Ryan said the training was Peer Support training. Tammy commented on stigma about high school experiences and that the public needs information aside from what they get in the media. Joel commented that getting it out to the community fast. Joel also said to remember some of the stigma on mental health crisis and knowing what to do for suicide can be very good. Carol supports the skills of Mental Health First Aid may be more powerful when delivered by a peer with lived experience with a behavioral health condition. Carol commented on taking the course for her was a very professional course.

**X. Stages of Change and Smoking Carol Coussons de Reyes**

Carol Coussons de Reyes shared handouts on: How do I get through the rough spots after I stop smoking? QuitNOW.negov website, or call Nebraska Tobacco Quitline: 1-800-QUIT-NOW. How to Cope with Withdrawals Symptoms; Medications; Other ways to stay active; Stages of Change –Shirley Deethardt showed some scenarios in the handouts also Words of Encouragement; What about Slips and Relapse? When smokers quit-what are the benefits overtime? Discussion was made on how these handouts were used to support an upcoming webinar that will be released in September for National Wellness Week.

**XI. Veterans and Peer Support in Nebraska Joel Schneider and Ryan Kaufman**

Joel handed out handouts on Understanding Peer Support Services in Veterans Health Administrative (VHA). Joel and Ryan both presented and showed a video on the experience of Post-Traumatic Stress and Peer Support. Additionally, Joel shared a presentation on How do you talk to a veteran? TALK to ME. Joel and Ryan shared good questions and questions you might want to avoid –Use of common sense- Sometimes it's hard. Joel and Ryan both gave a very powerful presentation on what a Veteran is and what they have gone through. Thank you both for having served our country and for your peer support throughout the State.

**XII. Meeting was adjourned Judie Moorehouse**

Motion was made to adjourn meeting by Julie Moorehouse; Adjourned by Mary Thunker and seconded by Lisa Casullo. Meeting was adjourned at 3:20 pm August 5, 2014.

Next Meeting is scheduled for November 4, 2014 @ 9:00am – 3:00 pm @  
Region V 1645“N” Street Lincoln , Ne 68508

*Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide only a general summary of the proceedings.*

8/5/2014 Meeting Minutes

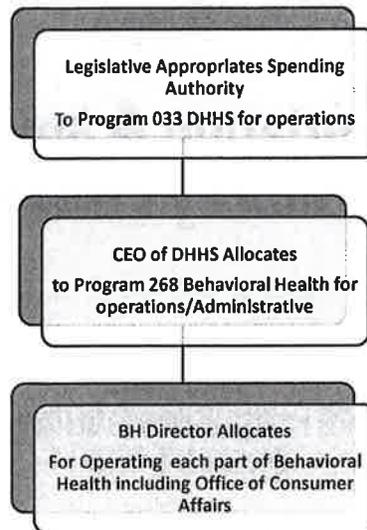
# Appropriation & Spending Authority Process

Karen Harker  
DHHS Division of Behavioral Health  
November 4, 2014

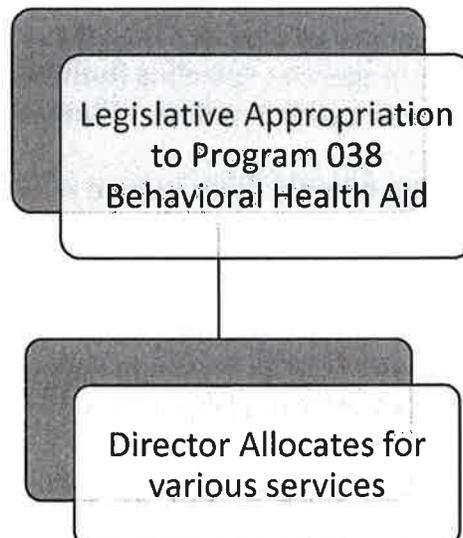
## Some Terms.

- Legislative Budget bill basically provides each State Agency or Programs in agencies **Spending Authority**
  - Think of it as a spending limit – “**Appropriate**” funds
- State Agencies **Allocate** funds to keep various parts running
  - Think of this as allowance
- State Budget is set two years at a time – **Biennium** budget
  - We are in the FY14-15 Biennium Budget and the Legislature will be setting the FY16-17 Biennium Budget in the Spring

## Administration Appropriation Process



## Aid Appropriation Process



## Current Funding

- While DHHS overall budget was reduced, DBH was not for FY15 and Director allocated \$10,000 more to OCA for training & TA needs
- Program 038 – which funds Behavioral Health Services
  - Was reduced by \$5 million but...
    - Rate increase awarded that added in \$1.59 million
    - FY14 unspent funding of \$4.24 million was authorized to be spent in FY15 to maintain services



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CARING FOR REFUGEES AND OTHER HIGHLY TRAUMATIZED  
PERSONS AND COMMUNITIES

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# THE NEW H<sup>5</sup> MODEL

TRAUMA AND RECOVERY:  
A SUMMARY

HARVARD PROGRAM IN REFUGEE TRAUMA  
MASSACHUSETTS GENERAL HOSPITAL  
HARVARD MEDICAL SCHOOL



HARVARD PROGRAM  
IN REFUGEE TRAUMA



HARVARD  
MEDICAL SCHOOL



MASSACHUSETTS  
GENERAL HOSPITAL

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## **Acknowledgements:**

Edited by Christopher James Mollica

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## I. NEW H<sup>5</sup> MODEL

Recognizing the urgent need to address the humanitarian care of those affected by human violence and aggression, the H<sup>5</sup> Model focuses specifically on the millions of refugees living in camps worldwide, but it is our hope that it can also be used to serve civilian and mainstream populations suffering from trauma. The H<sup>5</sup> Model addresses the mental and physical health issues related to trauma suffered by refugees, the relationship between mental and physical health problems prevalent among refugee populations, the potential for trauma to persist in refugee camps, and the need for a new, more comprehensive model of refugee care. This new model explores 5 overlapping dimensions essential to trauma recovery by highlighting findings from studies of refugee populations. It presents recommendations for implementing culture and evidence-based policies and actions for traumatized refugee populations around the world. The H<sup>5</sup> Model has received widespread acclaim since it is one of the first models to address from a theoretical perspective the major source of risk and vulnerability affecting highly traumatized persons and communities. Because of its comprehensive and holistic approach to recovery, it is receiving attention from mainstream media and mental health practitioners engaged in creating a culture of trauma-informed care policies and psychosocial and cultural programs. The complete model is presented in a chapter entitled *The New H<sup>5</sup> Model of Refugee Trauma and Recovery* in *Violence and Mental Health*, currently in press from Springer Publishing Company by Professor Richard F. Mollica and his co-authors Dr. Robert Brooks, Professor Solvig Ekblad and Dr. Laura McDonald.

A summary of the five overlapping dimensions and the core of the model, the *Trauma Story*, is presented below. This new model for the recovery of traumatized refugee communities worldwide is based upon five dimensions essential to recovery. These five dimensions are anchored in the centrality of the trauma story. All dimensions of the H<sup>5</sup> Model are culturally sound and evidence-based. (See Figure 1)

Figure 1: The Five Overlapping Dimensions and Core Elements of the H<sup>5</sup> Model



## THE TRAUMA STORY:

**Trauma stories** are stories told by survivor patients of distressing and painful *personal* and *social events*. Sharing these stories serves a dual function not only of healing the survivor but also of teaching and guiding the listener – and, by extension, society – in healing and survival. The *trauma story* has four elements. The primary element of the story is the **Factual Accounting of Events**, or what actually happened to the storyteller, i.e. the brutal facts. These facts are usually graphic and detailed embellished presentations of the individual's traumatic life experiences. When such facts are collected from even a few persons, they can provide historical documentation of the concrete behavior of perpetrators of crimes against humanity, revealing the intentional, well-orchestrated methods of perpetrators.

In addition to recounting the facts, each trauma story reveals the survivor's sociocultural history in miniature, depicting the traditions, customs and values in which their story is embedded. The storyteller cannot avoid revealing the **Cultural Meaning of Trauma**. Although men and women in every society perceive violence as deeply injurious and socially *degrading*, responses differ by culture.

The trauma story also provides a view into the survivor's spiritual life: his or her capacity to achieve an **Enlightened View of the World** divorced from ugly and distressful emotions. Often the survivor reaches deep insights when reflecting upon his or her situation, for example, coming to reject social beliefs or attitudes that say he or she is "bad" for having been involved in a tragic event. These insights can prove very liberating. Trauma stories provide unique insights into the narrator's cultural framework. In every tragic event, this is an opportunity to uncover deep revelation and gain insights. Some call this "posttraumatic" growth.

The fourth and final element of the trauma story is the **Listener-Storyteller Relationship**. Storytellers are vulnerable to physical and emotional pain when they retell their stories; therefore, a listener's patience and sensitivity are crucial. The trauma story does not in fact completely exist unless it is told to someone else; the listener must choose to become part of the story. Under ideal conditions, the storyteller is the teacher and the listener is the student. The obligation of the listener is to apply the lessons of survival and healing to their personal and professional lives. By understanding that they are part of a historical process, all involved in the sharing of trauma histories becoming personally stronger and more resilient.

The repetition of the story makes the storyteller more comfortable. In effect, having a listener is part of the therapeutic process. In turn, the listener becomes more knowledgeable, not just of the pain of the trauma survivor, but also of what the storyteller has accomplished. In particular, the trauma story, in each of its four elements and as a whole, offers an incredible amount of new information on survival and healing, of allowing the survivor to have the motivation and strength to fight for recovery once tragedy is shared with another. Survivors must be allowed to tell their stories in their own way, just as listeners must remain enthusiastic and sensitive, so that the trauma story will flow without any outside influence. The trauma story can be told in groups with other people who have faced similar events.

Carefully attending to the four elements of the trauma story lets the storyteller share their deeply private life experiences, in order that we all might heal from and survive human tragedies. Attention to these elements gives everyone a way to tell and interpret their own

stories, not only those of others. Appreciation of the trauma story's scope and depth allows it to have a significant personal and social role in recovery from violence's humiliating and disturbing goals.

### H.1. HUMAN RIGHTS

Human rights violations are embedded in the definition of refugee. Safety and security is a foundation of refugee care. All human beings faced with the experience of violence want to tell someone else they trust their *trauma story*. At some point in the refugee camp process, individuals must have an opportunity to officially tell camp officials their violent history and reveal to authorities all of their experienced human rights violations, past and present. While it is not expected that the refugee in the acute crisis will be able, or should be able to do this, ultimately as safety and security are established the individual's traumatic life story must be recorded and acknowledged. Some sense of justice must be discussed with the refugee and their community and related human rights violations.

All violence violates a human being's human rights. Usually we reserve the term human rights violations to describe actions of extreme violence perpetrated in international and foreign settings. But concern for human rights is equally valid in the American setting. Violence treats all citizens alike whether they are children being sexually abused by a parent or an elderly man being exploited physically and emotionally within a nursing home. This important aspect of healing is often overlooked in therapy. The denial of proper and culturally effective health and mental health care causes tremendous human suffering and can even lead to death. Stigma toward the mentally ill and social prejudice and abuse of people different from the mainstream is a lack of respect for the human dignity of all living beings. All violated people expect and crave justice. The refugee community cannot wait years (while it is common) to have their desire for justice addressed by the international community.

### H.2. HUMILIATION

Humiliation is closely associated with feelings of shame, embarrassment, disgrace, and depreciation that are common reactions to violent actions. These feelings are often hidden by other intense emotions. Perpetrators intentionally drive victims to a place where all the values and features of *normal* existence are destroyed. The goal of violent acts, regardless of intensity, is the same – to create a state of emotional humiliation. Every characteristic of the abused person becomes bad or wrong; perpetrators try to introduce into the minds of their victims their fundamental worthlessness.

Perpetrators of violence use humiliating acts (e.g. rape) to create the state of humiliation. Humiliation is a very complex human emotion because it is primarily linked to how people believe the world is viewing them – that others may view the survivor as worthless or deserving of pain. Humiliation leads to a total loss of self-respect and can have major impacts on a refugee's personal and social behavior, being associated with learned helplessness, leading to a lack of self-efficacy. Often, the state of humiliation is re-created in the camp environment when individuals are not allowed to work, grow food, or make money.

The healing and recovery process must consciously strive to overcome in the mind distortions that produce feelings of helplessness and worthlessness. The healing response must be clear that violence is wrong, no matter the rationale. For healing to move forward, it is important to identify the feeling of humiliation and its associated emotions. Every

traumatized person needs to find that solid ground of original sanity – unblemished by the lies of aggressors – where their personal power still exists and upon which the healing process can grow.

### H.3. HEALING (SELF-CARE)

Self-healing is one of the human organism's natural responses to psychological illness and injury. Like the body's response to physical damage, the healing of the emotional wounds inflicted on mind and spirit by severe violence is a natural process. After violence occurs, a self-healing process is immediately activated, transforming, through physical and mental responses, the damage that has occurred to the psychological and social self. For example, sharing a *trauma story* can lead to the reduction or elimination of emotional memories that have outlived their adaptive value. The trauma story is only one self-healing pathway that has not traditionally been fully acknowledged. Dreams are now slowly being appreciated as a major self-healing response in traumatized persons.

Self-healing occurs at the psychological level when the mind is able to construct new meaning out of violence. At that point, behaviors are implemented that help the traumatized person cope with their emotions of humiliation, anger, and despair. These behaviors can either restore the old life-world of the survivor or, more commonly, create a new one. At the core of the psychological dimension of self-healing is the will to survive and recover. The individual makes a decision to do whatever needs to be done, not to “cave in” to violent acts.

Self-healing involves a social dimension as well as a psychological one. Positive social behaviors such as *altruism*, *work*, and *spirituality* enhance neurobiological processes that promote health and reduce the negative consequences of stress. These behaviors and others, such as the use of humor, social support, and physical exercise, help the individual recover psychologically. One of the first steps of a traumatized person's recovery, whether child or adult, is to break his or her social isolation by acknowledging that the forces of self-healing are at work and will ultimately lead to a good outcome, including the return to normal life. In this regard, helpers are essential because they can use their empathic skills to reinforce this therapeutic optimism in survivors.

### H.4. HEALTH PROMOTION

There is emerging evidence that refugees, persons in post conflict countries and those impacted by conflict have increased levels of long term chronic illnesses attributable to their traumatic experiences and high levels of distress. Research demonstrates that persons who experience trauma are more likely to die younger of all causes, develop chronic illnesses (e.g. ischemic heart disease, diabetes) and severe social disabilities. Trauma survivors have poorer behavioral health, smoke more, use alcohol and drugs more, exercise less and have poorer eating habits resulting in obesity and the metabolic syndrome. All are risk factors for the development of chronic disease. In other words, trauma generates chronic disease through direct effects and indirect effects through mental illness (PTSD & Depression) and impaired lifestyle. This connection between trauma and poor physical health demands a new emphasis on health promotion.

### H.5. HABITAT

The word *habitat* is used in place of “housing” to connote the total surroundings and/or living environment occupied by refugees, which does not necessarily qualify as a

house. The word *habitat* is derived from the Latin *habitare* and in the ancient world meant the natural environment of a person or the place where an organism dwelled. And there was a belief that a reciprocal and positive relationship existed between the physical and natural environment and those living organisms who lived and prospered within that environment. The dilapidated tents that over 1/2 million Haitians have live in more than 3 years after the earthquake of January 12, 2010 are not just broken down tents but a social environment plagued by poverty, social chaos, and gender-based violence. Traumatized persons and communities need to enter after a humanitarian emergency into a *healing environment* that can begin to initiate the healing process. Unfortunately, the latter concept is still poorly understood by the international humanitarian aide community.

Habitat is a new area of refugee mental health research. Initial studies of refugee living conditions point to a significant relationship between health problems, mental illness, crowding, lack of privacy and chronic violence. The H<sup>5</sup> understands the overall quality of housing and its relationship to trauma recovery as an important and relevant issue, and suggests that new design and building materials can make modern, healthy and safe housing a cost effective option.

## THE H<sup>5</sup> MODEL APPLIED TO REFUGEE CARE

Recommendations based upon the H<sup>5</sup> Model are:

- 1.) All past and ongoing human rights violations and social justice issues must be openly addressed with the refugee community, immediately documented, closely monitored, and brought to the attention of refugee camp authorities, who can respond to and remedy these violations to the degree they are able.
- 2.) Refugee camp policies and programs should be designed to actively enhance self-healing, independence, and self-sufficiency. The humanitarian response must not further degrade refugees or tolerate any form of gender and child based violence. Similarly, UN staff and NGOs should never humiliate, degrade or exploit the vulnerability of the refugees they serve. A UN Code of Respect by the UNHCR must be written, enforced, and widely disseminated.
- 3.) All refugees should receive an initial needs assessment to determine their self-healing status and then be supported in their recovery by psychosocial programs built on the strengths illuminated by the aforementioned assessment, with psychiatric serves readily available for the seriously mentally ill.
- 4.) International aide should implement a universal health promotion program for all refugees that includes diet, exercise, stress reduction, and sleep promotion, among other health promotion techniques and programs.
- 5.) In order to ensure that the camp meets refugees' cultural and personal needs, refugees should participate in the design, construction and management of their homes and their new living environment. Homes should be safe and well-constructed and adequate lightning (e.g. solar powered) should be made available to all woman and children. New building materials that are ecologically sound and inexpensive need to

replace current use of tents with urban design replacing a haphazard and chaotic camp environment.

## II. THE H<sup>5</sup> MODEL APPLIED TO TRAUMA INFORMED CARE

The H<sup>5</sup> Model is extremely relevant and useful to mainstream health and mental health programs. It is consistent with the values and culture of the trauma-informed care movement (TIC). TIC sets a clear priority that all levels of the health care and social welfare system, introduce the values and practices of TIC for client/patient, staff and administrators. While the H<sup>5</sup> Model was developed for refugee populations, it certainly can be applied to those communities that have been traumatized by crime, poverty, catastrophic situations such as 9/11, the Boston Marathon bombings or Hurricanes Sandy and Katrina.

The H<sup>5</sup> Model helps us have a better appreciation of the underlying forces necessary for the recovery of those members of the general population who have survived or are coping with domestic violence, childhood sexual abuse, gender-based violence, and the stresses and strains of crime, poverty, family dysfunctionality and social stigma.

### THE TRAUMA STORY:

The *trauma story* again is the centerpiece of the medical and emotional care of all patients who have experienced or are experiencing violence. The four dimensions of the trauma story described above remains a good approach to understanding the life experience of traumatized patients living in our mainstream communities. These four elements detailed in the previous section are

1. *THE BRUTAL FACTS*
2. *CULTURAL MEANING OF TRAUMA*
3. *REVELATION "LOOKING BEHIND THE CURTAIN"*
4. *THE STORYTELLER-LISTENER RELATIONSHIP*

It must be remembered that all human beings experience tragedies in their lives. Because of this there is an immediate solidarity between trauma survivor and therapist. Extensive research has revealed the therapeutic power of *deep listening*, i.e. patients love being listened to and heard. There are many clinically effective approaches to listening to the trauma story, from a simple acknowledgment of the patient's traumatic narrative, through the use of diaries, and the systematic reliving of the trauma events through exposure therapy. Due to the potential to trigger upset in the patient, proper administration of story-telling techniques necessary – i.e. they should only be used once trust has been established; most patients maximize their recovery from having an ongoing conversation with the therapist. The moral of the story is that deep listening heals.

Therapists using a holistic approach are used to considering the *bio-psycho-social and spiritual* domains of the patient's suffering. The H<sup>5</sup> Model overlaps with the latter by offering a broader cultural, wellness and sociological approach that integrates into one model all aspects of the trauma survivor's health problems and underlying resiliency. Each of the H<sup>5</sup> elements is real and forms a platform for understanding the survivor's medical and psychiatric diagnoses such as PTSD and depression. The H<sup>5</sup> elements encompass survivor's personal narrative that helps us to determine the illness and resiliency of each and every survivor within the general population. The H<sup>5</sup> Model can be easily adapted to a trauma-informed care approach.

## H.1. HUMAN RIGHTS VIOLATIONS:

All acts of violence are human rights violations. TIC therapists should take a careful look at the *UN Declaration of Human Rights*. This document codified after World War II by the United Nations is one of our world's greatest achievements. It is sad that few American doctors and/or their patients have read the UN Declaration of Human Rights. Acts of domestic violence, for example, are human rights violations. A recent front page article in the *Boston Globe* (August 10, 2014) highlighted the hundreds of ways people, mainly women and children, are abused. This is not to say that men and the elderly are not frequent victims of domestic violence. This important article collected from the Boston Police files reveals that whatever is at hand becomes a weapon:

*The ways to hurt are infinite when you live with an abuser, everything is a weapon. In their hands innocent objects like ice-cube trays and checker boards and apples and pillows become ways to inflict suffering to demand submission.*

Over the past 3 decades using culturally validated instruments such as the *Harvard Trauma Questionnaire* (HTQ) we have been able to document the brutal facts associated with the refugee experience worldwide and for resettled refugees in the U.S. Now, we need to get this energy into the TIC approach for our local mainstream communities. The psychological experts on the *Holocaust* have called this "bearing witness." The horrible facts witnessed in the *Boston Globe* article for example need to be brought out in the doctor's office and made public as well. Unfortunately, in our medical and psychological settings, extensive research reveals that they rarely emerge, or are even acknowledged by medical professionals.

## H.2. HUMILIATION

Humiliation is the major instrument of violence used by perpetrators to create the state of humiliation in all violated persons. Unfortunately, that key emotional state is linked to self-destructive behaviors, self-deprecation and learned helplessness. Humiliation is hidden behind the more prominent symptoms of somatic complaints, depression and posttraumatic stress disorder. The state of humiliation needs to be identified and transformed – and can be transformed – as part of the recovery process. This phenomenon also explains why traumatized persons are very sensitive and emotionally distressed by the perceived empathic failure of insensitivity within the health and social service system.

HPRT's clinical experience after 3 decades of caring for torture survivors and survivors of mass violence (N=10,000) reveals the following:

First, *"healing is a shared empathic partnership between 2 people working together in a community to create a new world-view."* This aphorism acknowledges that the humiliated state of the survivor needs to be transformed and that it can only be done in a "shared" empathic partnership. The survivor and the therapists are *partners* and they each have empathy for the other. While the patient needs the empathic response of the healer, the healer needs the empathic response of the survivor. Otherwise, how can either of them bear to listen to such unbearable pain and suffering? And while humiliation destroys all that the survivor believed in was good, the survivor and therapist can create a new, and maybe better, worldview and reality. HPRT in it's clinic has witnessed the latter over thousands of times. It is not a rare experience.

The second acknowledged truth is that *"healing can only occur when the patient believes they can become whole again."* Some survivors feel so damaged, they believe they can never recover. This is called in the therapeutic scientific literature *self-efficacy*. In our clinic, we always take

this up immediately, otherwise if a patient has no belief in their own “self-efficacy,” the therapy will fail.

### H.3. HEALING (SELF-CARE)

The remarkable realization that all persons affected by violence have a powerful physical, mental, and social self-healing response is critical to facilitating the patient’s healing recovery. In essence, the therapists have to recognize this self-healing response and build upon it. Patient survivors are not passive recipients of medication or talk therapy. They are doing a lot to help themselves, over and beyond the brief and important time they spend with the health professional and/or therapist. In fact, in the HPRT clinic we tell every patient that they are our *teachers* and we are their *students*. It is incredible the joy this statement brings to the most *humiliated* person to be seen as a *teacher* of the doctor.

The self-healing activities revealed to the therapist are sometimes unbelievable but are always profound. Since we have learned through our scientific studies the important self-healing power of (1) work/school (2) altruism (3) spirituality, we check out each of these areas in the life of the survivor. If some area is lacking or underdeveloped we try to find out why – correct and remove the barriers – and work out a prescription to encourage the self-healing activity. Many of our older Cambodian women, for example, have little time for themselves. They are given a prescription to take home to their families and say something like: “*the doctor has ordered me to go to the temple on the weekends.*” And usually after seeing the doctor’s note, the families agree to this.

### H.4. HEALTH PROMOTION

The famous Adverse Child Events (ACE) study has done more than any other study in America to demonstrate to mainstream American communities the impact of child abuse and past traumatic life experiences on the health and well-being of community members. Many other studies have demonstrated in Canada and America the terrible long-term impact of past and current violence on all organ systems, but especially stress-related illnesses such as diabetes, hypertension, heart disease and the metabolic syndrome. Not surprisingly depression, PTSD, drug and alcohol abuse and suicide are also associated with traumatic life events.

HPRT has spent over a decade developing a culturally valid health promotion curriculum for Cambodian torture survivors as well as a special diabetes group. All persons who have experienced violence should be in a health promotion activity that includes diet, exercise, meditation, stress reduction and practical life style changes directed at caring for insomnia and symptoms of PTSD (e.g. flashbacks). The data from our refugee studies and from other mainstream population based studies reveal that health promotion alone can have a dramatic impact on reducing depressive symptoms.

### H.5. HABITAT

Many survivors not only live in psychologically oppressive environments but also in terrible housing situations. For many abused patients it is not uncommon to find them and their family living in terrible and filthy conditions; fire traps, over-crowding and many other adverse living situations negatively affect patients. Perpetrators of domestic violence often force their victims to stay in one room or a closet. In one situation at HPRT, an elderly Cambodian woman was forced to sleep on a couch in the middle of her landlord’s living room. In another situation, a small baby was brought to a crowded house of a boyfriend

with a lot of partying and drinking going on. The teenage mother and baby slept on the floor and the baby swallowed a small object, choking to death. Our patient's daughter was devastated by this situation. Yet, it is rare for health professionals and therapists to ask the survivor about their living environment. Hopefully the H<sup>5</sup> Model will help to change this very neglected area in therapy.

### III. THE H<sup>5</sup> MODEL SCALE:

A culturally valid scale with known psychometric properties is in its earliest stages of development. However, all therapists can rate the survivor's responses on the following scale as an overview of elements of the H<sup>5</sup> Model:

First try to define what *you* mean by each of the responses since the scale is still being developed. Then take a look and see how the survivor is doing. This should be very informative, especially those answers where the survivor is scoring a 3 or a 4. This simple assessment may be able to help you guide your treatment approach.

<b>H<sup>5</sup> Model Scale</b>	1 (none)	2 (minor)	3 (moderate)	4 (severe)
<b>H.1.</b> Human Rights Violation				
<b>H.2.</b> State of Humiliation				
	1 (very good)	2 (adequate)	3 (poor)	4 (totally inadequate)
<b>H.3.</b> Healing Activities (self) - Altruism - Work - Spirituality				
<b>H.4.</b> Health Promotion				
<b>H.5.</b> Habitat / Housing				

## RECOMMENDATIONS FOR TRAUMA INFORMED CARE BASED UPON THE H<sup>5</sup> MODEL:

Recommendations based upon the H<sup>5</sup> Model are:

1. Once trust is established try to conduct a *trauma story* interview reviewing the 4 elements of the *trauma story*. A diary that can be used called the *Trauma Story Assessment and Therapy* (TBAT) is available at <http://www.lulu.com/shop/richard-f-mollica/trauma-story-assessment-and-therapy-journal-for-field-and-clinic/paperback/product-20342010.html>.
2. Once trust is established try to understand the nature and scope of the survivor's experienced human rights violation(s). This will help you understand the abuse and recommend the appropriate medical, psychological and social support.
3. Evaluate the survivor's self-healing response. This interview is also available in the TSAT diary <http://www.lulu.com/shop/richard-f-mollica/trauma-story-assessment-and-therapy-journal-for-field-and-clinic/paperback/product-20342010.html>.
4. All survivors need to be in a health promotion program.
5. Extensively explore the living environment of the survivor. Make this a priority.

## IV. CONCLUSION

In conclusion, it is hoped that the H<sup>5</sup> Model will provide you with new insights and techniques for assisting the traumatized person in *all* environments. Patients/clients and therapists should add their experience and insights to this working document especially as the model is adapted to different cultures and ethnic groups. We look forward to your input and feedback.

## References

- Berkson S.Y., Tor S., Mollica R.F., Lavelle J. & Cosenza C. (2014). An innovative model of culturally tailored health promotion groups for Cambodian survivors of torture. *Torture, 24(1)*.
- Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A. M., Edwards, V., Koss, M.P., Marks, J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to many of the leading causes of death in adults, the Adverse Childhood Experiences (ACE) Study. *AM J Prev Med, 14:245-258*
- Mollica, Richard F. (2006). *Healing invisible wounds: Paths to hope and recovery in a violent world*. Orlando, Florida: Harcourt.
- Mollica, R., Brooks, R., Ekblad, S., & McDonald, L. (In press). The new H<sup>5</sup> model of refugee trauma and recovery. In J. Lindert & I. Levav (Eds.), *Violence and Mental Health*. New York, New York: Springer Publishing Company.
- Mollica, Richard F. (2012). *Trauma story assessment and therapy: journal for field and clinic*. Cambridge, Massachusetts: Harvard Program in Refugee Trauma.



Health Insurance for  
Young Adults Who  
Used to Be in Foster  
Care



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## Trauma Guide

### Trauma Tool Box for Primary Care

This 6-part series was designed with the primary care practice in mind – those who may or may not be familiar with adverse childhood experiences (ACEs) and the process of asking families about exposure to ACEs or other traumatic events. This project was funded through a grant (UC4MC21534) from the Health Resources and Services Administration, Maternal and Child Health Bureau.

### Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians

In partnership with the Dave Thomas Foundation for Adoption and Jockey Being Family, the AAP has developed materials for pediatricians on how to support adoptive and foster families.

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### **Adverse Childhood Experiences and the Lifelong Consequences of Trauma**

This document explains ACEs and how they contribute to adult physical and mental health outcomes.

- What Is the Role of Stress?
- The Biology of Trauma
- Effect of Trauma on Parenting Ability
- Resilience and Other Reasons for Optimism



### **Addressing Adverse Childhood Experiences and Other Types of Trauma in the Primary Care Setting**

This document provides initial suggestions for pediatricians to consider when addressing ACEs in their practices.

- The Medical Home: Ideal for Addressing Trauma
- The Process
- Assessing Readiness to Change
- Identifying ACEs and Other Sources of Trauma Is Quality Improvement
- Preparing Physicians and Staff for the Process



### **The Medical Home Approach to Identifying and Responding to Exposure to Trauma**

The following information will provide an introduction to specific things pediatricians can do to recognize evidence that a traumatic event has occurred and how to respond.

- Somatic Complaints and Physical Examinations: Recognizing When Something Is Trauma Related
- After Exposure to Trauma Is Identified: The Initial Response
- After Exposure to Trauma Is Identified: Responding to the Symptomatic Child



### **Bring Out the Best in Your Children**

Pediatricians can provide this handout to parents to help when their children's behavior can be challenging.

- Key Concepts
- Modeling Behavior
- The Attention Meter
- What About Time-Out?
- Motivating Your Child



### **When Things Aren't Perfect: Caring for Yourself and Your Children**

Pediatricians can offer this handout to parents to explain ACEs and the number of different factors that play a role in how children will respond to stress.



- Stress and the Body
- Parents Were Kids Once Too!
- Helping Kids: Strong and Healthy Parents



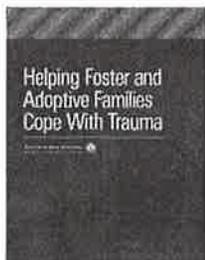
### **Protecting Physician Wellness: Working With Children Affected by Traumatic Events**

Pediatricians need to take care of themselves. The stress from working with children who have experienced traumatic events like ACEs can be particularly hard on pediatricians and their teams.

- The Practice Environment
- An Individual Response

## Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians

In partnership with the Dave Thomas Foundation for Adoption and Jockey Being Family, the AAP has developed materials for pediatricians on how to support adoptive and foster families.



### **Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians**

The purpose of this guide is to support adoptive and foster families by strengthening the abilities of pediatricians to:

- identify traumatized children,
- educate families about toxic stress and the possible biological, behavioral, and social manifestations of early childhood trauma, and
- empower families to respond to their child's behavior in a manner that acknowledges past trauma but promotes the learning of new, more adaptive reactions to stress.



### **Coding Tips**

Pediatricians may use these codes for evaluations involving screening and anticipatory guidance related to trauma and other mental health/developmental concerns.



**Visit Discharge and Referral Summary for Family**

This discharge form is to be completed by the pediatrician and given to the family to guide them in following up on referrals and having the correct information to provide to the receiving/referred professional. It may also be useful to the pediatrician when communicating directly with a mental health professional. This form is not intended to provide a complete history nor is it for the referred professional to complete. The form can be completed electronically, printed, and provided to the family at the end of the visit. You may also save the

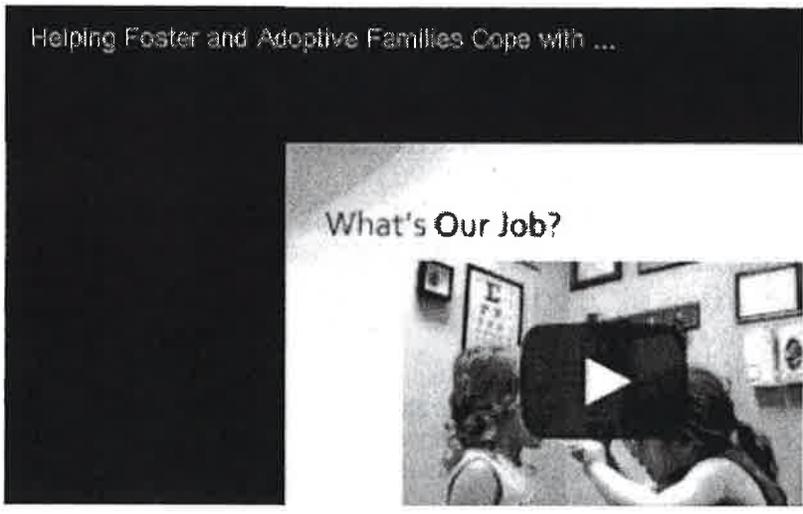
form to your files.



**Parenting After Trauma: Understanding Your Child's Needs**

This guide for families explains how trauma can impact a child and provides tips for making them feel safe in their new home. Pediatricians can reproduce and provide this handout to foster and adoptive parents. [Click here to download this handout in Spanish.](#)

**Helping Foster and Adoptive Families Cope With Trauma Webinar (Download PDF)**



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**Professional Resources**

- Practice Transformation
- Clinical Support
- AAP Policy