Trauma-informed Care for People with Intellectual and Developmental Disabilities

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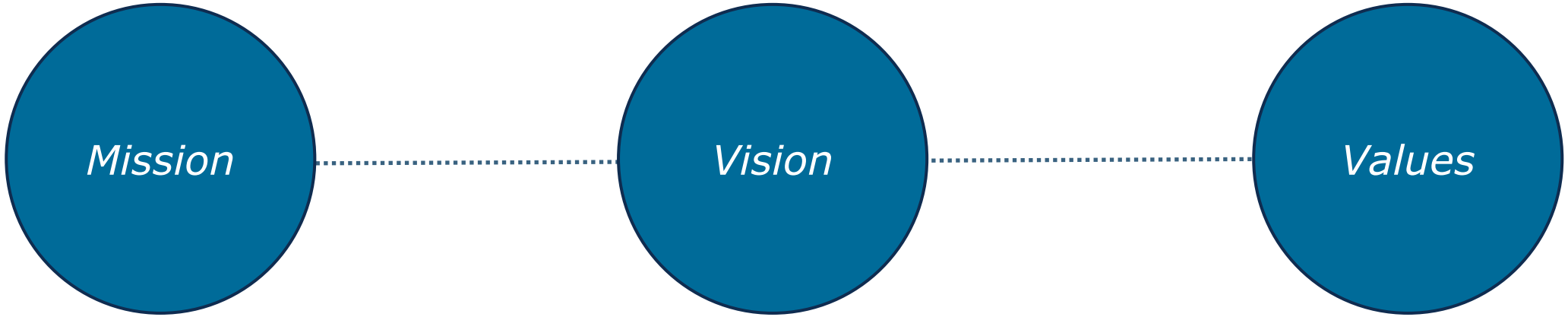
Developmental Disabilities

Washington state's lead section for long-term care supports for individuals with intellectual and developmental disabilities.

Find us online at: dshs.wa.gov/dda/



We partner with people to access support, care, and resources.

People find human services to shape their own lives.

Welcome all with access and inclusion.
Serve with respect and dignity.
Collaborate with community.
Improve services continually.
Communicate with clarity and choices.

A Common Voice

Planting Seeds of HOPE!

Learning Objectives

Trauma and IDD

Understand the Impact of Trauma

Recognize the types and effects of trauma on people with intellectual and developmental disabilities.

Principles of Trauma-Informed Care

Learn the key principles of trauma-informed care and how they apply to supporting people with IDD.

Implementation Strategies

Identify practical strategies for creating trauma-informed environments, including staff training and environmental modifications.

Therapeutic Techniques

Explore effective therapeutic techniques to support people with IDD, such as mindfulness, sensory modulation, and positive behavioral supports.

Advocacy and Support

Develop skills to advocate for trauma-informed care practices and build strong support networks for people with dual diagnosis.


Self-care means
giving yourself
permission to pause
-Cecilia Tran

Understanding the Impact of Trauma

Learning Objective #1

Trauma

Trauma results from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Extreme Acute Event

Car accident, assault, natural disaster.

Chronic Stressful Events

Abuse, violence, poverty, historical, systemic.

Complex Trauma

Chronic and multiple types of trauma experiences.

Often inflicted by parents/caregivers, usually beginning at a young age.

Substance Abuse and Mental Health Services Administration
SAMHSA (2014)

Defining IDD and DD

Intellectual Disability: This category predominantly centers on limitations related to intellectual functioning and adaptive behaviors. Individuals with intellectual disabilities exhibit challenges in cognitive aspects such as reasoning, learning, and problem-solving. Additionally, adaptive behaviors, which are crucial for daily living, may be affected, encompassing activities like communication, self-care, and social interactions.

Developmental Disability: In contrast, Developmental Disabilities cast a wider net, covering an extensive range of conditions that impact not only intellectual aspects but also physical, cognitive, and emotional development. While Developmental Disabilities may include intellectual disability, they extend their reach to conditions affecting physical health, sensory functioning, and mental health. This broader perspective recognizes that challenges in development can manifest across various domains beyond intellectual limitations.

Prevalence

65%	Lapshina and Stewart (2021) noted that 65% of children with IDD and mental health conditions experienced at least one potentially traumatic event.
70%	Scotti et al. (2012) noted that upwards of 70% of people with IDD experienced at least one traumatic event during their lifetime, with multiple experiences most common.
10 - 40%	Several studies have examined post-traumatic stress and identified prevalence rates ranging from 10% to more than 40% (Daveney et al., 2019;Mevissen et al, 2020; Nieuwenhuis et al., 2019).

Statistics on this topic are under-estimates.

Greater Risk of Victimization

- People with IDD may be 3 to 6 times more likely than the general population to be abused or neglected. (Hulbert-Williams et al., 2013)
- For women with disabilities, people with cognitive or developmental disabilities, people with psychiatric illness and people with multiple disabilities.
  - More than 1 in 5 people from ages 12-19 report sexual violence.
  - Three times more likely to experience violent victimization as adolescents and adults, to experience rape, sexual assault, aggravated assault and robbery, and to be sexually abused as children.
  - 1.6 times more likely to experience abuse or neglect as children.
  - 1.5 times more likely to experience repeated abuse or neglect as children.
- People with disabilities were more likely to experience police violence and comprised 33% to 50% of people killed by police interventions. (Perry and Carter-Long, 2016)

Greater Risk of Victimization

- 2 to 7 times more likely to experience maltreatment of all types than neurotypical peers (31% vs 9% in one study).
- More than 4 times the rate of violent victimization.
- 1 of 3 robbery victims.
- 7% victim of or witness to a violent incident in their neighborhood.
- At least 7 times the rate of rape/sexual assault of people with ID.
- One study found ~40% of disabled women have been sexually assaulted.
- 39% female victims of rape identify as disabled.
- Children with I/DD 3-5 times more likely to experience sexual abuse.
- Perpetrator usually well known to victim (19% of sexual assaults against people with I/DD are reported compared to 36% against non-disabled people.
- Frequently occurs more than once.

Bias and Stigma

People with disabilities are devalued.

People with disabilities are not seen as credible.

People with disabilities are isolated.

Compliance is expected.

People with disabilities are seen as "easy targets."

The problem is hidden.

Potential Sources of Trauma

- Sensory overstimulation
- Discrimination
- Othering
- Living in a world that doesn’t meet your needs
- Isolation from community and personal connections
- Abuse
- Changes in caregivers
- Unresolved traumatic experiences without support to process and heal
- The use of restraints
- Over-prompting
- Being bullied
- Lack of attention
- Staff turnover
- Loss of natural supports
- Rejection from social supports
- Not being able to express voice or choice
- Victimization
- Victimization without justice
- Barriers to accessing needed services

Signs of Acute Trauma

Assume overwhelm of the nervous system's ability to cope.

- Lose access to verbal communication.
- What appears to be aggression, or self-injurious behavior may be communicating an unmet need.
- Restrictive repetitive behaviors that help regulate may become more intense or more rigid.
- Regression of skills.
- Sudden change in sleep.

Signs of Chronic Trauma

Fluctuations in signs of distress and regulation.

- Signs of Acute Trauma.
- New restrictive repetitive behaviors.
- Physical expressions of stress.
- Leaving a setting without support or supervision or at unplanned times.
- Increase in behaviors that disrupt routines.
- Changes in sleep that persist over time or fluctuate.

Signs of Complex Trauma

Relational and co-occurring mental health factors or the intersection of multiple traumatic experiences complicate the response to distress.

- Signs of Acute and Chronic Trauma.
- Variable responses to the same stimulus.
- Avoidance of activities despite skill and desire to engage.

Our Challenge

It can be difficult to distinguish whether a change is associated with:

- A symptom of a psychiatric disorder.
- An unmet need.
- A learned behavior.
- A medical condition.
- The environment.
- Trauma and grief.

Impacts of Trauma

- More vulnerable to re-traumatization.
- Needs going unmet.
- Trauma not being healed because of lack of treatment.
- Unstable housing.
- Difficulty maintaining healthy relationships.
- Acute hospitalizations.
- Legal problems and detentions.
- Increased medical problems.
- Development of other mental health conditions.
- What may begin as acute or chronic trauma becomes complex.

Principles of Trauma-Informed Care

Learning Objective #2

Trauma-Informed Care

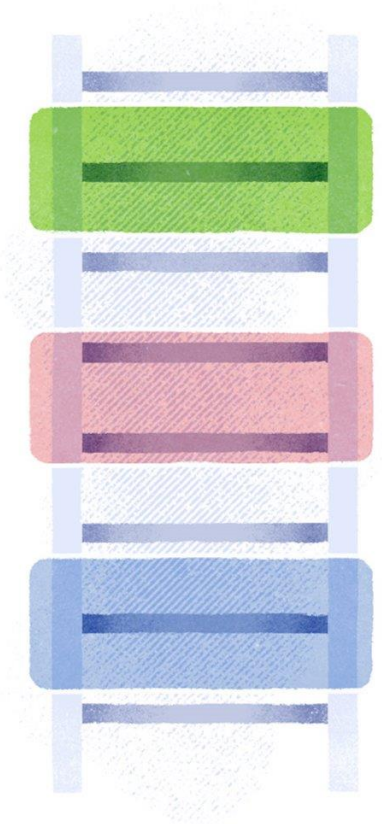
Trauma-informed care acknowledges that all humans are wired to assess signs of safety and danger.

It is necessary to consider people's life experiences when providing them with support.

When people have experienced trauma or have neurobiological differences, their nervous systems may become sensitive to environmental, relational, or internal cues.

Understanding how nervous systems respond to stress supports us in providing compassionate care.

Trauma as a stress response

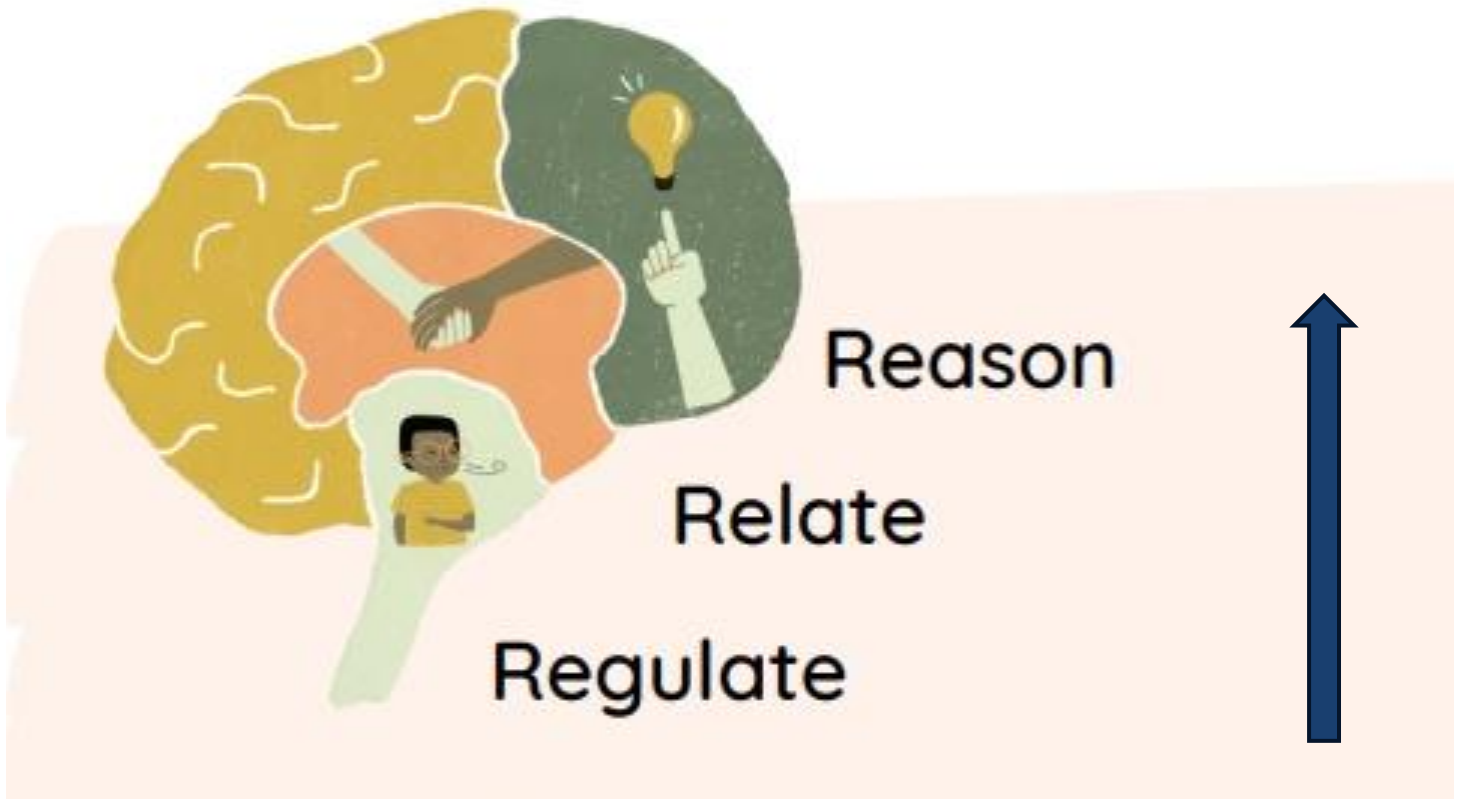


VENTRAL
Safe &Social
Feeling secure and connected to people around you

SYMPATHETIC
Mobilized for fight or flight
Feeling stressed or agitated

DORSAL
Freeze/Shutdown
Feeling disconnected or numb

Adapted from the *Polyvagal Theory in Therapy* by Deb Dana



Neurosequential Model by Dr Bruce Perry

Values/Principles of Trauma-Informed Practice

Safety	Trustworthiness	Choice	Collaboration	Empowerment
				

Definitions

Safety	Trustworthiness	Choice	Collaboration	Empowerment
Ensuring physical and emotional safety for all. Generally involves protection of self and others.	Maximizing trust, ensuring clear expectations, and having consistent boundaries. Refers to transparency.	Making individual choice and control a priority. Refers to the right to self-determination and autonomy.	Sharing power and working together with individuals. The idea of working with, not doing to or for.	Involves the recognition of strengths and skills to build a realistic sense of hope and possibility.

Institute on Trauma and Trauma-Informed Care (2021)

Implementation Strategies

Learning Objective #3

Values/Principles of Trauma-Informed Practice

Safety

Trustworthiness

Choice

Collaboration

Empowerment

Values/Principles in Practice

Create a welcoming environment.

Embrace diversity and inclusion.

Give consequences using supportive, non-confrontational language.

Provide clear information about expectations.

Inform others of transitions ahead of time.

Express patience and acceptance.

Inform others about options available to them.

Balance flexibility while defining parameters.

Reflect options regarding race, gender, and culture.

Seek ideas and feedback.

Explore others' circumstances from their perspective.

Acknowledge power dynamics.

Build on strengths and capacities.

Ensure interactions are validating and affirming.

Use person-first and inclusive language*

*Use the person's preferred language, pronouns, terms.

Strategies for individual support

- Allow access to preferred objects during the course of the day and NOT as a reward for good behavior.
- Focus on their interests – "play" alongside or with them, even if you consider the play to not be age-appropriate, allow the person to direct the activity.
- Observe what seems to calm them down – maybe eye contact is threatening but placing your hands out in front of you with palms facing up is not.
- Try various sensory strategies.
  - Playing calming music or sing.
  - Providing a low-stimulus environment.
  - Weighted vests or noise-cancelling headphones.
  - Go outside.
  - Show them images of things they love.
- Offer co-regulation – tending to our own histories and how they might show up in the moment, tending to our own nervous systems to return to regulation, noticing opportunities when the person we are supporting is escalating and could use the support of someone else's nervous system.

Connection is a biological imperative.

People with IDD may have their own ways of connecting.

Get curious and follow their lead.

Strategies for individual support

- Use plain language or visual images to help clients communicate their needs.
- Allow space if that's what they indicate they need.
- Allow time for transitions.
- Check basic needs - food, sleep, hygiene, movement, sensory needs.
  - Meeting needs may support regulation when they are the underlying cause of the dysregulation.
  - Tending to our bodies can support regulation so that we can then address the underlying cause.
- Include the person in goal setting and planning.
- Utilize their strengths to support areas where they are experiencing a challenge.

Strategies for your organization

- Invite people with lived experiences to share their input and engage in organizational planning.
- Train ALL staff, including security guards and front desk staff, in fostering a welcoming, trusting and non-judgmental environment and de-escalation techniques.
- Invest in staff wellness through trainings, mental health days, and an increased focus on self-care to help limit burnout and decrease secondary traumatic stress.
- Hire candidates who show high empathy, non-judgement, collaboration, or have experience in supporting others with trauma.
- Commit to ongoing assessment and monitoring of trauma-informed principles and the effective use of evidence-based practices.
- Engage community partners and develop a trauma-informed referral network to provide additional resources for those that need trauma-focused treatment.
- Acknowledge caregiver trauma in staff discussions about family needs.

Therapeutic Techniques

Learning Objective #4

Clinical strategies

Clinical processes

- Invite clients to be involved in the decision-making of their care.
- Screen for trauma.
- Train staff in trauma-specific approaches.

Utilizing and adapting common modalities

- Collaborative and Proactive Solutions
- Dialectical Behavioral Therapy
- Polyvagal Theory
- Internal Family Systems – Trailheads (instead of triggers)
- Positive Behavior Supports
- Adapted EMDR

Dual Diagnosis

- Coexistence of two disabilities: Intellectual/Developmental Disability and Mental Health Conditions
- 37% of Developmental Disabilities Community Services eligible clients have an identified mental health treatment need.

Best Practices for Co-occurring Conditions Report 2022

DDA's Guidebook: Meeting the mental health needs of people with intellectual disabilities

WA Include: ECHO Learning Communities

The National Child Traumatic Stress Network

NADD Certifications

Best Practices for Co-occurring conditions

NASDDDS Adaptive Strategies for MH Modalities

Advocacy and Support

Learning Objective #5

Building Support Networks

- Developing relationships takes time, making decisions that prioritize the continuity of relationships can support the development of a more solid network.
- Trauma informed practices can help shift the relationships and build trust – honoring the components of the felt sense of safety – these become the building blocks of relationship over time.
- Supporting building meaningful relationships outside of paid staff (FRANK) for families as well as for individuals.
  - Recognize the universal human need for connection.
  - Practical decision making such as scheduling to ensure that families have space for prioritizing those relationships.
  - Intentional work that supports the goals of relationship development – how can we meet skill building goals in environments where the people we support can interact with others around shared interests (gaming, cooking classes, etc).

Building Support Networks

- Connecting with organizations that support relationship development.
  - Social groups related to an area of interest.
  - Peer support.
  - Caregiver networks.
    - A Common Voice COPES.
    - ARC Parent to Parent.

Advocacy

- Communicating with all people as if they have a voice, even when their communication looks different than ours, reinforces that their perspectives matter. Taking the time to make space for authentic listening and honoring the perspective of the person empowers the individual to advocate for themselves in that setting and that translates to other settings.

- All children and youth age 5-21 have the right to access a basic education. All eligible children with disabilities age 3 through age 22 have a right to receive individualized supports necessary to access a Free Appropriate Public Education. Strategies and Resources to Support Trauma-Informed Schools

- Advocate for trauma-informed and person-centered practices when engaging with partners from all sectors of the system. Set the tone through the language that you use and be direct in inviting partners into person-centered conversations.

Resources

- A Common Voice COPE Project
- Washington State Parent to Parent Network – The Arc Washington
- Developmental Disabilities Administration (DDA) | DSHS
- DDA's Guidebook: Meeting the mental health needs of people with intellectual disabilities
- WA Include: ECHO Learning Communities
- The National Child Traumatic Stress Network
- NADD Certifications
- Best Practices for Co-occurring conditions
- NASDDDS Adaptive Strategies for MH Modalities
- Regulate, Relate, Reason | Think:Kids
- ChildTrauma Academy
- Rhythm of Regulation Deb Dana Polyvagal Theory

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- Dana, D. (2018). *The polyvagal theory in therapy: Engaging the rhythm of regulation.* W. W. Norton & Company.
- SAMHSA's Concept Of Trauma And Guidance For A Trauma-Informed Approach | National Center on Substance Abuse and Child Welfare
- Presnell, J., Keesler, J. and Thomas-Giyer, J. (2022) *Assessing Alignment Between Intellectual and Developmental Disability Service Providers and Trauma-Informed Care: An Exploratory Study*
- Agency self-assessment for Trauma-informed Care
- Kramolis, K. and Stobbe, G. (2025*) The Intersection of Intellectual and Developmental Disability (I/DD) and Trauma*

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