FGI RCOE Webinar Transcript – Surviving & Thriving: Overcoming Trauma Through Recovery Housing & Programming
March 3, 2022

[00:00:00] **Michelle Day:** [00:01:00] Good afternoon, everyone. And welcome to The Fletcher Group Rural Center of Excellence's webinar series. Today's session is scheduled to run from 2:00 PM to 3:00 PM Eastern Standard Time. My name is Michelle Day. I am your moderator for the session, along with Jennifer White and Erica Walker. A couple of brief housekeeping items, and then we'll begin.

You entered today's session on mute and your video was off and will remain so for the entirety of the webinar. Your chat feature is located at the bottom right of your screen. Use the drop down feature to communicate with either the panelist only, or panelists and attendees. Please direct all questions regarding the webinar content to the Q and A section.

Be advised that this meeting is being recorded and will be available to you on our website, once it has been transcribed. You can access our website at [00:02:00] www.fletchergroup.org. Also at the conclusion of today's session, there will be a short survey regarding the webinar content. Your participation in that survey is greatly appreciated and only takes a few moments to complete.

Today's presenter is Dr. Sarah Scarbrough, founder and director at Real Life, which was birthed from her program in the Richmond City Justice Center, after continually seeing the obstacles and hurdles those exiting incarceration continued to face. Her vision was to more comprehensively serve those in adverse situations and through Real Life and the corresponding community center, 12 recovery houses, jail programs, and expectant mother program, she and her staff are able to do just that. Prior to Real Life, she was the program director in the Richmond City Justice Center jail for five years. She received her PhD and master's from VCU Wilder School and bachelor's degree from UVA Wise. When not working, she stays busy with her [00:03:00] three children and husband.

Dr. Scarbrough, the floor is yours.

[00:03:07] **Dr. Sarah Scarbrough:** Well, good afternoon, everybody. It is so wonderful to be with you all. Um, thank you so much for putting in the comments who you are and where you're from. I know we've got a bunch of folks on here, but I can't see anybody's faces except mine. So it was wonderful

to see where you're from and I'm happy to have at least one Richmond-er here with us, um, but have lots of the country represented.

So that is great. Um, it really is a treat being with you all. Um, I love talking about what we we're going to talk about today. It is something that over the years and what I've been doing in my profession is just become so abundantly important. Um, and also so incredibly, um, inspirational when I'm able to spend time with folks, um, and share this information with them.

Um, so feel free [00:04:00] to, um, Email me, uh, my information will be up if you have questions after the presentation and also please feel free to drop any questions in the chat. Um, I am more than happy to answer questions, of course, at the end. Um, but if you have a specific question about something, um, as we are going through, feel free, like I said, to drop it in there and I'm happy to, um, answer questions, uh, throughout the presentation.

So with that said, I am the Director of Real Life. We are a nonprofit organization here in Richmond that provides recovery, uh, transitional housing for folks that are primarily coming out of incarceration. Um, we do have some folks that are just coming in from the community, um, maybe referred from probation or drug court, but most of our folks are coming, um, through the jail or prison system or for courts, um, or through the courts.

Um, we currently have 14 houses. We opened a duplex yesterday, so we are at [00:05:00] 14 houses. I'm representing a little over 140 beds. So it's been a labor of love if for those of you that open houses and have them, you know, what, how much work it is, but it's certainly needed in this climate that we have. Just a real quick overview on what we do, just so that you folks, um, everyone on here will have an idea of the background that I'm coming from.

We have five core services. Um, the first one is the recovery housing, which we have talked about. Um, we couple the recovery housing with very intensive programming, case management, um, classes, those sorts of things. Um, oh, and you can change this slide. We have a community center, which is our recovery community organization, (RCO), which is a gathering place for folks that are in our program to come have groups, meetings, meet with their case manager, those sorts of [00:06:00] things.

Uh, we have an employment program where everybody in our program is met with somebody, uh, or meets with our employment coordinator who helps with that whole employment piece. Which has a whole, uh, bear in and of itself. As you all know, uh, we have a motherhood program that works with women who are currently pregnant and then also, uh, women that have children and just helping with all the things that they need.

Uh, and then jail programming. As was mentioned in my introduction, we started in the jail and so we continue to do programs in the jail, which we absolutely love. Um, but rolling into the trauma informed care piece. Um, I want to caveat. Now until the rest of this session, that this is not teaching you to be a mental health clinician.

It is not teaching you to diagnose somebody, nothing like that. I am not a clinician. I'm not a social worker. I'm not an LCSW. Um, this information is for [00:07:00] you to know when you are working with populations of people in recovery, um, often folks that are coming out of incarceration. Um, it is to really empower you to hopefully better work with the men and women that are in your program, um, better be able to address their needs and what they have going on.

Um, I will tell you this. A little less than an hour is a fraction of the overall trauma presentation that I have. Um, and that I do, so understand that there are some topics that I'm just not going to have time to get into, um, because of our time limit, but there's much, much more information. It goes much, much deeper.

Um, if you will flip to the next slide, you will see a picture. If you all can put in the chat, what strikes you about this image? Um, just share a word or two of what comes to mind when you look at this.

Hmm. [00:08:00] Love, absolutely. Abandoned, sad, caring, comfort, head down, kindness, care, solace. Oh. Where's mommy? Yes, absolutely. Unattached, lonely, danger, alone. Yeah, absolutely. Want you all to do the same things for Ooh, best friend. Um, I want you to do the same thing for the next slide. What, what comes to mind when you see this?

Upset, trauma, broken, real, fear, hurt, scared, hopelessness, alone, pain, hurt again, pain and sadness, no one there, again, where's mommy? Absolutely.

Detached. That's a good one. Thank you all so much for your participation. Um, so I want you to think about this. How many times do we jump to conclusions that fast about people?

We start about their life, about who they are, [00:09:00] um, before we get a chance to really get to know them. Now, clearly I prompted you and said, do this and do this now. Right? But often we don't get to know them. And we really, and we jumped to these conclusions that we we had in our mind. Fast to judge, absolutely, Violet.

Um, and this leads me to the next slide. Um, a heartbreaking poem, "Cause I Ain't Got a Pencil." This was written, it's a true story, um, from a seventh grade teacher.

"I woke myself up because we ain't got an alarm clock. Dug in the dirty clothes basket, cause ain't no one washed my uniform. Brushed my hair and teeth in the dark, cause the lights ain't on. Even got my baby sister ready, cause my mama wasn't home. Got us both to school on time, to eat us a good breakfast. Then when I got to class, the teacher fussed, cause I ain't got a pencil."

And this poem here is exactly what trauma informed care is about. [00:10:00] See, how many school teachers see somebody without a pencil. And they're like, I told you to bring your school supplies.

Why didn't you bring your pencil? Why aren't you prepared for school? You know, you need a pencil every day. But if they just knew the backstory, oh my goodness. Wouldn't that reaction be completely different. Um, and again, that's what trauma informed care is about. We are not excusing anything. We are not justifying anything.

What we are doing is understanding a story and understanding a situation of what is going on so we can better work for them and we can serve folks, um, more effectively. Uh, so to really hone in on this, um, we'll flip to the next slide and look at this beautiful diagram of a brain. Um, this, you know, really understanding the brain understands how trauma has affected and therefore how people work and how people tick.

So when you look at this, you're looking at the left side. The left side [00:11:00] of the brain is the logic, the linear, the language, right? That is where everything is neat and tidy and clean and organized. And all of that. The right side of the brain is your creativity, your imagination. Um, this is where things maybe are not quite as messy, or they are a little bit more messy.

Um, and so when you have the left side and the right side of your brain meshing and jelling, um, you have these little bridges. Clearly this is not a, um, medical diagram or anything like that, but this is just an easy way, um, to uh, explain it and for you all to understand through this diagram, right? So when you got that left side of your brain, the right side of your brain with the bridges, everything is jelling, right?

I'm hoping right now all of us are in a head space where our left and right side of our brain is working, right? Hopefully no one is super upset. Hopefully no one [00:12:00] is, you know, angry and about to blow a gasket. Hopefully everyone is relatively calm in a good Headspace. Hopefully you're looking forward to this presentation, all of that.

Right? So that means those bridges are connected, left, and right side is working. Trauma. However, basically cuts those bridges off, off and creates a disconnect between the left and right side of your brain. Um, why is that? Because you don't want to feel what is going on. In your body when trauma is going on.

Right. And so that's where that disconnect and split takes place. Um, so we'll flip to the next slide. And then, um, we're going to go back to that. So don't forget what I just said, but we're going to go back to that after I get through a few more details. So this is a Stroop Test (SCWT). It's not nearly as fun to laugh at people when you can't hear them.

Um, but I'm going to ask you to go ahead and do this at home or wherever you are, and hopefully you can laugh at yourself. Um, if you have not done this, a [00:13:00] Stroop Test really highlights the integration of the brain. So what I want you to do starting out, and then I'll explain the why after is, I want you to say the color, not the word. So on the count of three,

I want you to, at home, to yourself out loud, the say the color and not the word. Ready that go. Red, blue. Yellow green, black, red, continue.

All right. So hopefully you got a few laughs and you saw how something seemingly so easy actually ended up being a little bit difficult. Um, and this just shows, you are using the left [00:14:00] side of your brain, the language, and the right side of your brain, the creativity to do the assignment that I gave you.

Right. And so when that goes on, you've got to use both sides of your brain. And as I said, when we were talking on the last side, hopefully right now, all of y'all's brains are meshed and going well, and you got your bridges going on and everything. And even with that, Look at how using the left and right side of your brain was seemingly difficult.

Right? Think about somebody who is in trauma. If we asked them if they're in trauma brain, or survival mode, or their brain has been long-term effected by trauma. Think about when those bridges are not connected, how difficult a task like this would be. And a task like everything else that we in society asks them to do on a daily basis.

So moving to the next slide, um, the definition of trauma. Really understanding what trauma is and what this is all about. [00:15:00] Um, it is an individual trauma results from an event, a 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, and spiritual wellbeing. So the three E's that I said there and emphasized on it is very important. Why? Because trauma is in the eye of the beholder, right. What I went through and what you went through may seemingly be the same, but the effect of it is going to be different.

So if me and my invisible brother here, right, we grew up together, clearly we're siblings and, um, we had a very abusive father. And we knew that pretty much every night, what was going to happen and that mom [00:16:00] was going to go through some stuff with him. And when, when dad would start beating on mom, what would happen is my big brother.

My protector, would come scoop me up, bring me to my room, tuck me into my bed, give me a little kiss on the forehead, and then go back out there to peel dad off of mom. Okay. So as you see brother and I have been through the same event, right. But our experience of the event is very different. Which means are, the effect of the event on ourself is also going to be very different.

And so I'm sure that you have heard, I know I've heard a ton of times in my work of, well, well, my brother turned out this way and I turned out this way or how come my neighbor went this way? And I went, no, you can't because everyone experiences things differently. And everyone also handles, um, stresses and pressures a little bit differently, which we'll address a little bit more towards the end.[00:17:00]

Um, so looking at the next slide that's types of trauma. Um, obviously you and I can go on and on and on and on and on, and probably add to this list. But this is just some of the big things of trauma and, um, things that cause it. Um, or not things that cause it, but, uh, traumatic events that somebody can go through.

But before we move to the next slide, um, can anybody tell me what trauma looks like? What, and if you want to pop this in the chat, a behavior that may make you think, Hmm. They probably gone through trauma,

Anger and short temper. Absolutely. Anybody else? Withdrawal.

Hypervigilant, always apologizing. Detached, extreme anxiety.[00:18:00]

Absolutely. Constantly. Yup. Anxious, depression. Hoarding. Yes, absolutely. All right. So yes, these are all absolutely right. Um, one thing about. About this not showing up for appointments. Absolutely. So what I was going to say is don't look at the feeling words, right? So not somebody who looks sad right. But drilling down to the actual behavior.

So the actual behavior somebody had said, I'm not showing up for appointments. Absolutely. The self-sabotage, hoarding. That is a behavior of things that people physically do. Um, moving to the next slide, you kind of see six of the big areas of somebody who has signs of trauma, right? Avoidance of trauma related thoughts.

Um, this could be somebody who, um, you know, was in a severe car accident on their way to work one day. And once they, um, you know, [00:19:00] heal medically and everything, instead of doing that straight shot to work, they drive around 10 blocks out of the way to get to work. Why? Because they can't fathom the thought of going through that intersection where they were T-boned right.

It's doing what you can to avoid those thoughts. So you don't have to go back through it. Um, intrusive memories or nightmares about an event, um, hyper arousal or exaggerated startle response. You know, I think we all have those times where we jump, you know, somebody scares us, startles us, those sorts of things.

Um, but there are those people that again, have that exaggerated response, you know, somebody breathed and you, you jumped, right. That hyperactivity. Um, you know, a lot of us have those nervous twitches and habits and things like that. But those people that are just sitting there clicking their pen, or shaking their leg, or, you know, those sorts of things ,that hyperactivity is used to regulate their body. An irritable or aggressive behavior, or that withdrawal and social isolation.

Um, [00:20:00] remember that all of these behaviors that you see and what you see on the next slide is because people do not feel safe. But they are motivated and wanting to feel safe, right. So they don't feel safe, but they want to feel safe. And that is what motivates all those behaviors, but then leading into this, wanting to feel safe, but also wanting to feel in control. Folks that have gone through significant trauma feel as if they've had a loss.

Right. And so they seek to regain that loss because of that. Um, so the first one, power and control. Often, you know, let's talk about, go back to the abusive relationship. Right? My brother knew that what the situation was going to be at night. Right? Like he knew what was going to happen and he couldn't control it, even if he wanted to, which naturally he wants to peel down off of mom.

[00:21:00] Right. Even if you want to, he's a little boy, he can't do that. Dad's a big man, right? That is a loss of power. It's a loss of safety. And therefore, when he gets older, often, not all the time, regaining that very subconscious

sometimes. What does he do? He engages in that same behavior, because guess what?

When I am beating on somebody, I feel like I have the power and I am in control. Right. Um, so it's all about gaining that. Um, it is, it's an attempt to regain that loss to feel safe. Um. Looking down the line boundaries. You know, people who have experienced trauma are on one side of the spectrum or the other with boundaries.

You have the person that's in your program. And I know we have all seen it where it is, I meet a boy [00:22:00] today, tomorrow we fall in love. The next day we're talking about marriage. We move in together and within a week we're practically married and having babies, right? It is, he is the best thing since sliced bread.

Now, two weeks from now, we know what's going to happen. He's a jerk and it's over, but right now, boom, you fall hard. You fall hard, you all fall hard. Or it's the other thing. Get away from me. I don't want anything to do with you. I don't want anything to do with anybody. I don't trust people. You may be a case manager with the best of intentions.

You may be a boyfriend or a girl, don't, no. I don't want a relationship because everyone's going to hurt me again. Right. And so these are very similar situations through all of this, um, that you see people engaging in these behaviors, again, to try to regain the loss and also to feel safe in their situation.

Now, moving on, um, when people are in these situations, [00:23:00] naturally they are going to cope, right? We are going to cope with situations, negative or positive. We all hope it's positive, but we all know that that's also not reality. Um, so if you can type in the chat, what are some things that you think of, um, as ways that people negative cope.

How do you see people negative coping? Substance abuse, drinking, avoidance withdrawal, dissociation, drugs, drugs, drugs, panic. Cutting. Puts up a wall. Oversleep. Absolutely. Absolutely. Blaming others. Overeating. Hyper-sexual. 100%. So here's the thing with the negative coping. All of these negative coping and these, uh, things that you all have posted gambling, smoking, vaping, isolate.

Yes, absolutely. All of these [00:24:00] things have one common theme. And the common theme that we have here is that it is self gratification, or instant gratification. I'm sorry. Right. I get drunk. And guess what? I don't have to feel any more. I have lots of sex. Guess what? I don't have to feel during sex. I have sex with prostitutes and there's a rush from it.

The cutting. Cutting is not necessarily, um, well, cutting is not people trying to die by suicide. Cutting is different. Um, nine times out of 10, you know, you see people that have scars all up and down their arms and places like that. That is that thrill seeking, pain inflicting behaviors. That again, you're not feeling, you're not thinking about your traumas as you are cutting.

Um, often it is an additional pain infliction that might be tattoos or piercings. Um, we had a guy that was in our program, and I swear he had every inch of his body [00:25:00] tattooed in every inch of his face, had a piercing and he would come in and have a new piercing. And it took us a little while to figure out what he was doing.

And it was like, oh, every time he goes through a situation, he's piercing a body part. He has nowhere left to tattoo and that's what he was doing. Right. It is, um, it is easy to use negative coping skills than using positive. Absolutely. Absolutely. Especially if you have not been taught how to do something different before.

Um, so anything that causes that instant gratification, I feel good. But what happens here, right? I'm not drunk anymore. So what am I left to do? Feel. I'm not hiding anymore. So what am I left to do? My tattoo is over. I am done cutting. I have drawn enough blood. I know that wad money in my pocket is over, right?

What am I to do? Well look at how that vicious cycle of addiction starts. Right. And if I'm not drunk anymore, and I have to feel, what do you think I'm going to do? I'm going to go get drunk again, because guess what [00:26:00] I don't want to feel. And the list goes on and on and on. And so here, think about the children, right?

A child who's going through this trauma who starts, you know, tapping into mom or dad's beer or liquor at age nine or 10, because they know the abuse is

going to happen, progresses to cigarettes and progresses to weed, it progresses to heroin, right? Because that child was going through something and they negative coped.

And so they started coping at that age. And here they are in Real Life in Richmond, Virginia as a 50 year old. And they're still continuing to do the same thing that they did as a 10 year old. And we, as society are sitting here, scratching our heads saying why, why, why, why, why? Right. Looking at the positive side of things, you're looking at positive coping, obviously not doing things that are not, um, illegal, inappropriate, negative, have health disparities, all of that.

Right? And [00:27:00] this is where that level of resilience comes in. That is where we determine, um, is somebody going to cope positive or negative. And that is based upon, are they able to bounce back. More on that in a moment. But the key component of trauma informed care, next slide, please, is asking the question.

What happened to you? Right? Not, what is wrong with you? So. The, "I Ain't Got a Pencil" example from the beginning, right. They, the school teacher pretty much is going to go two ways. Why didn't you bring your pencil? Right. But if she knew what was going on, she wouldn't be yelling and screaming. And so again, instead of though, wow, what is wrong with you?

Why aren't you bringing your pencil to school? Hey, Billy, come here. Not had your pencil for the past couple of days in school. What's going [00:28:00] on? Well, actually. And then there you get it. And so instead of inflicting more trauma, uh, to them, and ensuring that they're basically going to have a negative response to you, you're really able to make an impact on what, on, on that person, by the way that you act.

But it's all about asking that question and that is absolutely key. So that brings us into ACEs. Adverse Childhood Experiences. Um, hopefully, usually I do a show of hand of who has heard of ACEs before, um, if you have, you can write yes if you have, if you haven't go ahead and write no. Um, but this is something that, oh, yay.

All right. You know, most groups that I talk with, most people have not heard of them before. So this is phenomenal. Well, since y'all have heard about ACEs, the pressure's on me, um, but hopefully you will learn something new through this. Um, so [00:29:00] what are ACEs? ACEs we're actually kind of discovered on accident.

There was not a plan for it. Um, so there was a weight loss clinic in, um, California. And this has been years ago, over 20 years ago. And they did their job good. It was a weight loss clinic for women. They did their job good. Those women, they were morbidly obese, and they would help them lose hundreds of pounds.

The issue was the women didn't always keep the weight off. And so why? And of course, doctors looking into all the medical stuff and healthcare stuff, they wanted to know why in the world, um, do some of these women lose the weight and keep it off. Whereas some of these women lose the weight and, um, regain it.

So, um. The doctors decided that [00:30:00] they were just going to do some little focus group type of things, right. They were going to do, um, talk to some of the women who had lost the weight, but gained it back, and see if they could come up with anything. So, one afternoon they did multiple focus groups talking with the ladies individually and kind of messed up their wording on what they were asking about, um, having sex.

And what ended up coming out of that conversation was finding out that this woman, as a child was molested by a family member. And the doctor was floored, but said, I've been in this practice in this field for 20 years. I've never heard of one person, um, actually going through being molested or sexually abused before.

So it's probably going to be another 20 years until I hear about it again. So we're just going to move on and, um, we'll deal with. And we'll see what's going on. Well, that afternoon, that was the second person that he had heard gone through it. That afternoon he heard 3, 4, [00:31:00] 5, and six, um, women that had gone through it.

Um, and so I thought, wow, there must be something to this. So he, um, basically took all of this information, flipped it over to Kaiser Permanente. Kaiser Permanente did a research study with 17,000 women. Um, looking at the correlations between such childhood trauma and adults in the future. And what they found was there was a big correlation between childhood trauma and adverse experiences in the future.

And so with this information came the ACEs or the Adverse Childhood Experiences. Um, and so in the ACEs or the ACE study or the ACE test, you'll hear it referred to as all the ways, um, as you'll see on the next slide, um, in the ACE test, there are 10 questions. They are all based on complex trauma. So complex [00:32:00] trauma, meaning, what happens in the home, right?

So you've got three questions on abuse, two on neglect, and five on household dysfunction. So why complex trauma? Because at home is where you're supposed to be safe, right? That is where you are supposed to feel loved. And so if the trauma is coming through there, from your caregiver, it complicates things a whole lot, and you really have no outlet because where your outlet should be your comfort, your safety zone, you don't have it.

Um, and so these are the 10 questions that Dr. Felleti and Dr. Anda, um, came up with, through the ACEs study that are the most significant trauma that a child can go through. Now, what is missing in the ACE study is non-complex trauma, right? So what is happening outside of the home as well? Um, so since this has been done [00:33:00] this ACE study with these 10 factors, um, there's been additional, um, that Dr.

Anda has consulted on through the Boston Trauma Institute and the Philadelphia Urban Institute, um, that have created, they went up to, um, right under 20 questions. And then the Boston Urban Institute, um, is up to 30, 36 or 37, question 37 questions, um, on the new ACE test. And so that includes things up, you know, bullying, violence, discrimination, things of that nature that are going on.

But so looking at this, the way to quote, unquote "measure" someone's trauma is through not diagnose anything. That's, let's make that very clear, but to essentially measure someone's trauma is through what's called an ACE test. So

for those of you who have not heard, or maybe are not completely familiar with an ACE test, basically it's 10 questions that ask about all of these situations.

It is meant for somebody who is over the age of 18 to quote, unquote take. But it asks about [00:34:00] experiences before the individual turned 18. So for instance, before the age of 18, were you physically abused by anybody in your home? Yes or no? The questions are a little bit longer, but that's the root of it. If you answer, yes,

you're going to give yourself a score of a one. If you answer no, you're going to give yourself a score of a zero on that individual question. If, um, if the answer. So at the end of the questions, you're going to have a bunch of zeros, a bunch of ones, um, with that, you will then add them all up. So you will, at the end, have a score of between zero and 10. Zero meaning no significant trauma, and a 10 being the opposite side of the spectrum with the most significant trauma that somebody could have.

So going into the next slide, you see how, um, health-related risk factors. Really hat or [00:35:00] higher, the higher your ACE is the higher you are for a health risk factor. Oh, sorry. My watch is wanting to record me. Sorry about that. Um, so when you look at a score of a zero to a four, look at the difference there of how much more likely you are to smoke, become obese, have an STD, experienced depression, bronchitis, use drugs, develop alcoholism, or, um, increase the likelihood of suicide.

Right? And that is just from an ACE score of a zero to a four. So it really shows you how significant the risks are. And that four is really where the, um, the tipping point is. Now I'm going to go back to what I said earlier that trauma does not predict your destiny, right? So this is public health statistics. Public health averages, um, from these 17,000 women, right?

So this does not predict [00:36:00] anybody's destiny, because as public health averages, you're going to have people above and below. And then you're going to have ways that you can really start chiseling away some of these statistics so that your likelihood and percentages go down. More on that in a moment. Uh, moving into the next slide, um, for the risk of prison and jail, as you see significantly increases.

Um, if, um, if, oh, sorry. I'm one of my slides got mixed up. So sorry about that. Um, so you see that the effect there gets significantly, um, changed if, or increases if they have an ACE score, right there. Moving to the next slide. Um, just shows a little bit more about jail and prison right here. Um, and also that their a lifespan expectancy is going to be about 20 years difference, um, from somebody who has an ACE score of a zero versus somebody who has an ACE [00:37:00] score of a six or more.

Um, so everyone has heard the saying "stress kills." Um, and that is so incredibly true. Stress really kills and it affects every single part of your body. And trauma causes that stress. And that is why we have these startling statistics. That's why there's so many negative health disparities associated.

That's why there's so many, um, you know, life expectancy, things like that. But again, remember it's not your destiny. Um, so a lot of people ask what is. What is the average ACE score of somebody incarcerated in America. Um, so if you want to throw in the box, what you think that average ACE score is, if somebody's incarcerated in our country,

6, 7, 6, 8. All right. It looks like Darien and Dawn hit it. Um, [00:38:00] absolutely. So the average ACE score of somebody incarcerated in America is seven. Well, for men. For women, it's a little lower it's about a 6.5. Um, and so that just shows something that we know that folks behind bars in our country are hurt people, right?

They are people who have gone through some stuff and most likely coped in a negative way. Therefore they are where they are, which is behind bars. Um, so jumping into the next slide. What's the difference. And I alluded to this earlier, but I didn't want to go into it too much. Right. What's the difference between somebody who, um, has an ACE score of a seven that ends up incarcerated versus a score of a seven that doesn't.

And one of the biggest areas is those three E's. What is the event? What's their experience. And therefore the, we have the effect. Um, the biggest influencer on this though, is resilience and the ability to negative or positive cope, right? [00:39:00] So the three biggest factors associated with resilience are communication, connection, and relationships.

And so if we don't have those three things, we are not going to be talking about our issues and our problems. Why is that important? Because research has shown us that the number one way to cope with things is to talk about it. So if we're not in relationship with others, we are not going to have connections or communication to talk about it.

Therefore, we are not coping in the number one way to cope. Which means what? We are most likely going to cope in a different way, which means we are going to get that outcome. Um, so when you look at those relationships related to those resilience factors. As we've discussed, trauma is coming. The trauma that we're talking about, is complex coming from the home.

So most likely those relationships are not within the home, but they're with maybe one of us, right. That works with folks on a daily [00:40:00] basis. They're with a guidance counselor, a coach, a teacher, a pastor, a grandma, a neighbor, the list goes on and on and on. Right. And that is critically important when you think about

how impactful that can be. And that just really shows the role that we have, and how much more critical our role is in helping somebody and resilience. And so if you can leave this presentation with only one thing, what I would love for you to remember is have an organization that is relationship driven. Have an organization that sows into people that you are looking at quality over quantity, and that if you don't have the staff, the structure and the infrastructure to support relationships with those, appropriate relationships, with those that are in your organization, don't grow anymore.

Because that is where you're going to have the tremendous impact is if though you have those relationships to help build their, their resilience. I will also recommend, and I'm going out of order a little bit, but [00:41:00] have your homes designed as a family. We do not allow televisions in the room. Why? Because if the TV's in the room, they're going to lay their butt in bed and watch TV all day.

That is isolation. That is the isolative behaviors that they were in when they were in their addiction. That's not what we want anymore. They need to drop their old people, places, and things come up with new people, places and things,

and develop those relationships we were just talking about. They're not going to do it.

If they have a TV in their room, however, our male house is never going to miss Sunday football. So guess what? Everyone is together in the family room, watching Sunday football together, right? We are forcing them to hang out because most of the time, those we serve, hanging out does not come naturally and easily.

Especially if you're sober. We have mandatory Sunday meals, family dinners on Sunday night. Our house managers are required to have family events at the house. Sometimes they'll do an extra meal. Sometimes they'll cook out. We have corn hole boards at all of our houses. Sometimes a couple of our house managers have even done [00:42:00] game night.

Um, our ladies love to do crafts, so they'll have craft night or painting night together. Um, but anything to build those relationships within your organization, staff and clients, um, is absolutely key critical to raising this resilience. Um, so moving forward to the trauma or to the brain piece. Okay. So I am going to roll through this brain piece super quick because of our time limit, um, understanding that you're only getting like snippet of a huge piece on brains, right?

So we talked about your left and your right brain, right? I'm going to reframe it now that you have that visual, hopefully you got it down, to your downstairs and your upstairs brain, right? You've got your right brain here, your left brain here. All right. You're downstairs where you have that creativity.

There is no language. There's no linear. There's no [00:43:00] logic. There's no judgment. It is simply, this is your, your, um, your emotions. This is your survival. This is where you're a fight, flight or fear, it will kick in. Your upstairs brain is all that other stuff. This is your logic. This is your linear. This is your language.

This is your rationalization. This is your judgment. If this, then, that. Right. So when those bridges are connected, my upstairs and my downstairs brain are working. Guess what? Everything is jelling and meshing good. Right? We could

do decent, like we did today, hopefully on that Stroop test. But when I flipped my lid, all of this is out the window, right?

I am in survival mode. I am running on emotion. Right. And when somebody is in their downstairs brain, when they are in survival mode, they're not thinking logically, right? How many times have we been in a situation and I'm not going to pick on anyone cause I can't see your faces right [00:44:00] now, but how many times are we in a situation right where we just lose our stuff and you yell and scream.

And then after it's over. I shouldn't have done that. That was a bad idea, right? That's cause we're in our downstairs brain, we're not using the judgment thing. And this is a bad idea. Or if this, then that, right. When somebody pulls their trigger to kill someone, they are not thinking logically. They are not thinking with their upstairs brain, for whatever reason, they are in survival mode and they're downstairs brain, right?

They're not thinking about consequences. When they come back down, they might be thinking about consequences. But right now that's not what they're thinking about. Right. So when somebody is in their downstairs brain, all the time, and we all know those people in our organizations, right. It's because they have trauma, right.

It is somebody whose brain is literally geared to be in survival, at all times. They don't know how to come down. They can't come down. That's where this I'm good. I'm good. I'm good. And you look at me. [00:45:00] What are you looking at? Why are you looking at me like that? Out of nowhere. I'm not even looking at you.

I was looking at my friend who was across the street, right? That's where all those hyper arousal, hyper exaggerated responses come in. It takes nothing to go into this emotional state of always looking over my shoulder to see who is coming after me. I don't know. Some of you might be right. That's where all of this is going on.

That is how people's brains are trained if they grow up in trauma. They're always in survival mode. So we have to retrain them and retrain their brain in order to bring it down. And, um, yes, disc, deescalating is so important. One of

the most vivid stories that I have from this, or about this, is one of those people that I did, a lot of my trauma training under, she used to be contracted by Red Onion State Prison, which is here in Virginia, it's Virginia [00:46:00] Supermax prison.

And, um, she would go in and help the, or work with the worst of the worst. People that they just could not control. And she tells this story about one time going in, and this guy was just absolutely tearing everything up, hanging from the ceiling joists, and they literally could do nothing, nothing, nothing to, um, to deal with him.

And so she went in and she went in with a ball and she starts throwing the ball at him. Well, and it, and very non, um, uh, threatening way right now, not just, just a light toss. He catches it, throws it back. They're playing this game of toss, right? So what, what is happening when you are throwing a ball at somebody? You are looking at their face.

I cannot throw a ball to you like this, and expect that it's going to go in the right direction for you to catch, right? So they're looking at each other. At this point, they are able to connect with one another. This is when his brain starts coming down, because when that happens, when you connect with somebody, you can automatically redirect [00:47:00] them.

And when you redirect them, you can have a conversation. Because they don't sense you as evil. They don't say, sense you as an enemy. What is the opposite story of what we probably know happened before Alison went in there and started doing this intervention? It was a correctional officers. I told you to get down from that table.

If you don't get down, I'm going to lock you up. You're going to be in isolation and I'm going to hit you with another, right? All this screaming, all this yelling going on. Well, what does that do? Is there ever been a time in history where someone has yelled at you, and you have become more calm?

Absolutely not. What happens? You get more mad. You get more ramped up. You're yelling at me. Guess what? I'm going to yell at you louder now, right? I'm probably going to throw in some cuss words now because you've really

made me mad. That is that downstairs brain that is activated. It is black noise, going in one ear out the other, you were making no impact.

The same thing with the child having a temper tantrum. Do children stop temper tantrums when you [00:48:00] tell them to stop? No! Never in the history. I have three kids. Never, never, never, never, never. Right. That is because of, they are in their downstairs sprain. They've got to have both sides of their brain gelling and, and connected in order to make an impact.

So when you are working with your people, you and people in addiction, 99 times out of a hundred have been through significant trauma before. So you need to understand that most likely they are operating in trauma brain. They are operating in their downstairs brain. So when you are working with them, you need to remember and understand that, how you need to talk to them and also how they are going to be acting.

Um, and so that you don't think they're being rude or nasty, it's just, what's going on. Again, we're not excusing a behavior, but we're understanding a behavior so that we as, um, you know, people that work in the field can better respond to it. So when somebody's, moving on to the next slide, super brief, when somebody is in their downstairs brain, they are not in [00:49:00] good positive relationships. Again, think of somebody in your organization who was in a relationship. They are in relationships to nurture. Guess what? If, if I feel like that you need me, that's gonna make me feel good. Think about the women who are always putting money on the books in the jail, right? It's not necessarily because of, oh, this is some like puppy love.

It's really because they are needed. They are nurturing. To be nurtured by, kind of the opposite. I'm going to take care of you, all of that. Um, to have sex with. To run away. To submit or to attack. Those are the types of relationships that people that operate in their downstairs brains are wired for, because that's all that they have the capability to do.

Hence, by folks in our programs, often have terrible relationships with everybody. Friends, intimate relationships, all of that. Um, and so working on, um, you know, getting them retraining on coping on all of those sorts of things, communication, healthy relationship, that is a way to [00:50:00] get them to realize how to have positive relationships.

Um, so moving onto the next slide, the building blocks to resilience, .Um, connection, we got to have connection to people. Um, it doesn't have to be a ton of people, but it has to be at least one person up to five, having those very, very positive relationships. Regulation. Sit down, be quiet, have some mindfulness. Meditation, yoga, or maybe going for a run.

Maybe that's how you regulate your body. Um, Competence and self-esteem. Have things in your life that you do well. Right? Who doesn't like to be told Good Job! Right. I might not be able to do what Johnny can do, but maybe I can do something else. Maybe I'm not an A student, but if. If I get a C and for me, that's good,

tell me good job. Don't tell me that, that I need to do better next time or study harder because I might not be able to. Right. Um, so really helping people [00:51:00] build their competence, build their self esteem, um, and congratulating them and telling them they, they've done a good job. Celebrating what they've done.

Gratitude. Um, gratitude has been found to have a profound impact on people and their attitude. You know, basically all of the world's, um, religions and faith have some type of foundation in gratitude and saying, thank you. Research, as I said, has shown the power of gratitude. Um, positive affirmations, absolutely. Keeping a gratitude, gratitude journal, writing down what we're thankful for.

Post-it note on the bathroom wall, um, that is critically important. Um, and then hope if I don't have hope for the future, what am I living for? Right. Um, so not necessarily hoping for a world of no COVID or hoping for a world of new mat, no mask, right. But looking at experiences and hope for a better day tomorrow, the next day, the next month, right?

These are really the five key areas [00:52:00] of what somebody needs to do to raise resilience. A lot of those factors are things that you and I can do, um, working with folks to help them. But some of them are things they need to do such as the gratitude journal such as that regulation piece. Right? So knowing all this information, you know, how you can work with somebody to help them raise their resilience and feel better.

Um, okay. So totally switching gears. Um, beautiful segue over there. Looking at trauma and rural areas. A lot of times it is much harder to deal with trauma in rural areas. Um, and it is, uh, you can go to the next slide, please. It is something that is absolutely critically important to understand when you are designing your program and when you were looking at it.

Um, there are a lot of ,really unique health barriers and health situations that go on in rural communities that maybe do not go on in other places. [00:53:00] Um, and there are many barriers that, um, also limit access to primary health care, behavioral health, um, shortages in work professions, things like that. That really, really, um, make it difficult when you want to address trauma.

But because of the area you're living in, you are limited. Um, so keep these things in mind. In isolated areas, training can be tough. Fortunately, we all know how to Zoom these days. And so that is a huge, um, huge potential, but training is very difficult. Um, in rural areas, everyone knows everybody. Right. Um, so I'm not going to come to your organization and talk about my trauma cause you know, my mom. Or, you know, those sorts of things, everyone knows everybody.

So just the shame of not wanting to talk about it. Um, there's shortages in healthcare and mental health, right? I know someone's gone through trauma. I know they most likely need mental health, but I don't have anywhere that can take them within the next three months. That's a problem. Um, [00:54:00] increased poverty, you know, often in rural areas that increased poverty, um, really is a prohibitor.

Um, and then are there an natural, natural disasters, natural, you know, wildfires, things like that, that just make things, um, Even worse. Um, I will tell you, there is research and evidence that child abuse and neglect as well as intimate partner violence and sexual violence, um, increased in communities that are affected by those disasters such as fires, um, which of course contributes to a higher ACEs.

Um, so keep that in mind. I'm going to the next slide. Um, there are, um, study of five ACEs that have found, um, that they are more prevalent among children in rural areas. Divorce, living with somebody with a drug or alcohol problem.

Um, having a guardian or parent in jail, I'm living with somebody who's mentally ill, or witnessed parental violence.

Um, so those five ACEs are more prevalent [00:55:00] among people in rural areas. And people from rural areas are more likely to experience this symptoms from five of the leading causes of death in the United States, which are, heart disease, stroke, chronic, um, uh, respiratory disease and cancer. And all of those factors are very highly, highly correlated with ACEs.

Um, so all of those things, um, are, you know, like I said, correlated to that, um. Now that said there's a couple of positive effects of rural areas. Um, yes, somebody commented in small communities trust is hard where everyone knows everybody. Absolutely. But, and, and that's to a point on this slide. Moving to the next slide, um, smaller close-knit communities sometimes have more support and connection because you do know everybody.

And so they're more willing to help you. And you're, you know, a big fish in a small pond versus a small fish in a big pond type of thing. Um, and then also that, um, [00:56:00] often doctors and such know you better. They're willing to take more time. They have a more in-depth knowledge and information on all of the things that are going on with your family.

Um, so ways to overcome this, um, on the next slide, looking at regional approaches, you know, are there ways to bridge resources among the close rural areas. Um, tele-health is a huge thing right now. So are there ways to do that? Are there ways to increase access to local referral sources? Um, are there coalitions and groups and things like that?

Um, so many there's great times. There's great resources out there that people just don't know about. So how can talk about it as a community? What are the best practices? What have you found that works? What have you found that doesn't work? Um, and then how can you expand the local workforce to really start addressing some of those situations, um, that are going on and getting people to work, financially sustaining and those sorts of things?

Um, so, you know, I, I like to bring up the pros and the [00:57:00] cons of everything because everything has an obstacle. Um, but 100%, um, Please consider these things, but don't let them discourage you, um, because they are,

um, can be overcome. I've seen it happen many times before. Um, and so, like I said, don't let it discourage you in your area.

Um, so with that, I am happy to answer any questions, uh, that you may have.

[00:57:28] **Jennifer White:** Thank you, Dr. Scarbrough. This was very well-rounded and very informative. So, um, I think you've covered enough that, um, we are getting close to time and we only have one question. Um, I will say before we go ahead with Olivia's question that anyone that is interested in, um, reviewing this presentation again or sharing it with others, they, it can be found next week on our website, um, at FletcherGroup.org.

And with that, um, we'll go to Olivia's question. And Olivia asks, [00:58:00] when you asked the question, what happened to you? And the individual is hesitant to share their experience. How do you get them to feel safe enough to open up?

[00:58:11] **Dr. Sarah Scarbrough:** Um, great question, Olivia and what Alicia and Susan listed is absolutely great.

Um, and so point on. Um, in order for somebody to open up, they have to trust you obviously, right? And that requires a relationship. That's going to take time, um, you know, same with any relationship. And so understand that on day one, week one, month one, you may not have their full trust because everyone else has dropped them in boredom.

Right. Um, but if you give it time and are consistent with them, you will build that trust. But that consistent is do what you say. Don't, don't not do something that you tell them. Um, put responsibility on them. You're not going to do for them what they can't do for themselves. Um, but be, be patient as Susan said, because eventually [00:59:00] the trust will be there for them to do it.

What I would also say is some tough love. Don't feel like trying to build their relationship is being a yes man or a yes woman or trying to appease them. It is okay to absolutely let them know. Listen, we're not going to do that in this program. This it, you know, the rules, you signed them when you came in and we're not going to do that.

Right. That's not breaking trust. That's making them see that there is a you there, they have a responsibility and there's accountability, and that helps build them. Why is that? Because most of the time in their life, no one has ever told them no. And if they have, it's been from somebody that they don't respect and it's been a very derogatory type of situation.

Um, so if you have that balance of, you know, spending time and establishing that rapport, but at the same time, ensuring that they're held accountable and doing your job and make sure they're doing yours, um, you absolutely, um, um, [01:00:00] it will take time, but you will gain their trust.

[01:00:05] **Jennifer White:** Thank you so much for following up on that. And that takes us to the end. Um, so thank you again, and anyone with a few questions out there. I will go ahead and throw Dr. Scarbrough's information into the chat again, and you can reach out to her. Um, and, um, again, the information will be on our website, um, next week.

And thank you again.

[01:00:35] **Michelle Day:** This concludes our webinar session. Thank you so much for joining us today. Also, please tune in on the first Thursday of each month from 2:00 PM to 3:00 PM Eastern Standard Time, where we will be hosting subject matter experts from across the nation to bring you valuable tools and resources for rural recovery house operators and SUD professionals.

If you would like information on technical assistance, you can go to our website, again [01:01:00] www.fletchergroup.org, which I have also copied in the chat, and submit a technical assistance request. Lastly, please take a moment to respond to the survey questions once they become available on your screen. Your feedback is very important and greatly appreciated.

Thank you and have a blessed day.