March 27, 2023

Senator Baldacci, Representative Meyer, and Members of the Joint Standing Committee on Health and Human Services:

My name is Eliza Burwell and I am a Licensed Master Social Worker, Conditional Clinical from Portland, Maine. I am here today in **support of LD 816, An Act to Provide Integrated Behavioral Health Services to Sexual Violence Survivors.**

Survivors of sexual violence often face many barriers to obtaining proper mental health services after experiencing violence. As a former Sexual Assault Response Team Advocate, I have spent hours trying to help survivors connect with knowledgeable trauma therapists. Unfortunately, many of the therapists with specific knowledge about working with survivors had long waitlists, were geographically inaccessible, or did not accept insurance. While I worked hard to help survivors overcome some of the barriers by accessing the Victims Compensation Fund, brainstorming ways to find a quiet space for telehealth, or exploring bus routes to get to appointments, many of the survivors I worked with were still unable to access the care they deserved.

Even when survivors are connected to mental health care providers, many clinicians do not have the specialized knowledge or training to work with survivors of sexual violence. In my graduate program, for instance, coursework on trauma informed care and working with survivors of trauma was optional rather than required. Specialized trainings in trauma treatment approaches such as Eye Movement Desensitization and Reprocessing (EMDR) or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are costly and time consuming. Due to the sensitive nature of trauma treatment, these courses require many hours of study, practice, and supervision before a provider is fully trained or certified. The barriers to receiving this education often dissuade providers from seeking specialized training and certification, creating further challenges for survivors to find care. By embedding specially trained clinical staff in Sexual Assault Support Centers, agencies can hire qualified staff with the necessary training and support their ongoing professional development to ensure the highest quality of care.

For many survivors, seeking mental health care from a provider not explicitly trained in trauma treatment often increases their distress and can lead them to drop out of treatment. In these instances, survivors may rehash details of the violence they experienced in activating rather than therapeutic ways.[1] Or providers who do not fully understand the power and control dynamics at play may blame survivors for the trauma they experienced. Providers may also fail to recognize the impact of ongoing legal issues which may limit a survivor's ability to heal when they are asked to re-live their trauma time and time again in a court setting.

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[1] Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances, 24,* 319-333. doi: 10.1192/bja.2018.29

Embedding providers in sexual assault support centers also eliminates the need to diagnose survivors as these labels are not needed to justify treatment to insurance. While diagnoses can be helpful in guiding treatment, many trauma survivors accumulate diagnosis after diagnosis to the point that these labels become meaningless to the survivor or provider.[2] These diagnoses, however, may hold great meaning in a court setting or a medical setting where a survivor may be unfairly discriminated against or discredited because of these labels. Trauma informed care focuses on what has happened to someone while a diagnosis identifies what is wrong with someone.[3] Once a survivor is labeled with a diagnosis, they carry it from provider to provider. They are no longer seen as someone who has experienced violence and hurt, but as someone who is broken, weak, and in need of fixing.

Survivors in Maine deserve accessible, high quality mental health care to heal from the trauma they have experienced. Thank you for your consideration. I would be happy to answer any questions you might have.

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[2] Brewin, C.R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R.A., Humayun, A., Jones, L.M., Kagee, A.,. Rousseau, C., Somasundaram, D., Suzuki, Y., Wessely, S., van Ommeren, M., & Reed, G.M. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and Complex PTSD. *Clinical Psychology Review, 58,* 1-15. http://dx.doi.org/10.1016/j.cpr.2017.09.001

[3] Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances, 24,* 319-333. doi: 10.1192/bja.2018.29