

Blueprint for Action

Building Trauma-Informed Mental Health Service Systems

State Accomplishments, Activities and Resources

December, 2007

DRAFT

Organized by Individual States

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Introduction

This 2008 updated “Blueprint for Action: Building Trauma-Informed Mental Health Systems” describes current state mental health system and organizational activities contributing to the development of trauma-informed mental health systems and the implementation of emerging best practices in trauma-specific services. Information on trauma-related activities, programs, services, written documents and resources is organized by state within a series of 12 Criteria for Building a Trauma-Informed Mental Health Service System (see pages). The 12 criteria were adapted from those developed by State Mental Health Commissioners and national trauma experts as part of several “Trauma Expert Meetings” convened by NASMHPD. They provide guidelines for state mental health systems in their efforts to meet the needs of recipients of mental health services with histories of abuse and trauma.

This document is an update of the original “Blueprint for Action: Building Trauma-Informed Mental Health Systems”, developed in 2004 for NASMHPD. Its expansion from 140 over 300 pages and from 30 to 45 involved states is indicative of a continued and dramatically increased recognition of trauma as central to the lives, treatment and recovery of persons with serious and persistent mental health problems.

Although there are many other resources that may be helpful to recipients of mental health services who have histories of trauma, the majority of the activities, programs and resources described in this document specifically and explicitly address trauma.

Many of the materials cited in this document are available electronically and many of them can be obtained by contacting the individuals listed at the end of this document in the Contacts section. Other resources used by states may need to be obtained from publishers or authors.

For further information about the trauma-informed and trauma-specific emerging best practice models implemented in several public mental health service systems and identified in this document, see the SAMHSA publication: “Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services”.

This is a continually updated, working document.

Criteria for Building a Trauma-Informed Mental Health Service System

The following elements should be in place in any public mental health system committed to meeting the needs of clients who have histories of trauma. Trauma is defined here as interpersonal violence, over the life span, including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence.

Administrative Policies/Guidelines Regarding the System

- 1. Trauma function and focus in state mental health department.** A single, high-level, clearly identified point of responsibility should exist within the state administrative structure charged with and supported in implementing trauma-informed service systems and use of evidence-based and emerging best practices in trauma throughout state supported services. This could be a senior staff, a unit or office within the department, and/or ongoing, high-visibility leadership on the part of the lead system administrator. This person or group should develop a written plan with trauma related goals, objectives and timelines, approved and activated by administration, and should meet regularly with system administrator.
- 2. State trauma policy or position paper.** A written statewide policy or position statement should be adopted and endorsed by administrative leadership, and disseminated to all parts of the service system, stakeholder groups, and other collaborating systems. This document should include a definition of interpersonal violence and trauma, make a clear statement about the relationship between trauma, mental health and recovery, and publicly declare trauma to be a priority health and mental health issue. Ideally, the position statement should commit the state to meeting the essential elements of a trauma-informed service system, and a trauma-specific clinical system. The *NASMHPD Position Statement on Services and Supports to Trauma Survivors* (www.nasmhpd.org) serves as a model of such a position paper.
- 3. Workforce Recruitment, Hiring, and Retention.** The system should prioritize recruitment, hiring, and retention of staff with educational backgrounds, training in and/or lived experience of trauma. This priority should be clearly described in job descriptions and postings. These staff or “trauma-champions” provide needed expertise and an infrastructure to promote trauma-informed policies, training and staff development, and trauma-based treatment and support practices throughout the service system. They advocate for consideration of trauma in all aspects of the system. There should be strategies for outreach to sources of prospective trauma-educated/informed employees (e.g. universities, professional organizations, peer-led and peer support programs, consumer advocacy groups; other training sites). Professional organizations and universities should be approached to offer curriculums preparing students to work with trauma survivors. Incentives, bonuses, and promotions for staff and supervisors should take into account their role in trauma-related activities. Support and training should be provided for direct

care staff to address impacts on staff of trauma work. There should be a written policy and regularly monitored plan for building and supporting workforce trauma-competency in all aspects of the service system.

Policies and procedures to ensure safety from sexual offenders should guide all recruitment, screening and hiring practices of both employees and volunteers, and guidelines should be established to prevent and respond to reported incidents of such abuse.

(Goal 5.3, 5.4: President's New Freedom Commission on Mental Health Final Report)

4. Workforce orientation, training, support, job competencies and standards related to trauma. All human resource development activities should reflect understanding of and sensitivity to issues of violence, trauma and coercion; incorporate relevant skill sets and job standards; and address prevalence and impact of traumatic events. Administrative policy should support accomplishment of the following goals.

All employees, including administration, should receive orientation and basic education about the prevalence and traumatic impacts of sexual and physical abuse and other overwhelming adverse experiences in the lives of service recipients. In order to ensure safety and reduction of harm, curriculums used for orientation and basic training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. All employees must also be educated about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status on individuals' experiences and perceptions of trauma and their unique ways of coping or healing.

Direct service staff and clinical staff should be educated in a trauma-informed understanding of unusual or difficult behaviors, in the maintenance of personal and professional boundaries, in trauma dynamics and avoidance of iatrogenic retraumatization, in the relationships between trauma, mental health symptoms and other problems and life difficulties, and in vicarious traumatization and self-care. They should learn application of trauma-informed issues and approaches in their specific content areas (including disaster response), and trauma-specific techniques such as grounding and teaching trauma recovery skills to clients. Curriculums and training programs for direct service and clinical staff should cover these issues.

Input from and involvement of persons (consumers and staff) with lived experience of trauma should be a part of all employee and staff trauma trainings.

Staff whose clinical work includes assessment and treatment, including those involved in disaster response, should be required and supported to implement evidence-based and promising practices for the treatment of trauma, and to attend ongoing advanced trauma trainings.

Disaster responders should be trained in trauma issues from the initial assessment through the intervention process, and disaster planning, policy and curriculums must include this.

Whenever possible, trainings and training programs should be multi-service system, inclusive of staff in mental health and substance abuse, disaster planning,

health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination.

(Goals 3.1, 3.2, 4.2, 4.3, 4.4, 5.3, 5.4: President's New Freedom Commission on Mental Health Final Report)

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.** The voice and participation of consumers who have lived experiences of trauma should be actively involved in all aspects of systems planning, oversight, and evaluation. Trauma-informed individualized plans of care should be developed in collaboration with every adult and child and child's family or caregivers receiving mental health system services. Consumers with trauma histories should be significantly involved in staff orientation, training and curriculum development and play a lead role in the creation of State Mental Health Plans, the improvement of access and accountability for mental health services, and in orienting the mental health system toward trauma and recovery. Special attention should also be paid to the rights of people with trauma histories (e.g. right to trauma treatment, freedom from re-traumatization, and rights to maximum choice, collaboration and empowerment) and to the ways in which these rights may be systematically violated. Administrative level policy or position statement should support these goals. *(Goals 2.1, 2.2, 2.3, 2.4, 2.5: President's New Freedom Commission on Mental Health Final Report)*

Administrative Policies/Guidelines Regarding Services

6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.** Funding strategies for trauma-specific services should be clearly identified, and should eliminate disparities in mental health services by improving access to evidence-based and promising practices in trauma treatment. Existing exclusions and barriers to reimbursement should be eliminated. Although new funds are not necessarily critical to developing a trauma-informed system, the development of sufficient trauma-specific services to meet the treatment needs of the high percentage of clients with histories of unaddressed sexual and/or physical abuse and trauma may require creative fiscal reimbursement strategies. Attention to reimbursement and funding issues is key to a successful change strategy. *(Goal 3: President's New Freedom Commission on Mental Health Final Report)*
7. **Clinical practice guidelines for working with children and adults with trauma histories.** Findings from studies, including SAMHSA's Women, Co-Occurring Disorders, and Violence study and more recently studies involving traumatized children, increasingly provide evidence that trauma treatment is effective. Numerous clinical approaches have been manualized and guidelines have been developed. Clinical approaches to trauma treatment should clearly identify trauma as the issue being treated, promote recovery, allow for survivors to tell their stories, include trauma-sensitive training and supervision, address secondary trauma and self-care for the caregiver, respect cultural diversity, and be experienced as empowering by consumer/survivors.

8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.** Policies and regulations that guide system-wide practices are central to ensuring that trauma-informed and trauma-specific assessment and services are adopted consistently. Trauma-informed policies and procedures are crucial to reducing or eliminating potentially harmful practices such as seclusion and restraint, involuntary medication, etc. They therefore must be carefully reviewed, revised, monitored and enforced to take into account the needs of trauma survivors. Licensing, regulations, certification, quality improvement tools and contracting mechanisms should all reflect a consistent focus on trauma. Policies and regulations addressing confidentiality, involuntary hospitalization and coercive practices, consumer preferences and choice, privacy, human resources, rights and grievances for employees are also key. They should be modified periodically to conform to developments in knowledge of evidence-based and emerging best practice and to promote provision of and access to trauma-informed and trauma-specific services. *(Goal 3: President's New Freedom Commission on Mental Health Final Report)*
9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.** Data on trauma prevalence, trauma impacts, effectiveness of trauma services and consumer satisfaction can provide rationale for support/funding of such services and the training necessary for their implementation. Such data should be regularly collected and used as part of ongoing quality improvement and planning processes. Evaluation and research activities should be carried out through internal staffing or through liaison with external evaluators and researchers, to determine the effectiveness of systems change to a trauma-informed system, and to identify outcomes of trauma-related services. These findings are incorporated into ongoing services modifications and planning. *(Goals 5.1, 5.4: President's New Freedom Commission on Mental Health Final Report)*

Trauma Services

10. **Universal trauma screening and assessment.** All adults and children who enter the system of care, regardless of which “door” they enter, should be screened for abuse and trauma at or close to admission. At a minimum, questions should include histories of physical and sexual abuse, domestic violence, and witnessed violence. Individuals with a positive response to the screen should have a trauma assessment as an integral part of the clinical picture, to be revisited periodically and used as a part of all treatment, rehabilitation, and discharge planning. Clients with trauma histories should be informed about and referred to quality, trauma-informed and trauma specific services and supports.
11. **Trauma-informed services and service systems.** A “trauma-informed” service system and/or organization is one in which all components of the system have

been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addictions services. A “trauma-informed” organizational environment is capable of supporting and sustaining “trauma-specific” services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor’s life over the lifespan, and therefore coordinates and integrates trauma-related activities and trainings with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics, including that caused by childhood or adult sexual and/or physical abuse shown to be prevalent in the histories of mental health consumers, should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented. *(Trauma-informed service systems increase capacity to address Goals 2, 3, 4 and 5 in the President’s New Freedom Commission on Mental Health Final Report)*

- 12. Trauma-specific services, including evidence-based and promising practice treatment models.** Services designed specifically to treat the actual sequelae of sexual or physical abuse and other psychological trauma should be available in adequate numbers to serve the population and should be accessible to all consumers, including adults, adolescents, and children and their families. As part of national research initiatives including the SAMHSA *Women, Co-Occurring Disorders, and Violence* study and SAMHSA’s *National Child Traumatic Stress Network*, numerous evidence-based and promising practice trauma treatment models appropriate for adults or children and applicable in public sector service systems, have been manualized and in many cases proven to be effective in reducing symptoms. Many of these evidence based and promising practice models have been identified in the SAMHSA publication “Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services”. Selected models should be implemented by state mental health systems to treat trauma. Health technology and telehealth should be used to make these programs accessible for individuals in remote areas or in underserved populations. Although program models may vary widely, all should be recovery-oriented, emphasize consumer voice and consumer choice, and be fully trauma-informed. In addition, because of the numbers of adult and adolescent trauma survivors with co-occurring disorders, and given significant positive findings from studies such as the WCDVS, trauma treatment programs should provide integrated trauma, mental health and substance abuse services and counseling designed to address all three issues simultaneously. *(Goals 2.1; 3; 4.3; 5.2; 6.1 President’s New Freedom Commission on Mental Health Final Report)*

Individual States Accomplishments, Activities and Resources In Building Trauma-Informed Mental Health Service Systems

Alabama

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**
 - January 17-18, 2007 – Safe and Sound II: Fostering Resiliency after the Storm Training held in Mobile Alabama. The purpose was to provide training to professionals who interact with children and families that potentially face long-term mental health issues (trauma, PTSD, resiliency, etc.) due to traumatic events, including the hurricanes of 2005.
 - January 24-26, 2007 and February 28-March 2, 2007 – Overview of Post-traumatic Stress hosted and sponsored by The University of Alabama College of Continuing Studies. *Understanding the Impact of Trauma and Post-traumatic Stress Disorder*-This basic course provided participants with an understanding of trauma responses, including PTSD and dissociation, as well as examined risk factors in the actual event and in the individual. The course explored the relationship of trauma experience and such issues as life span impact and memory. *Diagnosis and Assessment of Traumatic Stress*-This session presented the various interview schedules and instruments that assist in diagnosing and assessing traumatic reactions.
 - March 29-30, 2007 and April 5-6, 2007 – Assessing and Treating Traumatized Children hosted and sponsored by The University of Alabama College of Continuing Studies. *Traumatic Stress in Children*-This session addressed post-traumatic stress in children in relation to acute reaction and chronic response. Developmental issues, learning disabilities, and traumatic experiences will be discussed. *Treating Traumatized Children*-This segment presented individual and family approaches to treating traumatized children with both acute and chronic traumatic stress. Emphasis was placed on cognitive-behavioral approaches and the use of family support. *School-based Interventions for*

Traumatic Events-A model approach to implementing policy and programs for school-based classroom, individual, and support group approaches to dealing with in-school and community traumatic events such as disaster and death was presented. Disaster planning in schools was also discussed.

- May 2-4, 2007 and May 23-25, 2007 – Therapeutic Approaches to Treating Trauma hosted and sponsored by The University of Alabama College of Continuing Studies. *Cognitive-behavioral Therapies*-This segment examined behavioral conceptual models of PTSD, assessment methods, and behavioral treatment techniques with an emphasis on flooding, exposure therapies, and imagery. *Creative Arts Therapies*-The use of various creative art therapies utilizing the written word through journaling, art therapy, poetry, and dance. Examples of these techniques were shared. *Group Family Approaches to Treating Trauma*-A process for family therapy was discussed along with ecological approaches to dealing with group-exposed trauma such as that experienced by work, community, or other groups. The utility of support groups such as sexual assault and survivors of homicide was discussed.
- September 6-7, 2007 and September 20-21, 2007 – Interventions for Acute Trauma hosted and sponsored by The University of Alabama College of Continuing Studies. An overview of acute trauma in disaster, crime, war, and other traumatic experience. Chronic issues of trauma/domestic violence/ severe substance abuse by parent. *Grief and Trauma*-This session assisted the participant to address the differing issues of grief and trauma, understanding that the bereavement process differs after traumatic loss. Session addressed issues of complicated mourning, pathological grief, and traumatic grief as well as present bereavement counseling approaches to dealing with traumatized clients.
- To raise the awareness of issues around Post-traumatic Stress, DMH/MR partnered with the Children's Trust Fund, University of Alabama's Early Childhood Development Center, and the First Lady of Alabama, Patsy Riley, and through a media campaign, helped make parents aware of PTSD and how it may impact children's behavior and parenting.
- The Alabama Alliance to End Homelessness Conference is scheduled for October 2007 in collaboration with a national homeless technical assistance group and will focus on services to trauma victims, particularly those who are homeless.
- The Clinical Directors Associate group of the Alabama Council of Community Mental Health Boards is bringing in a national trauma expert to speak at their meeting in November 2007.

- In collaboration with University of Alabama created trauma specialty certification course and encourage mental health center staff to attend.
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
 - First Office of Consumer Relations in the country. Consumers involved in developing policies; 32-self-help groups operated through office.
 6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 7. **Clinical practice guidelines for working with children and adults with trauma histories.**
 - Practice standards are included in policy statement and address the reduction of retraumatization and further victimization of individuals served by the Alabama Department of Mental Health and Mental Retardation. Policy Statement available
 8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
 - Revised policy on Seclusion and Restraint details strategies for staff to work with clients to avoid use of seclusion and restraint
 - DMH/MR 430-2, Assessment and Care of Patients with History of Trauma or Abuse
 - DMH/MR 430-3, Trauma and Abuse Assessment
 - DMH/MR 430-4, De-Escalation Strategies
 9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**
 10. **Universal trauma screening and assessment.**

Trauma and Abuse Policy and Universal Assessment Instrument. Used upon admission to all state facilities and residences serving adults, children and adolescents. Training in the Trauma Policy and in trauma assessment procedures for all staff responsible for assessment and treatment.
 11. **Trauma-informed services and service systems.**

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Alaska

1. Trauma function and focus in state mental health department.

- Treating Trauma is a stated priority of the State of Alaska, Behavioral Health agency for prevention, early intervention and treatment initiatives.
- In FY07 the Alaska Child Trauma Center staff participated on several national working committees in the NCTSN including the Complex Trauma working group, the American Indian/Alaska Native working group, the Developmental Trauma Disorder working group, and the Rural Consortium working group. Josh Arvidson, LCSW, the clinical manager of the Alaska Child Trauma Center, is on the NCTSN steering committee.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

- State Level Staff -- The Alaska, Behavioral Health funds, with a HRSA grant, a Traumatic Brain Injury Coordinator position. Behavioral Health also funds a designated Disaster Response Coordinator. Both offer TA as requested and in response to our ongoing grant requirements.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Technical Assistance – The Alaska, Behavioral Health has requested additional technical assistance on Trauma Informed Care from NASMHPD by which we hope to bring the trauma initiative more deeply into our system's everyday practice. This will involve our provider agencies, state officials and tribal partners.
- Alaska Behavioral Health received TA funding from NASMHPD in FY 07 for a related effort to develop core competencies and to establish a standardized certification system. The core competencies will apply to the broad range of direct service workers who provide behavioral health care to all consumer populations, and will include knowledge of the effects of psychological trauma.
- We have included training on the topic at statewide behavioral health training conferences.
- All clinicians in the Child and Family Services Continuum have been trained to implement ARC (Attachment, Regulation, Competency), an evidence based model to treat children with complex trauma. The model

was developed by Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW from The Child Trauma Center in Brookline, Massachusetts. We are partners with that clinic in replicating the model. Staff members receive every other week phone consultation from Ms. Kinniburgh and Joe Spinazzola, Ph.D., Executive Director of the Center. Bessel van der Kolk, M.D. is the founder and Medical Director of the clinic.

- All staff in the Child and Family Continuum at ACMHS has been trained in trauma informed services and receive regular clinical supervision using principles from evidence based trauma treatment models. Our clinic provides, in addition to ARC, Parent Child Interaction Therapy (PCIT), Trauma Focused Cognitive Behavioral Therapy, and CARE (Child Adult Relationship Enhancement).
- The Alaska Child Trauma Center provided 1400 contact hours of trauma training to over 40 agencies (e.g., social workers, mental health, children's service and juvenile justice providers) in Alaska including in Anchorage and Bethel and to the Anchorage Police Department.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Our specific funding ability has been limited. Alaska, Behavioral Health has funded one pilot program using CMHS Block Grant funds in Anchorage with Akeela House. A second program has been funded with SAMHSA funds in Anchorage with the Anchorage Community Mental Health Services. A third program with one of our Alaska Native regional providers has also been developed with resources they have developed independent of the state. Child Advocacy Centers also provide Trauma informed services to child abuse victims.
- The primary funding comes from Medicaid and grant funded services for an extended array of clinical and rehabilitation services including services appropriate for trauma survivors. Additional grant opportunities are also sought when available.
- Alaska supports Child Advocacy Centers which provide investigation and counseling for children who have been abused. Services are often coordinated with the local Community Mental/Behavioral Health Center. There are currently 7 active centers in Wasilla, Anchorage, Fairbanks, Bethel, Dillingham, Juneau and Nome. Three more are under development in Glenallen, Kotzabue, and the Kenai Peninsula. In calendar year 2006, these agencies served nearly 1,400 children.

Funding for the Advocacy Center comes primarily from the federal Office of Juvenile Justice and Delinquency Prevention via competitive grants from Alaska's Office of Children's Services; various other funding sources are also sought from each of the centers.

7. Clinical practice guidelines for working with children and adults with trauma histories.

Clinical Practice Guidelines and access to treatment policies are being addressed with an ongoing process to update our integrated regulations for Medicaid and community behavioral health regulations. The University of Alaska is a participant in our efforts to develop undated clinical practice guidelines and certification of a developmental continuum for staff. No explicit mention of guidelines being trauma-informed or addressing trauma in any way.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- All of Alaska's policies and guidelines have been under review for the last 4 years with an emphasis on integrating mental health and substance abuse services. Development of the next 5 years will include National Accreditation of all our grantees. Multiple stakeholders are included in this development process. Trauma informed services are included in these processes but the process is ongoing and with a comprehensive focus.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Universal trauma screening and assessment.

The Child and Family Continuum at ACMHS has developed an intake assessment which specifically screens for trauma. In addition, we utilize the Child Behavior Checklist, the Trauma Symptom Checklist (Briere), the UCLA PTSD Index, and the Trauma Symptom Checklist for Young Children (Briere).

The Alaska Office of Children's Services (OCS) and Programs for Infants and Children (PIC) have partnered with the Alaska Child Trauma Center in the CAPTA Project to provide trauma and developmental screening for children in State's custody under the age of three. The Trauma Team uses the Infant Toddler Social and Emotional Scale for that assessment.

- Alaska Screening Tool (AST). Includes questions about trauma symptoms. Used by substance abuse treatment providers statewide in substance abuse and mental health programs. This screening specifically includes Traumatic Brain Injury. If symptoms are related to trauma, a trauma-informed treatment plan is developed and the individual is referred to trauma-informed services.
- TBI Needs Assessment –The AST information gathered indicates that twelve percent (12%) of the respondents screened positive for a Traumatic Brain Injury (TBI). This compares with eight percent (8%) of respondents who screen positive for Fetal Alcohol Spectrum Disorder (FASD). The indication is that TBI is a significant problem in Alaska. The highest concentrations of TBI per capita are located in the northern region of the state.
- Trauma Symptom Inventory. Psychological Assessment Resources, 1995. A comprehensive trauma assessment used by clinicians when a person is referred for trauma treatment and medication treatment.

11. Trauma-informed services and service systems.

Disaster:

- Alaska is organized into 29 Community Planning and Service Areas and each is required to provide 24/7 crisis services and Disaster planning/response capacity. Ongoing workforce development includes opportunities for CISM and related crisis counseling training. Each services area has a designated agency that will take the lead for the crisis counseling and recovery role in response to a major disaster. These plans must be updated each year.

The Alaska Women’s Resource Center’s (AWRC), (see Criteria # 12 for full description) has developed The Family Circle of Healing, a trauma-informed project serving Alaskan Native women and their children in a residential substance abuse treatment setting. This project empowers women and their families to choose a positive life path supportive of individual, family, and community balance and healing. AWRC has developed a Family Circle of Healing Program Handbook, which provides an orientation and on-going resource to women in the program. It is designed as a twenty-four week program and may involve a residential and outpatient phase. Staff in the project have been trained in trauma informed services and receive regular clinical supervision that utilizes evidence based trauma treatment models.

Many of the clients in the program experience multi-generational abuse and trauma. The Family Circle of Healing addresses the four basic types

of trauma: physical trauma, emotional trauma, sexual trauma, and endurance trauma. At the end of the second year, fifty-two (52) women successfully completed treatment.

Alaska Child Trauma Center: (See Criteria # 12 for full description)

All staff in the Child and Family Continuum at ACMHS has been trained in trauma informed services and receive regular clinical supervision using principles from evidence based trauma treatment models.

The Alaska Child Trauma Center provided 1400 contact hours of trauma training to over 40 agencies (e.g., social workers, mental health, children's service and juvenile justice providers) in Alaska including in Anchorage and Bethel and to the Anchorage Police Department. This training contributes to agencies becoming trauma-informed.

Child Advocacy Centers

Alaska also supports Child Advocacy Centers with provide investigation and counseling for children who have been abused. Services are often coordinated with the local Community Mental/Behavioral Health Center. There are currently 7 active centers in Wasilla, Anchorage, Fairbanks, Bethel, Dillingham, Juneau and Nome. Three more are under development in Glenallen, Kotzabue, and the Kenai Peninsula. In calendar year 2006, these agencies served nearly 1,400 children. Funding comes primarily from the federal Office of Juvenile Justice and Delinquency Prevention via competitive grants from Alaska's Office of Children's Services; various other funding sources are also sought from each of the centers. Ongoing staff development is trauma informed.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

The Alaska Child Trauma Center

Anchorage Community Mental Health Services (ACMHS) was awarded a SAMHSA grant in 2005 to establish a Community Integration and Adaptation Center as a part of the National Child Traumatic Stress Network (NCTSN). ACMHS opened the Alaska Child Trauma Center and became one of the NCTSN sites nationally to provide direct services to traumatized children and research evidence based treatment models in March 2006.

All clinicians in the Child and Family Services Continuum have been trained to implement ARC (Attachment, Regulation, Competency), an evidence based model to treat children with complex trauma. The model was developed by Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW from The Child Trauma Center in Brookline, Massachusetts. We are partners with that clinic in replicating the model. Staff members receive every other

week phone consultation from Ms. Kinniburgh and Joe Spinazzola, Ph.D., Executive Director of the Center. Bessel van der Kolk, M.D. is the founder and Medical Director of the clinic.

All staff in the Child and Family Continuum at ACMHS has been trained in trauma informed services and receive regular clinical supervision using principles from evidence based trauma treatment models. Our clinic provides, in addition to ARC, Parent Child Interaction Therapy (PCIT), Trauma Focused Cognitive Behavioral Therapy, and CARE (Child Adult Relationship Enhancement).

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The Alaska Child Trauma Center served 45 children with complex trauma in FY07. All children were between the ages of three and twelve and were in foster care. The Child and Family Services Continuum serves approximately 700 children annually and the majority of those children are severely emotionally disturbed due to trauma exposure (primarily child abuse and neglect).

In FY07 the Alaska Child Trauma Center staff participated on several national working communities in the NCTSN including the Complex Trauma working group, the American Indian/Alaska Native working group, the Developmental Trauma Disorder working group, and the Rural Consortium working group. Josh Arvidson, LCSW, the clinical manager of the Alaska Child Trauma Center, is on the NCTSN steering committee.

The Alaska Office of Children's Services (OCS) and Programs for Infants and Children (PIC) have partnered with the Alaska Child Trauma Center in the CAPTA Project to provide trauma and developmental screening for children in State's custody under the age of three. The Trauma Team uses the Infant Toddler Social and Emotional Scale for that assessment.

The Alaska Child Trauma Center provided 1400 contact hours of trauma training to over 40 agencies (e.g., social workers, mental health, children's service and juvenile justice providers) in Alaska including in Anchorage and Bethel and to the Anchorage Police Department.

The Alaska Women's Resource Center (AWRC)

The Alaska Women's Resource Center (AWRC), a project of Akeela, Incorporated was awarded a three year grant beginning in SFY06 from the State of Alaska Department of Health and Social Services – Behavioral Health. The project was funded through the State of Alaska Community

Mental Health Block Grant. The purpose of the project was to develop and deliver trauma-specific culturally appropriate services to Alaskan Native women and their children in a residential substance abuse treatment setting. The agency contracted with the Institute for Circumpolar Health Studies at the University of Alaska, Anchorage for the evaluation component. The long-term goal of this effort is to develop a research informed treatment model to serve Alaskan Native women.

The Family Circle of Healing Project empowers women and their families to choose a positive life path supportive of individual, family, and community balance and healing. AWRC has developed a Family Circle of Healing Program Handbook, which provides an orientation and on-going resource to women in the program. It is designed as a twenty-four week program and may involve a residential and outpatient phase. Staff in the project have been trained in trauma informed services and receive regular clinical supervision that utilizes evidence based trauma treatment models.

Many of the clients in the program experience multi-generational abuse and trauma. The Family Circle of Healing addresses the four basic types of trauma: physical trauma, emotional trauma, sexual trauma, and endurance trauma. At the end of the second year, fifty-two (52) women successfully completed treatment.

The interim evaluation has recently been completed and is under review by the state.

South East Alaska Regional Community Health Service (SEARHC) - Staff Development in Process SEARHC is implementing a National Institute of Drug Abuse best practice called "Seeking Safety" which is designed to increase awareness of trauma and provide group interventions. This training has been provided for most of their staff and to the many staff in allied agencies in their region, Southeast Alaska.

Child Advocacy Centers

Alaska also supports Child Advocacy Centers with provide investigation and counseling for children who have been abused. Services are often coordinated with the local Community Mental/Behavioral Health Center. There are currently 7 active centers in Wasilla, Anchorage, Fairbanks, Bethel, Dillingham, Juneau and Nome. Three more are under development in Glenallen, Kotzabue, and the Kenai Peninsula. In calendar year 2006, these agencies served nearly 1,400 children. Funding comes primarily from the federal Office of Juvenile Justice and Delinquency Prevention via competitive grants from Alaska's Office of Children's Services; various other funding sources are also sought from each of the centers. Ongoing staff development is trauma informed.

Arizona

1. **Trauma function and focus in state mental health department.**
 - Trauma is addressed as a component of all behavioral health services in Arizona.
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**
 - ADHS has a partnership with institutes of higher education to promote education of professionals in behavioral health.
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
 - The ADHS has a Bureau of Consumer Rights which is responsible for assisting consumers in protecting their rights with respect to receiving behavioral health services. The Bureau of Consumer Rights consists of the following offices: Customer Service, the Office of Grievance and Appeals (OGA), the Office of Human Rights (OHR), and the Human Rights Committees' Coordinator (HRC).
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
7. **Clinical practice guidelines for working with children and adults with trauma histories.**

Arizona provides a copy of the American Psychiatric Association Practice Guidelines for Treatment of Patients with Acute Stress Disorder and Post Traumatic Stress Disorder on the ADHS Web Site. Arizona has a clinical guidance document posted on the ADHS web site which provides information on The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS

8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**

- State Department of Health Services policy QMs.4: Reporting and Monitoring of the Use of Seclusion and Restraint applies to all clients served through the Division of Behavioral Health Services staff and institutions.
- ADHS established a Best Practices Advisory Council in 2007 which identifies all evidence based and emerging best practices in behavioral health treatment

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

Arizona has a statewide epidemiological workgroup which examines the statewide prevalence of substance abuse disorders and related behavioral health risk factors and conditions. This group conducted epidemiological profiles of behavioral health conditions across Arizona. Profiles were published in 2005 and 2007. No explicit mention of trauma here

10. Universal trauma screening and assessment.

Statewide implementation of the 24-Hour Urgent Response for children removed by Child Protection Services ensures that the behavioral health system rapidly looks at the trauma to the child, assesses the child and the caretaker resources, and arranges to meet their immediate and treatment needs to lessen the impact of the traumatizing event. Policy and assessment tool available.

11. Trauma-informed services and service systems.

The Arizona Families F.I.R.S.T program involves an innovative collaboration between the community, the Department of Economic Security, the Department of Health Services, faith-based organizations and regional behavioral health authorities to provide a continuum of services to substance abusing parents who have had their children removed from the home. Annual report can be accessed at www.azdes.gov/dcyf/first/. (I went to website and saw no evidence of this being trauma-informed)

Statewide implementation of the 24-Hour Urgent Response for children removed by Child Protection Services ensures that the behavioral health system rapidly looks at the trauma to the child, assesses the child and the caretaker resources, and arranges to meet their immediate and treatment needs to lessen the impact of the traumatizing event. Policy and assessment tool available.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Arkansas

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
 - The Arkansas State Hospitals employs a Peer Specialist Coordinator and a Peer Specialist. They lead Peer Groups with an emphasis on making life-plans to pursue after discharge from the hospital.
 - The Arkansas State Hospital intends to hire additional Forensic Peer Specialists during the coming year.
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**
 - The Peer Specialist and a Psychologist at the Arkansas State Hospital have been conducting in-service training on Trauma-Informed Care for Hospital Staff.
 - The Arkansas State Hospital presented a two-day workshop on September 26-27 on Intentional Trauma Informed Support. The workshop was led by Shery Mead, MSW, a noted national speaker on consumer issues in mental health.
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
 - The Arkansas State Hospitals employs a Peer Specialist Coordinator and a Peer Specialist. They lead Peer Groups with an emphasis on making life-plans to pursue after discharge from the hospital.
 - The Peer Specialist and a Psychologist at the Arkansas State Hospital have been conducting inservice training on Trauma-Informed Care for Hospital Staff.
 - The Arkansas State Hospital presented a two-day workshop on September 26-27 on Intentional Trauma Informed Support. The workshop was led by Shery Mead, MSW, a noted national speaker on consumer issues in mental health.
 - The Arkansas State Hospital intends to hire additional Forensic Peer Specialists during the coming year.

- Staff from the Arkansas State Hospital are actively interacting with staff from a Recovery-based program at the Little Rock / North Little Rock VA Medical Center.
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 7. **Clinical practice guidelines for working with children and adults with trauma histories.**
 8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
 9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**
 10. **Universal trauma screening and assessment.**

The Arkansas State Hospital completes Trauma Assessments on all patients. Information gleaned from the assessments is integrated into individual Master Treatment Plans.

11. **Trauma-informed services and service systems.**
12. **Trauma-specific services, including evidence-based and promising practice treatment models.**

At the Arkansas State Hospital, Therapy Groups that address trauma-related issues are provided for both adolescents and adults.

California

1. Trauma function and focus in state mental health department.

- The California Department of Mental Health has no such point of responsibility. However, across the State, there are several units and pieces of the administrative structure that are dedicated to assisting all of the populations exposed to trauma.
 - The Department of Mental Health has staff dedicated to Disaster Services for the mentally ill population.
 - The Governor's Office of Emergency Services has staff dedicated to victims of domestic violence, as well as victims of statewide disasters.
 - The Department of Health Care Services has staff dedicated to victims of domestic violence and victims of sexual assault.
 - The Department of Social Services has staff dedicated to child victims of abuse, neglect, and sexual assault.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

- The California mental health system is designed in such a way that the 58 counties have primary discretion over their programs and their target populations. The California Department of Mental Health is primarily the administrator of funds. That being said, many county mental health entities have systems in place to ensure that persons with learned or lived trauma experience work, recruit, and hire in their systems.
 - For county-specific questions, please address inquiries to the County Mental Health Directors Association at www.cmhda.org.
- Recent guidelines issued by the California Department of Mental Health for the Workforce Education and Training component of the Mental Health Services Act (MHSA) require that all trainers and consultants funded by the MHSA be well-versed in specific fundamental principles. These fundamental principles include the requirement that training must relate to increasing the county's ability to assess and treat trauma.
- The premise of the Mental Health Services Act is that California will transform their mental health system and move toward a recovery-based model. A transformed system means a system that recruits, hires, and retains persons who have utilized services in the mental health system and can advocate for persons in like circumstances.
- The California Department of Mental Health also has a cooperative with the California Department of Rehabilitation, which assists Californians living with disabilities to obtain and retain employment and live

independently in their communities. This assistance extends to persons in the mental health system, including those exposed to trauma.

- The California Department of Mental Health also has inpatient and outpatient programs designed for Sexually Violent Predators. These programs are designed to prevent re-traumatization to victims in work settings and otherwise.

4. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Recent guidelines issued by the California Department of Mental Health for the Workforce Education and Training component of the Mental Health Services Act (MHSA) require that all trainers and consultants funded by the MHSA be well-versed in specific fundamental principles. These fundamental principles include the requirement that training must relate to increasing the county's ability to assess and treat trauma.
- The California Department of Mental Health offers training to staff as well as training to county providers regarding Cultural Competence. In this training, the impacts of ethnicity, gender, age, etc. are discussed as they relate to exposure to trauma and possible manifestations of mental illness symptomatology.
- The California Department of Mental Health also has a cooperative with the California Department of Rehabilitation, which assists Californians living with disabilities to obtain and retain employment and live independently in their communities. This assistance extends to persons in the mental health system, including those exposed to trauma.
- County mental health providers within California are certainly trained in understanding unusual or difficult behaviors, trauma dynamics, and the relationship between trauma, mental healthy symptoms and other problems and life difficulties. This training varies depending on which counties provide them and to whom. For more information about county-specific programs, please contact the County Mental Health Directors Association at www.cmhda.org.
- The Department of Mental Health also funds training on a variety of evidence-based practices. Some of these EBPs focus on trauma and educate providers on how to avoid re-traumatization.

5. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Implementation of the Community Services and Supports component of the MHSA throughout California required that each county embark on a local community planning process to identify priorities for MHSA services consistent with identified State parameters. One focus for this process was outreach to previously un-served or significantly underserved populations. While the State cannot identify specific numbers of individuals who have experienced trauma that participated in these local processes and/or the State's MHSA stakeholder process, we can say absolutely that input from these individuals was received and addressed.
- Many county mental health entities involve Consumer/Trauma Survivor participation in all aspects of the mental health system. This is especially true with children and families, as well as with peer supports.
- Those exposed to trauma are also identified as being a priority population in the Prevention and Early Intervention component of the Mental Health Services Act. The identification of trauma victims as a priority population means that county mental health entities will take special care in identifying those who have been exposed to trauma and may be unlikely to seek help from a traditional mental health service.

6. Clinical practice guidelines for working with children and adults with trauma histories.

- Various requirements were established for counties requesting MHSA Community Services and Supports funding including one directing them to utilize more than 50% of their service dollars to provide Full Service Partnership (FSP) services to previously un-served or underserved individuals. This FSP service model is intended to operate with high staff-to-client ratios that enable staff to spend the time necessary to develop trusting relationships and explore the comprehensive needs of the individual and/or family being served including those who have experiences of trauma.
- Additionally, the Mental Health Services Act mandates that counties who receive funds under the Prevention and Early Intervention component also focus some of their efforts on the Trauma-Exposed.
- The Department of Mental Health also funds training on a variety of evidence-based practices. Some of these EBPs focus on trauma and educate providers on how to avoid re-traumatization.

7. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- The California mental health system is designed in such a way that the 58 counties have primary discretion over their programs and their target populations. The California Department of Mental Health is primarily the administrator of funds. That being said, many county mental health entities have developed clinical practice guidelines for working with persons with trauma histories. This is especially true in counties that have large populations of refugees and ethnic groups known to have had histories of exposure to trauma. Additionally, the State encourages counties, through the Mental Health Services Act and otherwise, to look at the development of clinical and treatment practices that consider historical trauma experienced by the Native American communities.
- For county-specific questions, please address inquiries to the County Mental Health Directors Association at www.cmhda.org.

8. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- There is no statewide policy or position statement that has been adopted by the Department of Mental Health. However, there is a Policy Brief that the Department has peripherally been involved in: “Gender Matters in Mental Health Brief No. 3: Domestic Violence” California Women’s Mental Health Policy Council.
- Many county mental health entities have developed policies, procedures, rules, regulations and standards to support access to trauma-informed services and avoid retraumatization. This is especially true in California’s large counties and those with large immigrant and /or refugee populations. Additionally, the State encourages counties, through the Mental Health Services Act and otherwise, to look at the development of policies, procedures, rules, regulations and standards to support access to trauma informed services and avoid retraumatization of the native American communities.
- For county-specific questions, please address inquiries to the County Mental Health Directors Association at www.cmhda.org.

9. Universal trauma screening and assessment.

- Many county mental health entities have developed needs assessments, evaluation tools, and research into prevalence and impact of trauma as well as data on service utilization. Counties submit this data to the Department, as well as bi-annual data including Consumer Perception Surveys. These surveys ask for self-reports of exposure to trauma. Counties are also required to submit data for the Mental Health Services Act, but that data is not specific to victims or survivors of trauma.

- For questions about county-specific services, evaluation tools, or needs assessment, please forward inquiries to the County Mental Health Directors Association at www.cmhda.org.

10. Trauma-informed services and service systems.

- ◆ The Department of Mental Health does not have any specific screening and assessment tools specifically geared for victims of trauma. However, there are many county mental health entities that do. Additionally, the California Department of Social Services is piloting a Differential Response system that will screen and assess for trauma within children in the Child Welfare system.
- ◆ Under the Prevention and Early Intervention component of the Mental Health Services Act, county mental health entities are encouraged to focus on individuals and families that have been exposed to trauma. In that, counties will likely develop screening and assessment tools that can be shared and utilized statewide.

11. Trauma-specific services, including evidence-based and promising practice treatment models.

- The Prevention and Early Intervention component of the Mental Health Services Act establishes Trauma Exposed as a priority population. This means that counties receiving funds through MHSA are encouraged to focus their efforts and resources on trauma. As such, counties are encouraged to develop services that focus on trauma and ultimately, build trauma-informed mental health systems.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

The Department of Mental Health does not have specific requirements for trauma-informed services. However, there are many county mental health entities that have requirements in place and encourage the use of promising and evidence-based practices.

However, under the MHSA, the Department has dictated that counties receiving funding under the Community Services and Supports component design services around those persons previously underserved or unserved. Additionally, under the Prevention and Early Intervention component, counties have been encouraged to design services around persons who have been exposed to trauma.

The Department of Mental Health funds training on a variety of evidence-based practices. Some of these EBPs focus on trauma and educate providers on how to avoid re-traumatization.

Colorado

1. Trauma function and focus in state mental health department.
2. State trauma policy or position paper.
3. Workforce Recruitment, Hiring, and Retention.
4. Workforce orientation, training, support, job competencies and standards related to trauma.
5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.
6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.
7. Clinical practice guidelines for working with children and adults with trauma histories.
8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

Colorado contracts with federal Substance Abuse and Treatment Block Grant intermediaries and their subcontractor providers contain the following language:

Infectious Disease Screening Tools. At each client admission the subcontractors shall use an ADAD-approved instrument to screen for TB, HIV, and other communicable diseases. Since many women substance abusers in need of treatment have trauma histories, it is recommended that subcontractors use a trauma-sensitive version with women clients.

Women, Co-Occurring Disorders and Violence Study Principles. The Contractor shall distribute to all subcontractors the Principles from the SAMHSA Women, Co-Occurring Disorders and Violence Study and use them as guiding principles for policies and procedures for any programs that serve women.

Women, Co-occurring Disorders and Violence Study Principles

- Service providers must better recognize the presence of trauma, past and present, as a central concern in a woman's life.
- Women should be encouraged to play an active role in their healing process and provided with a better understanding of how to do so, from the onset.
- There must be a more widespread and comprehensive recognition that

violence and trauma significantly impact a person's belief system, self-perception and relationships with others.

- Providers need to meet women where they are mentally and emotionally, with careful readiness assessments, pacing and patience.

The following are excerpts from the Substance Use Disorder Treatment Rules (Standards) that have been in effect in Colorado since March 1, 2006. These rules have been modified to be trauma-informed. A complete set of Rules is available upon request.

The following items explicitly addressing trauma have been excerpted from the Substance Use Disorder Treatment Rules:

"Treatment Planning": process based on differential assessments and other relevant client data that produces a written treatment plan, individualized for each client, that establishes measurable treatment outcomes described in behavioral terms, developmentally appropriate, strength-based, achievable within expected lengths of stay in treatment, and specifies time-limited therapeutic activities designed to support treatment outcomes.

"Strength-Based Treatment": treatment that focuses on client strengths, including the capacity to cope with difficult situations; maintain functioning under stress; rebound from significant trauma; use external challenges as opportunities for growth; and, use support systems as a basis for resilience.

Treatment of minors:

Treatment agencies shall assess minors for potential mental health and/or emotional issues, trauma symptoms, and behavioral problems and address them on site or refer minors to other agencies or support services.

In planning treatment, agencies shall apply prevention, intervention, treatment, rehabilitative, and continuing care strategies developed expressly for minors and their families that are gender and culturally appropriate. The use of age appropriate, evidence-based curricula is required and includes the impact of and recovery from trauma.

15.229 GENDER-SPECIFIC WOMEN'S TREATMENT

"Gender-Specific Women's Treatment" refers to a comprehensive package of services aimed at reducing substance use and associated problems among women. These policies and procedures are trauma-informed. Some rules explicitly addressing trauma follow:

15.229.1 J. Program policies and procedures shall reflect that women's substance use disorders differs from that of men both in its etiology and the treatment and services required for its remediation.

15.229.1 K. Program policies and procedures shall recognize the interplay

between substance use and trauma symptoms because of the very high prevalence of trauma among women experiencing substance use disorders.

1. Program policies and procedures shall reflect an understanding of the effects of traumatic experiences and the unique vulnerabilities of trauma survivors so that re-victimization and misdiagnosis do not occur;
2. Decisions about the course of treatment shall be considered with the understanding of the way symptoms of trauma shall affect treatment, progress in treatment, and the relationship between the program and the client;
3. Symptoms of trauma shall be understood to include dissociation, flashbacks, feelings of being unsafe, reluctance to participate in social or group activities, and/or pervasive or situational sadness or hopelessness;
4. Program services shall directly address trauma issues currently manifesting in the client's life.

15.229.2 Policies and Rules include Assessment of trauma sequelae and treatment of trauma. Examples follow:

C. Assessments shall include all of the following unless clinically contraindicated:

4. Assessment of trauma sequelae (if delayed for clinical reasons, the expected date of this assessment shall be documented in the client record);

15.229.3 Treatment

B. Where not clinically contraindicated, the following topic areas shall be addressed in treatment or by referral:

4. Trauma issues;

C. Treatment plans and interventions shall include all issue areas identified during the assessment.

15.229.4 Support Services

A. Support service needs identified during or subsequent to the assessment, but not directly met within the program, shall be met through referral to outside programs or agencies.

B. When trauma is identified in the assessment process, interventions to

ameliorate the effects of trauma shall be provided by the program or arranged through support services.

C. Referrals to support services shall be documented in the client record.

15.230 SERVICES TO CHILD WELFARE CLIENTS

15.230.1 General Provisions

B. 3. Program policies and procedures shall recognize the interplay between substance use disorder and trauma symptoms because of the very high prevalence of trauma among this population:

a. Program policies and procedures shall reflect an understanding of the effects of traumatic experiences and the unique vulnerabilities of trauma survivors so that re-victimization and misdiagnosis do not occur;

b. Decisions about the course of treatment shall be considered with the understanding of the way symptoms of trauma shall affect treatment participation, progress in treatment, and the relationship between the program and the client;

c. Symptoms of trauma shall be understood to include dissociation, flashbacks, feelings of being unsafe, reluctance to participate in social or group activities, and/or pervasive or situational sadness or hopelessness;

d. Program services shall directly address trauma issues currently manifesting in the client's life.

15.230.2 Assessment

B. Assessments shall consist of documented efforts to identify client needs related to the following areas:

4. Symptoms and/or behavior that can be attributed to exposure to trauma. If delayed for clinical reasons, the expected date of this assessment shall be documented in the client record;

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and

needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Universal trauma screening and assessment.
11. Trauma-informed services and service systems.
12. Trauma-specific services, including evidence-based and promising practice treatment models.

Connecticut

1. Trauma function and focus in state mental health department.

- The responsibility for the development and implementation of trauma initiatives has been charged to the Statewide Services Division within the Department and the Women's Services Administrator has been identified as staff lead. Statewide Services oversees very specific programs and services designed to meet the diverse and often unique needs of clients, or potential clients, statewide. This division responds to issues related to aging, housing and homelessness, special education, nursing home placement, HIV/AIDS, traumatic brain injury, visual and/or hearing impairments, compulsive gambling, surviving trauma, and pregnant or parenting women.
- The Trauma Initiatives in Connecticut are governed by a Trauma Guide Team comprised of key staff members, consumers, CEO's/Executive Directors, and hospital superintendents representing non-profit organizations as well as state-operated facilities. The Guide Team is also supported by work groups regarding Evaluation, Policy and Service Delivery. These work groups are comprised of individuals who have been identified, through a variety of trainings in the field, as "trauma champions" within their organization. Currently, the Guide Team is planning its first retreat to establish its mission and role as it also looks beyond replicating current efforts.

2. State trauma policy or position paper.

- DMHAS has a draft policy on trauma which includes the mission statement, definition and effects of trauma, meaning of recovery, value statement, value base, and governing principles. This document was developed in 2002 and is currently being revisited by the Policy Work Group. It is hoped that the Department's policy will be helpful to our funded agencies as they revise their policies as well.

3. Workforce Recruitment, Hiring, and Retention.

- As the Department revises its policies concerning trauma, the issues of recruitment, hiring and retention of staff will be paramount. The Department has a decorated history of providing training to over 1,000 clinical staff throughout its delivery system – be it state operated facility or private non-profit organization – in a particular clinical model. And while this initial training effort occurred 3-4 years ago, training and consultation has continued to be offered. In the process, trauma champions have been identified and today, assist in developing the future goals and efforts of the Department as members of either the Guide

Team or Work Groups. It is anticipated that the Departments' trauma policy will clearly address workforce recruitment – including partnership with educational institutions as well as professional and consumer organizations; hiring practices and strategies that address retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- DMHAS provides trauma training statewide at beginning, intermediate and advanced levels through its Education and Training Division as well as through a sub-grantee, The CT Women's Consortium. Emphasis continues to be on treating PTSD and co-occurring disorders with the emerging best practice models: TREM (Harris), Seeking Safety (Najavits) and TARGET (Ford).
- A second initiative of the Department is to address systems change, becoming a trauma informed service system. As this initiative has been implemented, hiring practices as well as human resource policies are impacted to reflect appropriate staff knowledge and/or familiarity with trauma vis-à-vis formal training or lived experience. Trauma-Informed Training models (Rogers and Russo) are being employed to transform Connecticut's service systems resulting in an increase in trauma-informed organizations and services. (See Criteria 11 for description)
- Forty, state-operated and private non-profit agencies (and their affiliates) and two state hospitals have received year-long, on-site training and supervision on delivering clinical trauma services.
- Statewide Trauma conferences with expert speakers from a variety of behavioral health perspectives.
 - 2001: Women's Conference: Defining A Vision for Behavioral Health Care
 - 2002: Psychological Trauma: Myths and Realities
 - 2003: Cultural, Biological and Psychological Foundations of Trauma
 - 2007: Co-Occurring Conference – Trauma Informed Care Workshop
 - 2007: Domestic Violence Across Communities: Enhancing Expertise – Trauma Informed Delivery Systems
- Training in TARGET, Seeking Safety, and TREM offered yearly statewide. Basic training in *Understanding Trauma* and *Staff Care* offered statewide on a quarterly basis.

- Training program for new hires' organizational orientation and basic training understanding trauma
- Supervision competencies for those supervising direct care staff and clinicians
- Pre-Service training is required of staff in DCF (Department of Children and Families) Family Support Centers, Respite Services, and Short Term Staff Secure Programs. Topics include: Principles of Gender Specific Programming, Understanding the Effects of Trauma, Motivational Interviewing and Crisis Intervention and De-escalation Techniques.
- As the Department's Policy Work Group develops its deliverables, the Guide Team will formally recommend to the Department appropriate policies and/or guidelines with a strategic plan that indicates timeframes for implementation statewide. These policies will include recommendations regarding staff support (supervision) and will also include recommended amendments to job descriptions and postings.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Consumers had a key role in the advisory committee that was formed to develop a strategy for addressing the needs of trauma survivors in the state at the outset of the Trauma Initiative.
- Along with clinical training, each of the agencies involved in the Trauma Initiative participate in a training presented by consumers and based around a film developed by the Department entitled Trauma: No More Secrets. Videotape and guidebook are available.
- Consumers participated in a multi-state study of service utilization by trauma victims, sponsored by the NASMHPD Research Institute and the Bristol Observatory.
- Consumer participation on the Guide Team continues to be solicited.
- Project Lead is a trauma survivor
- Position paper being developed regarding consumer input

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- The Department has identified trauma as one of four areas of priority
- The Department has allocated a discreet amount of funding for consultant services to organizations within the delivery system as they work toward transformation to being trauma informed.
- All training has been provided through state funding from the Department of Mental Health and Addiction Services (DMHAS).
- Adult services are paid for through state grants to providers and Medicaid.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- Currently, the Department is incorporating a “Fidelity Scale – Program Assessment Scale” that was developed by Roger Fallot, Ph.D. identifying domains that measure the organization’s reflection of being trauma informed.
- The Service Delivery Work Group is currently developing the guidelines for working with individuals with histories of trauma

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- Commissioner’s Policy Statements (*Important to note that these policies are currently in review*):
- #22A Seclusion utilization
- #22B Restraint for Behavioral Management
- #22E Behavioral Management in the Outpatient and Community Settings
- #22F Patient personal Safety Preferences for Preventing and Managing Behavioral Dyscontrol

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- Each of the Work Groups or subcommittees of the Trauma Guide Team will be addressing aspects of this element. In particular, the Evaluation Subcommittee will be identifying the data that should be collected including survivor/consumer satisfaction, the protocol on data collection, and meaningful outcome measures. The Service Delivery

Subcommittee will identify and develop the clinical protocols that ensure that screening leads to assessment, and assessment leads to treatment planning. The Policy Subcommittee will also indicate administrative (state) responsibility overseeing and monitoring for adjustments as the entire system moves forward as trauma informed, offering appropriate trauma specific service approaches.

Resources include:

- *Integrated Care*, “draft”, by Eileen Russo, MA, LADC
- Assessment tools from Fallot/Harris
- *Supervision Competencies*, by Eileen Russo, MA, LADC
- *Evaluation of the CT Trauma Center of Excellence*, Jaime Marra, MA

10. Universal trauma screening and assessment.

- A universal trauma screen and assessment tool is being addressed currently in the Department’s Evaluation Subcommittee. This subcommittee will also develop the protocols on the utilization of such instruments as well in order to sustain efforts of a trauma informed system of care.
- Clinical staff throughout the state has been trained to conduct brief screenings for trauma history and PTSD. Screening forms available.
- Trauma screening has been adapted for Project SAFE, to screen parents involved in the child welfare system who are suspected of having substance abuse problems. Screening forms available.

Department of Children and Families (DCF)

- Assessment for trauma history of mothers involved in Project SAFE. When trauma identified it is integrated into treatment. Instruments available.
- DCF has placed staff in three girl’s detention centers to identify girls’ mental health needs and histories of trauma, and to plan services for them to be recommended to the court and ordered by the judge. Evaluation and report forms available.

11. Trauma-informed services and service systems.

- Connecticut has developed a statewide network of trauma services within the mental health and addictions system. The capacity to address the long-term effects of trauma through identification, education, and individual and group treatment has increased significantly over the past three years. To date, more than 200 trauma treatment groups have been conducted. Leadership is also emerging

at the provider level that is now helping to maintain the momentum of this initiative.

- Trauma Center of Excellence (Trauma COE) is now being selected from one of the agencies participating in the Trauma Initiative. With assistance from a CSAT technical assistance grant, the Trauma COE will develop a blueprint for achieving system change in both a trauma and recovery framework and will become a clinical and teaching model in the state. The agency designated as the Trauma COE will be the one that has adopted (and is willing to further enhance) institutional policies, clinical practices, and a clinical culture that addresses the needs of trauma survivors with co-occurring mental health and addiction disorders.
- Trauma Informed Systems Expansion. The Department, with the direction and consultation of Roger Fallot, Ph.D. and Eileen Russo, MA, LADC, has begun replication of the systems change model used for the Trauma COE in other parts of the State. This model includes a 2-day training with a charge for providers to complete agency assessments and develop implementation plans where consultation from Dr. Fallot and Ms. Russo occur. The training audience has included a “host” agency and its affiliated organizations for true “systems” change. Simultaneously, Ms. Russo provides agency-specific training in *Understanding Trauma, Staff Care* and *Supervision Competencies*. She has been very successful in developing a train-the-trainer curriculum and, in identifying “champions” in many organizations who then provide training in the community as well as their respective organizations. In this manner, much of the training has become embedded within the organization’s hiring practices and orientations assuring continuity with new staff hires.

Additionally, a separate but similar process has been initiated with the addictions treatment community with great success. To date, approximately 650-700 individuals have received this training including local hospital staff who immediately employed changes, beginning with their Emergency Room policies.

Dr. Fallot has also developed a “Fidelity Scale” which helps agencies “monitor” their progress in becoming more trauma-informed and also helps the agency identify in a practical way, how/where efforts need to be targeted to raise or attain the “next level” in excellence. (*Trauma-Informed Services: A Self-Assessment and Planning Protocol, Trauma Fidelity Scale*)

Family With Service Needs (FWSN) (Status Offenders)

Family with Service Needs (FWSN) means a family that includes a child who: Has runaway; Is beyond control; Has engaged in indecent

or immoral conduct; Is a truant or habitual truant or defiant of school rules; Is 13 to 15 years old and has engaged in sexual intercourse with a person not more than 2 years older or younger.

A FWSN referral often is the beginning of a child's entry into the Juvenile Justice System and for some, the Criminal Justice System. In an attempt to remedy this, state legislation was passed that a child who was referred to the court as a FWSN could no longer be held in Detention for violating a court order as of October 1, 2007. The same legislation created an Advisory Board to make recommendations for implementing this change, including any additional services needed. The FWSN Advisory Board looked at models in other states including New York and Florida and developed a service delivery system for Connecticut. As result funds of \$3,484,094 in FY 07-08 and \$3,480,782 in FY 08-09 were allocated to service FWSN's who may have previously be sent to Detention. These services include:

- \$2 million for 4 Family Support Centers
- \$252,000 for Expanded Respite Beds
- \$950,000 for Staff Secure Beds (FWSN Centers)
- \$332,094 for 4 staff and Research and Evaluation component

The funds for these programs were given to the Court Support Services Division (CSSD) of the Judicial Branch. Staff from the Department of Children and Families (DCF) collaborated with staff from CSSD on the development of the program models to ensure they would meet the unique needs of girls and boys. Many of these children had prior or current contact with DCF because of allegations of abuse or neglect and have experienced a significant amount of trauma in their homes and communities. CSSD required that the "successful bidder demonstrate programming and services that are gender responsive".

1. Family Support Centers: Four were funded in the areas with the highest number of FWSN referral; Hartford, New Haven, Bridgeport and Waterbury. The plan is to seek additional funding and expand the number of Family Support Centers to serve the whole state. Services provided at the Centers include; Crisis Intervention, Screening and Assessment, Family Mediation, Educational Assessment and Advocacy, and Mental Health treatment and services, including trauma treatment and services.
2. Respite Services: There will be three six bed programs, two for girls and one for boys. Each will provide gender specific programming for girls and for boys. Children referred are

considered high risk due to their history of trauma and running away or being considered “beyond control”. Families are connected with services including Multidimensional Family Therapy (MDFI), Multi systemic Therapy (MST) or Brief Strategic Therapy (BSFT) with the goal of returning the child home after a brief stay (up to 14 days) in Respite.

3. Short Term Staff Secure Programs: There will be one “FWSN Center” for girls and one for boys, each with six beds. A child must have been adjudicated FWSN and found by a judge to either be in violation of a court order, or at imminent danger in order to be sent to a Center. While at the Center the child will be evaluated and services provided so that the child can return home. If a child is not able to return home, alternative plans will be developed including commitment to DCF for out of home placement. A child can remain at the Center for up to 45 days.

Pre-service training is required of staff in all of the programs and will cover numerous topics including; Principles of Gender Specific Programming, Understanding the Effects of Trauma, Motivational Interviewing and Crisis Intervention and De-escalation Techniques. CSSD has also contracted for an evaluation of the effectiveness of these services.

DCF has also begun providing Functional Family Therapy (FFT) to children and their families who are referred to the Juvenile Court as FWSN.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- Seeking Safety: Lisa Najavits: Designed to treat trauma and substance abuse at the same time. It focuses on coping skills to help clients achieve safety in their behavior, thinking, and relationships. Its 25 topics can be flexibly conducted in any order, including: *Compassion, Asking for Help, Setting Boundaries in Relationships, Detaching from Emotional Pain (Grounding), Taking Good Care of Yourself, and Creating Meaning*. It is present-focused, and can be used for group or individual treatment. It has achieved positive results in four outcome trials (with women, men, women in prison, and minority women.). See www.seekingsafety.org
- TARGET Trauma Adaptive Recovery Group Education and Therapy ~ Julian Ford: Ph.D. A strengths-based approach to education and therapy for trauma survivors who are looking for a practical approach to recovery. The goal is to help trauma survivors understand how trauma changes the body and brain’s normal stress response into an *extreme survival-based alarm response*, which can become PTSD. TARGET teaches a

practical seven-step approach, FREEDOM, to changing the PTSD alarm response into personal and relational empowerment that promotes lasting recovery from trauma. TARGET has been adapted to assist people with various types of traumatic experiences (acute trauma, acute or chronic mental illness, domestic violence, addiction) and in different developmental stages (adults, parents, children, adolescents.) See www.PTSDfreedom.org.

- TREM Trauma Recovery and Empowerment Model ~ Maxine Harris, Ph.D.: A three-part psycho educational group model focusing on skill building, trauma education, the development of an understanding of the responses to trauma, and group cohesion or support. Each session is built around one of 33 topics and includes experiential and culturally diverse exercises. The model has achieved an 80 percent retention rate with women who attend at least 75 percent of the sessions. There are separate versions of TREM for men and women that are highly gender specific. TREM is appropriate for consumers with mental health, co-occurring, or addictive disorders.
- Trauma Center of Excellence: Department in conjunction with SAMHSA Center for Substance Abuse Treatment (CSAT) designating single agency to become Trauma Center of Excellence with goal of implementing emerging best trauma treatment practices in each region of the state. The Trauma COE has adopted and is currently working on the Trauma Guide Team assisting the enhancement of its institutional policies, clinical practices in order to address trauma as a core treatment issue for clients with co-occurring psychiatric and addiction disorders and to incorporate clinical issues around trauma with recovery principles. The COE will serve as model for integrating trauma-informed and trauma-specific services throughout all agency programs and will resource for training other agencies. CSAT has provided technical assistance and additional training through the services of Roger Fallot, Ph.D.

Delaware

1. Trauma function and focus in state mental health department.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health Director designated the Disaster Mental Health Coordinator (DMHC) as statewide point of responsibility for trauma-related services. This position coordinates with Mobile Crisis Intervention Unit/Crisis and Psychiatric Emergency Services and reports to the Planning, Policy, and Program Evaluation Unit.

Division of Child Mental Health Services

- Department of Services for Children, Youth and Their Families Division of Child Mental Health Services (DCMHS) operates an accredited, public statewide children's behavioral healthcare system providing comprehensive array of mental health and substance abuse treatment. DCMHS hired a trauma expert as project manager for its \$1.6M 4-year SAMHSA grant to establish a Delaware Child Traumatic Stress Treatment Center, implement TF-CBT statewide, develop trauma-informed child-serving systems and promote public awareness of child traumatic stress in Delaware.

2. State trauma policy or position paper.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health Trauma Policy Statement is in development.

3. Workforce Recruitment, Hiring, and Retention.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health are recruiting for the position of All-hazards and Disaster Administrator. This position will work half time on trauma-related issues and community education, reporting to the DMHC. This position will provide team leadership on assigned projects by planning, assigning, and monitoring work of all-hazards and disaster community response team development. Epidemiologist position being requested for epidemiological research, trends, and analysis.

Division of Child Mental Health Services

- Department of Services for Children, Youth and Their Families Division Child Mental Health Services offers free to providers training on TF-

CBT, including 2 day clinical workshop, up to 16 weekly clinical consultation sessions, fidelity checks via digital session tape review, credential of competency upon successful course completion. Requires prior completion of free 10 credit CEU TF-CBTWEB course available through www.nctsn.org. Uses standardized trauma-informed screening across Children's Department.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health Training Office provides Orientation and continual updated training of all Division employees to work with co-occurring disorder and trauma. The Crisis, Trauma, and Suicide Prevention Workshop: Crisis Counseling in Disasters discusses the scope, prevalence, and psychosocial impact of traumatic events.
- Division of Substance Abuse and Mental Health Mobile Crisis Intervention Services staff are trained in Critical Incident Stress Management which is inclusive of trauma diffusion, debriefing and crisis management and utilizes individual and group brief therapy.
- Division of Substance Abuse and Mental Health Delaware Psychiatric Center (DPC), Community Mental Health Centers (CMHC), Mobile Crisis Intervention Services (MCIS) and Detoxification Center staff are trained in understanding the impact of trauma. De-escalation techniques are utilized to avoid or minimize the need for restraint and seclusion interventions. CMHC, MCIS and Detoxification Centers are restraint and seclusion free, and DPC aspires to be restraint and seclusion free.
- Division of Substance Abuse and Mental Health Training Office provides CPI: Non-Violent Crisis Intervention Training to all staff and new hires. This office includes annual refresher training for staff.

The Comprehensive Trauma Series: The Developmental Effects of Trauma (Vicki Kelly, LCSW, PsyD, MHA) provides a comprehensive study in the impact of trauma on an individual's development and behavior. Series includes:

- Part I-The Role of Attachment
- Part II- The Trauma of Child Maltreatment
- Part III-Trauma and Affect Regulation
- Part IV-The Effects of Trauma on Brain Development
- Part V-Trauma and Cognitive Functioning
- Part VI-Trauma and the Self System
- Part VII-Trauma and Interpersonal Functioning

The Evidence Based & Best Practices Workshop: Moving Beyond Trauma and into Recovery: Cognitive-Behavioral Therapy for Addicted Women with Children addresses distinct patterns of trauma, treatment avoidance and resistance, clinical presentations, and relapse patterns among women with traumatic stress. It also discusses current models of cognitive-behavioral therapy in treating addiction and trauma.

- Dr. Carla Storr, ScD., Johns Hopkins Bloomberg School of Public Health Grand Rounds Presentation on Trauma and Stress Disorders
- Mobile Crisis Intervention Services provides community-based psychological crisis/trauma sensitive training to individuals, community-based organizations and law enforcement.

Division of Child Mental Health Services

Department of Services for Children, Youth and Their Families Division of Child Mental Health Services offers the following:

- Annual clinical conference on child traumatic stress featuring nationally recognized expert presenters. More than 220 individuals attended the most recent conference in Sept. 2007.
- Free APA continuing education credits for trauma training and clinical workshops
- Statewide free training on TF-CBT
- Certificate of competency on successful completion of TF CBT training
- Annual refresher TF-C BT workshop required for ongoing certification

Division of Child Mental Health Services also:

- Provides free training in TF-CBT to providers, certifies competency
- Providers training on child traumatic stress, often using training toolkits developed by the National Child Traumatic Stress Network, for other child-serving systems
- Provides training in child traumatic stress and develops referral protocols with every public school in Delaware (210+)

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health recipients of state services or family members are involved in the planning process and to help with the formulation of policy and programs, service delivery, orientation for new hires, and problem solving for barriers to accessing needed services.

- Division of Substance Abuse and Mental Health Office of Consumer Affairs has organized a consumer group to provide input into The Consumer Recovery Advocacy Coalition of Delaware (CRACD) is a group of consumers of state provided services.
- CRACD is developing a strategic plan, including how to develop consumer peer services. Consumer representation on Governor's Advisory Council, the state planning and advisory council. Consumer advisory councils at most of our case management agencies.

Division of Child Mental Health Services

- Division of Child Mental Health Services is an accredited managed behavioral healthcare organization and provides the DCMHS HANDBOOK for Child/Family Entering Care to every child/family entering at any level of our system (crisis or outpatient to inpatient psychiatric hospital). This handbook provides a general orientation to the Delaware public children's behavioral healthcare system operated by DCMHS, the services provided, how the DCMHS clinical services management team works directly with children/families in care, and how to make a complaint or grievance (including Medicaid Fair Hearing request process).
- DCMHS' system is HIPAA compliant, with appropriate consent to treat and information sharing consents in place. There is a Children's Department Confidentiality policy which guides practice as well as a DCMHS Policy on Confidentiality.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

Division of Child Mental Health Services

- Division of Child Mental Health Services' \$1.6M 4-yr. SAMHSA Child Traumatic Stress Treatment Center Grant currently funds most of the division's activities relating to trauma, including:
 - Statewide TF-CBT Pilot (3 full time therapists)
 - Training 100% of outpatient mental health providers in TF-CBT/EBP
 - Developing trauma-informed child serving systems
 - Increasing public awareness of child traumatic stress and effective treatment

7. Clinical practice guidelines for working with children and adults with trauma histories.

- Division of Substance Abuse and Mental Health Mobile Crisis Intervention Services staff are trained in Critical Incident Stress Management which is inclusive of trauma diffusion, debriefing and crisis management and utilizes individual and group brief therapy.

Division of Child Mental Health Services

- Guidelines exist for the child traumatic stress grant TF-CBT pilot and DCMHS outpatient providers using TF CBT Intervention.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health Trauma Policy Statement is in development.
- Delaware Psychiatric Center Seclusion and Restraint Policy includes minimizing restrictive/coercive measures and use of counseling for trauma that may have been experienced from the incident.
- Mobile Crisis Intervention Services (MCIS) trauma-sensitive Policy on Use of Police includes limiting involvement of law enforcement when possible to alleviate increased anxiety and stress, which may contribute to experienced psychological trauma by the individual. MCIS makes every effort to conduct therapeutic assessments in the least intimidating environment when responding to critical incidents in the community.
- Division of Substance Abuse and Mental Health Delaware Psychiatric Center (DPC), Community Mental Health Centers (CMHC), Mobile Crisis Intervention Services (MCIS) and Detoxification Center staff are trained in understanding the impact of trauma. De-escalation techniques are utilized to avoid or minimize the need for restraint and seclusion interventions. CMHC, MCIS and Detoxification Centers are restraint and seclusion free, and DPC aspires to be restraint and seclusion free.
- Division of Substance Abuse and Mental Health Training Office provides CPI: Non-Violent Crisis Intervention Training to all staff and new hires. This office includes annual refresher training for staff.

Division of Child Mental Health Services

- Established TF-CBT as the treatment of choice statewide at the outpatient level of care for children with PTSD
- Statewide use of standardized initial screening for children entering care in child mental health, foster care and juvenile justice 24 hour services for

child traumatic stress, with linkage to trauma-specific treatment as indicated

- Statewide protocol for referral for children screening positive for child traumatic stress to trauma-specific treatment
- Provides free training in TF-CBT to providers, certifies competency
- Provides training on child traumatic stress, often using training toolkits developed by the National Child Traumatic Stress Network, for other child-serving systems
- Provides training in child traumatic stress and develops referral protocols with every public school in Delaware (210+)

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health is recruiting for the position of Epidemiologist, which will assist in the research to explore prevalence and impacts of trauma.

Division of Child Mental Health Services

- Uses standardized screening statewide to identify youth with child traumatic stress/link to trauma-specific treatment as indicated
- records care management and service utilization data (including cost of service, type of service, unit of service, provider, location, etc. – encounter data) in a state-of-the-art integrated electronic information management system called FACTS (Family and Child Tracking System).

10. Universal trauma screening and assessment.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health universal screening and assessments include but are not limited to BioPsychoSocial Assessment Intake, Suicide potential screening, Violence potential screening, Cognitive Behavioral Intervention: Cognitive restructuring, and the Step-wise Approach stages for trauma focused intervention (Hillman, J., 2002): develop trust and rapport, defining the problem, assessing danger and assuring safety, assessing coping skills, structuring the therapeutic relationship, providing psychoeducation, collaborating upon goals, mobilizing social

support, supplying a transitional object, maintaining professional boundaries, providing appropriate documentation, acknowledging counter transference, follow-up.

Division of Child Mental Health Services

- Statewide use of standardized initial screening for children entering care in child mental health, foster care and juvenile justice 24 hour services for child traumatic stress, with linkage to trauma-specific treatment as indicated
- Statewide protocol for referral for children screening positive for child traumatic stress to trauma-specific treatment
- The standard screen at entry to the service system is the DCMHS EPSDT Screen for child mental health and substance abuse. Where there are positive responses to any of the 5 trauma-related questions on that screen, the second level screen is to be administered (UCLA Reaction Index). Where the UCLA RI indicates likely PTSD diagnosis, the child/family is referred to trauma-specific treatment (TF CBT).

Division of Child Mental Health Services

- The standard screen at entry to the service system is the DCMHS EPSDT Screen for child mental health and substance abuse. Where there are positive responses to any of the 5 trauma-related questions on that screen, the second level screen is to be administered (UCLA Reaction Index). Where the UCLA RI indicates likely PTSD diagnosis, the child/family is referred to trauma-specific treatment (TF CBT).

11. Trauma-informed services and service systems.

Division of Substance Abuse and Mental Health

- Division of Substance Abuse and Mental Health services are trauma-informed through ongoing staff training.

Division of Child Mental Health Services

- Statewide child mental health crisis service. All children receiving service are screened at entry, provided second level screen as indicated (UCLA RI) and referred/linked to trauma-specific treatment where appropriate.
- Statewide DCMHS children's behavioral healthcare system – all children are screened for trauma/PTSD on entry to system. Next step: full implementation of second level screen for PTSD as

indicated by initial screen. This system includes a toll –free 1-800 number where the public can call for information and referral. Staff is trained in child mental health/child traumatic stress and can assist people seeking services/treatment.

- Juvenile Justice --- The 24 hr service system (Secure Care and Detention statewide) is a trauma-informed system. There is screening of youth for child traumatic stress and PTSD and linkage to treatment as indicated by screen. Currently, Probation Officers statewide are being trained to conduct initial screening for child mental health/child traumatic stress and to refer youth who may benefit trauma-specific treatment. Early training is yielding informed referrals from probation officers, a very promising start. Also gender-specific trauma-informed intervention (Life Skills/Life Story) is used with girls on Probation.
- Child Welfare: All children entering foster care (aged 4-17 yrs) receive initial behavioral health screen that is trauma-informed. If indicators for child traumatic stress are positive, second level screen is done – if positive, referred/linked to trauma-specific treatment (TF-CBT)
- Children’s Advocacy Centers Statewide are trained in and competent in identification of children with PTSD symptoms and referral/linkage to trauma-specific treatment (TF CBT)
- Law Enforcement – 700+ trained law enforcement officers and victims assistance workers in north Delaware including at the municipal, county and state levels. Trained in how to identify youth who may benefit from mental health treatment, including specifically youth with symptoms of child traumatic stress/PTSD and how to make an informed referral for treatment/services.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Division of Substance Abuse and Mental Health

Division of Substance Abuse and Mental Health provides individual and group counseling for consumers by clinicians with expertise in trauma-related occurrences. Consumers are provided services including but not limited to: psychoeducation, crisis support and management, brief therapy and psychopharmacotherapy.

Division of Child Mental Health Services

Is implementing state-wide use of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children with PTSD at the outpatient level of care and is also providing TF CBT at the intensive outpatient level of care (home-based services, more intense than office-based TF CBT) as part of the National Child Traumatic Stress Network’s East Coast TF CBT Learning

Collaborative. The Division has identified Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as the treatment of choice for children with PTSD treated in the outpatient level of care.

Uses Life Skills/Life Story, trauma-specific mental health intervention with girls who are on probation in the juvenile justice system (pilot). Local grant.

District of Columbia

1. Trauma function and focus in state mental health department.

- There is no specific trauma function or focus within the state mental health authority.
- However, the Child/Youth Services Division, which is within the state mental health authority and Saint Elizabeth's Hospital, the District of Columbia's state psychiatric hospital began working on trauma-informed care initiatives in FY 07, which will continue into FY 08. (See 9: Research; and see 12:Trauma Specific Services)

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

Private, community-based providers may have instituted policies and procedures regarding the recruitment, hiring and retention of trauma competent staff.

- DC Department of Mental Health's Training Institute sponsors several trauma-related trainings available to clinicians from all Mental Health Core Service Agencies in the city. This year trauma training topics included: Working with Adult Survivors of Trauma, Trauma Recovery and Empowerment Model, An Unexpected Trauma for Youth, and Domestic Violence

In FY 2008, all CBI providers are required to complete Ohio Mental Health Scales (OMHS) at 90-day intervals for all CBI-enrolled youth.

In FY 2008, the CBI training program will be repeated, with local training faculty, and the model will be employed for Trauma Focused Cognitive Behavioral Therapy (TF CBT) and Behavioral Coaching. DMH trained approximately 25 clinicians from its network in TF CBT in 2005. Today, only two clinicians continue to offer this therapy due to turnover and other institutional support factors.

Community Connections:

- Trauma issues are introduced to all staff, including administrative staff, residential and vocational counselors, substance abuse counselors, and case managers, through brief orientation and training using curriculum and Women Speak Out, a video of women sharing their lived experiences

with abuse and trauma. Monograph, Protocol, Curriculum and Video available

- A Self-Assessment and Planning Protocol is used to ensure all levels of the organization, staff, services and programs have understanding of trauma and the impact of trauma in shaping a consumer's response to subsequent experience.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

DMH Child/Youth Services Division Trauma-Informed Care Initiative

The Department of Mental Health's Child/Youth Services Division will be using the results of its FY2007 clinical study on Community Based Intervention to serve as a model for baseline and ongoing studies for Trauma-Focused CBT and Behavioral Coaching; training for both interventions will be implemented in FY 2008 and baseline chart reviews will follow. A second dimension of service quality analysis is outcomes assessment. In FY 2008, all CBI providers are required to complete Ohio Mental Health Scales (OMHS) at 90-day intervals for all CBI-enrolled youth.

In FY 2008, the CBI training program will be repeated, with local training faculty, and the model will be employed for Trauma Focused Cognitive Behavioral Therapy (TF CBT) and Behavioral Coaching. DMH trained approximately 25 clinicians from its network in TF CBT in 2005. Today, only two clinicians continue to offer this therapy due to turnover and other institutional support factors.

Saint Elizabeths Hospital Trauma-Informed Care Initiative

Saint Elizabeths Hospital, the District of Columbia's state hospital has engaged Dr. Joan Gillece through the National Association of State Mental Health Program Directors (NASMHPD) funding from SAMSHA to provide technical assistance with regard to the provision of trauma informed care. Dr. Gillece conducted an overview of trauma informed care for all of the Hospital staff during the summer of 2007.

Two units at Saint Elizabeths Hospital (RMB 6 and JHP 6) have been identified to pilot staff training on trauma informed care. Additional staff training on trauma-informed care will be scheduled for those units in FY 2008.

- DMH sponsors a half-day introductory trauma training for social work field placement students at St. Elizabeth's hospital.

In FY 2007, the District of Columbia Department of Mental Health, Training Institute offered the following training about trauma:

- Trauma Recovery Empowerment Model
- Introduction to Trauma in Male and Female Consumers
- Divorce: Unexpected Trauma

Additional training about trauma and trauma-informed care is planned for FY 2008.

Community Connections

- All potential employees are asked question regarding their knowledge and experience in working with trauma issues
- All new staff receive introductory orientation in trauma.
- Integrated Trauma Services Team's staff are trained in trauma-specific interventions (e.g. mindfulness; grounding) to assist clients in managing trauma symptoms. Training for ITS Teams are drawn from Risking Connection and TREM. Ongoing support and individual and group supervision is emphasized.
- Linkages with higher education : Between eight and fifteen social work students per year: field placement at Community Connections agency. All students exposed to trauma-informed model via placement and supervision and introduction to trauma orientation component.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

On September 26, 2007, the Department of Mental Health and the State Mental Health Planning Council co-sponsored a mental health conference about trauma-informed care. The Seventh Annual Judge Aubrey E. Robinson, Jr., Memorial Mental Health Conference was entitled: "Recovery Through the Ages: Trauma Informed Care." The keynote speaker for the conference was Joan Gillece, Ph.D., Project Director, National Coordinating Center for the Seclusion and Restraint Initiative National Association of State Mental Health Program Directors/National Technical Assistance Center for State Mental Health Planning. The conference included three panels discussing the Trauma Knowledge Utilization project, Specific Service Issues and Service Integration.

Conference attendees included consumers, clinicians and advocates. Approximately 250 people attended the conference.

Community Connections:

- Community Connections Consumer Advisory Board meets regularly to advise on policies and procedures.

- Women's Empowerment Center: a drop-in center for women mental health consumers who also may be or have been homeless and/or dually diagnosed with a substance use disorder, where the common thread is an extensive history of trauma and abuse. Consumer/survivors operate the Center, run educational groups and welcome new consumers, introducing them to opportunities for trauma recovery available at Community Connections.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Community Connections
 - TREM is a Medicaid reimbursable community support group treatment.

7. Clinical practice guidelines for working with children and adults with trauma histories.

Community Connections

- Trauma Recovery and Empowerment Profile (TREP) outlines 11 dimensions of recovery and menu of clinically appropriate strategies for intervening. TREP and A Menu of Strategies for Improving a Woman's Trauma Recovery and Empowerment Profile available

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

DMH has not adopted policies, procedures, rules, regulations or standards to support access to trauma treatment, develop trauma-informed service systems or avoid re-traumatization. However, DMH expects that Saint Elizabeths Hospital will be adopting such policies as part of its trauma-informed care initiative.

Private, community-based providers may have instituted policies, procedures and standards to support access to trauma treatment, develop trauma-informed service systems or avoid re-traumatization.

Community Connections:

- Community Connections Agency has applied its model of Using Trauma Theory to Design Service Systems to every aspect of its agency to provide safety and avoid re-traumatization. Wellness Recovery Action Plan (WRAP) is a component of treatment planning.

9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**

DMH Child Youth Services Division Trauma-Informed Care Initiative

The Department of Mental Health's Child/Youth Services Division will be using the results of its FY2007 clinical study on Community Based Intervention to serve as a model for baseline and ongoing studies for Trauma-Focused CBT and Behavioral Coaching; training for both interventions will be implemented in FY 2008 and baseline chart reviews will follow. A second dimension of service quality analysis is outcomes assessment. In FY 2008, all CBI providers are required to complete Ohio Mental Health Scales (OMHS) at 90-day intervals for all CBI-enrolled youth.

In FY 2008, the CBI training program will be repeated, with local training faculty, and the model will be employed for Trauma Focused Cognitive Behavioral Therapy (TF CBT) and Behavioral Coaching. DMH trained approximately 25 clinicians from its network in TF CBT in 2005. Today, only two clinicians continue to offer this therapy due to turnover and other institutional support factors.

Community Connections, Inc.

- NIMH-funded four-year study of the Trauma Recovery and Empowerment Model (TREM) groups for women. This study is an important next step that builds on the positive findings regarding TREM in the recently completed District of Columbia Trauma Collaboration Study. Enrolling 300 women trauma survivors with PTSD and severe mental health problems, the study design includes two conditions. 150 women will receive a full range of mental health and other community support services while 150 will participate in TREM groups in addition to the usual services. As a "randomized controlled trial" of TREM, women who agree to participate in the study will be assigned by chance to one of the two conditions. One of the two sites is at Community Connections in Washington, DC, the other is at North Baltimore Center in Baltimore, MD.
- Developers of the Men's Trauma Recovery and Empowerment Model (M-TREM) were awarded an intervention development (R34) grant from NIMH in 2005. This three-year study provides support for 1) refining the group manual based on feedback from men participants and from group leaders at various sites that have implemented M-TREM; and 2) conducting a small, randomized

controlled trial of M-TREM's effectiveness in reducing PTSD symptoms and other difficulties among men diagnosed with severe mental health problems.

10. Universal trauma screening and assessment.

Community Connections, Inc.

- All new intakes are asked about trauma and abuse during the initial intake interview, with clinical discretion used to determine extent of questioning..
- QI checks to see that treatment plans and treatments delivered are those suggested by responses to intake questions.

11. Trauma-informed services and service systems.

Saint Elizabeths Hospital Trauma-Informed Care Initiative

- Saint Elizabeths Hospital, the District of Columbia's state hospital has engaged Dr. Joan Gillece through the National Association of State Mental Health Program Directors (NASMHPD) funding from SAMSHA to provide technical assistance with regard to the provision of trauma informed care. Dr. Gillece conducted an overview of trauma informed care for all of the Hospital staff during the summer of 2007.
- Two units at Saint Elizabeths Hospital (RMB 6 and JHP 6) have been identified to pilot staff training on trauma informed care. Additional staff training on trauma-informed care will be scheduled for those units in FY 2008.
- The Child/Youth Services Division, which is within the state mental health authority and Saint Elizabeths Hospital, the District of Columbia's state psychiatric hospital began working on trauma-informed care initiatives in FY 07, which will continue into FY 08.

Community Connections

- Community Connections Inc. provides comprehensive trauma-informed mental health, addiction and residential services, and trauma-specific treatment services, to residents of District of Columbia and Montgomery County, Maryland.
- Community Connections. Co-Directors created and published monograph "Using Trauma Theory to Design Service Systems" based on experience integrating understanding about trauma into agency's core service programs. The model takes a systems change approach, using A Self-Assessment and Planning Protocol to ensure all levels of the organization, staff, services and programs have understanding of trauma and the impact of trauma in shaping a consumer's response to subsequent experience.

- Trauma issues are introduced to all staff, including administrative staff, residential and vocational counselors, substance abuse counselors, and case managers, through brief orientation and training using [curriculum](#) and [Women Speak Out](#), a video of women sharing their lived experiences with abuse and trauma. [Monograph, Protocol, Curriculum and Video available](#). Trauma-informed services include:
- Integrated Trauma Service Teams (ITSTs) emphasize the development of key skills in trauma recovery and empowerment. [Trauma Recovery and Empowerment Model \(TREM\)](#) groups and the accompanying self-help workbook are the core trauma interventions. Additional groups address substance abuse and trauma, parenting, domestic violence, and spiritual resources for recovery. Peer-run programs include activities at a Women’s Support and Empowerment Drop-In Center.
- [Women’s Empowerment Center](#): a safe and caring environment where abused women can drop in, unwind and be supported by one another in their recovery. Women have been or are homeless, substance abusers and suffering from mental illness, but the common thread is extensive history of trauma and abuse. Center is operated by consumer/survivors who run educational groups and welcome new consumers, introducing them to opportunities for trauma recovery available at Community Connections. [Description available](#)

[Community Connections has developed a number of group leader manuals for the following trauma-informed modules:](#)

- S-TREM, a self-help model combining TREM with “Healing the Trauma of Abuse: a Women’s Workbook.”
- [Parenting Skills](#) groups using 2 manualized interventions: [The Impact of Early Trauma on Parenting Roles](#), addressing the impact trauma has on women’s efforts to parent, and [Parenting at a Distance](#), on the specific parenting issues faced by women who are not able to be the full-time custodial parent for their dependent children. A third intervention [A Trauma Informed Approach to Parenting Skills](#) from book [Trauma Recovery and Empowerment: A Clinicians Guide](#), is also used. [Manuals and book available](#).
- [Domestic Violence Group Intervention](#). Assists women to break the cycle of abuse. [Leaders Manual available](#)
- [HIV and AIDS Psycho education and support groups](#) using group treatment intervention and manual [Trauma Issues Associated with HIV Infection](#). [Manual available](#).

- Spirituality in Trauma Recovery group, addresses spiritual and religious resources for empowerment and recovery. Manual available
- Trauma-Informed Addictions Treatment, a psycho-educational group intervention. Manual available
- Residential services and housing support services based on a trauma-informed perspective. See Trauma-Informed Approaches to Housing, chapter in Using Trauma Theory to Design Service Systems. Book available.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

DMH Child/Youth Services Division Trauma-Informed Care Initiative

In FY 2008, the CBI training program will be repeated, with local training faculty, and the model will be employed for Trauma Focused Cognitive Behavioral Therapy (TF CBT) and Behavioral Coaching. DMH trained approximately 25 clinicians from its network in TF CBT in 2005. Today, only two clinicians continue to offer this therapy due to turnover and other institutional support factors.

Community Connections

- Community Connections Inc. provides comprehensive trauma-informed mental health, addiction and residential services, and trauma-specific treatment services, to residents of District of Columbia and Montgomery County, Maryland.
- Intensive Trauma Services Team: women who have experienced sexual or physical abuse in childhood or adulthood receive integrated and fully trauma-informed clinical services. Staff specially trained to address issues related to PTSD disorders. Description available
- Women's Empowerment Center: a safe and caring environment where abused women can drop in, unwind and be supported by one another in their recovery. Women have been or are homeless, substance abusers and suffering from mental illness, but the common thread is extensive history of trauma and abuse. Center is operated by consumer/survivors who run educational groups and welcome new consumers, introducing them to opportunities for trauma recovery available at Community Connections. Description available
- Gender-specific TREM and M-TREM model (Trauma Recovery and Empowerment and Men's Trauma Recovery and Empowerment), and G-TREM for adolescent girls groups are offered for male and female

consumers who have experienced abuse and violent victimization during their lives. Self-Help manual “Healing the Trauma of Abuse: a Women’s Workbook” by Mary Ellen Copeland and Maxine Harris, is used as part of the Women’s TREM program. Manuals and materials available. See SAMHSA’s National Registry of Evidence-based Programs and Practices at website address <http://nrepp.samhsa.gov/find.asp>

- S-TREM, a self-help model combining TREM with “Healing the Trauma of Abuse: a Women’s Workbook.”
- Parenting Skills groups using 2 manualized interventions: The Impact of Early Trauma on Parenting Roles, addressing the impact trauma has on women’s efforts to parent, and Parenting at a Distance, on the specific parenting issues faced by women who are not able to be the full-time custodial parent for their dependent children.
- Domestic Violence manualized group treatment intervention. Manual available
- HIV and AIDS Psycho education and support group using group treatment intervention and manual Trauma Issues Associated with HIV Infection
- Spirituality in Trauma Recovery group, addresses spiritual and religious resources for empowerment and recovery. Manual available
- Trauma-Informed Addictions Treatment, a psycho-educational group intervention. Manual available

Florida

1. Trauma function and focus in state mental health department.

- The Florida Department of Children and Families Substance Abuse and Mental Health Services Plan 2007-2010 enumerates the areas where trauma-informed services have been implemented.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Substance Abuse and Mental Health Agencies in three counties: Polk, Highlands, Hardee, staff and consumers are trained to co-facilitate TRIAD Women's Group model, addressing substance abuse and mental health psycho-educational skills and trauma issues.
- Part of the mental health treatment facility internal training on seclusion and restraint has an emphasis on personal safety and individual preferences and a focus on verbal de-escalation and behavioral triggers so seclusion and restraint can be avoided.

Each of the mental health treatment facilities has:

- Received training from the National Association of State Mental Health Program Directors on Creating Violence Free and Coercion Free Environments
- Provided internal training with an emphasis on personal safety and individual preferences and a focus on verbal de-escalation and behavioral triggers so seclusion and restraint can be avoided
- Developed comprehensive action plans to achieve reductions of seclusion and restraints and create an environment consistent with trauma informed care
- Collected and monitored data relative to Seclusion and Restraint on an ongoing basis

Cross Training and Continuity of Care: In December of 2005, cross training was provided by the National Association of State Mental Health Program Directors for State Inpatient Psychiatric Programs and residential facilities contracted by the Department of Juvenile Justice. This training focused on:

- the effects of trauma in the lives of children served by both systems
- the possible impact on behavior of this trauma

- the additional effects introduced by the use of seclusion and restraint

Children’s Mental Health staff serve on the Department of Juvenile Justice’s Trauma Informed Care Leadership Committee and the Leadership Council for Florida’s Comprehensive Approach to Managing Juveniles who Sexually Offend.

The University of South Florida – Community Trauma Research Group, hosted by the Louis de la Parte Florida Mental Health Institute at the University of South Florida, was convened to provide a forum to promote transdisciplinary approaches to prevention, intervention and research on trauma across the lifespan and to understand its biological, psychological and societal effects. The purpose of the forum is to create opportunities for the USF community for mutual education, networking and collaboration to address this pressing and widespread issue. To date, participants have looked at traumatic stress as a result of child physical and sexual abuse, interpersonal violence, disasters, and war.

Meetings of the Trauma Research Group are held on the third Wednesday of each month at the Louis de la Parte Florida Mental Health Institute, Room MHC 1503.

The workgroup has developed a “Many Faces of Trauma “ series. The inaugural event was a conference with keynote speaker Ann Jennings. A series of lectures are offered by trauma scholars across the year for faculty, students, and community members covering trauma issues for populations across the developmental lifespan and for trauma related to abuse, violence, natural disasters, and war.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Wisdom of Women, Inc. A peer support group for women affected by substance abuse, mental illness, and trauma. Draws on traditional peer support group models with modifications sensitive to the women.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Currently collaborating with the Florida Department of Juvenile Justice on a grant for funding of trauma-informed care.
- Florida’s Administration for Healthcare Agency (AHCA) contracts with Florida Mental Health Institute to analysis services funded by Medicaid. A current study is evaluating facilities for children with SED to determine the level of trauma-informed care. This fall they will evaluate

the Triad Girls' Group, an intervention for adolescent girls with abuse issues, emotional problems, and substance use issues as implemented in out-of-home care facilities.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- Part of the mental health treatment facility internal training on seclusion and restraint has an emphasis on personal safety and individual preferences and a focus on verbal de-escalation and behavioral triggers so seclusion and restraint can be avoided. Figure where to move this!

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

Procedures to avoid retraumatization and reduce the impacts of trauma is a component of both the mental health treatment facilities and the juvenile justice trauma-informed care procedures.

- Baker Mental Health Act includes regulations on recommended interventions and protections for the rights of people with mental illness. Stipulates trauma assessment.
- Mental health treatment facilities seclusion and restraint procedures have been revised to include trauma-informed care.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

The University of South Florida – Community Trauma Research Group, hosted by the Louis de la Parte Florida Mental Health Institute at the University of South Florida, was convened to provide a forum to promote transdisciplinary approaches to prevention, intervention and research on trauma across the lifespan and to understand its biological, psychological and societal effects. The purpose of the forum is to create opportunities for the USF community for mutual education, networking and collaboration to address this pressing and widespread issue. To date, participants have looked at traumatic stress as a result of child physical and sexual abuse, interpersonal violence, disasters, and war.

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One of the Women, Co-Occurring Disorders and Violence Study sites located in the state: Triad Women’s Project, Central Florida:

- A substance abuse prevention, intervention and treatment agency and local mental health provider are partnering to offer services in rural Florida.
- Key service components: Triad has developed a 16-session, trauma-specific group intervention that addresses the interaction of substance abuse, mental health and violence, and also emphasizes cultural differences. An integrated trauma-informed case management system was also developed. Both the group and the case management model are manualized. The project’s peer-run group provides on-going community-based support for women once they have completed the Triad trauma group.
- SPARCC Project: See web site above. Contact hills@fmhi.usf.edu

10. Universal trauma screening and assessment.

- State Mental Health Act (Baker Act) recommends every individual consumer be screened for a history of trauma. This is part of state regulations.
- An Integrated BioPsychosocial Assessment includes questions about trauma, mental health and substance abuse and is used in substance abuse and mental health agencies in a three county area.

11. Trauma-informed services and service systems.

Both the mental health treatment facilities and the juvenile justice system have adopted procedures to avoid retraumatization and reduce the impacts of trauma.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- MH and SA abuse systems in three county, semi-rural district in Central Florida collaborate in cross-training and co-leading TRIAD Women’s

Groups addressing substance abuse, mental health, and trauma issues, cooperate on case management issues, and have developed a trauma-informed, integrated biopsychosocial assessment. Fleisher – Bond, M., Clark, C., Rich, A., Becker, M., Giard, J. (May 28, 2004) Final Report of the TRIAD Women's Project. Tri-County Human Services, Inc., Lakeland, Florida. (taken from systems integration criteria)

More intense recovery services were provided by Project Recovery, a supplementary grant from the Florida Department of Health and Human Services. Through Project Recovery, interdisciplinary teams were paced in the counties that were most impacted by the storms of 2004. The services were for survivors experiencing long-term emotional recovery issues. The techniques employed were service models developed by the National Center for Post-Traumatic Stress and the National center for Child Trauma, and will also be implemented in future disaster recovery services.

Polk, Highlands, Hardee Counties

- TRIAD Women's Group model, manualized, trauma-specific psychoeducational skills- based group intervention developed as part of WCDVS study, now used in local substance abuse and mental health agencies, inpatient and residential facilities and jails in large three-county area (Polk, Highlands, Hardee) in semi-rural, central Florida. Hispanic, African American and Caucasian women with histories of trauma, and substance abuse and/or mental health problems. Triad Women's Project Group Facilitator's Manual available.
- TRIAD Girls Group model implemented at two sites for adolescent girls with substance abuse problems and abuse and violence issues. Triad Girls' Group Treatment Manual available.
- Wisdom of Women, Inc. A peer support group for women affected by substance abuse, mental illness, and trauma. Draws on traditional peer support group models with modifications sensitive to the women.

Hawaii

1. Trauma function and focus in state mental health department.

The Adult Mental Health Division's (AMHD) special populations service director has the lead responsibility within the state office for this initiative. The Hawaii Center for Evidence Based Practice (A partnership between AMHD and the University of Hawaii) is discussing steps to address this area.

The Adult Mental Health Division leadership has identified six strategic priority areas to focus on during the next four years (July 2007 through June 2011). One of the six areas outlined in the strategic plan is recovery-based system of care and one of the plans to support the recovery-based system of care is the development of a trauma informed mental health system that provides trauma-specific services. A group of administrators, providers, researchers, family members and consumers will be convened in 2008 to move forward with this initiative. The AMHD strategic plan is expect to be on the amhd.org website in January 2008.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

A. The Hawaii State Hospital has two policies and procedures that relate to trauma: (1) Seclusion or Bodily Restraint (#04.250); (2) Abuse, Neglect, Sexual Harassment and Exploitation Prevention (#04.011). The first P&Ps requires that staff training concerning seclusion or restraints includes learning about the patient's experience of such episodes. Staff development is also responsible to provide training on Conflict Prevention Management Resolution for all staff that will be providing care to patients at Hawaii State Hospital. The second P&P specifically requires training to all new employees on identification, intervention, and prevention of sexual harassment and exploitation of patients on an annual basis.

B. MISA Coordinators, who ensure that mental illness and substance abuse services are provided with current Adult Mental Health Division and professional standards, are located in community mental health centers throughout the public mental health system. All MISA coordinators have been trained in the use of Seeking Safety. The Seeking Safety curriculum was also provided to providers in the Child and Adolescent Mental Health Division, Department of Health through a Joint Division Work Group. Staff at a local women's shelter were also trained in Seeking Safety so that Seeking Safety Groups could be offered.

Available Documents:

The Hawaii State Hospital P&Ps can be found at:

<http://www.hsh.health.state.hi.us/P&P/MasterList.asp?Sort=Heading>

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**

The Hawaii State Hospital has two policies and procedures that relate to trauma: (1) Seclusion or Bodily Restraint (#04.250); (2) Abuse, Neglect, Sexual Harassment and Exploitation Prevention (#04.011).

Available Documents:

The Hawaii State Hospital P&Ps can be found at:

<http://www.hsh.health.state.hi.us/P&P/MasterList.asp?Sort=Heading>

9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**

Two questions have been added to the AMHD's Self-Report Quality of Life

Interview that ask consumers about violent and non-violent victimization in the prior six months. Consumers receiving community based services complete the QOLI on admission into services, every six months during services, and on discharge.

Quality Improvement at the Hawaii State Hospital maintains a seclusion or restraint database on all episodes of seclusion and any type of restraint used at the hospital. Quality improvement provides a monthly report of seclusion or restraint usage, included any significant trends to the Performance Improvement Committee and Special Interventions Sub-Team. The Medical Director also monitors all use of seclusion or restraint on a daily basis. A "Patient Post Event Interview" is also completed by nursing staff to learn about the patient's experience of the episode. Finally, a De-escalation Assessment Form is completed upon admission to Hawaii State Hospital and annually to identify the techniques and methods that have previously helped deescalate and manage aggressive behavior, to ensure that patients

preferences for de-escalation are assessed, documented in the kardex and offered during episodes of de-escalation or restraint whenever possible, and to determine if a seclusion or restraint is contraindicated due to history of physical or sexual abuse, or other limitations.

Available Documents:

The QOLI survey can be found at:

<http://amh.health.state.hi.us/Public/REP/EvaluationInstruments.htm>

The Patient Post Event Interview (Attachment E Policy 04.250) can be found at:

<http://www.hsh.health.state.hi.us/P&P/MasterList.asp?Sort=Heading>

The De-Escalation Assessment Interview Form (Attachment A Policy 04.250) and the Flyer with Description and Color Coding of Stickers (Attachment F Policy 04.250) can be found at:

<http://www.hsh.health.state.hi.us/P&P/MasterList.asp?Sort=Heading>

10. Universal trauma screening and assessment.

The Hawaii State Hospital's policy and procedure on "Abuse, Neglect, Sexual Harassment and Exploitation Prevention (#04.011)" requires that all patients are screened for abuse and neglect, including: rape, sexual molestation, domestic abuse, elder neglect or abuse, child neglect or abuse, and physical assault.

A De-escalation Assessment Form is completed upon admission to Hawaii State Hospital and annually to identify the techniques and methods that have previously helped deescalate and manage aggressive behavior, to ensure that patients preferences for de-escalation are assessed, documented in the kardex and offered during episodes of de-escalation or restraint whenever possible, and to determine if a seclusion or restraint is contraindicated due to history of physical or sexual abuse, or other limitations.

Available Documents:

The Criteria for Identification and Assessment of all Forms of Abuse (Attachment D Policy 04.011) and the Abuse and Trauma Screen (Attachment E Policy 04.011) can be found at:

<http://www.hsh.health.state.hi.us/P&P/MasterList.asp?Sort=Heading>

The De-Escalation Assessment Interview Form (Attachment A Policy 04.250) and the Flyer with Description and Color Coding of Stickers (Attachment F Policy 04.250) can be found at:

<http://www.hsh.health.state.hi.us/P&P/MasterList.asp?Sort=Heading>

11. Trauma-informed services and service systems.

A De-escalation Assessment Form is completed upon admission to Hawaii State Hospital and annually to identify the techniques and methods that have previously helped deescalate and manage aggressive behavior, to ensure that patients preferences for de-escalation are assessed, documented in the kardex and offered during episodes of de-escalation or restraint whenever possible, and to determine if a seclusion or restraint is contraindicated due to history of physical or sexual abuse, or other limitations.

The De-Escalation Assessment Interview Form (Attachment A Policy 04.250) and the Flyer with Description and Color Coding of Stickers (Attachment F Policy 04.250) can be found at:

<http://www.hsh.health.state.hi.us/P&P/MasterList.asp?Sort=Heading>

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Seeking Safety group are offered at some of the Community Mental Health Centers. These groups are facilitated by MISA coordinators.

Idaho

1. Trauma function and focus in state mental health department.

The State of Idaho has no specific central office trauma function or focus at this time. Several areas are addressed within the system. These include education on aspects of trauma and the incorporation of trauma treatment within the context of existing service delivery systems. The State Mental Health Authority services include crisis response, Assertive Community Treatment, Psychosocial Rehabilitation, counseling and collaboration with other resources (e.g., homeless services, domestic violence, Sexual Abuse Now Ended (SANE), substance abuse, etc.).

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

The State of Idaho's Behavioral Health system recognizes the importance of training staff in trauma issues and treatment. The Division of Behavioral Health is in the process of developing a training package for new staff. This package will include a component on trauma identification and treatment. The Division of Behavioral Health is also in the final stages of completing a common assessment instrument that includes a section on trauma.

Recent trauma related trainings include:

- The State of Idaho supported bringing Dr. Phillip Resnick to Idaho to train first responders on risk assessment for violence in April 2007.

- Domestic Violence sponsored an interagency workshop in October 2007 that focused on trauma treatment services that were respectful of culture.

- Idaho's Children's Mental Health Program and System of Care has a training specialist who is currently planning three workshops for the spring of 2008 that will focus on trauma and treatment for trauma related disorders.

- The Division of Behavioral Health is in the process of developing a new assessment instrument that will include a component on trauma.

A training initiated by the Governor's Coordinating Council on Children was held the week of October 22, 2007. This training was provided by Dr.

Feletti, an expert on childhood trauma. Topics included education on symptoms manifesting later in life that may be related to childhood trauma.

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**
10. **Universal trauma screening and assessment.**

The Division of Behavioral Health is in the process of developing a common assessment that includes a trauma component.

11. **Trauma-informed services and service systems.**
12. **Trauma-specific services, including evidence-based and promising practice treatment models.**

Illinois

1. Trauma function and focus in state mental health department.

- Each of Illinois 9 State Operated Psychiatric Hospitals is in the process of developing and implementing strategies related to developing trauma informed services.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

Chicago Metropolitan Area:

A. City of Chicago: Chicago Department of Public Health

- The Chicago Department of Public Health has a strong commitment to addressing trauma across the lifespan, in terms of both prevention and intervention.
- The Chicago Department of Public Health (CDPH), Division of Mental Health, Centers of Excellence Project's three pilot sites received extensive training and 2 received ongoing, on-site consultation on trauma and domestic violence through the Domestic Violence & Mental Health Policy Initiative (DVMHPI). During the initial phase of the project, each site was partnered with one of 3 participating domestic violence (DV) programs. Direct service enhancing features of this project included: 1) access to mental health/trauma treatment services within 24-48 hours for women and children from partner DV programs, 2) referral to DV programs for clients receiving services at paired community mental health centers, 3), on-site consultation by an Adult Trauma Specialist, 4) cross-consultation and joint staffing between agencies. The model is focused on the creation of trauma-informed services within all partner sites. CDPH is committed to expanding this program to all of its community mental health centers and to developing a prevention approach to trauma across the lifespan. All centers will receive training on domestic violence and other lifetime trauma and two centers will receive regular on-site consultation each year.
- CDPH's ongoing disaster/bioterrorism activities include citywide psychosocial task force to oversee the city's mental health/trauma response to disaster.
- CDPH's Safe Start Initiative grew out of a five-year demonstration project funded by the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention that is now housed in CDPH's Office of Violence Prevention where it continues to bring together practitioners and policymakers to raise awareness, improve practice and

foster prevention of young children's exposure to violence and its consequences. www.chicagosafestart.net

- CDPH's Mayor's Office on Domestic Violence partnered with DVMHPI and the Division of Mental Health in the Centers of Excellence Pilot and has incorporated an awareness of trauma into its ongoing activities (e.g., Assessment of Domestic Violence Services in Chicago, Safe Havens Supervised Visitation Program, and Intersystem Assessment Study and ongoing Workgroup on Prostitution).
http://egov.cityofchicago.org/city/webportal/portalEntityHomeAction.do?BV_SessionID=@@@@0227472026.1193972439@@@@&BV_EngineID=cccdaddmglijjkjcefecelldffhdfhg.0&entityName=Domestic+Violence&entityNameEnumValue=141

Domestic Violence & Mental Health Policy Initiative & the National Center on Domestic Violence, Trauma & Mental Health

- DVMHPI: In 2006-2007, DVMHPI, in partnership with IDHS-DMH, Lifespan (a DV and legal services agency), The Growing Place Empowerment Organization (a mental health consumer advocacy organization), and Thresholds (a psychosocial rehabilitation agency) provided training and technical assistance to over 1,500 individuals across the state of Illinois. Trainings were part of a project that was designed to assist domestic violence, disability rights, mental health, and consumer advocacy providers in Chicago and throughout the state to respond more sensitively and effectively to survivors of domestic violence and other types of trauma who are living with a psychiatric disability. In fact, those trained represented a wide range of service providers including: mental health and substance abuse agencies, state-funded psychiatric hospitals, DV advocacy programs, disability and consumer advocacy providers, state's attorneys' offices, police departments, health care providers, and policy-makers. In addition to training, over 370 hours of post-training technical assistance was provided to participating agencies. One component of the project involved partnering with IDHS-DMH sites working on the SAMHSA *Alternatives to Restraint and Seclusion* grant to provide additional training and TA and to build on the excellent work and momentum of that project.
- The National Center on Domestic Violence, Trauma & Mental Health, a project of DVMHPI funded by a grant from the Administration on Children, Youth and Families of the United States Department of Health and Human Services, has also been working to promote the development of trauma-informed domestic violence and mental health services both in Illinois and nationally through conferences, written materials, training programs, technical assistance, needs assessments, and other educational and collaboration building activities. The Center also provides individualized telephone and e-mail technical assistance for organizations, individuals, and government agencies. It frequently receives requests for materials, research, training (or advice on designing training programs), information about how to better serve survivors of domestic violence or trauma within various settings, assistance in developing collaborative

relationships, personal assistance related to domestic violence, trauma, and/or mental health, and issues related to serving survivors with psychiatric disabilities. The Center has also developed an accessible web site containing information, links, and resources related to trauma, domestic violence, mental health, and psychiatric disabilities, including relevant legal issues. The site contains policy updates, research findings, information for survivors, and recommended articles, and will soon offer training curricula, practice guidelines, and assessment tools. The web site can be accessed at <http://www.nationalcenterdvtraumamh.org>

Dept

- In 2006, in collaboration with DVMHPI provided four one-day regional conferences across the state for State Operated Psychiatric Hospital Staff, and Community Mental Health and Domestic Violence Providers on “Developing Effective Responses to Trauma and Domestic Violence in the Lives of Women with Mental Illness.”
- In 2007, two 3-day follow up sessions were held in the Chicago Metropolitan Area for the same audience. The topics of the 3 days included; Session 1 – “Creating Physical and Emotional Safety: Overview and Key Principles for working with survivors of DV and other Lifetime Trauma;” Session 2 – “Understanding How Trauma Work Can Change Us as Providers: Tools, Skills and Insights for working with survivors who have experienced DV and other lifetime trauma;” and Session 3 “Assessment, Intervention and Treatment with Survivors of DV and Other Lifetime Trauma: Toolkit and Practical Applications.”
- There were three Statewide conferences focusing on Trauma Informed Care for State Operated Psychiatric Hospital clinical and leadership staff.
 - The first one targeted Leadership staff and was held April 10, 2006 presented by NTAC staff, “Trauma Informed Systems of Care.”
 - A two day follow up training conducted by NTAC targeted clinical staff took place on October 25th and 26th 2006. The first day was a train the trainer workshop on trauma informed systems of care, and the second day focused on the TAMAR trauma treatment model.
 - The third Statewide Conference was on September 12th and 13th, 2007. The presenters included Jon Briere, Ph.D. on “Treatment of Complex Psychological Trauma” and Jean MacLachlan, MS, OTR/L on “Using Sensory Approaches to Support Healing Environments” and “Personal Safety Plans.”

DVMHPI Adult Trauma Capacity-Building Projects

- DVMHPI is in the process of completing a two-part curriculum addressing domestic violence, trauma and mental health. *Access to Advocacy: Serving Women with Psychiatric Disabilities in Domestic Violence Settings*, the first part of the dual curriculum, is intended to assist domestic violence programs as they strive to address the needs of women with psychiatric disabilities who are also survivors of domestic violence and/or other lifetime trauma. *Responding to Survivors of Domestic Violence and Other Lifetime Trauma: Addressing Domestic Violence in Mental Health Settings* addresses the ways in which mental health providers can respond to the safety and other domestic violence and trauma-related needs of survivors seeking mental health services. Both curricula explore a range of topics including:

The impact of domestic violence and other lifetime trauma in the lives of women with psychiatric disabilities and the particular issues they face;

The need for, barriers to, and strategies for overcoming challenges to collaboration among domestic violence advocates, promoters of disability rights, and peer support advocates, and mental health providers;

A framework for bridging clinical, advocacy, and survivor perspectives including the concepts of universal access and recovery and the role of trauma theory in addressing the consequences of domestic violence and other lifetime trauma; and

An integrated model for addressing the mental health impact of domestic violence and other lifetime trauma and for ensuring that survivors who are experiencing both domestic violence and psychiatric disabilities have access to both advocacy and trauma services.

The curriculum provides specific recommendations for working with survivors in domestic violence or mental health settings, including information about documentation, confidentiality, use of advance directives in situations of domestic violence, disability law and other DV-related legal issues. It includes a participant guide, practice guidelines, assessment forms and tools, accompanying Power Point slides, and additional resource materials

Risking Connection-DV

- DVMHPI is collaborating with the Sidran Institute and TREATI to produce a version of Risking Connection for working with survivors of domestic violence and other lifetime trauma. Material for this curriculum was developed through DVMHPI's on-site training and

consultation with community mental health centers and DV agencies as part of the CDPH-MODV-DVMHPI pilot project.

DVMHPI: Child Trauma Capacity Building Project

DVMHPI collaborated with national child trauma and DV experts to develop two child trauma curricula to enhance capacity within community mental health and DV shelter and non-shelter based settings to deliver trauma-informed services. Both curricula use a dual trauma and child development lens and are culturally sensitive and relationally based. There is an emphasis on ways to intervene with the parent-child dyad and to strengthen the parent-child relationship in the wake of trauma and domestic violence. Both have been successfully piloted on-site with two Chicago-based MH agencies and two DV agencies. DVMHPI is in the final phase of producing a Trainer's Guide and companion Participant's Guide for each curriculum. These products will be ready for dissemination in 2008. The next phase of this project includes the initiation of monthly facilitated peer consultation groups (building on and enhancing materials from the curricula) and using a parallel group process with direct service practitioners and supervisors across 8-10 agencies in the Chicago metropolitan area.

Illinois was one of 8 States awarded a 3 year grant, Building Alternatives to the Use of Seclusion and Restraint from SAMHSA in 2004. Each of the 9 State Operated Psychiatric Hospital Leadership Staff have been trained in the 6 core strategies identified by NTAC, including additional training specifically on Trauma Informed Care. As a result of this training, each State Operated Psychiatric Hospital is in the process of developing and implementing strategies related to developing trauma informed services.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

The Illinois Division of Mental Health employs Recovery Specialists in both State Operated Psychiatric Hospitals and Region offices.

- Building Capacity to End Violence Against Women with Psychiatric Disabilities Project. DVMHPI received a grant from the Office on Violence Against Women, United States Department of Justice to fund a three-year project beginning October 1, 2007, that will focus on building service system capacity, enhancing safety and recovery, and reducing violence against women with psychiatric disabilities. DVMHPI will collaborate on the project with the Illinois Department of Human Services-Division of Mental Health/Office of Recovery Support Services, Thresholds, the Growing Place Empowerment Organization, Equip for Equality, Illinois Coalition Against Domestic Violence,

Lifespan, Mary Ellen Copeland, PhD, and Shery Mead, MSW. Pursuant to grant terms, DVMHPI and its partners will spend the first year conducting a needs assessment and planning activities to be implemented during the subsequent two years of funding.

Domestic Violence & Mental Health Policy Initiative & the National Center on Domestic Violence, Trauma & Mental Health

- DVMHPI: In 2006-2007, DVMHPI, in partnership with IDHS-DMH, Lifespan (a DV and legal services agency), The Growing Place Empowerment Organization (a mental health consumer advocacy organization), and Thresholds (a psychosocial rehabilitation agency) provided training and technical assistance to over 1,500 individuals across the state of Illinois. Trainings were part of a project that was designed to assist domestic violence, disability rights, mental health, and consumer advocacy providers in Chicago and throughout the state to respond more sensitively and effectively to survivors of domestic violence and other types of trauma who are living with a psychiatric disability. In fact, those trained represented a wide range of service providers including: mental health and substance abuse agencies, state-funded psychiatric hospitals, DV advocacy programs, disability and consumer advocacy providers, state's attorneys' offices, police departments, health care providers, and policy-makers. In addition to training, over 370 hours of post-training technical assistance was provided to participating agencies. One component of the project involved partnering with IDHS-DMH sites working on the SAMHSA *Alternatives to Restraint and Seclusion* grant to provide additional training and TA and to build on the excellent work and momentum of that project.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Illinois' Medicaid Rule 132 now includes a history of abuse/trauma (childhood sexual or physical abuse, intimate partner violence, sexual assault or other forms of interpersonal violence) as part of the assessment by funded providers.
- PTSD became a target diagnosis in Illinois.
- Chicago Department of Public Health will ensure domestic violence survivors and their children have access to trauma treatment at pilot mental health centers regardless of ability to pay.
- Chicago Department of Public Health is providing support for trauma training and consultation to assist in the implementation of promising and evidence-based trauma treatment models.

7. Clinical practice guidelines for working with children and adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and

needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- IDHS-DMH developed a culture assessment tool to be used by survivors accessing inpatient mental health services
- CDPH-MODV-DVMHPI Pilot: Evaluation included survivor satisfaction tools for both DV and mental health agencies
- CDPH-Mayor's Office on Domestic Violence conducted two large-scale community assessments – one of domestic violence services in Chicago, and the other on prostitution. Both identified the need for trauma-informed services and identified current resources and programs
- DVMHPI conducted a state-wide needs assessment with domestic violence and community mental health agencies on needs, services, community resources, gaps, and barriers to serving survivors of domestic violence and other lifetime trauma who are also experiencing a psychiatric disability. DVMHPI's National Center on Domestic Violence, Trauma & Mental Health conducted a similar study of state domestic violence coalitions across the country and is currently conducting a parallel survey of state mental health commissions.
- Illinois Department of Human Services, Bureau of Domestic and Sexual Violence Prevention, Domestic Violence Advisory Committee, Children's Trauma Task Force produced a set of recommendations for serving children exposed to domestic violence and their mothers

10. Universal trauma screening and assessment.

All persons admitted to Illinois State Operated Psychiatric Hospitals are screened for abuse and trauma. The development of a more detailed trauma assessment is in progress.

As part of the CDPH-MODV-DVMHPI Pilot project, CDPH's Division of Mental Health revamped its intake and assessment policies and procedures to incorporate questions about previous trauma, current abuse and ongoing safety. Accompanying tools and practice guidelines are available at each mental health center.

11. Trauma-informed services and service systems.

Alternatives to Seclusion and Restraint

Illinois was one of 8 States awarded a 3 year grant, Building Alternatives to the Use of Seclusion and Restraint from SAMHSA in 2004. Each of the 9 State Operated Psychiatric Hospital Leadership Staff have been trained in the 6 core strategies identified by NTAC, including additional training specifically on Trauma Informed Care. As a result of this training, each State Operated Psychiatric Hospital is in the process of developing and implementing strategies related to developing trauma informed services.

The Illinois Department of Human Services (IDHS) Division of Mental Health (DMH) just completed a three year SAMHSA-funded *Alternatives to Restraint and Seclusion* grant and has established a statewide workgroup to ensure that all state psychiatric hospitals become trauma-informed.

Personal Safety Plans are used in each State Operated Psychiatric Hospital in an attempt to be sensitive to potential triggers and to identify calming strategies prior to a crisis. Most hospitals also have developed comfort/soothing/relaxation rooms and/or comfort/soothing kits. Most hospitals have provided training to all staff on trauma informed care, focusing on the prevalence of trauma in persons served as well as describing how the effects of trauma can impact behavior and how the experience of trauma may influence the development of symptoms of mental illness. A statewide training module on trauma for new employee orientation is in development.

- IDHS-DMH is continuing its efforts to ensure that services in state psychiatric hospitals are trauma-informed through ongoing (internal and external) training and workgroup activities

Chicago Department of Public Health

- CDPH's Safe Start Initiative grew out of a five-year demonstration project funded by the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention that is now housed in CDPH's Office of Violence Prevention where it continues to bring together practitioners and policymakers to raise awareness, improve practice and foster prevention of young children's exposure to violence and its consequences. www.chicagosafestart.net
- CDPH's Mayor's Office on Domestic Violence partnered with DVMHPI and the Division of Mental Health in the Centers of Excellence Pilot and has incorporated an awareness of trauma into its ongoing activities (e.g., Assessment of Domestic Violence Services in Chicago, Safe Havens Supervised Visitation Program, and Intersystem Assessment Study and ongoing Workgroup on Prostitution). http://egov.cityofchicago.org/city/webportal/portalEntityHomeAction.do?BV_SessionID=@@@@0227472026.1193972439@@@@&BV_EngineID=cccdaddmglijikjccfecelldfhdhfg.0&entityName=Domestic+Violence&entityNameEnumValue=141
- CDPH-Division of Mental Health is engaged in ongoing work with DVMHPI to ensure all of its mental health centers are both domestic violence and trauma-informed

Domestic Violence & Mental Health Policy Initiative & the National Center on Domestic Violence, Trauma & Mental Health

- DVMHPI: In 2006-2007, DVMHPI, in partnership with IDHS-DMH, Lifespan (a DV and legal services agency), The Growing Place Empowerment Organization (a mental health consumer advocacy organization), and Thresholds (a psychosocial rehabilitation agency) provided training and

technical assistance to over 1,500 individuals across the state of Illinois. Trainings were part of a project that was designed to assist domestic violence, disability rights, mental health, and consumer advocacy providers in Chicago and throughout the state to respond more sensitively and effectively to survivors of domestic violence and other types of trauma who are living with a psychiatric disability. In fact, those trained represented a wide range of service providers including: mental health and substance abuse agencies, state-funded psychiatric hospitals, DV advocacy programs, disability and consumer advocacy providers, state's attorneys' offices, police departments, health care providers, and policy-makers. In addition to training, over 370 hours of post-training technical assistance was provided to participating agencies. One component of the project involved partnering with IDHS-DMH sites working on the SAMHSA *Alternatives to Restraint and Seclusion* grant to provide additional training and TA and to build on the excellent work and momentum of that project.

- The National Center on Domestic Violence, Trauma & Mental Health, a project of DVMHPI funded by a grant from the Administration on Children, Youth and Families of the United States Department of Health and Human Services, has also been working to promote the development of trauma-informed domestic violence and mental health services both in Illinois and nationally through conferences, written materials, training programs, technical assistance, needs assessments, and other educational and collaboration building activities. The Center also provides individualized telephone and e-mail technical assistance for organizations, individuals, and government agencies. It frequently receives requests for materials, research, training (or advice on designing training programs), information about how to better serve survivors of domestic violence or trauma within various settings, assistance in developing collaborative relationships, personal assistance related to domestic violence, trauma, and/or mental health, and issues related to serving survivors with psychiatric disabilities. The Center has also developed an accessible web site containing information, links, and resources related to trauma, domestic violence, mental health, and psychiatric disabilities, including relevant legal issues. The site contains policy updates, research findings, information for survivors, and recommended articles, and will soon offer training curricula, practice guidelines, and assessment tools. The web site can be accessed at <http://www.nationalcenterdvtraumamh.org>
- The Marjorie Kovler Center for the Treatment of Survivors of Torture, a program of Chicago Health Outreach and a partner of the Heartland Alliance for Human Needs and Human Rights, provides holistic, community-based services in which survivors work together with staff and volunteers to identify needs and to overcome barriers to healing. Comprehensive services include: mental health and primary health care, a wide range of social services, interpretation and translation, and legal referral.

- CDPH's ongoing disaster/bioterrorism activities include citywide psychosocial task force to oversee the city's mental health/trauma response to disaster.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

All State Operated Psychiatric Hospitals are in various stages of planning for the provisions of psycho-educational trauma groups. Some of the State Operated Psychiatric Hospitals have begun to provide psycho-educational trauma groups.

Chicago Metropolitan Area

The Domestic Violence and Mental Health Policy Initiative completed a project with 10 state-funded community mental health agencies and nine domestic violence organizations to implement trauma-informed and trauma-specific services utilizing the Trauma Recovery and Empowerment Model (TREM), and the Sanctuary model. Evaluation at the time (2003) indicated that the majority of agencies were integrating TREM and Risking Connection training material into agency assessment, in-service trainings and individual and agency practice.

- Chicago Department of Public Health (CDPH), Division of Mental Health Centers of Excellence Project: has led to the incorporation of trauma specific treatment into pilot sites (through training and regular onsite consultation with DVMPHPI's adult trauma specialist) and plans to expand this to all 13 clinics over the next several years.
- IDHS-DMH: AS follow-up to the SAMHSA Alternatives to Restraint and Seclusion grant, IDHS-DMH is exploring ways to incorporate trauma-specific treatment into its hospital settings.
- The Marjorie Kovler Center for the Treatment of Survivors of Torture, a program of Chicago Health Outreach and a partner of the Heartland Alliance for Human Needs and Human Rights, provides holistic, community-based services in which survivors work together with staff and volunteers to identify needs and to overcome barriers to healing. Comprehensive services include: mental health and primary health care, a wide range of social services, interpretation and translation, and legal referral.

Indiana

- 1. Trauma function and focus in state mental health department.**
 - Trauma has been recognized over the past several years by the Indiana Division of Mental Health and Addiction as a significant factor affecting consumer's mental illness, addictions, and their journey toward recovery. Indiana has been accepted by NASMHPD as a site to receive technical assistance regarding establishing a trauma-informed mental health treatment system.
- 2. State trauma policy or position paper.**
- 3. Workforce Recruitment, Hiring, and Retention.**
- 4. Workforce orientation, training, support, job competencies and standards related to trauma.**
 - Indiana has been accepted by NASMHPD as a site to receive technical assistance regarding establishing a trauma-informed mental health treatment system.
 - Additional training for the state hospital and community providers is anticipated as a result of the NASMHPD technical assistance.
 - The Seclusion and Restraint policy for the state hospitals in Indiana requires that each consumer be assessed at admission for a history of trauma (specifically physical and/or sexual trauma) and that this history be factored into decisions to implement seclusion and/or restraint. All staff involved in seclusion and/or restraint must have training specific to the impact of trauma on the individual's psychological well-being.
- 5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
 - The Consumer Council of the state mental health planning council and the Consumer and Family Involvement Committee of the state's Transformation Workgroup are discussing recommendations that would assure all consumers have access to information regarding trauma and trauma-informed treatments.
- 6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 - No specific activities currently. The state has implemented Consumer Service Reviews based on the principles of recovery. These reviews

provide an in-depth evaluation of individual consumers currently receiving services through the public mental health system. Often the results of the review lead to recommendations for evidence-based practices although not specifically trauma informed treatment.

7. Clinical practice guidelines for working with children and adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- The Seclusion and Restraint policy for the state hospitals in Indiana requires that each consumer be assessed at admission for a history of trauma (specifically physical and/or sexual trauma), and that this history be factored into decisions to implement seclusion and/or restraint. All staff involved in seclusion and/or restraint must have training specific to the impact of trauma on the individual's psychological well-being.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- No new activities since 2004 report. Implementation of the Child and Adolescent Needs and Strengths assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA) [see item 10 below] will provide specific data related to the prevalence of trauma for persons who access the public mental health system.

10. Universal trauma screening and assessment.

- Screening for children placed in foster care, as of July 1, 2004, includes questions about violence and trauma. Youth who screen positive for potential mental health problems are referred for further assessment and treatment when indicated.
- As of July 1, 2007, all youth served by the Division of Mental Health and Addiction are assessed with the Child and Adolescent Needs and Strengths assessment (CANS). Indiana has added a trauma specific module which is completed for all children with a history of trauma. This tool is also being used or will be used across systems including the Department of Child Services, Department of Correction, local school system, Psychiatric Residential Treatment Facilities. To view the tools, a website is available: <http://ibhas.in.gov>
- Beginning in July 2008, the Adult Needs and Strengths Assessment (ANSA) will be implemented for all adults (age 18 and over) served through the Division of Mental Health and Addiction. This tool will also have a trauma

specific module. Currently, the Office of Vocational Rehabilitation and the Department of Correction are interested in adopting this tool.

The Seclusion and Restraint policy for the state hospitals in Indiana requires that each consumer be assessed at admission for a history of trauma (specifically physical and/or sexual trauma) and that this history be factored into decisions to implement seclusion and/or restraint.

11. Trauma-informed services and service systems.

- Trauma has been recognized over the past several years by the Indiana Division of Mental Health and Addiction as a significant factor affecting consumers' mental illness, addictions, and their journey toward recovery.
- Indiana has been accepted by NASMHPD as a site to receive technical assistance regarding establishing a trauma-informed mental health treatment system.
 - Additional training for the state hospital and community providers is anticipated as a result of the NASMHPD technical assistance.
 - The Seclusion and Restraint policy for the state hospitals in Indiana requires that each consumer be assessed at admission for a history of trauma (specifically physical and/or sexual trauma) and that this history be factored into decisions to implement seclusion and/or restraint. All staff involved in seclusion and/or restraint must have training specific to the impact of trauma on the individual's psychological well-being.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

WRAP (Wellness, Recovery and Action Program) used as part of Office of Consumer Affairs services.

Group therapy for PTSD and traumatized individuals is offered at the State Hospitals.

Kentucky

1. Trauma function and focus in state mental health department.

In Kentucky, the responsibility for trauma services is divided among several agencies.

The Division of Child Abuse and Domestic Violence Services within the Department of Human Support Services funds and coordinates Designated Child Sexual Abuse Treatment Coordinators and Rape Crisis Counselors within the community mental health centers (CMHC), which provide state funded mental health, substance abuse, and mental retardation services.

In addition, the Division of Mental Health and Substance Abuse (DMHSA, the state mental health authority) within the Department of Mental Health and Mental Retardation funds and coordinates Early Childhood Mental Health Specialists in each CMHC, all of whom are trained to do trauma treatment for children 0-3.

- a. The following document can be found at www.kasap.org: Statewide Strategic Plan for the Prevention of Sexual Assault, Domestic Violence and Child Abuse, 2006.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

While no statewide policy exists for this focal area, the program staff mentioned in #1 who specialize in counseling for victimization issues are selected for their backgrounds and training.

A reporting form for Designated Child Sexual Assault Treatment Coordinators, which spells out the job responsibilities of that position, is available.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

While there is no statewide policy statement regarding workforce training, the state psychiatric hospitals have policies regarding staff hiring and orientation. In addition, the designated Program Administrator in DMHSA is able to conduct Trauma Informed Care training per the National Technical Assistance Center of the National Association of State Mental Health Program Directors. These trainings are available to community providers, and CMHC's are encouraged to offer training to their staff. Two of the 14 CMHC's in Kentucky currently offer universal training to all staff. Training

has also been provided for substance abuse and mental retardation service providers.

DMHSA also has a designated Program Administrator in the Substance Abuse Treatment branch who coordinates training for the department and for outside agencies.

Training on Seeking Safety and TAMAR is provided to service providers through our Kentucky School for Alcohol and Other Drug Studies and our Kentucky Conference on Best Practices.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

Service providers who receive Trauma Informed Care training are instructed to complete crisis prevention plans with their clients. Such plans are part of the policy of state psychiatric hospitals.

Attached is the Safety First Screening Tool which one of the state hospitals uses with patients.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- The Early Childhood Mental Health Specialists are funded through Tobacco Settlement Funds. The reduction of seclusion and restraint initiative is funded through a grant. The Designated Child Sexual Abuse Treatment Coordinator program is funded primarily through state general funds. Rape crisis and domestic violence programming is funded primarily through VOCA/VAWA funds, which are administered through the Justice Cabinet, along with some funding through the Department of Community Based Services and Sex Offense Sex Aside funds from the Public Health Block Grant and Rape Prevention Education funds from the Center on Disease Control. The 14 Emergency Disaster Planning Coordinators are partially funded with grant monies from the Kentucky Department of Public Health that originate from the office of the Assistant Secretary for Preparedness and Response.

7. Clinical practice guidelines for working with children and adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

No statewide policy exists, but the state psychiatric hospitals have policies regarding reducing seclusion and restraint in order to avoid re-traumatization and use the Safety First screening tool.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- The University of Kentucky has a recently formed Center for Research on Violence Against Women and an Injury Prevention Research Center, both of which conduct epidemiological studies related to domestic violence and sexual assault in Kentucky, along with other research projects. Rape Crisis Centers conduct client satisfaction surveys, as do the community mental health centers. As part of a SAMHSA-sponsored, Multi-State Study of Mental Health Service Utilization by Trauma Victims, hospital discharge data was analyzed in Kentucky. It provided basic demographic information for individuals with a diagnosis of Posttraumatic Stress Disorder. The study found that this group of individuals had a higher rate of community mental health service utilization than any other group examined in this project to date. Overall, 55 percent of those who received this diagnosis in a general hospital had received community mental health services the same year. Community health services utilization was highest for young people under 18 years of age (68 percent for boys and 70 percent for girls) and decreased, for both genders, to 21 percent of men and 46 percent of women in the 50 + age group.

10. Universal trauma screening and assessment.

At admission to services in a Community Mental Health Center, a complete bio-psycho-social history is taken for each client, including questions related to trauma history.

11. Trauma-informed services and service systems.

- While a comprehensive statewide initiative to ensure trauma-informed service delivery systems has not occurred, various agencies have focused on parts of this agenda, resulting in a number of well-planned and implemented programs.
- One of Kentucky's state psychiatric hospitals also coordinates a grant-funded project to reduce seclusion and restraint in the state hospitals utilizing trauma-informed methods.

The Kentucky Community Crisis Response Board (KCCRB) created under KRS Chapter 36 and recognized as the lead disaster behavioral health agency by the

Department for Mental Health and Mental Retardation Services, has the primary responsibility to provide disaster behavioral health services for the Commonwealth. Crisis intervention and disaster behavioral health services are the immediate and coordinated provision of consultation, assessment, risk assessment, referral, and psychological first aid to people affected by crisis or disaster. In addition to the services provided by KCCRB, each of the 14 Community Mental Health Centers have designated staff as Mental Health/Mental Retardation Emergency Disaster Planning Coordinators.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Because of a general lack of adequate funding, Kentucky has long waiting lists for most mental health and substance abuse services, restricting access to services. DMHSA recommends the following evidence-based or promising approaches to providers who work with co-occurring trauma and substance abuse: Seeking Safety, Trauma Recovery Empowerment Model, ATRIUM, Trauma Addition Mental Health Recovery (TAMAR), and Helping Women Recover. Training on Seeking Safety and TAMAR is provided to service providers through our Kentucky School for Alcohol and Other Drug Studies and our Kentucky Conference on Best Practices.

Louisiana

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**

The Department of Health and Hospital has posted a position statement on the use of seclusion and restraint which address trauma-informed care. This document was developed to demonstrate Office of Mental Health commitment to the safe and judicious use of seclusion and restraint and the development of systems of care that support the reduction of seclusion and restraint use.

OMH recognizes the role of trauma in the lives of people served by the mental health system; the principles of trauma informed care are essential to the establishment of a recovery oriented system of care and serve as the cornerstone to treatment approaches that promote the reduction/elimination of seclusion and restraint. All OMH facilities shall:

1. Provide on-going training in the dynamics and impact of trauma. Training shall also include assessment and intervention approaches.
2. Adopt a clinical approach that presumes that every person in a mental health treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences, therefore, requiring trauma assessment and appropriate interventions.
3. Develop and maintain policies and procedures that recognize that the use of seclusion, restraint, forced medication and other restrictive interventions can be re-traumatizing and thus avoided when possible.
4. Conduct ongoing assessments of treatment settings to assure that violence-free and coercive-free environments are maintained and staff practices demonstrate efforts to prevent crisis and avoid restrictive measures.

3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**

- As funded through SAMHSA's Seclusion & Restraint Grant Project, the National Advisory Technical Advisory Council (NTAC) conducted training(s) at our inpatient facilities (Southeast Louisiana State Hospital and Central Louisiana State Hospital) on Understanding the Effects of Trauma and Addressing the Effects of Trauma through the TAMAR Program; all training cost was paid through grant funding.
- NTAC will provide further training on trauma in 2008 to these facilities; all expenses will be paid through the Alternatives to Seclusion and Restraint grant funding. The facilities plan on sustaining these training(s) after the grant ends.

7. Clinical practice guidelines for working with children and adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- The Department of Health and Hospital has posted a position statement on the use of seclusion and restraint which address trauma-informed care. This document was developed to demonstrate Office of Mental Health commitment to the safe and judicious use of seclusion and restraint and the development of systems of care that support the reduction of seclusion and restraint use.
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4. Conduct ongoing assessments of treatment settings to assure that violence-free and coercive-free environments are maintained and staff practices demonstrate efforts to prevent crisis and avoid restrictive measures.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

The office of Mental Health is currently examining the trauma and violence indicators of the recently available Behavioral Risk Factors Surveillance Survey (BRFSS) data in order to gain estimates of the level of need related to these issues throughout the state.

10. Universal trauma screening and assessment.

Adult Service System:

- 1) The Level of Care Utilization System (LOCUS) assessment is part of all clients' initial assessment of level of care needs as well as an instrument that is used to determine continued stay level of care needs.

The LOCUS assesses the Recovery environment from the context of level of stress and level of support. Specifically, family or social milieu is assessed for disruption due to "torment and/or physical or sexual mistreatment" and the level of emotional support in the client's environment available.

Each adult clinician is trained on the LOCUS instrument and the regionally developed documentation tools to record level of care as well as general guidelines for service packages based on level of care.

Reference: <http://www.comm.psych.pitt.edu/find.html>

Regionally developed documentation tools available upon request

- 2) The Adult Psychiatric Evaluation includes specific assessment section related to History of Physical/Sexual Abuse

Regionally developed documentation tool available upon request

Child and Youth Service System:

- 1) The Child and Adolescent Level of Care Utilization System (CALOCUS) assessment is part of all clients' initial assessment of level of care needs as

well as an instrument that is used to determine continued stay level of care needs.

The CALOCUS assesses the Recovery environment from the context of level of stress and level of support. Specifically, family or social milieu is assessed for disruption due to “torment and/or physical or sexual mistreatment” and the level of emotional support in the client’s environment available. Additionally, Risk of Harm assesses for risks of victimization, abuse, or neglect.

Each child/youth clinician is trained on the CALOCUS instrument and the regionally developed documentation tools to record level of care as well as general guidelines for service packages based on level of care.

Reference: <http://www.comm.psych.pitt.edu/find.html>

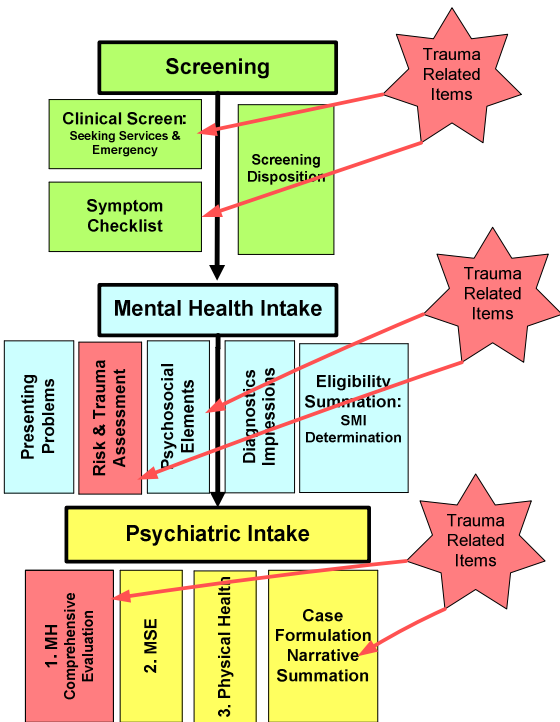
Regionally developed documentation tools available upon request

- 2) The Child / Adolescent Psychiatric Evaluation includes specific assessment section related to History of Physical/Sexual Abuse

Regionally developed documentation tool available upon request

Trauma Informed Evaluation for the Louisiana Mental Health System

The Office of Mental Health (OMH) for the state of Louisiana has been involved in the strategic development of a standardized screening and assessment process that incorporates specific elements that evaluate for possible trauma. The current process consists of a staged approach that continuously and repeatedly monitor for trauma. The first stage consists of a global screen for stressors, crises, or trauma. Included in this first stage is the use of a self-report instrument that formally screens for trauma related disorders. The second stage formally identifies and diagnoses trauma related disorders and as well begins to develop with the person different options for managing crises. The third stage of evaluation comprehensively explores the nature and complicating factors specific to that person’s trauma, which is critical to developing the corresponding recovery plan.



As a result of the 2005 hurricanes, Louisiana OMH has through its screening and assessment processes informally expanded its traditionally defined target population of the severe and persistently mentally ill (SPMI) to be more inclusive. In order to meet the mental health crisis of the state, most of the community mental health centers are aware of the significant need and are instituting mechanisms to meet the need of the traumatized population where resources allow. In addition, the screening and assessment procedures have been redesigned to monitor for potential trauma related vulnerabilities of the traditional SPMI population. Special attention is focused on the basic needs or individuals as well as potentially fragmented support systems.

The OMH United Medical Record (UMR) is utilized by all nurses to assess patients upon entry to the hospital that documents patient trauma history via input from patient

The OMH UMR Social History documents and assesses patients upon entry to the hospital with regard to any trauma history via input from patient

The family is encouraged to participate in the treatment planning process - if approved by patient. All patients are participants to the level of their understanding into their care.

The use of advocates or peers is not an option on the Forensic Unit due to the laws that prohibit visitation by former patients that are felons.

Research is conducted using the internet and an onsite library that has a large collection of psychiatric and associated research journal

The Risk Management and Progressive Behavior Management forms are administered upon admission to a facility; these forms do address trauma.

11. Trauma-informed services and service systems.

Restraint/Seclusion: Adults

As a part of the grant activities, NTAC provided presentations on Understanding the Effects of Trauma and Addressing Trauma through the TAMAR Program to both Southeast (December 5-6, 2006) and Central (June 1, 2007) hospital staff. Southeast has included content on Trauma Informed Care in their existing mandatory classes. Through this NTAC presentation, they were able to do further hospital-wide training for staff and have developed a series of in-services to conduct in the clinical areas. Those staff who completed the in-service training were designated as "Trauma Specialists" and would be available for Unit and/or case consultation with the intent to meet the best practice guidelines.

Alternatives to Restraint and/or Seclusion use with Children and Adolescents

The Office of Mental Health was awarded continuation funding for the Alternatives to Restraint and Seclusion project from SAMHSA to Build Capacity for Alternatives to Restraint and Seclusion. This project has focused heavily on continuing improvement efforts on staff training, education, and evaluation to promote practices in the prevention of seclusion and restraint use with children and adolescents placed in inpatient psychiatric treatment facilities. In collaboration with the National Technical Assistance Center (NTAC) and the Louisiana Federation of Families, trainings have been provided on trauma informed care, cultural sensitivity, crisis management skills without the use of physical intervention and family professional partnerships and family sensitivity-inclusion at each facility (SELH and CLSH). Although NOAH was released from the requirements of the grant following Hurricane Katrina, facility staff and patients have been included in recent trainings. There has been substantial progress made in the development of core strategies and intervention tools, cultural changes, and revisions of policies, procedures, and philosophy. The greatest improvement has been in restraint reduction with 75% of the goals achieved. The Office of Mental Health is in the process of filing for a "no-cost extension" for a fourth year. The total funding for the 2004 - 2007 [original] project period was \$610,000; OMH does not expect an increase of funds; but rather, anticipates the use of carry-over funds.

The Office of Mental Health is in the process of revising its Seclusion and Restraint Policy & Procedure, which addresses trauma-informed care as part of the P&P.

- The Department of Health and Hospital has posted a position statement on the use of seclusion and restraint which address trauma-informed care. This document was developed to demonstrate Office of Mental

Health commitment to the safe and judicious use of seclusion and restraint and the development of systems of care that support the reduction of seclusion and restraint use.

- OMH recognizes the role of trauma in the lives of people served by the mental health system; the principles of trauma informed care are essential to the establishment of a recovery oriented system of care and serve as the cornerstone to treatment approaches that promote the reduction/elimination of seclusion and restraint. All OMH facilities shall:
 1. Provide on-going training in the dynamics and impact of trauma. Training shall also include assessment and intervention approaches.
 2. Adopt a clinical approach that presumes that every person in a mental health treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences, therefore, requiring trauma assessment and appropriate interventions.
 3. Develop and maintain policies and procedures that recognize that the use of seclusion, restraint, forced medication and other restrictive interventions can be re-traumatizing and thus avoided when possible.
 4. Conduct ongoing assessments of treatment settings to assure that violence-free and coercive-free environments are maintained and staff practices demonstrate efforts to prevent crisis and avoid restrictive measures.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

As a part of the grant activities, NTAC provided presentations on Understanding the Effects of Trauma and Addressing Trauma through the TAMAR Program to both Southeast (December 5-6, 2006) and Central (June 1, 2007) hospital staff. Southeast has included content on Trauma Informed Care in their existing mandatory classes. Through this NTAC presentation, they were able to do further hospital-wide training for staff and have developed a series of in-services to conduct in the clinical areas. Those staff who completed the in-service training were designated as “Trauma Specialists” and would be available for Unit and/or case consultation with the intent to meet the best practice guidelines.

The office of Mental Health is in the process of revising its Seclusion and Restraint Policy & Procedure which addresses trauma-informed care as part of the P&P.

Maine

1. Trauma function and focus in state mental health department.

- Department of Behavioral and Developmental Services Plan for Improving Behavioral Health Services for Persons with Histories of Trauma, has guided the work of the Department in addressing trauma throughout the state.
- Maine DHHS / Children's Behavioral Health Services (CBHS) has teamed up with Tri-County Mental Health Services, Maine's leading mental health provider in trauma-informed care, to build a seamless 'system of care' for children and their families. This partnership has resulted in the creation of the Thrive Initiative. The \$9 million project is funded by SAMHSA and is the first trauma-informed system of care for children, youth and their families, in the nation. The principles of the system are that services be family driven, youth guided, culturally and linguistically competent and trauma informed. Under the director of Thrive and designated CBHS staff, Thrive brings together child welfare, juvenile justice, education, mental health providers, youth and their families and community members as stakeholders in system transformation. For additional information visit, www.thriveinitiative.org.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

- Maine DHHS recently created two new offices, the Office of Minority Health & Office of Multicultural Affairs to serve as statewide resources to state agencies and local communities to improve accessibility to services and the overall health of minority and multicultural populations in Maine.
- The Coordinator of Multicultural Affairs from Maine DHHS serves as a consultant on refugee and immigrant trauma to Thrive. Thrive has employed a member of the Somali Bantu community as a Cultural & Linguistic Coordinator to promote a greater awareness of the impact of trauma on the “new Mainers” in the system of care. These new Mainers are refugees and immigrants from Africa and Latin America.
- In August 2006, Maine hired its first full-time Program Director of Disaster Behavioral Health Services. This was a collaborative partnership between Children’s Behavioral Health, Adult Mental Health and the Maine CDC.
- Trauma-Informed Family and Youth Specialists are employed by Thrive to partner with families and youth involved in the Child Welfare and /or Juvenile Justice systems.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

The THRIVE trauma-informed children's system of care is the first in the nation. Maine DHHS Children's Behavioral Health Services has teamed up with Tri-County Mental Health Services, Maine's leading mental health provider in trauma-informed care, to build a seamless 'system of care' for children and their families. The \$9 million project is funded by SAMHSA. www.thriveinitiative.org

- Trauma Informed Training: Roger Fallot, PhD. from Community Connections in Washington D.C. and co author of, *Using Trauma Theory to Design Service Systems*, provided trauma informed training to major stakeholders. His training incorporated the youth voice of the Youth Leadership Advisory Council, a family member's perspective and the viewing of "War is Not a Game", the stories of refugee and immigrant children traumatized by the effects of war.
- The first set of stakeholders trained included Child Welfare supervisors and workers, foster parents, and mental health case managers. Trauma Champions were then selected by units to promote trauma informed practices in their organizations/programs. Child Welfare supervisors are currently working with Thrive to create a trauma informed supervisory training to enhance the current skill set of supervisors with an eye towards supporting staff in the issues of vicarious traumatization and increased staff morale and trauma sensitivity. Most recently a child welfare supervisor noted that "the outcome may be the same, but the process is now different". This statement reflects the changing awareness that although children may still be removed from families due to safety concerns, families and children will now feel informed and respected by a system that recognizes the effects of trauma and the possibility of re-traumatizing families who come into contact with Child Welfare.
- Another stakeholder, Department of Corrections / Juvenile Justice, will come on board the winter of 2007. They will be trained in November by Roger Fallot and Thrive staff to promote trauma informed practices among Juvenile Correction officers, detention facilities, the district attorney's office, and mental health providers working with youth and families coming into contact with the juvenile justice system. Thrive will also provide training and support to supervisors to address the issues of vicarious traumatization.
- Effects of Trauma on Classroom Learning and Student Achievement: Thrive has created a course for educators on the effects of trauma and the benefits of a trauma-informed approach to teaching. This course which began in October of 2007 will be a study group with reading

assignments and open discussion for educators on trauma and children's learning. The second part of this course will involve the creation of a trauma informed classroom for students. This course is currently being piloted in the schools of Lewiston and has been met with much interest. The hope is to expand this course to other schools and evaluate the attitudinal changes that come with a trauma informed approach to teaching. Educators are provided re-certification credits for participating in this course.

- Thrive and CBHS sponsored the first Statewide Cultural and Linguistic Conference in June of 2007, to promote awareness about mental health and trauma among diverse cultural communities.

The systemic trauma-informed approach used by THRIVES Trauma-Informed Childrens Systems of Care was first implemented in 2004 throughout the Tri-County Mental Health system for adults. The success of this model, developed by Roger Fallot of Community Connections, led to the Maine DHHS and Tri-County's decision to implement a similar trauma-informed systemic approach to childrens' services. It also led to adoption of the model by other agencies.

- A Trauma-Informed Approach to Human Services Training of senior staff and administration of four mental health agencies; self-assessment to determine if, where and how they are currently providing trauma-informed services and development of implementation work plan based on assessment. Training by Community Connections and Tri-County Rumford staff and consumers who took part in Trauma-Informed Pilot Project. Training curriculum and materials available, including self-assessment tool. Ongoing consultation by Community Connections was made available to the four mental health agencies as needed.

Additional Department wide training programs on addressing trauma in children:

- The promotion of evidence based trauma specific services has led to the creation of local learning collaboratives to train and support agencies and clinicians in the use of Trauma Focused Cognitive Behavioral Services and Child Parent Psychotherapy. These are two treatments selected by families and youth in the three counties that have been shown to effectively treat trauma symptoms in children and youth. Provider agencies and clinicians will begin this training in October of 2007 and continue over the next twelve months to develop core competencies on the assessment and treatment of trauma.
- Children's Behavioral Health Services in partnership with the Behavioral Health Science Institute developed a curriculum with 12 components; one specific module is oriented to working with children with a history of trauma. This training is available on DVD and in classroom settings. All community-based staff providing in-home supports & habilitation

services must successfully complete these training requirements prior to the provision of services.

DHHS Behavioral and Developmental Services Trainings

- Another example of professional training and education is through the Mental Health Rehabilitation Technician (MHRT) Certification Program. This program requires 10 courses, including one on trauma. This certification necessary for a variety of direct care positions including crisis intervention staff and community support workers.
- DHHS has developed a comprehensive train-the-trainer curriculum with the consultation of Jack Herman and the training materials developed by the University of Rochester, the New York State Office of Mental Health and the New York State Department of Health. The training curriculum is for Behavioral Health, Spiritual Care, Substance Abuse Professionals and Natural Community Helpers. Over 45 trainers completed this course in October, 2007.
- DHHS is co-sponsoring a November conference, *The Journey Home: Creating A Statewide Network of Support for Veterans and Their Families*. This conference will provide a framework for building statewide provider networks for addressing the needs of veterans and their families. Also there will be clinical training focused on best practices for trauma treatment, substance abuse, brain injury and families & children's needs.
- BDS Competency Model: Trauma identified as Core Competency area needed by all employees. Describes learning objectives under seven competency areas of trauma. Used in performance management process and in supervision, to identify training needs, and in the design of training programs and curriculums. Available at: <http://muskie.usm.maine.edu/cfl/Competencies/MH.html>.
- Risking Connection Training Program: a five-module trauma curriculum for use in public mental health, substance abuse and human service field, has been offered regularly across the state to all levels of direct care staff in a variety of disciplines and treatment and support settings. It provides a basic framework and context for understanding and responding helpfully to clients with histories of trauma.
- Risking Connection Train-The-Trainer Program for selected clinicians to provide in-services consultation and Risking Connection trainings for agencies throughout the state
- TREM (Women's Trauma Recovery and Empowerment Model) Training Programs conducted by Community Connection staff in all Regions of the state and cross-training in 2003 for mental health, substance abuse and sexual assault service providers. Three-day trainings in facilitation of

psycho-educational groups for women trauma survivors with serious persistent mental health and/or substance abuse problems. Published facilitators manual and materials

- MTREM (Men's Trauma Recovery and Empowerment Model) Training Programs. Conducted by Community Connection staff statewide. Two-day trainings of mental health and substance abuse clinicians to facilitate psycho-educational groups for male trauma survivors with serious persistent mental health and/or substance abuse problems. Published facilitators manual and materials
- The Office of Adult Mental Health Services contracts with NAMI Maine to provide training to law enforcement agencies, the Maine Criminal Justice Academy, and ambulance services regarding the use of the least restrictive, non-traumatizing transportation.
- Collaboration between the state Office of Adult Mental Health Services and the University of Maine on current university curricula and programs, including continuing education programs. Focus areas: evidence-based practices and emerging best practices in trauma-informed services.
- The Office of Adult Mental Health Services will collaborate with consumer groups, the Maine Hospital Association, Maine Chapter of the American College of Emergency Room Physicians and Maine State Nurses Association to develop training about mental health recovery, how to respond to and treat persons experiencing psychiatric crisis, and how to lessen trauma. The training will be delivered together with consumers on an ongoing basis to ED staff.
- Statewide Trauma Telephone Support Line provides 24 hour, 365 days a year coverage to adults and adolescents with histories of sexual abuse trauma who have serious mental health or addiction problems. Special training for these Level 2 Calls. Service supported by BDS in collaboration with the Maine Coalition Against Sexual Assault. Description document, Program Standards.

Office of Substance Abuse: The co-occurring disorders initiative:

In general, all trainings delivered as a part of this Initiative convey the importance of assessing for and treating trauma as part of the clinical picture of complex, co-occurring conditions. For instance, in November, 2007, the Initiative will sponsor a training on "An Integrated Approach to Trauma and Addiction Treatment" by Patricia Burke, a local clinician and trainer. The conference is already oversubscribed and has had to be scheduled a second time to accommodate the number of providers interested in attending.

A defined set of Core Competencies for those providing co-occurring services lists knowledge of trauma as an essential competency.

COSII Co-occurring Core Competencies is available upon request:

Mid-Coast Maine Trauma-Informed Community Project (MMTIC), a coalition of local community leaders in collaboration with local community organizations including libraries, mental health and health care providers, and early childhood caregivers and educators, conducts on-going trainings to local groups to raise awareness of the prevalence and impact of child abuse and trauma, and to discuss ways of empowering all members of the community (especially parents, caregivers, and children), with knowledge needed to prevent abuse, recognize and understand trauma impacts in children and, if the trauma is not addressed, over the lifespan, build resiliency, and reach out to traumatized children and adults in ways that are healing.

- Trainings are given pro-bono to numerous local groups and organizations, and include a powerpoint presentation “A Child’s Path to Mental Illness and Suicide” followed by an open discussion with MMTIC leaders. The presentation is given by the child’s mother, includes current research findings on adverse childhood experiences and tells the story of how unaddressed trauma can unfold in the life of a child, leading the child to tragic outcomes in adulthood. Participants then discuss ways to develop safer trauma-informed communities, and to empower all adults who interact with children knowledge they need to prevent abuse and/or respond to traumatized children.
- A local website is developed by MMTIC for community access to trauma resources and information.
- Members of MMTIC form an ongoing Learning Community, meeting regularly to share knowledge, resources and experience, and to explore model approaches to trauma healing which can be used by local community members with and without formal mental health training.

Powerpoint presentation can be viewed at www.theannainstitute.org. MMTIC trauma-informed community resources, including annotated book list on trauma for children ages 3-9, a “trauma-informed community matrix”, bookmarks listing local trauma related sources of help, and written description of the MidCoast Maine Trauma Informed Community Initiative, are available upon request.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Inclusion of Youth Voice in Trauma Focused Cognitive Behavioral Therapy (TFCT): Thrive, Tri-County Mental Health Services, and the CBHS Medical Director have participated and completed a nine month National Learning Collaborative on TFCT sponsored by Duke University and the National Child Traumatic Stress Network (NCTSN). The team selected to participate in the collaborative included a young adult trauma survivor, (Thrive's Youth Coordinator) who served as a consultant to the team. Adaptations to the model have been made by the team to incorporate youth voice and youth engagement strategies.
- The Office of Consumer Affairs (OCA), in partnership with Shery Mead, nationally known peer support expert, developed a trauma-informed Intentional Peer Support training curriculum that is now available statewide. The OCA has also created a state certification for peer specialists (Certified Intentional Peer Support Specialists), which is required training for individuals providing peer support on ACT teams, on warm lines and in Emergency Departments.

As more individuals receive the training and certification, trauma-informed peer support is more widely available in Emergency Departments across the state as well as through a statewide warm line.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Medicaid (MaineCare) encourages the provision of evidence-based practices under two main sections of our Medicaid State Plan: Children's Outpatient Services (Section-65F) and Children's Behavioral Health Treatment Services (Sections- 65M&N).
- State Medicaid regulations have been modified so that trauma-specific services are reimbursable. Medicaid now reimburses TREM and DBT services as well as trauma-informed peer support on ACT teams under section 17 of state MaineCare regulations
- SAMHSA is funding a \$9 million project to build a seamless system of care for children and their families. This project is first in the nation to develop a seamless system of care for children and families that is trauma-informed.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- Guidelines For Facilities: In Response to Sexual Abuse of Vulnerable Adult Populations. Applies to all state licensed residential facilities in Maine. Guidelines available.

From OSA

- And a defined set of Core Competencies for those providing co-occurring services lists knowledge of trauma as an essential competency.
- COSII Co-occurring Core Competencies:

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- Policy Regarding the Prevention of Seclusion and/or Restraint Informed by the Client's Possible History of Trauma. Applies to all clients (adults, adolescents and children) supported directly by Department staff and institutions. De-escalation Form # MRO 255 RI.
- Personal Safety Form for BDS Facilities/Staff: Guide to gathering information with clients for development of strategies to de-escalate agitation and distress. Used in conjunction with Trauma Assessment Form.

DHHS Policy on Integrated Services

- A general Departmental policy has been adopted that defines trauma as one of the potential co-occurring conditions to be addressed in integrated service delivery. A policy on Screening and Assessment requires assessment of trauma as part of integrated data gathering. And a defined set of Core Competencies for those providing co-occurring services lists knowledge of trauma as an essential competency.

COSII Policy on Screening and Assessment:

COSII Co-occurring Core Competencies:

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

The DHHS Office of Adult Mental health Services (OAMHS), in September of 2007, adopted Evidence-Based Practices Procedural Guidelines that guide the OAMHS in continued quality improvement and decision making based on data. Guiding principles include prevention, early intervention and a broad definition of health that encompasses safety across the lifespan.

- The Influence of Trauma on Public Mental Health Service Use and Expenditures for Children with Emotional & Behavioral Challenges (Yoe, Posner, McPherson & Burns, 2005):
 This study investigated the impact of trauma exposure on public service use, overall expenditures and functional outcomes for children/youth with serious emotional and behavioral challenges, who are recipients of targeted case management services in Maine. The study specially tests the hypotheses that children & youth with previous trauma histories, along with serious emotional and behavioral challenges will exhibit less behavioral/functional improvement over time, use more restrictive and high cost services (residential treatment, inpatient hospitalizations) and have higher public mental health service costs than children/youth recipients of targeted case management services who have not experienced childhood trauma.

The study sample includes 492 children and adolescents with severe emotional and behavioral challenges, who were enrolled in target case management services in either FY 2000 or FY 2001. The results indicated that children/youth with trauma histories were more likely to be female, had more complex diagnostic and clinical profiles and were significantly more likely to be involved with the child welfare system.

In addition, the presence of a previous trauma history was found to be associated with poorer treatment outcomes and with increased use of high cost and restrictive services. The current study expand on this previous work by specially assessing the impact of untreated trauma on change in behavioral / functional outcomes and public mental health service use and expenditures patterns over time.

(National presentation at the Children’s Mental Health Research Conference at the University of Southern Florida.)

- With All We Have To Do, What’s Trauma Got To Do With Us? National Webinar Presentation to SAMHSA System of Care Sites for Children and Adolescents (Yoe, Russell, Ryder and Boustead, 2005):
 This presentation reviewed the research on the prevalence of trauma among children & adolescents with emotional and behavioral challenges, presented findings from other national studies including: the SAMHSA Women, Co-Occurring Disorder and Violence Children’s Subset Study and Adverse Childhood Experiences Study; and introduced the core components of a Trauma-Informed System of Care, along with practical implementation strategies.
- Impact of Trauma on Children Served Within Systems of Care (Georgetown System of Care Institutes / Boustead, Yoe, Ryder, Labbe and Stambaugh, 2006):
 Recent research and evaluation, including evaluation data from system of care sites, indicate a high prevalence of children with or at risk of

SED have been exposed to trauma in their lives, with estimates of Between 50 to 70 percent suffering from post-traumatic stress disorder. Studies are showing that children and adolescents with trauma histories use more acute mental health treatment services at a higher cost. This has immediate and serious impact upon local system of care sites. Given the pervasiveness of trauma among children with SED, especially with co-occurring issues, or children served in the juvenile justice and child welfare systems, it is imperative that systems of care develop a systemic approach to addressing trauma. This workshop reviewed recent evaluation findings, current evidence-based and promising practices that have demonstrated positive outcomes, presented a family perspective on the importance of a trauma-informed approach, and provided practical strategies to assist systems of care in developing systems that are trauma-informed.

- SAMSHA National Evaluation: Thrive is participating in a national evaluation as a Phase V system of care. Local questions being evaluated are specific to trauma treatment and trauma informed practices. Those results will be forthcoming in the next year.
- A Trauma-Informed Agency Assessment Tool: This assessment tool will be administered to agency administrators, direct care staff and youth and family recipients of services to determine if, where and how they are currently providing trauma-informed services. The development of implementation work plans based on this assessment will be created by participating agencies with support from Thrive. Thrive will provide ongoing training and technical support to these provider agencies and organizations to ensure that they are able to implement trauma informed policies and practices.
- The Influence of Childhood Trauma on Public Mental Health Service Use and Expenditures: Preliminary Findings (February 2004). Study used Maine Medicaid to investigate the extent to which the histories of childhood trauma influence public mental health service use and expenditures for children and youth. Further analysis will look at the use of health and medical services and expenditures for the group of children who have experienced trauma and those who reported they had not. Child functional outcomes for the two groups will be compared over time. PowerPoint available. Manuscript of study being written for publication.

10. Universal trauma screening and assessment.

The timely assessment and treatment of trauma is also a goal of Thrive as Thrive and stakeholders attempt to create a universal screening tool that can screen for trauma and trigger the need for additional assessments. The screening tool will be created and reviewed by youth and families for ease of

understanding and trauma sensitivity. The screening will be rolled out to all interested stakeholders regardless of clinical training. Such a “Non Clinical” tool will demystify the issue of trauma and make screening a routine occurrence for all those who interact with families and youth.

Finally, Thrive is creating a “Trauma Informed Agency Assessment”. Such an assessment will be administered by youth consumers and their families to provider agencies. The assessment will focus on agency administrators, their staff and youth and family consumers currently receiving services. The intent is to assess the strengths and challenges experienced by individual agencies and organizations and offer them a “snapshot” of how trauma informed they are, based on all perspectives. Thrive will in turn provide training and technical assistance to those agencies in an attempt to create a trauma informed provider network. The assessment will be administered a second time, after a period of time elapses, to assess change over time and provide feedback to agencies on areas of improvement and growth.

- Universal Screening Tool for Children & Youth: Currently in development with youth and families. The timely assessment and treatment of trauma is a goal of Thrive, as Thrive and stakeholders attempt to create a universal screening tool that can screen for trauma and trigger the need for additional assessments. The screening tool will be created and reviewed by youth and families for ease of understanding and trauma sensitivity. The screening will be rolled out to all interested stakeholders regardless of clinical training. Such a “non clinical” tool will demystify the issue of trauma and make screening a routine occurrence for all those who interact with families and youth.
- Uniform Assessment Tool for Adult Mental Health incorporates brief assessment for trauma. Implemented throughout adult mental health system including state-operated and contracted agencies, community hospitals and state institutions. Tools available.
- TREP (Trauma Recovery and Empowerment Profile, Community Connection) is used as part of every consumer assessment. Looks at 11 domains of coping skills and is accompanied by skills building exercises for each domain. (Workbook, Community Connections)
- Self-Awareness and Recovery Profile, developed by Tri-County MHC, uses two psychological assessment tools: the Trauma and Attachment Belief Scale, and the Emotional Quotient Inventory. Piloted in one unit as pre-post improvement indicator for a Wellness Recovery Action Group (WRAP, Copeland) and a Trauma Recovery and Empowerment Group (TREM, Community Connections). Indicates strengths and opportunities for growth in areas of self-safety, trust, self-esteem, intimacy and control.

11. Trauma-informed services and service systems.

- Maine began developing a trauma-informed service system by funding a Model trauma-informed service system Pilot Project. The Department of Behavioral and Developmental Services (BDS) supported implementation and evaluation of a pilot project in one unit (Rumford) of Tri-County Mental Health Services, a major mental health agency serving rural and semi-rural counties. Community Connections, Inc., provided consultation throughout the project. Overall goal, based on pilot outcomes, was to develop trauma-informed service systems in mental health agencies and facilities across the state of Maine
- This systems change approach used criteria from “[Using Trauma Theory to Design Service Systems](#)”, to effect administrative commitment to change, universal screening for trauma histories, staff training and consultation, hiring and human resource practices, review of policies/procedures, involvement of consumer advisory team in all aspects of change process, modification of existing services, implementation of trauma-specific services, and development of model trauma-informed services system for replication throughout the state.
- [Organizational and Statewide Expansion of Pilot Project](#) Effectiveness of model led to implementation throughout the larger Tri-County organization of services, introduction to the Maine State Association of Mental Health Service Providers and adaptation of the model in three more of Maine’s largest community mental health centers. Evaluation results showed increased overall functioning, skills development and consumer satisfaction; decreased mental health symptoms, physical health concerns and use of hospitalizations and crisis services. Project implementation is described in Department’s “[Plan for Improving Behavioral Health Services for Persons with Histories of Trauma](#)” and in [agency workbook and materials](#). [Evaluation Report and Appendices available](#).

Thrive: A Trauma-Informed Childrens System of Care

- Maine DHHS / Children's Behavioral Health Services (CBHS) has teamed up with Tri-County Mental Health Services, Maine's leading mental health provider in trauma-informed care, to build a seamless 'system of care' for children and their families. This partnership has resulted in the creation of the Thrive Initiative. The 6 year \$9 million project is funded by SAMHSA and is the first trauma-informed system of care for children, youth and their families, in the nation. It operates in the counties of Androscoggin, Oxford and Franklin.
- The principles of the system are that services be family driven, youth guided, culturally and linguistically competent and trauma informed. The mission of Thrive is to develop a comprehensive system of care in collaboration with youth and families that is responsive and informed

about trauma to better address the unique needs of children and youth with severe emotional challenges and their families.

- Thrive has identified partners in the community that can apply the principles of trauma theory to redesign services currently being offered to children, youth and their families. It brings together child welfare, juvenile justice, education, mental health providers, youth and their families and community members as stakeholders in system transformation. For additional information visit, www.thriveinitiative.org.
- The first stakeholder to become trained in trauma informed practices was Child Welfare. Both staff and supervisors were trained in trauma informed practices by Roger Fallot of Community Connections, Washington D.C. and Thrive staff. Trauma Champions were then selected by units to promote trauma informed practices in the offices of child welfare. Child Welfare supervisors are currently working with Thrive to create a trauma informed supervisory training to enhance the current skill set of supervisors with an eye towards supporting staff in the issues of vicarious traumatization and increased staff morale and trauma sensitivity. Most recently a child welfare supervisor noted that “the outcome may be the same but the process is now different”. This statement reflects the changing awareness that although children may still be removed from families due to safety concerns, families and children will now feel informed and respected by a system that recognizes the effects of trauma and the possibility of retraumatizing families who come into contact with Child Welfare.
- Another stakeholder, Juvenile Justice, will come on board the winter of 2007. They will be trained in November by Roger Fallot and Thrive staff to promote trauma informed practices among Juvenile Correction officers, detention facilities, the district attorneys and mental health providers working with youth and families affected by Juvenile Justice. Thrive will also provide training and support to supervisors to address the issues of vicarious traumatization.
- Thrive has created a course for educators on the, “Effects of Trauma on Classroom Learning and Student Achievement”. This course which began in October of 2007 will be a study group with reading assignments and open discussion for educators on trauma and children. The second part of this course will involve the creation of a trauma informed classroom for students. This course is currently being piloted in the schools of Lewiston and has been met with much interest. The hope is to expand this course to other schools and evaluate the attitudinal changes that come with a trauma informed approach to teaching.

- The promotion of evidence based trauma specific services has led to the creation of local learning collaboratives to train and support agencies and clinicians in the use of Trauma Focused Cognitive Behavioral Services and Child Parent Psychotherapy. These are two treatments selected by families and youth in the three counties that have been shown to effectively treat trauma symptoms in children and youth. Provider agencies and clinicians will begin this training in October of 2007 and continue over the next twelve months to develop core competencies on the assessment and treatment of trauma.
- The timely assessment and treatment of trauma is also a goal of Thrive as Thrive and stakeholders attempt to create a universal screening tool that can screen for trauma and trigger the need for additional assessments. The screening tool will be created and reviewed by youth and families for ease of understanding and trauma sensitivity. The screening will be rolled out to all interested stakeholders regardless of clinical training. Such a “Non Clinical” tool will demystify the issue of trauma and make screening a routine occurrence for all those who interact with families and youth.
- Finally, Thrive is creating a “Trauma Informed Agency Assessment”. Such an assessment will be administered by youth consumers and their families to provider agencies. The assessment will focus on agency administrators, their staff and youth and family consumers currently receiving services. The intent is to assess the strengths and challenges experienced by individual agencies and organizations and offer them a “snapshot” of how trauma informed they are, based on all perspectives. Thrive will in turn provide training and technical assistance to those agencies in an attempt to create a trauma informed provider network. The assessment will be administered a second time, after a period of time elapses, to assess change over time and provide feedback to agencies on areas of improvement and growth.

Disaster:

- In 2003, the Director of Children’s Behavioral Health Services was awarded a two year federal SAMHSA grant to develop a Statewide Behavioral Health Disaster Response Plan. A very diverse statewide committee was organized that included the American Red Cross, Maine Emergency Management Agency, Maine CDC, Maine Hospital Association, Maine Psychological Association, Department of Education, Maine Pediatric Association, mental health & substance abuse providers, and many others. Along with drafting a plan that would serve as an addendum to the All Hazards Plan, there were multiple opportunities to practice at table top exercises and full drills at the community level. Training was provided for over 300 individuals in crisis counseling

techniques in order to build a strong cadre of citizens to call upon in future disasters or traumatic events. Maine has experienced two Presidentially Declared disasters over the past decade, that resulted in the Director of CBHS writing federal grant applications and successfully being awarded funding for Behavioral Health Response / Crisis Counseling Services under the FEMA/ Immediate Services Grant.

From other formal report

- In 2003 DHHS received a two-year SAMHSA federal grant to: plan the creation of the service system required to respond to a disaster in cooperation with mental health and substance abuse agencies and community groups; provide training to enhance the capacity of the current crisis service system to respond to potential disasters; and test and assess local response capability.
- DHHS, in cooperation with provider agencies and community groups, has drafted a Statewide Behavioral Health Disaster Preparedness Emergency Response Plan. In accordance with that plan, DHHS developed a statewide disaster behavioral health curriculum and is in the process of creating a volunteer infrastructure to provide a state level behavioral health response to traumatic incidents or disasters.

Maine Military Adjustment Program

- The Director of Children's Behavioral Health Services was actively involved in the initial development of the Maine Military Adjustment Program (MAP) for soldiers involved in the Afghanistan and Iraq war.
- This program is oriented to National Guard soldiers, both pre-deployment and upon re-entry to their home & local communities in Maine. A review of the common stress reactions to traumatic events (such as war), coping strategies, and availability of helping resources for the soldiers and their families are the key areas of attention. This program has been in place almost three years and has expanded to include spouses and children. The partners in this endeavor include DHHS, Togus VA, Vet Centers, National Guard, Domestic Violence and Sexual Assault Centers, University of New England, clergy, community agencies and private practice clinicians.

Trauma Informed Intentional Peer Support

The Office of Consumer Affairs (OCA), in partnership with Shery Mead, nationally known peer support expert, developed a trauma-informed Intentional Peer Support training curriculum that is now available statewide. The OCA has also created a state certification for peer specialists (Certified Intentional Peer Support Specialists), which is required training for individuals providing peer support on ACT teams, on warm lines and in Emergency Departments.

As more individuals receive the training and certification, trauma-informed peer support is more widely available in Emergency Departments across the state as well as through a statewide warm line.

Statewide Trauma Telephone Support Line

This trauma-informed service provides 24 hour, 365 days a year coverage to adults and adolescents with histories of sexual abuse trauma who have serious mental health or addiction problems. Special training for these Level 2 Calls. Service supported by BDS in collaboration with the Maine Coalition Against Sexual Assault. Description document, Program Standards.

Mid-Coast Maine Trauma-Informed Community Project (MMTIC)

MMTIC is a coalition of 15 local community leaders committed to creating a safe, “trauma-informed local community, in which all the adults in a child’s life are empowered to prevent or intervene early in childhood abuse and other traumatic childhood experiences. This is a grass roots totally volunteer initiative. Activities thus far have focused on developing a strategic plan and educating local librarians and school systems involved with young children ages 3 – 10 years old. The goal is to develop a community that:

- 1) Is aware of the prevalence of child abuse and trauma, of its epidemic proportions, and of the need to address it as central to creating a safe and healthy community for both children and adults;
- 2) Empowers all members of the community, (especially parents, caregivers, and children), with the knowledge they need to:
 - Prevent child abuse and trauma;
 - Understand how trauma impacts on a child and how its wounds may affect individuals throughout their lifespan and be passed on intergenerationally;
 - Build resiliency in children enabling them to weather adverse experiences;
 - Reach out to traumatized children and to each other in ways that are healing.”

Maine Office of Substance Abuse

Currently, the Office of Substance Abuse is engaged in providing trauma-informed services in two areas-- as part of our Differential Substance Abuse Treatment services in Correctional facilities, and as part of our Co-occurring State Integration Initiative.

Correctional Facilities:

Seeking Safety is a manualized cognitive behavioral substance abuse treatment curriculum for clients with trauma and addiction. *Seeking Safety* is being used by trained DSAT facilitators in the women’s prison substance abuse program and in several outpatient DSAT substance abuse agencies. This program was identified by OSA as an appropriate adjunct to the evidence-based DSAT

program because of the high rates of trauma in the criminal justice-involved clients referred to DSAT treatment.

Co-occurring State Integration Initiative: OSA participates in this 5-year initiative, funded by SAMSHA, geared towards changing state infrastructure and supporting providers in delivering integrated services for co-occurring conditions. One focus of the work is to develop clinical standards, particularly for screening and assessment, that reflect best practice in integrated care. Workgroups of the Initiative have developed various policies and procedure statements that include a focus on trauma as part of clinical competence for co-occurring treatment. A general Departmental policy has been adopted that defines trauma as one of the potential co-occurring conditions to be addressed in integrated service delivery. A policy on Screening and Assessment requires assessment of trauma as part of integrated data gathering. And a defined set of Core Competencies for those providing co-occurring services lists knowledge of trauma as an essential competency.

In general, all trainings delivered as a part of this Initiative convey the importance of assessing for and treating trauma as part of the clinical picture of complex, co-occurring conditions. For instance, in November, 2007, the Initiative will sponsor a training on “An Integrated Approach to Trauma and Addiction Treatment” by Patricia Burke, a local clinician and trainer. The conference is already oversubscribed and has had to be scheduled a second time to accommodate the number of providers interested in attending.

Finally, a comprehensive continuum of care for those with co-occurring mental health and substance abuse disorders includes the use of group treatment. One of the recommended treatments in a COD continuum is *Seeking Safety*. Many of the pilot sites engaged in implementing integrated practice in the COSII project offer this group to their co-occurring clients.

Available upon request:

- [DHHS Policy on Integrated Services](#)
- [COSII Policy on Screening and Assessment](#)
- [COSII Co-occurring Core Competencies](#)

12. Trauma-specific services, including evidence-based and promising practice treatment models.

The promotion of evidence based trauma specific services has led to the creation of local learning collaboratives to train and support agencies and clinicians in the use of Trauma Focused Cognitive Behavioral Services and Child Parent Psychotherapy. These are two treatments selected by families and youth in the three counties that have been shown to effectively treat

trauma symptoms in children and youth. Provider agencies and clinicians began this training in October of 2007 and will continue over the next twelve months to develop core competencies on the assessment and treatment of trauma.

- Trauma Focused Cognitive Behavioral Therapy (TFCBT): An evidence based practice for children and youth over age 5 is currently being offered through Tri-County Mental Health Services. Tri-County, Thrive staff and the Medical Director of Children's Behavioral Health Services recently participated in a National Learning Collaborative for TFCBT (see #4). A Local Learning Collaborative for TFCBT will start the winter of 2008 to train and support additional agencies and clinician in the provision of TFCBT. Thrive will continue to provide technical assistance on ensuring that the practice is guided, family driven and culturally and linguistically competent.
- Child Parent Psychotherapy: An evidence based practice for children ages birth to five who have experienced/witnessed trauma will be offered by a group of consultants who will employ the "learning collaborative" model as created by Duke University and the National Child Traumatic Stress Network (NCTSN). Agencies and providers have begun participation in this collaborative by first attending a three day Infant Mental Health Training which incorporated trauma informed practices.
- Statewide Trauma Telephone Support Line provides 24 hour, 365 days a year coverage to adults and adolescents with histories of sexual abuse trauma who have serious mental health or addiction problems. Special training for these Level 2 Calls. Service supported by BDS in collaboration with the Maine Coalition Against Sexual Assault. Description document, Program Standards.
- Trauma Recovery and Empowerment Model (TREM) psychoeducational Groups for Women offered through local centers of Maine Coalition Against Sexual Assault, ACT team at Maine Medical Center, and multiple mental health and substance abuse agencies throughout the state.
- Trauma Recovery and Empowerment Model (M-TREM) psychoeducational groups for men Offered through local centers of Maine Coalition Against Sexual Assault, and a variety of community mental health agencies.

Office of Substance Abuse

Correctional Facilities: *Seeking Safety* is a manualized cognitive behavioral substance abuse treatment curriculum for clients with trauma and addiction. *Seeking Safety* is being used by trained DSAT facilitators in the women's prison substance abuse program and in several outpatient DSAT substance

abuse agencies. This program was identified by OSA as an appropriate adjunct to the evidence-based DSAT program because of the high rates of trauma in the criminal justice-involved clients referred to DSAT treatment.

Finally, a comprehensive continuum of care for those with co-occurring mental health and substance abuse disorder includes the use of group treatment. One of the recommended treatments in a COD continuum is *Seeking Safety*. Many of the pilot sites engaged in implementing integrated practice in the COSII project offer this group to their co-occurring clients.

Maryland

1. Trauma function and focus in state mental health department.

- The Department of Health and Mental Hygiene, Mental Hygiene Administration has a full-time staff appointed as Director of trauma and jail mental health services. This position reports directly to the Director of the Office of Special Needs Populations.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

- The Department of Health and Mental Hygiene, Mental Hygiene Administration continues to have two full-time staff appointed as Director of Behavioral Health Disaster Services and Assistant Director. These positions report to the Director of the Office of Special Needs Populations.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

Statewide Training Conferences:

- Creating Trauma Informed Systems of Care for Human Service Settings
- Trauma and Resilience
- Lessons Learned Since Vietnam: What You Need to Know About Combat, PTSD, TBI, and Military Referrals (Conference will be held on September 25, 2007).

Training Materials on Trauma:

- Trauma and its Impact on Parenting: Helping mothers with histories of abuse provide their children with more supportive mothering than they experienced.
- Sisters Surviving Trauma: Treatment needs of and delivering culturally sensitive services to women of color who are survivors of trauma
- Trauma, Parenting and Attachment: trained 40 state agencies and private nonprofits in trauma-informed services for pregnant, substance abusing incarcerated women
- Putting the Pieces Back Together: treatment for people in Criminal Justice System who have co-occurring disorders and histories of trauma.

- Brochures and Speaker information available through GAINS Center.
- Working with Borderline Personality Disorder/Crisis Management for Survivors. (Sidran)
- Growing Beyond Survival: Trauma Symptom Management Training
1-day training of corrections staff, clinical staff, community mental health providers. Manual (Sidran)
- The Essence of Being Real: training on group dynamics and structuring peer support groups for trauma survivors. Manual and curriculum. (Sidran)
- Trauma Training In Corrections: Understanding Traumatic Stress
One-day trainings: Frederick County Detention Center, Frederick Maryland, and the Dorchester County Detention Center, Cambridge, Maryland. Provided general training information for providers at every level. Manual (Sidren)
- Managing Traumatized Inmates, half-day training for corrections officers. Baltimore County Corrections.
- Risking Connection: Curriculum for Working with Survivors of Childhood Abuse. Three day training for clinical staff, health department workers and administrative staff. Baltimore County Corrections.
- Risking Connection: Master Trainer Program: three-day train the trainer model. Manual Relational Teaching, Experiential Learning with PowerPoint available. (Sidran) Baltimore County Corrections
- Baltimore County Mental Health System trainings:
 - TREM (Trauma, Recovery and Empowerment Model),
 - G-TREM (Girls Trauma Recovery and Empowerment Model),
 - TREP (use of Trauma Recovery and Empowerment Profile), and
 - Introduction to Trauma Issues for Women on Inpatient or Short-Stay Units: a four-session group treatment intervention
- Addressing Vicarious Traumatization and Burnout in Trauma Care. one-day training. Personal and workplace-based strategies for addressing and preventing vicarious traumatization and managing burnout; explores aspects of VT that create risks for retraumatizing clients. (Sidran)
- Understanding Trauma. One-day training conducted throughout the State for Parole and Probation Officers, Police Officers, and Department of Juvenile Justice staff.

- Behavioral Health Disaster Management. One-day training conducted for personnel working as Command Center staff during drills and disaster events.
- The Art of Caring: One-day training conducted for disaster response workers and Maryland Professional Volunteer Corps members.

Higher Education:

- University of Maryland, School of Social Work, has developed a Trauma Certificate Program, in collaboration with the Mental Hygiene Administration
- University of Baltimore, Maryland State Victim Assistance Academy, sponsors Risking Connection training curriculum

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Consumers are consulted at all aspects of planning, evaluation, and delivering trauma services for every project developed within the Mental Hygiene Administration
- TAMAR peer support groups link with On Our Own Maryland, a consumer organization, which networks with all the consumer-run organizations throughout the state. Trauma workshop included for the last six years at statewide conference presented by On Our Own Maryland. TAMAR advocates' group started peer support groups in counties. Groups are using the curriculums: Growing Beyond Survival: a Self-Help Toolkit for Managing Traumatic Stress, and The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma, as guides for forming and training support groups. Peer groups recommended steps for forming model peer support groups for consumers with histories of trauma. Document available.
- Department of Corrections offers groups within prison where formerly incarcerated women come back and offer peer support. Currently incarcerated women then volunteer to become trained peer supporters.
- Training held December 14, 2000 Sisters Surviving Trauma: Women of Color and Trauma. Addressed how the treatment needs of women of color may be different than traditional needs and how to deliver culturally sensitive services to women of color who are survivors of trauma. Training brochures and materials available.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- TAMAR is funded through State general funds and local funding.
- Individual and Group Treatment authorized under the Public Mental Health System.
- The Chrysalis House Healthy Start Program (CHHS) which replaces the TAMAR's Children Program serves pregnant and postpartum incarcerated women and their babies.

Chrysalis House Healthy Start Program funding sources include:

- State general funds and local in-kind services
- Projects for Assistance in Transition from Homelessness (PATH)
- Public Mental Health Systems
- The Family Tree
- Baltimore City Healthy Start Program

7. Clinical practice guidelines for working with children and adults with trauma histories.

- Clinical guidelines for working with trauma survivors in jail are implemented through the TAMAR program, Maryland Mental Hygiene Administration. Expanded into Co-occurring Disorders pilot program at Springfield State Hospital, and applies to both women and men.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- Procedures for avoiding re-traumatization developed by the Department's TAMAR project have been implemented in jails and in community follow-up agencies. New projects have been developed with special application for women in jails who are pregnant.
- Taskforce studying gender-specific services and development of single sex units at state hospitals. Committee developing policy to implement trauma-oriented restraint policy for all psychiatric hospitals. Policy goals include: ensuring that all patients feel safe, expanding trauma treatment services to all State hospitals, and providing trauma training for all hospital staff.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- Research Project with former TAMAR's Children Program. Looking at the effectiveness of the Circle of Security intervention on at-risk mothers and infants in building healthy attachments.
- New Chrysalis House Healthy Start Program which began August 2007 provides trauma-based services using the Trauma, Recovery, and Empowerment Model (TREM). The effectiveness of intervention will be evaluated as the program evolves.

10. Universal trauma screening and assessment.

- Universal Intake form for DHMH Mental Hygiene Administration incorporates questions about trauma.
- All individuals coming into jails in 10 Maryland correctional facilities and in Springfield State Hospital are assessed for trauma through the Mental Hygiene Administration's TAMAR program. Two assessment instruments are used: a brief intake form and if indicated, a comprehensive trauma assessment form
- A Self-Report Scale is given to all inmates and patients asking 6 questions about trauma. They may choose to fill out and place in mailbox for a trauma specialist working in the facility, indicating if they want to receive trauma counseling.
- Bessel VanderKolk's Trauma Assessment Packet (including a trauma assessment questionnaire, the Dissociative Experiences Scale, and the Davidson scale) is used. Trauma specialists use a variety of assessment techniques that may include the use of the use of the Trauma Center Assessment Package. The Package includes: TAQ, SIDES, Trauma Center PTSD Symptom Scale, & Trauma Focused Initial Adult Evaluation. Other assessments may include: Briere's Trauma Symptom Inventory and the DES.

11. Trauma-informed services and service systems.

- Maryland Department of Health and Mental Hygiene's TAMAR program and the Chrysalis House Healthy Start Program is a trauma-informed multi-system approach involving correctional, mental health, substance abuse, social services, health care, legal and judicial systems..

- Risking Connection Model, a framework for understanding and working with individuals with mental health and/or substance abuse problems who are survivors of childhood abuse, is implemented for both women and men in the correctional system including 10 correctional facilities and one state hospital, and in the agencies serving these individuals during incarceration or hospitalization after their release.
- Maryland continues to recruit and train licensed behavioral health professionals for the Maryland Professional Volunteer Corps. The Mental Hygiene Administration (MHA) is assisting in revising the training agenda and will conduct behavioral health trainings for all volunteers regardless of Board jurisdiction. In addition, MHA will continue to present trainings on Stress Management for Disaster Workers to every volunteer.
- Mental Hygiene Administration has developed a Behavioral Health Officer Incident Command Staff Job Action Sheet for the Department of Health and Mental Hygiene (DHMH) and Mental Hygiene Administration. MHA has designed a protocol for DHMH Command Center staff providing defusings and debriefings to be conducted routinely after drills or real-life events.
- A June, 2007 conference entitled Trauma and Resilience was facilitated by the Mental Hygiene Administration to present the latest, evidence-informed treatment indicators for disaster-related events, including protocols for surges on emergency departments, stress management and self-care and information about the Crisis Counseling Programs available to States after Presidentially declared disasters.
- Presented Disaster Management training to all Mental Hygiene Administration and Alcohol and Drug Abuse Administration Command Staff.

Veterans

- Designed and developed a national model, pilot program to educate Maryland Army and Air National Guard families, significant others and communities about the issues related to deployment to and from combat zones. This program is a collaboration between the Mental Hygiene Administration, Department of Health and Mental Hygiene, the Maryland National Guard and the Maryland Defense Force. A Memorandum of Understanding was signed between these parties in March, 2007.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

TAMAR Program. Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration, Division of Special Populations. TAMAR Program (Trauma, Addiction, Mental health And Recovery), in partnership with Maryland Correctional Administrators Association, provides clinical services for male and female inmates who have serious mental illness, co-occurring substance use disorders, and histories of violence and trauma. Services provided in 10 county detention centers, one city detention center, the women's prison, and one state hospital. Recidivism rate dropped from approximately 39 percent to 3 percent. The TAMAR Program was developed as part of the SAMHSA WCDVS study (1998-2003) Trauma-specific services include:

- Trauma clinical specialists, trained in Risking Connection, work in each facility and provide group and individual trauma therapy, assessments, education of correctional staff, aftercare linkage. A variety of trauma treatment techniques including EMDR are offered.
- Advocacy and Peer Support Groups using Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress in groups and on own, and The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experience Trauma as a guide for forming and running support groups.
- Chrysalis House Healthy Start Program a diagnostic and transitional program that serves pregnant and post partum women offenders and provides trauma-based services using TREM. Women may have histories of severe trauma, substance abuse and mental health problems. Working with the courts, judges and correctional facilities, women are admitted into the program following positive identification of pregnancy. They are provided trauma group therapy, symptom management, mental health and substance abuse treatment. After delivery, women return to the transitional program for up to 12 months. They continue to receive treatment and follow up treatment.
- TAMAR Trauma Treatment Groups, manualized trauma-specific group intervention combining psycho-educational approaches with expressive therapies and designed for women and men with histories of trauma in correctional system. Groups offered in detention centers and in some communities. Trauma Treatment Manual available

Massachusetts

1. Trauma function and focus in state mental health department.

There is not a single identified point of responsibility for trauma services within the state administrative structure charged with implementing trauma-informed service systems and trauma-specific services. However, numerous trauma training and trauma-informed services are initiated and supported by the Bureau of Substance Abuse Services, The Department of Mental Health, The Department of Social Services Domestic Violence, The Department of Corrections. These are described under Criteria for training (#4), trauma-informed services (#11) and Consumer involvement (#5)

2. State trauma policy or position paper.

(DMH) Commissioner Monograph of March 10, 1999, summarizes key policy points and providing guidelines regarding treatment of Department of Mental Health clients with a history of trauma – recognized the “need...to be responsive to the unique needs of trauma survivors with mental illness” and develop “appropriate treatment plans and interventions” based on traumatic history. www.mass.gov/dmh.

MA Governor’s Commission on Sexual and Domestic Violence issues report entitled *Moving Massachusetts Toward an Integrated, Trauma-Informed System of Care*

(DMH & DPH) Commissioners Memorandum to all General Hospitals in Massachusetts (September, 2006) identifying a set of practice recommendations to improve the care, implement trauma-informed principles and to decrease coercion to patients with psychiatric disorders and/or behavioral issues in hospital emergency departments (ED’s). Available on request.

3. Workforce Recruitment, Hiring, and Retention.

- “Patient Liaison” personnel hired in state-operated facilities. Self disclosing individuals whose job duties include conducting debriefing sessions with clients and staff post-R/S, membership on the executive committees, and inclusion on client treatment teams as a support/liaison for the client.
-
- (DPH) The Bureau of Substance Abuse Services funds a part-time training and systems position to integrate trauma treatment into substance abuse services

- (DMH) Contracts with trauma integrations specialists to provide consultation and training to the adult state-operated inpatient facilities and state-contracted child and adolescent services.
- ASAP (Assaulted Staff Assistance Program) offers immediate telephone and on-site crisis intervention and support to staff victims of assault.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

Department of Public Health

- (DPH) The Bureau of Substance Abuse Services funds a three-quarter time training and systems position to integrate trauma treatment into substance abuse services.
- DMH has conducted and sponsored seven years of statewide training on preventing the use of R/S, and trauma related topics as part of the *Child/ Adolescent Restraint/ Seclusion Prevention Initiative*. These include but are not limited to:
 - Strength-based Care
 - Overview of trauma, trauma-specific modalities, neurobiology of trauma, creating positive trauma-informed care environments
 - Sensory approaches and interventions
 - Consumer and family voices
 - Use of apology
 - Holistic approaches
- (DMH) NTAC Training for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Environments. Provided to *all inpatient psychiatric sectors (approximately 75 hospitals/ units)* including state hospitals, inpatient community mental health centers, intensive residential treatment programs and licensee facilities, 2005 & 2006. Funded through SAMHSA grant and DMH monies, provided by the National Technical Assistance Center.
 - Major focus of training on the provision of Trauma-Informed Care including: Neurobiology of Trauma, Trauma-Informed Treatment Settings, Trauma-based Tools and Consumer Involvement. DMH staff served as founding faculty in the development of this national curriculum.
 - Training, in concert with the new DMH R/S Prevention Regulations (2006) required that all facilities licensed or operated by the Department develop strategic plans within a framework of trauma-informed care.

- DMH SIG to Reduce/Eliminate R/S. Grant funded training on a range of topics including sensory approaches and trauma.
- DMH revamped and rolled out a new training curriculum for direct care staff in state-operated facilities related to increased trauma awareness in state-operated inpatient programs. (2006-2007) All training modules are competency based and include an annual review component:
 - “Compassionate Alternatives and Techniques”
 - “Trauma Informed Care”
 - Sensory Approaches
- Technical assistance documents, information, tools and state-of-the-art literature (written by DMH staff) related to decreasing coercive practices including R/S and providing trauma-informed care, located on the DMH website. www.mass.gov/dmh

DMH Crisis Counseling Training Program

- DMH has revised its existing Crisis Counseling Training Program to include evidence-influenced, trauma-informed practices; these include “psychological first aid” and specialized use of cognitive behavioral therapies. DMH and DPH management participated in a half-day workshop (by National Center for PTSD, Dartmouth, JSI and others) showcasing these practices. DMH is preparing to offer the revised training to substance abuse personnel and staff in the private MH sector, in addition to the DMH staff who historically took the training. Special modules will be developed for health personnel such as ER staff, public health nurses, primary care practitioners, and epidemiology staff. The long-term goal is to train 1,750 behavioral health responders in the state, including re- certification of the ~600 persons on the current crisis counseling roster.
- Western MA Training Consortium (WMTC) hosts site visits for staff from the Department of Social Services/DV to further knowledge of community-based, peer, trauma-informed supports for women survivors.
- WMTC provides training (“Making a Difference: Providing Trauma-informed Care”) for the DMH peer subcommittee of the Seclusion and Restraint Committee, 2007
- Child-oriented trauma training provided to the Child and Adolescent Acute and Continuing Care inpatient and intensive residential program providers by Glenn Saxe, MD. Funded through SAMHSA grant provided by National Center for Child Traumatic Stress Studies.

- ASAP (Assaulted Staff Assistance Program) offers immediate telephone and on-site crisis intervention and support to staff victims of assault.
- Wellness Recovery Action Plan (WRAP) training for peer facilitators offered statewide
- Men's Trauma, Recovery and Empowerment (MTREM) training to facilitate psychoeducational groups for men with histories of abuse and substance abuse and/or mental health problems. Three-day training for Boston Public Health Commission.
- (DPH) The Bureau of Substance Abuse Services funds a three-quarter time training and systems position to integrate trauma treatment into substance abuse services.
- The Department of Mental Health contracts with a trauma integrations specialist to provide consultation and training to the state-operated inpatient facilities (Laurie Markoff, Ph.D) and state-contracted child and adolescent services (Janina Fisher, Ph.D)
- Department of Corrections issued RFP for training on trauma-informed correctional services for all correctional officers
- The Child and Adolescent Restraint Reduction Initiative (Sept. 2000 – present) includes all acute (licensed) and continuing care (state-operated and contracted) and intensive residential treatment programs serving children and adolescents in Massachusetts. Providers receiving statewide trauma training on development of collaborative strength based models of care.
 - Cambridge Hospital Children's Unit has adopted Ross Greene's collaborative, problem- solving approach on its unit. Adopted supportive/strength-based skills teaching and learning model with a result that no restraints were used in a month.
 - NASMHPD National Technical Assistance Center curriculum has three trauma-specific modules:
 Neuro-biological and psychological effects of trauma
 Trauma-informed care
 Trauma-informed tools.
This module has been implemented at the Worcester and Tewksbury State Hospitals. Massachusetts staff are founding faculty for this training and train nationwide.
- Harvard Medical School, two-day addictions conference with several workshops on trauma. March 2004.

- DMH Office of Multicultural Affairs has partnership with the Harvard Program in Refugee Trauma, Massachusetts Behavioral Health Partnership, University of Massachusetts Medical School Office of Community Program, Massachusetts Medical Society and DMH Western Mass Area Office. Collaboration provided 3 statewide trainings on *Healing the Wounds of Mass Violence: Assessment and Treatment of Refugees and Torture Survivors*. Included the Dissemination of the *Healing The Wounds of Mass Violence Clinical Toolkit* for practitioners as a resource guide for their work with refugees. *Available on request.*

Institute for Health and Recovery (IHR) has conducted and sponsored five years of statewide trainings on trauma and trauma related topics, for providers statewide. Many trainings evolved from IHR's participation as a site of the WCDVS in the WELL (Women Embracing Life and Living) Project. Trainings and consultations on the following: see www.healthrecovery.org.

- Gender-specific treatment: Training emphasize special needs of women for treatment that is comprehensive, trauma-informed, empowering, strengths-based, and includes a focus on relationships, including parenting and children
- Relational Model and Treatment. Understanding and utilizing principles of model
- Feminist approaches to substance abuse: treatment based on relational model of women's development and the empowerment approach
- Treatment for women with co-occurring disorders: on complex and multi-directional relationships connecting substance abuse, mental illness and trauma
- Trauma-informed and trauma-specific treatment: training explicates principles underlying such treatment and how to implement them. Includes list of curricula
- Overcoming barriers to integrated care for domestic violence, substance abuse and mental illness: Linkages among the three issues, barriers and ways to address barriers to providing services
- Systems change strategies for women with co-occurring disorders and trauma/victimization: training on strategies for addressing common barriers and moving toward an integrated system of care
- Working with children affected by substance abuse, mental illness and violence: training on effective trauma-informed treatment and service coordination for children whose mothers are affected by co-occurring disorders
- Promoting resiliency in children: how resiliency traits get nurtured, review of the literature and implications for treatment

- Psycho-educational groups for children whose mothers have co-occurring disorders: presentation of an effective resiliency, promoting, trauma-informed group intervention for children
 - Children who witness domestic violence: considers symptoms and treatment of children who witness such violence
 - Effects of substance abuse and violence on parenting and the parent-child relationship: teach providers how to promote successful nurturing relationships within families
 - Nurturing families through recovery (Curriculum-based Parenting program): training addresses effects of co-occurring disorders and trauma on parenting and the parent-child relationship
 - Designing Trauma-Informed Services Systems for Women and Children (Community Connections)
 - TREM (Trauma Recovery Empowerment Model) Three-day training. (Community Connections)
 - WELL Recovery: training describes model for peer-led self/mutual help groups for women with substance abuse and mental health problems and histories of trauma, including information necessary to conduct such groups
 - Offering Safe Choices: New England Conference on Integrating Services for Substance Abuse, Domestic Violence, and Mental Health, 2005
Descriptions of all trainings are available
- Department of Public Health/Bureau of Substance Abuse Services assists substance abuse treatment programs in meeting requirement to become trauma-informed through the Trauma Integration Initiative. Programs receive training, technical assistance, supervision, and co-facilitation of trauma-specific groups in a train-the-trainer model through the Institute of Health and Recovery. Programs are required to conduct a Trauma Self-Assessment prior to and subsequent to receiving these services, and must develop and implement a Trauma-Informed Strategic Plan in order to participate. This initiative will be presented at the American Public Health Association annual meeting in November 2007.
 - Spectrum Health Systems, Inc., subcontracts with the Institute for Health and Recovery to provide training and consultation on trauma-informed and trauma-specific services (Seeking Safety) to all substance abuse treatment programs in state correctional institutions for women.

Western Massachusetts Training Consortium, Inc., hosted ground-breaking Dare to Vision conference and one of nine sites in the SAMSHA-funded WCDVS research study continues to expand on and disseminate information on a peer approach to trauma recovery.

- ATRIUM (Addictions and Trauma Recovery Integration Model) (Miller). Peer co-facilitators are trained and supervised by Dr. Miller or an experienced group facilitator to conduct ATRIUM groups with male and female trauma survivors, Latinos, in battered women's shelters, and in prisons.
- WRAP (Wellness, Recovery Action Program) (Copeland). Training of peer facilitators at sites throughout western Massachusetts including NELCWIT in Greenfield and the WMA Women's Resource Centers
- "A Peer Model of Women's Growth and Development" presented at DSS Spring 2007 by women from the Western MA Women's Resource Centers
- "A Peer Approach to Healing From Trauma" presented at DPH/DV conference Fall, 2007 (Andersen and women from WMA Women's Resource Centers)
- Presentations on the WMA Women's Resource Center model on Women's Growth and Development at sites in California including San Diego State University/Interwork Institute fall 2006 and summer 2007
- Presentations on Trauma-informed Care at all DMH funded state-wide Certified Peer Specialists trainings.
- Boston Consortium of Services for Women in Recovery, substance abuse treatment programs (outpatient and residential), multiple TREM trainings and ongoing consultation

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- (DPH) Bureau of Substance Abuse Services awards a recovery community engagement center contract to Western MA Training Consortium based on a trauma-informed peer approach to community based approach to substance abuse recovery
- (DSS) Domestic Violence awards a multiyear contract to Western MA Training Consortium that focuses on a trauma-informed life-span focused peer approach to violence in women's lives.
- Initiative designed to improve the care of consumers with mental health or substance abuse issues in emergency departments. Stakeholders meetings involve state agency staff, consumers, advocates and mental health legal advocates.
- Contractual agreement with consumer group, M-Power / The Transformation Center, to provide client centered consultation to the DMH-operated adult inpatient facilities and a recovery / wellness story project. The recovery / wellness story project is designed to provide insight into the elements of life beyond the inpatient setting with a target audience of clients and staff. The Transformation Center coordinated a

Living and Learning Academy to train peer specialists to work in service provider settings in advocacy roles. Focus of contract is on developing a substantive role of consumers in MA DMH state-operated facilities. Funded through the R/S reduction SIG grant.

- Advisory Council formed as part of the implementation of the R/S reduction SIG grant to advise and review grant-related projects and development. Includes consumers, advocates, professionals, administrators in collaborative effort.
- Technical Experts Panel formed as part of the implementation of the R/S reduction SIG grant with consumer presence.
- “Patient Liaison” personnel hired in state-operated facilities. Self disclosing individuals whose job duties include conducting debriefing sessions with clients and staff post-R/S, membership on the executive committees, and inclusion on client treatment teams as a support/liaison for the client.
- Training by consumers on “Consumer Involvement” and continuous themes of consumer roles and client-driven treatment within the NTAC training that was provided to inpatient units/facilities statewide. (see #3)
- WMTC Training: “Consumer voices consider best practice models for individuals with co-occurring disorders” and “Trauma Informed treatment: A system of care response featuring the Franklin County experience – one community’s response to interpersonal violence”.
- Wellness, Recovery Action Program offered by staff trained by the Department of Mental Health and held at different sites: clubhouses, women’s resource centers, churches, survivor’s projects. WELL Project, consumer led mutual support group, published manual.
- Wellness Recovery Action Program (WRAP) is facilitated by peer-trained, peer-facilitators throughout the region. The DSS funded WMA Women’s Resource Centers in conjunction with the DPH funded RECOVER Center train peer facilitators to conduct groups.
- Well Recovery peer-run mutual help groups for women in recovery from substance abuse, mental illness and trauma. Several agencies. Manual offers guidance for consumers wishing to establish groups.
- Western MA Training Consortium has a multi-year DMH contract to support peer activities. The Recovery Learning Community staff is trained in trauma-informed support and services. ATRUIM groups will be offered and co-led by psychiatric survivors. These groups are bi-

lingual. WRAP groups are also offered. Trauma-informed care trainings are offered to all peer organizations requesting information.

- Peer-run, peer-driven groups are the focus of activities at the resource centers, which were part of the Franklin County Women and Violence site centers. They include The Writer's Way, Your Surviving Spirit (Miller on exploring spirituality) , Wellness Recovery Action Program (Copeland). Using their lived experience, facilitators integrate trauma-specific, trauma-informed exercises and insights into the curriculum. Groups are also available on a rotating basis on Reikki, movement, song writing, theater arts, and writing. CDs on songs and art are available for use. Guidelines for Developing Peer-Run Peer Driven Groups are available.
- Peer-run, peer-driven groups were the focus of activities in the Franklin County Women and Violence site. Programs continue, and include writing groups, movement groups, Reikki training, and theatre groups. CDs available on songs and art. Groups also explore spirituality using Your Surviving Spirit as curriculum. Guidelines for Peer Run, Peer Driven Programs available.
- The Department of Mental Health sponsored the development and showcased “The Dangers of Empathy” a unique, mother-daughter dramatic portrayal and play of their experience with trauma, mental illness, navigating trauma-insensitive services, and how they learned and managed through this process. This play has been presented to provider agencies, state offices and many inpatient programs.
- (DPH) Bureau of Substance Abuse Services awards a recovery community engagement center contract to Western MA Training Consortium based on a trauma-informed peer approach to community based approach to substance abuse recovery.
- (DSS) Domestic Violence awards a multiyear contract to Western MA Training Consortium that focuses on a trauma-informed life-span focused peer approach to violence in women’s lives.

Western Massachusetts Training Consortium, Inc, hosted ground-breaking Dare to Vision conference and one of nine sites in the SAMSHA-funded WCDVS research study continues to expand on and disseminate information on a peer approach to trauma recovery.

- ATRIUM (Addictions and Trauma Recovery Integration Model) (Miller). Peer co-facilitators are trained and supervised by Dr. Miller or an experienced group facilitator to conduct ATRIUM groups with male and female trauma survivors, Latinos, in battered women’s shelters, and in prisons.

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- Presentations on the WMA Women's Resource Center model on Women's Growth and Development at sites in California including San Diego State University/Interwork Institute fall 2006 and summer 2007
- Presentations on Trauma-informed Care at all DMH funded state-wide Certified Peer Specialists trainings.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- (DMH) Requirement for trauma-informed care embedded in some contractual agreements
- Mental health licensed providers bill third party payers for services. As long as an individual has a DSM IV mental health diagnosis, mental health providers can bill Medicaid for trauma group treatment through a managed care vendor: the Massachusetts Behavioral Health Partnership.
- The state is working on a system to bill for substance abuse services now provided through licensed mental health and substance abuse outpatient programs.
- Massachusetts has received \$3 million in federal disaster planning funds for public health funding of trauma services.
- Mental health licensed providers bill third party payers for services. As long as an individual has a DSM IV mental health diagnosis, mh providers can bill Medicaid for trauma group treatment through a managed care vendor: the Massachusetts Behavioral Health Partnership.
- The state is working on a system to bill for substance abuse services now provided through licensed mental health and substance abuse outpatient programs.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- Resource Guide: Developing Positive Cultures of Care, DMH, 2004, Sections on strength-based care, moving from control to collaboration, trauma-informed care, safety tools and sensory approaches.
- Resource Guide: Developing Positive Cultures of Care, (DMH, 2007), Extensive compilation of information gleaned from the Child and Adolescent Restraint Reduction Initiative reflecting trauma-sensitive best practices, resources and recommendations. The Guide, reflecting a four-year effort, contains sections on strength-based care, moving from control to collaboration, trauma-informed care, safety tools, client and family-centered care and sensory approaches. Given to inpatient and intensive residential treatment providers in Massachusetts and disseminated nationally. *Available on request.*
- Clinical Guidelines for working with Department of Mental Health clients with a history of trauma. www.mass.gov/dmh Included in DMH taskforce on the restraint and seclusion of persons who have been physically or sexually abused: Report and Recommendation, January 25, 1996. Available.
- Institute for Health and Recovery, Cambridge, MA, developed Principles for the Trauma-Informed Treatment of Women with Co-Occurring Mental Health and Substance Abuse Disorders, included in Developing Trauma-Informed Organizations: A Tool Kit.

Western Massachusetts

- Franklin Medical Center developed Trauma-Specific Clinical Practice Guidelines for working with patients on inpatient unit with histories of abuse and trauma.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- Massachusetts DMH Task Force on Restraint & Seclusion of Persons with Histories of Physical and Sexual Abuse: Report and Recommendations (1996), Carmen et.al, including Clinical Guidelines regarding DMH Clients with a History of Trauma and Trauma Assessment. Available.
- DMH Regulations effective January 1, 1998, requiring that all in-patients be asked about trauma history, and that staff develop approaches and strategies to reduce use of restraint and its traumatic impact on clients with a trauma history. Regulations apply equally to all public and private inpatient facilities that are operated, licensed or “contracted for” by DMH. Included in Massachusetts Dept of Mental Health Licensing and

Operational Standards for Mental Health Facilities. (104CMR 27.00)
Accompanied by Clinical Guidelines www.mass.gov/dmh.

- Massachusetts DMH Restraint and Seclusion Philosophy Statement commits to eliminating the use of R/S emphasizing that any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful. Focus of mental health treatment should be strength-based and promote client-centered goals of recovery and rehabilitation. The statement includes large section on impact of traumatizing environments on staff and clients. March 2004.
www.mass.gov/dmh

- DMH Restraint and Seclusion Prevention Regulations, Massachusetts, 104, CMR (*Code of Massachusetts Regulations*), 27.12 – promulgated April 3, 2006, with a clear emphasis on trauma, trauma assessment, education, and prevention of retraumatization. These regulations have been recognized as a national model in the professional literature and praised by NASMHPD and other mental health organization and States. They are considered national best practice state regulations. Some requirements include:
 - Training on the impacts of restraint or seclusion on individuals with a history of trauma, including the potential for retraumatization.
 - Training on the harmful emotional and physical effects of restraint and seclusion on patients and staff
 - Training on the impact of trauma including sexual, physical abuse and witnessing violence and linking to crisis prevention, de-escalation and alternative approaches
 - Individual crisis prevention plans with regular updates addressing triggers and strategies. In order to minimize trauma or re-traumatization, patient’s preferences (type of intervention and positioning) and gender of staff will be identified if R/S is used
 - Assessment of the impact of trauma and potential for retraumatization
 - Sensory interventions and therapies designed to calm and comfort consumers
 - Debriefing: consideration of counseling or medical evaluation and treatment for patient and staff to address emotional or physical trauma that may have resulted from R/S incident
 - Regular use of debriefing (consumer and staff) to address and ameliorate traumatic impact
 - Using debriefing information to identify what led to incident in order to prevent future occurrence
 - Patient comment and Debriefing Form submitted to the Human Rights Officer for follow-up. Attention to possible rights violation or other harmful consequence. www.mass.gov/dmh

- (DMH) Restraint and Seclusion Policy (September, 2007). Policy supports elimination of R/S, acknowledgement of experience of patients “coping with the aftermath of traumatic experiences”. Provides guidelines for DMH-operated and contracted facilities regarding definitions and procedures to prevent R/S and procedures that are as safe as possible when used. Forms, timelines for orders, restrictions are also included. www.mass.gov/dmh.
- The Child and Adolescent Restraint Reduction Initiative (September 2000 – present) includes all acute (licensed) and continuing care (state-operated and contracted) and intensive residential treatment programs serving children and adolescents in Massachusetts. State has continued to move forward on a statewide child and adolescent restraint reduction/elimination effort with an alternative focus on strengths-based care. As a result, seclusion and restraint have plummeted in acute and continuing care inpatient programs across the state. Best practice training and technical assistance offered by DMH. Providers must develop yearly strategic plans and present annually at a Provider Presentation Forum. Result: trauma-sensitive, strengths-based approaches being used.
- Demonstrates how state mental health authority can use its role as a change agent to provide direction and improve clinical care environments for children and adolescents. See Child and Adolescent Inpatient Restraint Reduction: A State Initiative to Promote Strength-Based Care. LeBel et.al, (2004). Article available.
- Individual Crisis Prevention Plan: a tool developed by clients and clinicians to address de-escalation planning and to identify triggers, warning signs and behavioral strategies. Applied to all populations in continuing care, acute inpatient and intensive residential treatment programs, e.g.:
The Adolescent Safety Zone Tool developed with adolescent clients,
The Safety Tool for Younger Children, an individual child-friendly tool using picture and age appropriate strategies. www.mass.gov/dmh.
- Massachusetts Department of Public Health Bureau of Substance Abuse Services Fiscal Year 2004 Request for Response: Terms and Conditions and Standards of Care for the Alcohol and Other Drugs Service System. Winter 2003. Requires all contract agencies be trauma-informed and provide access to trauma-specific services. **Available at:**
<http://MassCHIP.state.ma.us>;
<http://www.state.ma.us/dph/bsas>.
- Massachusetts Department of Corrections requires agencies contracted to provide substance abuse and mental health services in women’s correctional institutions to provide trauma-informed care.

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9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

Three sites of the Women, Co-Occurring Disorders and Violence Study:

- Boston Consortium of Services for Families in Recovery, Boston, a city health department based integrated system of services housed within three substance abuse treatment modalities: outpatient counseling, methadone maintenance and residential treatment serving primarily Latina and African American women in metropolitan Boston.

Key service components: women enrolled in substance abuse treatment programs will receive an enhanced intervention that includes TREM groups, trauma-informed Family Strengthening Groups and Family Reunification Groups, Consumer Survivor and Recovery Leadership Trainings and Economic Planning Groups developed specifically for women with co-occurring disorders.

- Women Embracing Life and Living (WELL), Cambridge, three dually licensed mental health and substance abuse providers servicing women with co-occurring disorders in eastern Massachusetts.

Key service components: WELL offers an adapted version of Seeking Safety, in conjunction with C/S/R facilitated mutual help groups and the Nurturing Families program, a parenting intervention designed to increase the capacity of parents to heal the parent-child relationship from the impact of substance abuse, mental illness and trauma. Women receive resource and care advocacy and coordination from integrated care facilitators and all sites receive integrated supervision from a clinical expert and cross trainer.

- (WMTC) Franklin County Women's Research Project, Greenfield, a collaboration between mental health and domestic violence service providers serving women with co-occurring disorders in rural Massachusetts.

Key service components: Three women's drop-in centers serve as the focal point of the intervention and offer peer resource advocates, trauma recovery groups using the Addiction and Trauma Recovery Integration Model (ATRIUM) and opportunities for consumer involvement.

Available Materials

Finkelstein, N. VandeMark, N., Fallot, R., Brown, V., Cadiz, S. and Heckman, J. (2004). Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment. Sarasota, FL: National Trauma Consortium.

Markoff, L.S., Finkelstein, N., Kammerer, N., Kreiner, P., and Prost, C.A. (2005). Relational systems change: Implementing a model of change in integrating services for women with substance abuse and mental health disorders and histories of trauma. *Journal of Behavioral Health Services and Research*, 32, 227-240.

National Abandoned Infants Assistance Center (2007) Trauma-Informed Services for Families Affected by Substance Abuse or HIV. *The Source*, 16 (1).

Many additional articles available in professional journals

Department of Mental Health

- Universal Trauma Assessment (computerized medical record) applicable to all DMH-operated programs. All licensed and contracted inpatient programs must assess patients for trauma on admission (by regulation.)

Department of Public Health Bureau of Substance Abuse Services

Assessment for trauma is required of all Alcohol and Other Drugs Services System providers under Fiscal Year 2004 Request for Response Terms and Conditions and Standards of Care.

- All women's residential substance abuse treatment programs incorporate a brief assessment for trauma in their regular intake process, screening and assessment tools.
- Massachusetts DMH conducted a point in time analysis/study examining trauma histories of all child and adolescent consumers in long-term care settings (2001) and repeated the analysis (2007). These findings have been included in NASMHPD-NTAC trainings, published in part in *Psychiatric Services* (2005) and will be published in 2008.
- Contract with trauma expert funded through the R/S reduction SIG grant to provide trauma-based consultation to two DMH state operated hospitals. This consultation will serve to support a pilot project aimed at delivering a trauma informed service with implementation guidelines. Scope of service includes:
 - Assess training needs at each facility to and build training plan.
 - Conduct training in key areas in trauma informed care skill development.
 - Provide final report identifying specific treatment tools to support identified activities, including person responsible for follow-up.
 - A best practice model will be followed.

- Establish a strategic plan for ongoing site support
- Part of R/S reduction SIG expectations is provision of de-identified facility and client information to the Human Services Research Institute (HSRI – Cambridge, MA) as part of the eight state, data aggregation project. These data expected to contribute to evidence base and include:
 - Facility characteristics (number of beds, types of treatment, staffing, age/gender of clients, etc.),
 - An inventory of seclusion and restraint reduction interventions which follows the NTAC Six Core Strategies© and requires the facility to document how these strategies are implemented.
 - Treatment and Event data which presents usual treatment information for all inpatient treatment (milieu demographics, previous living situations, admission diagnosis, court involvement or legal status, discharge planning, and discharge living situations) and specific event data related to a seclusion/restraint occurrence (type of event, type of intervention, staff and client injury data, etc.)

Western Massachusetts

- Adaptation and enhancement of DMH Trauma Assessment by Franklin Medical Center. Eastspoke inpatient unit and partial hospitalization program, gathers more comprehensive information on an individual's trauma experience, history, and needs.

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10. Universal trauma screening and assessment.

Department of Mental Health

- Universal Trauma Assessment (computerized medical record) applicable to all DMH- operated programs. All licensed and contracted inpatient programs must assess patients for trauma on admission (by regulation).
- DMH Restraint and Seclusion Prevention Regulations require trauma assessments, individual crisis plans and staff to be trained in trauma informed care and the consumer experience of seclusion and restraint.

Department of Public Health Bureau of Substance Abuse Services

- Assessment for trauma is required of all Alcohol and Other Drugs Service System providers under Fiscal Year 2004 Request for Response Terms and Conditions and Standards of Care.
- All women's residential substance abuse treatment programs incorporate a brief assessment for trauma in their regular intake process, screening and assessment tools.

Boston

- Boston Consortium of Services for Families in Recovery – Boston Public Health Commission developed and implemented co-occurring disorders

screening tool used for all admissions to substance abuse treatment services.

Western Massachusetts

- Adaptation and enhancement of DMH Trauma Assessment by Franklin Medical Center Eastspoke inpatient unit and partial hospitalization program gathers more comprehensive information on individual trauma experience, history and needs.

Department of Mental Health (required by regulation 104 CMR 27.12)

- Trauma Assessments required on all patients admitted to state-operated, contracted and licensed inpatient facilities and intensive residential treatment programs.
- Crisis Prevention Plans require identification of triggers & strategies on admission in order to provide support and minimize possible escalation

Department of Public Health Bureau of Substance Abuse Services

- Assessment for trauma is required of all Alcohol and Other Drugs Service System providers under Fiscal Year 2004 Request for Response Terms and Conditions and Standards of Care.
- All women's residential substance abuse treatment programs incorporate a brief assessment for trauma in their regular intake process, screening and assessment tools.

11. Trauma-informed services and service systems.

DMH Restraint and Seclusion Prevention

- MA-DMH received one of eight SAMSHA-funded State Incentive Grants (SIG) designed to reduce the use of R/S with the specific purpose of providing leadership training and changing facility/system practice in order to provide trauma-informed care and decrease coercion and violence. The goal of the grant is to support the facilities in the development and use of the NTAC Six Core Strategies©, Leadership, Consumer Involvement, Workforce Development, Prevention Tools, Debriefing and Use of Data. While two specific sites; Westboro and Taunton State Hospitals, are the facilities targeted, all DMH-operated inpatient services have been part of the formal in-state project. Trauma-informed Care is the bedrock of the initiative and significant reduction in the use of R/S has occurred. Technical assistance, training and equipment (sensory resources) funded over three years by the SIG grant.
- Worcester State and Tewksbury State Hospitals have been implementing the above NTAC Six Core Strategies© over the past four years since attending the NTAC training in 2003.
- DMH Restraint and Seclusion Prevention Regulations, Massachusetts, 104, CMR (*Code of Massachusetts Regulations*), 27.12 –

promulgated April 3, 2006, with a clear emphasis on trauma, trauma assessment, education, and prevention of retraumatization. These regulations have been recognized as a national model in the professional literature and praised by NASMHPD and other mental health organization and States. They are considered national best practice state regulations. Some requirements include:

- Training on the impacts of restraint or seclusion on individuals with a history of trauma, including the potential for retraumatization.
- Training on the harmful emotional and physical effects of restraint and seclusion on patients and staff
- Training on the impact of trauma including sexual, physical abuse and witnessing violence and linking to crisis prevention, de-escalation and alternative approaches
- Individual crisis prevention plans with regular updates addressing triggers and strategies. In order to minimize trauma or re-traumatization, patient's preferences (type of intervention and positioning) and gender of staff will be identified if R/S is used
- Assessment of the impact of trauma and potential for retraumatization
- Sensory interventions and therapies designed to calm and comfort consumers
- Debriefing: consideration of counseling or medical evaluation and treatment for patient and staff to address emotional or physical trauma that may have resulted from R/S incident
- Regular use of debriefing (consumer and staff) to address and ameliorate traumatic impact
- Using debriefing information to identify what led to incident in order to prevent future occurrence
- Patient comment and Debriefing Form submitted to the Human Rights Officer for follow-up. Attention to possible rights violation or other harmful consequence.

www.mass.gov/dmh

(DMH) Child and Adolescent Restraint Reduction Initiative

- (September 2000 – present) DMH has continued to move forward on its statewide child and adolescent restraint reduction/elimination effort with an alternative focus on strength-based care. Includes all acute (licensed) and continuing care (state-contracted) and intensive residential treatment programs serving children and adolescents in Massachusetts. Best practice training and technical assistance offered by DMH to support goal. As a result, seclusion and restraint and other

coercive practices have continued to decrease in acute and continuing care inpatient programs across the state. Providers develop yearly strategic plans and present annually at a Provider Presentation Forum. This initiative provided and continues to provide concerted focus on trauma, the impact of trauma, sensorimotor interventions, and trauma treatment. See publication: LeBel, Stromberg, Duckworth et al, "Child and Adolescent Inpatient Restraint Reduction: A State Initiative to Promote Strength-Based Care", *Journal of the American Academy of Child & Adolescent Psychiatry*, 2004,43:1, 37-45. Article available on www.mass.gov/dmh

This initiative demonstrates how state mental health authority can use its role as a change agent to provide direction and improve clinical care environments for children and adolescents. See [Child and Adolescent Inpatient Restraint Reduction: A State Initiative to Promote Strength-Based Care](#). LeBel et.al, (2004). [Article available](#).

Bureau of Substance Abuse Services

- (DPH) State Department of Public Health Bureau of Substance Abuse Services stipulates in its 2004 Request for Response [Terms and Conditions and Standards of Care for Alcohol and Other Drugs Service System](#) that all contracted programs must be trauma-informed and provide access to trauma-specific services.
- Department of Public Health/Bureau of Substance Abuse Services assists substance abuse treatment programs in meeting requirement to become trauma-informed through the Trauma Integration Initiative. Programs receive training, technical assistance, supervision, and co-facilitation of trauma-specific groups in a train-the-trainer model through the Institute of Health and Recovery. Programs are required to conduct a Trauma Self-Assessment prior to and subsequent to receiving these services, and must develop and implement a Trauma-Informed Strategic Plan in order to participate. This initiative will be presented at the American Public Health Association annual meeting in November 2007.

[Massachusetts State Leadership Council](#) members are from state agencies of mental health, substance abuse, child welfare, public health, childcare services, social services, Medicaid. Council developed toolkit and recommendations for integrating systems of care across state agencies for trauma survivors with co-occurring mental health and substance abuse disorders.

- Self-assessment, principles and guidelines in the Massachusetts State Leadership Council's Toolkit for Developing Trauma-Informed Organizations are used by State and Provider agencies to respond to state requirement that all contract agencies be trauma-informed and provide access to trauma-specific services. (See Section 12) Toolkit available.
- Toolkit and article "Relational Systems Change: Implementing a Model of Change in Integrating Services for Women with Substance Abuse and Mental Health Disorders and Histories of Trauma" available.

Governors Commission on Domestic Violence and Sexual Assault

- includes representatives of provider services, consumers and state agency systems. The Commission addresses policy, practice and interagency integration for people who are victims of domestic violence and sexual assault throughout the state service sectors.

Governor's Commission on Corrections Reform, Dedicated External Female Offender Review, Recommendations. Commonwealth of Massachusetts, Executive Office of Public Safety, Department of Correction

- Collaboration among representatives from DMH, Corrections, substance abuse, state legislators and higher education. Recommendations focus on need for trauma-informed environment and integration of health, mental health and substance abuse treatment, 2005. *Available on request*

Task Force formed to address and improve the treatment of people with mental health and behavioral disorders in Emergency Departments (ED's).

- Includes state agencies (DMH & DPH), consumers, advocates and Emergency Department (ED) professionals with the purpose of reviewing ED culture and practices and supporting the implementation of trauma informed care within these settings.
- This Task Force emerged out of complaints by consumers and substantiated by the Department of Public Health, the state regulatory authority. The complaints identified disrespectful treatment, harm and re-traumatization including unnecessary restraint, seclusion, forced stripping, forced medication, excessive physical force and other coercive practices. Joint DMH & DPH Commissioners memorandum offering a set of practice recommendations distributed to all Massachusetts General Hospitals. (See #2) *Available on request.*

Western Massachusetts

- Wellness Recovery Action Program (WRAP) is facilitated by peer-trained, peer-facilitators throughout the region. The DSS funded WMA Women’s Resource Centers in conjunction with the DPH funded RECOVER Center train peer facilitators to conduct groups.
- Spectrum Health Systems, Inc., subcontracts with the Institute for Health and Recovery to provide training and consultation on trauma-informed and trauma-specific services (Seeking Safety) to all substance abuse treatment programs in state correctional institutions for women.
- Department of Mental Health contracts with Institute for Health and Recovery to provide consultation on trauma-informed care in ten state mental institutions for adults.
- Hope Found contracts with Institute for Health and Recovery to provide training and consultation to their short-term women’s substance abuse treatment program (funded by SAMHSA) and their homeless outreach program to enhance their ability to provide trauma-informed care.
- A collaboration between Gosnold, Inc., Institute for Health and Recovery, Safe Harbor and Independence House provides trauma-informed substance abuse treatment, trauma-specific services, and trauma-informed parenting services for families experiencing domestic violence on Cape Cod.

The Children’s Trauma Recovery Foundation’s Community Services Program

- Children’s Trauma Recovery Foundation© :Funded by the Department of Mental Health – Metro Boston Area – Child/Adolescent Services, The Children’s Trauma Recovery Foundation’s Community Services Program (formerly The Trauma Response Program) provides an integrated, community-based trauma response program, utilizing state-of-the-art, trauma-specific intervention strategies with the goal of decreasing the negative effects of maltreatment and exposure to traumatic incidents on children and youth in the Boston Area and throughout the Commonwealth. Extensive service system including provision of child, adolescent, family and school services, family stabilization and coping groups. Comprehensive consultation and education. Ethno-cultural variables and Post Traumatic Stress Disorder addressed.
- Training module entitled “Compassionate Alternatives and Techniques” stressed the importance of cultural sensitivity within the

client/staff interaction. It also emphasized the possibility of cultural and political traumatization as part of client history.

Disaster

- The Massachusetts Department of Mental Health (DMH) has had structures in place for more than 18 years to provide emergency and disaster crisis counseling to the general public during times of President or Governor-declared states of emergency, or other local, regional, or statewide catastrophic events. These structures have been considerably revised and expanded following the events of 9/11/2001.
- DMH is a longstanding member of the Massachusetts Emergency Management Team (MEMT) and the support agency for mental health as part of the State Comprehensive Emergency Management Plan. DMH is also called upon to assist with Essential Support Functions, often in conjunction with the American Red Cross.
- Since 2004, DMH has co-chaired the Disaster Behavioral Health Committee (DBHC) along with DPH in a collaborative effort. This group is made up of public and private disaster behavioral health stakeholders including public health, mainstream emergency management, voluntary organizations such as the Red Cross, and Mental Health Professional Organizations that have disaster response capabilities. This committee acts as a resource network during times of disaster.
- DMH partnered with DPH to provide training and technical assistance in preparing an All-Hazards Disaster Plans guide (based on the SAMHSA/NASMHPD guide) for both DMH and DPH facilities and offices as well as provider-run programs. Three training sessions were held in 2006 in conjunction with Boston Medical Center (Center for Multicultural Mental Health). The guide is entitled: "All-Hazards Emergency Planning Guide for Mental Health and Substance Abuse Providers". Document available at:
http://www.mass.gov/samh/pdfs/all_hazards_guide.pdf
- DMH has a close partnership with DPH's CDC and the HRSA cooperative agreement projects since 2004. For FY'08, DMH is receiving funding from DPH through the ASPR Hospital Preparedness grant to develop emergency preparedness and behavioral health disaster response capabilities in relation to public health emergencies and hospital preparedness.
- The MassSupport project was completed in 2005. DMH continues to work on shared projects with DPH including the continuation of the disaster behavioral health public information activities and a 24-hr hotline. For further information, contact:
www.mass.gov/cohhs/MassSupport
- DMH participates with DPH in planning and drills related to bioterrorist and/or health threats. Since 2004, DMH responded to 8 major emergency events in the Commonwealth, including the FEMA

airlift of evacuees from New Orleans, LA to Massachusetts for recovery assistance in 2005. DMH continues to develop special protocols for behavioral health response.

- (DMH) One regional area demonstrated excellent practice (NorthEast Area) in providing rapid mental health response to a number of local emergencies in conjunction with the Red Cross and other state agencies. These included responding to the following: flood victims, explosion victims along with obtaining crisis counselors for deaf individuals affected by blast and victims in school emergencies including providing grief counseling. Also participated in a nuclear power plant federal graded exercise, 2004-2007.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

State Department of Public Health/Bureau of Substance Abuse

Services supports:

- Seeking Safety trauma groups in residential treatment, outpatient and drug court settings statewide. Groups for men and for women. Manual available.
- TREM (Trauma Recovery and Empowerment Model) groups are in approximately 35 residential treatment settings across the state, for women, women and children, and family shelter programs. Manuals available.
- Nurturing Families Parenting Groups for women and children in recovery from substance abuse, mental illness and trauma. Offered in outpatient substance abuse treatment settings statewide. Curriculum available.
- Helping Women Recover: Group approach to addressing trauma and addiction, used by substance abuse programs to facilitate groups and for individual use. Curriculum available.
- Well Recovery peer-run mutual help groups for women in recovery from substance abuse, mental illness and trauma. Several agencies. Manual offers guidance for consumers wishing to establish groups.
- BCSFR (BPHC) developed a cultural adaptation and Spanish translation of TREM for Latinas.
- MA-DMH received one of eight State Incentive Grants (SIG) awarded by SAMHSA with the specific purpose of providing leadership training

and changing facility/culture practices to become trauma-informed and decrease coercion and violence. The goal of the grant is to support the facilities in the development and use of the NTAC Six Core Strategies and submit relevant data with the goal of demonstrating evidence-based practice.

- Trauma Systems Therapy, developed by Glenn Saxe, MD and colleagues at Boston Medical Center, was formally implemented at the Boston Medical Center Intensive Residential Treatment Center which serves severely traumatized adolescents.
- The Riverside Trauma Center helps local communities, school, government agencies, healthcare and human services providers, and workplaces cope with the emotional aftermath of traumatic event such as natural disasters, accidents, suicides, or homicides. Riverside Trauma Center is funded in part by the Massachusetts Department of Mental Health.
- The Carson Center for Human Services is conducting a Fall 2007 Seminar: The Treatment of Post Traumatic Stress Disorders; and in October is starting their first group – Survivors of Domestic Violence.
- Cohannet Academy, a DMH-contracted intensive adolescent treatment program, has a partnership and grant with the Trauma Center in Brookline, Massachusetts. Specific application of a program and curriculum, ARC. *Affective Regulation Curriculum* is being used.

Boston

- English and Spanish curricula for the following group interventions developed and available through [Rita Nieves@bphc.org](mailto:Rita.Nieves@bphc.org): Spanish cultural adaptation of TREM; Economic Success in Recovery: An educational group curriculum for women in recovery; Exito Con Mi Dinero y Mi Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion; Pathways to Family Reunification and Recovery: An educational group curriculum for women in recovery; Caminos Para la Reunificacion y la Recuperacion; Women's Leadership Training Institute: An educational group curriculum for women in recovery; Instituto de Entrenamiento para Mujeres Lideres en Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion.

Western Massachusetts

- Western Massachusetts Department of Mental Health, Western Massachusetts Training Consortium, Inc, and two drop-in/resource

centers (Survivor's Project in Greenfield MA, and Turners Falls Women's Resource Center, in Montague, MA continue to offer trauma services developed through participation as one of the nine WCDVS study sites. (1998-2003): Services include:

- The Survivor's Project and the Turner's Falls Women's Resource Centers provide four core elements (safe space, trauma groups, peer resource advocacy and opportunities for valued roles), addressing each step in the recovery and growth model developed as part of the WCDVS site in Franklin County.
- ATRIUM (Addictions and Trauma Recovery, Integration Model), a trauma-specific group model integrating body-mind-spirit. Offered for women in substance abuse recovery with histories of trauma and mental health problems at two resource centers. Peer co-facilitators trained and supervised by experience group facilitator lead the groups.
- Peer-run, peer-driven groups are the focus of activities at the resource centers, and include The Writer's Way, Your Surviving Spirit (Miller on exploring spirituality) , Wellness Recovery Action Program (Copeland). Using their lived experience, facilitators integrate trauma-specific, trauma-informed exercises and insights into the curriculum. Groups are also available on a rotating basis on Reikki, song writing, theater arts, and writing. Guidelines for Developing Peer-Run Peer Driven Groups are available.

Michigan

1. Trauma function and focus in state mental health department.

Michigan's plan submitted to SAMHSA/CMHS for federal block grant funds Block Grant includes Michigan's commitment to support a trauma-informed system of care in the state's public mental health system. The state has provided training to the CMHSP staff, directors and board members regarding this policy initiative, best practices and impact on consumers.

The Director of the Office of Consumer Relations is directly responsible for the implementation of trauma informed and trauma related implementation for adults with mental illness.

The Director of the Division for Services to Children and Families is responsible for the trauma issues affecting children. Community mental health services are delivered through the state's public mental health system made up of 46 community mental health services programs (CMHSPs). CMHSPs are county-based organizations.

A trauma committee has been formed at the state level to begin the development of trauma-informed services in Michigan. Statewide trainings and keynote addresses have been carried out to begin the education initiative for CMHSPs. Federal SAMHSA/CMHS block grant funds are being used to implement training and system changes required to support a trauma-informed system of care.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

The Michigan Department of Community Health has linked with the Social Work Department at the University of Michigan regarding the promotion of education in mental health emphasizing trauma.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

The statewide Michigan Recovery Council comprised of consumers, state and county administrators and staff, advocates and families is the main connection to promote the consumer aspects of trauma and the need for trauma-sensitive services.

The Office of Consumer Relations has the lead in promoting and implementing trauma awareness among consumers and staff.

6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 - SAMHSA/CMHS block grant funding is being used to support trauma initiatives. Five pilot projects were funded in FY2007.
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**
10. **Universal trauma screening and assessment.**
11. **Trauma-informed services and service systems.**
 - Some initial steps in this area are underway through the Michigan Recovery Council.
 - A trauma initiative supported through the state's CMHS block grant is underway in the Detroit area. This initiative includes specialized trauma services to individuals from the Middle East who suffered torture.
12. **Trauma-specific services, including evidence-based and promising practice treatment models.**

Mississippi

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**

TRY of Catholic Charities in Jackson, MS, is a member of the effective evidence-based treatments for child trauma; collect data for systematic study; and, help to educate professionals and the public about the effects of trauma on children.

In working toward NCTSN's overall goal, TRY, along with Esther Deblinger and the University of Medicine and Dentistry of New Jersey –School of Osteopathic Medicine, sponsored a learning collaborative focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TFCBT).

The Department of Mental Health has allocated part of its increase to the FY 2007 CMHS Block (\$52,511) to expand training in the evidence-based practice of trauma-focused cognitive behavioral therapy, building on “lessons learned” through the four-year Mississippi Trauma Recovery for Youth (TRY) project. The first Learning Collaborative effort provided training in the evidence-based practice of trauma-focused cognitive behavior therapy for a core group of mental health therapists and their supervisors at Gulf Coast Mental Health Center (Region 13 CMHC) from October 2006 through April 2007.

This national collaborative learning model has become a part of an approach for implementing an evidence-based practice at the community level in Mississippi, beginning with implementation of trauma-informed services for youth. The conceptual framework of the project involves a collaborative learning approach targeting clinical/supervisory staff for intensive training in the evidence-based practice, followed by specified periods of implementation of standardized assessment and treatment approaches, during which the staff receive expert consultation through the project and peer support through focused staff meetings. The project also involves tracking of provision of services and treatment outcomes over a period of time. The project is designed so that clinical management information can be integrated into the overall quality management program at the direct service and administrative levels.

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- A grant for the Mississippi Trauma Recovery for Youth (TRY) project, funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA), began in October 2003. Catholic Charities, Inc. is leading this four-year project in the Jackson, tri-county area, to raise the awareness about child trauma and to improve access to services for children and youth who have been traumatized.
- The Department of Mental Health has allocated part of its increase to the FY 2007 CMHS Block (\$52,511) to expand training in the evidence-based practice of trauma-focused cognitive behavioral therapy, building on “lessons learned” through the four-year Mississippi Trauma Recovery for Youth (TRY) project.

7. Clinical practice guidelines for working with children and adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

The TRY project involves tracking of provision of services and treatment outcomes over a period of time. The project is designed so that clinical management information can be integrated into the overall quality management program at the direct service and administrative levels

10. Universal trauma screening and assessment.

The TRY project is supporting the validation of a strengths-based assessment tool for use with traumatized children and youth.

11. Trauma-informed services and service systems.

- A grant for the Mississippi Trauma Recovery for Youth (TRY) project, funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA), began in October

2003. Catholic Charities, Inc. is leading this four-year project in the Jackson, tri-county area, to raise the awareness about child trauma and to improve access to services for children and youth who have been traumatized. Through partnership with existing community agencies and programs, the project is developing the TRY Network, which is focused on increasing understanding about child trauma, endorsing the use of best practices in serving traumatized children and youth, and promoting collaboration between systems. The TRY Project is also supporting the validation of a strengths-based assessment tool for use with traumatized children and youth.

- TRY of Catholic Charities in Jackson, MS, is a member of the effective evidence-based treatments for child trauma; collect data for systematic study; and, help to educate professionals and the public about the effects of trauma on children. The goal of the NCTSN is to improve the quality, effectiveness, provision and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. In working toward NCTSN's overall goal, TRY, along with Esther Deblinger and the University of Medicine and Dentistry of New Jersey –School of Osteopathic Medicine, sponsored a learning collaborative focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TFCBT).

12. Trauma-specific services, including evidence-based and promising practice treatment models.

In working toward NCTSN's overall goal, TRY, along with Esther Deblinger and the University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine, sponsored a learning collaborative focused on adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TFCBT).

Missouri

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
 - Department of Mental Health (DMH) Position Statement on Services and Supports for Trauma Survivors. All three divisions of DMH: mental retardation, mental health, alcohol and drug abuse, come under this position statement. Available on department website at <http://www.dmh.mo.gov/spectopics/TraumaInit/Trauma.htm>
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**
 - Annual Spring Training Institute has a Trauma Track focused on trauma-informed care. Many experts in the trauma field have presented over the past seven years. The 2007 Spring Training Institute two and a half day training had over 1133 direct care staff and consumers participate.
 - A full time Psychologist/Consultant was recently hired to facilitate the implementation of Dialectical Behavior Therapy across the continuum of care in the State of Missouri. The major focus of this position will be on building system wide capacity to provide effective treatment to individuals diagnosed with Borderline Personality Disorder (a large percent of whom are also diagnosed with PTSD), as well as for other consumers who experience significant behavioral and emotional dysregulation. This skills-based focus will provide a foundation for trauma interventions that many individuals will require at a more advanced stage of treatment. In addition, training will be provided to staff in diverse treatment contexts in “validation”-or the technology of acceptance. Such training will focus on developing an understanding of the origins of difficult behaviors commonly seen in the mental health system, and on skill building that will allow providers to persist in a compassionate view of consumers in the face of painful or hostile interactions, intractable symptoms, and professional discouragement.
 - The Evidence Based Practice Model of Trauma Focused Cognitive Behavioral Therapy was presented to eight Administrative Agents in the Western Region of the state. The Clinical Supervisor and the primary therapist were encouraged to attend. There was a one-day session training on the model and supervision. There were 30 days of on-line exercises and responses to therapists utilizing the EBP model. There was a second day for consultation and follow up. Lastly, there was six months of supervisory oversight with the Clinical Supervisor and primary therapist provided. Nineteen therapists have been credentialed in the eight Administrative Agents to provide Trauma Focused Cognitive Behavioral Therapy.

- The DMH co-sponsored a successful conference in March 2007 titled *Mental Health Needs of Returning Soldiers and Their Families*. Nationally recognized speakers:
 - Provided theoretical overview and hands-on treatment practicum in dealing with treatment of returning soldiers and their families.
 - Identified current mental health issues of returning soldiers and their families.
 - Developed a plan for additional services to meet the current and future mental health needs of returning soldiers and their families.
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
 6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 - Division of Alcohol and Drug Abuse contracts with community providers for 12 gender specific Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs specializing in the treatment of women and their children. The programs are required to address therapeutic issues relevant to women, including safety and domestic violence. CSTAR fee-for-service/Medicaid pays for individual and group counseling and group education. Seeking Safety program is financed as individual or group counseling billing under CSTAR/Medicaid.
 - Billing codes for trauma individual counseling and trauma group education were created and added to the alcohol and drug abuse treatment contracts with community providers.
 7. **Clinical practice guidelines for working with children and adults with trauma histories.**
 8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
 - Department Operation Regulations (DOR) were rewritten to reduce seclusion and restraint in state psychiatric hospitals. The DOR requires “Administration of an instrument chosen by the facility to collect information about the consumer’s history of exposure to traumatic events, including physical and sexual abuse.” Missouri’s acute psychiatric facilities have incorporated “Use of an instrument or form that collects systematic information about stimuli or situations that typically increase the individual consumer’s degree of agitation, activities or interventions that are typically calming when the consumer is agitated and the consumer’s history of

restraint or seclusion in psychiatric settings.” Provides a tool – when coupled with JCAHO-required questions regarding histories of abuse – for clinicians to explore trauma-related issues. Close monitoring of use of seclusion and restraint is conducted. At the Focus on Safety grant site at Fulton State Hospital comfort carts and comfort rooms are being utilized.

9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**
10. **Universal trauma screening and assessment.**
11. **Trauma-informed services and service systems.**
12. **Trauma-specific services, including evidence-based and promising practice treatment models.**

Montana

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**
 - Evidence Based Practice trainings (PACT, IDDT, DBT) address trauma as an integral component of that practice.
 - The Mental Health Strategic Plan includes training to begin the implementation of Trauma Informed best practices in 2008-2009.
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**

Consumers are actively involved in all Mental Health planning activities. No explicit mention of trauma survivors or trauma activities – so no X

6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**
10. **Universal trauma screening and assessment.**

Trauma screening is a required element of client assessment in all programs

11. **Trauma-informed services and service systems.**

Ed Amberg, Administrator, Montana State Hospital is responsible for the implementation of a strategic plan to reduce the use of seclusion and restraint in that facility

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Nebraska

1. Trauma function and focus in state mental health department.

There is a 3 year statewide project, currently in year 2, funded through the Division of Behavioral Health. The project is called Trauma Informed Nebraska (TIN). The purpose of TIN is to plan, develop and implement strategies for a trauma informed system of Behavioral Health.

The Division of Behavioral Health has staff members on the Coercion Free Nebraska (CFN) Coalition, which focuses on alternatives to restraint and seclusion throughout the behavioral health system. It is co-chaired by the Division's Chief Medical Officer.

2. State trauma policy or position paper.

The Division of Behavioral Health Trauma Informed Services Policy is in the approval and signature process. Signing and a media event is targeted for November 2007.

The State's Regional Centers have a Trauma Informed Care Policy signed and implemented in May 2007.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Statewide 1-day 7-module trainings on Women, Substance Abuse and Trauma: Trauma signs and symptoms, screening for complex trauma using Complex Trauma Screen, response if trauma history is indicated. Representatives from every publicly funded behavioral health provider have received this training. Curriculum and Screening tool still available.
- Core Competencies for gender specific treatment apply statewide for providers working with women. Document still available.
- Trauma Informed Nebraska (TIN) has 6 workgroups. One workgroup focuses on Work/Educational Competencies; the other workgroups include Consumer/Survivor/Recovery; Mental Health; Addictions; Policy; Screening/Assessment.
- The Division of Behavioral Health's contracts and regulations are being revised to include Trauma Informed language and expectations. Contracts for FY 2008-2009 will include the revised language. Draft

regulations are expected to be through the review and approval process by the end of 2008.

- Regional Center staff orientation includes trauma informed care principles. There is an independent study packet which was developed and completed in October 2007.
- The Chief Clinical Officer for the Division and active participant in TIN is on staff at Creighton University Medical Center.

Nebraska

- Nebraska is one of two states chosen by SAMHSA as a pilot site for a training guide entitled Roadmap to a Restraint-Free Environment for Persons of All Ages. The Lincoln Regional Center was chosen as the public facility and Natchaug Hospital in Mansfield Center, Connecticut, was chosen as the private pilot site. A total of 16 states/facilities expressed interest in being a pilot test site.
- The training is consumer centered and was given to approximately 30 employees of the Lincoln Regional Center, March 31 – April 2, 2004. LRC is in the process of sharing pre-training and post-training restraint data with SAMHSA to determine the impact of the program. Several LRC staff were evaluated before the training and are in the process again post-training on perceptions of their knowledge, attitudes, beliefs, and use of alternatives to seclusion and restraint. The training materials will be revised, based on data and feedback from participants, and distributed to states nationwide.
- The National Association of Consumer/Survivor Mental Health Administrators provided all training materials. SAMHSA's Center for Mental Health Services contracted with the Association to evaluate the draft training guide.
- The Regional Centers have study packets regarding trauma principles as it relates to restraint and seclusion. The Regional Center's Restraint and Seclusion Reduction Committee meets monthly to coordinate coercion free and trauma informed processes.
- TIN year 3 recommendations will include procedures and models to avoid retraumatization.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- NASMHPD National Association of Consumer/Survivor Mental Health Administrators, a group of directors of offices of consumer affairs in states, published The Roadmap to Restraint and Seclusion Free

Environment. Pilot at Lincoln Regional Center, three-day staff training. Roadmap training kicked off by panel of consumers.

- Consumers were involved in reviewing the trauma-based training and toolkit material developed by the Women's Coalition.
- TIN members include consumer/survivor/recovering persons.
- The Division of Behavioral Health has an Office of Consumer Affairs as well as a Consumer Specialist in each of the six Behavioral Health Regional offices.
- TIN has website forums which are Peer Run Trauma Informed Support Groups (based on 16 steps for empowerment and recovery).
- The Regional Centers have a Consumer Advocacy Team (CAT) which meets regularly. The CAT will be involved in doing a self-assessment for Trauma Informed Services in November 2007.
- TIN has developed a self-assessment and a peer review process for providers to review the degree to which they are trauma-informed. Consumers will be a part of each of the review teams.
- Wellness Recovery Action Plan education for consumers is ongoing through the Division's Office of Consumer Affairs, the Regional Centers and the Division of Behavioral Health's Regional Consumer Specialists.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Currently TIN is funded under a 3 year contract. Final recommendations in year 3 of the contract are to address funding issues and implementation of a statewide model.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- TIN developed a Self-Assessment and Survey Tool for provider agencies to utilize.
- TIN will utilize survey data to develop and implement clinical guidelines for working with people with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- The Division of Behavioral Health regulations are currently being reviewed and Trauma Informed practices and treatment will be addressed. Review and approval process is targeted for the end of 2008.
- The Department of Health and Human Services Regulation and Licensure Division removed proposed trauma language in 2006, however, regulations are in the process of review again.
- The Division of Behavioral Health's contracts and regulations are being revised to include Trauma Informed language and expectations. Contracts for FY 2008-2009 will include the revised language. Draft regulations are expected to be through the review and approval process by the end of 2008.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- University of Nebraska of Omaha in conjunction with Women's Coalition developed survey for consumers and professionals on assessment and treatment of trauma.
- TIN is in the process of completing a survey tool and self-assessment tool which can be utilized by provider agencies. Additionally, TIN teams will be available to do a "peer review" evaluation for agencies desiring a fast track to implementation of trauma informed services.
- University of Nebraska at Lincoln Psychology Department reviewed trauma assessment protocols planned at the Regional Centers.

10. Universal trauma screening and assessment.

- Women's Complex Trauma Screen is used with both mental health and substance abuse clients in state facilities and appropriate trauma services are accessible if indicated.
- TIN is in the process of completing a survey tool and self-assessment tool which can be utilized by provider agencies. Additionally, TIN teams will be available to do a "peer review" evaluation for agencies desiring a fast track to implementation of trauma informed services.

- All Regional Center consumers are screened for trauma histories upon admission. Within the first 10 days a re-assessment will be completed as needed.

11. Trauma-informed services and service systems.

Trauma Informed Nebraska (TIN)

- There is a 3 year statewide project, currently in year 2, funded through the Division of Behavioral Health. The project is called Trauma Informed Nebraska (TIN). The purpose of TIN is to plan, develop and implement strategies for a trauma informed system of Behavioral Health.
- TIN Stakeholder quarterly meetings bring together representatives of the Division of Behavioral Health, Provider Groups, Consumer Groups, Advocacy Groups for purposes of planning and implementation.
 - The Division of Behavioral Health, the TIN Project Director, and Regional Center Representatives meet monthly to coordinate activities.
 - TIN Contract Manager is a member of the Divisions Behavioral Health Disaster Planning Steering Committee.
 - Coercion Free Nebraska and TIN share members to increase coordination of activities.
- The Strategic Plan for TIN identifies policies and services must also address culture, race, ethnicity, gender, age, sexual orientation and socio-economic status.
- Trauma Informed Nebraska (TIN) project final product will include a policy, assessment protocol, model for treatment and funding recommendations.

Coercion Free Nebraska

- The Division of Behavioral Health has staff members on the Coercion Free Nebraska (CFN) Coalition, which focuses on alternatives to restraint and seclusion throughout the behavioral health system. It is co-chaired by the Division's Chief Medical Officer.
- Nebraska is one of two states chosen by SAMHSA as a pilot site for a training guide entitled Roadmap to a Restraint-Free Environment for Persons of All Ages. The Lincoln Regional Center was chosen as the public facility and Natchaug Hospital in Mansfield Center, Connecticut, was chosen as the private pilot

site. A total of 16 states/facilities expressed interest in being a pilot test site.

- The training is consumer centered and was given to approximately 30 employees of the Lincoln Regional Center, March 31 – April 2, 2004. LRC is in the process of sharing pre-training and post-training restraint data with SAMHSA to determine the impact of the program. Several LRC staff were evaluated before the training and are in the process again post-training on perceptions of their knowledge, attitudes, beliefs, and use of alternatives to seclusion and restraint. The training materials will be revised, based on data and feedback from participants, and distributed to states nationwide.
- The National Association of Consumer/Survivor Mental Health Administrators provided all training materials. SAMHSA's Center for Mental Health Services contracted with the Association to evaluate the draft training guide.
- The Regional Centers have study packets regarding trauma principles as it relates to restraint and seclusion. The Regional Center's Restraint and Seclusion Reduction Committee meets monthly to coordinate coercion free and trauma informed processes.
- TIN year 3 recommendations will include procedures and models to avoid retraumatization.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Seeking Safety groups offered in 4 substance abuse treatment agency-run programs: *Santa Monica's Women's Program*, *The Bridge Women's Program*, *Dual Disorders Women's Program* and *Seekers of Serenity*. Regional Centers are utilizing DBT and TAMAR training.

New Hampshire

1. Trauma function and focus in state mental health department.

State Mental Health Plan. Objectives include comprehensive trauma assessment, best practices for trauma treatment, continuing education and peer education, and minimizing restrictive/coercive measures that have traumatic effects on consumers.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Utilizing a planning grant from the NH Endowment for Health, other foundation and CMHC funds, a statewide videoconferencing infrastructure has been developed that includes the Dartmouth Trauma Research Center and the ten CMHC children's programs. This structure is being used for training, supervision and ongoing mentoring for the implementation of TFCBT.
- Disaster Behavioral Health Response Team (DBHRT) offers training to it's members and to other professionals in trauma topics
- New Hampshire Bureau of Behavioral Health has sponsored a number of presentations, including NHH Grand Rounds, on the topic of trauma, post-traumatic disorder, and their treatment, including the problem of trauma treatment for clients with primary Serious Mental Illness diagnoses.
- All Mental Health Centers were surveyed to determine current knowledge and practice regarding trauma, and perceived educational needs.
- Statewide Conference on Trauma : Cognitive Behavioral Therapy for Post-Traumatic Stress Disorder in Severe Mental Illness (1/13/04)
- Dartmouth Psychiatric Research Center provided two statewide trainings for clinicians: one on group-based interventions for PTSD; one oriented toward early intervention, and treatment through carefully controlled trials. Trainings have been for clinicians to work with people with serious mental illness and PTSD. Training model consists of 1 to 2 days of training, weekly supervision, and work with experienced clinicians over 6-month period of time.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Consumer education-Consumers discuss effects of trauma and how to overcome them. Videotape available.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- See description of grant initiative. The Bureau of Behavioral Health (BBH) will develop a budget proposal for FY 2010 to sustain the training and supervision structure for sustaining the Trauma Focused Cognitive Behavioral Therapy practice developed through grant funding.

7. Clinical practice guidelines for working with children and adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- Goal 1-3 of State Mental Health Plan: Recognize through practice that the experience of trauma is common in the lives of people served within the public mental health system.

Objectives:

- Assure assessment of trauma and trauma history is included as part of comprehensive assessment for persons seeking mental health services.
 - Incorporate best practices for treatment of trauma survivors.
 - Provide continuing staff and peer education for treatment of trauma-related disorders.
 - Minimize restrictive/coercive measures that have traumatic effects on consumers.
- State Contracts with CMHCs Exhibit A state that the development of the Individual Service Plan (ISP) shall also address trauma-related issues, if the provision of those services is deemed medically necessary.
- New Hampshire Hospital: Restraint and Seclusion guidelines.
 - Nursing Data Base Assessment (trauma-informed).

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- Dr. Kim Mueser at the New Hampshire Dartmouth Psychiatric Research Center, Department of Psychiatry, Dartmouth Medical School, evaluating PTSD reactions to illness and its treatment. Identifies three types of trauma exposure – psychotic symptoms themselves; coercive treatment such as handcuffs, etc; and exposure to others with psychotic symptoms. Developing intervention to minimize chances of developing a PTSD syndrome after these experiences. Article: Treating the trauma of first episode psychosis: A PTSD perspective, *Journal of Mental Health*, (2003) 12, 2 103-108.
- Cognitive-Behavioral Treatment of PTSD in Severe Mental Illness: Results of a Pilot Study, *American Journal of Psychiatric Rehabilitation* (In Press). There is a documented need for standardized treatments of posttraumatic disorder (PTSD) in people with severe mental illness. To address this need, researchers at New-Hampshire-Dartmouth Psychiatric Research Center, Department of Psychiatry, Dartmouth Medical School, and Department of Psychology, Indiana University at Purdue, developed a 12-16 week individual cognitive-behavioral treatment (CBT) program for PTSD. The program includes psychoeducation, breathing retraining, and cognitive restructuring, with treatment closely coordinated with clients' community support treatment teams. A pilot study was conducted and included clients with PTSD and SMI (such as schizophrenia or bipolar disorder) to evaluate the safety, feasibility, and preliminary clinical effectiveness of the program. Retention rate in the treatment was 86 percent with no serious adverse clinical events reported. Clinical outcomes were good, with reductions in PTSD diagnoses, based on the Clinician Administered PTSD Scale (CAPS) from 100 percent at baseline to 64 percent at post-treatment and 50 percent at three-month follow-up. Clients also experienced significant reductions in the affect subscale (depression and anxiety) of the Brief Psychiatric Rating Scale (BPRS) from baseline to three-month follow-up. The results support the feasibility and potential clinical effectiveness of the CBT program for PTSD in the SMI, and suggest that the intervention should be evaluated in a randomized clinical trial.
- Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness: Three Case Studies, *American Journal of Psychiatric Rehabilitation* (In Press). In-depth examination of three case studies of clients with severe mental illness (SMI) and post-traumatic stress disorder (PTSD) who participated in a recently developed cognitive-behavioral treatment program. Each client had PTSD, and a DSM-IV Axis I diagnosis (one bipolar disorder, two schizoaffective disorder), as well as multiple other problems that would ordinarily have resulted in exclusion from established cognitive-

behavioral programs for PTSD (e.g., substance dependence, suicidal ideation, cognitive impairment, psychotic symptoms, acute psychosocial stressors). All clients were able to complete the program, and all demonstrated significant improvements in PTSD, with two out of three no longer meeting criteria for PTSD at the 3-month follow-up. Clients also showed modest improvements in other psychiatric symptoms. These case studies, combined with the results of a larger pilot study of the treatment program, demonstrate the feasibility of the program, and suggest that PTSD can be effectively treated in persons with SMI.

- Interpersonal Trauma and Posttraumatic Stress Disorder in Patients with Severe Mental Illness: Demographic, Clinical and Health Correlates, Schizophrenia Bulletin (In Press). Study evaluates the prevalence and correlates of posttraumatic stress disorder (PTSD) in persons with severe mental illness. Standardized assessments of interpersonal trauma and PTSD were conducted in 782 patients with severe mental illness receiving services in one of five inpatient and outpatient treatment settings. Analyses examined the prevalence of PTSD, and demographic, clinical, and health correlates of PTSD diagnosis. Results: The overall rate of current PTSD in the sample was 34.8 percent. For demographic characteristics, the prevalence of PTSD was higher in patients who were younger, white, homeless and unemployed. For clinical and health variables, PTSD was more common in patients with major affective disorders (compared to schizophrenia-spectrum disorders), alcohol use disorder, more recent psychiatric hospitalizations, more health problems, more visits to doctors for health problems, and more non-psychiatric hospitalizations over the past year. Conclusion: The results support prior research documenting the high rate of PTSD in patients with severe mental illness and suggest that PTSD may contribute to substance abuse, psychiatric and medical comorbidity, and increased psychiatric and health service utilization.
- A Cognitive-Behavioral Treatment Program for Posttraumatic Stress Disorder in Persons with Severe Mental Illness, American Journal of Psychiatric Rehabilitation (In Press). Clients with severe mental illness (SMI) such as schizophrenia and bipolar disorder have high rates of exposure to trauma over their lives, and are at sharply increased risk for the development of posttraumatic stress disorder (PTSD). However, at present there are no validated treatments of PTSD in the SMI population. Researchers at Dartmouth and the National Center for Posttraumatic Stress Disorder in White River Junction, Vermont, review the research on trauma and PTSD in clients with SMI, summarize findings on treatment of PTSD in the general population, followed by the considerations one must examine in the development of a treatment program for clients with SMI. Dartmouth and NCPSD program is then described, which is based primarily on the principles of cognitive restructuring and involves treatment closely integrated with the ongoing provision of comprehensive services for the SMI. Researchers conclude with a description of how common challenges of

working with clients with SMI are handled in the treatment program, including substance abuse, cognitive impairment and psychosis.

- At New Hampshire Hospital, testing the use of computerized assessment to screen for trauma exposure and PTSD in acute admissions and provide psycho-education and triage for those with post-traumatic symptoms.
- At multiple regional mental health centers, conducting a randomized clinical trial of an individual. 12-16 session cognitive- behavioral treatment for PTSD for people with another severe mental illness.
- Pilot study of a 21-session, group-based cognitive-behavioral intervention for symptoms of PTSD in clients with severe mental illness was conducted at a regional mental health center. Groups continue to be provided. Educational video “Recovery From Trauma” available

10. Universal trauma screening and assessment.

- Trauma Screening in the Memorandum of Understanding to all ten CMHC contracts.
- The NH State Mental Health Plan Goal 1-3 states “Recognize through practice that the experience of trauma is common in the lives of people served within the public mental health system,” and set an objective to “Assure assessment of trauma and trauma history is included as part of comprehensive assessment for persons seeking mental health services.”
- A brief trauma history questionnaire, and the PTSD Checklist (PCL) a 17 item self-report measure based on the DSM-IV criteria for PTSD (Blanchard), are used to screen all admissions to Manchester Mental Health Centers and admissions to the New Hampshire Hospital
- Screening and Assessment instruments used in a pilot study implemented at a Community Mental Health Center in NH and a Veterans Administration Hospital in Vermont, of a Cognitive-Behavioral Treatment Program for clients with PTSD and Severe Mental Illness (e.g. schizophrenia or bipolar disorder). Instruments included: the PTSD Checklist (PCL) (Blanchard et al) a self-report measure; the Trauma History Questionnaire-Revised (THQ-R) (Green, Mueser) and the Revised Conflict Tactics Scale (CTS2) (Straus et al) used to assess for trauma history; the Clinician Administered PTSD Scale (CAPS) (Blake et al). (See Section 13: Research).
- Standardized assessments of interpersonal trauma and PTSD conducted with 782 patients with severe mental illness receiving services in five inpatient and outpatient treatment settings across four states, including

NH. Standardized instruments for trauma history included: the Sexual Abuse Exposure Questionnaire (SAEQ) (Rodriguez et al) to assess childhood sexual assault; three questions combining the most severe items from the violence subscale of the Conflict Tactics Scales (CTS) (Straus) to assess child physical assault; physical assault and sexual assault subscales of the Revised Conflict Tactics Scales (CTS2) (Straus et al) to measure assault in adulthood and over the past year; the PTSD Checklist (PCL) (Blanchard et al) to assess PTSD.

- Self-administered, computer assisted interview for both acutely ill and community support clients to gather information on trauma history and PTSD symptoms. Interview brief, easily understood, gives rapid feedback to clients and providers while maintaining a sense of privacy. Used in inpatient and community mental health settings.

11. Trauma-informed services and service systems.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- In 2006, the Dartmouth Trauma Research Center, in partnership with West Central Services and the DHHS Bureau of Behavioral Health was awarded a three-year grant funded through the National Child Traumatic Stress Network (NCTSN). The project is called Partners for Adolescent Trauma Treatment (PATT). The PATT project has introduced Trauma-Focused Cognitive Behavioral Therapy (TFCBT) to all ten CMHC children's programs. This is the first Evidence-Based practice for children's services through BBH.
- Utilizing a planning grant from the NH Endowment for Health, other foundation and CMHC funds, a statewide videoconferencing infrastructure has been developed that includes the Dartmouth Trauma Research Center and the ten CMHC children's programs. This structure is being used for training, supervision and ongoing mentoring for the implementation of TFCBT.
- 2 different models of a Cognitive Behavioral Therapy approach for PTSD in people with serious mental illness are currently implemented in New Hampshire. A 21-week group format of the program, the Trauma Recovery Group, is offered at the Greater Manchester Mental Health Center. An individual format of the program is implemented by the NH Dartmouth Psychiatric Research Center as part of a controlled trial at several regions throughout the state. Both the individual and the group approaches focus mainly on relaxation exercise, psychoeducation about trauma and its effects, and cognitive restructuring to address unhelpful thoughts, beliefs and behaviors related to trauma. Participants in groups

show substantially greater improvement in PTSD and Depression than people participating in fewer sessions or dropping out. Gains maintained in 3-month assessment. Assessment instrument, Group Facilitation Manual and Educational video tapes available

New Jersey

1. Trauma function and focus in state mental health department.

The Assistant Division Director who reports directly to the Assistant Commissioner of the New Jersey Division of Mental Health is responsible for the coordination, development and planning regarding trauma informed care. This task and function is performed in conjunction and collaboration with a number of executive level staff and their departments, which include Medical Director, Office of Policy, Planning, Program Evaluation and Technology, Community Services, Regional Offices, Consumer Affairs and State Hospital Management.

We do not address the needs of children since there is now a separate Division for Children and Families with a Child Behavioral Health Department.

Trauma Informed Care is an integral part of the Division of Mental Health's Transformation Plan, which directly focuses on our Wellness and Recovery Initiative. Our plan addresses the needs of consumers, providers, and stakeholders in both out-patients and in-patient settings and is designed to focus on the following areas: Workforce Development, Data Driven Decision Making, and Systems Enhancements that Promote Wellness and Recovery. A variety of stakeholders and providers have been instrumental in the development of this plan and will be intimately involved in the implementation of this plan. Our comprehensive approach will provide participants with an overall understanding and conceptualization of all of the systemic, organizational, administrative, clinical, and training needs to initiate a transformation of our current system. A thorough understanding of the history, assessment, treatment, and meaning of trauma for consumers is central to that process.

2. State trauma policy or position paper.

While we have not developed a position paper, we are in the process of developing an additional Administrative Bulletin entitled, "Trauma Informed Care in the Provision of Mental Health Services".

3. Workforce Recruitment, Hiring, and Retention.

Given our emphasis on trauma-informed Wellness and Recovery concepts, as well as our workforce development plan that fosters the development of core competencies, it is anticipated that these initiatives will positively impact recruitment, hiring, and ultimately effect retention. We have developed a set of competencies for our administrative workforce and staff who provide care. It is anticipated that wellness and recovery principles will have an

important focus on employee evaluations, supervision, professional development and training.

As part of our Workforce Development Plan, (Wellness and Recovery Transformation Plan), we will reach out to universities, graduate and medical schools, to present our plan and to foster and develop changes in the educational system. This will address areas of preparedness for staff working in mental health settings

We were recently awarded a SIG Grant and plan to hire 2.5 FTE Peer Specialists and a Program Coordinator. The Peer Specialists will be available to provide orientation and training to staff regarding trauma informed care. We will also hone and develop our capacity to utilize data to more adequately inform plans, policy and practice. In addition, we will standardize our data collection and practices.

Presently, consumers are utilized in a number of the new employee orientation sessions in our hospitals. With the recent award of the SIG Grant, it is anticipated that this resource will be expanded.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

The New Jersey Division of Mental Health sponsored statewide conferences regarding trauma informed care in '2005 and '2006. These conferences were designed to provide valuable information to a variety of stakeholders and providers who have different levels of expertise regarding trauma. Subject areas presented included the following: physical/neurological aspects of trauma, trauma assessment, various treatment modalities, and strategies focused on systemic issues and change, and consumer lived experiences of trauma. In addition, division staff have presented at various statewide conferences regarding ethno cultural issues of trauma, including the unique experiences of African-Americans.

This year we have begun a complete retraining effort of all of our staff in state psychiatric settings in the Mandt Training System. This system is a trauma informed crisis de-escalation model that teaches staff techniques designed to diffuse potential inflammatory situations. We are focused on developing a violence free therapeutic environment where there is less traumatic restraint.

Presently, consumers are utilized in a number of the new employee orientation sessions in our hospitals. With the recent award of the SIG Grant, it is anticipated that this resource will be expanded.

The Division of Mental Health Services within the New Jersey Department of Human Services, houses a mental health Disaster and Terrorism Branch.

The Branch is a part of the Office of Policy, Planning, Evaluation and Technology. The Branch is home to a multi-disciplinary Training and Technical Assistance Team which has the capacity to provide ongoing as well as on-demand training for mental health professionals in the wake of disaster to further increase the state's capacity to address the psychosocial needs of the community.

The services available through the Disaster and Terrorism Branch include: individual crisis counseling, psychological first aid, written or verbal psychosocial information on disaster, stress management, group crisis counseling, consultation and training, information and referral services, and toll free help line services. In addition, technical assistance is available to counties to assist with revision of mental health emergency response plans.

In order to assess the competencies of the mental health workforce using lessons learned from the events of September 11th, a program for certifying mental health professionals has been developed and is being implemented in partnership with the Mental Health Association in New Jersey. The credentialing process involves completion of an application which includes the following: a "disaster response readiness" self assessment, Completion of a structured personal interview by a qualified panel of experts, and submission of references are also required. Three levels of competence are integrated in the process to accommodate a range of skills. The application is also available on line.

Training to support the credentialing program is being offered at no cost and with continuing education credits attached. Participants must take the Introduction to Disaster and Trauma Counseling course endorsed by the Substance Abuse Mental Health Services Administration and the Federal Emergency Management Agency, as well as Incident Command System 100 and National Incident Management System 700 series.

Additional training includes the following:

- Psychological First Aid
- Ethics in Disaster Response
- Cultural Diversity
- Grief and Loss
- Working with Families in Emergency Room Settings
- The Emotional Consequences of Influenza Pandemic
- Continuity of Operations-agencies and hospital (to be developed)
- Psychological Consequences of Bioterrorism
- Interventions with Children
- The Role of Faith Based Communities
- Hostility and Rage Management
- Compassion Fatigue
- Disaster Preparedness for Ethnic Minorities

- Cognitive Restructuring-Complicated Grief
- Secondary Traumatic Stress
- Disaster Planning for Substance Abuse Providers
- Web based training programs

The Branch has been providing an average of three training events per month for the past two years.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

The New Jersey Division of Mental Health executive leadership includes a person whose role and responsibility is focused on consumer affairs. A consumer presence is evident in a number of our program models (i.e. PACT) and the participation of consumers with lived experiences is present throughout our organization. One of the key objectives of our Wellness and Recovery Action Plan is increasing the role of consumer and families in our mental health system. As previously indicated, the recent SIG award will increase the numbers of Peer Specialists in our system that will provide much needed training and skill building.

Consumers represented a key constituency in the development of our Wellness and Recovery Transformation and subsequent action plan. Their input indicated a need for consumers and families to increase their role and responsibility in our system.

We were recently awarded a SIG Grant and plan to hire 2.5 FTE Peer Specialists and a Program Coordinator. The Peer Specialists will be available to provide orientation and training to staff regarding trauma informed care.

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Presently, consumers are utilized in a number of the new employee orientation sessions in our hospitals. With the recent award of the SIG Grant, it is anticipated that this resource will be expanded.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- We have utilized funding to support the implementation of Evidenced-Based Practices in our hospitals and in the community. We currently provide training and implementation of the IMR model (Illness Management and Recovery) in all of our hospitals. As of Oct 1, 2007, the UMDNJ School of Health Related Professions will provide training and subject matter supervision to all staff providing IMR. We have supported the provision of training and implementation of the IDDT model (Integrated Dual Disorder Treatment) in community agencies and in our hospitals. The use of Family Psycho education and Multiple Family Psycho education groups has been utilized in the community.
- We are currently examining funding streams to implement our Wellness and Recovery Action Plan. This involves modifying and reconfiguration of existing funding to more adequately address current needs.

I saw in this report no fiscal mechanisms impacting on support for trauma-related activities.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- We plan to work on creating clinical practice guidelines for working with adults. We cannot comment on the status of children services, since that department has been transferred to the Division of Children and Families. No explicit mention of trauma-informed guidelines or applying to trauma services.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- New Jersey has an explicit statement in its Administrative Bulletin 3:21, which describes policies and procedures regarding seclusion and restraint. An assessment of a patient's history of sexual and/or physical abuse or experience of other trauma. This policy speaks directly to a trauma informed care system.
- An additional Administrative Bulletin entitled, "Trauma Informed Care in the Provision of Mental Health Services" is in development.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

Given our SIG grant we will develop standardized screening and assessment tools, obtain trauma survivor satisfaction, and utilize data to examine trends.

10. Universal trauma screening and assessment.

Our Administrative Bulletin 3:21 describing our policies and procedures regarding seclusion and restraint requires an assessment of a patient's history of sexual and/or physical abuse or experience of other trauma.

In many of our hospital and community programs we are performing universal trauma screening and assessment. We do plan to develop standardized instruments.

Given our SIG grant we will develop standardized screening and assessment tools, obtain trauma survivor satisfaction, and utilize data to examine trends.

11. Trauma-informed services and service systems.

While we have not developed a position paper, we have an explicit statement in our Administrative Bulletin 3:21, which describe our policies and procedures regarding seclusion and restraint. We require an assessment of a patient's history of sexual and/or physical abuse or experience of other trauma. We are also in the process of developing an additional Administrative Bulletin entitled, "Trauma Informed Care in the Provision of Mental Health Services".

This year we have begun a complete retraining effort of all of our staff in state psychiatric settings in the Mandt Training System. This system is a trauma informed crisis de-escalation model that teaches staff techniques designed to diffuse potential inflammatory situations. We are focused on developing a violence free therapeutic environment where there is less traumatic restraint.

The Division of Mental Health Services within the New Jersey Department of Human Services, houses a mental health Disaster and Terrorism Branch. The Branch is a part of the Office of Policy, Planning, Evaluation and Technology. The Branch is home to a multi-disciplinary Training and Technical Assistance Team which has the capacity to provide ongoing as well as on-demand training for mental health professionals in the wake of disaster to further increase the state's capacity to address the psychosocial needs of the community.

The services available through the Disaster and Terrorism Branch include: individual crisis counseling, psychological first aid, written or verbal psychosocial information on disaster, stress management, group crisis counseling, consultation and training, information and referral services, and toll free help line services. In addition, technical assistance is available to counties to assist

with revision of mental health emergency response plans. (See Section #4 for description of training)

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Please review responses previously outlined in items 2 and 4. (I saw nothing pertaining to trauma-specific services except in disaster.)

New Mexico

1. Trauma function and focus in state mental health department.
2. State trauma policy or position paper.
3. Workforce Recruitment, Hiring, and Retention.
4. Workforce orientation, training, support, job competencies and standards related to trauma.
5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.
6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.
7. Clinical practice guidelines for working with children and adults with trauma histories.
8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.
9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.
10. Universal trauma screening and assessment.
11. Trauma-informed services and service systems.

During implementation of the New Mexico Co-Occurring State Incentive Grant (Co-SIG), the need for trauma-informed, trauma-sensitive services in the community-based behavioral health system was elevated. Members of the Behavioral Health Services Division, in coordination with Co-SIG staff, ValueOptions (the single entity managing publicly financed behavioral health care for New Mexico) and the New Mexico Women's Services Task Force identified 2 key strategies designed to increase the knowledge, skills and abilities of providers in developing and implementing trauma-informed, trauma-sensitive services in their agencies. (put in trauma informed)

The first strategy included the identification of community-based providers interested in increasing the knowledge, skills and abilities of both staff and agency administrators regarding trauma and the impact

of the consumers of their services. Several agencies self-selected for additional training. Roger Fallot, a nationally recognized expert on trauma-informed services, provided a two-day training, which brought together each of these agencies. The agencies each had a BHSD staff contact. Utilizing the 12 criteria for Building a Trauma Informed Mental Health Services System, each agency was required to conduct a self-assessment and identify one key criterion. This criterion would serve as the basis for a work-plan that would enable the agency to begin work on implementing trauma-informed, trauma-sensitive services for their clients. At the end of this training, each agency reported to the other agencies on their criterion and work-plan. (also put in trauma-informed)

This initial training was followed up with on-going work-plan development by the agency and the BHSD contact. Work-plans were reviewed by Co-SIG staff and Mr. Fallot. Providers in the initial training were gathered together during the New Mexico Women's Treatment Conference in June, 2007 to provide updates on the plan, identify on-going challenges in the implementation of trauma-informed, trauma-sensitive services in their agency and community. (also put in trauma-informed)

The second strategy included the dissemination of trauma-informed, trauma-sensitive services information to a broad audience of agency administrators, clinicians, consumers of behavioral health services, ValueOptions, state agencies and others. The New Mexico Women's Treatment Conference in June, 2007, included nationally recognized experts such as Lisa Najavits, Charlotte Kasl, Roger Fallot, and Wyndi Anderson. Conference presenters also included New Mexico providers who had already adopted policies and procedures that resulted in services being provided in a more trauma-informed, trauma-sensitive manner. An example of these procedures was presented by Tierra Del Sol and the Albuquerque Health Care for the Homeless (HCH). For women residing in Tierra Del Sol receiving treatment at HCH, which is a campus setting and could be treating someone responsible for traumatizing that woman, Tierra Del Sol and HCH offers a "buddy" system. This system allows staff to meet the woman at the edge of campus and safely escort them to their service appointment, increasing the "show up" rate for service and decreasing the trauma associated with seeing a former perpetrator.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

New York

1. Trauma function and focus in state mental health department.

- Improving Services for Trauma Survivors Implementation Plan, original action plan which launched New York State's trauma initiative.

A number of bureaus and divisions have trauma-related projects, including adult services, children's services, quality management and recipient affairs.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

Office of Mental Health

- The Division of Children and Families Evidence Based Treatment Dissemination Center is providing training and year-long consultation in Trauma-Focused Cognitive Behavioral Therapy to clinicians serving children and families. Four hundred clinicians from both state and local programs were training last year and an addition 300-400 will be trained this year.
- Intensive training in Dialectical Behavioral Therapy for children and youth was provided for state-operated children's mental health providers.
- An innovative treatment approach, combining two evidence based trauma treatments is being tested at a state-operated children's psychiatric center. The program is being expanded to the day treatment program.
- In 2001, OMH sponsored three train-the-trainer sessions in Risking Connection. Since that time, trained trainers provide training to state and local mental health staff and recipients.
- Mental health staff who work in juvenile justice programs are Risking Connection trained trainers and provide training to direct care staff.
- OMH Core Curriculum, which is mandatory for all state staff, includes a module on trauma treatment as one of six clinical modules
- Satellite Grand Rounds teleconference programs periodically feature trauma issues among other topics.
- Since 1995, OMH has conducted and/or supported clinical training in trauma-related topics at statewide training programs, local programs, and state facility based training programs.
- OMH supports consultations by trauma experts to facility programs upon request.

- Policy on staff trauma requires that staff injured on the job receive support and assistance with physical treatment and referral to supportive counseling as needed. (Copies of policy available from OMH Bureau of Policy, Regulation and Legislation, 518-473-7945).
- Transcending Trauma: Evidence-Based and Promising Practices Symposium was held on July 12 and 13, 2004, and provided training for state and local staff.
- New York State OMH Evidence-Based Practices initiative identifies eight areas of focus, one of which is treatment for PTSD and trauma-based disorder. New York launched an evidence-based practices conference and “Winds of Change” science to practice campaign. (Campinello, et. al, 2002).

Other New York trainings:

- Rockland Children’s Psychiatric Center, an OMH psychiatric center, offered Growing Beyond Survival: Trauma Symptom Management for Children & Adolescents: a one-day training
- Rockland Children’s Psychiatric Center offered Risking Connection Master Training Program, a three-day training to its frontline mental health workers, residential treatment staff, and therapy staff.
- Palladia, formerly a Women, Co-occurring Disorders and Violence Study site, provided comprehensive trauma trainings for domestic violence and shelter programs. Trauma Training Curriculum available.

Linkages with higher education to promote education of professionals in trauma

- The Division of Children and Families Evidence Based Treatment Dissemination Center, which offers training and consultation in an evidence based trauma treatment model is a partnership between OMH and Columbia University.
- OMH’s New York State Psychiatric Institute, a research institute, is linked with Columbia University College of Physicians and Surgeons. The OMH Trauma Initiative and Project Liberty both have collaborated and received clinical consultation from Randall Marshall, MD, Director, Anxiety Disorders Clinic, as well as his staff.
- New York State Nathan Kline Institute, a research institute, is linked with the New York University Child Study Center.
- New York has two trauma programs at institutes of higher education; information is shared between these two programs and the OMH Trauma Unit regularly:

- State University of New York at Buffalo, School of Social Work, Trauma Certificate Program, Nancy Smyth, PhD.
 - New York University, Trauma Studies Program, Jack Saul, PhD.
- Transcending Trauma: Evidence-Based and Promising Practices Symposium (July 2004) was coordinated jointly by the Trauma Unit Director and the Cultural Competence Coordinator. All presenters were asked to submit descriptions of adaptations of their treatment program for diverse communities.
 - Transcending Trauma: Evidence-Based and Promising Practices Symposium (July 2004) was coordinated jointly by the Trauma Unit Director and the Cultural Competence Coordinator. All presenters were asked to submit descriptions of adaptations of their treatment program for diverse communities.
 - Mental health staff who work in juvenile justice settings are participating in the Evidence Based Treatment Dissemination Center, described above.
 - Mental health staff who work in juvenile justice programs are Risking Connections trained trainers and will be providing training to direct care staff
 - Transcending Trauma: Evidence-Based and Promising Practices Symposium (July 2004) will address treatment approaches for those developing symptoms following a disaster.
 - NYS Psychiatric Institute Anxiety Disorders Clinic provided training courses in treatment modalities for trauma survivors: Prolonged Exposure (Foa) and Traumatic Grief (Shearer). Hundreds of clinicians received this training.

Division of Trauma Studies and Services, NYSPI, completed the largest dissemination study to date in the United States, after the September 11 attack. Funded by the New York Times Foundation, the September 11 Foundation and Project Liberty, the trauma team provided training in the psychotherapy techniques of prolonged exposure and traumatic grief to more than 1,500 clinicians while researching educational models of learning psychotherapy. A follow-up study to determine how useful the training was to practicing clinicians is underway.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Forum on trauma issues, held in 1994, included testimony from service recipients, along with providers, family members, and researchers.
 - Statewide Committee on Trauma, which advised OMH on the development of the Trauma Initiative, included significant service representation by recipients and self-help organizations.
 - All statewide training programs have involved service recipients in planning and presenting; when programs require a fee, recipient scholarships have been available.
 - Many state psychiatric centers involve service recipients on their trauma committees and in staff training on trauma topics.
 - Many Risking Connection trained trainers are service recipients.
 - OMH Bureau of Recipient Affairs is distributing Growing Beyond Survival.
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
- New York Trauma-informed seclusion and restraint policy. (To request a copy, please contact NYS OMH Bureau of Policy, Regulation and Legislation, 518-473-6945).

To request a copy of any of the policies listed below, please contact NYS OMH, Bureau of Policy, Regulation and Legislation: 518-473-6945.

- Trauma-informed Seclusion and Restraint Policy.
- Trauma Response Policy requires that staff that are injured on the job receive support and assistance with physical treatment and referral to supportive counseling as needed.

- Safe and Therapeutic Environment Program Policy provides standards for eliminating or reducing the incidence of violence in state psychiatric centers through risk management efforts.
- Training for state psychiatric center risk managers on investigating sexual assault presented in collaboration with the New York State Police Domestic Violence and Sexual Assault trainers. In 1997, this program was presented to over 350 state staff.
- Manual for Clinical Risk Management: Guidelines for Investigation and Management of Incidents in OMH Licensed Facilities includes a chapter on investigating allegations of sexual assault and abuse. (To request a copy, please contact NYS OMH Bureau of Quality Management, 518-474-6587.)
- Some state psychiatric centers have implemented the Assaulted Staff Assistance Program, (Flannery), which has been demonstrated to reduce the level of violence on psychiatric in-patient units.
- All OMH policies and programs aim for cultural appropriateness

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- The Division of Children and Families Evidence Based Treatment Dissemination Center is providing training and year-long consultation in Trauma-Focused Cognitive Behavioral Therapy to clinicians serving children and families. Four hundred clinicians from both state and local programs were training last year and an addition 300-400 will be trained this year.
- An innovative treatment approach, combining two evidence based trauma treatments is being tested at a state-operated children's psychiatric center. The program is being expanded to the day treatment program.
- All New York State psychiatric centers routinely screen for trauma histories and perform targeted assessments as needed.
- Child and Adolescent Trauma Treatment Services (CATS), a treatment program for children and adolescents affected by 9/11, conducts comprehensive trauma assessments.
- Children's program in state psychiatric centers are working with psychiatric center clinical leaders and national experts to design a trauma

treatment program, based on existing evidence-based practices, to be implemented and evaluated. Currently in development.

- One site of the Women, Co-Occurring Disorders and Violence Study: Palladia's Portal Project, New York, N.Y., a large, multi-service agency providing residential and outpatient mental health and substance abuse services primarily to African American and Latina women.

Key service components: Women receive an enhanced trauma treatment program coordinated by a Women's Treatment Specialist which includes a clinical assessment, Seeking Safety groups, and two sets of peer-led support groups focusing on parenting and safety skills.

- NARSAD is conducting a collaborative study with Drs. Myrna Weisman and Marc Olfson from the Division of Clinical and Genetic Epidemiology and the AIM Clinic to examine the 9-11-related PTSD and depression in primary care. The following efforts are underway:
 - A study comparing paroxetine and psychotherapy to psychotherapy alone in victims of terrorism and a similar study in people with chronic PTSD.
 - Coordinating preparation of publications based on Project Liberty effort after the September 11 attacks.
 - Consulting with Disaster Psychiatry Outreach to examine the problems being experienced by WTC site workers.
 - Conducting a five-year, web-based, study of the effects of trauma and grief related to the attacks of September 11, 2001.
 - Received the first donation to create The Center for the Study of Trauma and Resilience that would be the first, nonprofit entity solely devoted to the state-of-the-art research and education in the area of psychological trauma and its aftermath

10. Universal trauma screening and assessment.

- The Evidence Based Treatment Dissemination Center provides training to clinicians in the use of evidence based screening and assessment instruments.
- The innovative trauma treatment program at a state hospital uses an evidence based trauma assessment instrument.
- All state psychiatric centers conduct trauma screening using forms of their own design. Examples of brief screens and nationally validated symptom assessment forms (PTSD Checklist and Trauma Symptom

Checklist for Children) have been circulated. Screening forms are available from the Trauma Unit.

- Starhill Treatment facility, a 385-bed, drug treatment facility for men and women in NYC, operated by Palladia, Inc., uses instruments from the WCDVS adapted for inner city population involved in criminal justice system with active drug use and trauma histories. WCDVS trauma assessment instruments looked at lifetime trauma history, current trauma exposure, and interpersonal trauma severity using the Life Stressor Checklist-Revised (LSC-R) (Wolfe et al), and assessed trauma-related symptom severity using the Post-traumatic Stress Diagnostic Scale (PDS) (Foa et al)
- All New York State psychiatric centers routinely screen for trauma histories and perform targeted assessments as needed.
- Child and Adolescent Trauma Treatment Services (CATS), a treatment program for children and adolescents affected by 9/11, conducts comprehensive trauma assessments.

11. Trauma-informed services and service systems.

- Building Connections project, a collaboration between the New York State Coalition Against Sexual Assault and the Mental Health Association, works with local coalitions of mental health, rape crisis, domestic violence and other service providers to share trauma resources and develop local programs.
- OMH hosted an interagency meeting on mental health issues for women in the criminal justice system; trauma issues were featured prominently.
- Office of Addiction and Substance Abuse Services, Administration for Children's Services, and Office of Mental Health collaborative workgroup focused on needs of families with addiction, mental health and trauma related problems and development of protocols to meet them.
- NYS OMH developed a statement of understanding with the NY Conference of Local Mental Hygiene Directors and all New York Chapters of the American Red Cross, which defines the working relationship among the three organizations and their respective and complementary roles, responsibilities, and expectations during moderate and major disasters.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- Child and Adolescent Trauma Treatment Services (CATS) is a treatment program for children and adolescents affected by September 11, 2001. CATS was adapted from the Trauma Focused Cognitive Behavioral Treatment for Children and Adolescents (Cohen), which has documented effectiveness.
- Project Liberty, New York's mental health crisis counseling program, has implemented an enhanced services model based on a service design developed by the National Center for PTSD's Brief Intervention for Continuing Postdisaster Distress, May 2003.
- An innovative treatment approach, combining two evidence based trauma treatments is being tested at a state-operated children's psychiatric center. The program is being expanded to the day treatment program.
- New York State OMH Evidence-Based Practices initiative identifies eight areas of focus, one of which is treatment for PTSD and trauma-based disorder. New York launched an evidence-based practices conference and "Winds of Change" science to practice campaign. (Campinello, et. al, 2002).
- Both the Evidence Based Treatment Dissemination Center and the innovative trauma treatment approach are examples of trauma-specific services being offered in state and locally operated programs.
- Children and Adolescents Trauma Services (CATS) program was developed in New York State, adapted from Cohen's Trauma Focused Cognitive Behavioral Therapy for Children and Adolescents, for children and adolescents affected by the World Trade Center disaster. This program is currently being pilot tested at seven sites in New York City.
- State and locally operated programs in New York are using national models:
 - Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress, Vermilyea
 - Sanctuary Model, Bloom
 - Seeking Safety, Najavitz
 - Trauma Recovery and Empowerment Model (TREM) and Men's-TREM, Harris
- Trauma Drop-In Group, developed in New York State, is a manual for a low intensity, low demand group for trauma survivors as a first step in the trauma treatment and recovery process. Manuals are available from the NYS OMH Trauma Unit at nominal cost from the NYS OMH Printing and Design Services, fax 518-473-2684.

Two residential substance abuse treatment facilities in NYC have adapted and implemented trauma services as an outcome of the WCDVS Portal Project site.

The Starhill Treatment facility, a 385-bed drug treatment facility, operated by Palladia, Inc., for men and women has implemented:

- A Women's Track, provides trauma assessment and offers an "island of safety" where the women can discuss trauma issues.
- Seeking Safety group trauma treatment model for women, modified for setting and addressing literacy barriers.
- Men's group trauma clinical intervention using Seeking Safety model.

Dreitzer Women and Children's Treatment Center, operated by Palladia, Inc., serving 25 women with co-occurring disorders, domestic violence and criminal justice issues, each admitted with one child between birth and age three.

- Group and individual treatment approach addresses past sexual and physical abuse trauma drawing from Seeking Safety.

Three residential settings for children in New York State have implemented the Sanctuary Model, with an NIMH research project based in one of the centers.

- Children's program in state psychiatric centers are working with psychiatric center clinical leaders and national experts to design a trauma treatment program, based on existing evidence-based practices, to be implemented and evaluated. Currently in development.
- One site of the Women, Co-Occurring Disorders and Violence Study: Palladia's Portal Project, New York, N.Y., a large, multi-service agency providing residential and outpatient mental health and substance abuse services primarily to African American and Latina women.

Key service components: Women receive an enhanced trauma treatment program coordinated by a Women's Treatment Specialist which includes a clinical assessment, Seeking Safety groups, and two sets of peer-led support groups focusing on parenting and safety skills.

North Carolina

1. Trauma function and focus in state mental health department.

- North Carolina has established a statewide point of responsibility for trauma services at the Division level. This responsibility was assigned to the Division of Mental Health, Developmental Disabilities, and Substance Abuse.
 - For additional information about state-wide system transformation efforts see the NC State Strategic Plan 2007-2010 at: <http://www.ncdhhs.gov/mhdddsas/announce/commbulletins/commbulletin074/strategicplan07-10finalweb-06-29-07.pdf> I checked this document out and there is nothing in it related to trauma.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

There is currently a general workforce development plan that will be completed and published in 12/07.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- The state has worked closely with Center for Child and Family Health – NC (CCFH) which both independently and in conjunction with certain state initiatives, provides training across the state of NC and nationally on several evidence-based treatments and promising practices (e.g., *Trauma Focused Cognitive Behavioral Therapy (TF-CBT)*) for children and adolescents exposed to a variety of traumatic events including family and interpersonal violence, community violence, abuse and neglect, natural disasters and terrorism.
- Similarly, collaborating with state and select counties, Center for Child and Family Health –North Carolina provides training related to trauma and trauma informed systems across the state for professionals from a variety of disciplines and systems including child welfare, law enforcement, guardians ad litem, schools, and juvenile justice. Support for these efforts have been sustained by state, local, foundation, and in-kind funding.
- State collaborative support (including DMHDDSA, Division of Social Services), Governor’s Crime Commission, as well as funding from the Kate B Reynolds Foundation, and The Duke Endowment have facilitated a pilot program, “NC Child Treatment Program” done in partnership with the NC Child Medical Evaluation and training faculty from the Center for Child and Family Health-NC. This program provides clinical training and implementation support

to clinicians in 28 rural counties in the northeastern region on clinically managing clients using the evidence-based practice, TF-CBT.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Created the State Consumer and Family Advisory Committee (SCFAC) for consumers and family members.
- Required and facilitated the creation of the local consumer and family advisory committee for Local Management Entities to provide advice and input to the Department of Health and Human Services and the Division.
- The National Child Traumatic Stress Network is currently developing community and organizational guidelines for partnering with youth and families who have experienced trauma.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- At present, North Carolina has used grant funding and state dollars to review (through the Practice Improvement Collaborative) best practices and to train providers in these best practices. Nothing explicitly addressing trauma here.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- North Carolina Practice Improvement Collaborative (PIC) a group of clinical leaders, research leaders, consumers, and advocates that evaluate new and promising services to ensure that NC offers the best array of services for individuals with mental illness, developmental disabilities and substance use disorders. No explicit mention of trauma-informed guidelines or applying to trauma services.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

DMH in response to questions about Reactive Attachment Disorder and out of state residential treatment has developed State Guidelines on Assessment and Intervention for Reactive Attachment Disorder

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- Outcome studies provided through the Center for child and Family Health grant programs which offer trauma-specific services, will inform future expansion of this project across the state.

10. Universal trauma screening and assessment.

- Center for Child and Family Health in conjunction with the National Center for Child Traumatic Stress have created a series of recordings to help underscore the clinical utility and importance of screening and assessment to enhance treatment planning and monitor progress. Trainings on best practices include assessment.
- In follow-up to the statewide Domestic Violence and Child-Well Being Task Force, a pilot project focused on youth residing in domestic violence shelters was developed to provide training on screening and assessment for community, private, and public sector systems that work with children exposed to domestic violence. This protocol also includes training on effective behavior management strategies.

11. Trauma-informed services and service systems.

- North Carolina is the location of one of the 2 offices (UCLA & Duke) of the National Center for Child Traumatic Stress (NCCTS) that coordinates 42 SAMHSA funded sites across the country. NCCTS has several guidelines for developing trauma-informed services and service systems. For more information visit: www.nctsn.org
- As part of the System of Care Effort being implemented across the state of North Carolina, Local Management Entities have created a number of opportunities via community collaboratives, and agency directors meeting to develop a preventive system of care for children and adolescents.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- Center for Child and Family Health-NC (CCFH) is part of the SAMHSA funded, National Child Traumatic Stress Network. CCFH provides a continuum of trauma-specific services including early intervention services, assessment and treatment, medical and forensic evaluations, training, and legal services. For more information visit: www.ccfhnc.org
- NC Child Treatment Program- As part of this training & implementation program, more than 60 clinicians are able to access funds for providing evidence-based treatment to youth that have experienced sexual abuse and other traumatic events.
- North Carolina Child Response Initiative (NCCRI) – Mental health professionals from CCFH in conjunction with law enforcement provide direct services to children and their families who have been exposed to violence.
- Statewide leadership team that includes DMH, Public Health, Military, Health Care Professionals, and several community based agencies has been assembled to guide and facilitate the implementation of Period of Purple Crying, universal educational program to prevent Shaken Baby Syndrome.

North Dakota

1. Trauma function and focus in state mental health department.

Specific Division program administrator to be hired next month will manage trauma-informed program portfolio. Within this portfolio, the Division will develop strategies to implement best practices in trauma services throughout the state supported services. The specific job duty description containing trauma focused work is located in the position information questionnaire for this employee.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

State Training offered in both annual mental health and substance abuse conferences over the past three years for direct care staff and clinicians. In partnership with the University of North Dakota School of Medicine and Health Sciences and the, Neuropsychiatric Research Institute (NRI), the Division is training two clinicians in each regional human service center in Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The initial training for each EBP is followed by supervision and consultative sessions for six months to ensure adherence to the fidelity of the model. Each regional human services center will offer therapies using these models. There are identified staff in five of the eight regional human service centers who provide evaluation and/or treatment services to individuals (children, youth, and adults) who have been sexually victimized and to sex offenders. Specific training is offered both in and out of state. A workgroup of these individuals meets quarterly to discuss policy, procedure, and related issues. Services to victims of domestic violence are also provided at the regional human service centers. Orientation, training, and ongoing supervision/support are provided by clinical supervisors at the human service centers.

In January 2008, 16 clinicians from the Human Service Centers will be trained in TF-CBT. This evidence-based, manualized, trauma specific treatment for traumatized children is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. The goal of TF-CBT is to help address the unique biopsychological needs of children with Post Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers.

Linkages with higher education to promote education of professionals in trauma. Dr. Steve Wonderlich of UND's NRI, has provided training to the Children and Family Services Conference attendees. He is also the lead in the Division's workforce training partnership for SPARCS and TF-CBT.

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 - The Division of Mental Health and Substance Abuse provided the funding for the 16 clinicians employed at the Human Service Centers to be trained in SPARCS and TF-CBT. Part of the focus on the behavioral healthcare workforce shortage does involve financial issues such as salaries as well as flexible working conditions.
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
 - SPARCS is based on three empirically validated interventions that were adapted and integrated in an effort to address the topics specifically relevant to adolescents exposed to chronic trauma. (See Criteria 12). The 16 clinicians who have been trained in SPARCS in June 2007 have been exposed to these clinical practice guidelines. SPARCS Techniques and Related Concepts include core skills that the clinician must implement to maintain the fidelity and integrity of the SPARCS Manualized EBP. These skills include; mindfulness (cultivating awareness), Distress Tolerance (coping in the moment), LET 'M Go (problem-solving and creating meaning), and MAKE a LINK (communication and connecting with others). Additionally, "MUPS", things that "Mess 'U' Up" and the "SOS" (Slow down, Orient yourself and Self Check) technique, are key elements of the treatment and are woven throughout.
 - Clinicians who are trained to provide services to individuals who have offended sexually rely on the Association for the Treatment of Sexual Abuse (ATSA) standards and guidelines.
 - Criteria for sex offender evaluations and treatment at the regional human service centers have been developed.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.
9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.
10. Universal trauma screening and assessment.
11. Trauma-informed services and service systems.
12. Trauma-specific services, including evidence-based and promising practice treatment models.

Ohio

1. Trauma function and focus in state mental health department.

- The Ohio Department of Mental Health (ODMH) convened the Childhood Trauma Task Force in May 2005, bringing together state and local representatives of Ohio's child-serving systems (child welfare, behavioral health, juvenile justice, health and education), as well as mental health consumers/trauma survivors and family members. The charge to the Task Force was to look at childhood trauma issues and its impact on child victims, and to develop a strategic plan to address the following:
 - Create a shared vision of effective prevention and treatment of childhood trauma
 - Identify what is needed to improve service system competence
 - Lay the groundwork for implementation of needed cross-system improvements

The Task Force met for over a year, developed a Strategic Plan and the Ohio Family and Children First Cabinet Council (OFCF), composed of the directors of the major child-serving state agencies who report to the Governor reviewed, and approved the Plan. The Plan identifies four primary goals, related objectives and strategy recommendations, which offer practical and concrete solutions to address this pervasive issue:

- 1) Increase statewide understanding and awareness of the broad range of impacts of childhood trauma on individuals, families and communities through development of public awareness and education materials/activities
- 2) Identify/adapt trauma-focused screening and assessment tools to help inform appropriate treatment interventions
- 3) Review and develop/adapt trauma-informed training curricula and EBPs for all child-serving systems
- 4) Look at methods to collect/analyze intersystem data that can be shared within and across child-serving agencies to better identify and serve kids who've experienced trauma

Four Implementation workgroups, each assigned to one of the four goal areas described above, will be convening cross-system workgroups on November 5, 2007 to look at how to implement these goals/objectives/strategies.

Additionally, the Task Force, in partnership with ODMH and the Ohio Family and Children First Initiative, hosted five regional educational forums on childhood trauma in November and December 2007. Over 800 individuals attended the forums, which were held in Columbus, Athens,

Toledo, Cincinnati, and Akron. The ODMH Childhood Trauma Strategic Plan, developed by the Task Force, was unveiled at the forums. Each forum concluded with a survivor luncheon with over 50 trauma survivor participants, who provided suggestions for improving the mental health system and input into the overall design of a statewide trauma-informed care effort.

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- ODMH has held two statewide conferences to highlight the importance of training, collaboration, and partnership in addressing trauma, as well as the key role of behavioral health in emergency response. Four hundred professionals representing emergency volunteers, clinicians, law enforcement, education, public safety, and other partner organizations, agencies and individuals, attended the most recent conference.
- Statewide Training for PATH: ODMH conducts at least three one-day trainings per year incorporating SAMHSA-identified training priorities and training topics identified by outreach workers via a training survey. Recent training topics include, Co-occurring Substance Abuse/Mental Illness, HIV/AIDS, Community Resources, Housing, and Consumer Involvement in PATH.
- Crisis Intervention Training (CIT): has now expanded into community-based settings. To date, 2300 law enforcement officers, along with representatives from 17 of Ohio's colleges and Universities have been trained on CIT. In the next two years, these figures are slated to grow by 10 percent annually.
- ODMH has created numerous communication materials to provide information and education to the public on preparedness, response, and recovery from catastrophic events including terrorist acts. These materials provide the public specific information regarding trauma reactions and coping mechanisms. This information is developed to address needs of the public, minorities, children, elderly, and other special populations.
- ODMH has held two statewide conferences to highlight the importance of training, collaboration, and partnership in addressing trauma, as well as the key role of behavioral health in emergency response. Four hundred professionals representing emergency volunteers, clinicians, law

enforcement, education, public safety, and other partner organizations, agencies and individuals, attended the most recent conference.

- ODMH has committed to training its staff on the concepts and principles of Incident Command Systems (ICS) and National Incident Management Systems (NIMS). Leadership, in both the ODMH central office and in the state hospitals, has participated in training. Ohio's 50 community mental health boards also support training. This training enables the ODMH staff to effectively participate in and provide support to statewide, regional, or local emergencies.

And for Ohio—take from what was said in training criteria as follows:

- Statewide Training for PATH: ODMH conducts at least three one-day trainings per year incorporating SAMHSA-identified training priorities and training topics identified by outreach workers via a training survey. Recent training topics include, Co-occurring Substance Abuse/Mental Illness, HIV/AIDS, Community Resources, Housing, and Consumer Involvement in PATH.
- Crisis Intervention Training (CIT): has now expanded into community-based settings. To date, 2300 law enforcement officers, along with representatives from 17 of Ohio's colleges and Universities have been trained on CIT. In the next two years, these figures are slated to grow by 10 percent annually.
- The Childhood Trauma Task Force Training/EBP workgroup will identify and recommend specific training curricula and best/promising practices for mental health professionals to consider using in their treatment and interventions with traumatized child and their families. Many of these curricula and best practices can also be employed and/or adapted for working with adult trauma survivors.
- The Childhood Trauma Task Force Training/EBP workgroup will identify and recommend specific training curricula and best/promising practices for mental health professionals to consider using in their treatment and interventions with traumatized child and their families. Many of these curricula and best practices can also be employed and/or adapted for working with adult trauma survivors.
- A workgroup composed of ODMH and state staffs from Ohio's youth and adult correctional systems have reviewed the trauma-informed care-training curriculum developed by the National Technical Assistance Center (NTAC), which is affiliated with the National Association of State Mental Health Program Directors. In June, 2007 they invited representatives from all the adult- and child-serving systems in Ohio, along with consumers, trauma survivors and family members to review and comment on the curriculum.

Feedback from the reviewers was very positive. They felt the curriculum could be modified and used to train multiple disciplines (i.e. child welfare, juvenile justice, health, education, behavioral health, law enforcement, etc.) on general trauma-informed care principles and approaches. The curriculum does not provide specific detailed information on treatment and intervention approaches, but does provide a basic understanding on what a trauma-informed system/organization should look like and how it should function. It has been used to successfully train corrections staff in two Ohio jails (TAMAR Project), and, as previously indicated, is easily adaptable for training staff in other disciplines.

- The culture of the state inpatient facilities emphasizes Recovery and hope. We believe that everyone can feel and be better while continuing to experience a mental illness. Active treatment along with dignity and respect will make a difference in people's lives. The implications for active treatment focus for patients who are experiencing Mental Illness co-occurring with chronic Stress or Trauma include:
 - Recognition of fight-flight condition
 - Accurately assessing degree of threat
 - Learn to reduce threat and increase personal safety planning
 - Construct safety plans involving physical, psychological and social safety
 - Minimize physiological hyperarousal
 - Teach self-soothing skills
 - Address continuing dissociation
 - Attend to physical illness
 - Improve cognitive skills
 - Address addictive behaviors – substance and behavioral
 - Teach affective management skills
 - Alter attitude toward authority figures
 - Teach parenting skills
 - Address traumatic reenactment
 - Specific trauma-resolution, integration techniques
 - Encourage pathways for grieving behavior
 - Restore capacity for healthy relationships
 - Pull toward vision of a better, alternative future
 - Inspire hope, transcendence, transformation

Our patients have been through a lot in their lives we know nothing about. As competent staff, we cannot assume otherwise and must use all the skills taught in the Crisis Intervention Training (CIT) to design crisis interventions that will allow patients to regain control while being respected by staff during the process. Not to do so may re-traumatize patients. Using understanding, taking the time to assess and maintaining professional attitude and respectful demeanor are the first steps toward real crisis intervention, ensuring a safe therapeutic environment for all patients and staff in the hospitals.

- The Core Competencies curriculum addresses the increased trauma in the dually diagnosed population, as do the trainings from the CCOE.
Higher Ed
- The ODMH Residency and Training Program provides grants to colleges and Universities to provide training to students and residents with the goal of increasing the capacity and skills of the public mental health workforce in Ohio. Beginning in 2005, Trauma Informed Care was adopted as an area of need in the funding priorities for this grant.
- The Childhood Trauma Task Force has consumers, trauma survivors and family members included in its membership, and a Consumer/Survivor Subgroup has been formed to help recruit additional consumers, survivors, and family members to participate in the four Implementation workgroups cited in # 1 above. Additionally, a team of one professional and one consumer/survivor/family member facilitates each of the four Implementation workgroups. Sharon Glover, a consultant for the National Child Traumatic Stress Network is doing a training Sept 20 – 21 in Columbus entitled “Creating Effective Partnerships.” The Implementation workgroup co-facilitators, Task Force members and other consumers/survivors/family members recruited by the Consumer/Survivor Subgroup are participating in this event. The purpose is to help people understand and respect the different perspectives that all bring to the table.
- The Childhood Trauma Task Force, in partnership with ODMH and the Ohio Family and children First Initiative, hosted five regional educational forums on childhood trauma in November and December 2007. Over 800 individuals attended the forums, which were held in Columbus, Athens, Toledo, Cincinnati, and Akron. The ODMH Childhood Trauma Strategic Plan, developed by the Task Force, was unveiled at the forums. Each forum concluded with a survivor luncheon with over 50 trauma survivor participants, who provided suggestions for improving the mental health system and input into the overall design of a statewide trauma-informed care effort.
- All of the Behavioral Healthcare Organizations within the IBHS provide clinical placement sites for colleges and universities in their respective regions of the state. Included in the orientation provided to students is a modified CIT to address both safety and trauma informed care needs, as previously described in item #3.
- While we haven't been specific in this regard (culture, race, ethnicity, gender, age, sexual orientation) as yet, there are two things that are relevant. First, ODMH has sponsored two kinds of trainings around person-centered care (which is a critical component of culturally

competent care, and vice versa)--the first was the training around Medical Necessity, establishing need and person-specific treatment planning. The second was the SOQIC training which was organized around person-centered planning in the context of a forms set that included questions about trauma.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- ODMH has referred persons to our state P&A Organization - Ohio Legal Rights Service. They have produced documents for trauma survivors relating to their rights and resources and provide training on this topic.
- The Childhood Trauma Task Force has consumers, trauma survivors and family members included in its membership, and a Consumer/Survivor Subgroup has been formed to help recruit additional consumers, survivors, and family members to participate in the four Implementation workgroups cited in # 1 above. Additionally, a team of one professional and one consumer/survivor/family member facilitates each of the four Implementation workgroups. Sharon Glover, a consultant for the National Child Traumatic Stress Network is doing a training Sept 20 – 21 in Columbus entitled “Creating Effective Partnerships.” The Implementation workgroup co-facilitators, Task Force members and other consumers/survivors/family members recruited by the Consumer/Survivor Subgroup are participating in this event. The purpose is to help people understand and respect the different perspectives that all bring to the table.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- The Childhood Trauma Task Force Training/EBP workgroup will be identifying strategies for long-term financing of best practice trauma-informed treatment and interventions. Finalization of these recommendations is not expected until next year.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- The Childhood Trauma Task Force Training/EBP workgroup will be identifying strategies for clinical trauma-best practices, which should

include how to avoid re-traumatizing children when working with them. Finalization of these recommendations is not expected until next year.

8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**

- ODMH has funded the following research projects related to trauma:

-Measuring psychological distress in Somali refugees (completed)

Kent Schwirian, PhD & Patricia Schwirian, PhD, RN, Dept. of Family Medicine, The Ohio State University conducted the study in Franklin County (Columbus), OH at a community health clinic. (The research report can be found in New Research in Mental Health, Vol. 17; the Somali Psychological Distress Scales that were developed through this research project can be found on the OPER website.)

-Treatment of traumatic stress for the seriously impaired (in progress)

Stevan Hobfall, PhD, Christina Kraft, PhD, & Dawn Johnson, PhD, Center are conducting the study for Traumatic Stress, St. Thomas Hospital, Summa Health System in Summit County (Akron), OH. (Stevan Hobfall is the Director of the Center.)

-Understanding youth aggression (in progress)

Patricia Kerig, PhD, Department of Psychology, Miami University is conducting the study in four schools (7th and 8th grades) in Butler and Hamilton Counties, OH.

-Treatment of traumatic survivors: Effects of meditation practice on client's mental health outcomes (in progress)

Mo Yee Lee, PhD, RSW, College of Social Work, The Ohio State University; Amy Zaharlick, PhD, Dept. of Anthropology, The Ohio State University; & Deborah Akers, PhD, Dept. of Anthropology, Miami University, are conducting the study located in a substance abuse treatment & housing program for homeless women in Franklin County (Columbus), OH.

In addition, the Ohio Consumer Outcomes System Adult Provider instrument has victimization items that ask if an event has occurred in the last six months. The instrument is used with adult consumers considered to have severe mental illness. The following data are from FY07, but the

collection of data is ongoing. These reports come from the Outcomes Data Mart and are based on 106,410 surveys that were collected at various points in treatment.

Victim of:

Rape-9%
Assault-16%
Threats-18%
Harassment-16%
Exploitation-10%
Suicide Attempt- 13%
Self Harm Attempt-9%
Hate Crime-2%
Theft-11%

NTAC has been very impressed with the Learning community model in Ohio and has asked us to publish our experiences. To this end, each Learning Community conducted a survey that outlined the following components:

- Description of the LC members
- Number of Participants
- Brief Description of the Planning Process
- Actions Taken
- Results of those Actions: Data Collected, Intangibles
- Successes and Challenges
- Identify Needs for Sustainability and Growth for the Future

The results of these surveys will be used by the Learning Communities to sustain current efforts and to grow new membership and initiatives. Toward this goal, newly created flexible performance indicators for the State of Ohio include several measures that are designed to specifically monitor the use of S&R in kids residential facilities. In addition to tracking these S&R outcomes, it is also the goal of the Children's Learning Community to increase its membership 50% by 2010. To help with these initiatives, the Children's Learning Community, through the Department of Mental Health, will be requesting additional technical assistance and support from NTAC.

10. Universal trauma screening and assessment.

- Solutions for Ohio's Quality Improvement and Compliance (SOQIC), is a statewide initiative within the mental health system dedicated to improving quality, reducing costs and ensuring compliance with federal requirements. Among multiple areas of work, current emphasis is being placed on the creation of a standardized clinical documentation forms set. Current proposed Diagnostic Assessment forms for both adults and

children/adolescents contain data fields on abuse history and traumatic stress. In winter, 2008, a statewide committee will be convened to review and improve the SOQIC form set. Data fields regarding abuse history and traumatic stress are included in scope of the review.

- The Childhood Trauma Task Force will be convening an Implementation workgroup to identify/adapt trauma-focused screening and assessment tools to help inform appropriate treatment and interventions across systems.
- An IBHS Nursing Assessment has been implemented and is being utilized in all BHOs. Included in the assessment is a “Trauma Informed Care Screen” used to identify those persons who have been the victims of trauma. Recovery-based treatment decisions are made with this assessment in mind.

11. Trauma-informed services and service systems.

- The Ohio Trauma Task Force membership is composed of professionals representing a variety of different systems, and the Task Force is operating under the auspices of the Ohio Family and Children First Cabinet Council, whose membership includes the directors of all the child/family-serving state agencies.

Ohio Disaster Planning

- The Ohio Department of Mental Health (ODMH) in collaboration with community partners has conducted trainings of behavioral health clinicians in the eight Homeland Regional Planning areas to address potential surge in service needs following disaster or terrorist events. ODMH, Ohio Department of Alcohol and Drug Addiction Services (ODADAS), and university faculty with expertise in trauma and psychological first aid, developed a training curriculum for mental health professionals to provide first response following a traumatic event. The curriculum, titled “Helping People find Strength Following Disaster,” was completed in 2006.
- ODMH has developed a two-day training curriculum titled “Responding to Behavioral Health Needs Following Disaster and Terrorist Events.” The two-day curriculum is designed to provide clinicians with behavioral health skills in response to disaster and education on the various administrative and operational functions of emergency response services.
- A shorter one-day curriculum was developed to focus more specifically on behavioral health clinician needs in providing services to persons impacted by a disaster or emergency event.

- The state is currently in process of developing a psychological first aid training that will be available to emergency responders. This training is to provide a basic understanding of psychological first aid for anyone who providing emergency response services.
- Ohio has registered over 1100 clinicians in the state's volunteer emergency database. These individuals are officially recognized as ODMH identified behavioral clinicians and have completed the state curriculum training.
- ODMH has created an All Hazards Coordinator position to monitor emergency preparedness activities and to assist the State Risk Administrator in achieving priority goals and objectives identified by the department All Hazards Leadership and a state- wide All Hazards advisory committee. Local community health boards are participating in exercises and drills to assure readiness to disaster events. These exercises have included biological events such as pandemic influenza; tornadoes and man made events such as terrorist events.
- ODMH has created numerous communication materials to provide information and education to the public on preparedness, response, and recovery from catastrophic events including terrorist acts. These materials provide the public specific information regarding trauma reactions and coping mechanisms. This information is developed to address needs of the public, minorities, children, elderly, and other special populations.

Combat Veterans

- ODMH is closely aligned with initiatives of the Ohio National Guard and Veterans Administration in addressing behavioral health needs of service members and their families. The department has trained over a hundred clinicians on issues and interventions for working with returning service members. ODMH in collaboration with the Ohio National Guard and ODADAS has also developed the Service Member Resource Guide. The guide provides behavioral health information on emotional issues, PTSD, substance abuse, stressors, coping strategies and links to service providers. The guide also provides county-by-county description of types of services and other educational information on a successful transition to life at home.
- The department also created an All Hazards web link to preparedness, response, and recovery information. <http://www.mh.state.oh.us/all-hazards-preparedness/index.html>. This link provides information on disaster and emergency related topics from state, local, and federal resources.

- The department of mental health has also collaborated closely with the Ohio Department of Public Safety and Emergency Management Agency in creation of state's strategic planning documents including the Ohio Homeland Security Strategic Plan and the State Emergency Operations Plan. In each of these planning documents, ODMH is clearly defined as partner agency with specific responsibilities in emergency or disaster events.
- ODMH is currently working with the state Board of Regents to promote behavioral health linkage with colleges and universities (public and private) and to develop prevention strategies that will mitigate instances of violence on college and university campuses. The charge by the Governor to the Board of Regents was to develop recommendations and strategies to reduce incidents of violence on college and university campuses. Some of those recommendations include specific tasks that will be addressed by ODMH in partnership with local community mental health systems and colleges.
- ODMH has committed to training its staff on the concepts and principles of Incident Command Systems (ICS) and National Incident Management Systems (NIMS). Leadership, in both the ODMH central office and in the state hospitals, has participated in training. Ohio's 50 community mental health boards also support training. This training enables the ODMH staff to effectively participate in and provide support to statewide, regional, or local emergencies.

Youth and Adult Correctional System

- A trauma-informed approach is being considered for implementation in the Youth and Adult Correctional System. A workgroup composed of ODMH and state staffs from Ohio's youth and adult correctional systems have reviewed the trauma-informed care-training curriculum developed by the National Technical Assistance Center (NTAC), which is affiliated with the National Association of State Mental Health Program Directors. In June, 2007 they invited representatives from all the adult- and child-serving systems in Ohio, along with consumers, trauma survivors and family members to review and comment on the curriculum. Feedback from the reviewers was very positive. They felt the curriculum could be modified and used to train multiple disciplines (i.e. child welfare, juvenile justice, health, education, behavioral health, law enforcement, etc.) on general trauma-informed care principles and approaches. The curriculum does not provide specific detailed information on treatment and intervention approaches, but does provide a basic understanding on what a trauma-informed system/organization should look like and how it should function. It has been used to successfully train corrections staff in two Ohio jails (TAMAR Project), and, as previously indicated, is easily adaptable for training staff in other disciplines.

State Inpatient Facilities

- The culture of the state inpatient facilities emphasizes Recovery and hope. We believe that everyone can feel and be better while continuing to experience a mental illness. Active treatment along with dignity and respect will make a difference in people's lives. The implications for active treatment focus for patients who are experiencing Mental Illness co-occurring with chronic Stress or Trauma include:
 - Recognition of fight-flight condition
 - Accurately assessing degree of threat
 - Learn to reduce threat and increase personal safety planning
 - Construct safety plans involving physical, psychological and social safety
 - Minimize physiological hyperarousal
 - Teach self-soothing skills
 - Address continuing dissociation
 - Attend to physical illness
 - Improve cognitive skills
 - Address addictive behaviors – substance and behavioral
 - Teach affective management skills
 - Alter attitude toward authority figures
 - Teach parenting skills
 - Address traumatic reenactment
 - Specific trauma-resolution, integration techniques
 - Encourage pathways for grieving behavior
 - Restore capacity for healthy relationships
 - Pull toward vision of a better, alternative future
 - Inspire hope, transcendence, transformation

Our patients have been through a lot in their lives we know nothing about. As competent staff, we cannot assume otherwise and must use all the skills taught in the Crisis Intervention Training (CIT) to design crisis interventions that will allow patients to regain control while being respected by staff during the process. Not to do so may re-traumatize patients. Using understanding, taking the time to assess and maintaining professional attitude and respectful demeanor are the first steps toward real crisis intervention, ensuring a safe therapeutic environment for all patients and staff in the hospitals.

Ohio's Coercion-free Violence-free (CFVF) Learning Communities:

The CFVF Communities in Ohio were created in 2004 following a National Technical Assistance Center presentation on the six best practices to reduce seclusion and restraint. These six core strategies are

1. Leadership towards organizational change(e.g., leadership requires a multidisciplinary team and supports culture change);
2. Using data to inform practice;
3. Workforce development (e.g. recovery for staff and staff empowerment);
4. Use of S/R Reduction tools (e.g. trauma informed care and crisis planning);
5. Consumer/family inclusion (e.g., in planning, etc.); and
6. Debriefing techniques.

The following Learning Communities are currently in existence:

- The Ohio Hospital Association organized the private psychiatric service providers (PPSP) Learning Community of 15 -20 members;
- The Ohio Association of Child Caring Agencies (OACCA) sponsored the Children's Residential Learning Community of a dozen or so members; and
- The state hospital system (Integrated Behavioral Healthcare System) convenes IBHS Learning Community that includes representatives from five BHOs.

Recently, in 2007, a new Learning Community was created that includes members from the Department of Youth Services (DYS). Although they have been part an informal participant in the Children's Learning Community for several years, DYS believed that they could be best served by creating their own independent community on account of their unique mission and the population of clients served.

A recent evaluation of Learning Community progress indicates the state hospital system has had a 30% reduction in both episodes and time of restraint. The Children's Learning Community reported decreased restraint utilization in their non-secure units; however, slightly increased use of S&R in their secure facilities. The PPSP Learning Community is currently analyzing their results. Reasons for identified trends are being investigated.

NTAC has been very impressed with the Learning community model in Ohio and has asked us to publish our experiences. To this end, each Learning Community conducted a survey that outlined the following components:

Description of the LC members

Number of Participants

Brief Description of the Planning Process

Actions Taken

Results of those Actions: Data Collected, Intangibles

Successes and Challenges

Identify Needs for Sustainability and Growth for the Future

The results of these surveys will be used by the Learning Communities to sustain current efforts and to grow new membership and initiatives. Toward this goal, newly created flexible performance indicators for the State of Ohio include several measures that are designed to specifically monitor the use of S&R in kids residential facilities. In addition to tracking these S&R outcomes, it is also the goal of the Children's Learning Community to increase its membership 50% by 2010. To help with these initiatives, the Children's Learning Community, through the Department of Mental Health, will be requesting additional technical assistance and support from NTAC.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Ohio's Childhood Trauma Training/EBP workgroup will be reviewing evidence-based practice treatment models during the next year.

Oklahoma

1. Trauma function and focus in state mental health department.

- The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) have dedicated a full time position focusing on coordination of trauma services efforts within the organization and provide technical assistance and training to providers and staff on trauma informed care.

2. State trauma policy or position paper.

- ODMHSAS currently has a draft policy statement on trauma.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- We have also weaved trauma sessions into all of our statewide conferences and began to build capacity within our state to train staff on trauma.
- Partners with University of Oklahoma to provide training to staff on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent Child Interactive Therapy.
- We are currently formulating plans, in partnership with the University of Oklahoma, to foster experts within various regions in Oklahoma to serve as regional experts in TF-CBT to better provide support and supervision to clinicians using TF-CBT. We plan to utilize the Learning Collaborative Model (adopted from the National Child Trauma Stress Network) to facilitate this process.
- Established a multidisciplinary team of trainers within Oklahoma that can provide Systematic Training to Assist in the Recovery from Trauma (START) Training of Trainers. The team consists of representative from ODMHSAS (both the mental health and substance abuse divisions), Oklahoma Office of Juvenile Affairs, and Domestic Violence/Call Rape Intervention Services.
- Established a leadership team of Sanctuary provider experts in Oklahoma. The team consists of members from 5 residential providers, three of which service adult women, one is a psychiatric hospital for children, and one provides residential substance abuse services to adolescents.

- ODMHSAS currently uses a set of criteria for trauma informed care for our community mental health centers (CMHCs), which includes both children and adult services state wide. These criteria were transformed into an organizational self assessment, which was used to determine areas of success and areas for improvement.
- DMHSAS has also provided training on Psychological First Aid statewide, in collaboration with the University of Oklahoma Health Sciences Center.
- Contract with Oklahoma Mental Health Consumer council to provide WRAP (Wellness Recovery Action Plan) training to adult mental health consumers for illness self-management (outpatient and inpatient facilities).
- Crisis Intervention Training provided to local law enforcement and Mental Health Recovery Training provided to prison personnel includes concepts to decrease re-traumatization.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- DMHSAS has a Consumer Affairs Division which links with consumer groups to provide feedback and recommendations. Furthermore, since 2004, DMHSAS now hire former consumers of services as Recovery Support Specialists to provide feedback and recommendations and serves as a linkage between providers and consumers.
- In May 2007, DMHSAS invited Shery Meade to conduct training on Trauma Informed Peer Support. It was held in both Oklahoma City and Tulsa and providers and consumer advocates statewide attended the training. DMHSAS obtained permission from Ms. Meade to tape the training, which was provided to providers to be used during orientation for a new employee.
- DMHSAS also promotes the involvement of consumers and family members in planning and development process.
- The DMHSAS System of Care state level advisory team is composed of at least 50% consumers and/or family of consumers.
- Contract with Oklahoma Mental Health Consumer council to provide WRAP (Wellness Recovery Action Plan) training to adult mental health consumers for illness self-management (outpatient and inpatient facilities).

- Consumer Provided Support Groups in Prisons utilizing WRAP (Wellness Recovery Action Plan), DBSA (Depression and Bi-polar Support Alliance), and IOOV (NAMI's "In Our Own Voice") models.
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
- Through annual state appropriations DMHSAS currently has funding available for outpatient mental health services, primarily evaluation and assessment, referral, individual counseling, family counseling, and case management to child victims of trauma. The primary target population is children. Programs must utilize research-based models of intervention and include a program evaluation component.
 - Also, through annual appropriations, DMHSAS has funding available for mobile crisis teams, which serve to decrease the impact of trauma and chances for re-traumatization.
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
- The criteria for trauma informed care used by DMHSAS also promotes the use of clinical practice guidelines and use of evidence based models. Some of these models used include Sanctuary, TF-CBT, PCIT, CBT, Trauma Recovery and Empowerment (TREM), and Seeking Safety. Criteria document is available upon request.
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
- Participation in NASMHPD's Initiative for Reduction of Seclusion and Restraint. The pilot site, Griffin Memorial Hospital (adult civil inpatient behavioral health), with current efforts focused on policy revision and implementation and introduction of recovery concepts to consumers and staff. The project includes collaboration with Oklahoma Youth Center's project in sharing information to train staff in trauma-informed concepts and reduction of seclusion and restraint at both facilities. ODMHSAS recently received funding through SAMHSA to continue to focus on reducing seclusion and restraint at these two sites.

- It is the policy of DMHSAS that all employees receive training that enhance an employee's verbal and non-verbal communication skills and foster attitudes that ensure safety, promote the consumer's dignity and self esteem, and contributes to the creation of a trauma sensitive environment that support recovery and resilience. See attached DMHSAS policy #12.1.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Universal trauma screening and assessment.

At admission, all providers conduct co-occurring screening and assessment, which includes questions related to trauma and histories of abuse. DMHSAS tracks the number of trauma screens conducted by contracted providers through our Client Data Core.

11. Trauma-informed services and service systems.

- All contracted CMHCs are required through Oklahoma Administrative Rules and contracts to be trauma informed.
- ODMHSAS currently uses a set of criteria for trauma informed care for our community mental health centers (CMHCs), which includes both children and adult services state wide. These criteria were transformed into an organizational self assessment, which was used to determine areas of success and areas for improvement. (*Criteria Document available upon request*)

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Currently, some trauma specific models used by some ODMHSAS providers include Trauma-Focused CBT, Parent Child Interactive Therapy, Seeking Safety, TREM, and Cognitive Behavioral Therapy.

Oregon

1. Trauma function and focus in state mental health department.

Addictions and Mental Health Division- Trauma Policy Advisory Committee-Oregon's Trauma Policy Advisory Committee (TPAC) has met for the last four years. During that time, TPAC addressed the following items:

- Oregon's priorities in implementing the Addictions and Mental Health Trauma Policy.
- Creating a TPAC Vision Statement.
- Developing Strength, Weakness, Opportunities and Threat (SWOT) worksheet on the status of trauma-informed systems and use of trauma-specific services.
- Creating a 5-year preliminary strategic plan on how to implement a state wide trauma-informed system.
- DHS Assistant Director together with Extended Care Unit Manager responsible for leadership in implementing trauma-informed practice throughout the mental health and addiction service system.

Oregon has developed a list of "Expected Outcomes" in its planning as follows:

Expected Outcomes

Administrative Policies/Guidelines Regarding The System

1. Publicly funded behavioral health services deliver a system of care that includes the concept of a trauma-informed system and the implementation of trauma-specific services by 2011.
2. Increased collaborative efforts within the Department of Human Services reflect a trauma-informed system within 5 years.
3. Oregon Administrative rules, policies, procedures, regulations and standards incorporates the concept of trauma-informed system and trauma-specific services within 5 years.
4. All institutions of higher learning require a curriculum on trauma-informed systems and provide training on assessing trauma and implementing trauma-specific services within 5 years.
5. Licensing boards require all mental health and alcohol and drug counselors to demonstrate knowledge on trauma-informed systems and trauma-specific services through testing and supervision.

Administrative Policies/Guidelines Regarding Services

1. The Legislature passed a law by 2012 that requires all behavioral health agencies to meet the standards of a statewide trauma-informed system.
2. All publicly funded behavioral health agencies offer trauma-specific services unique to the needs of the client.
3. Peer-delivered services incorporate trauma-informed philosophy.
4. Trauma-specific services are culturally specific and gender informed.

Trauma Services

1. Seclusion and restraint are eliminated in all publicly funded behavioral health facilities within 5 years.
2. Families receiving services in the behavioral health system reduce risk factors for trauma by reducing substance use and increase protective factors by creating a safe environment for their children.
3. Behavioral health agencies provide a cultural specific, gender informed, universal screening instrument on trauma for all clients accessing services.

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The Oregon State Hospital and Addictions and Mental Health Division developed hospital policies, procedures, and provided training for the trauma-informed services. The operational impact of this since 2004 as resulted in many changes in policy, environment and practice. They are described in Section 11, Trauma Informed Services

2. State trauma policy or position paper.

- Department of Human Services, Addictions and Mental Health Services Trauma Policy. (Updated 2004, revision in 2007 will include language to include the importance of recognizing the relationship between trauma and psychosis).
- The Department of Human Services (DHS) is in the process of adopting the Addictions and Mental Health Division Trauma Policy. DHS responded to the recovery movement grassroots efforts to ensure that there is a department wide trauma policy.
- Procedures have been developed on how to incorporate revisions to the Addictions and Mental Health Trauma Policy. The Department of Human Services' draft Psychological Trauma Policy is posted on this Division's Trauma web site. Procedures for implementation and training of all DHS human service workers are underway through the Department's Executive Training Council.
- It is monumental to have an entire state human services department adopt such a comprehensive trauma informed services approach to the way service delivery is handled. Oregon has an outstanding opportunity to see an entire paradigm shift in service delivery from education of workforce through to screening, assessments, all treatment planning, misdiagnoses, reduction in seclusion and restraint, long-term unsuccessful repeat hospitalization or repeat program participation, and the reduction of stigma for what has in the past been referred to as "non-compliant" when treatment programs were ineffective.

3. Workforce Recruitment, Hiring, and Retention.

Addiction and mental health providers are actively seeking mental health and addiction professionals who are experienced in trauma counselors. As examples:

- Blue Mountain Recovery Center (BMRC) is very cognizant of the trauma issues that most of our clients have endured at one level or another, during their lifetime. Therefore we provide classes and information on this subject both during Orientation, annual mandatory trainings, and periodic debriefing of significant events.
- BMRC also realizes that there are several levels to "Trauma Informed Care". Clients are asked on admission if they have ever been traumatized. However, due to the rather short Length of Stay at our facility, the center offers only Trauma Awareness trainings and **not Trauma Intervention trainings**. Employees are encouraged to assume that all clients have been traumatized at some point and in some way. They are taught to respond to each client with Respect, Compassion, and *Trauma Sensitive Thoughtfulness* so as to not traumatize the client again by their intervention approach.

- We do have a *Standardized Trauma Assessment Instrument* at our disposal, should a more in-depth intervention be necessary with a specific client. We also have identified *Clinical Staff* that would be available if a specific client was in need of an acute trauma intervention, for a recent trauma. Finally, if a client has identified significant trauma events that are continuing to affect their daily lives, recommendations for *continued outpatient treatment* are made to the *mental health provider* in the community to which the client is transitioning.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

A. Addictions and Mental Health's Workforce Development Unit is working with several community colleges, Portland State University, and several provider employer education programs to increase the number of class hours spent on trauma informed and trauma sensitive services. In 2007, AMH is recruiting individuals in recovery to become part of a Recovery Leadership Training Cadre. Candidates must be life-experienced in the field of mental health and addictions and in recovery, meet core competencies to demonstrate subject matter expertise, and have an ability to teach/public speaking. These trainers are to be recruited by colleges, universities, provider, and community agencies to educate from the truest perspective of education...life experience. This form of instruction provides the unique perspective of "being the evidence" of best practices that have played a part in their recovery.

B. AMH provided a trauma-focused workshop (3 to 4 hour power point presentation) reviewing Oregon's Trauma Policy including the integration of trauma-informed and trauma-specific services. Training is statewide, multi-agency, and community oriented. In 2001, the Office of Addictions and Mental Health published a Trauma Policy to draw attention to the importance of providing trauma-informed and trauma-sensitive services throughout Oregon. The Office recognized the overwhelming impact of trauma in the lives of a majority of clients served, and the inadvertent retraumatization of those seeking services. This workshop is designed to help connect the dots...to demonstrate the correlation between trauma, attachment, and substance use disorders. Since 2006, the workshop was presented to:

- 13 conferences throughout the State of Oregon
- 8 Alcohol and Other Drug agencies

C. AMH sponsored a Seeking Safety training by Lisa Najavitis and Martha Schmitz. Seventy-five counselors from Oregon Youth Association (OYA) and 25 addiction counselors from the community attended the training.

D. New Directions Adult and Adolescent addiction provider in Eastern Oregon received Seeking Safety training.

E. Jeanne Cohen, Project Network, conducted a 1 hour introduction training (December 2006) and a 9-hour credited training for Project Network staff.(Summer 2007). She plans to conduct a 12-week adapted training for consumers at Project Network, which is part 1 of a peer specialist training. In spring 2008, she will conduct a class at Chemeketa Community College, using the following curriculum. Cohen, J. (2005). Using Key Relationships as a Catalyst for Family Healing in Human Services./ Healing Community: A Trauma Curriculum (Instructor Guide).

F. A number of the addiction treatment providers have been trained in trauma-specific services using Stephanie Covington curriculum “A Long Journey Home. A “Companion Guide for Creating Trauma-informed Services for Mothers and Children”.

G. Southern Oregon Adolescent Study and Treatment Center is staff was trained on trauma-informed care from Dr Sandra Bloom.

H. Lane County sponsored a two-day training on The Sanctuary Model by Dr Sandra Bloom. A consortium of mental health and addiction providers around the state attended the training. Plans are underway to invite the Sanctuary Leadership Development Institute to Oregon for further training.

I. A number of state agencies, psychiatric and adolescent addiction provider, Native American addiction agencies and community providers attended Dr Bruce Perry’s Child Trauma Academy in Klamath and Josephine County. Jackson County developed a cross disciplinary team to work with children that are traumatized.

J. Over the past year, the Addictions and Mental Health Division (AMH) has facilitated, supported, staffed, assisted and/or developed training in the following first responder/public awareness efforts to improve community attitude regarding persons with behavioral health disabilities, reduce stigma, reduce negative outcomes in crisis response, increase understanding and skills when providing first response intervention to a person experiencing a mental health or substance abuse crisis:

- First Responder Training to Salem Police Officers – The Crisis From the Consumer Perspective and Intro to Major Mental Illness—Symptoms and How a Person May Present in Crisis—How to Communicate with a Person Hearing Voices.
- Crisis Intervention Team (CIT) Training for Marion County Sheriff’s Department – (2) 40-hour session; 80 Officers trained.

- Disaster Preparedness Training for Behavioral Health First Responders.
- Numerous trauma informed services trainings to community members, consumers, families, and service providers.
- Trauma Informed Services and Crisis Response from a Peer-to-Peer Perspective – Trauma Support Project, Project ABLE, Marion County.
- “Addictions and Mental Health Basics” to front-line case management staff of DHS-Child Welfare, TANF Program.
- Community meetings with county and local consumer/survivor groups regarding trauma informed services and self-care plans to focus on Recovery and avoid the need for crisis first response and hospitalization. Presentations and discussion forums conducted live and through the use of videoconference sites.
- Participation in the national SAMHSA and Ad Council Anti-stigma campaign targeting 18-25 year old friends of friends suffering from a mental illness.
- Co-Chair of the Statewide STOPSTIGMA Campaign in response to negative outcomes and violence during first-responder intervention.
- Partnership with domestic violence prevention, substance abuse prevention, early childhood care and education intervention programs to increase community collaboration in first responder/crisis response for all ages.

K. State hospital staff training on trauma-informed and trauma-specific services.

- Presentation by Beckie Child, Consumer Advocate and Co-Director of Peer LiNC/MHA-Oregon (a consumer run organization) on working with Trauma Survivors from a consumer perspective to ATS-Portland staff.
- Unit 35C had two day training and consultation by Dr. Maggie Bennington-Davis on the Sanctuary Model.
- Units P5A and 35A are working on scheduling training by Dr. Bennington-Davis this fall.
- Pro-ACT (Professional Assault Crisis Training) has been provided to 20 Trainers and 306 employees as of July 1, 2005.
 - a) Pro-ACT grew out of the PART program that put emphasis on assessment skills and verbal interactions rather than physical interventions. Pro-ACT puts

emphasis on principles to problem-solve potentially dangerous situations and avoid or even eliminate restraint.

- b) If restraint is needed, Pro-ACT provides a 4-hour workshop, Restraint Certification, designed to minimize the risk of injury. Pro-ACT emphasizes safety and dignity through problem solving, maintaining that the only risk-free restraint is the one that is avoided.
 - c) Established Trainer and Pro-ACT Steering Committee.
 - d) Provided additional training on how to debrief Seclusion and Restraint events.
-
- Formal presentation given by David Williamson, MD, from Clifton T. Perkins Hospital, Maryland's maximum-security forensic psychiatric hospital. Topic- Assessment and Management of Violence.
 - Strength-Based Practice has been presented on 16 occasions to 187 employees and a total of 80 classroom hours. Strength-Based Practice focuses on the strengths of patients and promotes a philosophy and culture of collaboration and respect for patients.
 - Hospital-wide Recovery competency completed with all staff.
 - Motivational Interviewing is an Evidence-Based Practice class offered to OSH employees that promotes respect and collaboration. Staff is encouraged to listen, ask open-ended questions, reflect patient thoughts and statements, use affirmations and summarize what patients say. The goal of the class is to promote a culture where the patient is valued and a history of trauma is revealed and appreciated. To date this class has been provided on 5 occasions to 66 employees for a total of 24 classroom hours.
 - Consultation with Sandra Bloom, MD and consumer, regarding Sanctuary Model for hospitals nationwide.
 - Attendance by a number of staff at several Sanctuary trainings.

Salem Hospital, a private hospital in the state's capital works in partnership with the Psychiatric Crisis Center and law enforcement agencies to assist and provide medical and psychological crisis services to hundreds of Oregonian's receiving public funding for services. Their report is as follows:

- At Salem Hospital Psychiatry, on 9/25/07 hit a milestone. This is a portion of an email that went out to the staff and hospital leadership: *We have just passed a significant milestone that probably we at psych have generally been aware of...today, September 25th, marks the 5th year of no use of mechanical*

restraints at Salem Hospital Psychiatry. (The last one occurred in the early morning hours of 9/25/02.)

- Salem Hospital Psychiatry has not had a seclusion event since 2004 and only one that year, lasting 15 minutes. Prior to that, no seclusions for 11 months.
- Staff have received training and attended workshops on a multitude of subjects, but with focus on motivational interviewing, stages of change, trauma, self harm, and updates on dialectical behavioral therapy and cognitive behavior therapy.
- Patient centric treatment plans (non-jargon) were rolled out July 2006, with emphasis on recovery and self direction. The plans incorporate values of safety, emotion management, dealing with loss (trauma) and future planning. The acronym and plan title is Treatment and Recovery Plan for Taking Care of My SELF. (Safety, Emotions, Loss, Future)

L. Trauma training programs, in addition to Addictions and Mental Health Evidence-Based Practices added since 2004, and training models added since 2004, have introduced providers of public mental health services to the following models for understanding and responding to trauma:

- Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse; (Sidran)
- TREM: Trauma Recovery and Empowerment Model for Working with Women in Groups (Harris)
- MTREM: Trauma Recovery and Empowerment Model for Working with Men in Groups (Harris, Fallot)
- Seeking Safety: Model for working with trauma and addiction (Najavitz)
- Dialectical Behavior Therapy (Linehan)

M. Conferences

- Beyond Sensitivity and Awareness: Improving Mental Health Services to Diverse Communities: Statewide Conference.
- Recovery Model Services for Trauma Victims: Learning from the Oregon Experience. North Sound Regional Support Network.
- Psychological Trauma Policy: Statewide Regional Forums
- Trauma Awareness and Responsive Mental Health Services: Oregon HMOs.
- Trauma and Transformation. Trauma Relief Services of the Northwest

N. Risking Connection: Working with Survivors of Childhood

Abuse: 3-day training in trauma-informed care framework including a clinical understanding of trauma and its effects, attachment and therapeutic alliances, and vicarious traumatization. Clinical tools and intervention techniques. (Sidran)

O. Addressing Vicarious Traumatization and Burnout in Trauma Care offered to staff at Mid-Valley Behavioral Care Network.

P. SAFE, Inc., Oregon's only entirely consumer/survivor owned and operated drop-in centre, has presented trauma-informed workshops across the state and in Vancouver, B.C., including a multi-media presentation entitled Art and Healing at SAFE, Inc., Feminist Visions of Mental Health Care and Trauma and Re-traumatization, using the SAFE Trauma Handbook, SAFE Guidelines for Implementing: he Client-Focused Oregon Trauma Policy as a text. SAFE offers trauma-informed consumer advocacy training. SAFE's website is <http://members.efn.org/~safe>.

Q. Staff at Project Network Alcohol and Drug and Northeast Portland Oregon Treatment Community received a training conducted Dr. Joy Leary from Portland State University on post-traumatic slave syndrome.

R. ChristieCare is a private non-profit organization providing a wide array of mental health services for children, adolescents and transition aged youth (17-24years old.) 2006 ChristieCare determined that we would become a fully integrated Trauma Informed Service Delivery Organization in all aspects of our work including our organizational administrative structures including, human resources, quality assurance, facilities and maintenance, finance etc, our current existing clinical models and new program development.

- ChristieCare has secured some grant funding, start up training funding and has made a personal significant financial investment in training and consultation to facilitate this organizational change process.
- ChristieCare has contracted with, and has begun work with Tim Murphy, MS and Maggie Bennington-Davis, MD., to provide our workforce development, training and consultation.
- ChristieCare has also invested in training with Sandra Bloom, with the goal of having ChristieCare become a Sanctuary Certified Program; and training with Bessel Van der Kolk.
- ChristieCare has committed to making a regional investment of trauma proficiency by integrating it into all of our regionally located programs. We currently have programs in the Central Oregon Coast

region; Clackamas County (serving the metropolitan tri-county and Mid-Valley region) and have several programs in development in Douglas County.

This Office has participated and/or developed community education programs as described above since 1999. The AMH Workforce Development Unit has developed Workforce Development Plan for 2007-2009, that will include aspects of all of the above.

Responding to individuals in crisis

Over the past year, the Addictions and Mental Health Division (AMH) has facilitated, supported, staffed, assisted and/or developed training in the following first responder/public awareness efforts to improve community attitude regarding persons with behavioral health disabilities, reduce stigma, reduce negative outcomes in crisis response, increase understanding and skills when providing first response intervention to a person experiencing a mental health or substance abuse crisis. Many of these training have contributed to the development of more trauma-informed response to individuals in crisis.

- First Responder Training to Salem Police Officers – The Crisis From the Consumer Perspective and Intro to Major Mental Illness—Symptoms and How a Person May Present in Crisis—How to Communicate with a Person Hearing Voices.
- Crisis Intervention Team (CIT) Training for Marion County Sheriff's Department – (2) 40-hour session; 80 Officers trained.
- Disaster Preparedness Training for Behavioral Health First Responders.
- Numerous trauma informed services trainings to community members, consumers, families, and service providers.
- Trauma Informed Services and Crisis Response from a Peer-to-Peer Perspective – Trauma Support Project, Project ABLE, Marion County.
- “Addictions and Mental Health Basics” to front-line case management staff of DHS-Child Welfare, TANF Program.
- Community meetings with county and local consumer/survivor groups regarding trauma informed services and self-care plans to focus on Recovery and avoid the need for crisis first response and hospitalization. Presentations and discussion forums conducted live and through the use of videoconference sites.

- Participation in the national SAMHSA and Ad Council Anti-stigma campaign targeting 18-25 year old friends of friends suffering from a mental illness.
- Co-Chair of the Statewide STOPSTIGMA Campaign in response to negative outcomes and violence during first-responder intervention.
- Partnership with domestic violence prevention, substance abuse prevention, early childhood care and education intervention programs to increase community collaboration in first responder/crisis response for all ages.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Trauma Policy Advisory Council – over 50% consumer membership Consumer/Survivor Council – 100% consumer membership Lane County’s Trauma Healing Project – over 50% consumer lead.
- Through co-management of GOBHI (Greater Oregon Behavioral Health) a mental health organization (MHO) and Eastern Oregon Human Services Consortium (EOHSC) they have been able to use EOHSC money to do some program development work which would be difficult to do with Medicaid Funds. EOHSC has awarded \$10,000 per year to each of its 13 counties (9 of which are GOBHI Counties) for development of peer-to-peer services in these counties for each of the last three years. These funds were instrumental in bringing a Peer Services Specialist to the region, development of informed peers in very small counties, and creating a network of trained peers throughout the region who are now doing valuable work in their home communities.
- SAFE, Inc. and VALIA – a consumer run organization and as of spring, 2007 a Medicaid Provider Agency, produced the Healing in Safety manual and a trauma awareness video for use by all providers. Most of the peer providers are or will soon be qualified Mental Health Associates. They offer clients many types of alternative treatments and necessities that they are unable to obtain from other agencies, such as yoga, meditation instruction, music lessons, food, shelter, rent money, clothing, accompaniment to social events, in-home support and assistance. Clients create and manage their own treatment plans. SAFE does employ 3 qualified mental health associates who do not identify as consumer/survivors, and one non-consumer professional who can prescribe medication for those who make that choice. SAFE offers nutrition and health classes focusing on alternative methods of handling mental health challenges. Coercion or force are never used. SAFE staff

will work in shifts to support, listen to and stay with a person in crisis who is afraid of commitment and maltreatment and does not want to go to a hospital. Their agency may be unique in the country.

In 2007, the Addictions and Mental Health Division is recruiting individuals in recovery to become part of a Recovery Leadership Training Cadre. Candidates must be life-experienced in the field of mental health and addictions and in recovery, meet core competencies to demonstrate subject matter expertise, and have an ability to teach/public speaking. These trainers are to be recruited by colleges, universities, provider, and community agencies to educate from the truest perspective of education...life experience. This form of instruction provides the unique perspective of “being the evidence” of best practices that have played a part in their recovery.

Crisis First Response

- First Responder Training to Salem Police Officers – The Crisis From the Consumer Perspective and Intro to Major Mental Illness—Symptoms and How a Person May Present in Crisis—How to Communicate with a Person Hearing Voices.
- Trauma Informed Services and Crisis Response from a Peer-to-Peer Perspective – Trauma Support Project, Project ABLE, Marion County.
- Community meetings with county and local consumer/survivor groups regarding trauma informed services and self-care plans to focus on Recovery and avoid the need for crisis first response and hospitalization. Presentations and discussion forums conducted live and through the use of videoconference sites.

State hospital staff training on trauma-informed and trauma-specific services.

- Presentation by Beckie Child, Consumer Advocate and Co-Director of Peer LiNC/MHA-Oregon (a consumer run organization) on working with Trauma Survivors from a consumer perspective to ATS-Portland staff.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Addictions and Mental Health’s Workforce Development 07-09 Plan has allocated \$30,000 for trauma informed services training to advance trauma informed and trauma specific services awareness and implementation at the Division and Community Provider levels.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- AMH developed “Listening to High Utilizers of Mental Health Services: Recognizing, Responding to and Recovering from Trauma”. A report recommending a map of safe options models of treatment and support for survivors of severe childhood and adult trauma. This recommendation is based on interviews with adult consumers, visits to mental health organizations and a review of clinical research and practice.
- In early 2007, **ABHA** formally adopted the AMH Trauma Policy as a practice guideline. This adoption was seen as consistent with a Recovery-Based Model of care. The next big challenge is one of culture change. Members and customers are aware of these concepts, but moving a large group from the place of recognizing a concept and actually making a rather large cultural shift is no easy task. The Division is forming a workgroup to make recommendations to the Quality Management Committee on how to best implement these guidelines and provide for some TA in helping to get providers to make these moves.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

“Behavioral Health Emergency Response Field Guide” and “Annex F, Public Health and Medical Services: Volume II- State of Oregon Emergency Operations Plan” (two guides developed as part of the All Hazard Behavioral Health Plan) incorporates trauma-informed disaster responses.

B. The Addictions and Mental Health Division plans to address trauma issues in their administrative rules, beginning with a new section of trauma-informed, trauma-specific and trauma-service provider rules. Next will be the inclusion of these rules into the general rules that all providers follow, with special attention paid to staff awareness and training, intake, assessment, and treatment. The goal of these rules is recognizing, and reducing or eliminating trauma in all areas of provider contact with clients.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

The AMH Trauma Implementation Plan contains steps to conduct statewide needs assessments and customer satisfaction surveys. Some programs have moved ahead in creating their own customer satisfaction tools, as follows:

- Mid-Valley Behavioral Care Network, one of Oregon's Mental Health Organizations has created several models of a customer satisfaction survey. These were developed through a collaborative process between providers and consumers. Please see documents at:
- <http://www.mybcn.org/shop/images/BCNCrisisPlan-apr06.pdf>

10. Universal trauma screening and assessment.

- TPAC is in the process of evaluating adult and children universal screening instruments and developing procedures on how to administer universal screening instruments. A preliminary recommendation is due by the end of 2007.
- Legacy Health System Project Network in Portland, Oregon has incorporated trauma assessment into their comprehensive mental health and substance abuse assessment.
- Oregon's State Hospital is drafting a revised Nursing Assessment to include abuse history, victim of: (physical abuse, sexual abuse, emotional abuse, physical assault, rape, sexual molestation, domestic abuse, elder neglect or abuse)
- Current psychosocial history completed by social workers includes information about possibility of patient being a victim of abuse.
- Blue Mountain Recovery Center realizes that there are several levels to "Trauma Informed Care". Clients are asked on admission if they have ever been traumatized. However, due to the rather short Length of Stay at our facility, the center offers only **Trauma Awareness trainings** and **not Trauma Intervention trainings**. Employees are encouraged to assume that all clients have been traumatized at some point and in some way. They are taught to respond to each client with Respect, Compassion, and *Trauma Sensitive Thoughtfulness* so as to not traumatize the client again by their intervention approach.
- We do have a *Standardized Trauma Assessment Instrument* at our disposal, should a more in-depth intervention be necessary with a specific client. We also have identified *Clinical Staff* that would be available if a specific client was in need of an acute trauma intervention, for a recent trauma. Finally, if a client has identified

significant trauma events that are continuing to affect their daily lives, recommendations for *continued outpatient treatment* are made to the *mental health provider* in the community to which the client is transitioning.

11. Trauma-informed services and service systems.

The Oregon State Hospital and Addictions and Mental Health Division developed hospital policies, procedures, and provided training for the trauma-informed services. Many trauma informed activities took place since 2004, including those recommended by the Sanctuary Model. These changes were hospital wide and included a focus on patient and staff safety and non-violence. Nursing Assessments, psychosocial history and Emergency Seclusion and Restraint Review form were modified to include abuse and trauma history. (*Document of all changes is available upon request*)

Over the past year, the Addictions and Mental Health Division (AMH) has facilitated, supported, staffed, assisted and/or developed training in the following first responder/public awareness efforts to improve community attitude regarding persons with behavioral health disabilities, reduce stigma, reduce negative outcomes in crisis response, increase understanding and skills when providing first response intervention to a person experiencing a mental health or substance abuse crisis. Many of these training have contributed to the development of more trauma-informed response to individuals in crisis.

- ChristieCare has developed and opened the first Transition Age Youth Group Home to prevent or divert young adults from placement at Oregon State Hospital by integrating Trauma Informed Care, and a strong community based Recovery Model, and close collaboration with Community Mental Health. In order for this model to work, ChristieCare has included Community Mental Health staff in our training and on-going consultation for that program. This program is in Clackamas County. There is currently another identical program in development for Douglas County. ChristieCare is committed to including consumers and youth in both a practical and advisory capacity in the planning and implementation of this initiative. Trauma-Informed processes are currently being built into our clinical and administrative documentation, policy and procedures, safety protocols etc.

ChristieCare is planning to open (early November) a culturally specific program for Native American and Alaska Native youth developed in collaboration with Oregon and Alaska tribal representation and a Native American Advisory Council. This program is the first of it's kind in the nation, and is founded in principles of trauma informed care, integrating cultural proficiency, and traditional healing practice (which are congruent with more current neurophysiological healing techniques); and embracing

the additional insult of historical trauma and the impact that has had on this population. We are most blessed and honored to be able to begin this journey with our tribal partners and believe that this collaboration will help us to create healing in a way that is more humane and accessible for people.

Statewide Initiative Partnership for Best Environments for Supporting Success in Treatment (BESST): Since 1992, the state and Child & Adolescent Residential Psychiatric Programs (CHARPP) have worked in partnership to continuously improve the quality of treatment to children and families. The BESST initiative seeks to create violence and coercion-free environments to reduce and ideally eliminate the use of seclusion and restraint by improving staff training and supervision; implementing trauma-sensitive care; and enhancing and expanding data collection and monitoring efforts, including positive process and outcome indicators. Initiative is linked to training for behavioral health staff dealing with response to disasters and to experience generally in dealing with clients. PowerPoint available.

D. Salem Hospital, a private hospital in the state's capital works in partnership with the Psychiatric Crisis Center and law enforcement agencies to assist and provide medical and psychological crisis services to hundreds of Oregonian's receiving public funding for services. Their report is as follows:

- At Salem Hospital Psychiatry, on 9/25/07 hit a milestone. This is a portion of an email that went out to the staff and hospital leadership: *We have just passed a significant milestone that probably we at psych have generally been aware of...today, September 25th, marks the 5th year of no use of mechanical restraints at Salem Hospital Psychiatry. (The last one occurred in the early morning hours of 9/25/02.)*
- Salem Hospital Psychiatry has not had a seclusion event since 2004 and only one that year, lasting 15 minutes. Prior to that, no seclusions for 11 months.
- Staff have received training and attended workshops on a multitude of subjects, but with focus on motivational interviewing, stages of change, trauma, self harm, and updates on dialectical behavioral therapy and cognitive behavior therapy.
- Patient centric treatment plans (non-jargon) were rolled out July 2006, with emphasis on recovery and self direction. The plans incorporate values of safety, emotion management, dealing with loss (trauma) and future planning. The acronym and plan title is Treatment and Recovery Plan for Taking Care of My SELF. (Safety, Emotions, Loss, Future)

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- A. Morrison Child and Family Services (a psychiatric program for children) are in the process of implementing a trauma policy that includes trauma-informed and trauma-specific protocols. They are utilizing the following trauma-specific services:
- Seeking Safety
 - Dialectical Behavioral Therapy
 - Trauma-Focused Cognitive Behavioral Therapy
- B. The majority of Oregon's Residential Addiction providers are using Seeking Safety for their residential and intensive outpatient clients that are dual diagnosed.
- C. OYA uses Seeking Safety for their adjudicated youth that suffer from trauma related symptoms.
- D. Addiction treatment providers conduct trauma groups using Stephanie Covington curriculum "A Long Journey Home: A Companion Guide for Creating Trauma-informed Services for Mothers and Children".
- E. A number of state agencies, children residential psychiatric and adolescent addiction providers, Native American addiction agency and community providers attended Dr Bruce Perry's Child Trauma Academy in Klamath and Josephine County. The training lasted a year. Jackson County has developed a cross disciplinary team to work with children that are traumatized.

The shift to the delivery of services based on scientific evidence of effectiveness is a major shift for both the mental health and addiction treatment systems. This shift includes a focus on lifelong recovery for person with mental illness as well as those with substance abuse disorders." For a list of the many evidence-based practices, many of which address trauma sensitive services, refer the link below.

<http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml>

Body of Being, a Holistic Mental Health Facility located in Portland, Oregon, has the mission of helping individuals achieve emotional, physical, spiritual, and energetic healing. A group of dedicated practitioners, Body of Being is seeking to provide an alternative to those frustrated by, or skeptical of, traditional treatments of mental health issues.

Individuals currently affected by issues stemming from varying forms of childhood trauma receive a unique and comprehensive therapy plan, looking at the issues from as many perspectives as possible and providing integral support toward the goal of optimal health.

Body of Being addresses four basic elements of health: Emotional/Mental, Physical, Spiritual and energetic. IN order to adequately address these basics aspects of being, Body of Being brings together of diverse and highly trained group of professionals that cover a wide range of disciplines. Acupuncture, Naturopathy, Energy Work, Body Work as well as a Psychiatric Nurse Practitioner, Clinical Psychologist and a mental health counselor. This team of professionals combines their talents to provide clients with a unique blend of comprehensive, compassionate and effective treatment options. The results of such care include not only the balance of one's energies, but a sense of empowerment and overall well-being.

Body of Being is hoping to reach a broader client base through the launch of a new web site (www.bodyofbeing.com). The new web site features detailed philosophy behind the services that Body of Being provides, along with biographical profiles of every team member. A map to the Body of Being facility and information about flexible service fees can also be found on the Body of Being web site.

For more information, visit <http://www.bodyofbeing.com>

- SAFE, Inc. and VALIA – a consumer run organization and as of spring, 2007 a Medicaid Provider Agency, produced the Healing in Safety manual and a trauma awareness video for use by all providers. Most of the peer providers are or will soon be qualified Mental Health Associates. They offer clients many types of alternative treatments and necessities that they are unable to obtain from other agencies, such as yoga, meditation instruction, music lessons, food, shelter, rent money, clothing, accompaniment to social events, in-home support and assistance. Clients create and manage their own treatment plans. SAFE does employ 3 qualified mental health associates who do not identify as consumer/survivors, and one non-consumer professional who can prescribe medication for those who make that choice. SAFE offers nutrition and health classes focusing on alternative methods of handling mental health challenges. Coercion or force are never used. SAFE staff will work in shifts to support, listen to and stay with a person in crisis who is afraid of commitment and maltreatment and does not want to go to a hospital. Their agency may be unique in the country.
- Project: ITS-GIRLS: Integrated Treatment Services for Girls
Applicant Agency: Willamette Family Treatment Services, Inc. (WF)
Grant# SM57131: CMHS/National Child Traumatic Stress Service Center Grant. Willamette Family Treatment Services, Inc. (Willamette Family) has funds and is seeking additional funding through the National Child Traumatic Stress Initiative (NCTSI) for a third year to integrate a responsive program of gender sensitive trauma services into currently offered substance abuse treatment programs for adolescent girls in Lane County, Oregon.

This project expands the reach of the National Child Traumatic Stress Network into the specific population of adolescent females, and will build on current work with girls utilizing evidence based substance abuse interventions. Project staff will be able to contribute their expertise on working with adolescent girls to the Network, and will be able to evaluate trauma interventions with this population. The addition of trauma focused services under this NCTSI grant will augment the mental health services at WF available to adolescent girls and their families and will create a complete array of healing interventions for this vulnerable population.

Pennsylvania

1. Trauma function and focus in state mental health department.

The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) in the Department of Public Welfare recognizes the impact that trauma has on the lives of the individuals it serves. The State Mental Health Planning Council, Adult Committee, established Trauma Informed Care as a priority in the 2007 – 2010 planning cycle, with a specific focus on working with the community based hospital system.

The OMHSAS has numerous initiatives related to Emergency Behavioral Health Response coordinated by an Emergency Behavioral Health Manager. (see Section 11)

OMHSAS advocates for and participates in efforts to support veterans impacted by the trauma of war, participating in statewide workgroups and conferences.

The OMHSAS supports the work of the PA Trauma Cross Disabilities Advocacy Coalition, comprised of statewide stakeholders/experts in trauma and trauma-informed care, and facilitated a strategic planning session of this coalition in 2006. The following objectives and actions were identified.

Goal 1: To provide training and education

Objective A – Work with treatment providers on the issues of sexual violence, domestic violence and trauma related to individuals with mental illness, developmental disabilities and co-occurring disorders.

- Provide training to OMHSAS State Hospital Unified Practice Committee
- Train staff in all 7 state hospitals and 1 state nursing home
- Train staff at Extended Acute Care units developed upon closure of Harrisburg state hospital
- Train staff at state Mental Retardation Centers
- Develop next steps in training plan, including updating the Co-Opt Victims Empowerment (COVE) project manual
- Do studies/analysis of specific individual experiences, and make recommendations to various systems involved

Objective B – Foster partnerships, connections and understanding between service systems (i.e., county mental health and mental retardation, sexual assault and domestic violence shelters.)

- Identify statewide rape crisis and domestic violence resources and develop director
- Create awareness of the availability of training on screening tool
- Promote/endorse Project Illumination

Goal 2: Legislative and Systems Advocacy

Objective - Provide advocacy at legislative and systems level to increase awareness, support and funding for trauma services and supports

- Develop a paper on “The Cost of Trauma”
- Support Adult Protective Services legislation
- Participate in Victim’s compensation and Victim’s Rights, making recommendations specific to Victims of Crime with Disabilities
- Include disabilities to the work begun under the Prison Rape Elimination Act (PREA)

Goal 3: Support organizations developing trauma treatment residential centers

Numerous outcomes of the plan have occurred, most significantly a Department of Justice – Office of Violence Against Women grant received by three of the major coalition partners (PA Coalition Against Rape, Disabilities Right Network and PA Coalition on Domestic Violence.) The first year of the grant allows for planning, with the Cross Systems Group serving as the advisory committee for the grant. One goal is to more effectively implement Goal 1, Objective B, by establishing a cross-systems group in each county/county joinder in the state.¹

2. State trauma policy or position paper.

3. Workforce Recruitment, Hiring, and Retention.

Other than workforce orientation and training, no specific initiatives are in place on a statewide level specifically related to the workforce.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Drexel University Behavioral Healthcare Education program is funded by the State Office of Mental Health and Substance Abuse Services to train about 12,000 practitioners a year. One goal is to train teams of people as trainers so that the entire spectrum of providers and professional specialties are trained in trauma. Multiple courses range from Posttraumatic Stress Disorder (PTSD) Across the Life Span to Adults with Mental Illness and Histories of Abuse in Childhood to Addictions and Trauma – Co-existence.

¹ Pennsylvania is a state funded, county administered system.

- First trauma conference held Fall 2003 at Drexel University, Trauma Through the Life Cycle. Brochure. Brochures and Speaker lists available.
- Second trauma conference on Complex Psychological Trauma. Brochure and Presenter lists available.

- State Department of Public Welfare exploring large project to include multiple mental health service delivery organizations in participation in Sanctuary Leadership Development Institute and Sanctuary Network
- Philadelphia:
 - Department of Behavioral Health created Trauma Task Force
 - Two Philadelphia programs trained at the five-day, Sanctuary Leadership Development Institute – Children’s Crisis Treatment Network and Pathways – now part of Sanctuary Network
 - Several Philadelphia are programs involved with Department of Human Services clients (homeless shelters, mental health agencies, residential treatment program) have been trained in SELF: A Trauma-Informed, Psychoeducational Group Curriculum
 - Behavioral Health Training and Education Network (funded by the Philadelphia Office of Behavioral Health) coordinates The Behavioral Health Trauma Training Initiative. Since 1998, this initiative has provided multiple level training to inform behavioral health and other human services provider staff about the impact and nature of trauma/interpersonal violence and way to begin to address these issues. As of June 2004, more than 2,500 staff have been trained through this initiative in the following areas:
 - Cycles of Violence Series: eight-10 full day training workshops on trauma-related topics.
 - Interventions Training, developed by Maxine Harris at Community Connections, Washington, DC.
 - Recovery Model Training for Consumers/Trauma Survivors/Recovering Persons, Peers and Staff.
 - Symposia offering opportunities for administrators and practitioners to learn about various topics in depth and to be exposed to a variety of intervention techniques:
 - Cycles of Violence and Welfare Reform: Past, Present and Future –2001
 - Second Annual Trauma and Behavioral Health Symposium, 2002
 - Understanding the Impact of Trauma and Neglect Across the Lifespan: Toward Reframing Behavioral Health Practice, 2003
 - The Sanctuary Model of Organizational Change, 2004.

Luzerne County

- Luzerne County Domestic Violence Task Force sponsored SAGE (Safety, Affect Management, Grief, Empathy) Model training for over 350 social service professionals. From Sanctuary Model (Bloom)
- Public mental health organizations sponsored a series of trainings in SAGE and Sanctuary model (Bloom)

Erie County

- Sarah Reed Children's Center has become a member of the Sanctuary Network and participated in the Sanctuary Leadership Development Institute.

Allegheny County

- Pace School has become a member of the Sanctuary Network and participated in the Sanctuary Leadership Development Institute.
- Community Cares Behavioral Health beginning to develop standards within managed care system for trauma-informed approaches to treatment

Linkages with higher education to promote education of professionals in trauma

Drexel University

- Initial funding just obtained to start an institute within Drexel University School of Public Health with particular emphasis on urban violence, trauma and social justice.

University of Pennsylvania:

- The University of Pennsylvania School of Social Work hosts a bi-annual conference on family violence aimed at training service providers and advocates who work with perpetrators and survivors of intimate violence and trauma. The 2004 conference, "Finding New Directions for Responding to Intimate Violence," was co-sponsored by the Philadelphia Mayor's Taskforce on Domestic Violence and received funding from the Pennsylvania Department of Aging. Brochure and speaker list available.
- The Certificate Program in Organizational Trauma will provide training on assessing and responding to trauma in organizations.
- The Penn Social Work Professional Continuing Education Program offers a variety of courses related to trauma to human service professionals, including: Handling the Impact of Trauma in the Family Context (6 hours); Abuse in Intimate Relationships (6 hours); Creating Sanctuary (from the Sanctuary Model, Bloom, 6 hours); Tragedy, Trauma, Loss,

Grief, and Resiliency (6 hours); Assisting in the Aftermath of Disasters and Other Crises (6 hours); Forensic Assessment of Adult Sex Offenders (6 hours); Child Abuse and Child Welfare (6 hours); Elder Abuse (6 hours).

- Penn also offers a credit-bearing course in the MSW program taught by Dr. Sandra Bloom (The Sanctuary Model) on creating and sustaining trauma-informed social systems in mental health settings, schools, shelters, other social service settings, and the community-as-a-whole. COURSE TITLE: SW 799-001 Creating Sanctuary: Sustaining Safe Environments for Social Learning (Free Elective)
INSTRUCTOR: Sandra Bloom, MD., President, Community Works, Inc.

Bryn Mawr School of Social Work

- During the 203-2004 academic year, Bryn Mawr School of Social Work offered two, six-hour courses by Dr. Sandra Bloom in trauma theory and trauma-informed treatment.
- During 2006-2008, Bryn Mawr School of Social Work are offering a certificate program in Introduction to Trauma Studies prepared and taught by Dr. Sandra Bloom, Joseph Foderaro, and RuthAnn Ryan
- State Department of Mental Health and Substance Services has an agreement with Drexel University on Behavioral Healthcare Education. 12,000 people per year trained from entry-level case managers to seasoned professionals who need updates on new research findings. Drexel also hosts annual conference on Trauma Through the Life Cycle.

Pennsylvania con't

The OMHSAS sponsors an annual training program delivered by Drexel University College of Medicine, Behavioral Healthcare Education, to provide training to behavioral health managers, supervisors, licensed and non-licensed professional staff, line staff, consumers, families, partners from other service systems and the general public. Courses related to trauma-informed treatment and support offered by Drexel in 2007/2008 are:

- Posttraumatic Effects Across the Lifespan
- Moving Beyond PTSD: Individual Treatment Models that Work
- Current Approaches to Working with Trauma in Families
- Dialectical Behavioral Therapy: Applications for High Risk Behavior
- A Path to Hope in Trauma Recovery

Additionally, the University of Pittsburgh's Western Psychiatric Institute and Clinic, Office of Education and Regional Programming offer training related to trauma-informed treatment and support to the western portion of the state in face-to-face venues and webcasts.

The OMHSAS oversees DCORT training at the county level, and collaborates with Critical Incident Stress Management (CISM) leaders in Pennsylvania. Also, OMHSAS collaborates with highly trained Victim Advocate teams called KCIT (Keystone Crisis Intervention Teams) in Pennsylvania.

Training curriculum for DCORT and other responder training includes the Federal Emergency Management Agency (FEMA) and Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines/training manuals, as well as curriculum recommendations from the National Center for Post Traumatic Stress Disorder (NCPTSD).

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Philadelphia Trauma Task Force comprised of clinicians and People-With-Lived-Experienced
- Pennsylvania has received approval from the Center for Medicaid Services to include Certified Peer Specialist Services in the state plan. Over 450 peers have been trained, many who identify as trauma survivors. These individuals will work within the Medicaid community-based service system in addition to roles in non-Medicaid funded peer services. Pennsylvania's state hospital system is also employing Certified Peer Specialists. Training to Peers within the Medicaid and non-Medicaid behavioral health system on trauma-informed rights is being offered by the Trauma Coalition. A recent statewide meeting of peers involved in county-based Consumer/Family Satisfaction Teams offered training on trauma-informed rights.
- The Pennsylvania State Planning Council, comprised of a Children's, Adult and Older Adult Committee meets every other month. Member appointments to the Council are made with a goal of diversity of representation, including individuals who represent and advocate for trauma-informed policies and programs.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Statewide disaster coordinator appointed. Following NASMHPD model and working with county mental health agencies as well as emergency response agencies.
- By establishing trauma-informed treatment and support as a priority in the behavioral health system, planning and training activities become a focus and resources, as they are made available, are considered to support development of a trauma-informed service system. Through the OMHSAS training program, evidence-based and promising practice in the area of trauma-informed services is promoted.
- The mayor of Philadelphia appointed a Task Force on Domestic Violence in 2003 with the mayor serving as the honorary chair and the police commissioner and Women's Law Project Executive Director serving as co-chairs. The Task Force is charged with making recommendations as to what operational policies; practices and points of accountability should exist to drive a more coordinated response on the part of the city. As a result of early assessment of needs, Major John Street allocated a million dollars to expand hotline services and shelter beds. In April 2004, Dr. Sandra Bloom presented training on trauma theory to the entire Task Force.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- Although there are no specific practice guidelines for working with children with trauma histories currently endorsed by OMHSAS, there are numerous Guidelines for Best Practice in Child and Adolescent Mental Health Services which engender many practice guidelines relevant to children with trauma histories (<http://www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines/>) No specific practice guidelines are currently identified as a standard in supporting adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- State OMHSAS has adapted a non-seclusion/restraint policy for state psychiatric hospitals. Information available at <http://www.dpw.state.pa.us/omhsas/omhleadingway.asp>.

In the late 1990's, Pennsylvania initiated a statewide program to reduce and ultimately eliminate the use of seclusion and restraints in the state hospital system. This initiative has continued as a Department of Public Welfare Restraint Free Initiative. Key elements of Pennsylvania's Seclusion and Restraint (S/R) Reduction policy:

- Seclusion and restraints must be the intervention of last resort.
 - S/R are exceptional and extreme practices for any patient. They are not to be used as a substitute for treatment, nor as punishment or for the convenience of the staff.
 - S/R are safety measures, not therapeutic techniques, which should be implemented in a careful manner.
 - Staff shall include patient strengths and cultural competence to prevent incidents of S/R.
 - Staff must work with the patient to end S/R as quickly as possible.
 - A physician must order S/R.
 - Orders are limited to one hour and require direct physician contact with the client within 30 minutes.
 - The patient and family are considered part of the treatment team.
 - The patient advocate is the spokesperson for the patient (if the patient desires it) and is involved in care and treatment.
 - Patients being restrained cannot be left alone.
 - Chemical restraints are prohibited.
 - The treatment plan includes specific interventions to avoid S/R.
 - Patients and staff must be debriefed after every incident, and treatment plans must be revised.
 - Staff must be trained in de-escalation techniques.
 - Patient status must be reviewed prior to utilizing S/R. Voluntary patients who did not agree to these procedures must be involuntarily committed before these procedures may be initiated.
 - Leaders of the hospital, clinical department heads and ward leaders are accountable at all times for every phase of an S/R procedure. Accountability is demonstrated as a component of the hospital's "performance improvement" index and in staff competency evaluations.
 - Data regarding the use of S/R are made available to consumer and family organizations and government officials.
- This effort is now being forwarded in the community hospital system.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

City of Philadelphia

- The PVS (Poverty, Violence and Substance Abuse) Disaster Pilot, conducted by the Philadelphia Women's Law Project and funded by a grant from the city of Philadelphia to evaluate treatment for pregnant, parenting, substance abusing women. Information gathered via focus groups, interviews and multiple meetings from consumers and all systems and professional disciplines involved in the delivery of services.

Extensive review of the professional literature including over 700 articles focused on interrelatedness of substance abuse with trauma and violence. Findings included poverty, domestic violence, sexual assault and substance abuse as recurrent and concurrent themes in the lives of women in the city's health, social service, and criminal justice systems. Final Report includes recommendations to the City and a literature review by Sandra Bloom, M.D. Trauma was identified as central to all other issues. Report and Literature review by Dr. Bloom *The PVS Disaster: Poverty, Violence and Substance Abuse in the Lives of Women and Children*, are available from the Women's Law Project.

The OMHSAS has, with the PA Department of Health, instituted an Emergency Behavioral Health Consortium to advise both agencies about the Emergency Behavioral Health Response Plan in PA. Included on the committee and co-chairing the consortium is a consumer advocate, who has made trauma service utilization and needs a priority. Members of a consumer satisfaction team are also represented.

The consortium, in September, brought in a SAMHSA approved trainer to discuss the current training trends and included was a discussion that any cognitive behavioral health treatment provided to survivors/victims of a disaster, including terrorism, be provided by a trauma trained therapist.

10. Universal trauma screening and assessment.

- Luzerne County Domestic Violence Task Force Trauma Workgroup is reviewing multiple trauma assessments for adaptation and use across all systems in Luzerne County serving children, including John Briere's brief assessment used in the courts and child welfare system: Trauma Symptom Checklist For Children (TSCC, TSCC-A) www.johnbriere.com

No universal tool has been adopted in Pennsylvania for screening and assessment; however the PA Trauma Cross Disabilities Advocacy Coalition has established a goal of creating awareness of the availability of training on a screening tool.

11. Trauma-informed services and service systems.

Seclusion and Restraint

The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) in the Department of Public Welfare recognizes the impact that trauma has on the lives of the individuals it serves. The State Mental Health Planning Council, Adult Committee, established Trauma Informed Care as a priority in the 2007 – 2010 planning cycle, with a specific focus on working with the community based hospital system. The state run system of 7 state

hospitals and 1 nursing home have been recognized nationally for moving forward a seclusion and restraint free environment, a trauma-invoking practice as well as one that retraumatizes individuals. Additionally, each of the hospitals attempts to identify abuse/trauma histories for individuals it treats upon admission and has established uniform training and approaches in the provision of dialectical behavioral treatment.

Emergency Response

The OMHSAS has numerous initiatives related to Emergency Behavioral Health Response coordinated by an Emergency Behavioral Health Manager. This staff oversees the State Hospital Disaster Crisis Outreach and Referral Teams (DCORT), Crisis Counseling Programming following federally declared disasters, and other initiatives related to supporting communities impacted by disasters. The OMHSAS oversees DCORT at the county level, and collaborates with Critical Incident Stress Management (CISM) leaders in Pennsylvania. Also, OMHSAS collaborates with highly trained Victim Advocate teams called KCIT (Keystone Crisis Intervention Teams) in Pennsylvania.

Combat Veterans

OMHSAS advocates for and participates in efforts to support veterans impacted by the trauma of war, participating in statewide workgroups and conferences.

City of Philadelphia:

- The mayor of Philadelphia appointed a Task Force on Domestic Violence in 2003 with the mayor serving as the honorary chair and the police commissioner and Women's Law Project Executive Director serving as co-chairs. The Task Force is charged with making recommendations as to what operational policies; practices and points of accountability should exist to drive a more coordinated response on the part of the city. As a result of early assessment of needs, Major John Street allocated a million dollars to expand hotline services and shelter beds. In April 2004, Dr. Sandra Bloom presented training on trauma theory to the entire Task Force.
- Statewide disaster coordinator appointed. Following NASMHPD model and working with county mental health agencies as well as emergency response agencies.

City of Philadelphia

- Institute for Safe Families (ISF) RADAR for Mental Health: Five years ago, ISF formed a working group of mental health professionals to adapt RADAR for use by behavioral health providers. RADAR for Mental Health is both an assessment and intervention tool for detecting and intervening in family violence situations. This tool is informed by trauma theory and the Transtheoretical Model of Behavior change. During the

past four years, ISF has trained and continues to train psychiatric residents, social workers, drug and alcohol counselors and family violence service providers on use of this tool. Providing these trainings has brought to light the hesitancy of domestic violence advocacy organizations to refer their clients for mental health services because of the lack of expertise of most mental health providers in understanding family violence dynamics. With this in mind, a partnership has been formed to address the need for increased training of psychiatric residents and other mental health practitioners. ISF is currently seeking funding to support a training program.

- The Clinical Network on Men and Violence: ISF and the Delaware Valley Community Health (DVCH) programs formed a clinical network to develop and support more services for men who are violent, particularly economically disadvantaged and Spanish-speaking men. The goal: form a batterers' intervention group for poor Spanish-speaking men and build skills and competency among mental health providers who work with men. Twenty mental health providers trained in the Duluth Model. They then met regularly and received trauma-informed supervision of their clinical work with men and families. ISF convened a group of primary care providers to develop RADAR for Men. This tool is informed by trauma theory and is being presented at a national conference on Healthcare and Domestic Violence in October 2004. DVCH recently completed a prevalence study that looked in part at the relationship between depression and anxiety disorders (including PTSD) and exposure to violence. Trauma-informed behavioral health services are fully integrated into the delivery of primary medical care at DVCH.
- Women Against Abuse (WAA), Domestic Violence Shelter, Women Against Abuse Legal Center and Sojourner House: WAA operates the only women's domestic violence shelter in Philadelphia and also operates Sojourner House, a transitional living center for victims of domestic violence. WAA is creating a trauma-informed system for women and children in its care. Retreats and trainings on the trauma-informed system for women and children in its care. Retreats and trainings on the trauma-informed approach have been held with the entire staff and board of directors; trauma-focused SAGE group are being held at the shelter for women and children; the clinicians at the shelter are receiving regular supervision with a specialist in trauma-informed treatment.
 - Interim House, a women's residential and outpatient substance abuse program, recognized the need to become trauma-informed based upon program research data that indicated more than 90 percent of its clients had suffered significant trauma and abuse as children and/or adults. In 2002, Interim House implemented a yearlong, agency-wide training on the SAGE model. Trainings were held monthly and included all staff. The program incorporated

gradual changes to the program structure that reflected the core principles of safety, affect management, grief, and emancipation. Changes were administrative as well as clinical.

- Philadelphia Department of Juvenile Probation and the Philadelphia Family Court system have both participated in courses in trauma theory and treatment by Dr. Sandra Bloom. Non-profit agencies in the city that have contracted with Dr. Bloom to become trauma-informed include: Lutheran Settlement House; Family Support Services; Family Parenting Network.

Luzerne County Domestic Violence Task Force (DVTF) Trauma Sub-Committee Workgroup has established guidelines and actions steps for making all systems trauma-informed. Powerpoint Presentation: Luzerne County Domestic Violence Task Force: Developing a Coordinated Community Response to Trauma.

- Trauma sub-Committee is working with Dr. Sandra Bloom to develop a community based model employing a trauma-informed method for creating or changing organizational cultures in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. Leadership Training manual and Institute in development.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Luzerne County Human Services has initiated a Taskforce on Domestic Violence to develop a coordinated community response to trauma that considers the importance of both a trauma-informed system and trauma-specific services.

- A community based Trauma Sub-Committee was formed involving private and public sector advocacy groups, clergy, service agencies, health care, private practitioners, agency staff, courts, law enforcement, social services and hospital unit, with the goal of developing, promoting and supporting coordinated community-wide service system responsive to any adult or child who may experience overwhelming stress resulting from abuse, interpersonal violence or other traumatic life events.
- Following recommendations of the NASMHPD Position Statement on Services and Supports to Trauma Survivors, a series of trainings and consultations took place in the SAGE and Sanctuary Models (Dr. Sandra Bloom), an action plan is being developed for implementation by public and private sector mental health and mental retardation, drug and alcohol, children and youth, and aging programs, Best practice treatment models are being reviewed and recommended, and specialized trauma treatment

programs have been established in some public and private agencies. (And look in other criteria from Dept.)

Rhode Island

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**

Trauma experience is a priority in Kent Center job descriptions. Listed responsibilities for clinicians, clinical supervisors, and program managers include providing therapy for clients with trauma histories. Program manager job posting also expresses a preference for experience with trauma and co-occurring disorders.

Kent Center staff who work on the Kent County Behavioral Health Disaster Team are required to take courses in self-care.

Rhode Island Council of Community Mental Health Organizations Case Management Certification program, sponsored and funded by the Department of Mental Health and Mental Retardation, includes a trauma assessment treatment module.

4. **Workforce orientation, training, support, job competencies and standards related to trauma.**

Kent Center staff receive regular training from the Sexual Assault and Trauma Resource Center through a reciprocal agreement with the Center. Staff are trained in DBT and EMDR to work with trauma survivors.

Crisis Prevention and Intervention (CPI) trains staff in alternative dispute resolution.

Trauma-Informed Model training provided for agency staff by Community Connections of Washington, D.C. Open to the public. CARR (Coalition for Abuse Recognition and Recovery) Continue to work with the guidelines for consumer friendly programs and have been training clinical and non-clinical staff in becoming informed.

RI MHRH and The Kent Center sponsored (2) full-day trauma trainings, conducted by the National Center for Trauma-Informed Care in 2007. The training, entitled Creating Trauma Informed Systems of Care in Human Service Settings, was open to staff from all community behavioral healthcare centers, other social services providers, police officers, probation and parole workers, and correctional officers.

The Kent Center's Emergency Services Team assisted the Warwick Police Department with creating a training on mental illness, including how to avoid

re-traumatizing, for officers. Kent Center staff also assist with conducting the trainings. This training will be provided to Warwick police officers every three years when their department is up for re-accreditation. This training has also been expanded and will be provided to all new police recruits who attend the Municipal Police Academy (all Rhode Island cities and towns, except Providence; also does not include State Police). This training will occur two to three times per year with each new class.

The Kent Center is the lead agency in the Kent County Behavioral Health Disaster Team. The Kent Center's Emergency Services Program Manager is the team leader. Other members of the team are from the Warwick Police Department and Warwick Public Schools. Members of the team are trained in trauma issues. There are eight Behavioral Health Disaster Teams across Rhode Island and they are organized through the RI Department of Mental Health, Retardation and Hospitals.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

Coalition for Abuse Recognition and Recovery (CARR), a group of consumers and professionals, designed a system of care for Kent Center, established criteria for consumer friendly programs, performed community education and training on trauma issues. At least one-third of the members of the Kent Center Board of Directors are trauma survivors. Written documents available.

The Kent Center has a Client Speakers' Bureau. They speak in the community and at staff orientation. Trauma is included in the topics they address.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Victims of Crime Act (VOCA): grant provides both counseling and case management to individuals with no insurance, who are a victim of a crime (domestic violence, victims of crime such as robbery, assault, survivors of childhood physical and/or sexual abuse); are low income; and residents of the state of Rhode Island. This grant has been received at the Kent Center for more than 10 years and is funded by the Governor's Justice Commission from a federal grant from the United States Department of Justice, Office for Victims of Crime. While priority is given to residents of Kent County, services are available on a statewide basis to clients who qualify. These clients pay no fee for counseling but are expected to pay a sliding scale for medication services after three medication management appointments.

- Victims of Trauma (VOT): This grant is funded by a Community Development Block Grant through the City of Warwick solely for residents of the city. Services include both counseling and case management for mental health and substance abuse concerns. Specifically, it targets adult survivors of childhood sexual and physical abuse, victims of domestic violence, and other traumatic situational stressors. These clients pay no fee for counseling but are expected to pay a sliding scale for medication services after three medication management appointments.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- The Kent Center for Human & Organizational Development worked with consumers and providers in the Coalition for Abuse Recognition and Recovery (CARR) to establish Guidelines for Working With Trauma Survivors.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Universal trauma screening and assessment.

- The Kent Center has a single intake procedure for all clients, which includes a trauma screening.

The Kent Center for Human & Organizational Development's intake package used with all clients includes several questions regarding trauma. Staff responsible for intake screening and assessment must be trauma-informed. If client is found to have strong trauma background, a readiness assessment for trauma specific services is done. Goal is to join the client 'where they're at.'

11. Trauma-informed services and service systems.

The Kent Center for Human & Organizational Development services are trauma informed. The Center has a single intake procedure for all clients,

which includes a trauma screening. All staff have been trained in DBT, including clinical, support, and administrative staff. A common language around trauma issues exists throughout the agency due to wide exposure and education around DBT skills. For 9 years staff have regularly attended agency sponsored trauma conferences with national trauma experts. They receive monthly staff training from the Sexual Assault and Trauma Resource Center. They recently received training and are implementing the Harris/Fallot model “Using Trauma Theory to Design Service System” throughout their agency and its services. Description of trainings; conference brochures. See Models.

Center trainings for staff and community members uses a Trauma-Informed Model with an emphasis on providing a safe environment and reducing re-traumatization.

To sustain a high level of trauma-informed practice, the Kent Center works continually to train as many staff as possible, both within its organization and in other organizations throughout the state, initiating a statewide intensive training program on EMDR through the Council for all State CMHCs and training in Critical Incident Stress Management across the state.

Kent Center Court Clinic Program. Established in the Kent County courthouse. Service is trauma-informed. Clinical evaluation and referral of clients who would benefit from a behavioral health alternative to incarceration or who treatment should be provided in conjunction with incarceration. Evaluation for trauma history and referral to trauma-specific services where indicated.

Warwick Truancy Program for children and youth from elementary to senior high school who are in need of counseling services due to truancy, absences and/or discipline issues. Service is trauma-informed. Assessment looks at history of abuse and trauma and referrals are made for trauma-specific counseling if indicated.

Coalition for Abuse Recognition and Recovery (CARR), a group of consumers and professionals, designed a system of care for Kent Center, established criteria for consumer friendly programs, and performed community education and training on trauma issues.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

The Kent Center for Human & Organizational Development offers trauma-informed and trauma-specific services. For nine years staff have regularly attended agency sponsored trauma conferences with national trauma experts. They receive monthly staff training from the Sexual Assault and Trauma Resource Center. Trauma-specific services include:

Trauma-specific individual and group counseling

Victims of Crime Program and Victims of Trauma Program. Persons with no insurance can receive trauma-specific services through these programs.

South Carolina

1. Trauma function and focus in state mental health department.

The Project Director of South Carolina Department of Mental Health's Trauma Initiative has full-time responsibility for addressing trauma throughout the state service system. The Project Director works with liaisons appointed by each of the centers in developing and implementing trauma focused practices throughout DMH

The SCDMH Strategic Plan has specific goals for trauma focused services. Document is available upon request

2. State trauma policy or position paper.

A position paper addressing the need for trauma focused policies and interventions has been written by the director of SCDMH. The SCDMH Strategic Plan also has specific goals for trauma focused services.

Documents are available upon request.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

The Trauma Initiative provides training to staff receiving the Case Management Training which is provided to all new hires who will be providing services to clients. Additionally, the Trauma Initiative has video taped several treatment series that are a part of the training protocol for clinicians throughout DMH. These series include:

- Assessment and Treatment of Trauma Related Problems in Children and Adolescents
- Treating PTSD in Adult Consumers of Mental Health
- Trauma Awareness for Inpatient Staff.

Documents available Upon Request:
Case Management Training Power Point

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

Throughout its existence the Trauma Initiative has integrated the input from clients in various roles into its policies and procedures. The Trauma

Initiative is currently identifying clients who are serving in roles as Consumer Affairs Coordinator or Peer Support Specialists to serve on an Advisory Committee to the Initiative

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- The SC DMH has received and continues to seek various grants to provide evidence based trauma treatment models. Additionally, the Trauma Initiative is funded as a part of the SCDMH annual budget.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- For clinical guidelines refer to: The Expert Consensus Guideline Series: “Treatment of Post Traumatic Stress Disorder”, by Foa, Davidson and Frances. Supplement in Journal of Clinical Psychiatry.
www.psychguides.com/ptsdgl.pdf

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

SCDMH has specific yearly goals for the assessment and treatment of trauma related problems. A department of Mental Health Workgroup was trained by the National Executive Training Institute and revised policies and procedures and implementing training curriculum for in-patient staff to increase trauma sensitive services and avoid re-traumatization of clients.

Documents available Upon Request:

Seclusion/Restraint Policy

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

Trauma Within The Psychiatric Setting: A Preliminary Empirical Report, Administration and Policy in Mental Health, Vol. 30, No. 5, May 2003.
NIMH-funded study examines men and women with a history of psychiatric hospitalization who were attending one of five mental health center clinics in South Carolina.

Study provides initial empirical support for concerns raised by consumer and advocacy groups that the psychiatric setting often can be a frightening and/or dangerous environment. In general, the study results indicate that mental health consumers have experienced a number of traumatic, humiliating, or distressing events during their hospitalization. In addition, results indicate that consumers are adversely affected by these experiences. The results also provide a strong basis for the need to further investigate the issue of sanctuary trauma and sanctuary harm. Subjects were affected not only by practices already considered to be harmful (i.e. restraints), but a number of other experiences also contributed to the feeling of being unsafe, helpless and frightened. Although 91 percent of subjects reported experiencing at least one negative hospital experience and 70 percent had experienced three or more negative hospital events, few subjects had ever been asked about these events by mental health staff. Research indicates that the assessment of any type of trauma history is lacking in public mental health clinics, let alone the assessment of events occurring within the psychiatric setting.

Trauma History Screening in a Community Mental Health Center, *Psychiatric Services*, Vol. 55, No. 2, February 2004. Researchers affiliated with the trauma initiative department of the South Carolina Department of Mental Health and with the Department of Psychiatry and Behavioral Services at the Medical University of South Carolina assessed the lifetime prevalence of traumatic events among consumers of a community mental health center by using a brief trauma-screening instrument. The study also examined the relationship between trauma exposure and physical and mental health sequelae and determined whether the routine administration of a trauma screening measure at intake would result in increased diagnoses of posttraumatic stress disorder (PTSD) and in changes in treatment planning in a practice setting. A total of 505 out of 515 consumers who presented to the CMHC consecutively were surveyed from May 1, 2001 to January 31, 2003. Data from the initial assessment on trauma exposure and on rate of PTSD diagnosis were examined, and a chart review was conducted on 97 cases (19 percent) to determine the extent to which CMHC services addressed trauma-related problems.

Results of the study indicated that 460 consumers (91 percent) had been exposed to one or more traumatic life experiences. The number of traumatic events was negatively correlated with physical and mental health functioning on the 12-item Short-Form Health Survey. (SF-12). Subjects with a history of sexual abuse scored significantly higher on the SF-12, reflecting poorer physical and mental health. Although the rate of PTSD diagnosis increased after implementation of the trauma-screening instrument, the rates of actual PTSD treatment services provided did not change.

Conclusions: This study strongly suggests that screening for trauma history should be a routine part of mental health assessment and may significantly

improve the recognition rate of PTSD. However, much work remains to be done in implementing appropriate treatment.

Treatment Development Grant: NIMH funded, three-year project, ending December 2005, on CBT Treatment for PTSD Among Consumers with SMI. Based on this project, article, Cognitive-Behavioral Treatment for PTSD in Severe Mental Illness, published in the Journal of Psychiatric Practice. Treatment groups have been completed.

Documents available Upon Request:

- A list of published articles

10. Universal trauma screening and assessment.

All persons seeking services from SCDMH are screened for a history of trauma, violence, abuse or neglect. Nine of the seventeen centers are implementing detailed assessment instruments at intake to identify both traumatic events and related symptoms:

Adult Intake Packet includes a Trauma Assessment, and the PTSD Checklist, a brief assessment for trauma symptoms, National Center for PTSD.

An Interview for Children: Traumatic Events Screening Inventory (TESI-C) includes 16 items that survey the domains of potential traumatic experiences. The National Center for PTSD. Dartmouth Child Trauma Research Group.

Parent Questionnaire (TESI-P), includes questions about child and about self. The National Center for PTSD. Dartmouth Child Trauma Research Group

Trauma Symptom Checklist for Children, by John Briere, Ph.D. and Psychological Assessment Resources, Inc. www.johnbriere.com

Department of Mental Health Quality Improvement procedure audits when each mental health center implements a trauma assessment to ensure trauma screening is universally in effect.

11. Trauma-informed services and service systems.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

The Trauma Initiative has developed a Hands On training for Trauma Focused therapy for Adults and for Children utilizing Cognitive Behavioral Techniques and is in the process of providing this training to all clinicians over the next few years.

South Dakota

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**

The Division of Mental Health has submitted a proposal for technical assistance in trauma informed care to Projects for Assistance in Transitioning from Homelessness (PATH). The Division of Mental Health will partner with South Dakota's 3rd Annual Homeless Summit. Through this conference, basic knowledge regarding trauma informed care can reach a broad audience of stakeholders and providers through a breakout session. A full training will follow the Summit and provide an overview for trauma informed services and end with a planning session to develop a system for trauma informed care in our state including strategies to provide more effective and appropriate services to individuals who have experienced trauma

Training on strategies, such as trauma screening and assessment will take place at the Annual Homeless Summit targeting mental health providers and other key stakeholders.

5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**

The Division of Mental Health recognizes the importance of having consumer and family involvement in the planning and implementation of transformational activities and is committed to having involvement from consumers/trauma survivors as we orient, train and build a trauma informed system.

6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
7. **Clinical practice guidelines for working with children and adults with trauma histories.**
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Universal trauma screening and assessment.

Training on strategies, such as trauma screening and assessment will take place at the Annual Homeless Summit targeting mental health providers and other key stakeholders. Move to 4

11. Trauma-informed services and service systems.

As the State Mental Health Authority, the Division of Mental Health (DMH), under the auspices of the South Dakota Department of Human Services (DHS) is responsible for the administration of a comprehensive, community-based mental health delivery system. Central to South Dakota's community-based mental health delivery network is eleven private, non-profit community mental health centers (CMHCs). Each is designated catchment areas to insure services are provided to all of the state's 66 counties.

The State of South Dakota has embraced systems transformation and has three major initiatives: recovery, co-occurring and systems of care. The importance of conducting appropriate, strength- and family-based assessments are essential in establishing individualized plans and providing appropriate services. Training in appropriate assessments must and should include basic knowledge for trauma informed care so that appropriate assessment and planning can occur without victimizing individuals further. The Division of Mental Health strives to maintain an ongoing, continuous, quality improvement mentality. Thus, the Division of Mental Health recognizes the need to increase staff competency in trauma informed care and then build a system with policies, procedures, rules, regulations and standards that support trauma-informed services, increase access to trauma treatment while not traumatizing individuals again when they seek services.

The Division of Mental Health has submitted a proposal for technical assistance in trauma informed care to Projects for Assistance in Transitioning from Homelessness (PATH). The Division of Mental Health will partner with South Dakota's 3rd Annual Homeless Summit. Through this conference, basic knowledge regarding trauma informed care can reach a broad audience of stakeholders and providers through a breakout session. A full training will follow the Summit and provide an overview for trauma informed services and end with a planning session to develop a system for trauma informed care in our state including strategies to provide more effective and appropriate services to individuals who have experienced trauma.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Tennessee

1. Trauma function and focus in state mental health department.

Tennessee Department of Mental Health and Developmental Disabilities (TMHDD)

The Director (Assistant Commissioner) of Special Populations and the Director of the Office of Children and Youth are responsible for addressing and promoting implementation of trauma concepts.

The TMHDD Three Year Plan Report incorporates development of collaboration on counseling and training programs for community mental health agencies who work with victims of trauma. TMHDD is a participant with Tennessee's centers of excellence on the Tennessee Child Maltreatment Best Practices Project which will create changes to promote the delivery of effective trauma practices in Tennessee.

The Tennessee Department Mental Health and Developmental Disabilities (TMHDD) and The Tennessee Department of Children's Services (DCS)

TMHDD and DCS have met regularly over the past year in multi-departmental/organization meetings on "Children's Mental Health Issues", and "Transition of Youth from Custody", which have addressed issues of trauma at the state departmental policy level.

2. State trauma policy or position paper.

The Tennessee Department Mental Health and Developmental Disabilities (TMHDD) TMHDD is in a developmental stage for policy relating to trauma and retraumatization.

3. Workforce Recruitment, Hiring, and Retention.

Recruitment, Hiring, and Retention of trauma competent staff is accomplished at the provider organization level in Tennessee. Organizations throughout the state of Tennessee establish their own criteria for these practices.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD)

Training was presented to the TDMHDD Regional Mental Health Institutes (RMHIs) by Glenn Saxe M.D., Chairman, Department of Child and Adolescent Psychiatry, Boston University School of Medicine on May 19,

2004 by video conference: “Creating Violence and Coercion Free Treatment Environment”. Each RMHI and central office had staff that participated in the video conference training.

Tennessee Association of Mental Health Organizations (TAMHO)

Treatment providers across Tennessee have access to web-based training via the Tennessee Association of Mental Health Organization’s multi-media learning portal. Trainings on this site include workshops from Jan Hineman, Paris Goodyear Brown and the Casey Brain Train model. Each of these experts share practice strategies that encourage providers to utilize Cognitive-Behavioral techniques and other best-practices.

Tennessee Centers of Excellence (COEs)

The Southeast Center of Excellence on Children in State Custody has sponsored a workshop on CBT with children experiencing anxiety disorders. Approximately 150 private providers, COE staff and others attended this training. The program dealt with all anxiety disorders and the treatment model was applicable in working with PTSD specifically.

Centers of Excellence (COE)

The Vanderbilt COE and Memphis COE are trained in PCIT (Parent Child Interactive Therapy) which is an evidence based practice.

Volunteer Behavioral Health Care System (provider agency)

Volunteer Behavioral Health Care System (VBHCS) has therapists with training in trauma-specific treatment strategies. VBHCS sent 21 therapists and medical staff to the Southeast Center of Excellence workshop on CBT with children experiencing anxiety disorders. VBHCS training for case management and residential treatment staff includes discussion of trauma-related treatment issues. Specific outcome studies have not yet been completed, but a large number of those admitted to our residential treatment programs report past trauma. The treatment regimen incorporates work relative to issues stemming from trauma exposure.

The Tennessee Chapter of Children’s Advocacy Centers (CAC)

The Tennessee Chapter of Children’s Advocacy Centers is sponsoring its 4th Annual “Connecting for Children’s Justice” Conference in Nashville in November, 2007. This is the fourth CAC conference that has had tracks focusing on trauma. The November conference will feature nationally known speakers on trauma and abuse. John Briere, Ph.D., will deliver the keynote address titled, “Our Evolving Understanding of Trauma and Abuse: the Past, the Present, and Future Implications”. Ben Sanders, Ph.D. will also present on trauma issues.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

Federal Block Grants and SAMHSA require provider organizations to have consumer involvement in their organizations as well as advocacy representation. Tennessee complies with these requirements at various levels within organizations receiving these funds and grants. Tennessee is evolving a peer support structure which will increase the advocacy involvement of consumers at all of these levels. **No explicit mention of trauma survivor involvement or trauma related activities**

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

Tennessee Centers of Excellence (COEs)

- The Tennessee COEs for Children in State Custody are promoting Trauma Training events for CMHCs in Tennessee. The COEs are promoting the use of Evidence Based Practices across the state with an initial effort in the training and dissemination of TF-CBT. This is funded by a grant for the Tennessee Child Maltreatment Best Practices Project through TennCare (Tennessee's statewide 1115 Medicaid waiver) over the next two years. This project will involve statewide collaborative efforts of the COEs, Department of Children's Services, Child Advocacy Centers, TDMHDD, and other child serving entities.
- The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) provides funding through state dollars, Block Grant and SAMHSA Federal Grant funding for programs to providers, supporting several programs which address trauma: Peer Power; Tennessee Lives Count (TLC); and Teen Screen. (See Criteria 11)

7. Clinical practice guidelines for working with children and adults with trauma histories.

- TDMHDD has revised the best practice guidelines for working with adolescents and is currently revising the best practice guidelines for adults.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD), Division of Clinical Leadership

- Best Practice Guidelines Adult Behavioral Health Services
The Division of Clinical Leadership's Best Practice Guidelines for Adult Behavioral Health (last published July 2002) are currently under revision and will address trauma and retraumatization.
- Tennessee Department of children's Services (DCS)
DCS Administrative Policies state that disruptions in continuity of care are damaging to children. They can result in additional trauma, delayed development, interruptions in education, and interfere with a child's ability to attach and trust others.
- Behavioral Health Services for Children and Adolescents: Ages 6-17
The Division of Clinical Leadership's Best Practice Guidelines for Children (revised August 2007) and addresses the reduction of traumatization in children and of retraumatization and further victimization. Document available at:
<http://www.state.tn.us/mental/BestPractice/bpg.pdf>.
- The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD): Isolation and Restraint
TMHDD, in concert with consumer advocacy groups and mental health organizations, asserts the right of service recipients of mental health care to be free from isolation (seclusion) and restraints. Tennesseans value this right so strongly that the right is codified in statute ([T.C.A. 33-3-120. Isolation and restraints prohibited](#)). Rules have been promulgated in Rules of Department of Mental Health and Developmental Disabilities [Division of Mental Health Services Chapter 0940-3-6, Hospital Isolation and Restraint](#). TDMHDD adopts the National Association of State Mental Health Program Directors [Position Statement on Seclusion and Restraint](#).

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

Tennessee Centers of Excellence (COEs)

The COEs for Children in State Custody are developing three separate regional learning collaborative across the state for the Tennessee Child Maltreatment Best Practices Project. The chosen intervention for this project is Trauma Focused Cognitive-Behavioral therapy (TF-CBT) for providers across Tennessee. The project is working with trainers in the intervention model as well as with experts from the National Center for Child Traumatic Stress at Duke University. Duke University staff will be assisting with the learning collaborative effort helping organizations create changes to promote the delivery of effective practices. Participating agencies will develop core

teams for their agencies to incorporate a trauma assessment and to collect data over the course of the next year. The Tennessee Child Maltreatment Best Practices Project is funded for two years through TennCare (Tennessee's statewide 1151 Medicaid waiver).

The Tennessee Department of Children's Services (DCS)

DCS is deliberately linking services to trauma in children as they come into care and at intervals throughout their custodial stay. DCS uses the Child and Adolescent Needs and Strengths (CANS) measure in conjunction with three teaching hospitals (Centers of Excellence) to evaluate the trauma in terms of the severity, duration, and effects of trauma with a specialized component for children who have experienced sexual abuse. Children with a trauma history are evaluated in terms of the type of trauma experienced (including abuse victimization, witness to domestic or community violence, medical trauma, or natural disaster) and the findings are linked to services and permanency planning. Significant findings are interpreted by staff from one of the Centers of Excellence for recommendations to the child and family team which is empowered to plan appropriate services for the child. Additionally, DCS works in partnership with Child Advocacy Centers and Child Abuse Review Teams to minimize trauma on children who come into care with associated trauma.

Tennessee Association of Mental Health Organizations (TAMHO)

TAMHO is currently conducting a survey of its provider organizations for the Tennessee Child Maltreatment Best Practices Project (described previously). This survey information is requested from mental health providers in order to better plan for training events related to trauma in children. The survey will gather information on programs or practices that agencies use and programs that would be beneficial in their areas.

10. Universal trauma screening and assessment.

Family and Children's Service (provider agency)

Family and Children's Service uses the UCLA PTSD Revised Child Index, the Child Behavior Checklist, and Trauma Screening Child Checklist as standardized trauma assessments and measures for success. Family and Children's Service clinicians are trained and are use the evidence-based Trauma Focused-Cognitive Behavioral Therapy model (TF-CBT).

Centers of Excellence (COE)

The Vanderbilt COE and Memphis COE are trained in PCIT (Parent Child Interactive Therapy) which is an evidence based practice. Move to 4

11. Trauma-informed services and service systems.

The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD)

The following are some of the programs funded which address trauma:

- Peer Power is a violence prevention program based on the Second Step curriculum. Peer Power helps children deal and cope with stress, including but not limited to bullying which is traumatic and can have a lifelong consequences. Peer power makes referrals as necessary. Peer power is funded by TDMHDD.
- Tennessee Lives Count (TLC) provides post-vention to schools and communities that have experienced a suicide. The focus is educational and helps identify youth who may have been traumatized by the events. TLC makes referrals as necessary. TLC is the recipient of a Federal SAMHSA grant through TDMHDD.
- Teen Screen identifies youth who are experiencing depression, drug use and suicide. Many of these children may have issues of trauma that also need to be addressed. Teen screen makes these referrals as necessary. Teen Screen is funded by TDMHDD.

The Tennessee Chapter of Children's Advocacy Centers (CAC)

The Tennessee Chapter of Children's Advocacy Center's has a focus on Trauma and Abuse. Their mission is to promote, assist, and support, development, growth, and continuation of child advocacy centers in their service to abused and neglected children and their families.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Volunteer Behavioral Health Care System (provider agency)

The Healing Childhood Trauma Program is an intensive outpatient program specifically designed to serve children who have experienced trauma including physical and sexual abuse, and exposure to traumatic events. The program works with children, families and others involved in their lives. The Achenbach Child Behavior Checklist is used at baseline, 3 and 6 months to measure behavioral stability and changes and parent self-report surveys are used to assess caregiver perception of progress.

Family and Children's Service (provider agency)

The Trauma Intervention Center for Children & Adolescents (TICCA), is a nationally recognized program of child trauma specialists and is expert in delivering evidence-based practices such as Trauma Focused-Cognitive Behavioral Therapy (TF-CBT). TICCA is a partnership between Family & Children's Service and the Nashville Child Advocacy Center in collaboration with the Metropolitan Nashville Police Department, the Department of Children's Services, and the Metropolitan Nashville Public Schools. Service is

for children and their families who witness or have exposure to violence or traumatic events. TICCA is built on evidence-based and established best practices as determined by the Office for Juvenile Justice Department (OJJDP) and the Substance Abuse Mental Health Services Administration (SAMHSA).

Tennessee Centers of Excellence (COEs)

The COEs for Children in State Custody are developing three separate regional learning collaborative across the state for the Tennessee Child Maltreatment Best Practices Project. The chosen intervention for this project is Trauma Focused Cognitive-Behavioral therapy (TF-CBT) for providers across Tennessee. The project is working with trainers in the intervention model as well as with experts from the National Center for Child Traumatic Stress at Duke University. Duke University staff will be assisting with the learning collaborative effort helping organizations create changes to promote the delivery of effective practices. Participating agencies will develop core teams for their agencies to incorporate a trauma assessment and to collect data over the course of the next year. The Tennessee Child Maltreatment Best Practices Project is funded for two years through TennCare (Tennessee's statewide 1151 Medicaid waiver).

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Texas

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**

Veteran's Conference: Old Traumas, New Traumas, and New Approaches to Treating Trauma. The Texas Mental Health Transformation Project co-sponsored a conference in Houston on May 15, 2007. Additional co-sponsors included the Department of Veterans Affairs Employee Education System, South Central Veteran's Integrated Services Network (VISN 16) Mental Illness Research Education & Clinical Center, Texas A&M University Department of Psychiatry, Veteran's Integrated Services Network 17 PTSD sub-committee, Texas Army National Guard and Baylor College of Medicine. The purpose of the meeting included a focus on innovative approaches to treating trauma related to combat in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), as well as the effects of Hurricanes Katrina and Rita on individuals and on the health care system in the Gulf Coast area.

The conference presented frontline clinicians with the latest information on psychopharmacological treatments, assessment of traumatic brain injury, telemedicine approaches for treating Post Traumatic Stress Disorder (PTSD), family and community interventions for trauma, the effect of deployment in hurricane disaster areas on National Guard units, the effect of the hurricanes on mental health care, and an approach for promoting hope and resilience. An article (published in *The Communiqué*-a publication of the Mental Illness Research, Education, and Clinical Center) provides a detailed description of the conference and is included in Appendix I.

Trauma informed management training, conducted by Roger Fallot, PhD DSHS sponsored travel for the Executive Directors and Clinical Supervisors of specialized residential substance abuse programs for women to attend an initial training conducted by Dr. Fallot in August 2007. Consultation has since been made available to these service providers in their efforts to develop plans to introduce trauma informed management. Plans are being made to allow participating organizations to meet again with Dr. Fallot in January and August of 2008. Information about training offered by Dr. Fallot can be found at:
http://www.communityconnectionsdc.org/consultation_training.htm

Provider staff were sponsored to attend clinical training: *Seeking Safety*, conducted by Lisa Najavits, PhD DSHS sponsored travel for staff from: Outreach, Screening, Assessment and Referral; Outpatient Women's programs; and each of eleven Pregnant/Post-Partum Intervention programs to attend clinical training based on the *Seeking Safety* model, listed in the National Registry of Evidence-Based Practices. Information regarding technical assistance by Dr. Najavits can be found at: <http://www.seekingsafety.org/>

Training related to the Reduction of Seclusion and Restraint The use of seclusion and restraint with people at risk of harming themselves or others is an issue that impacts many agencies including juvenile justice, psychiatric hospitals, residential treatment centers, and schools. The Hogg Foundation for Mental Health at the University of Texas has convened several conferences, seminars, and training events targeting this topic. The Foundation has also compiled a wealth of resources on seclusion and restraint reduction. Additional information can be found at: http://www.hogg.utexas.edu/programs_S&R.html

In addition to the training provided through the Hogg Foundation, training models have been developed and implemented within state institutions. These curricula are designed to train direct care staff on skills that will reduce the incidence of restraint and seclusion. Descriptions of these training models are available.

Training for Mental Health Intervention in Disasters The DSHS is the lead agency for ensuring mental health services are available during and after a disaster. In this role, a specialty Disaster Mental Health Services Team (DMHS) works collaboratively with other state organizations including the Texas Crisis ISM Network, the Office of the Attorney General's Victim Services Division, the Texas Department of Criminal Justice Crime Victim's Clearinghouse, and the Texas Department of Public Safety's Victim Services.

DMHS provides disaster mental health training at the emergency management basic workshop for local government officials and DEM reservists. The program also participates in the annual State Emergency Management Conference and Hurricane Preparedness conferences in an effort to heighten disaster mental health awareness.

The DMHS website includes materials targeted to mental health workers, local government officials and volunteer organizations. Training resources can be found at: <http://www.dshs.state.tx.us/compred/dmh/bibmain.shtm>

DMHS developed a training video, "Hope and Remembrance". The video seeks to demonstrate the need for post-disaster mental health response and the important part the disaster anniversary plays in emotional and psychological recovery. This video can be made available upon request.

Rape Prevention and Education Funds have been awarded to local sexual assault programs across the state and to a state coalition, the Texas Association Against Sexual Assault (TAASA). Sexual assault programs are utilizing these funds to attend training on primary prevention and to build their capacity to implement primary prevention activities. TAASA is using the funds to train sexual assault program staff and partners, and develop materials to assist in the implementation of primary prevention activities.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Federal Crisis Counseling (CCP) Grant Programs DMHS has been involved in over 70 local, state and federally declared emergencies since September 1994. This includes: the Texas A&M Bonfire collapse, the Luby's massacre in Killeen, TX, multiple line of duty deaths of law enforcement officers, and hurricane response efforts in the wake of Hurricane's Katrina and Rita.
- The primary responsibilities of disaster mental health services are to utilize and coordinate disaster mental health resources prior to, during, and after an event and to establish and manage short-term crisis counseling programs in a presidentially-declared impact area. The Crisis Counseling Program, funded by the Federal Emergency Management Agency, establishes a team at a host mental health and mental retardation center and provides outreach, screening, assessment, counseling, information and referral, and public education about the effects of and means to manage stress.
- These Crisis Counseling Programs have been hosted and co-managed through the local Community Mental Health and Mental Retardation Centers with DMHS providing programmatic and fiscal oversight. A Disaster Mental Health Manual, including sample position descriptions for CCP staff can be found at:

<http://www.dshs.state.tx.us/comprep/dmh/dmhplan.shtm>

- A recent article from *EPI LINK* (a professional journal for epidemiologists) describing the Texas Disaster Mental Health Program can be found at:

http://www.dshs.state.tx.us/idcu/epilink/volume_64/issue_6/docs/64_06_01.pdf

- State of Texas Alternatives to Restraint and Seclusion (STARS) Grant
The State of Texas received a grant from SAMHSA to advance evidence-based infrastructure improvements in four public psychiatric hospitals to reduce and ultimately eliminate the use of restraint and seclusion on consumers with mental health disorders, including those with co-occurring substance abuse disorders and/or developmental disabilities. The abstract from the STARS project is included in Appendix III.

7. **Clinical practice guidelines for working with children and adults with trauma histories.**
8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**

Senate Bill 325 Texas is the first state to attempt to address the reduction of restraint and seclusion from a cross agency perspective. To address the use of restraint and seclusion, the Texas Legislature passed S.B. 325, during 2005. This legislation directed the HHSC to establish a work group to review and provide recommendations regarding best practices in policy, training, safety, and risk management that could be used to govern the management of facility residents' behavior related to restraint and seclusion practices. The work group was comprised of representatives from the relevant state agencies, providers, advocates and consumers. The work group developed a set of principles to: (1) Document the current trends recognized in the industry; (2) provide a starting point for reducing the use of restraint and seclusion; and (3) offer alternative behavioral interventions to reduce the use of restraint and seclusion. A copy of this legislation can be found at:

<http://www.capitol.state.tx.us/tlodocs/79R/billtext/html/SB00325E.htm>

A copy of a report describing progress on implementation through January 2007 can be found at:

http://www.hhsc.state.tx.us/reports/SB325_March2006.pdf

Sentinel Event Guidelines The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) defines a Sentinel Event as any unexpected patient occurrence involving death or serious physical or psychological injury or the risk thereof. Guidelines have been developed to provide direction to state hospitals regarding the development of procedures. The intent is to have a positive impact in improving patient care and safety by understanding the causes that underlie certain events and on making systemic changes to reduce the probability of recurrence. Guidelines are available upon request

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

Trauma Registry Surveillance and epidemiologic methods are used to define the magnitude of injuries in the state, identify populations at risk, monitor injury trends, investigate public concerns, and assist in science-based prevention activities. It is mandated by law that all EMS providers (800+ entities) in the state and all hospitals (400+) designated to provide trauma care must report cases of injury to the EMS/Trauma Registry.

Based on data reported to the Registry, violence is a leading cause of injury in Texas (assault being third and suicide being fourth). In 2003, there were 8,519 hospital admissions reported to the Trauma Registry regarding victims of violence. This includes self-inflicted injuries and assaults by others. Over 80% of these events occurred in people under 45 years of age. There were 1,126 hospital admissions for suicide attempts reported to the Trauma Registry in 2003.

The collection of these data makes it possible to analyze injury data to determine the incidence, causes, and circumstances of fatal and non-fatal injuries. The results of these analyses, in turn, help inform outreach and education efforts, and provide the information necessary to make informed policy changes.

Additional information and reports from the Trauma Registry can be found at:

<http://www.dshs.state.tx.us/injury/data/>

Collaboration to Develop and Evaluate Tools and Measures Related to Prevention of Sexual Assault. The Office of the Attorney General (OAG), DSHS and TAASA are currently collaborating on activities including: the development and evaluation of a survey gathering information from sexual assault programs and other identified partners on existing primary prevention activities; the development and evaluation of a needs assessment identifying the training and technical assistance needs of sexual assault programs; and development of primary prevention outcome measures.

STARS Project Evaluation the infrastructure improvements in the STARS project are designed to increase system capacity for implementation, span workforce development and staff training, policy and procedure development, and changing participating hospitals' physical environments.

Methods and strategies proposed are aligned with SAMHSA's *Six Core Strategies to Reduce Seclusion and Restraint*, with the addition of an enhanced emphasis on promoting the infusion of trauma-informed theories and consumer perspectives into each strategic initiative and all activities.

An independent evaluation of outcomes and processes and attention to all performance measures are integral to its continuous quality improvement focus, and will be conducted in partnership with Human Services Research Institution (HSRI) and other project grantees.

10. Universal trauma screening and assessment.

11. Trauma-informed services and service systems.

Because of the organizational framework in which Texas health and human service agencies operate, trauma-informed services cross the spectrum of numerous systems. These include:

- The Texas Department of Protective and Regulatory Services (DFPS),
- The Texas Department of State Health Services (DSHS),
- The Texas Department of Aging and Disability Services (DADS),
- The Texas Health and Human Services Commission (HHSC), and
- The Texas Department of Assistive and Rehabilitative Services (DARS)

Hence, in documenting activities associated with developing trauma-informed systems of care, it was necessary to look beyond the traditional behavioral health system to the broader Texas Health and Human Services Enterprise. There are specific steps being planned in the behavioral health area, such as the addition of contract language related to trauma treatment/trauma-informed services. Comparable steps are being taken in other areas of the Texas Health and Human Services Enterprise.

There are numerous examples of the State's commitment to meeting the needs of individuals who have histories of interpersonal violence, over the life span, including sexual and/or physical abuse, neglect, loss, abandonment, threat, and/or witnessing of violence, and experiences such as natural disasters, terrorism and combat. Any of a number of these traumatic experiences may have played a part in the lives of individuals accessing services from one of the agencies noted above. Consequently, the information noted in this report constitutes a cross-systems approach to trauma-informed care impacting Texans.

Texas Partnership for Family Recovery Research and practical experience repeatedly show a high correlation between parental substance use disorders and child maltreatment. Many children under the jurisdiction of child welfare agencies and the courts come from families with substance abuse disorders.

National and local data reveals that up to 80% of adults associated with a child welfare case have a substance abuse problem that contributes to the abuse and neglect of their children.²

The Texas Partnership for Family Recovery brings together three systems – judicial, child protection and substance abuse – that work together to achieve systems integration and coordination for the benefit of children and families. Project partners include: DSHS, the [Office of Court Administration](#) (OCA), DFPS, and the Court Improvement Project (CIP). The Texas Partnership for Family Recovery recognizes the need for an integrated system. The problems of child maltreatment, substance use and related mental health disorders demand an approach that requires the use of evidence based practices that promote child safety, permanency and family well being. The purpose of the Partnership is to provide assistance to communities that wish to find a better way to address the problem of child abuse and neglect due to substance abuse/addiction and related mental health disorders and to improve outcomes for families in the foster care system.

Additional information can be found at: <http://www.dshs.state.tx.us/sa/txpartnership/>

Mental Health Transformation The topic of building trauma-informed systems of care has been approached in the Mental Health Transformation Workgroup (TWG). The TWG brings together representatives of 15 service providing agencies, consumer and family representatives, and representatives of key Legislative offices for the purpose of building quality services that meet the behavioral health needs of Texans. The TWG offers the forum to consider the development of a position statement regarding trauma-informed systems of care that will guide further development in each of the partner agencies.

Training related to the Reduction of Seclusion and Restraint The use of seclusion and restraint with people at risk of harming themselves or others is an issue that impacts many agencies including juvenile justice, psychiatric hospitals, residential treatment centers, and schools. The Hogg Foundation for Mental Health at the University of Texas has convened several conferences, seminars, and training events targeting this topic. The Foundation has also compiled a wealth of resources on seclusion and restraint reduction. Additional information can be found at: http://www.hogg.utexas.edu/programs_S&R.html

In addition to the training provided through the Hogg Foundation, training models have been developed and implemented within state institutions. These curricula are designed to train direct care staff on skills that will reduce the incidence of restraint and seclusion. Descriptions of these training models are available.

² *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare.* Nancy L. Young Ph.D., Sidney L. Gardner, M.P.A., Prepared by Children and Family Futures, Inc. for the Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment, Technical Assistance Publication Series 27.

Training for Mental Health Intervention in Disasters The DSHS is the lead agency for ensuring mental health services are available during and after a disaster. In this role, a specialty Disaster Mental Health Services Team (DMHS) works collaboratively with other state organizations including the Texas Crisis ISM Network, the Office of the Attorney General's Victim Services Division, the Texas Department of Criminal Justice Crime Victim's Clearinghouse, and the Texas Department of Public Safety's Victim Services.

DMHS provides disaster mental health training at the emergency management basic workshop for local government officials and DEM reservists. The program also participates in the annual State Emergency Management Conference and Hurricane Preparedness conferences in an effort to heighten disaster mental health awareness.

The DMHS website includes materials targeted to mental health workers, local government officials and volunteer organizations. Training resources can be found at: <http://www.dshs.state.tx.us/comprep/dmh/bibmain.shtm>

DMHS developed a training video, "Hope and Remembrance". The video seeks to demonstrate the need for post-disaster mental health response and the important part the disaster anniversary plays in emotional and psychological recovery. This video can be made available upon request.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

Vermont

1. Trauma function and focus in state mental health department.

The Vermont Agency of Human Service (AHS) which oversees the Department of Mental Health, as well as five other departments including the Department of Corrections, Department of Health, Department of Disability, Aging and Independent Living, Department for Children and Families, and the Office of Vermont Health Access, hired an Agency Trauma Coordinator in 2005. The Trauma Coordinator is charged with and supported in implementing trauma-informed service systems and use of evidence-based and emerging best practices throughout all state supported services. The Coordinator is a staff member of the AHS Secretary's office which is a highly visible leadership position within the Agency. The Vermont AHS Strategic Plan (2006) includes a section on the Agency's commitment to a trauma-informed system.

Additionally two Advisory Groups have been established to oversee the AHS Trauma Initiative. The *AHS Trauma Steering Committee* is composed of diverse leadership from AHS's six departments as well as community partners to focus on trauma-informed practices throughout the system of care. The *AHS Child Trauma Work Group* was formed in January 2004 to focus on trauma-specific services to children who have experienced trauma. The *AHS Child Trauma Work Group* has leadership from the Department of Mental Health, Community Mental Health Centers (CMHC), private providers, Department for Children and Families Division of Family Services, VT Network Against Domestic and Sexual Violence, and the VT Adoption Consortium; the AHS Trauma Coordinator is the chairperson.

Available Documents, Materials, Other Resources:

- Vermont AHS Trauma Coordinator Job Description
- AHS Organizational Chart
- Diagram of Elements of a Trauma-Informed Human Service Agency
- Vermont Agency of Human Services Strategic Plan (2006)

2. State trauma policy or position paper.

An Agency-wide Policy on Trauma-Informed Systems of Care has been formally adopted by AHS. The Policy includes a definition of interpersonal violence and trauma, and commits the Vermont AHS to meeting the essential elements of a trauma-informed service system.

Report to the Vermont General Assembly on Psychological Trauma: Impact on Vermont Citizens and Recommendations for Public Policy (November

13, 2000). Includes definition of psychological trauma, impact of trauma, impact of incomplete diagnosis, psychological trauma services in Vermont, recommended support and treatment services, and Commission recommendations.

The Effects of Psychological Trauma on Children and Adolescents (June 30, 2005) report by Kathleen J. Moroz, DSW, LICSW, was prepared for the Vermont Agency of Human Services, Department of Health, Division of Mental Health, Child, Adolescent and Family Unit. This report includes a definition and description of trauma in children, long-term effects of trauma, relationship between trauma and attachment, data of Vermont children effected by trauma, national trends and best-practices in treating trauma, and specific recommendations to improve Vermont's system of care for children who have experienced trauma. This document was widely distributed to the community mental health system and related providers and continues to be utilized by the AHS Child Trauma Workgroup to guide and prioritize work goals.

The Department of Mental Health was re-created in state statute effective July 1, 2007. As a result of new legislative language, the new Department of Mental Health is creating new Vision-Mission-Principles document to guide its work and provide the framework for the development of a strategic plan. The management team has done some preliminary work on this document and has asked an internal staff work group to draft a document that reflects our enabling legislation. After a draft is developed, this document will be widely distributed to a broader group of stakeholders for input and discussion. The concept of a trauma-informed service system will be fundamental to this document and the work that flows from it.

Available Documents, Materials, Other Resources:

- AHS Policy: *Trauma Informed Systems of Care*
- Report to the Vermont General Assembly on Psychological Trauma: Impact on Vermont Citizens and Recommendations for Public Policy (2000)
- The Effects of Psychological Trauma on Children and Adolescents by Kathleen J. Moroz, DSW, LICSW (June 30, 2005) Available at <http://healthvermont.gov/mh/docs/cafu/pubs-cafu.aspx>

3. Workforce Recruitment, Hiring, and Retention.

As the result of becoming more informed about the incidence and impact of trauma, Vermont mental health agencies are making efforts where possible to hire qualifying consumers with a history of trauma into staff vacancies in order to sensitize other agency staff to the issues inherent in delivering trauma-sensitive services.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

Training and consultation for Agency of Human Service (AHS) department managers on *Trauma Informed Service Systems* occurred in 2002. 150 AHS department senior managers received ½ day of orientation from Maxine Harris and Roger Fallot of Community Connections, plus ½ day of consultation for each department concerning planning for improving trauma sensitivity within the department. Model described in published monograph Using Trauma Theory to Design Service Systems by Harris and Fallot.

The AHS Trauma Coordinator has developed an extensive curriculum of trauma trainings to meet the individual needs of the multiple departments and community service providers who request trauma training. Each presentation includes information on the complex impacts of trauma, the dynamics of retraumatization, elements of a trauma-informed service system, skills to increase sensitivity to consumers with lived experience of trauma and information on vicarious traumatization.

It is widely recognized that many veterans who are returning from active duty have experienced psychological trauma or Traumatic Brain Injuries. These experiences are likely to lead to adjustment and coping problems for them upon returning to family life. In an effort to sensitize human services workers to the trauma issues faced by returning U.S. veterans and their families, the Department of Mental Health co-sponsored a conference in June, 2006 titled "From the War-zone to the Home –front. War: The Hidden Cost to American Armed forces and their Families". This conference also served to introduce outreach and mental health workers to the many resources offered by the Veteran's Administration (VA) for returning vets and their families. A key organizer of this conference was a long-standing out-patient services director at Vermont's largest community mental health agency who is also a member of the National Guard. His commitment and expertise has enabled the development of collaborative interstate efforts to ensure that appropriate services are available to victims of battle trauma and their families. This individual has chaired a statewide working group of clergy, support services workers and other stakeholders who meet monthly to monitor access to services for returning vets and strategize about solutions for improving outreach or services to address needs. Also, through the leadership of this individual, federal funds were granted to Vermont for the hiring of 5 peer outreach workers to identify returning vets with mental health needs and refer them for appropriate services.

Over the last year, Vermont's efforts to develop integrated mental health and substance use disorder treatment have also led to increased recognition of the correlation between substance abuse/dependence and trauma. Based on this recognition, the Department of Mental Health and the Division of

Alcohol and Drug Abuse Programs will be planning training for mental health providers on this subject matter.

Available Documents, Materials, Other Resources:

- Numerous Trauma Training PowerPoint presentations are available from AHS Trauma Coordinator

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

As the result of becoming more informed about the incidence and impact of trauma, Vermont mental health agencies are making efforts where possible to hire qualifying consumers with a history of trauma into staff vacancies in order to sensitize other agency staff to the issues inherent in delivering trauma-sensitive services

The *AHS Trauma Initiative Steering Committee* and the *Child Trauma Work Group* have consumer members. These “volunteers” are reimbursed by the state for mileage to attend meetings as well as with a small stipend to support their participation

The Vermont State Hospital has recently contracted for the services of a new “Patient Representative” who is employed by a peer services organization. The individual hired for this position is a peer and works with VSH patients and staff to promote patient rights and the resolution of issues that may contribute to traumatizing events such as restraint and seclusion. This individual serves as a resource to other hospital staff as the hospital continually moves toward creating an environment free of coercion.

The Department of Mental Health has also been using Federal Block Grant funding to support local peer-run initiatives to combat stigma, provide public education, and develop different types of peer support (e.g. warm lines). A portion of the consumers involved in these initiatives are trauma survivors and incorporate their personal experience in the peer activities they are involved with.

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Vermont is implementing a series of new services that are the result of a multi-year planning process designed to create appropriate, innovate and effective alternatives to the state hospital. Services such as a new sub-acute residential recovery program and more community-based crisis stabilization beds for acute inpatient diversion offer such alternatives. Additionally, as an alternative to secure law enforcement transport, funding is available to support restraint-free transportation options for

persons placed in involuntary care when clinically appropriate. Providers who enter into contractual arrangements with the state to offer these services must demonstrate that these services will be provided in a trauma-informed manner.

7. Clinical practice guidelines for working with children and adults with trauma histories.

- The Vermont DMH has established Core Capacity guidelines for the children's programs in Designated Agencies/ Special Service Agencies (the Community Mental Health Center system) which describe the operating guidelines for services, including services that mitigate the effects of risk factors, minimize any trauma potential, and eliminate any further trauma or re-traumatization.

Available Documents, Materials, Other Resources: DMH Child, Adolescent and Family Unit *Core Capacity Services Summary* (2004)

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

AHS has partnered with our state-wide Domestic Violence Network to create the *AHS Domestic Violence Initiative*. While the initiative has a broad scope of activities to create system change, its ultimate purpose is to reduce the retraumatization of and increase safety for service users experiencing domestic violence. There are two reports that can be accessed below.

A significant piece of legislation for trauma-informed service delivery has been in the area of transportation for persons who are subject to an emergency examination for involuntary inpatient mental health care. Existing transportation statutes were amended in 2005 to include consideration of individual trauma in decision-making for transportation during the course of involuntary mental health care for both adults and children.

Available Documents, Materials, Other Resources:

- Vermont State Statutes Annotated: Title 18, Chapter 179 § 7511.
- Report on Domestic Violence Policy and Practice at the Vermont Agency of Human Services: Recommendations for Systems Change (2005).
- Phase One Recommendations for Domestic Violence Policy and Practice at the Vermont Agency of Human Services

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

A Multi-State Study of Mental Health Service Utilization by Trauma Victims (2004, SAMHSA-sponsored):

Data sets provided by the child protection agencies in Vermont were analyzed to determine the rate at which these young people were served by public community mental health programs. Results indicate that, overall, 24 percent of young people identified by the state child agency as having been abused and/or neglected were served by the public mental health system. Children under seven years of age were substantially less likely to receive community mental health services than young people in the 7-12 or 13-17 age groups (14 percent versus 29 percent and 28 percent) Girls were less likely to be served than boys.

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The Multi-State Study also analyzed databases that recorded individuals treated for injuries in hospital emergency rooms. The analysis included both unintentional injury and injury that was the result of assault. More than 20 percent of the assault victims, but only 7 percent of victims of unintentional injury, received community mental health services during the same year. Women and children were significantly more likely to receive community mental health services than men (29 percent and 30 percent vs. 11 percent for assault victims, and 10 percent and eight percent vs. four percent for unintentional injury.)

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The Multi-State-Study also analyzed the database of the Vermont Center for Crime Victims Services to determine whether crime victims who may have experienced trauma utilized the mental health system. The database provided basic demographic information on all adult service recipients. For the analysis, adults, ages 18 and over, who were victims of domestic violence, sexual assault, or other assault, were selected for analysis.

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Research indicates that more than 10 percent of these crime victims received community mental health services in Vermont in 2003. Women were significantly more likely to receive mental health services than men (14 percent vs. 6 percent). Among women, participation in mental health programs for individuals aged 50 and older was substantially less than younger women (6 percent vs. 15 percent and 16 percent). Among men, however, participation in mental health programs for individuals aged 50 and older was substantially greater than for younger men (22 percent vs. 7 percent and 0 percent).

The Multi-State-Study also examined the use of the community mental health system by refugees who were traumatized before, during, or after their relocation. The Vermont Refugee Resettlement Office and the Health Department refugee health program provided data. In Burlington, the highest utilization rate of the community mental health system was for women in the 50 + age group (23 percent vs. eight percent to nine percent for children and younger women, respectively). The highest utilization rate for men in Burlington was in the 35-49 year age group (18 percent vs. four percent to eight percent for boys and other men respectively).

Findings from surveys and training needs assessments were reported in The Effects of Psychological Trauma on Children and Adolescents (June 30, 2005) report by Kathleen J. Moroz, DSW, LICSW. Surveys of trauma screening, assessment and treatment included the Survey of Community Mental Health Center Children's Directors (February, 2005) and the Vermont Network Against Domestic Violence Survey of Child/Youth Advocates (July, 2004). Surveys of trainings needs in Vermont conducted by the Child Welfare Interagency Training Committee (CWITC Training Needs Survey, Fall, 2004) and another conducted by the Children's upstream Services (CUPS) Training Team (2004) identified training related to trauma as a training priority for mental health providers in Vermont.

The AHS *Child Trauma Work Group*, a broad partnership of agency and community partners focusing on improving trauma-specific services for children and their families who have experience trauma, disseminated a survey to 200 direct service providers in 2006 to assess their needs with regard to providing trauma-specific services to children as well as an assessment of their program's trauma-specific policies and practices. The survey, adapted from Fallot and Harris's work, is available.

Act 114 is a Vermont law that identifies the limited conditions under which the use of non-emergency involuntary medications can be administered to patients in hospitals. The Vermont legislature has required that two reports be written and submitted to them annually, one by the Department Commissioner and one by an Independent evaluator. The authors of the latter must make efforts to seek out and interview individuals who have recently been the recipients of non-emergency involuntary medications, and must include a summary and analysis of what resulted based on interviews with persons involuntarily medicated under the provisions of Act 114. This feedback is useful for understanding the continuing need to improve staff awareness of potentially sensitizing events in psychiatric hospital settings.

Available Documents, Materials, Other Resources:

- *A Multi-State Study of Mental Health Service Utilization by Trauma Victims* (2004). John A. Pandiani, Ph.D.; Lucille Schacht, Ph.D.; and Steven M. Banks, Ph.D. Presentation at Conference On State Mental Health Agency Services Research, Program Evaluation and Policy: <http://www.nri-inc.org/conferences/Presentations/2004/MonPandiani.pdf>
Also: <http://www.thebristolobservatory.com/fulltext/SAMHSA%20Multi%20State%20Trauma.pdf>
- *The Effects of Psychological Trauma on Children and Adolescents* (June 30, 2005) by Kathleen J. Moroz, DSW, LICSW
- *Trauma-Informed Assessment* (2006) for direct service workers providing trauma-specific services (Adapted from Fallot and Harris)

10. Universal trauma screening and assessment.

The Vermont Department for Children and Families has added a Trauma screening for children (ages 7 and up) who come into custody and are likely to remain 30 or more days. A screener completes the Trauma Symptom Checklist and indicates if the cumulative response reaches the clinical range (score of 65 or better) in the comments section for the social worker's review.

Through Vermont's efforts to implement integrated mental health and substance use treatment, one of Vermont's Community Rehabilitation and Treatment programs has chosen to use the *Alaskan Screening Tool*, which screens for both substance use disorders and trauma disorders.

Available Documents, Materials, Other Resources:

- DCF Trauma Screening Tool
- Alaskan Screening Tool

11. Trauma-informed services and service systems.

Vermont has made its first step toward creating a trauma-informed Agency of Human Services. The creation of the Trauma Coordinator position, as well as the adoption of an agency-wide Policy on trauma-informed systems of care has created the opportunity to create system change within the agency. Trauma Training efforts are well underway and approximately one third of all AHS Staff have received trauma training. In addition, Vermont is poised to possibly receive two significant SAMSHA grants that would greatly enhance trauma specific services for children with complex trauma and eliminate the use of traumatizing restraint and seclusion in two Vermont psychiatric settings. (See #7).

The AHS Child Trauma Workgroup researched various treatment models for children with complex trauma and selected the *ARC Model* from the National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices (www.NCTSN.org). Over 200 mental health and system of care providers received initial training on complex trauma and the ARC model in 2006.

There have been many activities and efforts undertaken by the State of Vermont's Department of Mental Health (DMH) to develop a flexible and responsive behavioral health response plan to be implemented and serve citizens of the state in the event of a disaster, either man made or natural.

DMH, through its contractors, has provided and continues to provide training to the ten designated community mental health agencies throughout the state. To date, there are over two hundred individuals who have been trained as behavioral health disaster first responders. These individuals have been trained on basic disaster behavioral response, trauma recognition, response and referral and sudden death notification. DMH staff is responsible for assessing the nature and extent of disasters and the need for crisis counseling. DMH staff has the capability and training to write a FEMA Crisis Counseling Program Grant if the disaster eclipses what the DMH system can currently provide.

DMH has also partnered with colleagues in NH, ME, MA and NY, to share written materials, experience and expertise about working effectively with populations who experience trauma via crisis and disaster

Four years ago the Vermont DMH and Vermont's psychiatric inpatient unit for children and adolescents began working together on a quality improvement initiative dealing with a number of issues of mutual concern. One of those issues was the level of use of seclusion and restraint on the adolescent and child units. As part of an initiative to reduce the use of these interventions, the inpatient unit obtained consultation and launched a staff training program based on trauma informed approaches to the adolescents. The result has been a significant reduction in seclusions and restraints. The DMH conducted a quality of care site visit after this initiative was under way and observed the staff working with kids. They clearly were utilizing trauma informed approaches to working with the children when this review occurred. Follow-up quality of care site visits will continue to be conducted by the Department of Mental Health.

In recognizing the potential for emergency procedures such as restraint and seclusion to re-traumatize individuals in psychiatric hospitals, Vermont State Hospital (VSH) carefully monitors and tracks all episodes of these emergency procedures. The data are presently at a monthly EIPRP (Emergency Involuntary Procedures Review Panel) meeting attended by clinical leaders at VSH, peer advocates, members of Vermont Protection and Advocacy and other interested individuals.

In spite of this monitoring effort and in recognition of the potential traumatizing effect of involuntary procedures, DMH has recognized the need to have a more dedicated and strategic effort to reduce the incidence of restraint and seclusion at both VSH and the Brattleboro Retreat (a private Vermont psychiatric hospital that serves as Vermont's inpatient setting for children and adolescents). In May 2007, DMH developed and submitted to SAMHSA, a funding proposal in response to the federal agency's RFP for proposals intended to address this issue. Although the Department has not been notified of its standing vis-à-vis this proposal, the state remains committed to continue its efforts to eliminate traumatizing involuntary procedures and find more positive, effective, trauma-sensitive methods of helping patients manage challenging behavior.

- State Policy on Seclusion and Restraint requires staff to assess an individual for history of trauma upon admission to the facility.
- Staff are trained in understanding the impact of trauma and the positive therapeutic value of de-escalation techniques to avoid the need for restraint and seclusion.
- The Office of Health and Quality Care monitors the use of seclusion and restraint in the department. They are continually working with facilities to reduce the use of seclusion and restraint.
- Department staff are trained in techniques to avoid triggering and re-traumatization using the NASMHPD National Technical Assistance Center curriculum.
- Participation in NASMHPD's Initiative for Reduction of Seclusion and Restraint. The pilot site, Eastern State Hospital has reduced seclusion and restraint and is currently working with NASMHPD to provide training on trauma informed care to staff.

Available Documents, Materials, Other Resources:

- DMH Child, Adolescent and Family Unit *Core Capacity Services Summary* (2004)
- DMH Grant Application to SAMHSA to Implement Alternatives to Restraint and Seclusion
- The 2007 Vermont Department of Health, Division of Mental Health (Department of Mental Health as of 7/1/07) application for a SAMHSA State Incentive Grant to Build Capacity to Implement Alternatives to Restraint and Seclusion.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

The Child Trauma Workgroup (CTWG) secured funding through multi-agency contributions to sponsor a 3-day conference in 2006 on effective treatment of trauma in children. Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW of the Trauma Center at Justice Research Institute in Massachusetts provided training on complex trauma and the ARC model of trauma treatment ([Attachment, Self-Regulation, and Competence \(ARC\): A Comprehensive Framework for Intervention with Complexly Traumatized Youth](#)). Over 200 Vermont mental health and related service system providers attended the conference entitled “Restoring Connections: Improving Care for Children and Families Impacted by Trauma.” ARC manuals were provided by DMH to each of the Community Mental Health Centers. The CTWG is in process to build on the initial training with more in depth consultation and implementation of the model into the statewide service system.

A partnership of CMHCs and the Justice Resource Institute (The Vermont Partnership of the New England Trauma Services Network) submitted a proposal for SAMHSA funding to implement the Attachment, Self-Regulation and Competency (ARC) model of care in four of Vermont’s communities and to establish a Community Treatment and Services Center.

DMH has created a stakeholder committee charged with 1) reviewing evidence-based and promising practices and 2) developing recommendations regarding which practices should be available to all adult mental health consumers in the state. This committee, known as the *Clinical Practices Advisory Panel*, has plans to review and develop recommendations on trauma treatment models in 2008.

Through Vermont’s efforts to implement integrated mental health and substance use treatment, several of Vermont’s Community Rehabilitation and Treatment programs have chosen to implement the *Seeking Safety* group treatment model for individuals with co-occurring mental health, substance abuse, and trauma-related conditions.

Available Documents, Materials, Other Resources:

- *National Child Traumatic Stress Initiative Community Treatment and Services (CTS) Center FY07 grant proposal* by Washington County Mental Health Services as applicant (The Vermont Partnership of the New England Trauma Services Network).
- *ARC manuals* were obtained from Margaret Blaustein, Ph.D. and Kristine Kinniburgh, LICSW of the Trauma Center at Justice Research Institute, MA (http://www.traumacenter.org/products/prod_overview.php)

Virginia

1. Trauma function and focus in state mental health department.

Department of Mental Health, Mental Retardation and Substance Abuse Services(DMHMRSAS)

- Director of the Office of Health and Quality Care designated responsibility for the development and implementation of trauma services for individuals receiving service throughout the state mental health, mental retardation and substance abuse system.

2. State trauma policy or position paper.

Department of Mental Health, Mental Retardation and Substance Abuse Services Trauma Policy Statement will be finalized by May 2008.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Department staff are trained in techniques to avoid triggering and re-traumatization using the NASMHPD National Technical Assistance Center curriculum.
- Staff are trained in understanding the impact of trauma and the positive therapeutic value of de-escalation techniques to avoid the need for restraint and seclusion.
- Participation in NASMHPD's Initiative for Reduction of Seclusion and Restraint. The pilot site, Eastern State Hospital has reduced seclusion and restraint and is currently working with NASMHPD to provide training on trauma informed care to staff.
- The Office of Health and Quality Care in DMHMRSAS will be working with the clinical leadership of facilities to develop plans to train staff in approaches to trauma assessment and treatment to guide treatment planning and service delivery.
- Therapeutic Options of Virginia (TOVA) training program, which is the Department's behavior interaction and management training program, has incorporated a section on trauma. This training is provided annually to all employees who provide direct care.
- Training provided by National Association of State Mental Health Program Directors (NASMHPD) in August and September 2007 is now

being made available by way of DVD and video tapes to employees who did not have an opportunity to attend the live sessions and to new employees.

- Wellness Recovery Action Plan (WRAP) training for peer facilitators is offered statewide by the Virginia Organization of Consumers Asserting Leadership.

Wellness Recovery Action Plan (WRAP) training for peer facilitators *is* offered statewide

- The DMHMRSAS has a long-established relationship with the University of Virginia Institute of Law, Psychiatry and Public Policy to train adult and juvenile forensic evaluators. The DMHMRSAS will explore opportunities to expand the current curricula to incorporate trauma and violence as a core part of the training of all future evaluators.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- DMHMRSAS *will be* partnering with the Virginia Organization of Consumers Asserting Leadership in developing *training* for trauma informed care.
- Wellness, Recovery Action Program offered by consumers trained by the Department of Mental Health and classes are held for individuals receiving services in all of the department's mental health and substance abuse services settings.
- Wellness Recovery Action Plan (WRAP) training for peer facilitators is offered statewide by the Virginia Organization of Consumers Asserting Leadership.

Wellness Recovery Action Plan (WRAP) training for peer facilitators *is* offered statewide

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Funding is currently being provided by DMHMRSAS. The department is seeking grant funding to support specific components of its trauma informed care initiative

7. Clinical practice guidelines for working with children and adults with trauma histories.

- To guide treatment planning and service delivery, The Office of Health and Quality Care in DMHMRSAS will be working with the clinical leadership of facilities on approaches to trauma assessment and treatment

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- State Policy on Seclusion and Restraint requires staff to assess an individual for history of trauma upon admission to the facility.
- Staff are trained in understanding the impact of trauma and the positive therapeutic value of de-escalation techniques to avoid the need for restraint and seclusion.
- The Office of Health and Quality Care monitors the use of seclusion and restraint in the department. They are continually working with facilities to reduce the use of seclusion and restraint.
- Department staff are trained in techniques to avoid triggering and re-traumatization using the NASMHPD National Technical Assistance Center curriculum.
- Participation in NASMHPD's Initiative for Reduction of Seclusion and Restraint. The pilot site, Eastern State Hospital has reduced seclusion and restraint and is currently working with NASMHPD to provide training on trauma informed care to staff.
- DMHMRSAS, Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Services require private providers of mental health services to document when there is a history of trauma and to flag the individual's record to alert staff in the event of a behavioral emergency. Regulations apply equally to all public and private inpatient facilities that are operated, licensed or "contracted for" by DMHMRSAS.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Universal trauma screening and assessment.

- State Policy on Seclusion and Restraint requires staff to assess an individual for history of trauma upon admission to the facility.
- Several state mental health facilities and residences serving adults, children and adolescents currently assess individuals for trauma histories during admission intake

11. Trauma-informed services and service systems.

- DMHMRSAS is in the initial stages of developing a system that addresses trauma in all aspects of service delivery.
- The Governor’s Commission on Sexual Violence has submitted a recommendation to the Virginia General Assembly to require each community to establish services for victims of sexual abuse.
- The state is in the process of training community staff who may be called upon to respond to a disaster or emergency and there are plans to partner with other agencies in the future to have them include in their basic emergency orientation a section on mental health impacts of trauma.
- The Forensics Office of the DMHMRSAS is working with jail programs in the state and will be developing trauma informed care training for the staff of local jails.
- The Department is currently reviewing the disaster plans for its facilities to ensure they address the needs of individuals with trauma, mental health and substance abuse histories.
- DMHMRSAS has a system in place to provide emergency and disaster crisis counseling to the general public during times of President or Governor-declared states of emergency, or other local, regional, or statewide catastrophic events. *Emergency responders receive training on trauma as part of their required training.*

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- DMHMRSAS uses recovery-oriented and evidence-based practices in all aspects of its service delivery system. The Department will be assessing its system to ensure that trauma specific services are included.

Washington

1. **Trauma function and focus in state mental health department.**
2. **State trauma policy or position paper.**
3. **Workforce Recruitment, Hiring, and Retention.**
4. **Workforce orientation, training, support, job competencies and standards related to trauma.**
 - Trauma informed care trainings have occurred at all three state hospitals and is ongoing.
 - Trauma informed care training is now provided in new employee orientation for all new employees at the three state hospitals

North Sound Mental Health Administration

 - Trauma trainings are conducted for staff and consumers
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
 - Consumers in recovery worked on development of training at state hospitals.
 - Consumers in recovery are included as trainers for new employee orientation related to trauma informed care.
 - North Sound Mental Health Administration:
 - Consumers are involved in all aspects of administration and services at the North Sound Mental Health Administration.
 - The consumer and family member Advisory Board to NSMHA includes an acting committee on trauma
6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 - Delivery of services in response to a disaster is funded through existing funding structures. Once need rises beyond existing capacity the mechanism is put in place to trigger a FEMA grant application for further services.
 - The three state hospitals were able to fund the original training on Trauma Informed Care from the SAMHSA Seclusion and Restraint Grant. On-going training on Trauma Informed Care is funded through existing mechanisms for new employee orientation.

7. Clinical practice guidelines for working with children and adults with trauma histories.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

Procedures to avoid retraumatization and reduce the impacts of trauma

- Avoiding use of seclusion and restraint, person focused treatment, verbal de-escalation techniques, relaxation training, comfort rooms.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

10. Universal trauma screening and assessment.

Screening, including for trauma, is being implemented in State Hospital intake process

11. Trauma-informed services and service systems.

MHD has developed All Hazards Emergency Management Plan. MHD charged with evaluating the psychological and emotional needs of the community, the emergency responders and the victims/survivors. MHD has a disaster coordinator, a clear communication channel (including satellite phones) through the state emergency response system, a clear role in FEMA grant application processes, and is charged with maintaining vital services at the three state hospitals

- Avoiding use of seclusion and restraint, person focused treatment, verbal de-escalation techniques, relaxation training, comfort rooms in each of the three state hospitals.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

- Avoiding use of seclusion and restraint, person focused treatment, peer counseling, verbal de-escalation techniques, relaxation training, comfort room in each of the 3 state hospitals.

Wisconsin

1. Trauma function and focus in state mental health department.

- The Division of Mental Health and Substance Abuse Services (DMHSAS) is in the process of hiring a Trauma Coordinator. The position has been approved and should be filled within the next six months.

2. State trauma policy or position paper.

In May, 2007 the Department of Health and Family Services (DHFS) held its first Trauma Summit. There was representation from every division in the Department, treatment partners, county human service providers, consumer advocacy groups, and clients and their families. The Final Report for the 2007 Trauma Summit is available upon request.

3. Workforce Recruitment, Hiring, and Retention.

- Trauma information and skills building workshops are held on an annual basis at both the DMHSAS sponsored Crisis Conference and the Annual Mental Health and Substance Abuse Services Training Conference. Both of these events target clinicians in the fields of mental health and substance abuse, court personnel, law enforcement, school administrators, social workers, hospital professionals, and jail personnel. These workshops consistently cover gender issues and addressing trauma across the lifespan. In September 2007, the Crisis Conference included 2 workshops on Trauma Informed Peer Support conducted by Sherry Mead.
- The University of Wisconsin, in both Madison and Milwaukee offer coursework on trauma education.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Trauma information and skills building workshops are held on an annual basis at both the DMHSAS sponsored Crisis Conference and the Annual Mental Health and Substance Abuse Services Training Conference. Both of these events target clinicians in the fields of mental health and substance abuse, court personnel, law enforcement, school administrators, social workers, hospital professionals, and jail personnel. These workshops consistently cover gender issues and addressing trauma across the lifespan. In September 2007, the Crisis Conference included 2 workshops on Trauma Informed Peer Support conducted by Sherry Mead.

- The University of Wisconsin, in both Madison and Milwaukee offer coursework on trauma education.
- Three models for in-service training of DHFS employees and staff of 72 county mental health service systems are included in the Wisconsin Trauma Workgroup recommendations to the Bureau of Mental Health and Substance Abuse: 1. Risking Connections; 2. a trauma curriculum and materials developed as a result of the Women and Violence project, 3) a Consumer Curriculum, New Partnerships for Women Consumer Curriculum, developed by consumers and providers.
- Disability Rights Wisconsin (DRW) received a Violence Against Women Act Grant for cross systems trainings between six sexual assault and domestic violence organizations and disability organizations. Document: “Wisconsin’s Violence Against Women with Disabilities and Deaf/deaf Women Project: Summary” is available upon request. Six trainings were held statewide. Violence Against Women with Disabilities Project Cross Training Workbook and Accessibility Guide for Domestic Violence and Sexual Assault Service Providers available through DRW website: <http://www.disabilityrightswi.org/>
- Department of Health and Family Services contracted with Sidran Institute to address traumatic stress in homeless population and elders.
- Growing Beyond Survival: Trauma Symptom Management: a one-day training offered to consumers, frontline county healthcare providers, developmental disability staff, mental health and substance abuse staff, with discussion and demonstration of specific trauma interventions. Training conceptualizes trauma symptoms as adaptations to be understood in context before being addressed in treatment. Based on Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress (Sidran)
- Risking Connections Master Trainer Program . 3-day train-the-trainer model for individuals and systems Madison, WI. Thirty-five clinicians in the fields of mental health, substance abuse, and child welfare, who went through the Risking Connection training have now been certified Risking Connection trainers by the Sidran Institute. They began to teach the curriculum to others within their service systems and in their respective state regions. Manual and Powerpoint available
- All women-specific treatment providers received initial training in the Risking Connections to become trauma informed, sensitive, and responsive.
- Risking Connection: Using a Trauma Framework to Support Survivors with Developmental Disabilities. Wisconsin Council on Developmental Disabilities worked with Sidran to adapt the Risking Connections training to apply to staff working with those with developmental disabilities.

- Mental Health and Substance Abuse Teleconferences. BMHSAS sponsors teleconferences on an ongoing basis for front line professionals in the mental health and substance abuse fields. Trauma, its effect, assessment, and treatment have been, and will be, addressed. Current and past topics, and their handouts can be found at the respective websites: Mental Health—
http://dhfs.wisconsin.gov/MH_BCMH/Teleconference/TeleconferenceSch.htm. Substance Abuse:
<http://www.dhfs.state.wi.us/substabuse/Education/ConfCalendar.htm>.

5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.

- Division of Mental Health and Substance Abuse Services has one position dedicated exclusively as a Consumer Affairs Coordinator.
- Promoting Partnerships with Consumers: An Experiential Report and “How To” Guide (Greenley, Barton, Hennings, Marquez, and Michaelis). Paper informing state system developed through The Women and Mental Health Study Site of Dane County.
- New Partnerships for Women Consumer curriculum was updated in May 2007 and distributed at the Department’s Trauma Summit.
- Trauma psychoeducational groups for consumers, co-taught by consumers and providers, are provided by New Partnership for Women, Inc. in five counties across the state. A curriculum and manual include: 1) understanding effects of trauma, 2) symptom self-management, 3) meeting basic needs, and 4) self-advocacy. The groups are funded by state grant. New Partnerships for Women Consumer Curriculum available through npw@choiceonemail.com

6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.

- Comprehensive Community Services (CCS) is a new Medicaid benefit to assist persons with Mental Disorders and Substance-Use Disorders provide a flexible array of individualized community based psycho-social rehabilitation services authorized by a mental health professional to consumers with mental health or substance use issues across their lifespan. CCS website:
http://dhfs.wisconsin.gov/mh_bcmh/CCS/index.htm
- There are currently 20 counties statewide offering the CCS benefit.
Does this qualify? No explicit mention of support for trauma services or trauma survivors – does the new Medicaid benefit apply to any trauma-informed or trauma-specific services???

7. Clinical practice guidelines for working with children and adults with trauma histories.

- The DHFS Trauma Summit (report is available upon request) establishes clinical practice recommendations for integrating trauma identification and resolution across the lifespan.
- The women-specific treatment programs for substance use disorders have a treatment standard that states, “Agencies/programs must develop a process to identify and address abuse/violence/trauma issues. Services will be delivered in a trauma-informed, trauma-sensitive setting and provide safety from abuse, stalking by partners, family, other participants, visitors, and staff.”

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

- Division of Mental Health and Substance Abuse Services established standards for women-specific substance abuse treatment services that include addressing trauma. Available through this website: <http://www.dhfs.state.wi.us/substabus/Programs/Women'sPrograms/wiwmstxstandards.htm>
- Department of Health and Family Services created a state administrative directive for seclusion and restraint reduction. Directive applies to state hospitals as well as community services. It is available at this website: http://dhfs.wisconsin.gov/dsl_info/InfoMemos/DDES/CY_2005/InfoMemo2005-04.htm
- Division of Disability and Elder Services (DDES) now the Division of Long Term Care, has organized a workgroup focused on reduction of seclusion and restraint called the Champion Team.
- The Inpatient Recovery Subcommittee, part of the Recovery Task Force has been addressing the issue of seclusion and restraint. They have based their work on the SAMHSA document on seclusion and restraint.
- Best Practices for Crisis Incidents Emergency Detention prepared by state Crisis Network. Collaboration between the sheriff's department, police, county human services association, and Department of Health and Family Services.

Recommendations regarding seclusion and restraint of individuals with histories of trauma are included in [Wisconsin Workgroup on Trauma's Draft Recommendations to the Bureau of Community Mental Health](#)

- Rules and regulations around nursing homes and hospitals regarding restraint and seclusion policies.
- Current state statute HFS 75 – Community Substance Abuse Service Standards and HFS 36 – Comprehensive Community Services both require addressing trauma.
- The draft outpatient mental health rule, and Chapter 51.61, patient rights are currently being revised to include identifying and addressing trauma.

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.

- Wisconsin’s Fact Sheet on Trauma is included in the Final Report from the 2007 Trauma Summit (see pg. 32).
- Executive Summary available of Forging New Partnerships With Women Report. Needs assessment in terms of the prevalence of trauma; random sample of those who received mental health and/or substance abuse treatment in the public sector. Trauma prevalence identified at 91 percent.
- The MH/AODA Functional Screen has identified a 50 percent trauma prevalence rate.

10. Universal trauma screening and assessment.

- Trauma is included in assessment of all adults with serious mental illness in community support programs, CCS, and women-specific AODA treatment programs.
- The MH/AODA Functional Screen also include a trauma identification section.
- The **Global Appraisal of Individual Needs (GAIN)** assessment tool that is being used in the Project Fresh Light includes trauma identification. Project Fresh Light is an evidence-based approach to treating adolescent substance abuse in Wisconsin.
- Project Fresh Light has developed a work plan to distribute the Wisconsin Version of the Problem Orientated Screening Instrument for Teenagers(Posit) to all Wisconsin Juvenile Intake Units. The Wisconsin Version of the POSIT includes a trauma symptom index. The data for this screen will be gathered comprehensively in partnership with the Office of Justice Assistance
- Project Fresh Light for adolescent substance abuse treatment has developed a comprehensive approach to identifying and screening for trauma and providing necessary services based on the assessment.

11. Trauma-informed services and service systems.

A summary of activities occurring across the Department of Health and Family Services is included in the attached Final Report from the 2007 Trauma Summit. Report available upon request

- The Inpatient Recovery Subcommittee, part of the Recovery Task Force, has been addressing the issue of seclusion and restraint. They have based their work on the SAMHSA document on seclusion and restraint.
- Trauma psychoeducational groups for consumers, co-taught by consumers and providers, are provided by New Partnership for Women, Inc. in five counties across the state. A curriculum and manual include: 1) understanding effects of trauma, 2) symptom self-management, 3) meeting basic needs, and 4) self-advocacy. The groups are funded by state grant. New Partnerships for Women Consumer Curriculum available through npw@choiceonemail.com.
- Wisconsin's Project to end violence against women with disabilities and Deaf/deaf women involves a statewide focus that is grounded in the strength of Wisconsin's disability, domestic violence (DV), and sexual assault (SA) organizations and individuals. Since 2002, the Project's Multi-Disciplinary Team is comprised of Disability Rights Wisconsin (DRW), Wisconsin Coalition Against Domestic Violence (WCADV) and Wisconsin Coalition Against Sexual Assault (WCASA).

Our Mission:

Women with disabilities and deaf/Deaf women who experience sexual assault and/or domestic violence will be supported by people who have actively prepared for access and who think about the meaning of respect one woman at a time.

Our Goals:

Elevate collaboration among state and local sexual assault, domestic violence and disability programs and
Enhance their collective capacity to respond appropriately and effectively to women victims with disabilities and Deaf women.

Activities to Date:

- Support programs to forge relationships that foster commitment to working together to respond to victims/survivors with disabilities and Deaf victims/survivors.
- Develop practical, safe and effective protocols on legal issues that impact programs working collaboratively with women victims with disabilities and Deaf women.

- Team up to perform on-site access assessments of domestic violence and sexual assault programs, and provide feedback on program and physical accessibility issues.
- disability programs, county human services agencies and the disability providers counties fund, other facility settings with residents with disabilities, and consumer-run organizations.
- Technical assistance may be provided through training, phone consultation, on-site discussion or email communication. Possible topics or issues of technical assistance might include:
 - learning about the dynamics of sexual assault, domestic violence and stalking unique to women with disabilities and Deaf women;
 - ensuring compliance with the Americans with Disabilities Act (ADA);
 - learning new techniques for managing communication barriers with victims/survivors;
 - clarifying legal rights involving victims/survivors with disabilities;
 - identifying procedures for working with guardians and interpreters; or
 - assisting programs and/or facilities on related issues to enhance services for women with disabilities and Deaf women who experience violence.

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12. Trauma-specific services, including evidence-based and promising practice treatment models.

- Wisconsin uses the National Registry of Evidence-based Programs and Practices (NREPP), for evidence-based practices in trauma treatment.
- Project Fresh Light for adolescent substance abuse treatment has developed a comprehensive approach to identifying and screening for trauma and providing necessary services based on the assessment.

- Trauma psychoeducational groups for consumers, co-taught by consumers and providers, are provided by New Partnership for Women, Inc. in five counties across the state. A curriculum and manual include: 1) understanding effects of trauma, 2) symptom self-management, 3) meeting basic needs, and 4) self-advocacy. The groups are funded by state grant. New Partnerships for Women Consumer Curriculum available through npw@choiceonemail.com.
- Adolescent Trauma Treatment Programs and developed by Mental Health Center of Dane County, Madison, through a federal grant for the SAMHSA National Child Traumatic Stress Network initiative. Curriculum available.
- Women-specific AODA Projects in Wisconsin all include the use of trauma-specific services.
- All women-specific treatment providers received initial training in the Risking Connections to become trauma informed, sensitive, and responsive.
- Those providers have received training and use Seeking Safety, developed by Dr. Lisa Najavits, as the trauma treatment model.

Wyoming

1. Trauma function and focus in state mental health department.

- The department has been working with the Veterans Administration and other stakeholders to determine the level of need and care for returning Veterans to the state in response to trauma they may have received.

2. State trauma policy or position paper.

- Policy regarding trauma embedded in Consumer Rights Policy Statement.

3. Workforce Recruitment, Hiring, and Retention.

4. Workforce orientation, training, support, job competencies and standards related to trauma.

- Staff licensing procedures may include trauma training.
- State patient advocate training on how to conduct an investigation into an allegation of mistreatment against a state employee without re-traumatizing the consumer.
- Trainings on Trauma Informed Care

Linkages with higher education to promote education of professionals in trauma

- Working with the University of Wyoming on an Early Childhood Certification which will focus on the social-development and early trauma.
- The University of Wyoming has a PTSD clinic associated with its Psychology Department.
- The trainings should promote use of assessment tools that are sensitive to these issues (culture, race, ethnicity, gender, age, sexual orientation, disability, socio-economic status). All trainings have some component of taking these issues into account in working with clients.

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- Statewide staff training on identifying behaviors that may come from traumatic experience and providing safe environment for consumers. Awareness of how restrictive environment may cause re-traumatization.
- Training for staff on how to conduct an investigation from a client regarding abuse by a state employee without re-traumatizing client.
- Training for professionals on trauma informed care.

- Training in trauma for professionals and consumers is scheduled to occur.
5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.**
 - Statewide consumer affairs association developed; have held three to four consumer conferences including discussion of trauma and traumatization.
 - Peer-to-peer program in place where consumers are hired to provide peer counseling.
 6. **Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.**
 7. **Clinical practice guidelines for working with children and adults with trauma histories.**
 8. **Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.**
 - Staff licensing procedures may include trauma training.
 - Policy regarding trauma embedded in Consumer Rights Policy Statement.
 - Seclusion and Restraint Policy. Sensitivity to past and recent trauma is built into all practices and procedures including physical examinations, dressing and undressing, transporting consumers, seclusion and restraint. Policies cross reference with accreditation body. Data available on reduction in restraint and seclusion techniques.
 - Trauma-Informed Seclusion and Restraint Policy available including data and training information
 9. **Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilization and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.**
 10. **Universal trauma screening and assessment.**
 11. **Trauma-informed services and service systems.**

Most services are trauma-informed through ongoing training of employees in recognizing when behaviors come from experiences of trauma, how a restrictive environment may in itself be traumatizing, how all practices must be sensitive and empathic to the consumers experience of trauma and how that has impacted him or her, recognizing and understanding the impact of constant “mini-insults” over time, and how one might re-traumatize a person inadvertently.

- Although our current system is not adequate to meet the needs of our clients, we continue to assess and build services based on what the consumer’ need.

Combat Veterans

- The department has been working with the Veterans Administration and other stakeholders to determine the level of need and care for returning Veterans to the state in response to trauma they may have received.

12. Trauma-specific services, including evidence-based and promising practice treatment models.

University of Wyoming’s PTSD clinic.

Collaborating with VA and stakeholders to determine the needs of Veterans.

If you are interested in obtaining more information about the activities, programs and resources described in this document, contact the appropriate individual(s) from the following organizations and state offices.

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Alaska Suicide Prevention Plan:
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