



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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The Damaging Consequences of Violence and Trauma

*Facts, Discussion Points, and
Recommendations for
the Behavioral Health System*

**DRAFT
(As of Oct. 29, 2003)**

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Table of Contents

Acknowledgements.....	v
Introduction.....	vii
How to Use This Publication	xi
The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for Behavioral Health Systems.....	1
Priority Issues Selected for Their Current Public Policy Import	3
Co-occurring Disorders.....	5
Substance Abuse Treatment Capacity	13
Seclusion and Restraint.....	17
Prevention and Early Intervention	21
Children and Families	25
Terrorism and Bio-Terrorism.....	29
Homelessness.....	37
Mental Illness.....	41
Serious Medical Problems and Health Risks	45
Criminal Justice	49
Aging.....	53
Severe Social Problems.....	55
Cross-Cutting Principles for Each Priority Issue	57
Data and Evidence-Based Outcomes	59
Collaboration with Public and Private Partners	63
Cultural Competency	67
Community and Faith-based Approaches.....	69
Violence/Physical and Sexual Abuse.....	71
Financing Strategies and Cost-Effectiveness.....	77
Workforce Development.....	81
Peer Support and Self-Help	83
Appendix A: Trauma Services Implementation Toolkit for State Mental Health Agencies.....	87
Other Available Resources	111
Publication Contacts	115
Appendix B: NTAC National Experts Meeting on Trauma and Violence Participants List.....	119



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Introduction

The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System is a uniquely valuable publication in that it combines elements of a technical report, literature review, and a de facto call-to-action under one cover. However, the most accurate description of this document is that it is a collection of evidence compiled to help inform state mental health officials and the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) about trauma and to generate interest in this daunting public health and public policy issue.

Both NASMHPD and SAMHSA have longstanding commitments to the study of violence and to the development of effective interventions to address its consequences. This report builds on work stimulated by the landmark SAMHSA-sponsored Dare to Vision conference held in 1994; the national Women and Violence Research Project sponsored by CMHS, Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP); the Final Report of the President's New Freedom Commission on Mental Health; and by two national trauma experts meetings convened by NASMHPD (held in April, 1998 and August, 2002). This report is structured to reflect the interests and priorities of both SAMHSA and NASMHPD/NTAC.

In fact, the information is organized according to the programs and cross-cutting principles of the SAMHSA Priorities Matrix as well as the goals and recommendations found in the President's New Freedom Commission Final Report, *Achieving the Promise: Transforming Mental Health Care in America*. The categories used in this document reflect these aforementioned guides, while also reflecting the input of the participants at the second NASMHPD/NTAC trauma experts meeting, held in August 2002. The categories are therefore based on what these experts saw as the "essential elements" of a trauma-informed service system.

This document is a resource for people—at the local, state, and/or federal levels—who are in the process of transforming systems of care into systems that recognize and address trauma and for those who are trying to prove that a trauma-informed system of care is a priority now. The findings reported in this document demonstrate clearly that trauma must be addressed on policy, practice, and educational levels so that individuals who suffer from trauma can have a better chance at recovery, paralleling the vision presented in the *Achieving the Promise* report.

This publication is based on the following premises:

- ◆ The experience of trauma can be extremely damaging and often has enormous costs.
- ◆ Unresolved, untreated trauma is central to the development of multiple, severe, and persistent health and mental health problems, substance abuse, criminal

behavior, and social problems in our society, and should therefore be a key consideration for policy making in each of these fields.

- ◆ Addressing trauma must be central and pivotal to public health and human service policy making including fiscal and regulatory decisions, service systems design and implementation, workforce development, and professional practice. Unless trauma is addressed, the damage to individuals and to society will continue.

The report's facts and discussion points are taken from published and unpublished services research conducted in single sites/states; epidemiological studies; qualitative and quantitative research; and in some cases, personal communications from individuals with experience and expertise in the field. Recommendations are based on the literature cited. This report is not intended to be an exhaustive research review, but a sampling of the knowledge base that exists in the field. All data sources are referenced for further exploration in each priority issue's accompanying bibliography/reference list.

Appendix A, the "Trauma Services Implementation Toolkit for State Mental Health Agencies," is a detailed listing of resources that state and local policy makers have developed to improve trauma services within their areas. Deciding which resources to include was challenging, given the constantly changing nature of the field. The decision was made to include only completed tools that are already in use in one or more sites, those that are available in written form, and those that explicitly address trauma. For people who are already interested in systems change in support of a trauma paradigm, this appendix should be especially informative.

This overall document is a product of a group of individuals, including providers, consumers, and policy makers, who responded to an invitation to contribute data and recommendations within a brief period of time. The product is the beginning of an ongoing effort, and should be viewed as a work-in-progress. Some sections are incomplete, and others may be somewhat dated before this report goes to press. If some sections have less information than others, it does not necessarily mean that little or no research has been conducted in that area. However, it does imply that findings in that area may not yet be widely known to people working in the field.

The authors and publishers of *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* encourage readers to cite the information contained herein as necessary, and to utilize the document as a technical report, a call-to-action, a body of evidence, or all of the above in the hopes that the document helps bring effective and appropriate trauma services to the forefront of today's behavioral health care systems.

"We now know a great deal about the impact of trauma and despite this, training programs, degree programs, teacher preparation courses, etc., are still woefully deficient in conveying the research data to the people who need to know it," said trauma expert Sandra Bloom, M.D. "Trauma training is not about the seemingly simple problem of giving people information. The real problem is that the material is challenging,

threatening, and it may elicit resistance to change and denial within individuals and within entire systems. Any effort to [improve trauma services] will have to contend with this resistance if efforts are to be in any way successful,” said Bloom.

This publication is intended to encourage system transformation through the dissemination of data-based information, practical recommendations, and existing practices, while adhering to the message and spirit of the goals and recommendations from *Achieving the Promise*.



How to Use This Publication

The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System is a technical report that includes a toolkit as an appendix.

The report lists priority issues within the umbrella topic of trauma services systems and then presents a series of facts, discussion points, and recommendations for readers on each issue. After many of the bulleted facts, discussion points, and recommendations, the reader will notice superscript citation numbers that are intended to direct the reader to a corresponding reference located within the numbered reference list immediately following each section. Each priority issue is listed in the table of contents.

Appendix A, entitled “Trauma Services Implementation Toolkit for State Mental Health Agencies,” lists categories of trauma service factors to be considered by policy makers. Within each category, the information is organized by an alphabetical listing of states that have relevant materials to share. The listings include underlined words and phrases representing documents that may aid policy makers in creating trauma-informed systems of care. A detailed contact list—again, organized by state—is included at the end of this appendix to help readers identify and locate these helpful documents.



**The Damaging Consequences
of Violence and Trauma:
Facts, Discussion Points, and Recommendations
for Behavioral Health Systems**



**Priority Issues Selected
for Their Current Public Policy Import**



Co-occurring Disorders

People who have both mental health and substance abuse problems are highly likely to have trauma histories; in fact, trauma is often their central problem.

Co-occurring Disorders Facts and Discussion Points

- ◆ Fifty-five percent of consumers and former consumers at a Maine state mental hospital with a dual diagnosis of mental illness and substance abuse report histories of physical and/or sexual abuse.¹
- ◆ In adults, the rates for co-morbid Posttraumatic Stress Disorder (PTSD) and substance use disorders are two to three times higher for females than males, with 30% to 57% percent of all female substance abusers meeting the criteria for PTSD. Women's increased risk for co-morbid PTSD and substance dependence is related to their higher incidence of childhood physical and sexual abuse.²
- ◆ Many mental health and substance abuse providers may be under the impression that abuse experiences are an additional problem for their clients, rather than the central problem. PTSD is often the only diagnosis utilized to address abuse; in fact, every major diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) can sometimes be related to trauma.³
- ◆ Statistics on abuse history increase dramatically if respondents are questioned regarding emotional/mental abuses and neglect.³
- ◆ A high prevalence of trauma exposure and PTSD exists among the dually diagnosed.^{4, 5, 6}
- ◆ It is estimated that fewer than 20% of substance abuse programs offer specialized trauma-related services for the dually diagnosed.^{7, 12}
- ◆ Among women in substance abuse treatment, rates of PTSD are double those in the general population, ranging from 30% to 59%.²
- ◆ Untreated PTSD among people with co-occurring disorders often increases the need for more frequent hospitalizations, entitlement benefits, and supportive services (Rosenberg, Mueser, Friedman, Gorman, Drake, Vidaver, Torrey, & Jankowski, 2001).⁶
- ◆ Up to two-thirds of men and women entering substance abuse treatment suffer PTSD or Posttraumatic Stress Symptoms (PTSS).⁸

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- ◆ Individuals diagnosed with substance abuse disorders and PTSD, compared with those without a diagnosis of PTSD, are more likely to use inpatient and outpatient services and often seek medical rather than mental health or substance abuse treatment.^{9, 10}
 - ◆ An independent assessment of recipients of public mental health inpatient and outpatient services revealed 43% had a diagnosis of PTSD not previously assessed by any of the facilities. Mental health staff had only noted a diagnosis of PTSD in the charts of 2% of the consumers (Mueser et al., 1998).⁴
 - ◆ Both mental health and substance abuse providers may be investing significant effort providing services that are only partially related to their clients' underlying causes of need (Switzer et al., 1999).¹¹
 - ◆ When compared to those without PTSD, dually diagnosed individuals with PTSD—particularly those with psychotic disorders—report significantly greater needs for comprehensive services, including drug abuse treatment services, relapse prevention, and services related to level of functioning and health issues. Trauma/domestic violence counseling was rated as very important by this group.¹²
 - ◆ Sexual abuse and physical abuse have been identified as significant childhood risk factors for the development of addiction in adulthood.¹³
 - ◆ Survivors of early sexual abuse may use drugs and alcohol to cope with abuse-related emotional and physical pain, abuse memories, and symptoms stemming from the abuse. PTSD symptoms are widely reported to become worse with initial abstinence. There is high probability of drug or alcohol relapse when trauma is not addressed and no alternative means of coping with the pain are provided.^{14, 15}
 - ◆ In a sample of 100 male and female subjects receiving treatment for substance abuse, more than a third were diagnosed with some form of a dissociative disorder stemming from childhood sexual or physical abuse.¹⁶
 - ◆ Trauma alone is an important issue in increasing the risk of alcohol abuse. When combined with psychiatric disorder, risk significantly increases.¹⁷
 - ◆ Substance abuse, posttraumatic depression, or social phobia may not be effectively managed until the trauma-based memories have been addressed.¹⁸
 - ◆ Without trauma-informed interventions, there can exist a self-perpetuating cycle involving PTSD and substance abuse, where trauma (childhood or adult physical and/or sexual abuse, crime victimization, disaster, combat exposure) leads to the development of PTSD symptoms, triggering the use of alcohol and drugs, resulting in higher likelihood of subsequent traumatic events and retraumatization, leading to development of more chronic PTSD symptoms, triggering heightened substance use, and so on.¹⁹

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- ◆ Substance abuse consumers with PTSD are more impaired than those without PTSD, with more co-morbid Axis I and Axis II disorders, medical problems, psychological symptoms, inpatient admissions, interpersonal problems, and lower level of functioning, lower compliance with aftercare, and reduced motivation for treatment. Women with PTSD and substance abuse have numerous co-occurring life problems, such as homelessness, loss of custody of their children, maltreatment of their children, and “battered woman syndrome.”^{19, 20, 21, 22, 23, 24, 25, 26, 27, 28}
 - ◆ In adults, the rates for co-morbid PTSD and substance use disorders are two to three times higher for females than males, with 30 to 59% of all female substance abusers meeting the criteria for PTSD, most commonly deriving from a history of repetitive childhood physical and/or sexual assault.²
 - ◆ Sexual victimization in childhood and in adulthood is an important factor in dual diagnosis in women. Women with PTSD and alcohol abuse have a particularly severe level of symptoms (severe PTSD, dissociation, borderline personality traits) relative to women with only PTSD and controls.²⁹
 - ◆ Neither trauma, nor alcohol and drug problems—key risk factors that complicate psychiatric disability and recovery—are commonly identified or addressed in treatment in the mental health sector. Many clinicians lack proper training on how and when to ask about sexual abuse and substance use, how to listen to the answers, or how to incorporate this information into effective treatment.³⁰
 - ◆ Men with dual diagnoses (severe mental disorder and significant substance abuse problems) frequently have histories of trauma exposure. This group of men has usually been excluded from trauma studies.³¹
 - ◆ An ethnographic study of the longitudinal course of substance abuse among people diagnosed with severe mental illness indicated a very close association between reported or experienced abuse in childhood at the hands of care-givers, and continuing substance use.³²
 - ◆ Several studies suggest that trauma sequelae must be addressed concurrently to permit successful treatment of dual diagnosis.^{32, 33}

Co-occurring Disorders Recommendations

- ◆ Develop and implement educational programs for educators and health care professionals to identify high-risk (abused) youth and offer counseling regarding their vulnerability to substance abuse.³⁴

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- ◆ Develop and implement clinical training for substance abuse and mental health professionals that will aid in understanding co-morbidity of addiction and PTSD, identifying dual disorders, and treating trauma-related syndromes.³⁴
 - ◆ Develop and implement academic curricula that train medical personnel, social workers, and mental health professionals to include an understanding of substance abuse and PTSD.³⁴
 - ◆ Develop and implement specialized programs within inpatient and outpatient substance abuse facilities that offer direct treatment to trauma survivors.³⁴
 - ◆ Train mental health and substance abuse treatment providers to assess clients/consumers for abuse/trauma histories and provide or refer to experienced trauma services.
 - ◆ Routinely assess all consumers in treatment for mental health and/or substance abuse for physical and/or sexual abuse, and refer to appropriate services if needed.
 - ◆ Cross train mental health and substance abuse services staff to ensure consistent treatment and to eliminate duplication of effort.

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Substance Abuse Treatment Capacity

Childhood physical and sexual abuse and neglect have a staggering impact on the prevalence of substance abuse in adulthood. Current treatment capacity is inadequate to meet the need.

Substance Abuse Treatment Capacity Facts and Discussion Points

- ◆ Up to two-thirds of both men and women in substance abuse treatment report childhood abuse or neglect.¹
- ◆ Seventy-five percent of women in treatment programs for drug and alcohol abuse report having been sexually abused.²
- ◆ HMO adult members who had experienced multiple childhood exposures to abuse and violence had a 4- to 12-fold increased risk of alcoholism and drug abuse, and a 2- to 4-fold increase in smoking.³
- ◆ Adults abused during childhood are more than twice as likely as those not abused during childhood to abuse substances.⁴
- ◆ In a study of 100 adult consumers with polytoxic drug abuse, 70% of the female and 56% of the male drug users had been sexually abused before the age of sixteen. Forty percent of the male and 50% of the female participants had a history of severe sexual abuse with sexual intercourse. In over 50%, friends or relatives were the perpetrators; parents were not perpetrators in any of the cases. More than 40% also showed a history of physical abuse. Significantly more drug users than alcohol abusers had a sexual trauma. Especially severe sexual abuse was associated with abuse of hard illegal drugs.⁵
- ◆ Nine out of ten children who need drug treatment are not getting it. One million, one hundred thousand American children 12- to 17-years-old have problems with drugs and alcohol. Only about 122,000 of them received treatment in 2000.⁶
- ◆ Teenagers with alcohol and drug problems are 6 to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems.⁷
- ◆ About 4.7 million Americans age 12 and older are abusing or dependent on illegal drugs. Of that number, 3.9 million received no treatment in 2000.⁸
- ◆ Nearly 8% of individuals in the U.S.—20 million people—will have full-blown PTSD in their lifetime. Fifty to sixty percent of consumers with PTSD (10 to 12

million people) will develop alcohol or substance abuse. Many of these people do not get the help they need because the problem (PTSD) is not identified and they don't receive appropriate treatment.⁹

- ◆ Substance abuse (SA) treatment recovery rates are very poor for clients who have histories of victimization and are treated in programs where the link between trauma and SA is not dealt with. Money spent on treatment for SA is often lost due to high relapse rates from un-addressed problems.¹⁰
- ◆ Nearly 90% of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent.¹¹
- ◆ Seventy-one to ninety percent of adolescent and teenage girls and 23% to 42% of adolescent and teenage boys in a Maine inpatient substance abuse treatment program reported histories of childhood sexual abuse.¹²

Substance Abuse Treatment Capacity Recommendations

- ◆ Address trauma in all SAMHSA policies and activities concerned with the substance abuse treatment gap. Thoroughly investigate and deal with unresolved trauma as a causative or co-occurring factor in addiction development—in all prevention and/or early intervention programs, all treatment approaches and programs, all public education campaigns, and in all related funding and insurance coverage programs.
- ◆ Train substance abuse treatment providers to assess clients/consumers for abuse/trauma histories and to provide or refer to experienced trauma services.
- ◆ Routinely assess all clients in treatment for substance abuse for physical and/or sexual abuse and refer to appropriate trauma services if needed.
- ◆ Encourage all substance abuse services staff to integrate concept of trauma as direct and primary cause of a majority of substance use.
- ◆ Clients in substance abuse programs who are assessed as having trauma histories should learn the direct connection between trauma and substance abuse as self-medication.
- ◆ All substance abuse programs should actively support and integrate the teaching and use of trauma symptom management skills as an alternative to substance use.

Substance Abuse Treatment Capacity References

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Seclusion and Restraint

Many people with trauma histories are routinely and unnecessarily retraumatized in the mental health system through the use of seclusion and restraint and other coercive interventions.

Seclusion and Restraint Facts and Discussion Points

- ◆ Consumers with trauma histories are often re-traumatized in psychiatric inpatient units and other settings when subjected to restraint and seclusion.^{1,10}
- ◆ When asked, individuals virtually always report experiencing seclusion and restraint as traumatic. Children, adolescents, and adults report experiencing vulnerability, neglect, and a sense of punishment while in seclusion.²
- ◆ Restraint and seclusion have been responsible for consumer deaths and other adverse effects, and also place staff at higher risk for injury.^{4,3}
- ◆ Effective practices exist to reduce and/or eliminate restraint and seclusion.³
- ◆ Best practice models based on collaboration, consumer empowerment, and a clinical approach that emphasizes the development of skills, teaching and learning processes, conflict resolution, and pro-active strategies exist, but they are inconsistently utilized.⁵
- ◆ The use of restraint and seclusion among children and adolescents is particularly high in some states. Child-oriented best practice models demonstrating little or no use of restraint and seclusion include: Girls and Boys Town Psychoeducational Treatment Model (PEM), Teaching Family, and Ross Greene's Collaborative Problem Solving Approach.⁵
- ◆ For persons with histories of trauma, seclusion and restraint can cause disturbing behavior to increase (rather than de-escalate), thereby re-traumatizing the client and increasing risk to staff and other consumers.⁶
- ◆ Seclusion and restraint can trigger responses to previous experiences with coercive control, physical abuse, isolation, bondage, etc. These responses might include flashbacks (hallucinations), dissociation, aggression, self-injurious behaviors, depression, etc.⁶
- ◆ Coercive interventions involving forcible medication (whether physical, legal, or both) are often experienced as retraumatizing. Forced psychotropics are a form of chemical restraint.⁷

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- ◆ Conventionally accepted psychiatric practices and institutional environments may retraumatize consumers with histories of trauma by replicating the dynamics and even the specific abuses of the original childhood trauma, thus exacerbating the pain and sequelae of the traumatic childhood experience.⁸
 - ◆ Without knowledge of medications known to be helpful in treating symptoms of trauma, the use of psychopharmaceutical interventions can cause both physical and psychological damage. Forced medication violates personal boundaries, alters the mind, body and emotions, and may replicate the original traumatic abuse.⁸
 - ◆ Restraint and seclusion, which are currently accepted methods for the management of psychiatric consumers in this country, meet the DSM-IV definition of human-induced traumatic stressors. Both exert violent and absolute control while engendering utter helplessness and fear.⁹
 - ◆ Trauma survivors may be especially vulnerable to additional traumatic and/or iatrogenic (physician-caused) experiences that occur within the psychiatric setting.¹¹ For example, routine use of seclusion, restraints, or handcuffs may serve to recapitulate previous traumatic experiences, and thereby exacerbate symptoms of PTSD.¹²

Seclusion and Restraint Recommendations

- ◆ SAMSHA should establish clinical guidelines that reflect the most promising evidence-based practice models to reduce and ultimately eliminate the use of seclusion and restraint.
- ◆ Consider incorporating a public health prevention model that includes the following: primary prevention (organizational leadership accountability, empowering strength-based culture, well-trained staff), secondary intervention (knowing triggers and using trauma-informed strategies, creative/innovative early interventions to de-escalate conflict) and tertiary intervention (if intervention is necessary), which will allow for the least traumatic treatment experience, early release, and active de-briefing of staff and consumers in order to minimize risk of harm. Feedback from each stage needs to inform the next stage and support ongoing prevention.³
- ◆ Immediate post-event debriefing followed by a timely root cause analysis should be standard practice in all treatment settings.
- ◆ Assessment of all service recipients for trauma histories should be routine.
- ◆ Create (with client, upon admission) an individualized “de-escalation” plan.

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- ◆ Train staff on specific alternative, trauma-informed responses to aggressive or behaviorally inappropriate actions.
 - ◆ Wherever referencing “seclusion and restraint,” include the phrase “and the violence associated with the use of these measures” as a reinforcing step to be assimilated into the literature.
 - ◆ Involve survivors of forced mental health treatment in all aspects of policy and intervention development and practice.

Seclusion and Restraint References

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Prevention and Early Intervention

Prevention and/or early intervention of childhood abuse could have a substantial impact on the prevalence of adult mental health and substance abuse problems. New biological findings suggest that prevention and early intervention may be the *only* ways to avoid enduring problems.

Prevention and Early Intervention Facts and Discussion Points

- ◆ Early intervention and prevention of childhood abuse are crucial recommendations for almost every one of the top axis items, given the link between unresolved childhood abuse trauma and: co-occurring disorders, substance abuse, seclusion and restraint, terrorism, homelessness, aging, HIV/AIDS, criminal justice.¹
- ◆ Nine out of ten children who need drug treatment are not receiving it. One million, one hundred thousand American children ages 12 to 17 have problems with drugs and alcohol. Approximately 122,000 got treatment in 2000.²
- ◆ Teenagers with alcohol and drug problems are 6 to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems.³
- ◆ Primary prevention of major mental illness in adulthood (and other problems associated with child abuse) through prevention of severe child abuse is possible. This can be shown by intervention studies.⁴
- ◆ Home visiting programs (HFA-Healthy Families America) are associated with reduced rates of child abuse. Families enrolled in HFA are two to three times less likely to maltreat their children than comparable families who are not enrolled.⁵
- ◆ Maladaptive coping skills (dissociation, substance abuse, coercive control, etc.), typical of survivors of chronic abuse, can substantially interfere with successful parenting skills including attachment, bonding, and development of empathy between parent and child at developmentally critical stages. This problem is a primary factor contributing to the cycle of abuse and family dysfunction.⁶⁻⁹
- ◆ Until recently, psychologists believed that mistreatment during childhood led to arrested psychosocial development and self-defeating psychic defense mechanisms in adults. New brain imaging surveys and other techniques have shown that physical, emotional, or sexual abuse in childhood (as well as stress in the form of exposure to violence, warfare, famine, pestilence) can cause permanent damage to the neural structure and function of the developing brain

itself. These changes can permanently affect the way a child's brain copes with the stress of daily life, and can result in enduring problems such as suicide, self-destructive behavior, depression, anxiety, aggression, impulsiveness, delinquency, hyperactivity, and substance abuse, and conditions such as Borderline Personality Disorder, dissociative episodes, hallucinations, illusions, psychosis, paranoia, volcanic outbursts of anger, and impaired attention. These results suggest that much more effort is needed to prevent childhood abuse and neglect. New approaches to therapy may also be indicated.¹⁰

- ◆ Stress sculpts the brain to exhibit various antisocial, though adaptive, behaviors. Whether in the form of physical, emotional or sexual trauma, or through exposure to warfare, famine, or pestilence, stress can set off a ripple of hormonal changes and key brain alterations that may be irreversible.¹⁰

Prevention and Early Intervention Recommendations

- ◆ Target the young population assessed with addiction problems (the majority of whom have histories of unresolved trauma) in early intervention programs. Insure that all federally funded early intervention and prevention programs appropriately address unresolved past trauma and/or ongoing trauma as a core issue in the development and maintenance of addictions and in the individual's recovery.
- ◆ Collaborate with HFA to create educational material that includes relevant information that links childhood trauma and violence with the onset of adult difficulties. The material should also identify methods of recognizing and responding to these difficulties.
- ◆ Create trauma/attachment theory-informed parenting programs specifically for women with abuse histories.
- ◆ Research, implement, and evaluate effectiveness of child abuse prevention strategies. Justify intervention based on new findings of permanent damage to the brain caused by child abuse and its impact on the individual, society, and human service fields. Justify cost of prevention strategies by a fiscal analysis that shows actual cost savings due to child abuse reduction.

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Children and Families

Violence is a significant causal factor in childhood and adolescent mental health problems, brain damage, substance abuse, developmental disabilities, school failure, and delinquency. Violence against children is a significant and inadequately addressed public health problem.

Children and Families Facts and Discussion Points

- ◆ People who are abused as children may be more prone to developing schizophrenia. A high rate of physical and sexual abuse is reported among children who were later diagnosed as schizophrenic. A particularly strong link exists between childhood abuse and the hearing of voices. Changes in the brain seen in abused children are similar to those found in adults with schizophrenia.¹
- ◆ Adolescents with alcohol dependence are 6 to 12 times more likely to have a childhood history of physical abuse and 18 to 21 times more likely to have a history of sexual abuse than those without substance abuse problems.²
- ◆ The U.S. Department of Health and Human Services reported that almost 1 million children were identified as victims of abuse and neglect in 1996, and more than 1,000 children died as a result. A survey by the National Committee to Prevent Child Abuse indicated that more than 3 million children were suspected of being victims of abuse and/or neglect in 1998. In the United States, a child is reported abused or neglected every ten seconds. Every two hours, a child is a homicide victim. And every four hours, a child commits suicide.³
- ◆ Among juvenile girls identified by the courts as delinquent, more than 75% have been sexually abused.⁴
- ◆ About 3.9 million adolescents have been victims of a serious physical assault, and almost 9 million have witnessed an act of serious violence.⁵
- ◆ About 1.8 million adolescents have met diagnostic criteria for PTSD during their lives.⁶
- ◆ The level of exposure to catastrophic violence and loss together with the resulting posttraumatic stress have been found to be as severe in America's inner cities as in post-earthquake Armenia, war-torn Bosnia, post-invasion Kuwait and other trauma zones. Yet, the United States has no formal public health policy to address the problem.⁷

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- ◆ When failing adolescent students with severe PTSD symptoms were recognized and treated for trauma, their symptoms were markedly reduced, they required no further discipline, and their grade point averages went up significantly.⁸
 - ◆ Three to six percent of all children have some degree of permanent disability as a result of abuse.⁹
 - ◆ Between 20 and 50% of abused children suffer mild to severe brain damage.¹⁰
 - ◆ Violence is a significant causal factor in 10 to 25% of all developmental disabilities.^{9,11}
 - ◆ Eighty-two percent of all adolescents and children in continuing care inpatient and intensive residential treatment programs in Massachusetts have histories of trauma as reflected by a point-in-time review of medical records.¹²
 - ◆ The number of children whose lives have been disrupted by war, oppression, terror, and other forms of conflict has grown significantly—from 1.5 million refugees and displaced persons following WWII, to 14 million refugees and displaced persons by 2001. Many of these young people experience long-term physical and emotional health problems, including PTSD.¹³

Children and Families Recommendations

- ◆ SAMHSA should take the lead in developing a formal public health policy to address the problem of PTSD in children. This policy should caution service providers against overlooking or misdiagnosing abuse and PTSD symptoms as symptoms of Attention Deficit Hyperactivity Disorder (ADD), Oppositional Defiance Disorder (ODD), etc.
- ◆ Mandatory trauma assessment should be available for all children referred for behavior, learning, or emotional disturbances, followed by referral to appropriate trauma treatment.¹⁴⁻¹⁷
- ◆ Trauma training should be made available for juvenile justice settings.¹⁸
- ◆ SAMHSA should take the lead in developing and promoting a strength- and resiliency-based care program for children and adolescents who have immediate or past trauma histories. This program should be based on formal curriculum that includes pragmatic instruction, techniques and activities for children designed to promote emotional strength and to decrease vulnerability to stress, adversity and challenges.¹⁹

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Terrorism and Bio-Terrorism

Community disasters (including terrorism) have a particularly devastating impact on people who have previously experienced trauma, increasing the length and severity of Posttraumatic Stress Disorder (PTSD), interrupting recovery, and leading to high rates of hospitalization. In the event of continued terrorism or disasters, the mental health system is ill-prepared to offer effective help to victims. Many mental health professionals have received little or no training in trauma. There are also some groups who are at higher risk for developing severe, lasting, and pervasive psychological effects after a disaster. In addition, a shortage of mental health workers with knowledge of trauma is widely reported.

Terrorism and Bio-Terrorism Facts and Discussion Points

- ◆ The majority of people recover from grief and shock after a few months. However, 25% to 30% of people *directly* affected by terrorist attacks or other disasters may eventually develop full-blown PTSD or other debilitating psychological conditions such as major depression.^{1, 2, 3, 4, 5}
- ◆ Five to eight weeks following the 9-11-01 terrorist attacks, almost 10% of adults living below 110th Street in Manhattan reported symptoms of PTSD or clinical depression, and 3.7% met criteria for both diagnoses. These rates are 2 to 3 times higher than those normally reported in any given year.⁶
- ◆ Some traumatized individuals may take months or years to notice troubling symptoms or to seek help. Using formulas derived by the federal government following disasters such as the 1995 Oklahoma City bombing, the New York OMH estimates that as many as 1.5 million New Yorkers may eventually need some kind of mental health help as a result of 9-11-01.^{7, 8}
- ◆ Almost 6% of Americans across the country, including children, had substantial symptoms of stress following the 9-11-01 terrorist attacks.^{9, 10}
- ◆ Nearly 90% of the 710,000 New York City schoolchildren in grades 4 through 12 showed at least one symptom of posttraumatic stress six months after 9-11-01. An estimated 10%, or 75,000 children, are suffering six or more symptoms of post-traumatic stress.¹¹
- ◆ New York City schoolchildren with PTSD, at least two-thirds of whom have not received mental health services, are at high risk of suicide and substance abuse and may find their symptoms worsen if ignored.^{11, 12}
- ◆ Survivors of previous traumatic experiences who have not successfully resolved their trauma are at particular risk for developing symptoms severe enough to

interfere with normal life. They may re-experience thoughts, emotions, symptoms, and arousal levels associated with their original experiences, and are at high risk for developing chronic PTSD.^{13, 14, 15}

- ◆ Abuse survivors with prior exposure to interpersonal violence (physical, sexual abuse or neglect) in childhood or adulthood, have significantly heightened susceptibility to severe and chronic PTSD, anxiety, and clinical depression following exposure to any type of traumatic event.^{6, 16, 17, 18, 19}
- ◆ Women or girls in 42 of 45 studies (93%) were affected more adversely by disasters than were men or boys; the effects lasted longer, and the strongest adverse effects were noted in cases of PTSD for which women's rates often exceeded men's by a ratio of 2:1.^{6, 21, 22}
- ◆ The number of women victimized by domestic violence increases significantly (46% in one study) following major disasters. Thirty-nine percent of abused women develop post-disaster PTSD compared to 17% of other women, and 57% of abused women develop post-disaster depression, compared to 28% of other women.²³
- ◆ People diagnosed with severe mental illness (SMI) may have an increased risk for distress, especially posttraumatic stress symptoms, after a disaster. More than 90% of people with SMI report exposure to previous trauma. Most experienced multiple traumatic events of an interpersonal nature including sexual and physical assault in childhood and adulthood. Approximately 30% to 40% of these people currently have PTSD. This rate is 20 to 30 times greater than that of people without SMI. Events such as a terrorist attack can exacerbate pre-existing PTSD symptoms and may cause people with SMI to be at increased risk for developing PTSD over time.^{22, 24}
- ◆ Children and adults with prior psychiatric disorders or with family histories (especially parental) of psychiatric or addictive disorders are at high risk for psychosocial impairment when exposed to trauma (including disasters and community or domestic violence).^{18, 22}
- ◆ Individuals whose parents have been previously traumatized are at risk of experiencing increased symptoms when exposed to a violent event.²⁵
- ◆ Significantly higher rates of both PTSD and clinical depression following the 9-11-01 terrorist attacks were found among people who lived close to ground zero, who suffered personal losses as a result of the attacks, who had endured other stressful events, who experienced extreme panic during or shortly after the attacks, or who had disengaged from coping efforts early on (e.g., giving up, denial, self distraction).^{6, 10, 22}

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- ◆ Rates of PTSD and clinical depression were higher among New York City Hispanic respondents than among Whites, Blacks or Asians. Hispanics were 2.6 times more likely to have experienced posttraumatic stress and 3.2 times more likely to experience depression than were Whites.⁶
 - ◆ Refugee clients who had been previously traumatized in their native war-torn countries and who were diagnosed with PTSD reacted intensely to televised images of 9-11-01. Cross-cultural reactivation of trauma has a significant clinical impact. It is essential that clinicians anticipate PTSD symptom reactivation among refugees when they are re-exposed to significant traumatic stimuli.²⁶
 - ◆ As more time elapses after a trauma, PTSD symptoms and co-morbidity increase. This finding implies that PTSD is a chronic disorder with a downward course, and suggests the necessity for early recognition and intervention.²⁷
 - ◆ Before severe, lasting, and pervasive psychological effects appear, professional help from providers trained in the early identification, recognition, and treatment of stress disorders is recommended.²⁸
 - ◆ Existing mental health systems are not designed for the scope and the nature of the needs created by terrorism acts such as those seen on 9-11-01.¹³
 - ◆ Few New York-based mental health clinicians were trained to treat the level of trauma or the profound psychological impact incurred by the World Trade Center attack. Left untreated, the most serious mental health disorders brought on by trauma can lead to suicide.^{29, 30}
 - ◆ Across the country, few universities offer comprehensive trauma programs that prepare their graduates to address trauma. As a result, mental health clinicians are often scared, uncomfortable and uncertain about whether they have the skills they need to help victims of traumatic events.^{29, 30}
 - ◆ Without sufficient training in techniques to treat trauma, clinicians may: 1) offer untested therapies; 2) fail to recognize and treat symptoms ranging from flashbacks to anxiety to physical effects; or 3) provide treatment that is harmful.^{13, 29}
 - ◆ Individuals who have successfully resolved previous traumatic reactions have been shown to be more resilient to disasters, and should be viewed as a resource for disaster-stricken communities.¹⁴
 - ◆ A program in Hawaii successfully identified and treated children with posttraumatic stress symptoms following a 1977 disaster and noted a gulf between children who had received counseling for PTSD and those who had not. Children who were treated reported fewer trauma-related symptoms, and the positive effects were maintained a year later.^{8, 31}

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- ◆ The development of a meaningful narrative of trauma experience is an important factor in recovery. Religious beliefs may provide meaning for trauma survivors and may be a useful focus for intervention with trauma survivors.^{32, 33}

Terrorism and Bio-Terrorism Recommendations

- ◆ Invest in training to enable the mental health system to address trauma specifically. Collaborate with academia, professional organizations and policy makers to develop comprehensive trauma programs and curricula that teach best practices in the treatment of trauma.³⁰
- ◆ Develop mental health system capacity to provide early diagnosis, trauma assessment and intervention. Evaluate trauma history to aid in early intervention efforts. Interventions addressing initial reactions to a disaster, such as panic attacks, may help prevent the development of long-lasting psychological sequelae.^{6, 27, 28}
- ◆ Mental health providers should make additional support and services available including routine assessment for PTSD and consultation with trauma specialists when a client experiences symptom exacerbation following recent trauma.^{3, 24, 27}
- ◆ Mental health workers should collaborate with primary care physicians, family practice physicians and health care personnel to ensure prompt recognition of signs of PTSD and early intervention.
- ◆ Health care workers can prepare for the effects of disaster and terrorism by establishing tertiary prevention initiatives to reduce the impact of retraumatization on vulnerable groups.
- ◆ A national volunteer agency has been created called Citizen Corps, which among other activities will aid in recruiting and training retired doctors and health care workers for emergencies, and increase training for disaster preparedness in local communities. As part of the new USA Freedom Corps (which includes Peace Corps, Senior Corps and AmeriCorps), Citizen Corps will include trauma experts, training, and educational materials on how to respond to people who are most at risk of developing PTSD following a catastrophe. This educational initiative should also be included in ongoing disaster preparedness work in local communities.
- ◆ Collaborate with the National Disaster Team program to address 9-11-01 and other community disasters and the continuing impacts of terrorism. Create basic, easy-to-read educational material on: 1) how prior trauma (childhood abuse or other events) can put people at risk for developing chronic or severe PTSD

symptoms when exposed to subsequent trauma; and 2) how to recognize and respond to those who are at-risk.

- ◆ Implement programs of self-care for volunteers, crisis workers, first responders, and clergy, etc. who are at increased risk of developing secondary stress reactions following a disaster.
- ◆ Develop peer-professional alliances in support of a trauma-preparedness support system. One such example in Connecticut is a systematic, comprehensive, and relatively inexpensive statewide network of professionally guided, peer-conducted trauma education and support programs for people in recovery.
- ◆ Develop partnerships between women in recovery and providers around the issue of community safety and preparedness, which could lead to consumer-driven support services linked with gender-specific treatment.
- ◆ Educate teachers, school administrators, and parents about how to recognize children in distress. All schoolchildren impacted by a disaster should be screened, childcare professionals should be trained on handling traumatized children, and more funding should be directed toward treatment.
- ◆ Develop collaborations with faith-based organizations. Combine spiritual support with a basic framework for understanding and responding to traumatized individuals (such as the Risking Connections curriculum).
- ◆ Train clinicians to anticipate PTSD symptom reactivation among refugees when they are re-exposed to significant traumatic stimuli.²⁶

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Homelessness

A high percentage of homeless women and girls have experienced physical or sexual violence as children and/or adults, and have experienced substance abuse or mental health problems (including attempted suicide) as a result.

Homelessness Facts and Discussion Points

- ◆ Ninety-two percent of homeless mothers have experienced physical and/or sexual assault.¹
- ◆ More than 66% of homeless mothers have experienced severe physical violence by a caretaker and 43% were sexually molested during childhood. Sixty percent of homeless mothers were abused by the age of 12.²
- ◆ Abuse often continues into adulthood. Sixty-three percent of homeless mothers have been victims of intimate partner violence and 32% are current or recent victims of domestic violence.²
- ◆ More than half of homeless mothers who have been abused by an intimate partner were physically injured as a result of the abuse, and 27% required medical treatment.²
- ◆ Over 39% of homeless women who have been abused have experienced PTSD, more than three times the level of the general female population. Forty-seven percent have had a major depressive disorder, more than twice the rate of the general female population.³
- ◆ One-third of homeless women who have experienced violence have attempted suicide at least once.³
- ◆ Forty-five percent of homeless women who have experienced abuse during their lives have subsequently been alcohol or drug dependent at some time.³
- ◆ Seventy percent of women living on the streets or in shelters report abuse in childhood. Over 70% of girls on the streets have run away from violence in their homes.^{4,5}
- ◆ Ninety-seven percent of mentally ill homeless women have experienced severe physical and/or sexual abuse, and 87% experienced this abuse both as children and as adults.⁶

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- ◆ Childhood abuse has been correlated with increased adolescent and young adult truancy, running away, and risky sexual behavior. Many of these children are homeless or living in shelters.⁷
 - ◆ More than 40% of women on welfare with repeated incidence of leaving the welfare rolls were sexually abused as children. These women often become homeless along with their children.⁸

Homelessness Recommendations

- ◆ Violence is pervasive in the lives of homeless and other extremely poor women. SAMHSA should examine its current and future programs to ensure that they respond to the impact of trauma on women. In addition, SAMHSA should work with other Department of Health & Human Services (HHS) agencies and other departments providing services to homeless women (U.S. Department of Housing and Urban Development [HUD], U.S. Department of Labor, etc.) to ensure the same response.
- ◆ Many homeless and homeless-related service programs serving women do not address the impact of trauma on the lives of homeless women and are sometimes retraumatizing. Service providers and program administrators should make their services and programs more responsive to the needs of women. Such efforts might include:
 - Education/training on the pervasiveness of violence on homeless and other poor women for providers (such as health and mental health clinicians, substance abuse treatment providers, shelter workers, welfare case workers, etc.) who work with women and their children.
 - Development and broad dissemination of sensitive violence screening and referral processes to be used in a variety of social service settings. Training should be provided to ensure proper use.
- ◆ SAMSHA should support a knowledge development and application effort designed to integrate and coordinate violence and homeless related services and delivery systems for women at the community level.
- ◆ Many shelters and programs for the homeless receive federal money; all perform substance abuse and mental health assessments. Trauma/violence should be added to these assessments.
- ◆ Homeless shelters and programs should be assessed for safety and to uncover any policies/practices that might re-victimize homeless persons. Persons seeking shelter should be assessed for histories of trauma.

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- ◆ Homeless and formerly homeless persons should be involved in every aspect of program design and management.

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Mental Illness

(includes Suicide, Self-Injury)

The relationship between childhood physical and sexual abuse and the development of psychiatric symptomatology in adulthood is well documented. Childhood abuse is a significant causal factor in suicide and self-injury.

Mental Illness Facts and Discussion Points

- ◆ Fifty to seventy percent of all women and a substantial number of men treated in psychiatric settings have histories of sexual or physical abuse, or both.¹⁻³
- ◆ Up to 81% of men and women in psychiatric hospitals who are diagnosed with a variety of major mental illnesses have experienced physical and/or sexual abuse. Sixty-seven percent of these men and women were abused as children.⁴
- ◆ Seventy-four percent of Maine's Augusta Mental Health Institute consumers, interviewed as class members, reported histories of sexual and physical abuse.⁵
- ◆ The majority of adults diagnosed with Borderline Personality Disorder (81%) or dissociative identity disorder (90%) were sexually and/or physically abused as children.⁶⁻⁷
- ◆ Women who were molested as children are at four times greater risk for Major Depression than those with no such history. They are significantly more likely to develop bulimia and chronic PTSD.⁸⁻¹¹
- ◆ Childhood abuse can result in adult experiences of shame, flashbacks, nightmares, severe anxiety, depression, alcohol and drug use, feelings of humiliation and unworthiness, ugliness, and profound terror.¹²⁻¹⁸
- ◆ Adults who were abused during childhood are:
 - more than twice as likely to have at least one lifetime psychiatric diagnosis;
 - almost three times as likely to have an affective disorder;
 - almost three times as likely to have an anxiety disorder;
 - almost 2 1/2 times as likely to have phobias;
 - more than 10 times as likely to have a panic disorder; and
 - almost 4 times as likely to have an antisocial personality disorder.¹⁹

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- ◆ Ninety-seven percent of mentally ill homeless women have experienced severe physical and/or sexual abuse. Eighty-seven percent experienced this abuse both as children *and* as adults.²⁰
 - ◆ Adults who were abused as children may be more prone to developing schizophrenia. A high rate of childhood physical and sexual abuse is evident among children later diagnosed as schizophrenic, with a strong link between childhood abuse and hearing voices. In addition, changes in the brain seen in abused children were similar to those found in adults with schizophrenia.²¹
 - ◆ There is a significant relationship between childhood sexual abuse and various forms of self-harm later in life, i.e. suicide attempts, cutting, and self-starving.²²
 - ◆ For adults and adolescents with childhood abuse histories, the risk of suicide increases 4- to 12-fold.²³
 - ◆ Most self-injurers have a history of childhood physical or sexual abuse. Forty percent of persons who self-injure are men.²⁴⁻²⁶
 - ◆ Approximately 8% of individuals in the U.S.—20 million people—will be diagnosed with full-blown PTSD in their lifetime. As many as 20 million more people may experience PTSD-related symptoms. In many cases, problems are not identified, or consumers do not receive appropriate treatment.²⁷

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Serious Medical Problems and Health Risks

(Includes HIV and Developmental Disabilities)

Maltreatment at an early age can have enduring negative effects on the brain and can cause multiple risk factors for several of the leading causes of death in adults. Both adults and children with trauma histories are at high risk for HIV/AIDS. A significant percentage of developmental disabilities are the result of child abuse.

Serious Medical Problems and Health Risks Facts and Discussion Points

- ◆ Medical impacts of childhood abuse include: head trauma, brain injury, sexually transmitted diseases, unwanted pregnancy, HIV infection, physical disabilities (back, orthopedic, neck, etc.) chronic pelvic pain, headaches, stomach pain, nausea, sleep disturbance, eating disorder, asthma, shortness of breath, chronic muscle tension, muscle spasms, and elevated blood pressure.¹⁻⁵
- ◆ Adults who experience multiple types of abuse and violence in childhood (compared to those who do not) are found to have a 2- to 4-fold increase in smoking, poor self-rated health, more than 50 sexual intercourse partners, sexually transmitted disease, a higher rate of physical inactivity, and severe obesity.⁶
- ◆ Adverse childhood exposures show a relationship to the presence of adult diseases, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.⁶
- ◆ Severe and prolonged childhood sexual abuse causes damage to the brain structure, resulting in impaired memory, dissociation, and symptoms of PTSD.⁷⁻⁹
- ◆ Women with histories of sexual abuse are at higher risk for unprotected sex, increased number of sexual partners, prostitution, drug and alcohol addiction—all of which are risk factors for HIV/AIDS.¹⁰
- ◆ Homeless women, especially homeless mentally ill women, are at high risk for sexual abuse, sexual assault, and “sex for barter” activities that increase their risk for HIV/AIDS.¹¹
- ◆ Promiscuity and prostitution (as a means of supporting substance abuse/addiction) often correlate to prior sexual abuse, and result in increased risk of HIV infection.¹²
- ◆ Childhood violence is a significant causal factor in 10 to 25% of all developmental disabilities.^{13, 14}

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- ◆ Three to six percent of all children will have some degree of permanent disability as a result of abuse.^{13, 14}
 - ◆ Between 20% and 50% of abused children suffer mild to severe brain damage.¹⁵

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Criminal Justice

(Includes Delinquency, Violence, and Criminal Behavior)

Women and children in the criminal justice system show rates of childhood physical or sexual abuse that are comparable to rates in the mental health and substance abuse systems. Almost all murderers and sex offenders (male or female) have a history of childhood maltreatment.

Criminal Justice Facts and Discussion Points

- ◆ Victims of child sexual abuse are at increased risk of becoming prostitutes.¹⁻³
- ◆ Childhood abuse or neglect increases the likelihood of arrest as a juvenile by 53%, as a young adult by 38%, and for violent crime by 38%.⁴
- ◆ Eighty percent of women in prison and jails have been victims of sexual and physical abuse.⁵
- ◆ Reenactment of victimization is a major cause of violence in society. Many violent adult criminals were physically or sexually abused as children.⁶⁻⁷
- ◆ The majority of murderers and sex offenders have a history of childhood maltreatment. The majority of women and men in the criminal justice system were abused as children.⁸
- ◆ One-third of individuals abused in childhood may abuse or neglect their own children.⁹
- ◆ Of 16 men sentenced to death in California, a history of family violence was found in all cases. Fourteen were victims of severe childhood physical and/or sexual abuse. Individual impairments were found in 16 cases, including 14 with Posttraumatic Stress Disorder, 13 with severe depression, and 12 with histories of traumatic brain injury; community isolation and violence occurred in 12 cases; and institutional failure in 15, including 13 cases of severe physical and/or sexual abuse while in foster care or under state youth authority jurisdiction. Interventions may have made a difference in reducing lethal violence and its precursor conditions.¹⁰
- ◆ Boys who experience or witness violence are 1,000 times more likely to commit violence than those who do not.¹¹
- ◆ In 1998, 92% of incarcerated girls reported sexual, physical or severe emotional abuse in childhood.¹²

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- ◆ A Maine study of 15 girls at Long Creek Youth Development Center (formerly Maine Youth Center), found 12 out of 15 girls to have a known history of early childhood trauma.¹³

Criminal Justice Recommendations

- ◆ Teach trauma theory and tools in corrections settings.
- ◆ Empower corrections staff to use tools other than coercive control (which can increase reactivity among inmates)—see Seclusion and Restraint section.

Criminal Justice References

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Aging

If untreated, the psychological impact of violence can remain throughout one's life. Elderly populations display high levels of symptomatology related to early trauma.

Aging Facts and Discussion Points

- ◆ Approximately 818,000 elderly Americans were victims of domestic abuse in 1994. Two thirds of the victims were women.¹
- ◆ Negative life events in childhood lead to a strong association between the number of negative life events experienced in adulthood and depressive symptoms in later life.²
- ◆ In a study of 14 elderly women (ages 68-83) with a history of severe depression, most were shown to have experienced significant childhood trauma.³
- ◆ Unresolved childhood sexual abuse in elderly women is characterized by chronic depression, re-victimization, and misdiagnosis of residual abuse trauma as dementia or mental illness.⁴
- ◆ Posttraumatic Stress Disorder may present many years after the original trauma. Elderly PTSD consumers often avoid talking about traumatic experiences due to associated distress. Without taking a military and trauma history from elderly consumers, a diagnosis of PTSD may be missed.⁵
- ◆ As external and internal resources diminish in the elderly population, psychological effects of trauma may reappear.⁶
- ◆ Elderly consumers who encounter psychological trauma earlier in life may have persisting symptoms including: marked disruptions of sleep and dreaming, intrusive memories, impairment of trust, avoidance of stressors, and heightened vulnerability to various types of age-associated retraumatization.⁷

Aging Recommendations

- ◆ Health care and mental health care providers should take a comprehensive trauma history from elderly consumers, including military and interpersonal violence, and abuse experiences in childhood and adulthood. A diagnosis of PTSD should be followed by treatments known to be effective with elderly persons.

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- ◆ Statistics should be obtained (possibly through Medicare records) regarding the very high incidence of older women who are subjected to electroconvulsive therapy (ECT).⁸

Aging References

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Severe Social Problems

The long-term impacts of childhood sexual and physical abuse may significantly impair a person's life and lead to serious social difficulties. Predators look for victims who have been abused as children, especially victims of sexual abuse who are vulnerable to re-victimization.

Severe Social Problems Facts and Discussion Points

- ◆ More than 40% of women on welfare were sexually abused as children. These women are often unable to keep a job and become homeless along with their children.¹
- ◆ Sixty percent of housed, low-income mothers on Aid For Dependent Children (AFDC) experienced severe childhood physical abuse and 42% were sexually molested as children.²
- ◆ Victims of father-daughter incest are four times more likely than non-incest victims to be asked to pose for pornography.³
- ◆ Children who experience multiple exposures to abuse and violence (compared to those who do not) may experience multiple (sometimes 50 or more) sexual intercourse partners and sexually transmitted disease.⁴
- ◆ Promiscuity and prostitution (as a means of supporting substance abuse/addiction) have a correlation with prior sexual abuse, and result in increased risk of HIV infection.⁵
- ◆ Women with a history of sexual abuse are at higher risk for unprotected sex, increased number of sexual partners, prostitution, and drug and alcohol addiction—all of which are risk factors for HIV/AIDS.⁶
- ◆ Among juvenile girls identified as delinquent by a court system, more than 75% were sexually abused.⁷
- ◆ Childhood abuse has a correlation with increased adolescent and young adult truancy, running away, homelessness, and risky sexual behavior.⁸
- ◆ Women who were sexually abused during childhood are 2.4 times more likely to be re-victimized as adults than women who were not sexually abused.⁹

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- ◆ Sixty-eight percent of women with a history of childhood incest report incidents of rape or attempted rape after age 14, compared to 38% of women in a random sample.³
 - ◆ Girls who experience violence in childhood are three to four times more likely to be victims of rape than those who do not.¹⁰
 - ◆ Twice as many women with a history of incest become victims of domestic violence as women without such a history. Twice as many also report unwanted sexual advances by an unrelated authority figure.³

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Cross-Cutting Principles for Each Priority Issue

The following section details principles that “cut across” the issues that are itemized in the first part of this report. From evidence-based practices to culturally competent services, these cross-cutting principles affect each priority issue facing behavioral health providers, administrators, and consumers.

Data and Evidence-Based Outcomes

Many promising treatment interventions for the consequences of trauma exist; further work in this area will help to establish an evidence-based approach to trauma treatment.

Data and Evidence-Based Outcomes Facts and Discussion Points

- ◆ A wide variety of treatments are available for Posttraumatic Stress Disorder. Some have been proven effective. Others may work, but have not yet been studied extensively (among these treatments are Cognitive Behavioral Therapies [CBT], Drug Therapies, Eye Movement Desensitization and Reprocessing [EMDR], Group and Individual Therapy).¹
- ◆ To date, CBT (but not EMDR) has shown promise in controlled studies that exclude or simply fail to include people with chronic and persistent mental illness or addictions. Recent studies of Rosenberg et al.'s use of a Cognitive Restructuring Approach—combined with individual therapy—is showing promise with people hospitalized and diagnosed with schizophrenia who also have PTSD symptoms.²
- ◆ Alternative approaches emphasizing skills and support for managing trauma-related symptoms in the “here-and-now” are showing promise.²
- ◆ Dialectical Behavioral Treatment, though not designed specifically for treatment of PTSD, is a helpful treatment approach for some survivors.³
- ◆ Practitioners trained in evidence-based treatment, such as cognitive behavioral approaches, may be hard to find. Locating effective treatment for consumers with traumatic stress symptoms can be difficult, as many therapists have no training in treating stress disorders.^{1, 4, 5}
- ◆ There is currently a shortage of health and mental health professionals who are educated and trained to work with trauma. Most clinical education programs lack formal courses or educational opportunities in trauma. American universities have been slow to contribute to advances in the study and treatment of trauma.^{1, 4, 5}
- ◆ Research monies are being spent on techniques directed at symptom management of PTSD as well as other mental health categories. Managed care often overlooks trauma-focused relational psychotherapy. CBT, meds, and EMDR target symptoms and do not address the core of trauma work, which is relational.⁶

Data and Evidence-Based Outcomes Recommendations

- ◆ SAMHSA should integrate comprehensive trauma programs into the academic mainstream, and should require trauma education to be required for key professional groups (psychologists, nurses, social workers, neurobiologists, public health workers, medical researchers, etc.). SAMHSA should convene key professionals from universities, guilds, and licensing and accrediting bodies to organize practical programs in traumatology that draw from existing models and facilitate cross-fertilization between fieldwork, university research, and curricula.
- ◆ SAMHSA should encourage professional accrediting bodies to include some form of trauma training in their programs.
- ◆ Develop a “Certificate of Proficiency in the Treatment of Trauma Disorders.”
- ◆ Collaborate with the National Area Health and Education Center Program (AHEC) to bring trauma training programs and educational opportunities to professionals and communities served by AHEC Centers across the country.
- ◆ Foster and fund increased training in trauma theory and application to all service providers.
- ◆ Foster and fund treatment outcome research for existing models.
- ◆ Promote funding for trauma-specific psychotherapy, and trauma-informed services in general.
- ◆ Trauma survivors should be involved in every aspect of research design, development, practice, and analysis of trauma education programs.
- ◆ Assist evaluators in developing research practices that identify the relational components of trauma work in the assessment of interventions for trauma survivors.

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Collaboration with Public and Private Partners

Due to the multiple severe consequences of trauma, including physical, psychological and social problems, trauma treatment and services should be developed and implemented through integrated systems of care.

Collaboration with Public and Private Partners Facts and Discussion Points

- ◆ Systems that duplicate efforts may waste time and money.¹
- ◆ Medical impacts of childhood abuse include: head trauma, brain injury, sexually transmitted diseases, unwanted pregnancy, HIV infection, physical disabilities (back injury, orthopedic, neck, etc.), chronic pelvic pain, headaches, stomach pain, nausea, sleep disturbance, eating disorder, asthma, shortness of breath, chronic muscle tension, muscle spasms, elevated blood pressure.²⁻⁶
- ◆ Among the physical sequelae of trauma are autoimmune disorders.⁷
- ◆ Adults who experience multiple types of abuse and violence in childhood, compared to those who do not, have a 2- to 4-fold increase in smoking, poor self-rated health, a higher rate of physical inactivity, and severe obesity.⁸
- ◆ A study of adverse childhood exposures shows a relationship to the presence of adult diseases, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.⁸
- ◆ Severe and prolonged childhood sexual abuse causes damage to the brain structure, resulting in dysregulated emotional systems, dissociation, and symptoms of PTSD.⁹⁻¹¹
- ◆ Primary care physicians are often the sole or first professional seen by abused children and adults who present with medical or physical problems and/or behavioral problems.¹²
- ◆ Some primary care physicians prescribe as many anti-psychotic medications to asymptomatic children as they prescribe to symptomatic children.¹²
- ◆ Drugs are often prescribed for children misdiagnosed with Attention Deficit Hyperactivity Disorder (ADD), Oppositional Defiance Disorder (ODD), etc., whereas these children's symptoms are indicative of trauma (chronic community/gun violence as well as sexual/physical abuse).¹²

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- ◆ Theories and interventions on traumatic stress issues have been generated in the private sector for decades (Eye Movement Desensitization and Reprocessing [EMDR], Dialectical Behavior Therapy [DBT], Risking connection, Sanctuary, etc.).¹³
 - ◆ Due to perceived high cost of individual treatment, existing approaches have not been widely implemented in public sector settings.¹³
 - ◆ Many private practice trauma specialists are not aware of growing interest in the public sector to address trauma issues in public settings.¹³
 - ◆ Unless affiliated with a research university, private sector trauma specialists generally cannot afford to conduct outcome studies that prove anecdotally successful approaches.¹³
 - ◆ The lack of a shared language or a shared conceptual framework (e.g., mental health and criminal justice, or mental health and public health) significantly impairs the capacity of systems to collaborate effectively.¹⁴

Collaboration with Public and Private Partners Recommendations

- ◆ Launch an educational campaign targeting health care professionals (psychiatrists, primary care physicians, physician assistants, nurses, health clinicians, and other organizations and associations), which focuses on recognizing the signs and symptoms of trauma, and assisting children and adults via appropriate referrals and interventions.
- ◆ Collaborate with the Department of Health & Human Services Bureau of Primary Health Care (BPHC), which provides medical and mental health care in underserved urban areas through schools and community clinics.
- ◆ Collaborate with existing non-profit organizations that educate about trauma, abuse, domestic violence, etc., to provide widespread information and referral services.
- ◆ Collaborate with American Nurses Association, International Association of Psychiatric Nurses, and American Psychiatric Nurses Association, a professional population with people who are familiar with the incidence of violence and trauma, sympathetic to the cause, and who may hold influential positions.
- ◆ Foster and fund adaptation of existing models for public education settings.
- ◆ Create venues for teaching partnerships between private sector teachers and public sector learners.

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- ◆ Foster models for group clinical supervision, in which experienced trauma therapists can supervise novice clinicians in both the public and private sector.
 - ◆ Create and/or increase funding for outcome studies on the most successful trauma treatment approaches.
 - ◆ Educate both public and private systems on the existing literature of trauma-informed system of care practices.

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Cultural Competency

The treatment needs of one cultural/age/gender group may be different than those of another. Trauma services must be specific and sensitive if they are to be of value to the recipient.

Cultural Competency Facts and Discussion Points

- ◆ In the state of Connecticut, only 1% of women in substance abuse treatment are in gender-specific residential or intensive outpatient programs. There are very few gender-specific programs for women in mental health treatment.¹
- ◆ The number of children whose lives have been disrupted by war, oppression, terror, and other forms of conflict has grown from 1.5 million refugees and displaced persons following WWII, to 14 million refugees and displaced persons by 2001. Many of these young people experience long-term physical and emotional health problems, including PTSD.²
- ◆ The use of traumatizing, restrictive measures is used disproportionately in minority populations.³ Research is needed in this area.

Cultural Competency Recommendations

- ◆ Leadership is needed at the federal level to bring the message to states about the importance of delivering culturally competent services to better meet the needs of all persons requiring such services.

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Community and Faith-based Approaches

Faith and spirituality are frequently cited by trauma survivors as a primary support and a key to their healing.

Community and Faith-based Approaches Facts and Discussion Points

- ◆ Many survivors of abuse and trauma look to their spiritual leaders for guidance and healing.¹
- ◆ Faith communities, prayer circles, and clergy are the primary source of support for trauma survivors in communities of color.²
- ◆ In addition to physical and psychological crises, traumatic experiences may generate spiritual crises, loss of faith, and questions of identity, meaning, and world-view.²
- ◆ For people who have strong religious belief systems, trauma-informed, faith-based responses are critical to successful recovery from trauma.²
- ◆ Spiritual leaders may lack knowledge in the area of trauma.²
- ◆ Some religious/spiritual leaders are actual perpetrators of trauma or they may protect perpetrators. This should be recognized and addressed.²
- ◆ A religious belief system may provide a framework by which survivors of traumatic events can construct a meaningful account of their experience, and may be a useful focus for intervention with trauma survivors.³
- ◆ Consumers suffering from Posttraumatic Stress Disorder appear to benefit from psychosocial therapy and spiritual support, in conjunction with medication.⁴

Community and Faith-based Approaches Recommendations

- ◆ Work with Catholic leaders to fund and collaborate with trauma experts in a public education campaign about interpersonal violence/abuse trauma, its long-term impacts, the consequences of unresolved trauma, the need to prevent child abuse, the need to intervene early, and the need to help adult trauma and abuse survivors get treatment.
- ◆ Support education of clergy and lay leaders in all faiths regarding their role in responding to traumatized congregants, i.e. to recognize, counsel, and refer to trauma treatment, when appropriate.

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- ◆ Foster collaboration between clergy/denominational leaders and mental health service providers to de-stigmatize the acknowledgement of trauma, and to bring appropriate trauma services to the churches and faith-based service providers.

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Violence/Physical and Sexual Abuse

Along with childhood neglect, emotional abuse, and the witnessing of violence, childhood physical abuse and sexual abuse are key causal factors in many of the most debilitating and persistent social, medical, and mental health problems experienced by adults. If not recognized and addressed, these childhood experiences lead to a cycle of violence and victimization in adulthood. The traumatization of children in our society remains highly prevalent, underreported, and ignored.

Violence/Physical and Sexual Abuse Facts and Discussion Points

- ◆ The number of children traumatized in the United States in a single year equals the number of combat veterans who served in Vietnam for a decade.¹
- ◆ The United States has the highest rate of rape of any country that publishes such statistics: 13 times higher than Great Britain and 20 times higher than Japan.²
- ◆ Approximately 20% of children are sexually abused in some way before they reach adulthood, with this figure cumulating at a rate of about 1% each year.⁴ The sexual victimization rate is generally considered to be between 20% to 30% for females and between 10% to 20% for males.³⁻⁶
- ◆ Girls are about 2.5 to 3 times at higher risk for sexual abuse than boys, although approximately 22% to 29% of all child sexual abuse victims are male.^{4,7-10}
- ◆ Thirty-eight percent of women report at least one experience of incest or extra-familial sexual abuse before age 18; 28% report at least one such experience before age 14. Of these women, 16% were sexually abused by a relative and 4.5% by their fathers.⁴
- ◆ Girls in high-income families are more frequently victims of incest than girls in lower-income families.⁴
- ◆ A 1994 survey found 44.8% of African American women, 38% of white women, 25.6% of Latina women, and 21.1% of Asian American women had histories of child sexual abuse.¹¹
- ◆ Persons with disabilities are at 1.5 to 5 times greater risk of sexual abuse and assault than are members of the general population.⁹ Of the most frequent crimes against people with disabilities, more than 90% are sexual offenses.^{12,13}
- ◆ Three to 10 children per 100 children under the age of 18 experience severe physical abuse.¹⁴

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- ◆ In 1992, 2.94 million cases of child abuse and neglect were reported in the United States. In the same year, an estimated 1,261 children died from abuse and neglect. An estimated rate of child neglect is 14.6 per 10,000 children.¹⁵
 - ◆ An estimated 2,000 children (90% under the age of 5) die annually in the United States from maltreatment, the leading cause of injury fatality in this age group.^{16,17}
 - ◆ Over 90% of American parents have performed corporal punishment on their children by spanking, slapping, or other physical discipline. The same behavior between adults would be grounds for criminal proceeding.¹⁸
 - ◆ Twenty-five percent of infants one to six months are hit. This figure rises to 50% of all infants by six months to a year.²⁰
 - ◆ In the United States, about 4 million adolescents are victims of serious physical assault, and 9 million have witnessed serious violence during their lifetime.¹⁹
 - ◆ Each year, at least 3.3 million children in the U.S. witness physical and verbal abuse among adults in their homes—behaviors ranging from insults and hitting, to fatal assaults with guns and knives.²⁰
 - ◆ Each year, between 3.5 and 10 million children witness the abuse of their mother. Up to half are victims of abuse themselves.²¹
 - ◆ The number of seriously injured children who are victims of abuse and neglect quadrupled between 1986 and 1993.¹² This is not thought to be due to increased reporting but to an actual real rise in incidence.²²
 - ◆ Between 1986 and 1993 and under a restrictive standard of harm, the following estimates were reported: the number of sexually abused children rose by 83%, the number of physically neglected children rose by 102%, the number of emotionally neglected children rose by 333%, and the number of physically abused children increased by 42%.²⁵
 - ◆ Homicide is the third leading cause of death for girls ages 11 to 14 and the second leading cause of death for girls ages 15 to 18.²³
 - ◆ In inner-city neighborhoods, homicide is the fourth leading cause of death for all children ages 1 through 4, third for youth ages 5 through 14, and second for persons ages 15 through 24.²²
 - ◆ Child neglect is more commonly reported than physical or sexual abuse and has profound consequences. Research sometimes fragments abuse experiences into distinct categories that do not distinguish the impacts of trauma such as poverty and neglect.²⁴

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- ◆ Social discrimination, racism, sexism, and war may be considered culturally supported child maltreatment.²⁵⁻²⁸
 - ◆ One in five school-age children and 1 in 4 preschoolers live in poverty. Extreme poverty and homelessness may indicate ways in which American society withholds support for many of its citizens and indirectly maltreats large numbers of children.²⁹
 - ◆ Reports of physical and sexual abuse are significantly lower than actual incidence due to repression, cultural shame, reporter unwillingness or inability to disclose or identify experiences as abusive, and other factors.^{29,30}

Violence/Physical and Sexual Abuse Recommendations

- ◆ Public policy for the prevention and early intervention of child abuse and neglect in the United States is necessary to prevent the often severe and disabling neurological, psychological, physiological, and social effects of such abuse.
- ◆ The prevention and/or treatment of interpersonal violence, especially childhood abuse, should be considered an extremely high priority for the behavioral health system as well as other public systems.

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Financing Strategies and Cost-Effectiveness

There are significant social and economic costs to ignoring trauma. Numerous reputable studies have documented the link between the abuse and neglect of children and a wide range of medical, emotional, psychological, and behavioral disorders in adulthood.

Financing Strategies and Cost-Effectiveness Facts and Discussion Points

- ◆ Child abuse and neglect cost the United States almost \$94 billion per year, or \$258 million per day (\$1,462 annually for every American family). The annual cost is conservatively estimated to be \$94,076,882,529 per year in a 2001 report. Direct costs associated with the immediate needs of abused or neglected children total \$24,384,347,302. They include: hospitalization, \$6,205,395,000; chronic health problems, \$2,987,957,400; mental health care system, \$425,110,400; child welfare system, \$14,400,000,000; law enforcement, \$24,709,800; judicial system, \$341,174,702. Indirect costs associated with the long-term and/or secondary effects of child abuse and neglect total \$69,692,535,227. They include: special education, \$223,607,830; mental health and health care, \$4,627,636,025; juvenile delinquency, \$8,805,291,372; lost productivity to society, \$656,000,000; adult criminality, \$55,380,000,000.¹
- ◆ Clients with a history of sexual abuse (with or without physical abuse) utilize significantly more crisis, inpatient, and restrictive residential setting services than those with a history of physical abuse alone.²
- ◆ Long-term sequelae of severe child abuse generate over \$100 billion in psychiatric and medical health care costs per year in North America. The majority of these costs are unrecognized and misattributed.³
- ◆ In psychiatry, trauma-specific psychotherapy is the most financially cost-effective intervention.³
- ◆ Annual cost of mental health care for victims of attempted or completed rape is \$863 million. Total annual mental health care costs for adult survivors of child sexual abuse is \$2.1 billion.⁴
- ◆ In Massachusetts, PTSD that is caused primarily by physical or sexual abuse in childhood costs the mental health care system about \$47 million per year.⁵
- ◆ Money is often spent in vain on treatment for substance abuse due to high relapse rates from unaddressed trauma-related problems.⁶

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- ◆ According to the National Mental Health Association (NMHA), American businesses, governments, and families contribute \$113 billion per year to the cost of untreated and mistreated mental illness. Between 50% and 75% of these untreated and mistreated people have a history of trauma that either caused or is contributing to their mental illness. Based on the above figures, the cost of untreated trauma is between \$65,500,000,000 and \$84,750,000,000 per year.⁷
 - ◆ Seventy-five percent of adults in substance abuse treatment have a history of childhood abuse and neglect.⁷ The cost of unaddressed childhood trauma, based on public health care costs related to substance abuse treatment provided through Medicaid, is:
 - \$582 million for addictive disorders;
 - \$84 million for diseases attributable to substance abuse;
 - over \$2 billion for disease for which substance abuse is a risk factor; and
 - \$252 million for consumers with a secondary diagnosis of substance abuse (estimated % applied to figures from MIMH Policy Brief, June 2002).^{7, 8}
 - ◆ The total cost of substance abuse and mental illness per year is more than \$300 billion. Of this amount, 75% or \$225 billion may be attributable to unaddressed childhood trauma (estimated percentage applied to figures from MIMH Policy Brief, June 2002).⁸
 - ◆ Trauma caused by the Oklahoma City bombing resulted in long-term mental health problems for many people. The average costs of mental health services *not* covered by insurance were:
 - \$2.8 million in treatment of direct victims;
 - \$1.15 million out-of-pocket cost for rescuers;
 - \$2.2 million for others in community with depression or PTSD; and
 - \$3.2 million for substance abuse treatment.⁹

Financing Strategies and Cost-Effectiveness Recommendations

- ◆ Increase collaboration between systems (substance abuse, mental health, correctional, etc.), and include trauma assessment and treatment to reduce costs.

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- ◆ Advocate routine intake assessment and screening for consumers with abuse history and trauma symptoms, as well as referral to trauma services as needed. Early treatment will help reduce the cost of care.
 - ◆ Incentivize private sector entities to join the initiative by articulating actions they can take that will decrease costs.

Financing Strategies and Cost-Effectiveness References

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Workforce Development

The public mental health workforce is largely unprepared to recognize and address the serious psychological impacts of unresolved trauma in the lives of the majority of children, adolescents, and adult consumers of mental health services.

Workforce Development Facts and Discussion Points

- ◆ Newly graduated mental health professionals across the country are unprepared to treat individuals with symptoms related to trauma. Almost no universities offer comprehensive trauma programs that prepare their graduates to address this complex disorder. As a result, clinicians may be scared, uncomfortable, and uncertain about their readiness to help survivors of trauma.^{1,2}
- ◆ Without adequate training in evidence-based techniques to treat trauma, clinicians may: 1) offer untested therapies; 2) fail to recognize and treat symptoms ranging from flashbacks to anxiety to physical effects; or 3) provide treatment that is harmful.^{1,3}
- ◆ Because few clinicians are trained to treat trauma, the mental health system was unprepared to help people—adults or children—deal with the profound psychological impact of the World Trade Center attack. Left untreated, the most serious mental health disorders brought on by trauma can lead to suicide.¹
- ◆ Traditionally the domain of psychology, the effects of trauma are more recently being examined by nurses, social workers, neurobiologists, public health workers, medical researchers, and others. Universities have been slower to combine these disciplines and create comprehensive study and research programs.⁴
- ◆ Because of the multi-disciplinary approach needed to treat the impact of trauma, the study of trauma disorders does not easily fit into the existing structure of universities. It may take years before comprehensive trauma programs that incorporate current scholarly and professional work in trauma are included in the academic mainstream.⁴
- ◆ There is a shortage of skilled medical or other professionals who have the expertise to treat or provide services to sexually abused children. Nor are there training programs which are standardized across disciplines and easily accessible.⁵
- ◆ Much is known now about the impact of trauma. Training programs, degree programs, teacher preparation courses, etc., are deficient in conveying the research data to service providers.⁶

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- ◆ Material presented in trauma training may be challenging or threatening, and may elicit resistance to change and denial within some individuals and within entire systems. This resistance should be confronted and reduced.⁶

Workforce Development References

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Peer Support and Self-Help

Peer support, mutual support groups, and self-help approaches contribute greatly to recovery from abuse and trauma. These approaches are recognized as promising and/or evidence-based practices.

Peer Support and Self-Help Facts and Discussion Points

- ◆ Individuals who have resolved previous traumatic reactions are more resilient to disasters and should be viewed as valuable resources for disaster-stricken communities.¹
- ◆ By joining together, consumers have power and a voice that not only impact their individual treatment but attitudes toward and treatment of all consumers. This power has increased under the motto “Nothing About Us Without Us.”²
- ◆ In its priority set of evidence-based practices for adults, New York State includes self-help and peer-support education and treatment for Posttraumatic Stress Disorder. As an example of evidence-based practice,^{3,4} self-help is a lifelong support that is beneficial to the sustained management of many health conditions.^{5,6,7} In response to the catastrophic events of 9-11-01, New York utilizes current research for the most effective treatments.⁸
- ◆ The role of peer support and mutual support groups is of fundamental importance for many women survivors. Resources such as transportation, meeting space, funding for information resources, drop-in centers, and alternative peer-run crisis support centers are necessary for such “informal” networks to thrive. These networks provide a larger community of peers, and also greatly enhance healing.⁹
- ◆ Many communities lack adequate peer advocacy services or peer support systems that can assist a trauma survivor in obtaining the necessary information or help to avert crisis or hospitalization. Without information as to which therapeutic approaches work best, it is difficult to advocate for trauma survivors or to control the therapeutic process.¹⁰
- ◆ Peer support and self-help are useful and cost-effective tools in helping survivors overcome the shame that often accompanies trauma, and these tools also provide leadership, motivation and guidance.
- ◆ Peer support and self-help are characterized by the following:
 - People experience themselves and their relationships across multiple roles.

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- People have the opportunity to de-construct and re-construct their mental health story within the context of these multiple roles and relationships.
 - People can express concern about coercive mental health practices without fear of retaliation.

 - As rights issues emerge, they may be viewed as political rather than personally pathologized (e.g., the effects of trauma and abuse).

 - People can practice “help” as both the receiver and the giver.

 - As peer support becomes an adjunct/alternative to traditional practice, people find they need less intensive professional treatment.

 - As people feel confident in their ability to help others, their sense of self-efficacy strengthens (many go back to work).

 - People begin to make meaning of their experience outside the traditional rubric of mental health/mental illness (i.e. symptoms of trauma and abuse are no longer seen as personal pathology but rather as understandable reactions to the trauma).

 - People build relationships that establish new ways of understanding their experiences.

 - Peer communities develop norms, rituals, language, and outcomes from these new practices that may ultimately inform future direction for mental health services.¹¹

Peer Support and Self-Help Recommendations

- ◆ Teach trauma survivors how to support each other. They can often be more helpful to each other than professional helpers through mutual understanding of their experience.¹⁰

- ◆ Create means for consumers to feel supported through support groups, newsletters, conferences, warmlines (a support phone line). Train volunteers who are survivors to coordinate peer support services.¹⁰

- ◆ Provide training for survivors that includes understanding of their own illness, better control of the therapeutic process, creating a positive attitude, meditation, and ways of managing symptoms. Teach techniques that deal with PTSD (i.e. focusing on something other than the trauma or flashbacks, using imagery, keeping a journal, listening to tapes, reading materials, enjoying self, and experiencing pleasure).¹⁰

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- ◆ Create support groups for sharing and discussing ways survivors have found to help themselves. Topics could include work, school, volunteering, supportive friends and family, participation in treatment programs.¹⁰
 - ◆ Develop a Web site in each state to provide information and education about trauma. This could be a project for graduate students.¹⁰
 - ◆ Develop “Trauma Information Centers.” Make materials available for self-education, including books and other materials that provide survivors with tools to manage their own symptoms in non-traditional ways and in ways others have found helpful.¹⁰
 - ◆ Develop cost-effective, comprehensive peer-professional alliances in support of a trauma-preparedness support system. Such alliances provide a “surge buffer” to prevent relapse/crises among vulnerable people in the event of subsequent local traumas or mass disasters.
 - ◆ The facts on peer support fit with new ways of thinking about crisis, elimination of seclusion and restraint, minimizing the need for professional intervention with substance abuse, the Olmstead Act (in terms of least restrictive environment), and awareness of the effects of violence in relation to mental health.

Peer Support and Self Help References

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Appendix A: Trauma Services Implementation Toolkit for State Mental Health Agencies

This toolkit identifies written documents and products (the underlined words and phrases) providing examples of state systems activities contributing to the development of trauma-informed mental health systems and trauma-specific mental health services. The documents and products are listed by state within a series of Trauma Services Categories. Although there are many other resources that may be helpful to recipients of mental health services who have histories of trauma, only those that specifically and explicitly address trauma will be listed in this appendix.

The majority of these materials are available electronically and many of them can be obtained by contacting the individuals listed at the end of this appendix in the Publication Contacts section. Other publications used by states may need to be obtained from publishers or authors.

This is a continually updated, working document. Last update: Fall 2002.



Trauma Services Categories

1. State trauma policy or position paper and/or definition of trauma

Connecticut:

- ◆ Department of Mental Health and Addiction Services Policy on Trauma-Sensitive Services. Includes mission statement, definition and effects of trauma, meaning of recovery, value statement, value base, governing principles.

Maine:

- ◆ Definition of Trauma included in Department of Behavioral and Developmental Services Plan for Improving Behavioral Health Services for Persons with Histories of Trauma, August 2001.

Maryland:

- ◆ Department of Health and Mental Hygiene, Mental Hygiene Administration's Division of Special Populations Trauma Addictions, Mental Health And Recovery (TAMAR) project Definition of Trauma for all Department programs in jails.

Massachusetts:

- ◆ Commissioner Monograph of March 10, 1999, summarizing key policy points and providing guidelines regarding treatment of Department of Mental Health clients with a history of trauma.

Oregon:

- ◆ Department of Human Services, Health Services, Mental Health and Addiction Services Trauma Policy (7/01/02). Includes Policy statement, definition of psychological trauma, background information and implementation plan.

South Carolina:

- ◆ Department of Mental Health Position Statement on Services for Trauma Victims.
- ◆ DMH Definition Document on Trauma, Sanctuary Trauma, and Sanctuary Harm.

Wisconsin:

- ◆ Definition of Trauma by Bureau of Community Mental Health.

Wyoming:

- ◆ Policy regarding trauma is imbedded in Consumer Rights Policy Statement.

2. Trauma assessment

Connecticut:

- ◆ Clinical staff in 2 hospitals and 25 state-operated and private non-profit agencies are being trained to conduct brief screens for trauma history and PTSD. Screening forms available.
- ◆ Trauma screening is being done in connection with a statewide program, Project SAFE, to screen parents involved in the child welfare system who are suspected of having substance abuse problems. Screening forms available.

Illinois:

- ◆ Chicago's Domestic Violence and Mental Health Policy Initiative's Trauma Assessment Committee, in collaboration with the Office of Mental Health Chicago Bureau of Network Operations (CBNO), is developing domestic violence, trauma and safety assessment questions for 18 state-funded mental health and domestic violence agencies participating in an Intensive Trauma Training and Implementation Program. Questions will be reviewed by the DV/Trauma committee of the Greater Chicago Area Mental Health Planning Council and will be made available to all OMH-funded agencies.

Maine:

- ◆ Uniform Assessment Tools for Adult Mental Health incorporating brief assessment for trauma has been completed. These tools are designed for implementation throughout Maine's adult mental health system including state operated and contract agencies, community hospitals and state institutions.
- ◆ Uniform Assessment Tools for Children/Adolescent Mental Health incorporate trauma.
- ◆ Trauma Screening Questionnaire, Introductory Information and Guidelines for Administration created by clinicians and consumers as part of Department of Behavioral and Development Services pilot project to develop trauma-informed systems of services within local Community Mental Health Centers.

Maryland:

- ◆ All individuals coming into jails in eight Maryland counties are assessed for trauma through the Mental Hygiene Administration's TAMAR project. Two assessment instruments are used: a brief intake form, and if indicated, a comprehensive trauma assessment form.

Massachusetts:

- ◆ Universal Trauma Assessment (computerized medical record) applicable to all DMH-operated programs.

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- ◆ Requirement that all licensed and contracted inpatient programs assess consumers for trauma on admission (by regulation).

New York:

- ◆ Brief Trauma Screening and Assessment forms for adults and for children will be incorporated into New York State Automated Medical Records. These forms are in development and will be pilot tested prior to final draft. The tested trauma screening and assessment instruments will be finalized within one year and implemented in all 28 New York State Hospitals. Adult assessments use PTSD checklist from the National Center for PTSD, adding 4 questions and treatment recommendations.

Rhode Island:

- ◆ Kent County Mental Health Center intake package includes several questions regarding trauma histories.

South Carolina:

- ◆ Detailed trauma & PTSD screening instruments implemented for adults and children. Assessment in place for 2 Mental Health Centers and 2 hospitals. Six additional Mental Health Centers have begun assessments.
- ◆ Adult Intake Packet includes SF-12v2 TM Health Survey, a Trauma Assessment, and PCL-C an 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, includes questions about child and about self.
- ◆ Trauma Symptom Checklist for Children, by John Briere, Ph.D. and Psychological Assessment Resources, Inc.

Vermont:

- ◆ Universal screening for trauma: Draft set of questions addressing trauma as part of intake for all Departments within the Vermont Agency of Human Services. Questions are incorporated into existing standard intakes.

Wisconsin:

- ◆ Guidelines for Assessment of Trauma: an approach to doing an assessment with referrals to various kinds of instruments.

Wyoming:

- ◆ Existing assessment tools incorporate questions about trauma issues.

3. Clinical practice guidelines for working with trauma survivors

Illinois (Chicago):

- ◆ State of Illinois Office of Mental Health Chicago Bureau of Network Operations' (CBNO) Greater Chicago Area Mental Health Planning Council has a Domestic Violence/Trauma Committee to develop practice and policy guidelines on trauma and domestic violence for State Office of Mental Health-funded clinics and State Operated Facilities.
- ◆ The Domestic Violence and Mental Health Policy Initiative is completing its Recommendations for Addressing Domestic Violence in Mental Health Settings.

Maryland:

- ◆ Clinical guidelines for working with trauma survivors in jail have been developed and implemented through the TAMAR project.

Massachusetts:

- ◆ Clinical Guidelines – 8/6/96 for DMH Clients with a History of Trauma.

New York:

- ◆ Evidence-Based and Promising Practice Initiative mandates NY State's entire outpatient service system to make eight proven or promising practices available to clients. Trauma has been designated a promising practice. Technical Assistance Documents to the Field are being developed for each of eight practices, including guidelines, minimum standards and core competencies. Compliance will be tied to certification of agencies under contract with NYOMH, affecting mental health clinics, day programs, partial hospitalization and rehabilitation programs across the state.

Oregon:

- ◆ Draft Guidelines: Chemical Dependency and Mental Health Services for Co-occurring Mental and Substance Use Disorders. Incorporates trauma in program policy and procedures, service delivery criteria, documentation, and staff competencies and training. Used and available in draft form.

Rhode Island:

- ◆ Kent County Mental Health Center worked with consumers and providers in the Coalition for Abuse Recognition and Recovery (CARR) to establish guidelines for working with trauma survivors.

4. Specialized trauma treatment and/or support programs, including both trauma-informed services and trauma-specific services

Connecticut:

- ◆ Statewide trauma treatment services are currently being developed. Two state hospitals and 25 state-operated and private non-profit mental health and addiction treatment agencies are participating in year-long, on-site training and consultation in identification and treatment of trauma. State/agency agreement, information and manuals on the treatment models, and information on the training model are available.
- ◆ Each agency can choose one of the three following treatment models:
 - Seeking Safety: Designed to treat trauma and substance abuse at the same time. Focuses on coping skills to help clients achieve safety in their behavior, thinking, and relationships. Twenty-five topics, with client handouts, 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. Has achieved positive results in four outcome trials with women, men, women in prison, and minority women. Model, manual and materials developed by Lisa Najavits. See www.seekingsafety.org
 - Trauma Adaptive Recovery Group Education and Therapy (TARGET): A strengths-based model, explaining PTSD in terms of the body's survival/alarm system and teaching a set of practical skills to enable participants to gain control of PTSD symptoms. Uses self-regulatory skills approach and experiential exercises to address topics including self-esteem, anger, grief, shame, re-victimization, and spirituality. TARGET has versions of different lengths: 3-5 sessions, 9 sessions, and 26 sessions. Model, manual and materials developed by Julian Ford.
 - TREM (Trauma Recovery and Empowerment Model): A three-part psychoeducational model focusing on skill-building, trauma education, development of understanding of responses to trauma, and group cohesion and support. Each session is built around one of 33 topics and includes experiential and culturally diverse exercises. The model has achieved an 80% retention rate with women who attend at least 75% of the sessions. There are separate versions of TREM that are highly gender specific for men and women. TREM is appropriate for consumers with mental health, co-occurring, or addictive disorders. Model and published manuals developed by Community Connections D.C.

Illinois (Chicago):

- ◆ The Domestic Violence and Mental Health Policy Initiative is working with nine state-funded community mental health agencies to pilot the development of trauma-informed and trauma-specific services utilizing the Trauma Recovery and Empowerment Model (TREM), the Sanctuary model (S.

Bloom) and Risking Connection model (Sidran Foundation and Traumatic Stress Institute) and Harris and Fallot's work on Trauma Informed Systems, Using Trauma Theory to Design Service Systems. This work is undertaken in conjunction with the authors of each model to address lifetime trauma in the context of ongoing abuse. Three hundred representatives from over 55 domestic violence and mental health agencies participated in an introductory training on these issues in November 2001. Documents describing the Initiative are available.

Maine:

- ◆ Pilot project to develop a model trauma-informed system of services, initially in one unit of a major mental health agency, based on criteria outlined by Maxine Harris and Roger Fallot in monograph Using Trauma Theory to Design Service Systems. Project described in Department's Plan for Improving Behavioral Health Services for Persons with Histories of Trauma. Evaluation pre- and post- implementation. Outcomes will determine replication of model in larger agency and across the BDS service system. Documents available include Plan, Evaluation Package, Screening Tools, Consumer Satisfaction Questionnaire.
- ◆ Statewide Trauma Telephone Support Line provides 24-hour, 365-days-per-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, RFP available.
- ◆ Trauma Clinical Consultation Service. Department funds available regionally to all providers serving public mental health clients, to purchase trauma clinical consultation service on an as needed, fee-for-service basis. Description Document available.
- ◆ Trauma Recovery and Empowerment Model (TREM) Psychoeducational Groups for Women offered through local centers of Maine Coalition Against Sexual Assault, and a variety of agencies for women with histories of sexual abuse and other trauma who have serious mental health and/or addiction problems. Model developed by Community Connections D.C. Published facilitator and participants manuals (See CT).
- ◆ Trauma Recovery and Empowerment Model (M-TREM) Psychoeducational Groups for Men who have serious mental health and/or addiction problems. Offered through local centers of Maine Coalition Against Sexual Assault and a variety of community mental health agencies. Model and materials developed by Community Connections D.C. (See CT).

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- ◆ Maine Trauma Providers Listserve: a vehicle for dialogue between and among providers, educators, researchers, and others involved in trauma treatment and/or training in the state of Maine. Sponsored by Counseling Services Inc. in collaboration with the Department. Purpose, directions and guidelines available.

Maryland:

- ◆ 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 eight county jails, and in the agencies serving these individuals after their release. Model developed by the Sidran Foundation in collaboration with the states of Maine and New York. Published Curriculum and Manual.

Minnesota:

- ◆ Ananda Project/Dialectical Behavior Therapy: for multi-diagnosed, difficult-to-treat clients, usually with histories of severe trauma; used to treat clients who are demonstrating out-of-control behaviors that interfere with standard treatments for individuals with trauma histories. Intensively trained team that teaches and consults with both state-operated and community-based agencies to treat clients with Borderline Personality Disorder and other trauma-related disorders within their home counties/cities. Service delivery plan and updated work plan now available.

New Hampshire:

- ◆ Trauma Recovery Group offered at the Greater Manchester Mental Health Center and West Central Services in Claremont. Twenty to twenty-one weeks long. Candidates are screened for referral via PTSD screening tool (PCLS). A cognitive restructuring approach combined with individual therapy. This is a pilot study, headed by Dartmouth Psychiatric Research Center (PRC). Description of study.

New York:

- ◆ Trauma Drop-In Groups: Low intensity groups facilitated by clinicians as a first step toward addressing trauma in treatment. Facilitators Manual: The Trauma Safety Drop-In Group: A Clinical Model of Group Treatment for Survivors of Trauma.

Oregon:

- ◆ Trauma-based Sanctuary Model (Sandra Bloom, M.D.) implemented at Salem General Hospital Psychiatric Inpatient Unit. Model universally applicable for all consumers. Has almost eliminated use of seclusion and restraint and other coercive measures. Articles available describing Sanctuary Model.

Rhode Island:

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- ◆ Kent County Mental Health Center services are trauma informed. For 6 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. Description of training and conference brochures.
 - ◆ A Victims of Crime Program and a Victims of Trauma Program are implemented at Kent County Mental Health Center. Description of Programs.

Vermont:

- ◆ Statewide Trauma-Informed Service System is being implemented through the Vermont Agency for Human Services, based on model and criteria outlined in monograph Using Trauma Theory to Design Service Systems developed by Community Connections D.C. Overall implementation plan and plans for each Department (Mental Health, Social Welfare, Aging and Disabilities, Health, Corrections, Vocational Rehabilitation, Social Services and Child Welfare) are being developed.

Wisconsin:

- ◆ New Partnership for Women: a state-supported collaborative consumer/provider project operated out of the Madison YWCA is developing a consumer curriculum on trauma to be co-taught by consumers and providers for groups of consumers with histories of trauma across the state. This service includes working with groups on 1) understanding effects of trauma, 2) symptom self-management, 3) meeting basic needs, and 4) self-advocacy. The Consumer Curriculum and Manual is available.

Wyoming:

- ◆ Existing programs such as DBT and other groups incorporate trauma. Written materials.

5. Procedures to avoid re-traumatization, including but not limited to seclusion and restraint reduction policies

Maine:

- ◆ Department of Behavioral and Developmental Services (BDS): 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 BDS staff and institutions (Mental Health, Mental Retardation, Substance Abuse).
- ◆ 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.

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- ◆ Trauma Assessment form for BDS Facilities/Staff.

Maryland:

- ◆ Procedures for avoiding retraumatization developed by the Department's TAMAR project are implemented in jails and in community follow-up agencies. New procedures are being drafted with special application for women in jails who are pregnant.

Massachusetts:

- ◆ Massachusetts DMH Task Force on Restraint & Seclusion of Persons with Histories of Physical and Sexual Abuse: Report and Recommendations (1996).
- ◆ DMH 8/6/96 Clinical Guidelines regarding DMH Clients with a History of Trauma, De-Escalation Form and Trauma Assessment.
- ◆ The Safety Tool: a crisis prevention tool developed by clients and clinicians to address de-escalation planning and to identify triggers and behavioral strategies.
- ◆ The Adolescent Safety Zone Tool.
- ◆ Safety Tool Development for the Younger Child: An individual child-friendly (using pictures) de-escalation planning tool is being developed by DMH with experts Glenn Saxe, M.D., and Beth Caldwell, M.A., and members of the provider community.
- ◆ Dr. Solomon Carter Fuller Mental Health Center Admission Assessment incorporating trauma.

Minnesota:

- ◆ Guidelines for assignment to intensive behavior care units in the Anoka-Metro Regional Treatment Center and the Willmar Regional Treatment Center intentionally separate individuals with known histories of trauma from those with known histories of perpetration.

Missouri:

- ◆ Form used at state facility modeled after language from Massachusetts Department of Mental Health Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused, as presented at the first NASMHPD Summit of State Psychiatric Hospitals. All Missouri's acute and psychiatric facilities have incorporated prompts/forms to assist in determining triggers. Provides a tool—when coupled with JCAHO required questions regarding histories of abuse—for clinicians to explore trauma-related issues.

New Hampshire:

- ◆ New Hampshire Hospital: Restraint and Seclusion guidelines.
- ◆ Nursing Database Assessment (trauma-informed).

New York:

- ◆ Trauma-Informed Seclusion and Restraint Policy mandated at all state facilities.

Wisconsin:

- ◆ Recommendations regarding seclusion and restraint of individuals with histories of trauma are included in Wisconsin Workgroup on Trauma's Draft Recommendations to Bureau of Community Mental Health.

Wyoming:

- ◆ Sensitivity to past and recent trauma is built into all practices and procedures including physical examinations, dressing and undressing, transporting consumers, seclusion and restraint. Written documents available.

6. Staff training, support, core competencies and job standards related to trauma

California (Los Angeles):

- ◆ Psychological Trauma Among People with Mental Illness and Substance Use Disorders: half-day, one-day, or two-day trainings offered once per year through the Los Angeles County Department of Mental Health Training and Cultural Competency Bureau in collaboration with UCLA Integrated Substance Abuse Programs Dual Diagnosis Study. Training is offered to mental health and substance abuse providers and reviews the background events and the conceptual basis for the development of the diagnosis of PTSD. Training materials available. Topics covered include prevalence rates, the neurobiology of trauma exposure, risk and resiliency factors, issues related to assessment and diagnosis, a trauma framework, and treatment approaches. This training incorporates several models: 1) The Risking Connection Curriculum (Sidran Foundation and Traumatic Stress Institute) provides training infrastructure; 2) Seeking Safety Model (developed by Lisa Najavitz); 3) TREM - Trauma Recovery and Empowerment Model (developed by Maxine Harris); 4) The Body Remembers (Rothschild).

Connecticut:

- ◆ Statewide Meeting: Psychological Trauma: Myths and Realities (May 10, 2002). Brochure.
- ◆ Statewide Meeting: CT 2001 Women's Conference: Defining a Vision for Behavioral Health Care (Oct 2-23, 2001). Brochure.

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- ◆ Three-day training offered once per year emphasizes cultural sensitivity and consumer perspective in treatment of trauma. Brochure.
 - ◆ Behavioral Management Strategies (BMS) training program has incorporated a unit on trauma. This is provided annually to all employees who participate in consumer care.

Maine:

- ◆ BDS Competency Model: Trauma identified as a Core Competency area required of all BDS employees. Describes learning objectives that must be met under seven competency areas of trauma. Used in supervision to identify training needs, and in design of training programs and curriculums.
- ◆ Risking Connection Training Program: A 5-module trauma curriculum for use in public mental health, substance abuse and human service fields is 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. Current trainings include:
 - Train-The-Trainer program for selected clinicians to provide in-service and other Risking Connection trainings throughout the state
 - Risking Connection (RC) training for Intensive Case Managers statewide
 - RC trainings for middle management and supervisory personnel in mental health and mental retardation fields
 - RC training for service providers working with clients with co-occurring disorders
 - RC training for clinical supervisors statewide
 - RC training on vicarious traumatization and burnout issues
 - RC training for providers in inpatient and residential settings
 - RC training for providers in partial hospital/day program settings
- ◆ Crisis System Training and Case Consultation: Use of Dusty Miller's ATRIUM model (an assessment and treatment recovery model for women, men and adolescents with addictions and trauma-generated co-occurring disorders) in training program for crisis system staff statewide. Training focus on responses to individuals in crisis who self-injure, are suicidal, or are otherwise at risk. Model published in Addictions and Trauma Recovery: Healing the Body, Mind and Spirit, by Miller and Guidry.
- ◆ Six Annual Two-day Statewide Trauma Clinical Training Conferences: Summer 2000 Trauma in Childhood and Adolescence; fall 2001 Trauma, Substance Abuse and Mental Health; spring 2003 Trauma, Substance Abuse and Mental Health. National keynotes and multiple workshops. Conference brochures, all topics and presenter information.

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- ◆ TREM (Trauma Recovery and Empowerment Model) Training Programs conducted by Community Connection staff in all Regions of the state. Three-day trainings of clinicians to facilitate psychoeducational groups for women trauma survivors with serious persistent mental health and/or substance abuse problems. Published facilitators manual and materials, by Maxine Harris, Ph.D.
 - ◆ MTREM (Men's Trauma Recovery and Empowerment Model) Training Programs. Conducted by Community Connection staff statewide. Two-day trainings of clinicians to facilitate psychoeducational groups for male trauma survivors with serious persistent mental health and/or substance abuse problems. Published facilitators manual and materials, by Roger Fallot, Ph.D.

Maryland:

- ◆ Mental Hygiene Administration and local detention centers in-service training for all jail personnel, related community agencies and state hospitals, using varied adaptations of the Sidran Risking Connections model.
- ◆ Conference April 12, 2000, Trauma and It's Impact on Parenting presented by Sharon Melnick, Ph.D., Harvard Medical School. Topics: impacts of past traumatic experiences; how they affect relational capacities and current behaviors; common parenting dilemmas; major emotional themes with mothers seeking to provide their children with more supportive mothering than they received themselves. Brochure.
- ◆ Conference December 4, 2000 Within the Walls of Change: Trauma Treatment in Correctional Settings, presented by Andrea Karfgin, Ph.D., Director of Trauma Services for MHA and Elizabeth Vermilyea, M.A., of Sidran Institute. Educate correctional personnel about the relationship between trauma, substance abuse, mental illness, and criminal behavior. Topics: interventions for managing traumatized inmates, reducing re-traumatization, basic trauma understanding and responses, effect on workers. Brochure.
- ◆ Conference December 14, 2000 Sisters Surviving Trauma, conducted by Jackie McKinney, founder National People of Color Consumer Survivor Network, and Denyse Hicks, Ph.D., Correctional Program and Training Specialist. Topics: treatment needs of, and delivering culturally sensitive services to, women of color who are survivors of trauma. Brochure.
- ◆ October 19, 2001 Trauma, Parenting, and Attachment, presented by Sharon Melnick, Ph.D., Harvard Medical School, Andrea Karfgin, Ph.D., Director of Trauma Services for MHA, Victor Welzant, Psy.D., Director of Anne Arundel County Critical Incident Stress Management Team. Topics: effects of trauma on individual's ability to parent. Brochure

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- ◆ Working with Borderline Personality Disorder/Crisis Management for Survivors, February 2002 and March 2002 trainings conducted by Elizabeth Vermilyea, M.A., Sidran Institute.
 - ◆ Trauma Symptom Management Training March 2002, by Elizabeth Vermilyea, M.A., Sidran Institute.
 - ◆ Maryland Mental Hygiene Administration Annual Conference: Trauma, Disaster, and Resiliency. National presenters covered topics related to trauma issues. Brochure.

Massachusetts:

- ◆ Child-oriented trauma training provided by Glenn Saxe, M.D. to the Child and Adolescent Acute and Continuing Care inpatient and intensive residential program providers. 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.
- ◆ 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. Providers receiving statewide trauma training on development of collaborative strength-based models of care.

Minnesota:

- ◆ Addressing vicarious traumatization of staff that work with trauma survivors to prevent burnout. Partially based on Perlman and Saakvitne's Trauma and the Therapist.

New York:

- ◆ OMH Core Curriculum mandatory for all state employees with client contact, from housecleaners to doctors. Clinical module addresses trauma.
- ◆ Comprehensive trauma training initiative for seven years including statewide training programs, conferences, consultations, discipline-based trainings, agency and facility-based trainings. Training descriptions, training models, conference brochures, training materials, and training strategic plans available.

Oregon:

- ◆ Trauma focused trainings, forums and conferences (two hours to two days) given, on average, three times a month in 2001 and 2002. Trainings are statewide, multi-agency, culturally diverse, and for the full age range.

Brochures, handouts and overheads available following all trainings and conferences.

- ◆ Trauma training programs 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
 - TREM: Trauma Recovery and Empowerment Model for Working with Women in Groups
 - MTREM: Trauma Recovery and Empowerment Model for Working with Men in Groups
 - Seeking Safety: Model for Working with Trauma and Addiction
 - Dialectical Behavior Therapy

- ◆ 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: OR HMOs
 - Trauma and Transformation. Trauma Relief Services of the Northwest

Rhode Island:

- ◆ Kent County MHC 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, co-sponsor an annual trauma conference, and to perform alternative dispute resolution and CPI (Crisis Prevention and Intervention). Agency designated by Center for Nonviolence and Peace Studies as the only nonviolent community mental health center in Rhode Island. Documents describing trainings; conference brochures.

Vermont:

- ◆ Training and consultation for Agency of Human Service (AHS) department managers re: Trauma Informed Service Systems. One hundred and fifty AHS department senior managers will receive a half-day of orientation from Maxine Harris and Roger Fallot of Community Connections, plus half-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.

Wisconsin:

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- ◆ Three models for in-service training of department employees and staff of 72 county mental health service systems are included in Wisconsin Trauma Workgroup recommendations to the Bureau of Community Mental Health and the Bureau of Substance Abuse: 1) Risking Connections developed by Sidran Foundation and Traumatic Stress Institute in collaboration with states of Maine and New York and adapted for cross-systems training; 2) a trauma curriculum and materials developed as a result of the Women and Violence project (description available); and 3) a Consumer Curriculum developed by consumers and providers. Curriculum draft available.

Wyoming:

- ◆ Staff certification and re-certification procedures incorporate understanding and sensitivity to trauma.

7. Linkages with higher education on trauma issues

Maine:

- ◆ Mental Health Rehabilitation Technician (MHRT) Certification Program requires 10 Associates Degree level courses, including one on trauma (see MHRT Trauma Competencies). Certification necessary for variety of direct care positions including community support workers and crisis workers.

Rhode Island:

- ◆ 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.

8. Quality improvement, regulations and evaluation processes addressing trauma

Maine:

- ◆ Rules currently under revision will strengthen existing requirement to reduce use of restraint or time-out in mental retardation settings and to include a specific evaluation for the presence of trauma-related issues in the development of treatment plans that may include intrusive procedures.
- ◆ Licensing rules are being developed to bring all services regulated by BDS into a common level of compliance. Included in these rules are assessment standards that require steps to identify both the presence of trauma and any self-soothing or self-calming techniques developed by the person receiving services. The rules further require that treatment plans recognize and support these techniques.

Massachusetts:

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- ◆ DMH Regulations effective January 1, 1998, require that all inpatients be asked about trauma history, that this information be considered in the use of restraint, 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. Accompanied by clinical guidelines.
 - ◆ The Child and Adolescent Restraint Reduction Initiative (Sept. 2000 – present) includes all acute (licensed), continuing care (state-operated and contracted), and intensive residential treatment programs serving children and adolescents in Massachusetts. Regulations to eliminate the use of restraint for children under the age of 10 and to increase trauma-sensitive training requirements are under development as part of the initiative.

New Hampshire:

- ◆ 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.

9. Research, surveys, needs assessments regarding trauma used for planning

California (Los Angeles):

- ◆ A five-year NIDA-funded UCLA Integrated Substance Abuse Program dual diagnosis treatment outcome study that evaluates the delivery of public sector mental health and substance abuse treatment services within Los Angeles County delivered to individuals with both severe mental illness and substance use disorders. Extensive assessments of demographic and background data, level of functioning, psychiatric and drug treatment histories, drug and mental health treatment services received, substance use and psychiatric family histories, criminal activities, risky sexual behaviors, trauma symptoms, trauma exposure and PTSD and other Axis I diagnoses assessed with the SCID for the DSM-IV. Participants were 400 men and women (age 18 or older) consecutively recruited from 11 residential drug treatment programs and also either receiving or seeking mental health services from outpatient mental health programs in Los Angeles County. Study found 60% of sample experienced five or more different types of exposures to traumatic events at some time in their lives. Article “Perceived Need for Treatment Services Among the Dually Diagnosed In Drug Treatment With and Without Posttraumatic Stress Disorder” by Leslie Cooper, Christine E. Grella, and Lisa Greenwell is under submission for publication.

Connecticut:

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- ◆ Through the DMHAS Research Division and in collaboration with the University of Connecticut Health Center Department of Psychiatry, the following ongoing projects guide Department thinking about how to approach trauma treatment:
 - Clinical Feasibility Study: Consultation with teams of front-line clinicians interested in trauma-related services from two community mental health agencies and three community substance abuse treatment agencies led to the successful adaptation, pilot testing for clinical feasibility, and refinement of a manualized treatment model (TARGET) over a 12-month period (Ford, 1999). Target Manual.
 - Assessment Study: Funded by DMHAS and the University of Connecticut Health Center, this study involves an intensive interview assessment of trauma history, PTSD, disorders of extreme stress, other psychiatric, addictive, and medical illnesses, resilience and positive adaptation, and health care utilization in women and men in community mental health treatment for severe and persistent mental illness (including hearing impaired, Spanish-speaking, and African American clients). Results used to assist in determining criteria for the selection of trauma treatment models. Article available.
 - Randomized Controlled Trial: A three-year SAMHSA-funded randomized controlled trial of the TARGET treatment model versus trauma sensitive usual care is ongoing in three outpatient substance abuse treatment facilities. Article available.

Illinois (Chicago):

- ◆ The Domestic Violence Mental Health Policy Initiative conducted a needs assessment with 16 domestic violence agencies and 55 community mental health and social service agencies (47% return rate) re: trauma and domestic violence. Eighteen agencies (9 OMH-funded) completed a baseline trauma self-assessment as part of an ongoing evaluation of an Intensive Trauma Training and Implementation Program to address adult and child trauma in the context of domestic violence.

Maine:

- ◆ Trauma Cost Study Using Medicaid Claims Data from 1996 to 2001 on 1,397 Class Members (past and present consumers at Augusta Mental Health Institute). Projected Completion of findings: fall, 2002. Study in collaboration with Nathan Kline Institute. Report on methodology and preliminary findings available.
- ◆ Trauma Advisory Groups Needs Assessment of Survivors and Professionals: Written description of process and focus group question.

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- ◆ *In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps, and What Is Needed for Trauma Services.* (1997). Report on Trauma Advisory Groups findings.
 - ◆ Survey of Maine Mental Health Service Providers regarding Trauma Training and Service Needs: Questionnaire.
 - ◆ *Maine Mental Health Services Provider Survey Report: Trauma Training and Service Needs.* (1997).

New Hampshire:

- ◆ New Hampshire Dartmouth Psychiatric Research Center (PRC) is piloting programs and conducting trials at the state psychiatric hospital to improve recognition and treatment of trauma and post-traumatic disorders.
- ◆ At New Hampshire Hospital, testing the use of computerized assessment to screen for trauma exposure and PTSD in acute admissions, and providing psycho-education and triage for those with post-traumatic symptoms.
- ◆ At multiple regional mental health centers, conducting a randomized clinical trial of an individual. Twelve to sixteen-session cognitive-behavioral treatment for PTSD for people with another severe mental illness.
- ◆ At one regional mental health center, conducting a pilot study of a 21-session, group-based, cognitive-behavioral intervention for symptoms of PTSD in clients with severe mental illness.

Pennsylvania (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. 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. Final Report available from Women's Law Project.

South Carolina:

- ◆ Survey of adequacy of assessment and clinical services in SCDMH centers and hospitals: Summary of findings.
- ◆ Survey of clinician training needs and summary of findings.
- ◆ Pilot study of Trauma in the Psychiatric Setting and summary of findings.
- ◆ Study of trauma history and PTSD diagnosis from intake, summary of findings.

10. Financing mechanisms to pay for trauma services

Connecticut:

- ◆ Providers bill third party payers for group trauma treatment as they would for other services.

Maryland:

- ◆ Fee for Service system includes treatment of trauma as a medical necessity.

Rhode Island:

- ◆ Insurance companies pay for clinical services such as EMDR, DBT, treatment of Posttraumatic Stress Disorder.

Wyoming:

- ◆ Financing process is liberal and flexible; covers individual and group trauma treatments.

11. Consumer trauma survivor involvement in all aspects of planning, evaluation and delivery of trauma services

Connecticut:

- ◆ Along with clinical training, each of the 25 state-operated and private non-profit mental health and addiction treatment agencies participate in a training presented by consumers and based on a film developed by the Department entitled *No More Secrets*. Videotape and guidebook are available.

Maine:

- ◆ Consumer/trauma survivor staff of Department's Office of Consumer Affairs are members of the Department Trauma Services Implementation Team, responsible for trauma planning and implementing as well as overseeing the delivery and evaluation of trauma services. Described in *A Plan for Improving Behavioral Health Services for Persons with Histories of Trauma* and in two Updates.

Maryland:

- ◆ Consumers are consulted during all aspects of planning, evaluation, and delivering trauma services for every project developed within the Mental Hygiene Administration. The Division of Special Populations has developed a position, Director of Advocacy Services, that oversees development of peer support groups as well as the TAMAR Advocates Board, a group of consumers who meet monthly to discuss the delivery of trauma informed services. Description documents available.

Rhode Island:

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- ◆ Coalition for Abuse Recognition and Recovery (CARR)—a group of consumers and professionals—designed a system of care for Kent County MHC, established criteria for consumer friendly programs, and performed community education and training on trauma issues. Trauma survivors serve on Kent County MHC Board of Directors. Written documents available.

South Carolina:

- ◆ The DMH Trauma Initiative committee is co-chaired by the Director of the Office of Consumer & Family Affairs, with 5 Consumer Affairs Coordinators on the committee. Consumer speakers conduct sensitivity training at state facilities and mental health centers. Description of work available.

Wisconsin:

- ◆ 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.

12. Culturally, racially, and ethnically relevant trauma policies and services

Connecticut:

- ◆ Trauma policy addresses cultural issues.
- ◆ Three-day training offered one time per year to address cultural issues in treatment of trauma. Brochure.
- ◆ Training film being developed on trauma/culture. Video will be available by 2003.
- ◆ All trauma planning, policy, and training is reviewed by the Office of Multicultural Affairs. Policy description.

Maryland:

- ◆ Any policy or service that is developed is reviewed by Mental Hygiene Administration’s Coordinator of Multi-Cultural Affairs to ensure the product’s cultural competency. Policy description.
- ◆ A 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.

13. Systems integration/coordination between and among systems of care serving trauma survivors and including life-span perspective

Illinois:

- ◆ Chicago Domestic Violence Mental Health Policy Initiative (DVMHPI) facilitates ongoing cross-training between domestic violence and mental health agencies, and has conducted a cross-training conference on Domestic Violence, Lifetime Trauma and Mental Health: Addressing the Mental Health Needs of Domestic Violence Survivors and their Children, November 2001. DVMHPI is currently cross-training nine Domestic Violence and nine Mental Health agencies in Risking Connection, Trauma Recovery Empowerment Model (TREM), Trauma Recovery Empowerment Profile (TREP) client rating sheet, Trauma Informed Systems (Community Connections), and Shelter From the Storm (a curriculum for treating children exposed to violence, developed by Betsy McAlister Groves at Boston University). Additional cross-trainings planned for 2002-2003 include Creating Sanctuary; Domestic Violence, Mental Health Trauma and the Law; Addressing Issues of Culture, Community and Spirituality.

Massachusetts:

- ◆ WELL project (Women and Co-occurring Disorders and Violence grant awarded to IHR) state leadership council (including DMH) is developing recommendations for integrating systems of care across state agencies for trauma survivors with co-occurring mental health and substance abuse disorders

Minnesota:

- ◆ Ananda Project/Dialectical Behavior Therapy: for multi-diagnosed, difficult-to-treat clients, usually with histories of severe trauma; used to treat clients who are demonstrating out-of-control behaviors that interfere with standard treatments for individuals with trauma histories. Intensively trained team that teaches and consults with both state-operated and community-based agencies to treat clients with Borderline Personality Disorder and other trauma-related disorders within their home counties/cities. Service delivery plan and updated work plan now available.

Vermont:

- ◆ Vermont Agency of Human Services: Trauma Policy Cluster, a multi-department and multi-discipline approach to implementing Year 2000 Vermont Legislative Commission on Psychological Trauma recommendations. Based on criteria outlined by Maxine Harris and Roger Fallot in monograph Using Trauma Theory to Design Service Systems (New Directions for Mental Health Services #89, Spring 2001). A Policy Cluster approach to providing services is being implemented by AHS among department leaders in order to integrate multi-departmental responses and break down barriers so they can map out unified, coherent strategies for

individuals and families in trouble
(www.ahs.state.vt.us/PolicyClusters/Trauma020507update.cfm).

Wisconsin:

- ◆ Bureau of Community Mental Health Cross Trauma Training with mental health, substance abuse, domestic violence and sexual assault organizations. Crossroads Cross Training Manual, 1999 Crossroads Conference Proceedings, and video Meeting at the Crossroads.
- ◆ Cross-systems training using the Risking Connections model with Substance Abuse, Mental Health, Developmental Disabilities Network, Sexual Assault Coalition, Lutheran Social Services, and the Department of Corrections.

14. Disaster planning and response (including response to terrorism) is trauma informed

Connecticut:

- ◆ Center for Trauma Response, Recovery, and Preparedness (CTRP) is joint project of DMHAS, UConn Health Center Department of Psychiatry and Yale Department of Psychiatry. Statewide training and development of behavioral health response infrastructure. www.CTRP.org

Rhode Island:

- ◆ Kent County Mental Health Center services to school children around issues of trauma and terrorism through United We Stand Grant. Numerous community presentations after September 11th about trauma and its relationship to terrorism. Descriptive documents available.

Other Available Resources

State Publications, Newsletters, Web Sites Addressing Trauma

Connecticut:

- ◆ Trauma Matters: Newsletter to keep the behavioral health community, trauma survivors, and other interested persons informed about current efforts to address trauma as a public health issue. Produced by the Connecticut Women's Consortium and the Connecticut Department of Mental Health and Addiction Services in support of the Connecticut Trauma Initiative.
- ◆ Trauma Matters Web site includes information on Trauma Initiative and bulletin board Q&A for clinical staff who can pose questions to Lisa Najavits, Julian Ford, and Maxine Harris. www.traumamatters.org
- ◆ Training Videotape and guidebook, *No More Secrets*.
- ◆ *From the Heart: Women Speak Out About Trauma*. (2001). DVD.

Illinois:

- ◆ Domestic Violence Mental Health Policy Initiative quarterly newsletter.
- ◆ Forthcoming working papers (print and Web-based):
 - *Recommendations for Addressing Domestic Violence in Mental Health Settings*
 - *Mental Health and Domestic Violence: Collaborative Initiatives, Service Models and Curricula*
 - *Report on Mental Health Issues and Service Needs in Chicago Area Domestic Violence Advocacy Programs*
 - *Domestic Violence, Trauma and Mental Health: Developing Collaborative Responses, Domestic Violence, Trauma and Mental Health: Critical issues for Public Policy*

Maine:

- ◆ *Break the Silence, Support the Healing: What Happens To Abused Children When They Grow Up?* (1999). Public Education pamphlet.
- ◆ *What Happens to Abused Children When They Grow Up – If No One Notices, Listens or Helps? Some Statistics from the Research*. (2001).
- ◆ *In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps, and What Is Needed For Trauma Services*. (1997). Book.

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- ◆ Community Retraumatization. (1997).
 - ◆ Trauma and Recovery Resource: Books Recommended by Survivors for Survivors: An Annotated Bibliography. (1997).
 - ◆ Trauma Referral, Training, Consultation: Resource Book. (May, 1999). Book.

New York:

- ◆ Office of Mental Health Trauma Newsletter.

Oregon:

- ◆ Listening to High Utilizers of Mental Health Services: Recognizing, Responding to and Recovering from Trauma. By Lyn Blackshaw, Ph.D., Andrea Levy, M.A., L.P.C., Janice Perciano, B.S., State of Oregon Mental Health and Developmental Disability Services Division (2/1999). This 114-page report recommends a map of safe options model of treatment and support for survivors of severe childhood and adult trauma.

South Carolina:

- ◆ The South Carolina Department of Mental Health Trauma Initiative Newsletter: A publication of the Trauma Initiative Task Force.

Vermont:

- ◆ Integrated Responses to Complex Problems: Trauma Policy Cluster. A Web site of Vermont Agency of Human Services: www.ahs.state.vt.us/PolicyClusters/

Wisconsin:

- ◆ Networking Exchange Web site: A consumer-run Web site facilitating communication between providers and consumers, and between consumers and consumers. Addresses trauma, substance abuse, and mental health issues. www.networkingxchange.advoc8.com

State System Progress Reports and Planning Documents Addressing Trauma

Connecticut:

- ◆ Summary of Trauma Initiative, March 28, 2002
- ◆ Preferred Practices Guidelines for Treatment of Trauma

Maine:

- ◆ A Plan for Improving Behavioral Health Services for Persons with Histories of Trauma, August 2001: Includes historical background, accomplishments, next steps and future activities, with objectives, action steps, timing and

budget. Two Updates to the Field have been distributed describing progress made.

Maryland:

- ◆ Mental Hygiene Administration's Annual State Mental Health Plan FY 2001, FY 2002 and FY 2003 objectives all address using State funds to implement and expand trauma treatment programs in correctional facilities and their surrounding communities.

New Hampshire:

- ◆ New Hampshire State Mental Health Plan: Goal 1–3 stipulates recognition through practice that the experience of trauma is common in the lives of people served within the public mental health system, and outlines objectives which address trauma assessment, best practices, staff and peer education in trauma, and minimization of traumatizing restrictive/coercive measures.

Rhode Island:

- ◆ Kent County Mental Health Center Strategic Plan and operational goals specifically address trauma issues.

South Carolina

- ◆ Department of Mental Health Trauma Initiative Progress Report: 6/20/02: Includes mission, committee description, trauma definitions, progress to date, timeline, research summaries, and attachments of newsletters, conference brochure, assessment instruments and DMH Community Plan excerpts.
- ◆ Making Recovery Real: A Planning Document for the South Carolina Department of Mental Health: Includes goals and implementation plan for improved screening and diagnostic practices to appropriately identify and treat trauma-related symptomatology in children, adolescents and their families; includes goals and implementation plans to improve understanding of the relationship between trauma and mental health, and to improve services to address trauma issues for adults with trauma histories.

Vermont:

- ◆ Report of The Commission On Psychological Trauma to the Vermont House and Senate Committees on Health and Welfare: Impact on Vermont citizens and Recommendations for Public Policy (November 2000).

Wisconsin:

- ◆ Wisconsin Workgroup on Trauma's Draft Recommendations to Bureau of Community Mental Health.

Wyoming:

- ◆ Sensitivity to trauma is imbedded in system of care plans including suicide prevention and programs that address community trauma

Publication Contacts

If you are interested in obtaining more information about the underlined documents listed in Appendix A of this document, contact the appropriate official from the following state offices.

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**Appendix B:
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**National Experts Meeting on Trauma and Violence
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