UNCLAIMED CHILDREN REVISITED
Working Paper No. 2

# Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma

Janice L. Cooper ▪ Rachel Masi ▪ Sarah Dababnah
Yumiko Aratani ▪ Jane Knitzer

July 2007

NCCP National Center for Children *in* Poverty
Columbia University
MAILMAN SCHOOL OF PUBLIC HEALTH

**The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.**

# Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma

by Janice L. Cooper, Rachel Masi, Sarah Dababnah, Yumiko Aratani, and Jane Knitzer

This report reviews current policies and practices to support children, youth, and families exposed to trauma and highlights reasons for optimism and concern. Trauma-informed policy needs to balance current knowledge about effective practices with supportive financing, cross-system collaboration and training, accountability, and infrastructure development.

AUTHORS

Janice L. Cooper, Ph.D., is Director of Child Health and Mental Health at NCCP and Assistant Clinical Professor, Health Policy and Management at Columbia University Mailman School of Public Health. Dr. Cooper directs *Unclaimed Children Revisited*, a series of policy and impact analyses of mental health services for children, adolescents, and their families.

Rachel Masi, B.A., is a Research Assistant for Children's Mental Health at NCCP. Ms. Masi organized the meeting: *Strengthening Federal, Tribal, State and Local Policies for Children, Youth and Families Who Experience Trauma*.

Sarah Dababnah, M.P.H., is Project Coordinator for *Unclaimed Children Revisited: California Case Study* at NCCP.

Yumiko Aratani, Ph.D., is a Post-doctoral Research Scientist for Children's Mental Health at NCCP. Dr. Aratani is the lead data analyst for *Unclaimed Children Revisited*.

Jane Knitzer, Ed.D., is NCCP's Executive Director and Clinical Professor of Population and Family Health at Columbia University's Mailman School of Public Health. She has contributed many important studies on how public policies can promote the healthy development of low-income children and better support families, particularly those who are most vulnerable.

CONTRIBUTORS

Shannon CrossBear provided significant guidance to the project. Ms. CrossBear is Co-Director of Training and Evaluation at the Federation of Families for Children's Mental Health and a member of Fort William First Nation, Lake Superior Ojibwe. Rachel Masi, Parsa Sajid, Marie Zimler Wu, Sarah Dababnah and Janice L. Cooper wrote the case studies. Joey Coyle provided research assistance and interviewed participants for the Medicine Moon Initiative. Yumiko Aratani and Janice Cooper compiled the charts of state-by-state trauma policy initiatives.

ACKNOWLEDGMENTS

NCCP benefited from the wisdom and expertise of many in the fields of children's mental health, trauma, and prevention sciences. Leaders and staff of the initiatives featured and several of our colleagues, contributed to this report. We gratefully acknowledge assistance from Mary Compo, Tim Gawron, Deborah Painte, Jay Yoe, and Julie Young. In addition, we thank all of our respondents whose names are included in Appendix B. We especially thank Robert Franks, Director, Connecticut Center for Effective Practices, and Mareasa Isaacs, Senior Consultant to *Unclaimed Children Revisited* who contributed to this project. Julie Wilson of the Kennedy School of Government at Harvard University provided sound advice and support on conducting the case studies. Without Patrick McCarthy and Abel Ortiz at the Annie E. Casey Foundation, this project would not have been possible. We are also grateful to Telly Valdellon and Carole Oshinsky who provided research assistance, production help, and editorial support. Michael Soward, Juan Carlos Abreu, Lilliana Ortiz, and Susan McMahon provided administrative support. All errors and omissions remain the responsibility of the authors.

Copyright © 2007 by the National Center for Children in Poverty

# Table of Contents


**EXECUTIVE SUMMARY** . . . . . 1

**FOREWORD: CONTRIBUTIONS FROM TRAUMA SURVIVORS** . . . . . 3

Reflections from a Sister in Sorrow . . . . . 3

One Youth's Take on Trauma in Juvenile Justice . . . . . 4

**INTRODUCTION** . . . . . 6

**SECTION 1: UNDERSTANDING TRAUMA AND ITS EFFECT** . . . . . 7

Trauma is Pervasive . . . . . 7

Children and Youth Who are Disproportionately At-Risk . . . . 7

Children and Youth Who Survive Abuse, Neglect and Sexual Violence . . . . . 7

Children and Youth in Juvenile Justice . . . . . 9

Children and Youth at Risk of Suicide . . . . . 9

Children and Youth Affected by Natural and Man-Made Disasters . . . . . 10

Children and Youth Exposed to Chronic Urban Trauma . . 10

Children and Youth with Substance Use Disorders . . . . . 11

Impact of Trauma is Long-lasting and Varied . . . . . 11

**SECTION 2: INADEQUACIES OF CURRENT SERVICE AND POLICY RESPONSES** . . . . . 12

Missed Opportunities for Trauma-Informed Services Common at Community Level . . . . . 12

Empirically-Supported Practice Lacks Traction . . . . . 12

Practices That Retraumatize Children . . . . . 13

Seclusion and Restraint . . . . . 13

Boot Camps . . . . . 13

Staff or Peer Abuse . . . . . 13

Unrelated Policies Affect the Trauma Experience . . . . . 14

Immigration Policy . . . . . 14

Housing Policy . . . . . 15

Inadequate Response to Unexpected Disasters . . . . . 15

Current Responses are Costly . . . . . 16

**SECTION 3: EMERGING BEST PRACTICES** . . . . . 17

Core Components of Trauma-informed Care . . . . . 17

Standardized Screening and Assessments . . . . . 17

Evidence-Based Interventions . . . . . 20

Culturally-Based Strategies . . . . . 20

Family and Youth Engagement and Support . . . . . 22

Early Identification and Intervention . . . . . 22

Examples of Early Childhood Interventions . . . . . 23

Organization/Program Capacity . . . . . 23

Building a Skilled Workforce . . . . . 24

Strategies to Strengthen Local Capacity to Respond to Disasters . . . . . 25

The Resiliency Program and Operation Assist . . . . . 25

Trauma-Informed Practices Across Settings and Ages . . . . . 25

School-based Strategies . . . . . 25

An Urban School District . . . . . 25

A School-Based Health Clinic . . . . . 25

Community-Based Systems of Care . . . . . 27

A Multi-tribal Strategy . . . . . 27

A Regional Strategy . . . . . 27

Public Systems . . . . . 28

**SECTION 4: POLICIES TO SUPPORT TRAUMA-INFORMED PRACTICE** . . . . . 29

State Policy Initiatives . . . . . 29

Targeted Legislation . . . . . 29

Illinois . . . . . 29

Massachusetts . . . . . 30

Sustaining Infrastructure . . . . . 31

Oklahoma . . . . . 31

Reducing Harmful Practices . . . . . 34

Seclusion and Restraint . . . . . 34

Improving Early Identification and Treatment . . . . . 34

The Federal Role . . . . . 35

Legislative Initiatives . . . . . 35

Suicide Prevention . . . . . 35

National Child Traumatic Stress Network . . . . . 35

Traditional Healing . . . . . 36

Targeted Initiatives . . . . . 36

Eliminating Seclusions and Restraints . . . . . 36

National Child Traumatic Stress Network Initiatives . . . . . 36

Supporting Trauma-Informed Care Through Fiscal Policy . 36

Unaddressed Challenges . . . . . 37

Lack of Coherent Strategic Plans . . . . . 37

Funding Restrictions Impede Care and Sustainability . . . . . 38

Limited Support for Prevention and Early Intervention . . . 39

Inadequate Workforce Supply and Quality . . . . . 39

**SECTION 5: TOWARD THE FUTURE: WHAT CAN BE DONE?** . . . . . 42

Recommendations . . . . . 43

Making Trauma-Informed Practices Happen . . . . . 43

**ENDNOTES** . . . . . 45

**SECTION 6: CASE STUDIES** . . . . . 54

**Case Study #1**
**School-Based Health Center: The North Country Children's Clinic, New York** . . . . . **55**

Program History. . . . . 55

Program Components . . . . . 56

Program Successes . . . . . 57

Positive School Relations . . . . . 57

Collaboration with the Military HMO . . . . . 58

Outstanding Challenges . . . . . 59

Military Reimbursement for Physical Health Care . . . . . 59

Sustainable Program Funding. . . . . 59

Capacity to Meet Needs . . . . . 59

Filling Gaps in Continuum of Care . . . . . 60

Looking to the Future . . . . . 60

**Case Study #2**
**Tribal Initiative: Turtle Mountain Sacred Child Program and the Medicine Moon Initiative, North Dakota** . . . . . **61**

Program History. . . . . 61

Program Components . . . . . 63

Program Successes . . . . . 64

Program Challenges . . . . . 64

Lessons Learned . . . . . 65

**Case Study #3**
**System of Care—THRIVE: Trauma-Informed System of Care Initiative, Maine** . . . . . **66**

Program History. . . . . 66

Program Components . . . . . 66

Program Successes . . . . . 67

Program Challenges . . . . . 70

Lessons Learned . . . . . 70

Looking to the Future . . . . . 70

**Case Study #4**
**Disseminating Trauma-Informed Best Practice: Promoting Trauma-Informed Practices, National and State Initiatives** . . . . . **71**

National Models—National Child Traumatic Stress Network . . 71

Program Components . . . . . 71

Program Successes . . . . . 72

State-Level Efforts—Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET), Connecticut . . . . . 72

Program Components . . . . . 73

Program Successes . . . . . 73

Lessons Learned . . . . . 73

Response to Disaster—The Resiliency Program, New York, and Operation Assist, Mississippi and Louisiana. . . . . 74

Program Components . . . . . 74

Program Successes . . . . . 74

Looking to the Future . . . . . 75

Evidence-Based Practices in Juvenile Justice—Multisystemic Therapy (MST) in Connecticut . . . . . 75

Program Components . . . . . 75

Program Successes . . . . . 76

**APPENDICES**

Appendix A:

Table 1: Trauma-Informed Specific Services in the States . . . . . 77

Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States. . . . . 84

Appendix B: Meeting Participants . . . . . 96

Appendix C: Case Study Participants . . . . . 97

# Executive Summary

Policy responses to children, youth, and families who experience trauma remain deficient. Often reactive, they lack intentionality, long-range strategic planning, and system wide application. Further, they rarely reflect the on-the-ground realities of trauma in communities in the United States.

Trauma is pervasive among children, youth, and families in the United States, particularly for children and youth involved in public systems. Trauma exposure among children and youth is associated with lifelong health, mental health, and related problems and with increased related costs. The impact of trauma exposure can be mitigated by developing a care delivery and support system that is trauma-informed, prevention oriented, and focused on improving mental health functioning for children, youth, and their families.

This report documents critical considerations in strengthening policies to support trauma-informed practice. It reviews current policies and practices to support children, youth, and families exposed to trauma. A range of strategies were used to gather the information, including an extensive literature review, a meeting of policy and practice experts, and several case studies.

The review reveals both reasons for optimism and concern in building a trauma-responsive system. Several gaps are highlighted. First, current policy and practice responses do not match in urgency, depth, or quality the epidemic levels of trauma symptoms among children and youth in general and in selected populations. In particular, children and youth of color, sexual minority youth, and youth at increased risk for suicide have higher rates of trauma. Exposure to trauma is particularly high in certain settings, especially those that involve the mental health, child welfare, and juvenile justice systems. Second, much of the emerging and important knowledge base about trauma, how to intervene, and how to prevent further harms to children and youth, especially young children, are largely absent in current children's mental health and related policies. Third, some policies serve to undermine tribal, state and local efforts to develop and sustain trauma informed practices.

Some states, tribes, and communities have made strides toward developing and sustaining trauma-informed care. However, supportive policies remain the exception in most communities. An invigorated federal role, combined with trauma-informed policies at the tribal and state levels, can result in improved health, mental health, and related outcomes for children, youth, and families exposed to trauma.

Reconciling the balance between current knowledge about effective practices and implementation of a trauma-informed framework requires a set of coherent trauma-responsive policies. These policies must include supportive financing, cross-system collaboration and training, accountability, and infrastructure development.

## Key Recommendations

- **All federal, tribal, state, and local policies should reflect a trauma-informed perspective. A trauma-informed response encompasses a fundamental understanding of trauma and how it shapes an individual who has experienced it.**
  - Policies should support delivery systems that identify and implement strategies to prevent trauma, increase capacity for early identification and intervention, and provide comprehensive treatment.
  - Policies should support and require that strategies are designed to prevent and eliminate treatment practices that cause trauma or retraumatization.
  - Policies should reinforce the core components of best practices in trauma-informed care: prevention, developmentally-appropriate effective strategies, cultural and linguistic competence, and family and youth engagement.
- **Policy and practice reflective of trauma-informed principles must be developmentally-appropriate, based on a public health framework, and engage children, youth, and their families in healing.**
  - Policies should focus on prevention of trauma and developing strategies to identify and intervene

early for children, youth, and their families exposed to trauma or at-risk of exposure to trauma.

- Policies should focus on enhancing child, youth, and family engagement strategies to support informed trauma care delivery.
- Policies should support strategies that encompass family-based approaches to trauma intervention.

- **Trauma-informed and related policies must include responsive financing, cross-system collaboration and training, accountability, and infrastructure development.**
  - Policies should ensure that funding is supportive of trauma-informed care and based upon sound fiscal strategies.
  - Policies should make funding contingent upon eliminating harmful practices that cause trauma and retraumatization across child serving settings.
  - Policies should support comprehensive workforce investment strategies.

# Foreword: Contributions from Trauma Survivors

**Individual children, youth and families lie at the core of the health and social service delivery system. They are behind the headlines and statistics on trauma. This report begins with two personal stories on the meaning of trauma and how trauma affects families. The first, "Reflections from a Sister in Sorrow," takes the form of a letter to a fellow grandmother who also experienced the loss of a child through suicide. The second presentation uses an interview format to reveal a young man changed by his years in the juvenile justice system.**

## Reflections from a Sister in Sorrow

—Shannon CrossBear

*Recently one of my native sisters, who, like me, experienced the devastating impact of trauma with the loss of a son to suicide, was expecting a new grandchild. As sisters in sorrow, we support and encourage each other on our collective path to healing. I am sharing the words I shared with her because I think it speaks to the critical nature of the work we need to accomplish.*

### To the New Ones Coming

Wow, a new grandbaby on the way. It is our hope for the future that things are done in a good way for these little ones. We have to arm them all with shields of protective factors, so the arrows of life do not defeat them. There are so many battles in Indian Country, so much current trauma coupled with historical trauma that it is sometimes hard to feel like we are advancing. Before we can defeat the outside "enemy", we must first come to terms with the nature of our collective human condition. Our traditions, ceremonies, and language give us a framework in which to live our lives in a good way and to create a strong defense that cannot be penetrated by those things that might intentionally or unintentionally bring harm to the people. There are many battles being fought every day over land, over protecting the sacred waters, over the protection of all our relatives. The battle rages over the reclamation of our children and the greed, graft and corruption that has seeped into some of our own tribes. These are born out of desperation and generations of denial of the depth of trauma and its impact. Our battlefields are littered with our diseased, dying and dead. The physical illness causes include diabetes, kidney failure, infant mortality and suicide. The emotional conditions encompass alcoholism, chemical dependency, violence, and unresolved trauma. The mental health disorders range from thought disorders, fetal alcohol affect, depression and post-traumatic stressors. Other contributors are inferior education and conflicting values. Spiritual assaults also accrue including cultural annihilation, destruction of our life-giving earth, our waters, and even our children.

As bleak as these spoken words may be, as dark as the night might be, we have a way. It is not written up as evidence-based practice. It is not quantified and many times cannot and should not be replicated. It is more complex than all the words in all the manuals ever written, and it is as individual as a single blade of grass in an abundant prairie. It is in recognizing the strengths we have as a people. It requires us to be grateful to the fallen warriors along the way, to the ancestors who shared as many of our traditions and beliefs as they could. They helped guide us so that we could make a choice to honor and practice these gifts that were given to build resiliency. We can build a strong shield through the seven grandfathers' teachings: love, honesty, humility, courage, respect, trust and wisdom. Through the wisdom embedded in the teachings about how to live in a good way, be on the sweet grass path, the blessing way, we can reclaim our children. We can demonstrate and teach tolerance. We can act in a way that shows we understand that the mending of the sacred hoop of life requires inclusion of all the collective knowledge, skills and talents to survive and thrive. Some may say that is

not concrete enough, that we must know, beyond the words, the stories, the songs, and the ceremonies. That may be, but it is what we bring to the table of truth. We aim to honor all life, to bring into practice, promote policy, and create conditions which support the building of a bridge that will bring our children safely to the future. We have made progress along the way and there are sprouting seeds of hope among many.

Many children know who they are. Many children are learning respect for others based on respect for self. Children, who have the commitment of their elders to ensure that they are not denied opportunities for guidance. There are other children being born who do not have these things and they will be lost. They will wander without purpose or understanding. They will perish in the apathy that surrounds them.

We are all fallible human beings on our own path of healing, so we must be gentle with and strong for each other, at the same time. It is in reclaiming ourselves, joining our collective strengths and determination that we will ultimately reclaim the children. Whether the battlefield is within our nations, within our neighborhoods, within our families, or within ourselves, we can commit to reclaiming the children. We can say to this new one, we recognize the sacred nature of your life, we will honor that and contribute in the best way we can to a brighter future. We can help gather the materials for shields of protective factors and build resiliency to sustain ourselves and our children and grandchildren in this reclamation. When we become weary and suffer from battle fatigue, we can remind each other to rest but not retreat. It is the work we are called to do as warriors.

Shannon CrossBear is a member of Fort William First Nation, Lake Superior Ojibwe. Through her business, Strongheart Resource Development, she has consulted with the National Indian Child Welfare Association, Georgetown University, the Surgeon General's Conference on Children's Mental Health and the Aboriginal Healing Strategy. She has also worked with numerous national organizations. She is a member of the Executive Committee of the Mental Health Outcomes Roundtable for Children and Families supported by SAMHSA/CMHS and an advisor to *Unclaimed Children Revisited*.

## One Youth's Take on Trauma in Juvenile Justice

—Interview with Perry Jones

**Q: What is the "Beat Within"?**

**A:** *The Beat Within is a weekly youth-based publication that I edit. It serves as a vehicle for youth in juvenile justice facilities to voice their opinions on issues. It comes out of a creative writing program in juvenile justice facilities. I facilitate a writing program in juvenile hall. The writing program and its' products are therapeutic for young people. The publication is widely distributed throughout juvenile facilities in Northern California and has been used as far away as Louisiana and Arizona. Recently, a writing program modeled after the Beat Within began in Louisiana.*

**Q: What has it meant to you?**

**A:** *When I was in juvenile hall, I was one of the first writers for the Beat Within. David Ignatio, the program's founder was in CYA and he and the Beat Within helped me. Today, I enjoy working with the youth and telling them about my own experience. I like seeing them learn through their own writing.*

**Q: When did you enter the California Youth Authority (CYA)?**

**A:** *I entered CYA in January 1996.*

**Q: You have described CYA as "hell on earth." Why?**

**A:** *It is 'hell on earth' because you are completely isolated. You are in the middle of nowhere. Detached and dehumanized. It is like a dump site for youth. Overall, you are among some of the worst young people. You are surrounded 24-7 by a negative environment. You are in the midst of a state of unforgivingness. In my case, I was not able to see my mother for 5 years. My defiant nature, my insistence on speaking up for myself, my refusal to take medication meant that I was isolated and sent far from my family as punishment.*

**Q: What changed for you when you were in CYA?**

**A:** *Personally? I realized that I did have psychological problems and that I was a product of my environment. I understood that my problems frustrated me, confused me, made me behave in dysfunctional ways. Respond aggressively. Impulsively. I kept digging a deeper hole, then getting depressed. My change was self-initiated. I reached*

*outside to people who I knew before I came to CYA. They were my support. I turned the negative of being isolated to seeing what I was missing inside and the positive I had before coming here.*

**Q: You have been described as a survivor of the system. What did you survive?**

**A:** *I survived being misunderstood. Being mis-diagnosed. I survived a lot of providers who thought I needed to be medicated. A lot of people, some of my friends committed suicide, or fell into deeper psychopathology. I promised my mom I would not take medications. I suffered a lot to keep that promise. A lot of my friends killed themselves, some tried to. They reacted to the brutal, inhuman treatment.*

**Q: How would you reform CYA to be more trauma-sensitive?**

**A:** *I would have a consistent person to work with the youth especially those that are there for an extended period. There needs to be someone who understands trauma, understands the youth and their background. At times, youth receive news that someone has died by speaking with a relative at home. You may learn your best friend got shot. There is no one there to respond to the trauma or that can speak with you. I think of trauma like a bio-hazard that you need to treat individually and that you cannot let the person go until they are treated and their trauma is addressed.*

*There are many in the community that want to help CYA. There are good people in the community who want to donate their time and they are quality people. They may not have degrees, but they are from the community and can help.*

*When I was leaving CYA I read some of my evaluations, they were all so negative. There needs to be an appraisal system that focuses on the positive things that youth are doing, give them some strokes and credit. They need to learn from their mistakes, I did. I was lucky to have a psychiatrist who helped me learn from the negative things. He helped me identify the things I needed to work on.*

**Q: Today, you spend a lot of time in CYA, giving back. What has changed for youth currently in the system? What remains the same?**

**A:** *I have a cousin and a couple of my peers coming out. I can tell you things have gotten worse. Since CYA is under constant media and government scrutiny, there is a constant power struggle between the staff who do not think it's their job to create a "therapeutic" environment and the youth. This is a real opportunity to help youth. I always wanted to go to college. It would have been great to get the educational opportunities and skills to prepare me while I was in CYA to transition into the community and pursue my dreams.*

Perry Jones is a full time student at San Francisco State University majoring in Criminal Justice with a minor in Sociology. He is 25 years old. He spent 10 years in the California Youth Authority. He is on the Mayor of San Francisco's Youth Task Force and is involved in the California Coalition for Youth Relations' Roundtable Series on Children in Foster Care and Mental Health. He is also an advisor to NCCP's *Unclaimed Children Revisited: California Case Study*.

*I worry about our children. Most of them [are] doing better, but they are still very agitated and irritated. Many are depressed. Whenever it rains there is anxiety. When the tornado hit last week they were freaked out again.*

—Mental Health Leader in New Orleans

## Introduction

In 1982, Jane Knitzer's seminal study, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services,* called attention to the desperate state of the mental health system for children and adolescents with mental health problems and their families. The study became a turning point in the mental health field and led to a series of reforms. Twenty-five years later, the National Center for Children in Poverty (NCCP) has undertaken a national initiative to reexamine the status of policies that impact the optimal well-being of children and adolescents with or at increased risk for mental health problems and their families. As part of that initiative, NCCP convened roundtable discussions to help us better understand critical issues that deeply impact the lives of children, youth, and families experiencing mental health problems.

This report, the second of five special reports, is based on a forum convened by the National Center for Children in Poverty with support from the Annie E. Casey Foundation. The meeting brought together a cross-section of policymakers, researchers, community leaders, family members, youth, and practitioners in trauma-related areas. (See Appendix A.) The aims were to explore: (1) the current state of service delivery and supports for children, youth, and their families exposed to trauma; and (2) ways to advance a more coherent trauma-informed policy agenda, particularly through mental health agencies. In addition to the stakeholder meeting, two other methods were used to collect data: a literature review and interviews with key stakeholders involved with trauma-informed initiatives.

The report is organized into six sections. The foreword consists of contributions from two survivors of trauma, a parent and a young adult. Section 1 sets the context, highlighting both general prevalence data and what is known about specific populations. The second section describes the policy response. Section 3 defines the core components of trauma-informed practice, drawing on research findings and stakeholder advice. In Section 4, we provide examples of efforts to promote trauma-informed practice in communities. The fifth section sets forth recommendations for federal, tribal, and state governments. Section 6 includes case studies of trauma-informed policies in action. Appendix A lists the names of meeting participants. Appendix B includes a list of case study respondents. Appendix C contains two charts that list state-by-state information on trauma-informed services and infrastructure supports.

*Our institutions are in denial about trauma. One of those in most in denial is education. When I brought the issue to the Superintendent, the person with the highest level of authority to direct resources, he claimed it was outside of his purview.*

—Meeting participant

## SECTION 1
# Understanding Trauma and Its Effects

## Trauma is Pervasive

Trauma refers to the severe distress, harm, or suffering that results from overwhelming mental or emotional pain or physical injury. A core feature of the impact of trauma is the long- and short-term loss experienced by those exposed to traumatic events. Traumatized children and youth often sustain damage to critical elements of their development. Important assets such as healthy attachment, social and emotional competency, self-assurance, confidence and independence can be undermined as a result of trauma.[1] The impact of trauma can be profound at multiple levels, from the loss of physical integrity and a sense of safety, to alienation from friends and community because of shame, secrecy, or impaired development.[2] For children and youth who suffer trauma at the hands of a parent or caregiver, the emotional wounds can be even more severe and the impact of the assets lost even more devastating.[3]

Estimates vary on the proportion of children and adolescents who experience trauma—from 25 percent in the general population of children and youth to 90 percent for children and youth in specific child-serving systems and high-risk situations.[4] For example, studies show that up to 50 percent of children and youth in child welfare, 60-90 percent of youth in juvenile justice, and 83-91 percent of urban youth experience trauma.[5] In the mental health system, exposure to trauma ranges from 59 percent in an urban community mental health clinic to 63-91 percent in a suburban hospital-based outpatient clinic.[6] Youth with a history of trauma in inpatient mental health settings make up between 42 and 93 percent of youth hospitalized for psychiatric conditions.[7] While trauma cuts across class and race, low-income children and families and children and families of color disproportionately experience trauma.[8]

### Children and Youth Who are Disproportionately At-Risk

Some populations and groups have rates of exposure to trauma that are often dramatically higher than the general population of children.

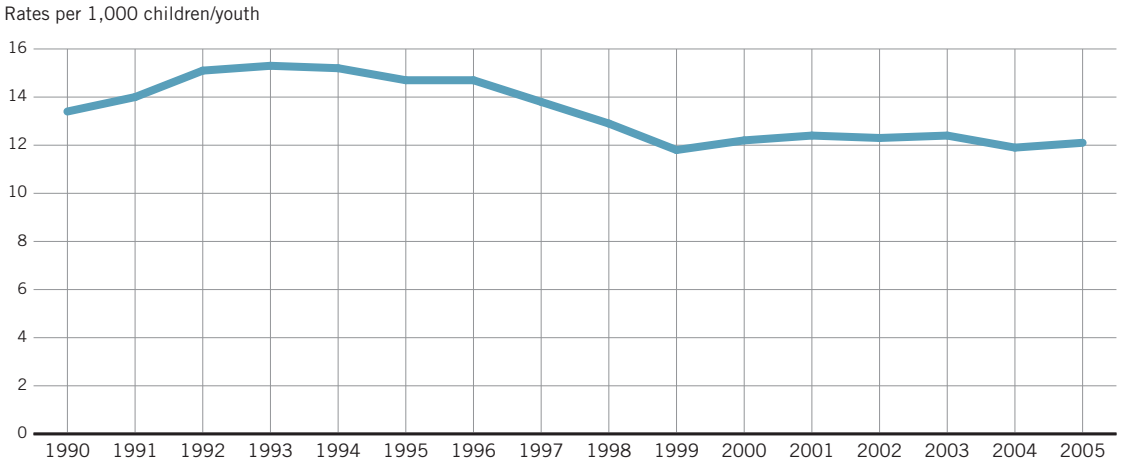
#### *Children and Youth Who Survive Abuse, Neglect and Sexual Violence*

By definition, children and youth who enter the child welfare system are among the most vulnerable. A state study of children and youth receiving child welfare case management services in Maine shows that one-third of females and more than two-thirds of males have a trauma-related diagnosis or are involved in child welfare as a result of a traumatic event.[9]

Nationally, child maltreatment rates have hovered between 11.8 and 15.3 per 1000 children for the last decade and a half. (See Figure 1.) An estimated 899,000 children and youth are victims of maltreatment, reportedly a gross underestimation of the actual rate of child abuse and neglect.[10] The majority of child abuse cases are cases of neglect (62.8 percent in 2005).[11] However, at least one-third of the victims of child maltreatment are sexually, psychologically, or physically abused.[12]

Fully half of female survivors of rape and 70 percent of male survivors of rape are raped before their 18th birthday.[13] More than a fifth of women and nearly half of men who are raped are under age 12 at the time of

**Figure 1: Child maltreatment rates, 1990-2005**



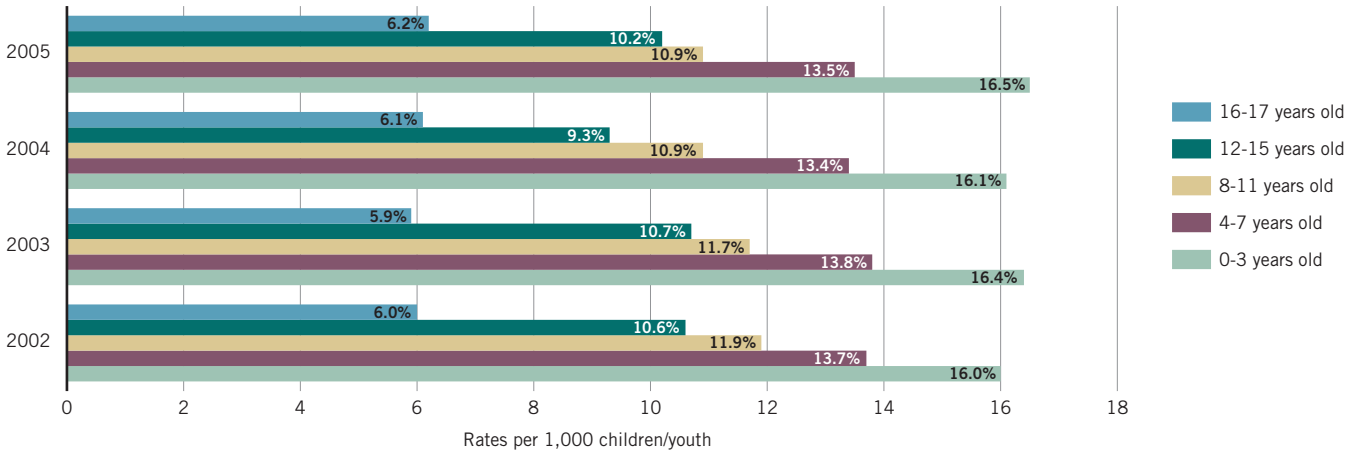

Source: Administration for Children and Families (2006).

the trauma.[14] Most victims of child abuse and neglect are under 5 years old. Since 2000, the proportion of very young children who are victims of child abuse and neglect has remained steady. (See Figure 2.)

Children and youth with disabilities, including behavioral disorders, are at increased risk for maltreatment.

- Disabled children and youth were more likely to be physically (1.5 times) and sexually abused (2.2 times) and to experience longer periods of abuse than their nondisabled peers.[15]
- Children and youth with communication-related disabilities are at an higher risk for maltreatment than other children and youth with disabilities (except those with behavioral disorders) and than nondisabled children and youth.[16]
- Children and youth who are deaf and hearing impaired experience significantly higher rates of neglect, physical abuse, and sexual abuse than non-disabled children and youth and children and youth with other communications disorders and learning disabilities.[17]
- Ample evidence also points to the high cost of trauma experienced by children and youth, especially very young children. Nearly 80 percent of child fatalities due to maltreatment involved children under age 4.[18]

**Figure 2: Child maltreatment rates for children and youth by age, 2002-2005**




Source: Administration for Children and Families (2006).

Youth of color and homeless and runaway youth are especially vulnerable to child maltreatment.

- African-American and American Indian/Alaska Native children (AI/AN) and youth are overrepresented in 82 percent and 42 percent of state child welfare systems, respectively.[19]
- Latino children are overrepresented in 20 percent of state child welfare systems.[20]
- Youth of color, particularly African-American and American Indian/Alaska Native (AI/AN) youth, have the highest rates of victimization in child welfare. In 2005, 19.5 /1,000 African-American children and 16.5 /1,000 AI/AN children in child welfare were traumatized.[21]
- Homeless and runaway youth also have high rates of maltreatment. Approximately 60 percent of female and 25 percent of male homeless and runaway youth are victims of sexual abuse *before* they leave home.[22] Gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth also report higher rates of physical and sexual abuse than their peers.[23]

Research suggests that child maltreatment is also associated with increases in suicidal behaviors, mental health and behavioral problems, and poor school outcomes.[24]

### *Children and Youth in Juvenile Justice*

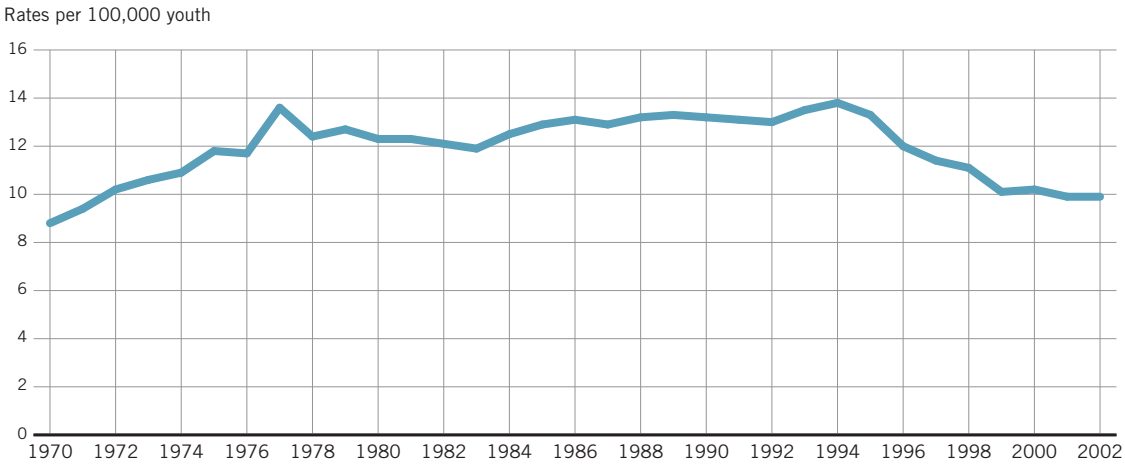
An overwhelming majority of youth in the juvenile justice system have experienced trauma. Over 90 percent of youth in juvenile detention in a large urban county have been exposed to at least one traumatic event, and nearly 60 percent have experienced six or more traumatic events.[25] At clinical assessment, 11 percent of youth in juvenile justice are diagnosed with post-traumatic stress disorder (PTSD).[26] Among juvenile offenders in residential placements, 30 percent report prior physical and sexual abuse.[27] Many youth in juvenile justice experience multiple incidences of unaddressed and unrecognized trauma.[28]

### *Children and Youth at Risk of Suicide*

Trends show that annual suicide rates have declined in recent years, probably linked to a reduction in substance use, improvement in life-saving technologies, and increases in the use of new anti-depression medications.[29] (See Figure 3.) However, experts estimate that for every completed suicide, there are 13 attempts that do not result in death.[30] Further, for some groups of youth, there have been increased rates of suicide and suicidal behaviors. AI/AN youth, adolescent Latinas, and GLBTQ youth are at the greatest risk.

- **American Indian/Alaska Native.** A combination of historical trauma and current deprivation and trauma cause AI/AN children and youth to have the highest rates of suicide, violence, and substance abuse.[31] AI/AN youth commit 64 percent of all the completed suicides nationally (17.6/100,000 compared to 10.4/100,000 in the general population).[32]

**Figure 3: Annual suicide rates in the U.S., youth ages 15-24, 1970-2002**




Source: McKeown, R. E., Cuffe, S. P., & Schulz, R. M. (2006). US Suicide Rates by Age Group, 1970-2002. *American Journal of Public Health, 96*(10), 1744-1749.

According to the Indian Health Services, AI/AN children and youth suicide rates are more than 2.5 times higher than other American youth (ages 5-14). For older AI/AN adolescents (ages 15-24), suicide rates are almost 3.5 times higher than their age peers.[33]

- **Adolescent Latinas.** In recent years, young Latinas report higher rates of suicidal behaviors than their male counterparts or other children and youth. In 2005, 11 percent of all Latino students reported that they had attempted suicide.[34] Adolescent Latinas reported a higher risk for suicide than Latino boys (15 percent versus 7.8 percent) and non-Latino boys and girls.[35] Among girls, Latinas attempted suicide 52 and 60 percent more than white and African-American female adolescents, respectively. Early studies show that only 32 percent of adolescent Latinas at risk for suicide report using mental health services prior to or during the period they experience suicidal thoughts or behaviors.[36] Latina girls are also more likely to have a suicide attempt that results in treatment by a clinician than Latino boys or their white or African-American counterparts.[37]
- **Gay, Lesbian, Bisexual, Transgendered, and Questioning Youth.** GLBTQ youth are at an increased risk for suicide. Gay and lesbian adolescents are between 1.7 and 2 times more likely than their nongay and lesbian peers to have suicidal thoughts.[38] Gay and lesbian adolescents are more than two and a half times more likely to attempt suicide than their nongay peers.[39]

### *Children and Youth Affected by Natural and Man-Made Disasters*

Research on children and youth from war-torn regions and children, youth, and families impacted by September 11th and natural disasters show a high prevalence of mental health disorders (between 21-43 percent) and significant residual mental health problems 6, or even 12 months later.[40]

- One-fifth of youth seen at a regional network of trauma services have directly experienced war or terrorism.[41]
- Nearly half of parents in a recent survey of hurricane survivors in the Gulf Coast report that their children and youth exhibit new post-Katrina emotional or behavioral problems.[42]

Families also suffered.

- Nearly half of survivors of Katrina who were also parents and caregivers report that they "never or only sometimes" feel safe compared to one-fifth of parents and caregivers prior to the storms.[43]
- Children and youth of parents serving in the military are another group of children and youth—nearly 700,000—with at least one parent deployed at risk. These children and youth are exposed to daily trauma and often receive very little support due to provider shortages, stigma, and overburdened community-based services.[44]
- Young adults returning as veterans from Iraq and Afghanistan (ages 18-25) are at the greatest risk for developing PTSD.[45]

Homeless children, youth, and families often reflect the scars of trauma.

- Two-fifths of the U.S. homeless population is made up of families.[46] Their homelessness puts them at increased risk for other trauma, including physical and sexual violence, emotional abuse, and intense anxiety and uncertainty.
- Homeless and runaway youth living on the streets report extensive histories of trauma, including witnessing and experiencing violence.
- Almost two-thirds of homeless youth have witnessed violence and between 15-51 percent have been physically or sexually assaulted.[47]

### *Children and Youth Exposed to Chronic Urban Trauma*

Inner-city youth experience trauma that is chronic in nature.

- A recent study of inner-city youth shows that 83 percent have been exposed to one or more traumatic events, such as an unexpected death/trauma of a close relative or friend, assault-related violence, or other injury.[48]
- Urban males overall experience higher levels of exposure, especially to assault-related violence; however, females were four times more likely to be at risk for developing PTSD following exposure to this type of trauma.[49]

### *Children and Youth with Substance Use Disorders*

Children and youth with substance use disorders (SUD) are at higher risk (3-4 times higher) for developing PTSD when they are exposed to trauma.[50] In addition, their substance use disorder may interfere with their ability to regulate emotions and may put them in situations where they are at risk of victimization.[51]

- Youth with exposure to trauma—either to single or multiple events—are more likely than those without a history of trauma to become dependent upon alcohol or drugs.[52]
- Multiple exposures to traumatic events increases the likelihood that youth will develop SUD.[53]
- Children and youth with co-occurring SUD and PTSD function more poorly than children and youth with one disorder alone.[54]
- Some children and youth are at increased risk for co-occurring SUD and PTSD or SUD and other trauma symptoms.
  - American Indian/Alaska Native youth have higher rates of PTSD, SUD, and co-occurring PTSD and SUD.[55]
  - Homeless youth are more vulnerable than youth who are not homeless to have co-occurring PTSD and SUD.[56]

Substance use disorders correlate with trauma in three main ways.

1. They often feature as factors for those with a history of traumatic experiences, such as community and interpersonal violence, child maltreatment, and self harm.
   - Youth who witness violence are nine times more likely to have co-morbid PTSD.[57]
   - Youth who experience physical or sexual assault are 3-7 times more likely to have co-occurring PTSD.[58]
2. They can serve as a means to cope with symptoms of trauma.[59]
3. They impede effective trauma treatment and unaddressed trauma undermines effective substance use disorder treatment.[60]

There are significant societal costs associated with the impact of co-occurring substance use disorders and trauma. In particular, a recent survey of over 300 counties in 13 states on the impact of the methamphetamine epidemic reveals the devastating toll of methamphetamine use on children and youth.[61]

- Nearly 40 percent of county child welfare agencies attributed increases in out-of-home placements to the epidemic.
- In 75 percent of those counties, child out-of-home placements increased by more than 20 percent in five years.

## Impact of Trauma is Long-lasting and Varied

For children and youth, the consequences of trauma are visible in difficulties with learning, ongoing behavior problems, impaired relationships, and poor social and emotional competence.[62] Both younger children and youth exposed to trauma, especially violence, experience more learning and academic problems and externalizing and internalizing problems.[63]

Young children in particular are acutely vulnerable to negative outcomes following exposure to traumatic situations, such as violence in the home or in the community. In fact, chronic exposure to severe stress can negatively affect children's brain development.[64] Also, children who experience traumatic events prior to age 12 are three times more likely to develop PTSD.[65]

Children and youth who have been maltreated are at an increased risk for mental health problems and poor psychological adaptation, as well as lifelong health and mental health problems.[66] One body of research known as the Adverse Childhood Experiences Study demonstrates the strong relationship between youth suicide attempts and adverse childhood experiences. Children and youth exposed to five or more adverse experiences were more likely to attempt suicide, experience chronic illness, or die prematurely.[67]

Equally troubling, research now points to the multigenerational sequelae of trauma. Increasingly, researchers are linking poor parenting practices for young children, including infants and toddlers, with the experience of unaddressed trauma.[68]

*Even when children and youth are explicitly referred for a traumatic event, clinicians too often lack the information they need to provide appropriate interventions and supports… 84 percent of agencies in [a] survey indicated that they received no or limited information on a child or youth's trauma history upon referral.*

## SECTION 2
# Inadequacies of Current Service and Policy Responses

### Missed Opportunities for Trauma-Informed Services Common at Community Level

One of the fundamental challenges of treating trauma is that it is not always recognized. Researchers document that the presenting problem in mental health treatment is rarely the underlying trauma exposure problem.[69] Given how pervasive trauma is, service systems should routinely determine whether or not trauma is an issue. Yet, service systems regularly treat children, youth, and their families without recognizing or treating the symptoms as trauma. The resulting services tend to be inconsistent, based upon scanty or no evidence of effectiveness, and fail to address underlying problems. This is the essence of poor or sub-quality services described in the Institute of Medicine's 2005 report on quality in the mental health system.[70]

Even when children and youth are explicitly referred for a traumatic event, clinicians too often lack the information they need to provide appropriate interventions and supports. For instance, one study found that irrespective of the setting, child-serving agencies rarely received detailed information about a child or youth's trauma history.[71] Some 84 percent of agencies in that survey indicated that they received no or limited information on a child or youth's trauma history upon referral.[72] Most mental health facilities lack the capacity to screen children and youth who experience trauma.[73] When staff cannot provide trauma-specific interventions they are compelled to refer children, youth, and their families to other institutions, where they encounter long waiting lists to access specialized services.[74]

### Empirically-Supported Practice Lacks Traction

Despite overwhelming evidence of the pervasive nature of trauma among children and youth, intentional trauma-informed care remains the exception in most communities. The spread of evidence-based practices and the growth of service systems' capacity for quality improvement and supporting policies continue to lag behind in the implementation of effective trauma-informed practices. Consequently, much of the emerging knowledge base, including how to intervene, prevent further harms to children and youth, and address complex trauma[75] fails to make it into daily practice.[76] A study of child-serving agencies found that more than one-third did not train their staff to assess trauma. Fewer than half the agencies reported that they trained their staff in the use of evidence-based treatment for children and youth with trauma histories.[77]

Poor performance on the part of service systems is most flagrant when interactions with them result in harm. Failure to apply our knowledge about trauma can end up hurting children and youth in child serving systems. Despite emerging knowledge over the last two decades on the impact of punitive practices on children and youth, too often child-serving systems continue to use poor practices. Although more recently, there have been efforts to use information to improve care, this is not yet commonplace. In the mental health, child welfare, education, and juvenile justice systems, lack of application of effective practices is contributing to child trauma.

## Practices That Retraumatize Children

### Seclusion and Restraint

The use of practices such as seclusion and restraint when not absolutely necessary has resulted in trauma, and in some cases, untimely death in residential and hospital-based mental health settings. A 1998 investigative report by a Connecticut-based newspaper revealed that over 142 deaths due to seclusion and restraint occurred in a 12-month period and that more than one-quarter of the victims were children and youth.[78] A federal government report that followed attributed at least 24 U.S. deaths in 1998 to the use of seclusion and restraint. More children and youth experience seclusion and restraint than adults. The report charged that publicly available data *underestimated* the scope of the problem since no comprehensive reporting system for monitoring deaths and injuries associated with the use of seclusion and restraint by facilities existed. Only 15 states had any systematic mechanism for psychiatric residential treatment settings to report deaths that occurred in their facilities to regulatory agencies. The report noted that federal regulations related to the use of seclusion and restraint varied by facility type with no regulations pertaining to psychiatric hospitals, residential treatment facilities or group homes. Further, only a small number of states had successfully reduced rates of seclusion and restraint through state regulatory leadership, including reporting requirements.[79]

### Boot Camps

A federal Office of Justice study of boot camps[80] in juvenile corrections found that such camps failed to decrease recidivism but rather contributed to increases in the number of repeat offenses.[81] Youth with emotional problems, traumatic experiences (especially at an early age), and substance use disorders were less likely to succeed in boot camp.[82] In addition to poor outcomes, boot camps have increasingly been associated with practices that harm children and youth. In 1998, the U.S. Department of Justice, after a six-month investigation, listed a litany of civil rights violations of youth housed in Georgia's juvenile justice system. Investigators cited "unconstitutional excessive discipline" and a "pattern of physical abuse of residents" in boot camps, among the systemic offenses.[83] More recently, boot camps have been associated with deaths, severe injuries, and physical and sexual abuse of youth at the hands of staff.[84] Today boot camps represent 2 percent of all juvenile correctional facilities.[85]

### Staff or Peer Abuse

Facilities and programs beside boot camps face scrutiny for unorthodox treatment of youth. More than 2,800 allegations of sexual violence were reported in youth facilities in 2004 and 30 percent were substantiated in state, local and private facilities.[86] Among substantiated cases of violence perpetrated by other youth, 35 and 45 percent occurred in state and local/private facilities respectively. Of the incidences of sexual violence perpetrated by staff, state-operated facilities accounted for 17 percent while 15 percent occurred in local or private facilities.[87] Physical violence is also commonplace. In one facility directors' survey, respondents reported that on average 18 percent of youth in their facilities needed "protection" from other youth.[88]

In child welfare systems, children and youth are also not immune from practices that leave them vulnerable to trauma and retraumatization. A small proportion of child maltreatment is perpetrated by foster parents and residential facility staff (less than 1 percent).[89]

In child welfare practice and policy, the challenge has been marrying policies that address:

1. Trauma caused by maltreatment.
2. Keeping children safe.
3. Reunifying children and youth with their families when possible.
4. Attaining permanency for children.

Achieving that balance while ensuring that children and youth are not retraumatized and that they receive the treatment they need has been difficult. Several factors lead to trauma or re-traumatization in the child welfare system:

- Children and youth do not always get the help that they need. Less than 25 percent of children and youth in child welfare with an identified need receive mental health treatment.[90]
- Children and youth are not always transferred to less abusive situations. A small proportion (less than 1 percent of children and youth in child welfare) are abused by staff or caregivers in their placements.[91]

*Service systems regularly treat children, youth, and their families without recognizing or treating the results of trauma. The resulting services tend to be inconsistent, based upon scanty or no evidence, and fail to address underlying problems. This is the essence of poor or sub-quality services described in [a national report].*

- Children and youth may experience frequent and multiple placements that magnify their trauma. One study found an increase in placement changes of over 20 percent.[92] Frequent placement changes have been associated with significantly increased behavioral problems and increased associated treatment costs.[93]

In education, the existence of unlicensed therapeutic/residential schools has raised considerable concerns about quality, safety, and the impact on child and youth trauma and retraumatization. Over the last two decades such facilities have been charged with abusive care by staff and peers, inferior programming, negligent professional behavior, and poor therapeutic conditions.[94]

## Unrelated Policies Affect the Trauma Experience

### Immigration Policy

Recent immigration policies reflect how unrelated policies may harm children and youth by contributing to trauma. For example, in December 2006, the Immigration and Customs Enforcement (ICE) Division of the federal Department of Homeland Security conducted coordinated raids of Swift International meat-packing plants in six states—Minnesota, Iowa, Nebraska, Utah, Colorado, and Texas. As a result of the raid, nearly 1,290 persons were detained.[95] Many of these individuals have children, some of whom are U.S. born citizens. More recently, three other states were targets of similar ICE raids.[96] (See Box 1.)

**Full Circle: Addressing Trauma**

*Marleen Wong, PhD, Director, Los Angeles Unified School District (LAUSD) Crisis Counseling and Intervention Services, LAUSD/RAND/UCLA Trauma Services Adaptation Center for Schools in Los Angeles, recounts her grandmother's early trauma-filled years as an immigrant in California.*

From the time I was six years old, my grandmother told me stories about her early life in San Francisco. That beautiful city was part of the Wild West in the early 1900s, and for Chinese immigrants it was a vibrant and dangerous place. Often innocent people were caught in the crossfire. The process of immigration from Macao to San Francisco was no less dangerous. Pirates and thieves preyed on children and adults who boarded boats to escape the Boxer Rebellion in South China on their way to "Gold Mountain", the name that was given to California and the promises it held for a new life.

My grandmother was five when she took the long trip form Macao to San Francisco… As a child, she was terrified by the violence in the streets and businesses of Chinatown. Once, she saw a group of men refuse to pay their bill for dinner and many bottles of liquor. When the owner insisted, they drew guns and shot bullets into the walls and the floors, smashing the furniture and laughing as they left. She hid in a corner, unharmed but traumatized. In the following weeks, she refused to go to school or to leave her home. She feared that she would be killed and that the violence would happen again.

In 1905, there was no counseling available in schools nor was there recognition of the paralyzing effects of violence on children. The year my grandmother died, in 1999, I began my association with CBITS, and since that time…I have witnessed firsthand the transformation of children's lives.

[My grandmother's] scars of violence last[ed] a lifetime, but with early identification and early intervention [with a trained professional]…the distress, anxiety, and depression suffered by children can be lifted and healed.

Source: Jaycox, L. (2004). CBITS: Cognitive behavioral intervention for trauma in schools. Longmont, CO: Sopris West Educational Services. Copyright The RAND Corporation.

**Box 1: Impact of Immigration and Customs Enforcement (ICE) Raids on Children and Youth—Selected Examples**

- In Colorado, over 100 children and youth were left without parents.[1]
- In Minnesota, an estimated 360 children and youth had one or both parents detained.[2]
- In Nebraska, over 61 students were left without one or both parents after a raid.[3] In Utah, 158 adults were arrested and approximately 82 families impacted by the arrests.[4] In Texas, approximately 80 children and youth had at least one parent arrested and detained.[5]
- In Iowa, ICE officials claimed at least 120 people arrested had children and other dependents.[6]

Sources:

1. Finley, B. (2007). Raid leaves families fractured. *Denver Post*, December 14. <www.denverpost.com/ci_4835267> (accessed April 4, 2007).

2. Aizenman, N. C. (2007). U.S. immigration raids spurs fear in children. *Boston Globe*, April 3. <www.boston.com/news/nation/articles/2007/04/03/us_immigrant_raids_spur_fears_in_children/> (accessed April 4, 2007).

3. Swift raid still affecting school enrollment as court date comes. (2007). <www.kwwl.com/Global/story.asp?S=6076739&nav=2Ifu> (accessed April 4, 2007).

4. Sanchez, J. W. (2007). Split families struggle to cope after swift immigration raids. *The Salt Lake Tribune*, March 12. <www.sltrib.com/ci_5415879> (accessed April 4, 2007).

5. Morales, I. C. (2007). Swift plant raid devastated cactus. *Dallas News*, February 11. <www.dallasnews.com/sharedcontent/dws/dn/latestnews/stories/021107dntexcactus.1e8e591.html> (accessed April 4, 2007).

6. Keen, J. (2007). Effects of raid still felt in Iowa town. *USA Today*, February 12. <www.usatoday.com/news/nation/2007-02-11-marshalltown-raid_x.htm> (accessed April 4, 2007).

## Housing Policy

At the practice level instances abound of policies that harm the most vulnerable children and youth. For example, a survey conducted in 27 cities revealed that 56 percent of homeless families were compelled to break up as a condition for entering emergency shelters.[97] Despite acknowledgement that youth transitioning into adulthood have been neglected, a host of federal laws deny formerly incarcerated youth and young adults access to public housing, educational loans, and other benefits.[98] Yet research suggests engagement in school, contact with family, and public benefits to get a young person on their feet are factors that might facilitate a successful transition.[99]

## Inadequate Response to Unexpected Disasters

States need more assistance to ensure that children and youth are appropriately screened and assessed to prevent further trauma and to intervene as early as possible in the event of a disaster. A 2006 assessment of state-level preparation to cope with trauma related to natural disasters like Hurricanes Katrina and Rita makes clear that states need help. The resulting U.S. Government Accountability Office (GAO) report highlights some of the lessons learned from Hurricane Katrina.[100]

- Less than half of all states and the District of Columbia reported that they have a written plan that addresses which steps should be taken to meet the needs of children and youth in the foster care system in the event of an emergency or disaster.
- Two-fifths of the states with written plans did not address how to find and promote service use in a disaster. This omission is a major concern: parents, children, and youth may be separated at a point where the risk for abuse, victimization, and violence may be more acute.
- Nearly half of the states did not identify in their written plans how they would coordinate services and share information with other states.
- Slightly more than one-quarter of states that experienced disasters in 2005 had disaster plans for children and youth in child welfare.
- Less than one-third of states reported that their plans addressed meeting the placement needs of traumatized children and youth.

States' ability to mount trauma-informed responses to disasters can be greatly enhanced if they adopt a public health approach, grounded in systematic and holistic approaches that encompass funding for screening and treatment. Few states currently use such a model. For instance, while 60 percent of states report requiring or working with providers to screen mental health service users for histories of trauma, the proportion of those efforts targeted at children, youth, and their families, and the quality and impact of such efforts remain largely unknown.[101]

## Current Responses are Costly

Frequently uninformed by our best knowledge about trauma, the current system of service delivery is inefficient and more costly. Average per hospitalization charges for abused and neglected children and youth were $10,000 higher than those for children and youth hospitalized due to other causes.[102] An estimated 5,000 youth accounted for approximately $92 million in hospital-related expenditures. Even in community-based care settings, expenditures are higher for traumatized children and youth.[103] A recent study of the costs of delivering care to children and youth who experience trauma shows median annual per child/youth costs for all health care to be $23,000 compared to $15,000 for a child or youth not exposed to trauma.[104] These dramatic cost differentials reflect almost 75 percent more mental health services spending for children/youth who experience trauma.

Yet, research shows that trauma-related evidence-based practices can achieve significant cost savings. For example, studies of parent child interactive therapy (PCIT) have shown significant advantages in cost effectiveness, as have other trauma treatments with young children.[105] The cost of reducing or eliminating harmful practices is also being documented. A recent study shows that reducing the use of restraining episodes by 90 percent in an inpatient adolescent unit can spur a reduction in aggregate costs from $1.4 million to less than $200,000.[106]

*Trauma-informed strategies ultimately seek to do no further harm; create and sustain zones of safety for children, youth, and families who may have experienced trauma; and promote understanding, coping, resilience, strengths-based programming, growth, and healing.*

## SECTION 3
# Emerging Best Practices

## Core Components of Trauma-Informed Care

Trauma-informed practices refer to an array of interventions designed with an understanding of the role of violence and/or trauma in the lives of children, youth, and their families. Trauma-informed strategies ultimately seek to do no further harm; create and sustain zones of safety for children, youth, and families who may have experienced trauma; and promote understanding, coping, resilience, strengths-based programming, growth, and healing.[107] Strategies include an array of services and supports that screen and assess appropriately, provide trauma-specific services when needed, coordinate services when necessary, and that create environments that facilitate healing.[108] Below we highlight the core components of trauma-informed practice, drawing on lessons from research and practice, as well as the insights of those who participated in the NCCP meeting on which this report is based. (See Box 2 for a description of an initiative that features many core components of trauma-informed care.)

### Standardized Screening and Assessments

A trauma-informed system requires both the universal use of standardized screening tools and the selective application of standardized assessments. Universal screening within 24 hours of entry significantly lowers the risk of attempting suicide among juvenile offenders.[109] Many standardized and validated tools to screen, assess, and inform a trauma-related clinical diagnosis exist and are widely used. They include parent and self reports and clinician and observer reports.[110] A review of 12 trauma screening tools shows that 75 percent of them could be administered in 10 minutes or less, fulfilling a crucial practical requirement of public health responses to trauma.[111]

The assessment process may occur in two phases: the screening phase, which is, when warranted, followed by an assessment. A screening using a brief standardized tool is designed to quickly help determine if a child/youth needs a referral for an in-depth evaluation. An assessment is an information gathering process that may be continual and occur over more than one visit or session. During an assessment the provider seeks to determine whether or not the signs and symptoms discussed represent components of a particular disorder or set of disorders.

Assessment of children and youth exposed to trauma is important in ensuring that they are appropriately treated. Children and youth may exhibit distress or experience impairment in functioning that does not meet clinical levels and therefore does not result in a diagnosis. They still need interventions and/or supports.

Experts generally acknowledge that no "gold standard" assessment currently exists, although there are many good tools.[112] No single instrument measures functioning across all areas of PTSD for example, and use of any instrument must be complemented with careful and thorough interviews directly from the child/youth and with the parent(s).[113] Experts agree that an appropriate assessment includes:

- Use of multiple tools and data from various sources[114]
- Clinical interviews with the child/youth and his/her primary care givers and sometimes the teacher(s)[115]
- Well-trained and skilled staff to conduct or oversee assessments[116]
- Developmentally appropriate tools that match the age and cognitive abilities of the child/youth[117]

**Box 2: Child and Adolescent Trauma Services Program—CATS**

The Child and Adolescent Trauma Services program (CATS) is an initiative created in response to the extensive child, youth, and family trauma following the terrorist attacks on September 11th, 2001 in New York City.

The initiative addresses the treatment needs of children, youth, and families exposed to multiple traumas:

- 44 percent witnessed community violence
- 34 percent survived community violence
- 18 percent experienced sexual violence

CATS services and supports include:

- Two developmentally-appropriate evidence-based treatments
  - Child and Parent Trauma-Focused Cognitive Behavioral Therapy for children ages 5-12
  - Trauma/Grief-Focused Group Psychotherapy Program for children and youth ages 13-21
- Evidence-based family and youth engagement strategies
- Ongoing provider training, support, and consultation

Participants in CATS include:

- Approximately 700 mostly low-income Latino children and youth (75 percent)
- Nine provider organizations
- Over 170 clinicians trained in at least one trauma intervention
- Providers and administrative/first contact staff who receive training on engaging youth and families using an evidence-based curriculum

CATS program evaluation:

- Child, youth, and family outcomes
  - More than 98 percent of the children and youth improved in functioning at six months.
  - An estimated 64 percent no longer met clinical criteria for a diagnosis.
  - Over 41 percent of participants who had received TF-CBT experienced reductions in post-traumatic stress disorder (PTSD).
  - Symptom reductions were evident in other disorders, such as depression and anxiety.
- Service delivery outcomes
  - Over 91 percent of participants remained in treatment.
  - More than 63 percent participated in all of the treatment sessions.

Sources: Kimberly Hoagwood, New York State Office of Mental Health, Columbia University Psychiatric Institute and McKay, M. M.; Hibbert, R.; Hoagwood, K.; Rodriguez, J.; Murray, L.; Legerski, J., et al. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention, 4*(2), 177-186.

- Instruments that have been tested and validated among the populations with whom they will be used[118]
- Tools that reflect linguistic and cultural competence[119]
- Tools that can help identify the initial traumatic event connected to a present diagnosis of PTSD

Table 1 includes a selective list of popular screening and assessment tools used to identify trauma symptoms and diagnose trauma-related conditions. A review of the chart shows that while the field has advanced significantly in the design and validation of instruments on children and youth, rather than simply adapting from adult models, a number of shortcomings remain.

1. There are few instruments to meet the needs of some specific populations. In particular, validation of instruments with specific groups such as very young children, children of color, children from rural or frontier communities, or children with specific co-occurring disorders.[120]
   - Culture may frame how symptoms manifest, thus undermining basic assumptions about how to conduct assessments and use measurement tools.[121]
   - Failure to design and test assessment tools with nonwhite children and youth and children and youth who live in nonurban areas leads to the development of "standardized instruments" that lack cross-cultural application.
   - These challenges are compounded by language barriers.
2. The main diagnoses upon which these instruments are based can be found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Many diagnoses relate specifically to post-traumatic stress disorder, a diagnostic category that is based upon a single traumatic event and primarily adult centered. Critics charge that this diagnosis fails in two main ways.
   - It does not reflect the spectrum of symptoms and trauma histories that children and youth with multiple and chronic trauma experience.

### Table 1: Selected Tools for Screening and Assessment of Children and Youth Exposed To Trauma

| Tool | Standardized [validity and reliability tested] | Who Administers | Age | Screen | Diagnostic |
|---|---|---|---|---|---|
| Acute Stress Checklist of Children | √ [children/youth] | Child/youth | 8-17 | √ | |
| Child Dissociative Checklist (CDC) {*Turkish, Spanish*} | √ [children/youth] | Adult observer | 5-12 | √ | |
| Child Post-traumatic Stress Reaction Index (CPSRI) [2 different questionnaires of different age groups and parent questionnaire] | √ [children/youth] | Parents, child/youth | 7-12 13+ | √ | |
| Child PTSD Symptom Scale (CPSS) [Spanish, Korean, Russian, Armenian] | √ [children/youth] | Child/youth | 8-18 | √ | |
| Child Stress Disorder Checklist (CSDC) | √ [children/youth] | Adult observer | 7-18 | √ | |
| Child's Reaction to Trauma Event Scale (CRTES) {*Cambodian, Arabic, Croatian, Armenian*} | √ [based upon earlier version adult] | Child/youth | 8-12 | √ | |
| Children's Impact of Traumatic Events Scale (CITES-R) | √ [children/youth] | Clinician | 8-16 | √ | |
| Children's PTSD Inventory | √ [children/youth] | Clinician | 7-18 | √ | |
| Children's PTSD Interview | √ [children/youth] | Clinician | 7-18 | | √ |
| Children's PTSD Inventory [Parent] | √ [children/youth] | Clinician | 7-18 | √ | |
| Children's PTSD Interview [Parent] | √ [children/youth] | Clinician | 7-18 | | √ |
| Children's Sexual Behavior Inventory 3 (CSBI-3) | √ [children/youth] | Parents | 2-12 | | |
| Clinician Administered PTSD Scale (CAPS-CA) | √ [based upon adult version] | Clinician | 8-15 | | √ |
| Diagnostic Interview Schedule for Children and Adolescents-PSTD Module [Youth interviews 9-17] [Parent interviews 6-17] | √ [children/youth] | Clinician | 6-17 | √ | √ |
| Diagnostic Interview for Children and Adolescents (DICA-R) PSTD Scale [2 different questionnaires of different age groups] {*Spanish and Arabic*} | √ [ children/youth] | Clinician | 6-12 13-17 | √ | √ |
| Lifetime Incidence of Traumatic Events (Parent and Student forms) {*Spanish, German, Persian, Swedish*} | √ | Child/youth | School-age | √ | |
| Los Angeles Symptom Checklist (LASC) | √ [children/youth] | Child/youth | Adoles-cents | √ | |
| My Worse Experience & My Worse School Experience Survey | √ [children/youth] | Child/youth | 9-18 | √ | |
| Report of Post-Traumatic Stress Symptoms (C/PR) reports | √ [children/youth] | Child/youth Parent | 7-17 | √ | |
| Trauma Symptom Checklist for Young Children (TSCYC) {*Spanish*} | √ [children/youth] | Child/youth | 3-12 | √ | |
| Trauma Symptom Checklist for Children (TSCC) {*Spanish, French, Cambodian*} | √ [children/youth] | Child/youth | 8-16 | √ | |
| When Bad Things Happen (WBTH) [at least 3rd grade reading level]. Includes other scales for parents and interview, can be used as diagnostic tool. | √ [children/youth] | Child/youth | 7-14 | √ | |

{*Languages in which instruments translated*}

Sources:


Cohen, J., & Work Group on Quality Issues. (1998). *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder.* Washington, DC: American Academy of Child and Adolescent Psychiatry.

Greenwald, R. (2004). Child Trauma Measures for Research and Practice: Poster Session Presented at the Annual Meeting of the EMDR International Association, Montreal, September 2004. Retrieved April 18, 2007, from http://www.childtrauma.com/mezpost.html.

Hawkins, S. S., & Radcliffe, J. (2006). Current Measures of PTSD for Children and Adolescents. *Journal of Pediatric Psychology, 31*(4), 420-430.

Nader, K. O. (1997). Assessing Traumatic Experiences in Children. In J. P. Wilson & T. M. Keane (Eds.), *Assessing Psychological Trauma and PTSD.* New York, NY: The Guilford Press.

Strand, V. C., Sarmiento, T. L., & Pasquale, L. E. (2005). Assessment and Screening Tools for Trauma in Children and Adolescents: A Review. *Trauma, Violence & Abuse, 6*(1), 55-78.

- It is not developmentally appropriate.

A movement is underway to adopt a new DSM diagnosis—developmental trauma disorder—to better reflect the needs of children and youth with chronic trauma exposure.[122]

3. Little consensus exists on how the information generated from the vast array of instruments and data sources should be integrated to provide a holistic picture.[123]

### Evidence-Based Interventions

Over the past several years, there has been a significant expansion in our knowledge about effective, research-informed treatments for children, youth, and their families. (See Box 3.) For example, evidence-based assessments and trauma-specific treatments for children, youth, and their families being used by children's mental health practitioners include:

- Parent-Child Interactive Therapy (PCIT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectal Behavior Therapy
- Trauma Recovery and Empowerment for Adolescent Girls and Young Women (G-TREM)
- Seeking Safety for Adolescents

Along with efforts to implement evidence-based practices, there should be efforts to eliminate practices that research shows are harmful. In recent years, one approach to early intervention in trauma practices, psychological debriefing, has come under increased fire for lacking an evidence base.[124] This long-established intervention with roots in military history, is now also considered harmful.[125] As an alternative, clinicians, first responders, and researchers have turned to the use of psychological first aid to provide psychological help immediately following a crisis. The process is based upon the concept that survivors of trauma need to address their immediate and basic needs first and that any mental health supports provided should be based upon the survivor's needs for safety, connection with others, and self-efficacy.[126]

### Culturally-Based Strategies

Current approaches to embedding evidence-based practice in cultural contexts hold much promise. For example, Dee BigFoot, Director of Indian Country Child Trauma Center at Oklahoma University, is one of the foremost researchers in culturally adapted evidence-based models for children and youth who have experienced trauma. Dr. Bigfoot's experience includes helping to bridge the gap between theoretical constructs that underpin evidence-based practice and practices that are compatible with communities, particularly traditional Native-American values. (See Box 4.)

Fueled by an understanding of the enduring nature of historical trauma and fundamental knowledge of the ways of American Indian/Alaska Native (AI/AN) communities, Dr. Bigfoot has filled a vital need in trauma-informed care. Among the successes of the Indian Country Child Trauma Center has been the adaptation and implementation of three evidence-based treatment approaches for use in AI/AN communities. These include cultural adaptations of (1) Parent Child Interactive Therapy (PCIT), known as *Honoring Children, Making Relatives*; (2) Treatment for Children with Sexual Behavior Problems, known as *Honoring Children, Respectful Ways*; and (3) Trauma-Focused Cognitive Behavioral Therapy, known as *Honoring Children, Mending the Circle*.[127] For each adaptation, a Native way of learning is referenced. Dr. Bigfoot stresses that the success of these adapted models come from restoring the sacred place children hold in Native society. The key, according to Dr. Bigfoot, is to "use Native ways as the foundation for teachings." For example, PCIT includes two core concepts compatible with Native ways and concepts of learning: attachment and behavioral management systems theory. Dr. Bigfoot queried, "When one looks at traditional ways, the question is how do these fit and how do you communicate these core concepts in a manner consistent with how Native communities learn?" (Also see the case study on the Medicine Moon Initiative.)

### Box 3: Examples of Evidence-Based Practices to Treat Trauma

**Parent-Child Interactive Therapy (PCIT):** An empirically supported, step-by-step intervention that engages both the child and the primary caregiver. It is focused on enhancing relationships, improving parenting skills of caregiver, and reducing problems associated with the child's behavior. Parents or other primary caregivers are trained through interactive coaching methods. They learn strategies that enhance stronger relationships between the child and the caregiver, such as positive discipline strategies. They also develop skills aimed at improving a child's ability to comply with directions from the parent or caregiver and the caregiver's ability to deliver commands and directions. A short-term intervention, lasting between 12-20 weeks, PCIT is appropriate for children and youth ranging from ages 2-7 with externalizing behaviors. It has also been used for children between ages 4-12 with a history of abuse or neglect.[1]

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** TF-CBT is a manual-based individual therapeutic intervention that focuses on the child/youth and his or her family member/primary caregiver. It is designed to address emotional and behavioral problems associated with trauma, especially post-traumatic stress disorder (PTSD). It has also been effective in treating sexually abused children and youth with symptoms of post-traumatic stress and youth who exhibit both internalizing and externalizing behaviors after being exposed to trauma. The treatment spans 12-16 weekly sessions in which children/youth and their parents learn strategies for coping with, managing, and overcoming challenges associated with trauma exposure. Children/youth develop techniques for reframing, communicating effectively, and relaxing. They also learn about the consequences of victimization. TF-CBT has been effective with children and youth from ages 4-18.[2]

**Dialectical Behavior Therapy (DBT):** DBT combines cognitive behavioral therapy (an evidence-based treatment) with interventions focused on addressing self-injurious behaviors, such as self-cutting, and suicidal behaviors. An empirically supported psychotherapeutic intervention, DBT focuses on emotional control, managing problems, building relationships, and establishing healthy connections. The treatment includes skills building, individual therapy and a consultative support group model. DBT has been adapted for special populations, including the developmentally disabled. The intervention's duration is approximately one year, with weekly individual and skills group sessions. It is appropriate for children and youth ages 8-21.[3]

**Trauma Recovery and Empowerment Model for Girls (G-TREM):** G-TREM is a manualized treatment approach based on cognitive behavioral therapy and relationship building. It is a best practice with some empirical support. Core components of the intervention include education and skills-building to help individual child/youth survivors gain confidence, become empowered, and problem solve. G-TREM is a modification of a treatment initially developed for adult women. It is designed to address trauma among girls who have suffered physical, sexual, and emotional abuse. Treatment duration is between 24-33 sessions. G-TREM is being used in residential treatment, community, and outpatient settings. Group size ranges from eight-12 members with one or two group leaders. The intervention is designed for girls ages 12-18.[4]

**Seeking Safety for Adolescents:** This is an empirically tested treatment designed to address co-occurring substance use disorders and PTSD in youth. Based upon Cognitive Behavioral Therapy, Seeking Safety for Adolescents is a manual-based intervention that can be used for individual or group treatment. Its main elements include skills building through experiential learning and role playing focused on safety and resourcefulness through cognitive and behavioral changes, interpersonal relationships, and care coordination. There is an integrated approach to substance use disorders and trauma. The treatment has been modified from one initially sponsored by the National Institute of Mental Health and developed for use with adults. Treatment ranges from 24-31 sessions. The manual is available in both English and Spanish. The intervention is used in residential treatment, community, and outpatient settings. Group size ranges from five-30 members (the latter in a residential program), with one or two group leaders. Adolescents aged 13-17 are the targeted age group for this intervention.[5]

Sources:


1. Parent-Child Interaction Therapy (PCIT). (2005). <www.nctsnet.org/nctsn_assets/pdfs/promising_practices/PCIT_fact_sheet_2-11-05.pdf> (accessed April 9, 2007); and, Chadwick Center. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices.* www.nctsnet.org/nctsn_assets/pdfs/reports/kauffmanfinal.pdf (accessed October 11, 2006).

2. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). (2005). <www.nctsnet.org/nctsn_assets/pdfs/promising_practices/TF-CBT_fact_sheet_2-11-05.pdf> (accessed April 9, 2007); Chaffin, M. & Friedrick, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26*(11), pp. 1097-1113; and, Chadwick Center. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices.* <www.nctsnet.org/nctsn_assets/pdfs/reports/kauffmanfinal.pdf>(accessed October 11, 2006).

3. Dialectical Behavior Therapy frequently asked questions. (Undated). <www.behavioraltech.com/downloads/dbtFaq_Cons.pdf> (accessed March 12, 2006); *Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP).* (2005). <www.nctsnet.org/nctsn_assets/pdfs/promising_practices/ADBT_SpecialPopulations_fact_sheet_3-21-07.pdf> (accessed April 4, 2007); and, Dykstra, E. J. & Charlton, M. (2003). *Dialectical Behavior Therapy: A new direction in psychotherapy.* <www.nctsnet.org/nctsn_assets/pdfs/reports/dialectical_behavior_therapy_dykstra_charlton.pdf.> (accessed April 12, 2007).

4. Trauma Recovery and Empowerment Model (TREM). (Undated). <traumamatters.org/documents/TREM—MaxineHarris.pdf> (accessed April 10, 2007); *Trauma Recovery and Empowerment Model Group Intervention for Adolescent Girls (Love and Life: G-TREM).* (2005). <www.communityconnectionsdc.org/publications.htm> (accessed April 12, 2007); and, Moses, D. J.; Reed, B. G.; Mazelis, R.; & D'Ambrosio, B. (2003). Creating trauma services for women with co-occurring disorders experiences. In: *SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study.* Delmar, NY: Policy Research Associates.

5. Najavits, L.; Gallop, R. J.; & Weiss, R. D. (2006). Seeking Safety for Adolescent Girls with PTSD and substance abuse disorders: A randomized control trial. *The Journal of Behavioral Health Services & Research, 33,* pp. 453-463; Seeking safety. (2007). <www.seekingsafety.org/3-03-06/aboutSS.html.> (accessed April 15, 2007); Moses, D. J.; Reed, B. G.; Mazelis, R.; & D'Ambrosio, B. (2003). Creating trauma services for women with co-occurring disorders experiences. In: *SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study.* Delmar, NY: Policy Research Associates; Najavits, L. (Undated). *Implementing Seeking Safety for PTSD and substance abuse: Clinical guidelines.* <www.bhrm.org/guidelines/PTSD.pdf> (accessed April 15, 2007); *Intervention summary: seeking Safety.* (2006). <nrepp.samhsa.gov> (accessed April 15, 2007) from; and *Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP).* (2005). <nctsnet.org/nctsn_assets/pdfs/promising_practices/ADBT_SpecialPopulations_fact_sheet_3-21-07.pdf> (accessed April 4, 2007).

**Box 4: Tips for Working with American-Indian/Alaska Native Communities**

When approaching communities:

- Do not come uninvited
- Always come bearing gifts
- Build on traditional customs
- Understand tribal communities (For example, what is the preferred learning style of the group you want to disseminate best practices to?)
- Mesh key themes and tribal philosophies

Source: BigFoot, D. S., Forum Presenter, *Strengthening Federal, State and Local Policies for Children, Youth, and Families who Experience Trauma*, meeting October 16, 2006, National Center for Children in Poverty at Columbia University's Mailman School of Public Health, New York, NY.

## Family and Youth Engagement and Support

As with evidence-based practices, evidence-based engagement strategies are critical to improving outcomes for children, youth, and their families who experience trauma. Engaged youth appear to possess enhanced self-esteem, increased prosocial actions, and positive peer-to-peer relationships and relationships with adults, especially among high-risk, non-white youth.[128] Related to this, research suggests that practices that include attention to strengthening protective factors are also important. High prosocial abilities prove protective for urban youth against committing violence.[129] Other studies of violence-exposed youth link individual factors such as temperament and external factors such as family functioning to youth's ability to rebound.[130] Across multiple studies, protective factors such as family cohesion, emotional cohesion, and warmth appear to be consistent factors associated with positive post-trauma adjustment and reduction in mental health problems.[131] For young children particularly, parents are a buffer. How their parents respond to trauma can help determine how younger children cope.[132]

The impact of families and youth, especially trauma survivors, as engaged participants in service design, delivery, and evaluation, is a recent trend that has not been well studied. However some practitioners attribute improved quality, especially the authenticity of trauma-specific interventions, to child, youth, and family survivors of trauma.[133] One review of family and youth driven research and policy initiatives in children's mental health shows that some are working with evidence-based initiatives and others are currently documenting program effectiveness. This review also describes an initiative led by survivors of unlicensed residential facilities.[134]

## Early Identification and Intervention

Research shows the importance of early intervention in aiding healing as well as promoting resilience.[135]

Several compelling factors support the need for systematic early identification and treatment for trauma. They include our growing knowledge about the impact of trauma on early development, the consequences of traumatic events on life-long morbidity and mortality trends, and what we know about factors that contribute to recovery.

Symptoms of traumatic stress do not dissipate if left untreated.[136] A study of preschool children revealed that 2-3 times more children exhibit symptoms of trauma-related impairment than have been diagnosed.[137] Research on the neurobiological effects of trauma suggests that the younger children are when they experience trauma, the more vulnerable they are, due to trauma's significant impact on early brain development.[138] Moreover, when the initial traumatic event is not readily identified, the potential for misdiagnosis increases.[139] There is also evidence that the impact of traumatic experiences among infants and toddlers manifest years later.[140]

Significant underreporting of current rates of childhood trauma, including child abuse, further advances the need for early identification and intervention.[141] Long-term health and mental health problems associated with trauma are well-documented.[142]

Over the last two decades, researchers have amassed a body of literature about factors that promote resilience, reduce psychopathology, and contribute to healthy child development. While trauma, especially maltreatment, is associated with a high rate of personality disorders and psychopathology, researchers have identified high levels of resilience among children.[143] Advances in our knowledge also include better understanding about the role of quality attachments and parent/caregiver-child relationships. Collectively these findings constitute strong grounds for early recognition and intervention. Unfortunately, these findings are not being incorpo-

rated into routine and standard practices as quickly as they should.[144]

The ongoing challenges that states confront when providing mental health services and supports for young children are amplified when it comes to young children who have been traumatized. Younger children with mental health problems are the least likely of all children and youth in child welfare to access needed mental health services.[145] Moreover, even a year after initial contact with child welfare services, less that 30 percent of children and youth who need mental health services actually received them. For younger children access was even more limited—less than 15 percent of young children, and 20 percent of children who remained in their homes.[146] Even when young children access services, providers do not routinely assess and use knowledge on early childhood development or systematically use standardized screening and assessment tools in part due to policy and infrastructural barriers.[147]

Trauma in young children happens not just directly to the children, but through the experiences of others, particularly their caregivers. Therefore other strategies are needed to help children that will also help their parents address their own untreated trauma—particularly mothers who themselves have been exposed to violence, sexually or otherwise abused, and/or involved in domestic violence.[148]

Effective strategies to address trauma in young children apply the evidence that points to the crucial role caregivers play in assisting trauma-exposed young children to heal. Both the quality of the child-caregiver relationships and the adult caregiver responses to a child that experiences trauma matters.[149]

### *Examples of Early Childhood Interventions*

Some communities are leading the way by adopting strategies designed to recognize signs of trauma exposure early and respond promptly. They provide reasons for hope. Below we highlight four of these communities.

**The Early Childhood Trauma Network.** This four-site initiative specifically focuses on trauma-exposed low-income, younger children from birth to age 6 who come from diverse backgrounds.[150] It uses Child-Parent Psychotherapy, an evidence-based intervention, to address the needs of traumatized young children.[151]

**Babies Can't Wait.** In New York State, the Permanent Judicial Commission on Justice for Children established a project called Babies Can't Wait.[152] The program meets the need for comprehensive information in a timely fashion to inform judicial decision making. Judges receive training. Among the features of the program are a well-informed court advocate, expeditious scheduling of hearings, and a checklist and guide that helps judges elicit the information necessary to promote healthy child development.

**Free to Grow.** In 15 communities across the country over the last decade, partnerships were formed through the Free to Grow initiative of the Robert Wood Johnson Foundation. Free to Grow was a strength-based organizational capacity-building approach to help Head Start and other early childhood programs better address the individual needs of higher-risk families. It also worked to organize families and strengthen community partnerships to reduce community-based risk factors such as the presence of drug dealers or lack of appropriate policing.[153]

**Arizona's practice improvement activities.** Trauma-informed practice is promoted by the Arizona Department of Health Services. Its Division of Behavioral Health Services supports quality improvement through the development and dissemination of practice improvement protocols and technical assistance documents.[154] The state developed a practice improvement protocol[155] in 2006 that focused on children and youth involved with child protective services and addressed the specific needs of very young children.

## Organization/Program Capacity

Two critical challenges emerge from an organizational perspective for developing trauma-informed systems. The first challenge revolves around organizational factors that enhance or impede the ability to adopt and sustain evidence-based practices. An ongoing study of organizational factors associated with adoption of evidence-based practices shows reduced staff turnover among juvenile justice and child welfare staff and improved service quality and outlook towards work.[156] Ten components of organizational culture, climate, and context were targeted for intervention, including participatory decision making; team building; continuous quality improvement; job redesign; development;

feedback; information and assessment; conflict resolution; and self-regulation and stabilization.[157]

The second challenge pertains to a condition known as secondary or vicarious trauma. Secondary trauma results from staff (also caregivers) interaction with traumatized children, youth, and their families. Research links organizational factors, particularly, workplace conditions and work load levels to secondary or vicarious trauma among providers and support staff. Caregivers often develop trauma-related symptoms that unfold as a result of working closely with trauma survivors. Secondary trauma manifests in professionals in job functioning, morale, interpersonal relationships and behavior, and in diminished performance on the job or changes in relationships with colleagues.[158] Some studies documenting the prevalence of secondary trauma reveal that among child protection workers, 45-50 percent experience clinical level symptoms of post-traumatic stress.[159] Other studies demonstrate varying rates of traumatic stress symptoms in lay counselors (8-11 percent), and among mental health professionals and others working with survivors of disasters and terrorism (52-57 percent).[160] Working with children and youth in a disaster is associated with increased risk for secondary trauma.[161] Moreover, among some caregivers the personal threat of violence and insecurity contribute to work-related stress. For example, over 70 percent of frontline child welfare workers report that they have been victims of violence or threats of violence while performing their jobs.[162] Recognizing the impact of secondary trauma among already stressed workers, Oklahoma and Oregon are among the states with established policies to address secondary trauma.[163]

## Building a Skilled Workforce

In order to improve the quality of trauma-informed care, service providers must have opportunities to become proficient in evidence-based interventions. This involves developing the infrastructure to support translation of new knowledge on the ground. Several initiatives support capacity-building for the workforce. These include statewide efforts to establish centers of excellence that engage in evidence-based dissemination activities with a trauma-focus; a web-based interactive learning program available to mid-level practitioners; and federal and state funded learning strategies. Below we highlight two of these strategies.

**Evidence-based Treatment Dissemination Center, New York.** This is a statewide initiative under the auspices of the New York State Office of Mental Health. It is a two-phased training design that combines a three-day program with a year-long biweekly expert consultation model. To date over 200 clinicians and their supervisors received training.[164] Highlights of this initiative include:

- Free training targeted at clinicians and supervisors of licensed mental health clinics.
- Training on evidence-based treatments for children and youth who experience trauma or depression.
- Fiscal incentives[165] that include enhanced rates, for example:
  - Providers can take up to three visits to complete a comprehensive assessment and up to nine visits for in-home treatment.
  - Screening and in-home treatment visits are reimbursed at a rate of $50 per visit above the base rate.
- A National Institute of Mental Health-sponsored evaluation strategy designed to:[166]
  - Assess the impact of the initiative
  - Track fidelity to the core components of the model
  - Support continuous quality improvement

**Trauma-Focused Cognitive Behavior Therapy Web (TF-CBTWeb), South Carolina.** A team of researchers and trauma experts at the Medical University of South Carolina launched the TF-CBTWeb—a 10-hour interactive web-based training—in 2006.[167] The web site is targeted at frontline, masters' prepared clinicians and their supervisors.[168] The training is free and delivered in 10 modules, but participants must register for the training.[169]

In the first year of operation, TF-CBTWeb achieved the following results:

- Over 3,500 individuals completed the training
  - Most were U.S.-based and in the fields of social work (40 percent), psychology (20 percent) and counseling (30 percent).[170]
  - Over 40 percent of U.S.-based clinicians who registered for the training completed it.[171]

Initial results from the training program's evaluation suggest:[172]

- High satisfaction levels with content and modality
- Improvement in trauma knowledge among those who completed the training
- Less satisfaction with the cultural competence component of the training primarily due to the lack of availability of the training in Spanish

## Strategies to Strengthen Local Capacity to Respond to Disasters

### The Resiliency Program and Operation Assist

The National Center for Emergency Preparedness at the Mailman School of Public Health of Columbia University, in partnership with the Children's Health Fund, developed a set of training strategies to help strengthen the infrastructure to deal with disasters. One project, the Resiliency Program, focuses on helping children in New York City impacted by 9/11. The program focuses on classroom- and community-based education and offers psychoeducational programs, therapy, group treatment, provider education on trauma services to teachers, social workers, pediatricians, and psychologists, and some specialty services such as case management and legal aid. Another project, Operation Assist, was developed in response to Hurricane Katrina and provides direct health and mental health services in mobile units in Louisiana and Mississippi. Operation Assist also partners with schools to train school-based health centers along the Gulf Coast in TF-CBT and other evidence-based treatments. Despite funding challenges, both programs are set to undergo formal evaluations and disseminate their models on a national scale.

## Trauma-Informed Practices Across Settings and Ages

### School-based Strategies

Below we highlight two examples of school-based strategies. The first is in Los Angeles and addresses chronic urban trauma in youth. The other focuses on trauma facing school-age children with parents in the military. Many of these parents are deployed in Iraq and Afghanistan. These initiatives, which embrace core principles of trauma-informed care emanating from research, are embedded in settings where children and youth spend much of their time. Program staff works hard to remove barriers to service and support access to optimize healing.

#### *An Urban School District*

**Cognitive Behavioral Intervention for Trauma in the Schools (CBITS), Los Angeles Unified School District (LAUSD).** The level of gun violence in Los Angeles is staggering. On average, there are three gun-related deaths a day in Los Angeles County.[173] Adolescents and youth adults are at the highest risk for gun-related incidents. Between 1995 and 2002, almost 1,300 youth died from gun-related homicides in the county.[174] Gun-related suicides accounted for 57 percent of all suicides involving children, youth, and young adults (5-20 years old) in 2002.[175] In 2002, over 600 children and youth were hospitalized for assault-related injuries (68 percent) among youth (15-17 years old).[176]

In response, over the last decade the Los Angeles Unified School District, the nation's second largest district, began infusing trauma-informed evidence-based interventions in the school, starting with a needs assessment.[177] The needs assessment, a survey of 1,000 children in 20 middle schools, showed that between 88 and 91 percent of students were exposed to community violence.[178] Most of these exposures involved multiple incidences. Over 27 percent of the respondents had clinical levels of post-traumatic stress disorders. A surprising finding was that many parents were unaware of the level of violence to which their children had been exposed. In collaboration with the RAND Corporation and UCLA's Health Services Research Center, LAUSD put into place a trauma-focused evidence-based treatment based upon cognitive behavioral therapy. (See Box 5.) The intervention, Cognitive Behavioral Intervention for Trauma in the Schools has proved very effective with the middle school students who receive it. Youth who receive the intervention have significantly lower levels of depressive and post-traumatic stress related symptoms than other children.[179] It has also been demonstrated to work especially well with Latino youth.[180]

#### *A School-Based Health Clinic*

**North Country Children's Clinic School-Based Health Center, Watertown, New York.** An intentional approach

*By far the greatest need for both our civilian and military families is the availability of mental health services. It is hard enough to secure care for our civilian population, but it seems nearly impossible for military dependents to be able to get mental health services.*

—School Nurse, New York

**Box 5: Cognitive Behavioral Intervention for Trauma in the Schools (CBITS)**

- A skill-building early intervention program
- Designed for youth ages 11-15
- Uses a structured, symptom-focused approach
- Gives teachers, youth, and their parents tools to function better using:
  - Education
  - Relaxation
  - Cognitive therapy
  - Real life exposure
  - Stress or trauma experience
  - Social problem solving

Source: Jaycox, L. (2004). *CBITS: Cognitive Behavioral Intervention for Trauma in Schools.* Longmont, CO: Sopris West Educational Services.

to a trauma-informed system provided the foundation for efforts in Watertown, New York, to respond to the emerging needs of children, youth, and their families impacted by America's recent wars. Largely driven by the North Country Children's Clinic School-Based Health Center's response to the needs of a large population of military families, service providers sought to institutionalize and sustain integrated primary care and mental health services available in the Watertown schools. North Country Children's Clinic serves an area that includes Fort Drum, home to 16,000 military personnel (60 percent of whom are deployed). It operates four school-based health centers in four elementary, middle, and high schools. Approximately 25 percent of all students served by the health centers are military dependents.

Many challenges emerge for a community-based provider reliant on a payer as large as the military. The initiative was able to surmount a major challenge facing military families, given that the military health management organization, TRICARE, limited access to mental health services for dependents (See Case Study in Section 6).

**A Family's Perspective**

*Submitted by a parent whose child attends one of North Country's Children's Clinics, Watertown, New York*

[My husband] deployed for Iraq in August 2006. We could tell before he left that our 9-year-old son was not going to handle it well. [My son] and his father were very close and this was my husband's second time going to Iraq. [My son] could not understand why his father had to go back since he had already been there. [My son] is also aware of his world and what is going on in it, he understood that it is a dangerous place. We were in Fort Belvoir, Virginia when the Pentagon was hit on 9/11; my husband worked there. That day will live with us for a very long time. [My son] started having nightmares in June 2005, along with crying spells and a sense that his Dad could not come back safe and sound two times when so many were not. He was also having violent outbursts at home.

We receive our medical care at the [local] Ambulatory Health Clinic. We took [my son there] in June and expressed our concerns for his mental health. The doctor wrote a referral for a child psychologist in our town. That doctor had a 3-month waiting list to get on the waiting list for an appointment. By now school had started and we were having nights where [my son] stayed up all night crying, wanting his father to come home. If I did get him to sleep, he woke up crying. It became a struggle even to get him to go to school, he saw no use in going to school if that meant growing up without his father. He had also started losing interest in church, and Cub Scouts, two things that he usually loves. He did not want to leave the house at all…With the help of the school-based clinic I was able to start helping my son cope with the deployment.

## Community-Based Systems of Care

Systems of care generally refer to collaborative partnerships across child serving agencies that build a seamless system for children and youth with mental, emotional, and behavioral challenges and their families. At a minimum, systems of care are required to provide core services and an individualized plan of care that builds on the unique strengths as well as needs of the child, youth and family. Stakeholders also aim to ensure that systems of care are family driven, youth guided and culturally and linguistically competent. Since so many children and youth involved with systems of care have been impacted by trauma, efforts are now building to rethink how systems of care can respond to trauma.[181]

Experts outline five requirements for creating a *trauma-informed* system of care: (1) Administrative commitment to change that includes funding (not simply grant funding), overall fiscal policies and administrative procedures (including hiring); (2) Universal screening that creates system wide awareness; (3) Training and education focused on what works, and on continuous attention to outcomes, fidelity, and consistency; (4) Employment practices, including careful selection of employees; and (5) Review of policies and procedures, with deliberate attention to eliminating harmful, traumatizing, and retraumatizing practices.[182]

Using this framework, the experts suggest that a trauma-informed system of care begins with a fundamental understanding of trauma and how it shapes an individual who has experienced it. The system responds to a trauma survivor using a strength-based and holistic approach. Services first and foremost seek to develop skills that permit individuals to adopt positive coping mechanisms and take control for moving forward. Providers' relationships with children and youth who experience trauma and their families are open, collaborative, and based upon mutual trust. From a practice perspective, a trauma-informed system requires universal screenings, comprehensive assessments, strength-based services, and a focus on skills-building.

Two examples show how a practice perspective can be combined with policies that support fiscal sustainability and infrastructural development. These initiatives include a multi-tribal strategy and a statewide strategy.

### *A Multi-tribal Strategy*

**Medicine Moon Initiative, North Dakota.** This culturally-based initiative involves four tribes whose goal is to build a trauma-informed child welfare system. The initiative integrates the lessons of a previous mental health system of care project entitled Sacred Child (the oldest sustained American Indian/Alaska Native system of care site), based on the wraparound process. Through a family-driven Child and Family Team Meeting, care is initiated and serves to reintroduce indigenous cultural strengths and protective factors. Care is grounded in the use of extended family and natural support systems, healing ceremonies and supports, and traditional values, such as respect, relationships, and spirituality. Services focus heavily on addressing the impact of historical trauma on children, youth, and their families involved with the child welfare system. With support from the Native American Training Institute, the Medicine Moon Initiative trains service providers and families. Strong emphasis is given to connections between the mind, spirit, body, and culture; work with the whole family, not just the child; and rekindling ancestral teachings and traditions that give honor and hold the child sacred. An emerging component of the project's work with the Training Institute is a focus on staff well-being and prevention of secondary trauma. The Medicine Moon Initiative's leaders attribute their success primarily to positioning practice in traditional ways and to their ability to bill Medicaid for specific services—especially for the use of assessment tools and interventions that are compatible with the culture of the children and families served. (See Case Study in Section 6.)

### *A Regional Strategy*

**THRIVE: The Tri-County Trauma-Informed System of Care (TISOC), Western Maine.** Androscoggin, Franklin, and Oxford Counties (the "Tri-County Region") in Western Maine are mostly rural, with a sizeable population below the poverty level. The region has the highest number of reports of child abuse in Maine (both allegations and substantiated cases) and the second highest number of children in out-of-home care, including the juvenile justice system. Through THRIVE, a new six-year SAMHSA grant, Tri-County Mental Health Services and Maine Department of Health and Human Services partnered to build a trauma-focused system of care. TISOC focuses on

children and youth, from birth to 12 years of age who are experiencing severe emotional and behavioral challenges and their families and who have come into contact with the child welfare system. Youth and family members are active partners in designing and making decisions for the system of care. In addition to full-time youth and family coordinators, each of the seven subcommittees of the Governing Council is co-chaired either by a family or youth representative. Children and youth do not need to have experienced trauma to be eligible for the services, but evidence shows that 50-80 percent of those with severe emotional disorders have in fact experienced trauma. Anticipated outcomes include decreased trauma and revictimization, reduced school drop-out rates, and the elimination or lessening of the stigma related to mental health. THRIVE uses a uniform system assessment tool to promote safety, achieve greater consistency in case management, and decrease out-of-home placement. (See Case Study in Section 6.)

## Public Systems

**Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET), Connecticut.** This state-level commitment to trauma-informed evidence-based practice uses a set of seven practical skills to counteract the negative outcomes of chronic trauma. TARGET was adopted by the juvenile justice system in Connecticut in 2002 for youth ages 10 to 18. Since then, many state and private agencies in Connecticut have trained their workforce in TARGET, and interest in the intervention is growing across the United States, Canada, and abroad. Preliminary analyses show that parents and children feel more confident in managing symptoms of trauma. TARGET researchers continue to promote dissemination of the program, while also focusing on developing tools for evaluation and quality assurance.

**Statewide Multi-Systemic Therapy (MST) Connecticut.** Connecticut has also expanded its use of evidence-based practices through the statewide adoption of multi-systemic therapy (MST). Although the state's move to adopt MST was driven primarily by external factors including a lawsuit, Connecticut has developed a strong model that promotes quality and accountability in the child welfare and juvenile justice systems. MST implementation has resulted in partnerships with stakeholders at multiple levels. Today, there are over 25 MST teams statewide and Connecticut has now expanded these teams' competencies to include a number of other evidence-based practices.

*Getting trauma-informed care remains subject to "dumb luck."*

—A meeting participant

## SECTION 4
# Policies to Support Trauma-Informed Practice

## State Policy Initiatives

State-led efforts to embed trauma-informed practice in child welfare agencies, juvenile justice and mental health agencies are increasing. Below we discuss three statewide approaches and trends across states to build infrastructure and infuse trauma information into policy.

### Targeted Legislation

#### *Illinois*

In Illinois, the state passed legislation in 2005 that specifically addressed trauma services as part of the continuum of services that must be available to children and youth in the child welfare system. (See Box 6.) These services include a trauma-informed work plan that implements standardized assessments and evidence-based practices.[183] The state used its poor performance on the Child and Family Service Reviews (CFSR)—a nationally developed and implemented measure of states' performance in child welfare—as an impetus for change within its child welfare system. According to the Illinois Statewide Behavioral Health Administrator, Tim Gawron, the state:

- Developed a conceptual framework for reform based upon promoting resilience and identifying service needs and gaps.
- Used a public health framework to identify three levels for intervention and support:
  - Primary or universal level, based upon risk factors.
  - Secondary or targeted level that focuses on children in the child welfare system.
  - Tertiary or intensive level that directly addresses the impact of trauma and/or serious emotional disturbance among children in the child welfare system.
- Sought to strengthen the state's infrastructure to support trauma-informed care by:
  - Developing and reinforcing a quality workforce.
  - Building community-based capacity to deliver evidence-based care.

**Box 6: State Policies: Illinois Child Trauma Legislation**

Illinois State Code: Sec. 5.25. Behavioral health services

a. Every child in the care of the Department of Children and Family Services under this Act shall receive the necessary behavioral health services including but not limited to: mental health services, **trauma services**, substance abuse services, and developmental disabilities services. The provision of these services may be provided in milieu including but not limited to: integrated assessment, treatment plans, individual and group therapy, specialized foster care, community-based programming, licensed residential services, psychosocial rehabilitation, screening assessment and support services, hospitalization, and transitional planning and referral to the Department of Human Services for appropriate services when the child reaches adulthood.

b. Services shall be appropriate to meet the needs of the individual child and may be provided to the child at the site of the program, facility, or foster home or at an otherwise appropriate location. A program facility, or home, shall assist the Department staff in arranging for a child to receive behavioral health services from an outside provider when those services are necessary to meet the child's needs and the child wishes to receive them.

Source: State of Illinois. (2005). *The Children and Families Act, Public Act 094-0034.*

### *Massachusetts*

In Massachusetts, the effort to address trauma as an impediment to learning led to a multi-year collaborative effort, driven largely by advocates. In turn, this effort resulted in The Safe and Supportive Learning law. Through this legislation, 34 schools districts have received grants commonly referred to as "trauma sensitive school grants," designed to improve the ability of schools to be trauma-responsive environments.[184] A plan of action by the collaborative was created to promote supportive policy and practice environments in the schools. (See Box 7.)

The initiative also resulted in the development of an advocates' handbook. Efforts to implement trauma-informed practices in schools face many challenges. These include:

- Low priority for building trauma-informed learning environments.
- Lack of time to plan or provide the supports for trauma-informed strategies.
- Educational administrative and system-related policies that hinder or disrupt building a trauma-informed climate.
- Insufficient funding for trauma-informed initiatives.

**Box 7: State Policies: Massachusetts—Fostering Trauma-Informed Environments in Schools**

Trauma leaders in Massachusetts developed an agenda to enable schools to become supportive environments, where traumatized children can focus, behave appropriately, and learn. Using Massachusetts Advocates for Children: Trauma and Learning Policy Initiative's *Helping Traumatized Children Learn: A Report and Policy Agenda*, they designed the Flexible Framework for teachers and schools. The Flexible Framework: an Action Plan for Schools, comprises six key elements amenable to school-by-school customization:

1. School-wide infrastructure and culture (engaging leaders and embodying trauma-responsive strategies in administrative structures)
2. Staff training (developing core competencies in trauma in teachers, clinicians, youth, families, administrative personnel, and community stakeholders)
3. Linking with mental health professionals (ensuring trauma-sensitive expertise onsite and in the community)
4. Academic instruction for traumatized children (using trauma-responsive strategies based on up-to-date knowledge and techniques)
5. Nonacademic strategies (for example, promoting extracurricular activities such as sports and/or theater to build self-esteem and confidence)
6. School policies, procedures and protocols (aligning discipline policies, day-to-day school management and procedures, and communication mechanisms, procedures, and policies with trauma-informed strategies)

Stakeholders sought to improve academic, health, and social well-being outcomes for students who have experienced trauma. Their recommended set of policy choices includes:

- Provide funding to schools and preschools to develop schoolwide action plans to address the needs of students exposed to trauma
- Develop consensus on laws, policies, and financing strategies to help schools identify and intervene early with students exposed to violence
- Establish knowledge about trauma, its impact, and how to recognize and address it as core competencies required of school personnel, particularly teachers and administrators, and mental health providers
- Reduce punitive responses such as expulsions, suspensions, and referrals to the juvenile justice system.

Source: Cole, S. F.; Obrien, J. G.; Gadd, M. G.; Ristuccia, J.; Wallace, D. L. & Gregory, M. (2005). *Helping traumatized children learn: Supportive school environments for children traumatized by family violence*. Boston: Massachusetts Advocates for Children in collaboration with The Hale and Dorr Legal Services Center of Harvard Law School and the Task Force on Children Affected by Domestic Violence <ww.opi.mt.gov/pdf/indianed/TeachTraumatizedKids.pdf>.

## Sustaining Infrastructure

### *Oklahoma*

Oklahoma has designed an approach to building workforce capacity for trauma-informed care that includes training (including cross-training of clinical and nonclinical staff), technical assistance and support, and monitoring. (See Figure 4.) Oklahoma attributes its success to:

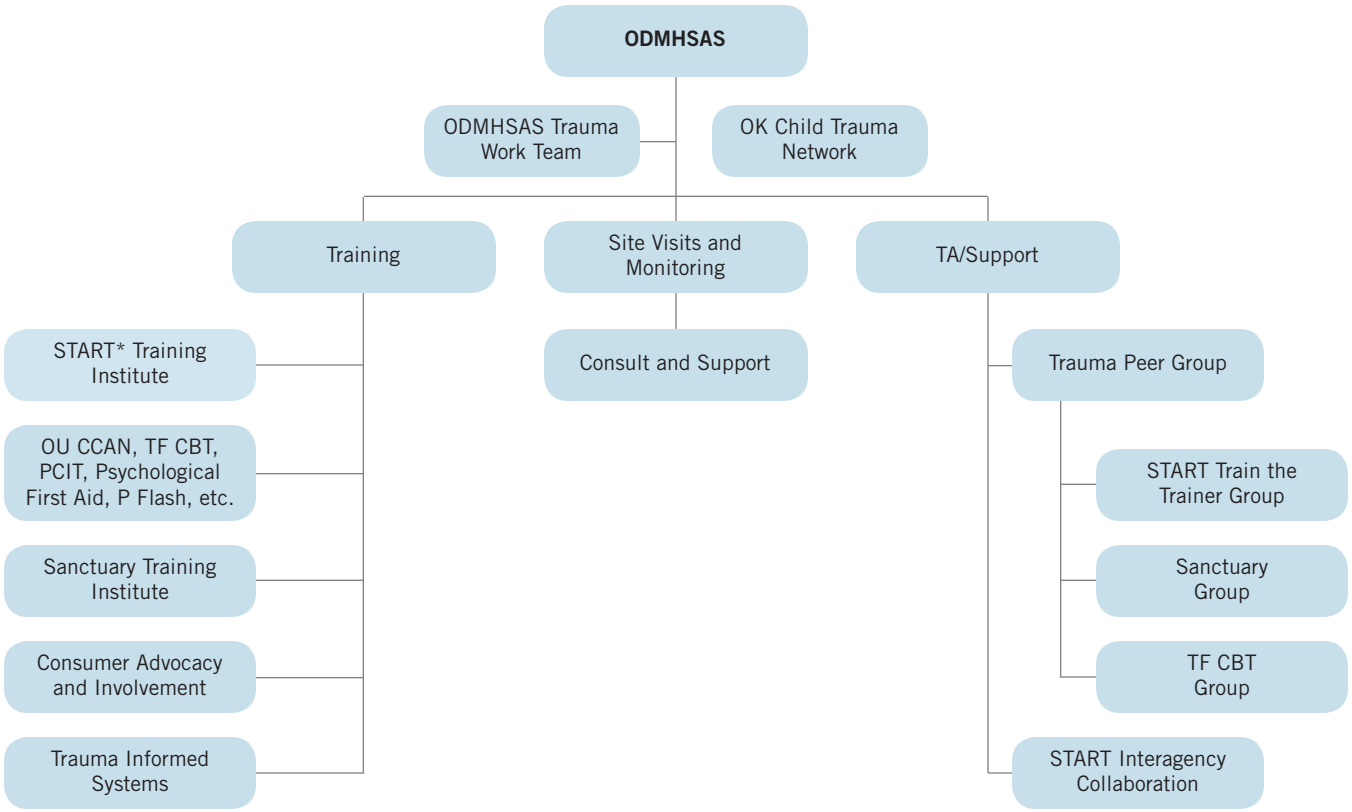
- Leadership support
- State and federal funding (including four federally funded initiatives)
- Dedicated staff
- Cross-program collaborations

Unique to this state's trauma strategy is a site visit and monitoring component that combines technical assistance with quality improvement to state contractors, using the Jennings checklist to enhance quality.[185] (See Figures 5a & 5b.) A set of eight criteria to guide administrative practices and six criteria related to services are included in the checklist. Administrative practices and trauma-related services are gauged according to their level of incorporation into the organization's way of operating. Oklahoma has also established a full-time position at the state level dedicated to trauma coordination.

Despite Oklahoma's success in laying the foundation for competent workforce development, challenges remain:

- The state continues to address mental health provider shortages, provider mobility, and workforce attrition. Additionally, the provider pool lacks ample racial, ethnic, and cultural diversity to meet many of the specific needs of trauma survivors, their families, and those at-risk.
- Staff burnout is a common issue affecting a workforce providing services to trauma survivors. The state's provider peer support initiative tackles issues of secondary trauma and staff burnout that tend to be more acute with providers who support trauma-informed initiatives.
- Fragmented funding streams, inflexible regulations and mechanisms for billing services, and uneven provider compensation hamper attempts to foster a workforce capable of delivering quality trauma-informed services.

**Figure 4: Oklahoma's organizational chart for trauma-informed services**




* START: Systematic training to assist in recovery from trauma

Source: Julie Young, Oklahoma Department of Mental Health & Substance Abuse Services (Draft) (2006).

**Figure 5a: Oklahoma Checklist for Trauma-informed Administrative Practices**

| | Criteria | None | Exist as Policy | Exist as Protocol | In Progress | Routinely Done | NFC Mental Health Final Report Goal(s) |
|---|---|---|---|---|---|---|---|
| 1 | A single, high level, clearly identified point of responsibility within the agency. | | | | | | |
| 2 | Agency trauma policy or position paper. | | | | | | |
| 3 | Workforce orientation, training, support, competencies, and job standards related to trauma. | | | | | | Goal 5.3, 5.4 |
| 3a | All employees should received basic education about the traumatic impacts of sexual and physical abuse and other interpersonal violence, to increase sensitization to trauma related dynamics and the avoidance of re-traumatization. | | | | | | |
| 3b | All human resource development activities should reflect understanding of and sensitivity to issues of violence, trauma, and coercion. | | | | | | |
| 3c | All human resource development activities should incorporate relevant skill sets and job standards, and address the impact of traumatic events. | | | | | | |
| 3d | Direct care and clinical staff should be educated in a trauma informed understanding of unusual or difficult behaviors. | | | | | | |
| 3e | Direct care and clinical staff should be educated in the maintenance of personal and professional boundaries. | | | | | | |
| 3f | Direct care and clinical staff should be educated in evidence based and emerging best practices in the treatment of trauma | | | | | | |
| 3g | Direct care and clinical staff should be educated in vicarious traumatization and self care. | | | | | | |
| 4 | Linkage with higher education to promote education of professionals in trauma. | | | | | | Goal 5.3 |
| 5 | Consumer involvement is at the core of all system activities. | | | | | | Goals 2.1, 2.2, 2.3, 2.4, 2.5 |
| 5a. | Trauma informed individualized plan of care should be developed with every adult and child receiving services. | | | | | | |
| 6 | Trauma policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status. | | | | | | Goals 3.1, 3.2 |
| 7 | Systems integration and coordination between and among systems of care. | | | | | | Goals 4.2, 4.3, 4.4 |
| 8 | Trauma informed disaster planning and terrorism response. | | | | | | Goals 5.2, 5.3 |
| 8a | All disaster responders should be trained and knowledgable about mental health trauma issues from the initial assessment through the intervention process, including skills of recognizing and coping with trauma reactions. | | | | | | |
| 8b | Clinicians should be trained in longer term interventions for recognizing, diagnosing, and treating those who develop PTSD or other stress responses and those whose existing history of abuse and trauma is further exacerbated by current disaster. | | | | | | |

Source: Julie Young, Oklahoma Department of Mental Health & Substance Abuse Services (Draft) (2006).

**Figure 5b: Oklahoma Checklist for Trauma-informed Services**

| | Criteria | None | Policy | Protocol | In Progress | Routinely Done | NFC Mental Health Final Report Goal(s) |
|---|---|---|---|---|---|---|---|
| 1 | Clinical practice guidelines for working with people with trauma histories. | | | | | | |
| 1a | Promotion of recovery. | | | | | | |
| 1b | Trauma-sensitive training and supervision. Address secondary trauma and self care for caregivers. | | | | | | |
| 1c | Clinical practice is experienced by consumers as empowering. | | | | | | |
| 2 | Procedures to avoid re-traumatization and reduce impacts of trauma. | | | | | | |
| 2a | Efforts should be made to reduce or eliminate any potentially retraumatizing practices such as seclusion and restraint, involuntary medication, etc. | | | | | | |
| 2b | Training should cover dynamics of retraumatization and how practices can mimic original sexual and physical abuse experiences, trigger trauma responses, and can cause further harm to the person. | | | | | | |
| 2c | Policies in place to create safety, acknowledge and minimize the potential for re-traumatization, assess trauma history, address trauma history in treatment and discharge plans, respect gender differences, and provide immediate intervention to mitigate effects. | | | | | | |
| 3 | Research on prevalence and impacts, services utilization and needs, trauma treatment intervention outcomes related to recovery and resilience, and satisfaction with trauma services should be regularly collected and should be used as part of ongoing quality improvement and planning processes. | | | | | | Goals 5.1, 5.4 |
| 4 | Trauma screening and should be conducted with all adults and children. People with positive screen should have access to a trauma assessment as an integral part of the clinical picture to be revisited periodically. | | | | | | |
| 4a | Consumers with trauma histories are informed about and referred to quality, trauma-informed and trauma specific services and supports. | | | | | | |
| 5 | Trauma informed service system. | | | | | | |
| 5a | Basic understanding of trauma and trauma dynamics are held by all staff and used to design services that recognize the potential for certain vulnerabilities of trauma survivors and allow services to be delivered in a way that will avoid re-traumatization and facilitate consumer participation in treatment. | | | | | | |
| 5b | Service delivery practices ensure the physical and emotional safety of the consumers and staff members. | | | | | | |
| 6 | Provision of evidence based trauma specific services. | | | | | | Goals 2.1, 3, 4.3, 5.2, 6.1 |
| 6a | All services are recovery oriented, integrated, emphasis on consumer involvement and choice, and trauma informed. | | | | | | |

Source: Julie Young, Oklahoma Department of Mental Health & Substance Abuse Services (Draft) (2006).

## Reducing Harmful Practices

### *Seclusion and Restraint*

Massachusetts, Louisiana, and Hawaii are part of an eight-state initiative led by SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD) to eliminate the use of seclusion and restraint in residential facilities and hospitals. These three states in particular focus on children. Massachusetts has reduced seclusion and restraints in institutions for children by 81 percent. Louisiana has reduced restraints by 79 percent, and Hawaii, which did not use restraints and seclusion widely, changed its culture to address children who were running away or being assaulted.[186]

## Improving Early Identification and Treatment

Beyond these specific examples, NCCP's review of services, training, policies, financing, and planning efforts suggests significant advances in states. (See Appendix C.)

- Most states offer some form of screening and assessment.
  - In nearly 60 percent of states and territories (data available on 46 states), universal or selective screenings and assessments are being conducted. In some cases the scope is limited.
  - In less than 20 percent of these states, the screening and assessment tools are evidence-based.
  - At least 20 states have implemented laws, regulations, or policies designed to reduce and ultimately eliminate the use of seclusion and restraint. Five of these states have implemented strategies with far-reaching impact.
- Many states have developed training strategies of varying depth to increase the clinical and support capacity of those who deliver services to children, youth, and their families who have been exposed to trauma.
  - Nearly 40 percent of states (data available for 38 states) report training on trauma-informed/specific evidence-based practices.
  - A small proportion of this training focuses on cultural groups, gender, or families.

While not widespread, some best practices in training in states include:

- Strategies aimed at developing trauma specialists, as in Oklahoma
- System wide or discipline-wide training, as in Connecticut, Maine, Nevada, New York, Oklahoma, Illinois, and Washington
- Trauma-related training that meets the conditions for state clinician certification, as in Wyoming
- Embedding a trauma focus in statewide evidence-based training dissemination centers, as in New York

A number of state legislatures have also appropriated funding for specific trauma-related initiatives. Other state leaders have expanded the Medicaid benefit set to reimburse evidence-based trauma treatments, to facilitate trauma-specific treatments through billing and to fund specific clinicians. Generally absent are any state specific strategies to focus on information technology to create a more trauma-informed system.

Many state-led initiatives signal a proactive, empirically-informed, public health and sometimes bold approach to trauma as documented in this report. Transforming systems is hard work and requires sustaining buy-in at multiple levels, building a common cross-system language, and developing strategies to address negative perceptions related to evidence-based practice. It also requires attention to the appropriate staging and implementation timeframes and performance incentives to enhance and maintain quality. Clearly it can be done; nonetheless, excitement about the potential of these efforts must be tempered by the realization that a public health perspective requires a workforce capacity that does not currently exist. National evaluator and family advocate Shannon Crossbear points out that, "In some areas, one must travel 150 miles to the nearest mental health worker." Transportation and provider shortages have been identified as major obstacles to accessing care.

*The adolescent Latina suicide crisis will continue until greater efforts are made to understand and take into account social, economic and cultural factors behind their despair. Mental Health services in its traditional form will not help to decrease or prevent Latina suicide. It is nothing more than a band-aid.*

—Sonia Garcia, meeting participant

## The Federal Role

### Legislative Initiatives

#### *Suicide Prevention*

In 2004, Congress passed the Garrett Lee Smith Memorial Act. The law contains two grant programs, (1) Youth Suicide Early Intervention and Prevention Strategies and (2) Mental and Behavioral Health Services on Campus.[187] Funding was appropriated at $7 million, $18 million and $30 million from 2005-2007 for the Youth Suicide component. The mental health services on campus component of the grant awarded $5 million per year from 2005-2007. These awards support efforts to develop or continue statewide or tribal suicide early intervention and prevention strategies and surveillance of these strategies; examine the cost and effectiveness of suicide prevention strategies; promote data sharing on youth suicide; and evaluate and disseminate best practices on positive outcomes of youth mental health services. To date, 29 states and seven tribal communities have received awards.[188] Five of these states currently implement statewide strategies, and eight initiated targeted efforts.[189] (See Box 8.)

#### *National Child Traumatic Stress Network*

In 2000, Congress established The National Child Traumatic Stress Network (NCTSN) to elevate the quality of trauma-informed services through the Children's Health Act. Now consisting of 70 centers, the network receives funding from the federal Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA). Network members provided trauma-informed services to approximately 50,000 youth per year.[190]

**Box 8: Youth Suicide Prevention Goals—U.S. Surgeon General**

1. Promote awareness that suicide is a preventable public health problem.
2. Develop broad-based support for suicide prevention efforts.
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.
4. Develop and implement community-based suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Implement training for recognition of at-risk behavior and delivery of effective treatment.
7. Develop and promote effective clinical and professional practices.
8. Increase access to and community linkages with mental health and substance abuse services.
9. Improve reporting of and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
10. Promote and support research on suicide and suicide prevention.
11. Improve and expand surveillance systems.

Source: U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action.* Washington, DC: U.S. Department of Health and Human Services <mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517/Default.asp>.

### *Traditional Healing*

Congress updated a law to protect and preserve American-Indian traditional religions in 1996 (Public Law 95-341, 42 U.S.C.§ 1996), thereby enabling American Indians/Alaska Natives to reclaim an important source for healing trauma, particularly historical trauma.

The 1978 law[191] stated that:

> "On and after August 11, 1978, it shall be the policy of the United States to protect and preserve for American Indians their inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use, and possession of sacred objects, and the freedom to worship through ceremonials and traditional rites...", and
>
> "The President directs the various federal departments, agencies, and other instrumentalities responsible for administering relevant laws to evaluate their policies and procedures in consultation with native traditional religious leaders to determine changes necessary to preserve Native American religious cultural rights and practices and report to the Congress 12 months after Aug. 11, 1978."

## Targeted Initiatives

One well-publicized example of efforts to eliminate harmful practices in treatment evolved around a national effort to eliminate the use of seclusion and restraints. Other strategies include addressing quality problems in settings with records of harmful outcomes for children and youth, such as boot camps and unregulated residential treatment facilities.

### *Eliminating Seclusions and Restraints*

In May 2003, SAMHSA under the direction of Charles Curie convened a National Call to Action to Eliminate Seclusion and Restraint.[192] The meeting followed a series of legislative and regulatory milestones and several investigative studies, including a series of high-profile articles in the *Hartford Courant* that chronicled a litany of adverse events, including 142 deaths associated with the use of restraints.[193] The newspaper published estimates that up to 150 deaths nationwide were due to restraints based on analysis conducted by Harvard University.[194] A subsequent GAO report in 1999 resulted in passage of the Children's Health Act of 2000 that instructed SAMHSA to develop reporting requirements and guidelines for the use of seclusion and restraints, and impose regulations on personnel and training.[195] SAMHSA's subsequent seclusion and restraint initiative ultimately included a $5.3 million infrastructure grant program to eight states (initial results showed a 79 percent decline in hours of seclusion and restraint and a 62 percent reduction in patients exposed), and a coordinating center for technical assistance and training.[196] In late 2006, the Center for Medicare & Medicaid Services (CMS) passed final rules for Medicaid and Medicare participating facilities and states that set minimum standards for patient care to include regulations on the use of seclusion and restraints. Training and reporting requirements are part of the final rules.[197]

### *National Child Traumatic Stress Network Initiatives*

The National Child Traumatic Stress Network, sponsored by the federal government, oversees two initiatives to train individuals in Trauma-Focused Cognitive Behavioral Therapy, the Breakthrough Series Collaborative and the Learning Collaborative. The initiatives both require senior-level organizational participation while engaging all levels of the organization in the training. NCTSN uses technology and frequent meetings to encourage partnerships between participants and promote knowledge dissemination and skills-building. Although both programs have faced challenges, particularly financial difficulties, the collaborations have created a ripple effect of knowledge dissemination for trauma-informed approaches to many sites in the country. The forthcoming results of a federally funded national evaluation of NCTSN conducted by MACRO[198] will help inform future efforts.[199] (See case study in Section 6.)

### *Supporting Trauma-Informed Care Through Fiscal Policy*

Since 1998, the U.S. Veterans' Administration (VA) has been reimbursing families of Navajo veterans for traditional Navajo healing ceremonies. The VA's decision to pay for traditional healing services came as a result of the Navajo Veterans Health Needs Survey.[200] The survey, conducted in 1992, found that more Navajo veterans used traditional healing ceremonies than any other form of health care. In addition, while the veter-

*This fragmented and often unsustainable approach means that the funding mechanisms do not support care delivery systems consistent with best practice. That is, they do not offer a full range of prevention efforts, the use of non-traditional providers such as natural helpers, or screening tools designed for specific populations or settings such as young children or youth in detention or juvenile facilities.*

ans considered traditional healing treatment as essential to getting better, most reported that they could not pay for the ceremonies.[201] Ceremonies that the VA has reimbursed include:[202]

| | |
|---|---|
| Enemy Way | Hand Trembling |
| Smoke Ceremony | Star Gazing |
| Protection Prayer | Shooting Way |
| Night Way | Evil Way |
| Blessing Way | Flint Way |
| Crystal Gazing | Monster Way |

Increasingly, payers like the VA reimburse for traditional Native healing ceremonies to address mental health conditions like PTSD and other mental health disorders. In a more recent study of rural residents in New Mexico, 62 percent of Navajo respondents report using traditional healers, and nearly 40 percent report using them regularly.[203] Depression is one of the health conditions for which respondents seek such treatment. Cost is a major obstacle to accessing traditional healing as part of a plan for recovery.[204]

## Unaddressed Challenges

Despite the evidence, public policies, particularly federal policies, have failed to keep up with the science on effective practices and policies, or even government generated data about poor outcomes for children and youth related to trauma. On the positive side, there have been some targeted federal initiatives such as the NTCSN, the SAMHSA seclusion and restraint initiatives, and the recently initiated National Network to Eliminate Disparities (NNED), a collaboration between SAMHSA and the National Alliance of Multi-Ethnic Behavioral Health Associations. Further, recent federal reports call for a public health model of mental health care and specific trauma initiatives, such as suicide prevention.[205]

Yet, executive agency, legislative, and fiscal policies serve to undermine both prevention and trauma-informed treatment practices. Four issues are particularly salient and in the end, mean that some funds that are expended have less impact than they otherwise might: (1) lack of coherent strategic plans, (2) funding restrictions that impede care and sustainability, (3) low support for prevention and intervention, and (4) an inadequate and uneven-quality workforce. Put plainly, federal restrictions mean that often trauma-targeted dollars are not used for maximum impact consistent with emerging knowledge.

### *Lack of Coherent Strategic Plans*

There is no coherent strategic plan across multiple federal agencies to help states and communities address trauma in consistent ways. Program-related centers in SAMHSA focus on mental health, substance abuse prevention, and substance abuse treatment. Trauma cuts across all of them. A coordinated trauma-informed strategy that incorporates knowledge about the intersection between trauma and substance abuse is lacking. This is despite significant knowledge within these agencies based on explicit research and service demonstrations that they have funded. Similar challenges are apparent within the federal Center for Mental Health Services. It is not clear how programs and staff with responsibilities for children, youth, and families in general connect with those that focus specifically on trauma. In 2004, SAMHSA's administrator initiated a set of 10 national outcomes measures for mental health and substance abuse.[206] None of these measures refer to trauma. Even more importantly, it is not clear how the federal government is helping states prepare to address future natural and man-made disasters to ensure that the states have an emerging child and family focused infrastructure in place.

### *Funding Restrictions Impede Care and Sustainability*

Funding silos and program restrictions characterizes and serve to limit the impact of available federal dollars. Federal fiscal policy present even more challenges The Finance Project identified 69 federal funding sources that provide funding at various levels (state/local/tribal government, and public/private) for different domains and categories of trauma; this number is up nearly 40 percent since a previous review in 2002.[207] Among the federal funds, 42 pay for direct trauma services, infrastructure, and capacity building; five programs fund trauma services and infrastructure; 17 fund infrastructures and capacity building, one funds trauma services and capacity building, and three fund only infrastructure.[208] (See Box 9.) Moreover, NCCP's own analysis shows that only four grant programs are funded by multiple federal agencies.[209]

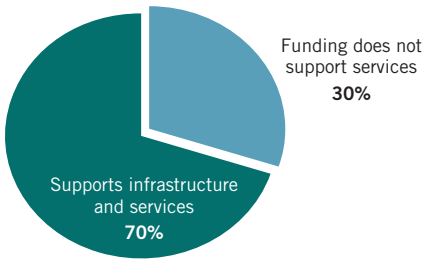
Financing for trauma-informed services for children, youth, and families remains unstable. Many federal initiatives rely on grant funding subject to the vagaries of the annual budget process. Discretionary grants account for nearly 70 percent of funding in this area.[210] And most important, the bulk of financing for trauma-related services and supports for children, youth, and their families remains outside the mainstream of health care financing. For example, a recent report identified only Medicaid and Title IV-E that could be portrayed as consistent funding sources [211] In each case, restrictions limit the program's flexibility support trauma-informed strategies. For instance, changes in Medicaid and Title IV-E due to the Deficit Reduction Act (DRA) places restrictions on which children and youth can benefit from Medicaid-funded trauma interventions, particularly noncitizen children and youth; and those children and youth who do not meet Title IV-E eligibility.[212] Specifically, DRA outlawed a range of relative placements for children and youth who were traumatized and would qualify for support and assistance irrespective of strict Title IV-E eligibility.[213] In addition, Title IV-E-sponsored training faces significant restrictions as a result of DRA.[214]

**Box 9: Federal Funding Sources by Categories**

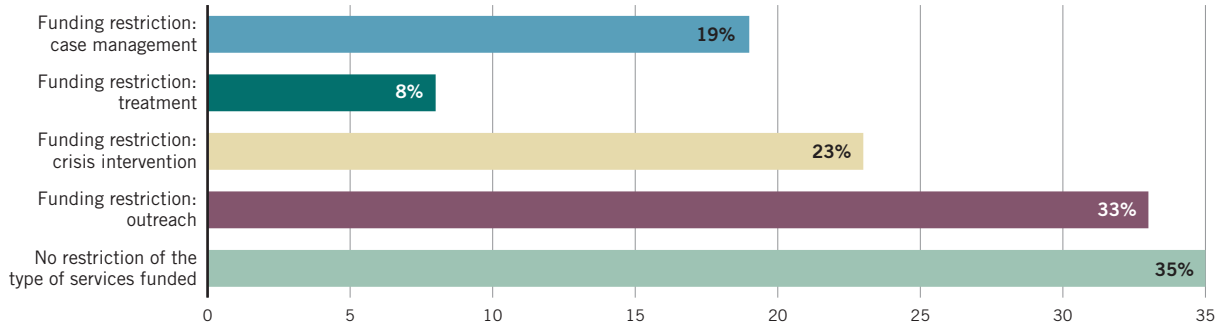
A recent report documents 69 federal funding streams that support trauma-related services and infrastructure. All of these provide funding for some kind of infrastructure support such as salaries, administrative costs, collaboration, facility maintenance costs, information technology, training and technical assistance.

Approximately 70% of these funding streams support the provision of trauma-informed services. Most service related funding include restrictions on the types of services funded (65%).

**Federal funding that supports trauma-related services and supports**




**Restrictions on federal funding for trauma-related services for selected federal programs by service restriction type**




Source: Grey, A. & Szekely, A. (2006). *Finding funding: A guide to federal sources for Child Traumatic Stress and other trauma-focused initiatives.* Los Angeles, CA, Durham, NC and Washington, DC: National Child Traumatic Stress Network and The Finance Project.

In addition, this fragmented and often unsustainable approach means that the funding mechanisms do not support care delivery systems consistent with best practice. They fail to offer a full range of prevention efforts. The use of nontraditional providers such as natural helpers, or screening tools designed for specific populations or settings, such as young children or youth in detention or juvenile facilities is often not supported. Moreover, rather than recognizing that trauma is a family crisis, some funding prohibits outright financing of any services and supports for any individual other than the "indicated child." Thus, parents, siblings, and other caregivers are often excluded from help, although they are integral to the healing and well-being of the child and the prevention of further trauma.[215]

Recent proposed changes to both Medicaid and Title IV-E, the two entitlement programs that provide funding for trauma services, will further impede states' ability to use these programs either due to new restrictions or funding availability. In particular, specific changes to components of Medicaid, such as the rehabilitation option, will hamper states' ability to flexibly fund prevention and early intervention services. Other proposed restrictions to case management will impact trauma-focused services in juvenile justice and child welfare.[216] Changes to Medicaid funding for transportation services related to school-based services and support for administrative-related costs in schools is also expected to negatively impact trauma-informed services.

### *Limited Support for Prevention and Early Intervention*

**There is no secure, ongoing funding stream that supports developmentally- and culturally-appropriate efforts for prevention and early intervention for children exposed to trauma, particularly young children.** As a result, there are relatively few services available to provide rapid and evidence-based family-focused help. Current federal policies essentially fall into two categories: those that require diagnoses and those that target children with less exposure to risk. To intervene with children exposed to potentially damaging experiences, such as domestic or community violence, programs and providers must scramble to piece together funding, often from unsustainable grants. Particularly problematic for young children is that, one important way of preventing the negative impacts of trauma is to address parental trauma. But the lack of family-focused funding makes it almost impossible to sustain even the most effective two-generation interventions. The adult system deals with adults, the children's system with children, and families fall in between.[217]

### *Inadequate Workforce Supply and Quality*

**The provider pool lacks the depth and quality to meet the current service demands.** Most providers simply do not have the expertise, knowledge, and certification to fulfill the increasing demand for specialized professionals knowledgeable in evidence-based practice, including trauma-informed practice, and outcomes-focused practice.

#### Psychiatry and Social Work

Training of the national behavioral health care workforce has been described as in "crisis."[218] With respect to children and youth, the gap between the need and the capacity is growing. Child and adolescent psychiatric provider shortages are well documented. The availability of specialists impacts the number of children who can access mental health care and the choice of other treatment options.[219] With only 6,300 child and adolescent psychiatrists nationally, and the uneven geographical distribution of mental health experts, the gap between the need for service providers and the supply remains wide. There are projections that this mismatch will persist; forecasts suggest that there is a need for at least 12,624 child and adolescent psychiatric physicians in the next 15 years, significantly more than the anticipated supply.[220] Shortages are projected for other mental health providers also. For example, the U.S. Bureau of Labor Statistics projects an increase in demand for social workers of between 18-26 percent.[221] Further, more than half of all counties in the United States, all of them rural, have no practicing mental health professionals.[222]

The lack of mental health providers who are trained in up-to-date practices compound the problems with availability of personnel. Even when trained, significant challenges persist in ensuring that providers implement trauma-informed strategies with fidelity and consistency. For example, recent research suggests that despite mounting evidence of the effectiveness of empirically supported treatments versus treatment as usual, uptake of evidence-based practices remains limited and pro-

vider resistance strong.[223] Factors that support provider adoption are often ignored. Organizational support is often wavering, training strategies inconsistent, and supervision underemphasized.[224]

To date, the federal government has supported analysis of the mental health workforce problem through the Annapolis Coalition. Yet there is no rigorous federal response, either through bold outcomes-focused legislation, fiscal incentives, or other initiatives. The challenges are compounded by the urgent need to address the workforce capacity through training institutions and post-secondary education. Noticeably absent are incentives aimed at post-secondary training and academic institutions designed to produce a better prepared workforce whose competencies better match the needs of the health and mental health workplace.

**Child Welfare**

Staff turnover in child welfare runs as high as 50 percent.[225] A GAO study found that issues with recruitment and retention of staff compromised quality and safety.[226] The study attributed the following factors to poor retention rates in child welfare:[227]

- Poor pay
- Inadequate supervision
- Insufficient training
- High and demanding caseloads

Child and family services social workers earn less than social workers in any field. Moreover, social workers who work with children and youth are more likely to be young, and less likely to reflect the culture, ethnicity, or racial background of the children, youth, and families they serve, and to work in agencies with high vacancy rates.[228]

As with mental health, child welfare failed to alter the trajectory of its workforce. The GAO admonished the federal government, noting that it had too narrowly construed its authority in addressing factors associated with workforce capacity such as caseloads.[229] Recently, the Child and Family Services Improvement Act, boosted federal funding to $40 million to enhance workforce development strategies and address substance abuse, especially methamphetamine abuse.[230] This funding emphasizes recruitment, retention, training, and integration of technology to improve the workforce.[231] It is not likely to be sufficient to adequately address the challenges of provider shortages and the serious mismatch between providers' qualifications and the skills they need to implement effective, empirically-based strategies.[232]

**Juvenile Justice**

The juvenile justice system's estimated 300,000 workers cannot adequately staff facilities and provide necessary trauma-related services[233] Nearly one-quarter of juvenile justice facilities face difficulty in recruiting a trained workforce because of:[234]

- Too few applicants
- A mismatch between the qualifications needed to perform the job and the caliber of workers who apply for jobs

Those who leave juvenile justice attribute the system's inability to retain workers to:[235]

- Lack of advancement
- Heavy caseloads
- Poor leadership and unsatisfactory supervision
- Unsafe working conditions
- Low pay

**Substance Abuse**

Retention, recruitment, and quality problems also plague the substance abuse field. One regional study found a yearly turnover rate of 25 percent per year among substance abuse treatment providers.[236] Substance abuse treatment directors cite failure of many applicants to meet basic minimum qualifications and poor pay as the major reasons they have trouble recruiting and later retaining staff.[237]

Even among providers with experience, several problems are common:

- Treatment of co-occurring disorders is complex and both mental health and substance abuse providers report that co-morbid conditions are the most difficult to treat.
- Cross-discipline training is limited:
  - Only 50 percent of mental health providers

(with the exception of psychiatrists) receive formal graduate level training in substance abuse treatment.[238]

- 50-60 percent of mental health providers had no continuing education on substance abuse treatment within the past year.[239]
- While most child and adolescent psychiatry residency programs have people with substance use disorders in the population treated by residents, less than 40 percent of residency programs have a clinical rotation devoted to substance use disorders.[240]

There are several implications of this mismatch between the workforce available to care for children, youth, and families exposed to trauma and the work required to practice in a trauma-informed manner.

- Without significant attention and resources, application of the core components of a trauma-informed care delivery model is likely to be limited.
- Alternative public policy options must be advanced to revamp the workforce.
- The cost implications of doing business as usual are significant.

*We can't afford to waste time. We [must] move with a sense of urgency. We talk about people in the military but people in reserves do not get these services. Young people are home for 6 months and there are big gaps, [we are] losing lots of children. We have to bring [these programs] to scale.*

—Meeting Participant

## SECTION 5
# Toward the Future: What Can Be Done

All child-serving systems have an obligation to help children and youth lead productive lives. Despite increased attention to trauma and the dedication of more resources, children, youth, and their families invariably encounter a service delivery system that is ill-prepared to serve them. Not only are many of these systems operating inefficiently using ineffective tools and strategies, they often serve to compound the risk of harm and contribute to further exposure to trauma. The challenge remains how to create, support, and sustain a care delivery system that reflects the best information we have about trauma, including how to prevent it and limit recurrence. Much of the public's attention has been directed at how to prepare for disasters to come.

This report shows that trauma in the United States is pervasive and persistent, particularly for children and youth who are abused emotionally, physically, and sexually; who are exposed to violence; or who experience natural and man-made disasters. Traumatic experiences sometimes result in suicidal behaviors and tragically, sometimes in suicide. Most often exposure to trauma results in long-term challenges in child and youth development, particularly impacting learning, health, and mental health. Some of these problems extend into adulthood and have lifelong consequences, including intergenerational transmission of trauma.

While all states have made some efforts to address trauma, overall comprehensive, systematic trauma-informed policies are limited. Current policy and service responses inconsistently apply what we know about effective trauma practice even when children and youth are identified as having been traumatized. In fact, some policies and practices place children, youth, and families at increased risk for trauma and retraumatization. Comprehensive efforts to adopt knowledge-based strategies are defined by standardized screening and assessments; empirically supported practices—some of which are culturally and linguistically-based; family and youth engagement; and a robust infrastructure. Some tribal nations, states, and local communities have used a trauma-informed lens to implement policies for children, youth, and families. A few are reported here. Those states, localities, and tribes that adopt knowledge-based strategies often encounter policy challenges that undermine these strategies. The policy challenges include lack of strategic planning, funding restrictions that stifle trauma-informed care delivery, inferior support for prevention and early intervention, and inadequate workforce capacity.

Consequently, NCCP recommends that federal, tribal and state governments provide strong leadership to promote trauma-informed policies rooted in sound and supportive fiscal practices. Governments should also implement a vigorous and comprehensive strategy to address shortcomings in workforce capacity. In the absence of more vital, intentional policymaking that is trauma-informed, children, youth, and their families exposed to trauma and/or at-risk for trauma-related symptoms remain vulnerable to immediate and long-term suffering. Accountability demands proactive policies. These must build upon the lessons learned. They also must support the scale of implementation that the unprecedented need and a lackluster history of attention to this issue warrants. Children, youth, and families, particularly trauma survivors, deserve such accountability. Listed below are specific strategies that federal, tribal and state governments can employ to build a trauma-informed service delivery system.

## Recommendations

- **All federal, tribal, state, and local policies should reflect a trauma-informed perspective. A trauma-informed response encompasses a fundamental understanding of trauma and how it shapes an individual who has experienced it.**
  - Policies should support delivery systems that identify and implement strategies to prevent trauma, increase capacity for early identification and intervention, and provide comprehensive treatment.
  - Policies should support and require that strategies are designed to prevent and eliminate treatment practices that cause trauma or retraumatization.
  - Policies should reinforce the core components of best practices in trauma informed care: prevention, developmentally appropriate effective strategies, cultural and linguistic competence, and family and youth engagement.
- **Policy and practice reflective of trauma-informed principles must be developmentally appropriate, based upon a public health framework, and engage children, youth, and their families in healing.**
  - Policies should focus on prevention of trauma and developing strategies to identify and intervene early for children, youth, and their families exposed to trauma or at-risk of exposure to trauma.
  - Policies should focus on enhancing child, youth, and family engagement strategies to support informed trauma care delivery.
  - Policies should support strategies that encompass family-based approaches to trauma intervention.
- **Trauma-informed related policies must include responsive financing, cross-system collaboration and training, accountability, and infrastructure development.**
  - Policies should ensure that funding is supportive of trauma-informed care based upon sound fiscal strategies.
  - Policies should make funding contingent upon eliminating harmful practices that cause trauma and retraumatization across child serving settings.
  - Policies should support comprehensive workforce investment strategies.

## Making Trauma-Informed Practices Happen

A trauma-informed strategy requires that all public policies, state, federal, and tribal, should:

- Reflect a trauma-informed perspective.
- Focus on trauma-responsive financing, cross-system collaboration, accountability, and infrastructure development.
- Provide incentives for and target resources supporting trauma-informed, developmentally and culturally appropriate care in community-based settings (for example, child care centers and schools) and in public systems to address prior trauma and prevent retraumatization.
- Designate specific resources to be used for prevention and rapid early identification and intervention for children and families exposed to trauma.
- Address workforce capacity and professional development challenges.

**To provide leadership in promoting trauma-informed practice:**

The federal government can:

- Require all federal block grants to include language that addresses trauma across the lifespan.
- Require service delivery systems to identify strategies they will employ to:
  - Prevent trauma for children and youth at risk in community settings.
  - Increase the capacity for rapid early intervention.
  - Train providers in trauma-informed, family-focused practice.
  - Proactively prevent retraumatization and safety in child welfare, juvenile justice, and mental health.
  - Support, through the National Registry of Effective Practices, the development of an expanded empirical base for culturally competent and family and youth-based trauma-informed interventions.
- Identify policies that cause trauma and retraumatization, and amend these to promote healthy child and youth development.

Federal, tribal and state governments can:

- Develop and implement plans to address trauma, including trauma linked to natural and man-made disasters.
- Spearhead initiatives that promote trauma-informed best practice and change the culture of public agencies serving high proportions of traumatized youth (building on seclusion and restraint initiatives).
- Promote trauma-sensitive normative cultures in community-based settings (for example, schools, child care centers, and early learning programs, as well as shelters) that serve children, youth and their families.
- Develop a stronger, more coherent research agenda that includes attention to the efficacy of family-focused trauma-linked strategies, particularly for young children.
- Develop performance measures related to trauma reduction and safety for children and youth in the care and/or custody of public agencies and agencies that receive public monies.

**To promote sound and supportive fiscal practices:**

The federal government can:

- Clarify and demonstrate that federal funds, particularly Medicaid, can be used for empirically supported trauma-informed care as well as family engagement and family support strategies.
- Provide fiscal incentives for adoption of trauma-informed and funding of associated start-up costs.
- Relax regulations and administrative procedures that impede widespread uptake of trauma-informed care, particularly restrictions that govern:
  - Billing for services in time increments
  - Coverage of family treatment
  - Mental health services to survivors in the event of a child's death
- Provide federal incentives for the use of trauma-informed health and mental health benefit packages.
- Carry out an intensive review of the potential impact of proposed Medicaid changes through a trauma-informed lens
- Eliminate barriers to multigenerational family-focused treatment.
- Make funding contingent on the elimination of harmful practices that cause trauma or retraumatization across child serving settings

Federal, tribal and state governments can:

- Ensure that family engagement strategies, natural helpers, culturally-specific workers, family members, traditional healing techniques, and mechanisms to lead people to specific interventions are adequately funded.
- Fund multigenerational approaches to trauma and eliminate current restrictions and barriers to funding family-focused approaches.
- Encourage the adoption of specific screening tools tied to appropriate market-based financing rates to increase early identification and subsequent interventions to prevent trauma exposure and treat children, youth, and families who have been exposed.
- Ensure that children and youth's needs are adequately represented in emergency mental health disaster plans.
- Promote the creation of state trauma coordinator positions for children, youth, and families.

**To promote a better trained workforce:**

Federal, tribal and state governments can:

- Support efforts to identify the most effective ways to train clinicians in empirically-based trauma-informed practices and administrative staff in creating supporting program and organizational practices.
- Provide support for fellowships in children, youth, and family trauma at all educational levels.
- Develop guidelines for regulations and/or certification pertaining to trauma expertise.
- Address and fund initiatives that support staff who work with traumatized children and youth and reduce secondary trauma associated with trauma-related work.
- Partner with tribal and other colleges that target specific populations to develop workforce capacity in evidence-based practices for both tribal and non-tribal communities.

# Endnotes


1. Cloitre, M.; Cohen, L. R.; & Koenen, K. C. (2006). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*. New York, NY: Guilford Press.

2. Ibid.

3. Ibid.

4. Breslau, N.; Wilcox, H. C.; Storr, C. L.; Lucia, V. C.; & James, A. (2004). Trauma exposure and post-traumatic stress disorder: A study of youths in urban America. *Journal of Urban Health, 81*(4), pp. 531-544.

National Child Traumatic Stress Network. (2004). *Children and trauma in America: A progress report of the National Child Traumatic Stress Network*. <www.nctsnet.org/> (accessed January 4, 2006).

5. Abram, K.; Teplin, L.; Charles, D.; Longworth, S.; McClleland, G.; & Duncan, M. (2004). Post-traumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry, 61*, pp. 403-410.

Wong, M. (2006). Challenges and opportunities: Perspectives across settings schools. In *Strengthening Federal, Tribal, State and Local Policies for Children, Youth and Families Who Experience Trauma*, October 16.New York, NY: National Center for Children in Poverty.

Yoe, T.; Russell, L.; Ryder, C.; Perez, A.; & Boustead, R. (2005). *With all we have to do, what's trauma got to do with us?* A Webinar conference for SAMHSA System of Care sites for children and adolescents, September 29.

See also Breslau, et al. in endnote 4.

6. Ford, J.; Racusin, R.; Daviss, W. B.; Ellis, C. G.; Thomas, J.; Rogers, K.; et al. (1999). Trauma exposure among children with oppositional defiant disorder and attention deficit-hyperactivity disorder. *Journal of Consulting and Clinical Psychology, 67*(5), pp. 786-789.

Silva, R. R.; Alpert, M.; Munoz, D. M.; Singh, S.; Matzner, F.; & Dummit, S. (2000). Stress and vulnerabilty to posttraumatic stress disorder in children and adolescents. *American Journal of Psychiatry, 157*(8), pp. 1229-1235.

7. Koltek, M.; Wilkes, T. C.; & Atkinson, M. (1998). The prevalence of post-traumatic stress disorder in an adolescent inpatient unit. *Canadian Journal of Psychiatry, 43*(1), pp. 64-68.

Lipschitz, D.; Winegar, R. K.; Hartnick, E.; Foote, B.; & Southwick, S. (1999). Post-traumatic stress disorder in hospitalized adolescents: Psychiatric comorbidity and clinical correlates. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(4), pp. 385-392.

8. Buckner, J. C.; Beardslee, W. R.; & Bassuk, E. (2004). Exposure to violence and low-income children's mental health: Direct, moderated, and mediated relations. *American Journal of Orthopsychiatry, 74*(4), pp. 413-423.

Bassuk, E.; Friedman, S. M.; Batia, K.; Holland, J.; Kelly, A. H.; Olson, L.; et al. (2005). *Facts on trauma and homeless children*. Los Angeles, CA & Durham, NC: National Child Traumatic Stress Network, Homelessness and Extreme Poverty Working Group.

9. See Yoe, et al. in endnote 5.

10. Putnam, F. W. (2006). The impact of trauma on child development. *Juvenile and Family Court Journal, 57*(1), pp. 1-11.

U.S. Department of Health and Human Services. Administration on Children Youth, and Families. (2007). *Child maltreatment 2005*. Washington, DC: U.S. Government Printing Office.

11. Ibid.

12. Ibid.

13. Tjaden, P. & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey*. Washington, DC: National Institute of Justice, Office of Justice Programs, U.S. Department of Justice.

14. Ibid.

15. Sullivan, P. M. & Knutson, J. F. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. *Child Abuse & Neglect, 22*(4), pp. 271-288.

16. Ibid.

17. Sullivan, P. M. & Knutson, J. F. (1998). Maltreatment and behavioral characteristics of youth who are deaf and hard-of-hearing. *Sexuality and Disability, 16*(4), pp. 295-319.

18. An estimated 8,550 children and youth died due to child maltreatment from 2000-2005.

U.S. Department of Health and Human Services: Administration for Children and Families. (2004). *Safety, permanency, well-being. Child welfare outcomes 2002: Annual report*. <http://www.acf.hhs.gov/programs/cb/pubs/cwo02/index.htm> (accessed December 28, 2005).

Also see endnotes 10 and 19.

19. U.S. Department of Health and Human Services: Administration on Children Youth and Families. (2006). *Safety, permanency, well-being. Child welfare outcomes 2003: Annual report*. <www.acf.hhs.gov/programs/cb/pubs/cwo03/index.htm> (accessed April 14, 2007).

20. Ibid.

21. See U.S. Department of Health and Human Services in endnote 10.

22. Interview with Dr. Ana Mari Cauci. (2004). *Research and Advocacy Digest, 7*(1), pp. 2-3.

23. Saewyc, E. M.; Skay, C. L.; Pettingell, S. L.; Reis, E. A.; Bearinger, L.; Resnick, M.; et al. (2006). Hazards of stigma: The sexual and physical abuse of gay, lesbian, and bisexual adolescents in the United States and Canada. *Child Welfare, 85*(2), pp. 195-213.

24. Burns, B.; Phillips, S.; Wagner, H.; Barth, R.; Kolko, D.; Campbell, Y.; et al. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(8), pp. 960-970.

Courtney, M. E.; Roderick, M.; Smithgall, C.; Gladden, R. M.; & Nagaoka, J. (2004). *The educational status of foster children*. Chicago, IL: Chapin Hall Center for Children.

Kaplan, S. J.; Pelcovitz, D.; Salzinger, S.; Weiner, M.; Mandel, F. S.; Lesser, M. L.; et al. (1998). Adolescent physical abuse: Risk for adolescent psychiatric disorders. *American Journal of Psychiatry, 155*(7), pp. 954-959.

Thompson, T. & Massat, C. R. (2005). Experiences of violence, post-traumatic stress, academic achievement, and behavior problems of urban African-American children. *Child and Adolescent Social Work Journal, 22*(5-6), pp. 367-393.

25. See Abram, et al. in endnote 5.

26. Ibid.

27. Sedlak, A. (2006). Educational problems, childbearing, and prior abuse among delinquents in custody. *Coordinating Council on Juvenile Justice and Delinquency Prevention Quarterly Meeting*. <www.juvenilecouncil.gov/summary/Meeting_Summaryfinal.doc> (accessed April 11, 2007).

28. See Abram, et al. in endnote 5.

Holden, W. & Santiago, R. (2003). Characteristics of youth referred to system of care services by juvenile justice agencies. *System of Care Evaluation Brief, 4(*6), pp. 1-4.

Spinazzola, J.; Ford, J. D.; Zucker, M.; van der Kolk, B.; Silva, S.; Smith, S. F.; et al. (2005). Survey evaluates complex trauma exposure, outcome and intervention among children and adolescents. *Psychiatric Annals, 35*(5), pp. 433-439.

29. McKeown, R. E.; Cuffe, S. P.; & Schulz, R. M. (2006). US suicide rates by age group, 1970-2002. *American Journal of Public Health, 96*(10), pp. 1744-1749.

30. Carmona, R. H. (2005). *Statement by Richard H. Carmona, Surgeon General of the United States on suicide prevention among Native American youth before the Indian Affairs Committee, United States Senate, June 15, 2005*. Washington, DC: U.S. Department of Health and Human Services.

31. Personal Communication with Shannon CrossBear, Co-Director of Training and Evaluation at the Federation of Families for Children's Mental Health, on January 16, 2006.

32. Middlebrook, D.; Running Wolf, P.; & Crossbear, S. (2005). *American Indian adolescent suicide: Risk factors and* prevention. Paper presented at the Suicide Prevention Grantee Orientation, December 14, Washington, D.C.

33. Indian Health Services. (2003). *Trends in Indian Country 2001-2002*. Rockville, MD: U. S. Department of Health and Human Services, Public Health Service..

34. Keaton, D. K.; Kann, L.; Kinchen, S.; Ross, J.; Hawkins, J.; Harris, W.; et al. (2006). Youth Risk Behavior Surveillance—United States, 2005. *MMWR, 55*(SS05), pp. 1-108.

35. Ibid.

36. The NHSDA Report. (2003). *Risk of suicide among Hispanic females aged 12 to 17*. Rockville, MD and Durham, NC: Office of Applied Research, SAMHSA and RTI.

37. See Keaton, et al. in endnote 34.

38. Russell, S. T. & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 91*(8), pp. 1278-1281.

39. Ibid.

40. de Bocanegra, H. T. & Brickman, E. (2004). Mental health impact of the World Trade Center attacks on displaced Chinese workers. *Journal of Traumatic Stress, 17*(1), pp. 55-62.

Mollica, R. F.; McDonald, L.; Osofsky, H.; Calderon-Abbo, J.; & Balaban, V. (2003). *The mitigation and recovery of mental health problems in children and adolescents affected by terrorism*. Boston, MA: Harvard Medical School and Massachusetts General Hospital.

Steel, Z.; Silove, D.; Phan, T.; & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. *The Lancet, 360*, pp. 1056-1062.

41. See Spinazzola, et al. in endnote 28.

42. Abramson, D. & Garfield, R. (2006). *On the edge: Children and families displaced by Hurricanes Katrina and Rita face a looming medical and mental health crisis.* New York, NY: National Center for Disaster Preparedness and Operation Assist, Columbia University, Mailman School of Public Health.

43. Ibid.

44. American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. (2007). *The psychological needs of U.S. Military Service members and their families: A preliminary report*. <www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf> (accessed April 15, 2007).

45. Seal, K. H.; Miner, C. R.; Sen, S.; & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103 788 US veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs Facilities. *Archives of Internal Medicine, 167*(5), pp. 476-482.

46. See Bassuk, et al. in endnote 8.

47. Kipke, M. D.; Simon, T. R.; Montgomery, S. B.; Unger, J. B.; & Iversen, E. F. (1997). Homeless youth and their exposure to and involvement in violence while living on the streets. *Journal of Adolescent Health, 20*, pp. 360-367.

48. See Breslau, et al. in endnote 4.

49. Ibid.

50. Giaconia, R. M.; Reinherz, H. Z.; Hauf Carmola, A.; Paradis, A. D.; Wasserman, M. S.; & Langhammer, D. M. (2000). Comorbidity of substance use and post-traumatic stress disorders in a community sample of adolescents. *American Journal of Orthopsychiatry, 70*(2), pp. 253-262.

51. Cohen, J. A.; Mannarino, A. P.; Zhitova, A. C.; & Capone, M. E. (2003). Treating child abuse-related posttraumatic stress and comorbid substance abuse in adolescents. *Child Abuse & Neglect, 27*(12), pp. 1345-1365.

See Giaconia, et al. in endnote 50.

52. Boyd-Ball, A. J.; Manson, S.; Noonan, C.; & Beals, J. (2006). Traumatic events and alcohol use disorders among American Indian adolescents and young adults. *Journal of Traumatic Stress, 19*(6), pp. 937-947.

53. Giaconia, R. M.; Reinherz, H. Z.; Silverman, A. B.; Pakiz, B.; Frost, A. K.; & Cohen, D. (1995). Trauma and posttraumatic stress disorder in a community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(10), pp. 1369-1380.

54. See Giaconia, et al. in endnote 50.

55. See Boyd-Ball, et al. in endnote 52.

56. See Kipke, et al. in endnote 47.

Thompson, S. J.; McManus, H.; & Voss, T. (2006). Posttraumatic stress disorder and substance abuse among youth who are homeless: Treatment issues and implications. *Brief Treatment and Crisis Intervention, 6*(3), pp. 206-217.

57. Kilpatrick, D. G.; Ruggiero, K. J.; Acierno, R.; Saunders, B.; Resnick, H. S.; & Best, C. L. (2003). Violence and the risk of PTSD, major depression, substance abuse/dependence and co-morbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology, 71*(4), pp. 692-700.

58. Ibid.

59. Identifying trauma & substance abuse in adolescents. (Undated). Fact sheet series for clinicians treating teens with emotional & substance use problems <www.bu.edu/atssa/Resources/Publications/IdentifyingT&SA.pdf> (accessed April 25, 2007).

60. Jaycox, L.; Ebener, P.; Damesek, L.; & Becker, K. (2004). Trauma exposure and retention in adolescent substance abuse treatment. *Journal of Traumatic Stress, 17*(2) pp. 113-121(9).

Riggs, P. D. (2003). Treating adolescents for substance abuse and co-morbid psychiatric disorders [Electronic Version]. *Science & Practice Perspectives,* 2. (Accessed April 25, 2007.)

61. National Association of Counties. (2005). *The meth epidemic in America. Two surveys of US counties: The criminal effect of meth on communities and the impact of meth on children*. Washington, DC: National Association of Counties.

62. Bogat, T.; DeJonghe, E.; Levendosky, A. A.; Davidson, W. S.; & von Eye, A. (2006). Trauma symptoms among infants exposed to intimate partner violence. *Child Abuse & Neglect, 30*(2), pp. 109-125.

63. Kim, J. & Cicchetti, D. (2004). A longitudinal study of child maltreatment, mother-child relationship quality and maladjustment: The role of self-esteem and social competence. Journal of Abnormal *Child Psychology, 32*(4), pp. 341-354.

Thompson, T. & Massat, C. R. (2005). Experiences of violence, post-traumatic stress, academic achievement and behavior problems of urban African-American children. *Child and Adolescent Social Work Journal, 22*(5-6), pp. 367-393.

63. Gorman-Smith, D. & Tolan, P. H. (2003). Positive adaptation among youth exposed to community violence. In S. S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities*. New York, NY: Cambridge University Press.

64. National Scientific Council on the Developing Child. (2005). Excessive stress disrupts the architecture of the brain. *Working Paper # 3* <www.developingchild.net/pubs/wp/Stress_Disrupts_Architecture_Developing_Brain.pdf.>

65. Davidson, J. & Smith, R. (1990). Traumatic experiences in psychiatric outpatients. *Journal of Traumatic Stress Studies, 3*(3), pp. 459-475.

66. Flores, E.; Cicchetti, D.; & Rogosch, F. A. (2005). Predictors of resilience in maltreated and non-maltreated Latino children. *Developmental Psychology, 41*(2), pp. 336-351.

Kaplan, H. B. (1999). Toward an understanding of resilience: A critical review of definitions and models. In M. D. Glanz & J. L. Johnson (Eds.), *Resilience and Development: Positive Life Adaptations*. New York, NY: Kluwer Academic/Plenum Publishers.

See Kaplan, S. J., et al. in endnote 24.

67. Dube, S. R.; Anda, R. F.; Felitti, V.; Chapman, D. P.; Williamson, D. F.; & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *JAMA, 286*(24), pp. 3089-3096.

Felitti, V.; Anda, R.; Nordenberg, D.; Williamson, D. F.; Spitz, A.; Edwards, V.; et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), pp. 245-258.

68. Tracy, E. M. & Johnson, P. J. (2006). The intergenerational transmission of family violence. In N. Boyd Webb (Ed.), *Working with traumatized youth in child welfare*. New York, NY: The Guilford Press.

69. Harris, M. & Fallot, R. (Eds.). (2001). *Envisioning a trauma-informed service system: A vital paradigm shift*. San Francisco, CA: Jossey-Bass.

70. Institute of Medicine of the National Academies. (2005). *Improving the quality of health care for mental and substance- use conditions*. Washington, D.C: National Academy of Sciences.

71. Taylor, N.; Siegfried, C. B.; Berkman, M.; Carnes, C.; Friedman, B.; Henry, J.; et al. (2005). Helping children in the child welfare system heal from trauma: A systems integration approach. Los Angeles, CA and Durham, NC: The National Child Traumatic Stress Network.

72. Ibid.

73. Hanson, T. C.; Hesselbrock, M.; & Tworkowski, S. H. (2002). The prevalence and management of trauma in the public domain: An agency and clinician perspective. *The Journal of Behavioral Health Services & Research, 29*(4), pp. 365-380.

74. Ibid.

75. Complex trauma refers to a history of multiple exposures to trauma that is frequently characterized by beginning early and being of a prolonged nature.

76. See Taylor, et al. in endnote 71.

77. Ibid.

78. Weiss, E. M. (1998). Deadly restraint: A nationwide pattern of death. Hartfort Courant, Oct. 11, 1998, p. A1.

79. United States General Accounting Office (GAO). (1999). Mental health improper restraint or seclusion use place people at risk (No. GAO/HEHS-99-176). Washington, DC: Government Accounting Office.

80. Boot camps are juvenile justice facilities that use techniques often modeled after those used by the military (such as demanding physical conditioning, and confrontational interactions) to instill discipline and address delinquent behaviors.

81. Parent, D. J. (2003). *Correctional boot camps: Lessons from a decade of research* (No. NCJ 197018). Washington, DC: U.S. Department of Justice, Office of Justice Programs.

82. Benda, B. B.; Toombs, N. J.; & Peacock, M. (2006). Distinguishing graduates from dropouts and dismissals: Who fails boot camp? *Journal of Criminal Justice, 34*(1), pp. 27-38.

83. Office of the Assistant Attorney General: Civil Rights Division. (1998). Findings of investigation of state juvenile justice facilities. *Report to Governor Zell Miller*. <www.gac.org/report.pdf> (accessed April 15, 2007).

84. Lacayo, E. (2007). Jury rules Kings Co. pay teen $4.6M: Suicide attempt in juvenile boot camp permanently damaged his brain. *Fresno Bee*, pp. 1. Fresno, CA: Knight Ridder Tribune Business News.

Miller, C. M. (2006). Minor offenses at camp brought beatings: A smile, a mumble and other forms of nonviolent behavior resulted in force against teenage boys at a Florida sheriff's boot camp - A Miami Herald Investigation. *Miami Herald*. Miami, FL: Miami Herald, distributed by Knight/Ridder Tribune News Service.

Sandburg, L. & Ratcliffe, R. G. (2007). Grand jury indicts two ex-TYC administrators: Men charged in alleged abuse of boys in their care. *The Houston Chronicle*, April 11, 2007, p. 1.

85. Sickmund, M. (2006). *Juvenile residential facility census, 2002: Selected findings*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

86. Synder, H. N. & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 national report*. Washington, DC: United States Department of Justice, Office of Justice Programs, Office of Juvenile Delinquency and Prevention.

87. Ibid.

88. Caeti, T. J.; Hemmens, C.; Cullen, F. T.; & Burton, V. S. (2003). Management of juvenile correctional facilities. *The Prison Journal, 83*(8), pp. 383-405.

89. U.S. Department of Health and Human Services. Administration on Children Youth and Families. (2007). *Child Maltreatment 2005*. Washington, DC: U.S. Government Printing Office.

90. See Burns, et al. in endnote 24.

91. See endnote 89.

92. Zinn, A.; DeCoursey, J.; Goerge, R.; & Courtney, M. E. (2006). *A study of placement stability in Illinois*. Chicago, IL: Chapin Hall Center for Children, University of Chicago.

93. Rubin, D. M.; Alessandrini, E. A.; Feudtner, C.; Mandell, D. S.; Localio, A. R.; & Hadley, T. (2004). Placement stability and mental health cost for children in foster care. *Pediatrics, 113*(5), pp. 1336-1341.

Rubin, D. M.; O'Reilly, A. L. R.; Luan, X.; & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics, 119*(2), pp. 336-344.

94. Friedman, B.; Pinto, A.; Behar, L.; Bush, N.; Chirolla, A.; Epstein, M.; et al. (2006). Unlicensed residential programs: The next challenge in protecting youth. *American Journal of Orthopsychiatry, 76*(3), pp. 293-303.

95. Preston, J. & Williams, M. (2007). Illegal worker, troubled citizen and stolen name. *The New York Times*. March 22. <select.nytimes.com/gst/abstract.html?res=F50E10FB3F540C718EDDAA0894DF404482> (accessed April 4, 2007).

96. Ibid.

97. Homeless Families with Children. (2006). *NCH Fact Sheet #12*. Washington, DC: National Coalition for the Homeless.

98. Altschuler, D. M. (2005). Policy and program perspectives on the transition to adulthood for adolescents in the juvenile justice system. In D. W. Osgood; E. M. Foster; C. Flanagan; & G. R. Ruth (Eds.), *On Your Own Without a Net: The Transition to Adulthood for Vulnerable Populations* (pp. 92-113). Chicago, IL: The University of Chicago Press.

99. Travis, J. & Visher, C. A. (2005). Prisoner re-entry and the pathways to adulthood: Policy perspectives. In D. W. Osgood; E. M. Foster; C. Flanagan; & G. R. Ruth (Eds.), *On Your Own Without a Net: The Transition to Adulthood for Vulnerable Populations* (pp. 145-177). Chicago, IL: The University of Chicago Press.

100. U.S. Government Accountability Office. (2006). *Child welfare federal action needed to ensure states have plans to safeguard children in the child welfare system displaced by disasters* (No. GAO-06-944). Washington, DC: US Government Accountability Office.

101. Jennings, A. (2004). *Blueprint for action, building trauma-informed mental health services and systems: State accomplishments, activities and resources*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors.

102. Rovi, S.; Chin, P.; & Johnson, M. S. (2004). The economic burden of hospitalizations associated with child abuse and neglect. *American Journal of Public Health, 94*(4), pp. 586-590.

103. Ibid.

104. See Yoe, et al. in endnote 5.

105. Washington State Institute for Public Policy. (2004). Benefits and costs of prevention and early intervention programs for youth. <www.wsipp.wa.gov/pub.asp?docid=04-07-3901> (accessed March 19, 2007).

106. LeBel, J. & Goldstein, R. (2005). The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services, 56*, pp. 1109-1114.

107. See Harris & Fallot in endnote 69.

108. Ibid.

109. Gallagher, C. A. & Dobrin, A. (2005). The association between suicide screening practices and attempts requiring emergency care in juvenile justice facilities. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(5), pp. 485-493.

110. Cohen, J. & Work Group on Quality Issues. (1998). *Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder*. Washington, DC: American Academy of Child and Adolescent Psychiatry.

111. Greenwald, R. (2004). *Child trauma measures for research and practice*. Poster session presented at the Annual Meeting of the EMDR International Association, Montreal, September 2004. <www.childtrauma.com/mezpost.html> (accessed April 18, 2007).

112. See Cohen & Work Group on Quality Issues in endnote 110.

113. Ibid.

114. Ibid.

Nader, K. O. (1997). Assessing traumatic experiences in children. In J. P. Wilson & T. M. Keane (Eds.), *Assessing Psychological Trauma and PTSD.* New York, NY: The Guilford Press.

115. See Cohen & Work Group on Quality Issues in endnote 110.

See Nader in endnote 114.

116. Ibid.

117. Ibid.

118. Hawkins, S. S. & Radcliffe, J. (2006). Current measures of PTSD for children and adolescents. *Journal of Pediatric Psychology, 31*(4), pp. 420-430.

119. Ibid.

See Cohen & Work Group on Quality Issues in endnote 110.

120. Strand, V. C.; Sarmiento, T. L.; & Pasquale, L. E. (2005). Assessment and screening tools for trauma in children and adolescents: A review. *Trauma, Violence & Abuse, 6*(1), pp. 55-78.

121. Manson, S. (1997). Cross-cultural and multi-ethnic assessment of trauma. In J. P. Wilson & T. Keane (Eds.), Assessing Psychological Trauma and PTSD. New York, NY: The Guilford Press.

122. DeAngelis, T. (2007). A new diagnosis for childhood trauma. *Monitor on Psychology, 38*(3), p. 32.

van der Kolk, B. & Courtois, C. A. (2005). Editorial comments: Complex developmental trauma. *Journal of Traumatic Stress, 18*(5), pp. 385-388.

123. See Hawkins & Radcliffe in endnote 118.

124. McNally, R.; Byrant, R. A.; & Ehlers, A. (2003). Does early psychological intervention promote recovery from post-traumatic stress? *Psychological Science in the Public Interest, 4*(2), pp. 45-79.

125. Choe, M. A. (2005). The debate over psychological debriefing for PTSD. *The New School Psychology Bulletin, 3*, p. 2.

126. National Center for Child Traumatic Stress & National Center for Post-Traumatic Stress. (2005). *Psychological first aid: Field operations guide*. Los Angeles, CA and Durham, NC: National Center for Child Traumatic Stress and National Center for Post-Traumatic Stress.

127. Indian Country Child Trauma Center. (2006). *Honoring children, making relatives*. <www.icctc.org/ICCTC%20-%20HCMR.pdf> (accessed April 13, 2007).

128. Choi, Y.; Harachi, T. W.; Gillmore, M. R.; & Catalano, R. (2006). Are multi-racial adolescents at greater risk? Comparisons of rates, patterns, and correlates of substance use and violence between monoracial and multiracial adolescents. *American Journal of Orthopsychiatry, 76*(1), pp. 86-97.

King, P. E. & Furrow, J. L. (2004). Religion as a resource for positive youth development: Religion, social capital and moral outcomes. *Developmental Psychology, 40*(5), pp. 703-713.

Kogan, S. M.; Luo, Z.; Murry, V. M.; & Brody, G. H. (2005). Risk and protective factors for substance use among African American high school dropouts. *Psychology of Addictive Behaviors, 19*(4), pp. 382-391.

McDonald, E. J., McCabe, K.; Yeh, M.; Lau, A.; Garland, A.; & Hough, R. L. (2005). Cultural affiliation and self-esteem as predictors of internalizing symptoms among Mexican American adolescents. *Journal of Child and Adolescent Psychology, 34*(1), pp. 163-171.

129. Brookmeyer, K. A.; Henrich, C. C.; & Schwab-Stone, M. (2005). Adolescents who witness community violence: Can parent support and prosocial cognitions protect them from committing violence? *Child Development, 76*(4), pp. 917-929.

130. See Gorman-Smith & Tolan in endnote 63.

Kliewer, W.; Cunningham, J. N.; Diehl, R.; Parrish, K. A.; Walker, J.; Atiyeh, C.; et al. (2004). Violence exposure and adjustment in inner-city youth: Child and caregiver emotion regulation skill, caregiver-child relationship quality, and neighborhood cohesion as protective factors. *Journal of Clinical Child and Adolescent Psychology, 33*(3), pp. 477-487.

131. Gorman-Smith, D.; Henry, D. B.; & Tolan, P. H. (2004). Exposure to community violence and violence perpetration: The protective effects of family functioning. *Journal of Clinical Child and Adolescent Psychology, 33*(3), pp. 439-449.

Pearce, M. J.; Jones, S. M.; Schwab-Stone, M.; & Ruchkin, V. (2003). The protective effects of religiousness and parental involvement on the development of conduct problems among youth exposed to violence. *Child Development, 74*(6), pp. 1682-1896.

132. McAlister Groves, B. (2002). *Children who see too much. Boston*, MA: Beacon Press.

133. Mazelis, R. (2005). Improving the quality of demonstration research: Integrating those with personal experience. *Journal of Substance Abuse Treatment, 28*, pp. 147-148.

Mollica, R. F.; McDonald, L.; Osofsky, H.; Calderon-Abbo, J.; & Balaban, V. (2003). *The mitigation and recovery of mental health problems in children and adolescents affected by terrorism*. Boston, MA: Harvard Medical School and Massachusetts General Hospital.

134. Dababnah, S. & Cooper, J. (2006). *Challenges and opportunities in children's mental health: A view from families and youth*. New York, NY: National Center for Children in Poverty.

135. Knapp, P.; Ammen, S.; Arstein-Kerslake, C.; Poulsen, M. K.; & Mastergeorge, A. (2007). Feasibility of expanding services for very young children in the public mental health system. *American Academy of Child and Adolescent Psychiatry, 46*(2), pp. 152-161.

136. Scheeringa, M. S.; Zeanah, C. H.; Myers, L.; & Putnam, F. W. (2005). Predictive validity in a prospective follow-up of PTSD in preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(9), pp. 899-906.

137. Ibid.

138. Weber, D. A. & Reynolds, C. R. (2004). Clinical perspectives on neurobiological effects of psychological trauma. *Neuropsychology Review, 14*(2), pp. 115-129.

139. Ibid.

140. Kaplow, J. B.; Saxe, G. N.; Putnam, F. W.; Pynoos, R. S.; & Lieberman, A. F. (2006). The long-term consequences of early childhood trauma: A case study and discussion. *Psychiatry, 69*(4), pp. 362-375.

141. Byrne, W. (Undated). Child maltreatment: Guidance for primary care practice. *National conference for nurse practitioners: Expanding roles, expanding practice*. <http://www.medscape.com/viewarticle/447173> (accessed May 9, 2007).

Freyd, J. J.; Putnam, F. W.; Lyon, T. D.; Becker-Blease, K.; Cheit, R. E.; Siegel, N. B.; et al. (2005). The science of child sexual abuse [electronic version]. *Science*, 308, 501. Retrieved May 9, 2007.

142. See Felitti, et al. in endnote 67,

Golier, J. A.; Yehuda, R.; Bierer, L. M.; Mitropoulou, V.; New, A. S.; Schmeidler, J.; et al. (2003). The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. *American Journal of Psychiatry, 160*(11), pp. 2018-2024.

Springer, K. W.; Sheridan, J.; Kuo, D.; & Carnes, M. (2003). The long-term health outcomes of child abuse: An overview and a call to action. Journal of General Internal Medicine, 18(10), pp. 864-870.

143. Rogosch, F. A. & Cicchetti, D. (2004). Child maltreatment and emergent personality organization: Perspectives from the five-factor model. *Journal of Abnormal Child Psychology, 32*(2), pp. 123-145.

144. Leslie, L. K.; Hurlburt, M. S.; Sigrid, J.; Landsverk, J.; Slymen, D. J.; & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services, 56*(8), pp. 981-987.

145. See Burns, et al. in endnote 24.

146. Hurlburt, M. S.; Leslie, L. K.; Landsverk, J.; Barth, R.; Burns, B.; Gibbons, R. D.; et al. (2004). Contextual predictors of mental health service use among children open to child welfare. *Archives of General Psychiatry, 61*, pp. 1217-1224.

147. Rosenthal, J. & Kaye, N. (2005). *State approaches to promoting young children's healthy development: A survey of Medicaid, and maternal and child health, and mental health agencies*. Portland, ME: National Academy for State Health Policy.

148. Knitzer, J. & Cohen, E. (2007). Promoting resilience in young children and families at the highest risk: The challenge for early childhood mental health. In R. Perry; R. F. Kaufmann; & J. Knitzer (Eds.), *Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems*. Baltimore, MD: Paul H. Brookes Publishing Co.

149. Lieberman, A. F. (2004). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Infant Mental Health Journal, 25*(4), pp. 336-351.

150. Groves, B. M. (2007). Early intervention as prevention: Addressing trauma in young children. *Focal Point, 21*(1), pp. 16-18.

151. Lieberman, A. F.; Van Horn, P.; & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with pre-schoolers exposed to marital violence. Journal of the American *Academy of Child and Adolescent Psychiatry, 44*(12), pp. 1241-1248.

152. Dicker, S. & Gordon, E. (2006). The essential advocate: Using CASAs to promote child well-being. *National Council of Juvenile and Family Court Judges Journal, 15*(2), pp. 19-23.

153. Free to Grow. (2007). *HeadStart partnerships to promote substance free communities*. <http://www.freetogrow.org/index.htm> (accessed May 10, 2007).

154. Arizona Department of Health Services. (2006). *Practice improvement protocol #15: The unique behavioral health needs of children, youth and families involved with CPS*. Phoenix, AZ: Arizona Department of Health Services, Division of Behavioral Health Services.

155. The strategies highlighted in the practice improvement protocols represent those recommended and endorsed, not mandated by the state. See Arizona Department of Health Services in endnote 154 for more information.

156. Glisson, C. (2002). The organizational context of children's mental health services. *Clinical Child and Family Psychology Review, 5*(4), pp. 233-253.

157. Ibid.

158. Richardson, J. I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. London, ON: Centre for Research on Violence Against Women and Children.

159. Bober, T. & Regehr, C. (2005). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention, 6*(1), pp. 1-9.

Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect, 30*(10), pp. 1071-1080.

160. Birick, A. (2002). Secondary traumatization and burnout in professionals working with torture survivors. *Traumatology, 7*(2), pp. 85-90.

Boscarion, J. A.; Figley, C. R.; & Adams, R. E. (2004). Compassion fatigue following the September 11 terrorist attacks: A study of secondary trauma among New York City social workers. *International Journal of Emergency Mental Health 6*(2), pp. 1-10.

Orlepp, K. & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress in workplace lay trauma counselors. *Journal of Traumatic Stress Studies, 15*(3), pp. 213-222.

161. Creamer, T. L. & Liddle, B. J. (2005). Secondary traumatic stress among disaster mental health workers responding to the September 11 attacks. *Journal of Traumatic Stress 18*(1), pp. 89-96.

162. Double jeopardy: Case workers at risk helping at-risk kids. (Undated). <www.afscme.org/publications/1331.cfm> (accessed April 23, 2007).

163. Psychological trauma informed services policy - Draft. (2007). <www.oregon.gov/DHS/addiction/trauma-policy/dhs-trauma-pol.pdf> (accessed April 13, 2007).

164. Hoagwood, K. (2007). Evidence-Based Treatment Dissemination Center (EBTDC): A training and consultation initiative for children in New York State's Office of Mental Health. New York, NY: Columbia University.

165. Cooper, J. (2007). Interview with David Woodlock, Deputy Commissioner and Director of Children and Family Services, New York State Office of Mental Health, April 4, 2007. New York, NY: National Center for Children in Poverty.

166. See Hoagwood in endnote 164.

167. TF-CBTWeb. (2007). <colleges.musc.edu/ncvc/resources_prof/TF-CBTWeb%20Information.pdf> (accessed April 17, 2007).

168. National Crime Victims Research & Treatment Center. (2007). *TF-CBTWeb: First year report*. Charleston, SC: Medical University of South Carolina.

169. See TF-CBTWeb in endnote 167.

170. National Crime Victims Research & Treatment Center. (2007). Percent of TF-CBTWeb U.S. learners correct on TF-CBTWeb pre-post questions by module. In *TF-CBTWeb: First year report*. Charleston, SC: Medical University of South Carolina.

171. Ibid.

172. See TF-CBTWeb in endnote 167.

173. Violence Prevention Coalition of Greater Los Angeles. (2007). *Firearms and firearm-related violence in Los Angeles County* <www.vpcla.org/factFirearms.htm> (accessed March 20, 2007).

174. California Department of Health Services. (2002). *Youth homicides, LA County trends (0-17)* <www.lapublichealth.org/childpc/data/safety.asp#gun> (accessed March 20, 2007).

175. Los Angeles County Department of Public Health. (2006). *Method of choice of suicide fatalities among ages 20 and under, Los Angeles County, 2002: Suicide statistics in Los Angeles County* <www.lapublichealth.org/ivpp/injury_topics/suicide/SuicideData.htm>

176. California Department of Health. (2007). *Hospitalizations from assaultive injuries 2007 by LA County age groups* <dhs.ca.gov> (accessed March 29, 2007).

177. Wikipedia Encyclopedia. (2007). *List of largest school districts in the United States by enrollment*. <en.wikipedia.org/wiki/List_of_the_largest_school_districts_in_the_United_States_by_enrollment> (accessed March 21, 2007).

178. Stein, B. D.; Jaycox, L. H.; Kataoka, S. H.; Wong, M.; Tu, W.; Elliott, M. N.; et al. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. *JAMA, 290*(5), pp. 603-611.

179. Ibid.

180. Kataoka, S. H.; Stein, B. D.; Jaycox, L.; Wong, M.; Escudero, P.; Tu, W.; et al. (2003). A school-based mental Health Program for Traumatized Latino Immigrant Children. *Journal of American Academy of Child and Adolescent Psychiatry, 42*(3), 311-318.

181. Walrath-Green, C. M. (2007). Suicide attempt subsequent to entering sysem of care services: How often does it happen and to whom? *Youth Suicide: Addressing the Issue Through Prevention and Intervention. Tampa, FL.: 20th Annual Research Conference: A System of Care for Children's Mental Health Expanding the Research Base, March 4-7.*

182. See Harris & Fallot in endnote 69.

183. The assessments include: (i) Child and Adolescent Needs and Strengths Assessment (CANS) supplemented with additional indicators from the Adverse Childhood Experiences Study; (ii) Parent-Child Relational Therapy (PCRT); (iii) Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); and, (iv) Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCs).

184. Massachusetts Advocates for Children. (2007). *Trauma sensitive school grants program* <www.massadvocates.org/safe_and_supportive_school_learning_environment> (accessed March 26, 2007).

185. See Jennings in endnote 101.

186. Slavin, L. A.; Hill, E.; LeBel, J.; & Murphy, T. (2006). Efforts by state mental health agencies to improve residential care and minimize seclusion and restraint. *19th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base*. Tampa, FL.

187. Garrett Lee Smith Memorial Act. (2004). 42 USC 290bb-36.

188. Sheehan, A. (2007). Suicide prevention: The Garrett Lee Smith youth suicide and early intervention program - Youth suicide: Addressing the issue through prevention and intervention. *20th Annual Research Conference: A System of Care for Children's Mental Health Expanding the Research Base*, March 4-7, Tampa, FL.

189. Ibid.

190. See DeAngelis in endnote 122.

191. American Indian Religious Freedom Act. (1996). P.L. 95-341., 42 U.S.C. §.

192. Curie, C. (2005). SAMHSA's commitment to eliminating the use of seclusion and restraint. *Psychiatric Services, 56*(9), pp. 1139-1140.

193. See Weiss in endnote 78.

194. Ibid.

195. Gross, G. (2003). *Restraint and seclusion: Overview of federal laws* <www.napas.org/issues/an/Restraintoutline03.htm> (accessed April 9, 2007).

See U. S. General Accounting Office in endnote 79.

196. See Curie in endnote 192.

Huckshorn, K. A. (2006). Re-designing state mental health policy to prevent the use of seclusion and restraint. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(4), pp. 482-491.

197. Federal Register. (2006). *Part IV Department of Health and Human Services Centers for Medicare & Medicaid Services 42 CFR*

*Part 482 Medicare and Medicaid Programs; Hospital conditions of participation; Patients' Rights; Final Rule* <a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-9559.pdf> (accessed April 13, 2007).

198. MACRO is an international consulting firm.

199. Cross-site evaluation of National Child Traumatic Stress Initiative (NCTSI) New. (2006). *Federal Register*, Vol. 71, pp. 2257.

200. VA to expand coverage for traditional ceremonies [Electronic Version]. *Independent*. <www.gallupindependent.com/2006/jun/061906vatrdcrm.html> (accessed March 12, 2007).

201. Roberts, M. (2005). Practitioners of healing arts help veterans cope. *Indian Country Today*. <www.indiancountry.com/content.cfm?id=1096412108> (accessed March 13, 2007).

202. See endnote 200

203. Kim, C. & Kwok, Y. S. (1998). Navajo use of native healers. *Archives of Internal Medicine, 158*(20), pp. 2245-2249.

204. Ibid.

205. Roanhorse, A. (2005). Written statement to the U.S. Senate Committee on Indian Health, April 13, 2005. Washington, DC.

206. Recent federal reports call for a public health model of mental health care and specific trauma initiatives, such as suicide prevention.

New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final report. <http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport-05.htm> (accessed August 9, 2004).

U.S. Department of Health and Human Services (DHHS). (2001). *Mental health: Culture, race, and ethnicity. Supplement to Mental Health: A report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services.

206. Manderscheid, R. (2006). *Information technology can drive transformation* (No. (SMA)-06-4195). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

207. Grey, A. & Szekely, A. (2006). *Finding funding: A guide to federal sources for child traumatic stress and other trauma-focused initiatives*. Los Angeles, CA, Durham, NC and Washington, DC: National Child Traumatic Stress Network and The Finance Project.

U.S. General Accounting Office (GAO). (2002). *Mental health services: Effectiveness of insurance coverage and federal programs for children who have experienced trauma largely unknown* (No. GAO-02-813). Washington, DC: US General Accounting Office.

208. See Grey & Szekely in endnote 207.

209. Cooper, J. (2007). *Review of catalogue of federal domestic assistance*. New York, NY: National Center for Children in Poverty. Unpublished.

210. See Grey & Szekely in endnote 207.

211. Ibid.

212. Laird, D. & Michael, J. (2006). Budgeting child welfare: How will millions cut from the federal budget affect the child welfare system? [Electronic Version]. *Children's Voices, 15*. <http://www.cwla.org/voice/0607budgeting.htm> (accessed April 25, 2007).

Rubin, D.; Halfon, N.; Raghavan, R.; & Rosenbaum, S. (2006). *The Deficit Reduction Act of 2005: Implications for children receiving child welfare services*. [Draft.] Philadelphia, PA: Prepared for Casey Family Programs.

213. See Laird & Michael in Endnote 212.

214. Bissell, M. & Miller, J. (2006). *Meth and child welfare: Promising solutions for children, their parents and grandparents*. Washington, DC: Generations United.

The Children's Defense Fund & Children's Rights Inc. (2007). *Promoting child welfare workforce improvements through federal policy changes*. Houston, TX: Cornerstones for Kids.

215. 2004 CMS document clarifies that Medicaid will not provide payment for services that are not "performed for the direct benefit of the Medicaid recipient." In 2004, Medicaid auditors denied claims for services "provided to family members and dealt with issues that did not pertain to the client's treatment". Centers for Medicare & Medicaid Services. (2005). *Medicaid support of evidence-based practices in mental health programs*. <http://www.cms.hhs.gov> (accessed September 10, 2005)

Office of Inspector General. (2004). *Audit of Medicaid claims for Iowa rehabilitation treatment services family-centered program* (No. A-07-02-03023). Rockville, MD: United States Department of Health and Human Services (DHHS).

216. The proposed legislation changing Medicaid and Title IV-E regarding trauma services:

Marron, D. (2006). *Letter to Congressman Joe Barton, Chairman Committee on Energy and Commerce, U.S. House of Representatives: Additional information on CBO's Estimate for the Medicaid provisions in the conference agreement for S. 1932, the Deficit Reduction Act of 2005*. Washington, DC: Congressional Budget Office, U.S. Congress.

See also endnote 212.

217. See Knitzer & Cohen in endnote 148.

218. Power, K. (2006). Strategies for transforming mental health care through data-based decision-making. In R. Manderscheid & J. Barry (Eds.), *Mental Health, United States, 2004*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration.

219. Sturm, R.; Ringel, J. S.; & Andreyeva, T. (2003). Geographic disparities in children's mental health care. *Pediatrics, 112*(4), p. e308.

220. Kim, W. J. (2003). Child and adolescent psychiatry workforce: A critical shortage and national challenge. *Academic Psychiatry, 27*(4), pp. 277-282.

221. U.S. Bureau of Labor Statistics. (2007). Social workers. *U.S. Department of Labor, Occupational outlook handbook, 2006-07 Edition* <www.bls.gov/oco/ocos060.htm> (accessed April 28, 2007).

222. Pion, G. M.; Keller, P.; McCombs, H.; & Rural Mental Health Provider Work Group. (1997). *Mental health providers in rural and isolated areas: Final report of the Ad Hoc Rural Mental Health Provider Work Group*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

223. Baumann, B. L.; Kolko, D.; Collins, K.; & Herschell, A. D. (2006). Understanding practitioners' characteristics and perspectives prior to the dissemination of an evidence-based intervention. *Child Abuse & Neglect, 30*(7) pp. 771-787.

Walrath, C. M.; Sheehan, A.; Holden, E. W.; Hernandez, M.; & Blau, G. (2006). Evidence-based treatments in the field: A brief report on provider knowledge, implementation, and practice. *The Journal of Behavioral Health Services & Research, 33*(2), pp. 244-253.

Tannebaum, S. J. (2005). Evidence-based practice as mental health policy: Three controversies and a caveat. *Health Affairs, 24*(1), pp. 163-173.

224. Phillips, S. & Allred, C. A. (2006). Organizational management: What service providers are doing while researchers are disseminating interventions. *Journal of Behavioral Health Sciences and Research, 33*(2), pp. 156-175.

See Walrath in endnote 223.

225. Nunno, M. (2006). The effects of the ARC organizational intervention on caseworker turnover, climate, and culture in children's services. *Child Abuse & Neglect, 30*(8), pp. 849-854.

226. U. S. General Accounting Office (GAO). (2003). *Child welfare: HHS could play a greater role in helping child welfare agencies recruit and retain staff* (No. GAO-03-357). Washington, DC: Government Accounting Office.

227. Ibid.

228. Whitaker, T.; Weismiller, T.; & Clark, E. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers—Special Report: Social Work Services for Children and Families*. Washington, DC: National Association of Social Workers.

229. Ashby, C. M. (2004). *Child welfare improved federal oversight could assist states in overcoming key challenges* (No. GAO-04-418T). Washington, DC: United States General Accounting Office.

230. Conway, T. & Hutson, R. Q. (2007). *In-depth summary of the Child and Family Services Improvement Act of 2006*. Washington, DC: Center for Law and Social Policy, CLASP.

231. Ibid.

232. See Baumann, et al. in endnote 223.

233. Howe, M.; Clawson, E.; & Larivee, J. (2007). The 21st century juvenile justice workforce [Electronic Version]. *Corrections Today*, 69. <www.aca.org/fileupload/177/prasannak/Larivee,%20Howe%20and%20Clawson.pdf> (accessed April 25, 2007).

234. Ibid.

235. National Council on Crime and Delinquency. (2006). *Job turnover in child welfare and juvenile justice: The voices of former frontline workers*. Houston, TX: Cornerstones for Kids.

236. Gallon, S. L.; Gabriel, R. M.; & Knudsen, J. R. W. (2003). The toughest job you'll ever love: A Pacific Northwest treatment workforce survey. *Journal of Substance Abuse Treatment, 24*(3), pp. 183-196.

237. Ibid.

238. Harwood, H. J.; Kowalski, J.; & Ameen, A. (2004). The need for substance abuse training among mental health professionals. *Administration and Policy in Mental Health 32*(2), pp. 189-205.

239. Ibid.

240. Waldbaum, M.; Galanter, M.; Dermatis, H.; & Greenberg, W. (2005). A survey of addiction training in child and adolescent psychiatry residency programs. *Academic Psychiatry, 29*(3), pp. 274-278.

## SECTION 6
# Case Studies

CASE STUDY #1

School-Based Health Center: The North Country Children's Clinic, New York

CASE STUDY #2

Tribal Initiative: Turtle Mountain Sacred Child Program and the Medicine Moon Initiative, North Dakota

CASE STUDY #3

System of Care—THRIVE: Trauma-Informed System of Care Initiative, Maine

CASE STUDY #4

Disseminating Trauma-Informed Best Practice: Promoting Trauma-Informed Practices, National and State Initiatives

CASE STUDY #1

# School-Based Health Center: The North Country Children's Clinic School-Based Mental Health Services, New York

## Responding to the Needs of Children with Deployed Military Parents

**David's Experience**

When David, age 9, decided he wouldn't go to school anymore, his mother Sarah didn't know what to do. David's father—a soldier in the 10th Mountain Division of the U.S. Armed Forces—was deployed to Iraq and David saw little point in continuing school. He feared he was going to grow up without his dad. David slept very little and woke up crying, plagued by night terrors whenever he did doze off. Sleepless nights left David and his parents without the energy to face each day. Although Sarah had approached David's pediatrician on the military base with her concerns and received a referral for a child psychologist in their area, the wait for an appointment was three months.

David and Sarah live in Watertown, a community of 27,000 people in rural northern New York State. Approximately a third of David's fellow third graders in the Watertown public schools are also children of enlisted personnel. The town is adjacent to Fort Drum, an army base of nearly 16,600 personnel—or 34,000 people inclusive of spouses and children. Around 9,500 of Fort Drum's soldiers are presently deployed, primarily in Afghanistan and Iraq.

As David's absences from school became an increasingly serious problem, Sarah shared her worries with the school secretary. Fortunately, the school offered a resource to help. The North County Children's Clinic, a local multiservice health care organization, had a school-based health program with mental health services. David and Sarah soon began family counseling sessions with a Licensed Clinical Social Worker (LCSW), located in the school, during David's regular school day.

Today, Sarah credits the Children's Clinic not just with easing her son's anxiety and improving his attendance, but with helping to bring her husband safely home. She notes, "By being able to help David to better deal with this deployment, by helping him to be able to talk to his Dad and plan activities for when his Dad comes home, and [by] helping me help David, our soldier could focus on the business of being a solider…I don't think we would have survived this last year without that support."

This case study reviews of the history, program components, successes, and ongoing challenges of the Children's Clinic's mental health program at its school-based health centers, with a particular focus on the Children's Clinic's response to the needs of children in military families.

Marie Wu prepared this case study.

### Program History

David was one of 172 children who used the mental health services at Children's Clinic's school-based health program during 2005. North Country Children's Clinic runs the school-based health program. Its' programming includes pediatric medical care, dental and mental health services, WIC/teen pregnancy services, and insurance access activities. Specializing in working with those at and below the poverty line to ensure access to quality health care, the Children's Clinic first opened its doors to a four-county population of northern New York children in the early 1970s. Originally a grassroots effort to develop well-child clinics, by 2005 the Children's Clinic had expanded to serve some 29,000 children and youth.

School-based health services were introduced in the early 1990s, starting at an elementary school in the city of Watertown. With the help of a planning grant from the Robert Wood Johnson Foundation, the original school-based program focused on children's medical needs. Through their presence in the schools, the need to develop a mental health component to their programming soon became apparent. Further, in pursuing school-based health funding from the State of New York, provision of mental health services was encouraged. Since the mid-1990s, Children's Clinic has employed three clinical social workers in the Watertown Public Schools, under the supervision of the doctoral-level clinical psychologist who runs the Children's Clinic's larger primary care-based mental health program.

*The Children's Clinic approach to working with children grows out of their history as an agency and from the diverse professional backgrounds represented on their team … Professionalism, attention to detail, and a highly qualified staff are also cited as essential components of the program's success.*

## Program Components

Children's Clinic's school-based social workers see students at all grade levels. Students face a range of concerns, from family tension to Attention Deficit Hyperactivity Disorder (ADHD) to histories of abuse or neglect. Among the children and youth of military families, deployment of one or both parents is often the source of particular stress and trauma. Many of these military families are headed by young parents, in their early 20s and relocated from their home states. Without the support of an extended family and network of nearby friends, the parents are often isolated and scared. Many times, military families' incomes hover at or near the poverty level. The nonenlisted parent may be working one or even two jobs, often at low wages and without the flexibility to attend children's appointments or school meetings on demand.

**School-based health centers are convenient for parents who face many other demands.** Amid these family stressors, the Children's Clinic strives to make access to care as simple for families as possible. At the school-based health centers, children can have routine medical health appointments in a timely manner without the need for their parents to take time off from work or provide transportation. In the mental health program, where parental participation is a required component of treatment and considered essential to success, clinicians strive to schedule appointments at times convenient for parents who are facing many other demands. For example, appointments are held first thing in the morning before parents must report to work but after their other children can already be dropped off to their classrooms—minimizing the need for special child care arrangements or extra trips to the school.

**Treatment focuses on the entire family as a system.** While the content of the child's sessions with their clinicians are individualized to their unique situations, a few themes emerge. First, and most importantly, the

Children's Clinic's response focuses on the entire family as a system. If parents—or other caregivers in cases where children are living outside of their birth families' homes—are unable or unwilling to participate, Children's Clinic will usually not work with the child. This firm rule comes from a deep belief by Children's Clinic staff that interventions that do not focus on the child in the context of the entire family will never be effective. As such, parents or caregivers are typically participants in half of their children's treatment sessions.

**Clinician's adopt holistic view of the child.** Taking a holistic view of the child is another core component of the Children's Clinic approach. Implementing this value is made far easier by the clinician's presence in the schools. Many referrals come directly from teachers. Once parental consents are obtained, the social workers are able to participate in school meetings regarding the child's performance. Due to the social workers' presence in the schools, they are familiar, trusted faces—giving them a head start on developing relationships with the children and their parents. If a child is struggling with behavior at a particular time of day or has an outburst

in a classroom, clinicians are available to make a visit to the child at the particular moment of need. Because of their close relationships with school personnel, treatment and educational goals can be shared and reinforced across multiple settings.

**Services are tailored to the developmental needs and age of the child.** Another principle for Children's Clinic staff is to tailor the content of the services to the developmental needs and age of the child. At the elementary school level, this means that play therapy is the central approach. For teens, group interventions as well as one-on-one sessions are common. Among older youth, exceptions to the parental involvement requirement may also be made, especially as they near age 18.

**Treatment uses a cognitive-behavioral approach focused on how the child thinks about what is happening in the family.** With so many children whose parents are deployed to all parts of the world, the primary care treatment room includes an oversized map. Together with the clinician, the child can then find where the deployed parent may be staying and talk about what the child knows about that place. The Children's Clinic also uses a book called *While You Were Away* by Eileen Spinelli to open dialogue with younger children. The book's themes are consistent with those the clinicians reinforce in their sessions, helping children to identify feelings they might be having related to their parents' deployment and to name activities they can still enjoy while they wait for the parent to return home. This cognitive-behavioral approach—which one clinician described as helping the child realize, "it is less what is happening and more how you think about what's happening that determines how you'll be affected by the situation"—is also a hallmark of the Children's Clinic's services.

**Diverse staff is seen as essential to the program's success.** The Children's Clinic approach to working with children grows out of their history as an agency and from the diverse professional backgrounds represented on their team. Janice Charles, the Executive Director, provides leadership to the agency and the school-based program. A public health nurse by training, she is credited as a persistent grassroots organizer. Much of the leadership also comes from within the program. Nancy Conde, Director of School-based Health, was formerly a teacher; Dr. Jeanne Emery, Director of Mental Health, is a clinical psychologist who spent some of her career administering the county's Head Start program. Professionalism, attention to detail, and a highly qualified staff are also cited as essential components of the program's success.

## Program Successes

### *Positive School Relations*

Originally, entering the school district was made far easier for the Children's Clinic by their positive relationships and reputation in the Watertown community. Still, the original idea for school-based health services was met with some skepticism. School nurses wondered if their role was being outsourced and replaced. Local pediatricians worried that the Children's Clinic was working out of the schools as a marketing ploy—potentially taking away the pediatricians "customers." However, by effectively defining their role—to provide primary care to children who are uninsured and/or at and below the poverty level, who would otherwise not have access to care—Children's Clinic effectively eased these concerns. Today, school personnel interviewed for this case study consistently sing the praises of Children's Clinic, repeating, "We don't know what we would do without this resource."

*First, and most importantly, the Children's Clinic's response focuses on the entire family as a system.*

Children are referred to the Clinic's physical and mental health services by various school personnel or directly by their parents. For most students in need, the first stop is a school nurse. For those with mental health concerns, school nurses as well as teachers and school administrators make referrals to the Children's Clinic's social workers. Parent must complete a permission and enrollment form—which most families do at the start of each school year. Clinicians then strive to see and assess all of the children referred to them. Occasionally, children with more intensive needs beyond regular therapy are referred to other providers for deeper levels of intervention. In most cases, though, the social worker initiates short-term services or ongoing treatment sessions with the child and his or her parents. Unfortunately, despite the Children's Clinic's social workers' best attempts to respond to all of the district's children in need, by mid-way through the school year, they typically have a waiting list for services.

The depth of the school's commitment to the Children's Clinic partnership is evidenced by their monetary contributions to maintaining the program. The school provides rent-free space that it built to the clinic's needs and specifications, in an already tight campus. The school district also provides utilities, phone, and janitorial services, and transportation for students. For those who must go between school sites, the district has dedicated a small school bus and a full-time driver, to ensure that all pupils can access the Children's Clinic's health and mental health resources.

### *Collaboration with the Military HMO*

Until recently, obtaining mental health services for the dependents of soldiers has been a particular challenge in Watertown. Since its inception, the Children's Clinic's school-based health centers have served children of military and nonmilitary families alike, regardless of their ability to pay. Over the past four years, the size of Fort Drum's personnel has nearly **doubled**. This, along with the change from peacetime to wartime has greatly increased the demands on the families at Fort Drum and on the community of Watertown. As such, the children of military families represent a sizable and growing proportion of the school-based social workers' caseloads.

The majority of military families are enrolled in the military health management organization (HMO), called TRICARE. Most of their service needs are met by military providers at the Guthrie Ambulatory Healthcare Clinic, located at Fort Drum. Although Guthrie believes it has sufficient capacity to respond to the outpatient medical needs of both the enlisted personnel and their dependents, mental health services are expressly limited to the soldier and not available to family members. Children of military families are covered by insurance, yet remain unable to access mental health care at the post. Still, the Children's Clinic was not being reimbursed for their therapeutic services to this group of children. At the school-based health centers during the first eight months of 2006, unreimbursed mental health services to children with TRICARE insurance totaled nearly $20,000; unreimbursed medical services totaled almost $30,000.

Armed with these figures and motivated by increasing concerns about the program's sustainability, Children's Clinic Executive Director Janice Charles decided to approach the leadership at Fort Drum and Guthrie as well as the regional manager for TRICARE. As recipients of a Kellogg Foundation grant, designed to help school-based health programs improve their sustainability and funding, the Children's Clinic was particularly determined to pursue TRICARE reimbursement. Furthermore, Charles was simultaneously developing a deeper relationship with the military leadership through her participation on the newly forming Fort Drum Regional Health Planning Organization—a communitywide team of service providers joining forces to assess and meet the future medical needs of area residents.

The moment was ripe, and Charles was pleased that her request for reimbursement was met with a supportive response. Recognizing their own lack of capacity to respond to mental health needs of the dependents of enlisted personnel, Fort Drum leaders were willing to find a solution. While the process still took several months,

staff involved noted that learning to work within the military system and culture was essential, although at times trying. Ultimately two Children's Clinic's school social workers who had six or more years of clinical supervision (known as "LCSW-R" designation, a qualification that is held by two of the three current staff) were added as recognized providers on the TRICARE system. Since the start of the 2006-2007 school year, treatment sessions with children in military families can be submitted for reimbursement.

## Outstanding Challenges

### *Military Reimbursement for Physical Health Care*

Charles continues to work closely with Fort Drum's leadership, as part of the larger Fort Drum Regional Health Planning Organization. A major remaining concern is obtaining similar reimbursement for school-based physical health services provided to children from military families. Because Guthrie does offer on-post medical care, it is not willing to recognize and reimburse Children's Clinic school-based nurse practitioners or doctors for health care. Nonetheless, the Children's Clinic remains persistent in pursuing this for two reasons. First, it believe that good physical and mental health care are best provided as an integrated team—which it is not able to achieve for TRICARE patients whose health care is obtained at Guthrie rather than in the school clinic. Second, in keeping with its mission, Children's Clinic believes that using school-based health care, particularly for working families, is an issue of access rather than just of convenience. With Fort Drum more than 20 minutes drive from Watertown, children are missing out on timely treatment for illness as well as preventive care that could be provided at school because parents cannot always make the trip to Guthrie.

### *Sustainable Program Funding*

Administrators and staff currently rely predominantly on grant dollars to sustain the mental health services in the school-based clinic, as all services not eligible for reimbursement are funded through Temporary Assistance for Needy Families (TANF) and tobacco lawsuit settlement money. As long as this is the case, staff recognize that the program's funding will continue to feel tenuous. Reimbursement from TRICARE is a noteworthy first step toward sustainable funding; however, the reimbursement rate from TRICARE remains lower than the actual program costs. The current amount is 95 percent of the Medicare fee schedule. A federal policy change would be required to increase the rate. Further, the largest population of children served in the school-based mental health program is covered by Medicaid. While Children's Clinic would like to bill for its therapeutic services, social workers are not presently recognized as reimbursable Medicaid providers under the State of New York's plan. State-level policy changes would be required to overcome this barrier.

### *Capacity to Meet Needs*

Another outstanding concern for the Children's Clinic school-based mental health services staff is their inability to respond to the magnitude or the depth of need presented in the school population. Recent communitywide analysis showed that local hospitals are admitting more patients—children and adults—for mental health needs than for any other single condition. The Fort Drum Regional Health Planning Organization, of which Children's Clinic is a member, began a needs assessment and strategic planning process in early 2006 and identified insufficient availability of mental health care as the biggest concern for the military and the general community.

Although the Children's Clinic occupies an important and sizable component of the Watertown community's continuum of care, it reports feeling at times overwhelmed by the size and scope of local needs. In the school-based health center, the current level of grant funding does not allow sufficient personnel to fully meet the scope of the students' mental health needs. Typically, each clinician ends the year with a dozen or more children who needed services, but capacity simply was not available. At least two more social workers could maintain a full case load in the Watertown Public Schools.

Further, a number of other school districts in the four-country area covered by Children's Clinic are interested in partnering with the agency to offer school-based health and mental health services. The Clinic is seeking private and public funding in order to afford this type of expansion. Mental health services, at the clinic and in the schools, are relatively small programs within the larger mission of the Children's Clinic.

*By effectively defining their role—to provide primary care to children who are uninsured and/or at or below the poverty level, who would otherwise not have access to care—Children's Clinic effectively eased concern[s of local pediatricians].*

### *Filling Gaps in Continuum of Care*

Gaps in other parts of the continuum of care also make the Children's Clinic's work more challenging. An ongoing problem is accessing certified child psychiatrists to work alongside the therapists, assessing the need for psychotropic medications and providing ongoing medication management. Currently, when a Children's Clinic social worker believes a child may need medication, the closest child psychiatrist for referral is in Syracuse, more than 60 miles away. For children and youth with the greatest needs—eating disorders, self-mutilation, autism-spectrum disorders, and schizophrenia—in-patient and outpatient treatment programs are similarly distant. This distance presents particular difficulty in a remote community like Watertown, where many families are without reliable transportation and the "lake effect" pushes annual snowfall to an average of approximately 120 inches per year.

The Children's Clinic, with its partner, Samaritan Medical Center, is presently pursuing an internal strategy of using nurse practitioners under the supervision of child psychiatrists to ease the difficulties of prescribing and managing medications. They are also working with a statewide taskforce to increase access and allow reimbursement under Medicaid for telepsychiatry. Still, other gaps in the continuum of care will be more difficult to fill. For example, the absence of direct services to parents—who may themselves be struggling with anxiety, depression, or substance use disorders—can be a serious barrier to successful intervention with the child.

### Looking to the Future

The Children's Clinic, and particularly the school-based mental health program, looks to the future with optimism. It is pleased to sit at the table with top military leadership through the Fort Drum Regional Planning Organization and optimistic that the same type of synergistic community planning that originally created the Children's Clinic in the 1970s is at work within this body. The group is slated to send a report to the U.S. Congress in early 2007, with the prospect of funding a pilot program to increase preventive health care for military personnel and their families. With mental health already identified as the number one concern of this group, the Children's Clinic anticipates positive expansions in the local continuum of care to come as a result.

The Children's Clinic team, their partners within the schools, and the children and families they serve also take great pride in what has already been accomplished. All agree that they are both pleased and grateful that high-quality services are provided to children who would otherwise be unable to access them. Children's Clinic is deeply woven into the fabric of the Watertown community. It hopes to find continuous and creative sources of funding—including grants, military funding, and Medicaid—to continue to expand and further develop its work.

CASE STUDY #2

# Tribal Initiative: Turtle Mountain Sacred Child Program and the Medicine Moon Initiative, North Dakota

## Enhancing Tribal Systems to Meet the Needs of Native Children, Youth, and their Families

### Native American Training Institute, North Dakota

This case study was compiled by Joey Coyle and Janice Cooper, with assistance from Deborah Painte.

"[Ours is a] way of teaching parents that children are *sacred*. People had gone away from seeing their children as sacred beings; this includes all aspects of their lives including a culture they have not been aware of. Children are not a piece of property." So begins the focus of most of the interviews with partners of the Turtle Mountain Sacred Child Project (SCP). It is a graduated Center for Mental Health Services (CMHS) service grantee, and the precursor to the Medicine Moon Initiative (MMI), a child welfare initiative funded through the Children's Bureau of the U.S. Department of Health and Human Services (DHHS), Administration for Children, Youth, and Families (ACYF). It had its genesis in the federal system of care movement. The project leaders of the Turtle Mountain SCP and the MMI were asked by the National Center for Children in Poverty to participate in a series of telephone interviews about their work and its impact on trauma. What follows is a case study based upon these interviews conducted specifically to inform a national meeting on developing trauma-informed systems and supportive policies.

**Tina's Experience**

Like many workers in the Turtle Mountain SCP, Tina [not her real name] sees herself in the young people and the families that are served by the program. A teen mother who was abandoned by her mother, she had a care coordinator and mentor who helped her though tough times. She now helps others in the program. Her participation has taken her to national conferences and to a deeper understanding of the program and of her community. Her work today had its genesis in 1993 and began as a result of a state legislative study on the well-being of children in North Dakota. While the rest of the state's children generally ranked first, second, or third on overall well-being indicators compared with other states, the study conducted by the Child Welfare League of American found that *"if the children who resided on the reservations in North Dakota were considered a state, that would rank 51st (or last) on every well-being indicator."* In response to those dire findings, an effort to improve the well-being of all children of North Dakota began. It was spear-headed through the North Dakota Indian Affairs Commission and the children's policy council of the Governor's office in North Dakota, then known as the state Children's Services Coordinating Committee (CSCC).

### Program History

With data from a legislative study and a Governor committed to working with the Tribes, a state-tribal collaboration between the state of North Dakota and the tribal nations of North Dakota focused on children was born. The collaborative includes the Spirit Lake Nation, Standing Rock Sioux Nation, and the three affiliated tribes (Mandan, Hidatsa, and Arikara Nation) and the Turtle Mountain Band of Chippewa, including the Trenton Indian Service Area. The collaboration was embodied through the creation and work of tribal children's services coordinating committees (TCSCC's), comprised of all of the children and family serving agencies on each of the reservations that conducted a wide-scale planning effort culminating with a Five Year Comprehensive Plan for Children and Family Services for each tribe. The plans paved the pathway for the establishment of the Native American Training Institute in 1995, which serves as a training entity for the four tribal child welfare agencies in North Dakota; the Sacred Child Project administered through the United Tribes Technical College, the first intertribal system of care (SOC) grantee, in 1997. It also administers the current Medicine Moon Initiative to Improve Tribal Child Welfare Outcomes through System of Care administered.

In 2003, building upon the success of a tribal system of care project (the Sacred Child Project), the DHHS/ACYF entered into a cooperative agreement with the Native American Training Institutes (NATI) and four

tribal child welfare agencies of North Dakota to support the Medicine Moon Initiative (MMI) to Improve Tribal Child Welfare Outcomes through System of Care. The initiative brings together the tribal child welfare agencies of Spirit Lake, Standing Rock, Turtle Mountain, and Three Affiliated Tribes to develop a trauma-informed outcomes focused system of care for indigenous children and youth in state and tribal foster care. The Native American Training Institute (NATI) began as a collaboration between the State of North Dakota, Casey Family Program, and the tribal communities of Standing Rock, Sioux Tribe, the Three Affiliated Tribes, the Spirit Lake Sioux Tribe, the Turtle Mountain Band of Chippewa, and the Trenton Indian Service Area. Start-up funds began with private monies (initially through the Bush Foundation) and is sustained through Title XIX, IV-B Training dollars to the Native American Training Institute. Its mission, which lies at the heart of building a trauma informed system, is to "empower individuals, families, and the community to create a safe and healthy environment so children and families can achieve their highest potential."

Under the auspices of the United Tribes Technical College (UTTC), the Sacred Child Project, a children's mental health program, was created. As an inter-tribal system of care project, it laid the ground work for, and modeled a service delivery framework for the Medicine Moon Initiative. Through the Sacred Child Project, which was a SAMHSA-funded tribal system of care site from 1997-2003, a comprehensive program operated that addressed negative child outcomes for Native children with serious emotional needs. The UTTC Sacred Child Project partnered with the Native American Training Institute to develop a wraparound training curriculum for Sacred Child Project staff on four reservations. Although each tribe selected which local tribal agencies would oversee the local Sacred Child Project activities, including the Tribal Health Program, Tribal Court, Tribal Youth Substance Abuse Prevention, and Tribal Child Welfare, eventually each tribe placed local responsibility for the Sacred Child Project with their tribal child welfare agencies. The Medicine Moon Initiative continued tribal system of care development from a child welfare perspective, where the Sacred Child Project left off. With new federal funding, it sought to continue the partnership for SOC infrastructure development between the state and tribal governments. Limited to infrastructure development and not for direct service provision, the MMI has three aims: (1) to help children and youth grow positively in mind, spirit, body, and culture; (2) to work with the whole family not simply the children; (3) to honor and hold sacred the child consistent with ancestral teachings and traditions.

The MMI not only benefits from a rich history of collaboration and a robust foundation of systems thinking. It is also well-served by a commitment to developing a solid infrastructure for tribal systems of care promoted and facilitated through a centralized training institute. This realization of quality and training as a mainstay is motivated by a need to confront and reverse negative outcomes for children and youth from tribal communities in North Dakota. Children and youth from tribal communities represented 9 percent of the child population but nearly 30 percent of children and youth in the child welfare system and 33 percent of those in out-of-home placement.[1] American Indians make up 5.2 percent of the population in North Dakota, although in three counties they account for approximately 70 percent of the population.[2]

Unemployment is high. Compared to the state unemployment rate of 3.4 percent, unemployment is 63 percent among American Indians.[3] Unemployment in Turtle Mountain is 65 percent, in Spirit Lake it is

**Tribal Community Demographics in North Dakota, 2006[3]**

| Tribal Community | Enrollment | Population | American Indian Population |
|---|---|---|---|
| Three Affiliated Tribes | 10,400 | 5,915 | 67.4 percent |
| Spirit Lake | 4,300 | 4,435 | 74.8 percent |
| Standing Rock | 13,893 | 4,044 | 84.6 percent |
| Turtle Mountain | 29,161 | 8,307 | 96 percent |
| Trenton IHS users | | 1,800 | N.A. |

*"[Ours is a] way of teaching parents that children are sacred. People had gone away from seeing their children as sacred beings; this includes all aspects of their lives including a culture they have not been aware of. Children are not a piece of property."*

47 percent, in Standing Rock it is 75 percent, and it is 42 percent in the Three Affiliated Tribes.[4] Methamphetamine use has reached epidemic rates. Methamphetamine use accounts for 90 percent of individuals entering treatment.[5] Faced with these harsh statistics, and saddled with a legacy of historical trauma, program administrators credit their success to the coalescing of a number of factors. "It was the right time and the right people", according to NATI MMI Project Director, Deborah Painte. The former director of the Sacred Child Project, Painte explained that "the stars were aligned". With data from a legislative study and a Governor committed to working with the Tribes, the Sacred Child Collaboration was born. Success and experience working with each other led to the Medicine Moon Initiative (MMI). Collaboration as a way of working together became formalized and MMI could take advantage of that.

**Program Components**

Recognizing the historical roots of trauma and resulting social isolation and sense of hopelessness of many tribal communities, the MMI builds upon the strengths-based philosophy first embraced by its predecessor, the Sacred Child Project (SCP). The SCP used the wraparound process to reintroduce indigenous cultural strengths and protective factors such as use of extended family and natural support systems; healing ceremonies and supports; and traditional values such as respect, relationships, and spirituality. According to one stakeholder, the initial focus is on the basic needs of a child and the family. Services begin with a strengths-based, Child and Family Team meeting (wraparound meeting). The family chooses who sits on the team and the family is in charge of the team meetings. The number of people on a team varies between five and 10 people. Only workers who are invited may participate. During these meetings, the focus is generally on how to help the child or youth, not on "what is wrong." Through a solution-oriented framework, the team works to secure an array of services for the child and the family. Through wraparound, according to one care coordinator, "you do whatever it takes. There is a deep sense of who the community leaders are and what the community has to offer." The entire wraparound process for the reservation is guided by a Wraparound Review Intake Team (WRIT), an interagency team of services providers and parent representative that makes enrollment decisions, serves as consultants to the teams, reviews for best practices, and assists in identifying resources for the family and wraparound teams.

WRIT has official criteria for admission, but the reality is more flexible. This includes a mental health diagnosis, a global assessment functioning (GAF) score of less than 50, and usually, a referral. The only hard line appears to be that the admission is voluntary. According to one service coordinator: "The children can't be court ordered. Referrals come from word of mouth, when parents are at their wits end. In some cases we do not get reimbursed because a child does not have a psychiatric diagnosis. Well, then it's my community service."

The program staff and operating costs are covered by third-party Medicaid reimbursements based on children eligible for Medicaid, thus limiting how many children can be served without the necessary medical criteria. This is a major limitation and challenge faced by the program. The Turtle Mountain Sacred Child Project was the only tribal site sustained after the federal Center for Mental Health Services grant ended.

Services and supports that children, youth, and their families receive through the Turtle Mountain Sacred Child Project include basic needs assessment, mentors, coordinated access to existing services, mental health services, intensive in-home care, and family group decision-making. There are also on-call family care coordinators. The support services are based on 12 life domains, including basic areas like housing, legal issues, culture, creativity, socialization, behavior, family, spirituality, health, emergencies, safety, and finance.

Despite low reimbursement rates, the Tribal Partners and the state were able to reach agreement for the proj-

ect to bill for Medicaid. Program leaders attribute the level of sustainability the initiative has achieved to this use of Medicaid as the financing stream for the eight staff mentors and the project's 2.5 full-time equivalent care coordinators.

## Program Successes

Since its inception, the Turtle Mountain Sacred Child Project has served over 175 children and youth with wraparound services and has demonstrated positive outcomes for the children and their families. On average children and youth will remain in coordinated care for up to 12 months; in a few cases, youth have stayed as long as one year. According to Jan Birkland, Project Director, Sacred Child Project, "They stay as long as they need us. We can't be a crutch, but we can't leave them… We never turn anyone away." This philosophy of unconditional care leads easily into addressing trauma. One worker remarked that the staff is able to address trauma "when the [children and their families] trust you enough to tell you their story."

Children and youth enrolled in Turtle Mountain Sacred Child Project face the impact of historical trauma, as well as present-day trauma as evidenced by high unemployment, lack of community resources to keep youth occupied, and high numbers of youth who end up incarcerated, substance addicted, and experiencing a sense of hopelessness. At the core of some of the sense of "dependency" as one system leader acknowledges, is the sense that few incentives exist to spur change and to reverse the trends in poverty. He observed: "Poverty has changed since I was a kid. When I was a kid, I didn't feel poor, not in my soul. Now, I see it, I see spiritual poverty, we do it to ourselves." According to one social worker, "Some family members are so disempowered it's hard to light a fire. We ask them if they love their kids, they all do." From that starting point, program leaders work on creative way to engage families. Oftentimes, those strategies include working to address the parent's health, mental health, or behavioral health issues.

## Program Challenges

The most challenging issue for the Turtle Mountain Sacred Child Project is the lack of resources to meet the most acute needs. It is frustrating for staff because the lack of sufficient psychiatric or behavioral health

**North Dakota's Indian Country**

resources compels them to send some children and youth to specialty facilities that are in another state. They resent their lack of capacity and they resent the high cost of care. One system leader lamented that if they had more funding they could create the services closer to home. Primarily, however, they feel the loss of the child. "When we do that, [send them to South Dakota] we risk loosing those kids, we send them so far away that parents' can't afford to see them," says one stakeholder. A continuing challenge is the limits put on federal Children's Bureau funding to infrastructure spending only.

The Turtle Mountain Sacred Child Project and the WRIT partners attribute their success to its philosophy, its focus on developing personal relationships that extend to staff and has families at its center, and being embedded in tribal culture. Along with a strengths-based philosophy, and holding culture at its roots, the Sacred Child Project focuses heavily on developing personal relationships through its staff. The staff is supported by a child and family support team that could include the teacher, bus driver, and other community people who the family feels they want on a wraparound review intake team. These team members and the staff all reflect the culture and strength of the community. All of this begins with "treating people with respect," according to Deborah Painte.

With a training entity at its core, the MMI takes seriously the need for a healthy and well-developed workforce. Often overlooked in trauma work is the need to acknowledge and address secondary trauma associated with working with highly traumatized populations. Despite

the "mission-driven" nature of the work, leaders and staff recognize that they need to take time for themselves. This continues to be a challenge for all North Dakota tribal communities. Not only is secondary trauma common among staff, but these individuals may also be part of the extended family relationships and work in small, close-knit rural communities. They are themselves sometimes family members who are dealing with trauma.

## Lessons Learned

Underlying the success of the Sacred Child Project and the Medicine Moon Initiative are community commitment, leadership, and keen attention to financing. Leaders of the project repeatedly identified the importance of strong committed leadership over the long haul. In addition, the importance of cultural grounding to community commitment and cohesion proved an enduring theme. According to one key informant, "A big metaphor when I was a kid was the garden. It was a place of work, sharing; it was the glue that kept family together. Today that glue is disappearing in the face of assimilation, becoming modern. Old- timers said it [started] was when we got the telephone." In the face of multiple community stressors, including drug addiction, poverty, and unemployment, the strength of the cultural underpinnings still appeared formidable.

The Sacred Child Project partners are pragmatic. They marvel at their foresight in establishing the Medicaid arrangements but look to push the envelope on program self-sufficiency. Over and over, program partners raised issues of costs that were either not reimbursed or inadequately reimbursed by Medicaid. They pointed to clear program gaps like the lack of adoption services for youth with alcohol and drug use disorders, inadequate reimbursement for mentors and care coordinators, and the failure on Medicaid's part to pay for services provided to the entire family when the indicated child was the only Medicaid-eligible recipient.

In the face of insurmountable odds, building upon the mantra of the Sacred Child, community partners in North Dakota have sought to build a system of care that is trauma-informed. "We are helping to build children, [and] families, to mend bridges between parents who have broken relationships with schools, [and] with tribal courts." The success to date in healing is simply the beginning.

## Endnotes


1. Ronningen, P. (2007). *Testimony Senate Bill 2012 Department of Human Services House Appropriations Human Resources Division*, Bismark, North Dakota, February 22, 2007. <www.nd.gov/human-services/info/testimony/2007/house-approp-hr/070222-sb2012-cfs-budget.pdf> (accessed April 14, 2007).

U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2006). *Child welfare outcomes 2003, Annual report. Safety, permanency, well-being*. Washington, DC: U.S. Department of Health and Human Services. <www.acf.hhs.gov/programs/cb/pubs/cwo03/index.htm> (accessed April 14, 2007).

2. Rural Policy Research Institute. (2006). *Demographic and economic profile of North Dakota*. <www.rupri.org/Forms/NorthDakota.pdf> (accessed March 22, 2007).

3. North Dakota Indian Affairs Commission. (2006). North Dakota's First Nations. <www.health.state.nd.us/ndiac/statistics.htm> (accessed March 22, 2007).

4. Native American Training Institutes (NATI). (2005). *Strengths, weakness, opportunities, and threats analysis: Medicine Moon Initiative*. <nativeinstitute.org/mmi%20pdf/Final%20Str.Plan%20-%20SWOT.pdf> (accessed March 22, 2007).

Spirit Lake Tribe. (2006). In Wikipedia. <209.85.165.104/search?q=cache:ZeABwTedM-wJ:en.wikipedia.org/wiki/Spirit_Lake_Tribe+spirit+lake+unemployment+north+dakota&hl=en&ct=clnk&cd=8&gl=us&client=firefox-a> (accessed March 22, 2007).

*Standing Rock Sioux Tribe Community Environmental Profile*. (2006). <www.mnisose.org/profiles/strock.htm> (accessed March 22, 2007).

*Three Affiliated Tribes of Fort Berthold Community Environmental Profile*. (2006). <www.mnisose.org/profiles/3affl.htm> (accessed March 22, 2007).

5. Azure, A. (2006). *Oversight hearing on the problem of methamphetamine in Indian country, Testimony to the United States Senate Committee on Indian Affairs*, April 2, 2006. <www.indian.senate.gov/public/_files/Azure040506.pdf> (accessed March 22, 2007).

CASE STUDY #3

# System of Care—
# THRIVE: Trauma-Informed System of Care Initiative, Maine

## Building a Trauma-Informed System of Care for Children, Youth, and Families

### Why Trauma Informed?

Traditionally, system of care (SOC) refers to an arrangement whereby a host of child-serving agencies collaborate to build a seamless system for children with mental, emotional, and behavioral challenges and their families. A successful system of care is a partnership between service providers, children, families, teachers, and others community stakeholders involved in the care of a child/youth. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines services and supports as including, "diagnostic and evaluation services, outpatient treatment, emergency services (24 hours a day, 7 days a week), case management, intensive home-based services, day treatment, respite care, therapeutic foster care, and services that will help young people make the transition to adult systems of care."[1] Using this definition, an individualized service plan is developed for each child and family that draws on their unique circumstances, strengths, and cultural and social needs.

**THRIVE's major contribution to SOC development stems from its integration of trauma-informed principles, making it unique among other currently-funded SAMHSA SOC sites.** The main characteristics of trauma-informed systems include: (1) incorporating knowledge about trauma (prevalence, impact, recovery/resilience) into all aspects of service delivery; (2) minimizing revictimization of children, youth, and families; (3) facilitating growth, resilience, healing, empowerment, and hope; and (4) building a safe, hospitable, and engaging system for children, youth, and families.[2] The service delivery philosophy is straightforward. Rather than focusing on correcting deficits and problem behaviors by questioning, "What is wrong with this child and family?" trauma-informed systems view behaviors as adaptive coping mechanisms to challenging circumstances and ask "What has happened to this child and family?" This refashioned method is the bedrock of a trauma-informed approach that aims to shift attitudes and transform entire systems that care for children and youth with serious emotional challenges and their families.

A trauma-informed approach is important. A growing body of research documents the pervasive nature of trauma and its long-term mental, emotional, social, and physical consequences. Trauma, left untreated or ineffectively treated, may lead to long-term dependency on public mental health systems, higher use of restrictive and costly service alternatives, and poorer outcomes for children and youth. Collectively, the current knowledge base presents a strong case for early intervention. A trauma-informed approach addresses trauma in all aspects of service delivery, both from cost and health care perspectives.

Parsa Sajid, Sarah Dababnah, and Janice Cooper prepared this case study with assistance from Jay Yoe.

The goal of THRIVE Trauma-Informed System of Care (TISOC) is to make improvements in outcomes for children, youth, and their families by strengthening the care delivery system. Its focus is on building a comprehensive trauma-informed system of care for children and youth with serious behavioral and emotional challenges and their families that promotes family-driven, youth-guided, and culturally and linguistically competent care. The THRIVE initiative seeks to instill greater awareness and understanding for trauma survivors and their families and broader knowledge of trauma and its effects at all levels of the system of care. Specifically,

THRIVE intends to restructure the system by enhancing collaboration among key system and community partners (including youth, families, the community, and state child/family-serving agencies such as Child Welfare, Juvenile Justice, Education, and Children's Behavioral Services), improving access to a broad array of community-based services, and supporting individualized strength-based planning and system wide implementation of evidence-based trauma-specific treatments and practices.

## Program History

THRIVE is a $9 million, six-year, federally-funded initiative. Through THRIVE, Tri-County Mental Health Services (TCMHS) partnered with the Maine Department of Health and Human Services (Maine-DHHS) Children's Behavioral Services to build a TISOC for children, youth, and their families. Research that demonstrated the influence of trauma on service use, expenditures, and outcomes for children in Maine's mental health system largely informed the initiative's design.[3]

TCMHS is the lead agency in this grant and the home of THRIVE. This agency's history in the delivery of trauma-informed services and its track record as a provider of mental health, substance abuse, and developmental disabilities-related services made it a natural leader of the initiative. For example, TCMHS piloted a successful trauma-informed initiative aimed at adults that included consumer/patient involvement in program design and implementation. Moreover, the agency is well-known for its collaboration in Western Maine, an area encompassing Androscoggin, Franklin, North Cumberland, and Oxford Counties.

Three factors drove the creation of THRIVE: (1) poor outcomes and inefficient care for child survivors of trauma; (2) the need for a holistic understanding of trauma; and (3) geography. Although Maine was at the forefront of systems of care development in the early 1990s and provided an array of services (both in terms of diversity and availability), children and youth outcomes did not improve. The Maine-DHHS study demonstrated that despite receiving intensive services, compared to their nontraumatized peers, child and youth trauma survivors were less likely to experience functional improvements. Also, costs for treatment of these youth were 73 percent higher than other youth. Furthermore, there was a need for greater understanding of the effects of trauma and victimization across the lifespan and its related behavioral and health consequences.

THRIVE covers three counties in Western Maine, including Androscoggin, Franklin, and Oxford. The total population is 192,000, including 46,000 children and adolescents. The area is mostly rural, with a sizeable population below the federal poverty level. There is considerable ethnic diversity, including a recent influx of refugees from Sudan and Somalia and a growing Latino

population. The proportion of African Americans in the area exceeds the state average. Spurred by an agro-based economy, there are large numbers of migrant workers in the region. In all, the proportion of individuals who speak a language other than English is twice the state average. The Tri-County region also has the highest number of reports of child abuse (both allegations and substantiated cases) and the second highest number of children in out-of-home care, including in the juvenile justice system.

## Program Components

Critically aware of the area's capacity for quality trauma-informed care juxtaposed against the high levels of out-of-home placements and placement changes (sometimes up to 5-6 times in a given year), THRIVE sought to reunify families, address trauma at the onset, and reduce revictimization and retraumatization of children, youth, and their families. THRIVE is overseen by a multi-agency Governing Council whose work is structured around seven subcommittees and operates with a full complement of staff. These include a project director, family and youth coordinators, a social marketing coordinator, and a cultural competency consultant.

The initiative first designed a service delivery model that supports increased trauma identification and recognition and coordinated culturally-appropriate service delivery among partner agencies. The initiative planned a new system infrastructure to reduce stigma around mental health, identify and rectify issues related to access to care, and reform budget and funding obstacles. Most important, it sought to create a platform and model for increased family and youth involvement in every aspect of the initiative, from hiring staff to evaluation.

*A successful system of care is a partnership between service providers, children, families, teachers, and others community stakeholders involved in the care of a child/youth.*

To date, 19 youngsters and their families have been referred to THRIVE. The target population is children and youth birth to age 12 who are experiencing severe emotional and behavioral challenges and their families and have come in contact with the child welfare system. By year three of the initiative, plans are to expand the age group to 18 or 21 years and to extend service capacity beyond child welfare referrals to education, corrections, children's behavioral services, and other relevant agencies. Children do not have to have experienced trauma to be eligible for THRIVE services, but evidence shows 50-80 percent of those with SED have in fact experienced trauma. An estimated 100 children and youth, and by extension their families, will be enrolled annually.

### Program Successes

Great strides have been made and THRIVE's mark on Maine's system of care is already evident. To date, there has been increased awareness of trauma and its pervasiveness, improvement in governing infrastructure, greater awareness among providers, and an increased understanding of the need for continuous evaluation for success. Most noteworthy are THRIVE's effects on the structure of service delivery and on outcomes for children, youth, and families.

Several factors have contributed to THRIVE's initial success. This initiative is knowledgeable about trauma-informed practice based on research as well as Tri-County's experience with adult trauma services. According to one stakeholder interviewed, most of Tri-County's adult consumers were child trauma victims originally; however, due to ineffective or no treatment, their victimization became more entrenched. As a result, they became more high-end users of the mental health system.

**The initiative recognizes that family and youth are essential to governance.** THRIVE involves youth and family members as active partners in designing and making decisions for the system of care. In addition to full-time youth and family coordinators, each of the seven subcommittees is co-chaired either by a family or youth representative. The evaluation team consists of two family member evaluators. It is the goal of the evaluation committee to turn the responsibility of the group over to family members, with the evaluators serving as consultants to the process.

**The state history of system wide collaboration among child-serving agencies, such as the successful Children's Cabinet, promotes streamlined and integrated services delivery.** The Children's Cabinet provides a direct connection with the highest level of state government. It affords the opportunity of cross-learning and knowledge dissemination around trauma practices across the state, with a direct impact on THRIVE. Maine's Department of Health and Humans Services, a partner in the Children's Cabinet, contributes at least four staff that provide in-kind support to THRIVE in the areas of evaluation, financial planning, and social, psychiatric, and clinical services. Recent events have fostered opportunities for even closer collaboration. The consolidation of the Department of Human Services and Department of Behavioral and Developmental Services into Maine-DHHS produced more streamlined and integrated services delivery structures, and accordingly, a decrease in duplicative and unwieldy policy planning and service delivery. For example, the consolidation resulted in the merging of children's behavioral health services and child welfare into the Office of Child and Family Services. This has led to joint planning efforts and colocation of personnel in many offices across the state.

**The participation of state and local leaders ensures high-level commitment and grassroots support.** The contribution of state and local leadership to THRIVE's success cannot be overstated. THRIVE's leadership includes hired staff, in-kind support, and state level oversight groups (such as the Children's Cabinet). Robust leadership and a drive for learning and listening have resulted in quick adoption during the planning phase. One example of the high level of commitment is the hiring of a youth coordinator. Under the coordinator's leadership, THRIVE has built partnerships with statewide youth organizations such as Outright, Leadership Advisory Team for Children and Youth, New Beginnings, and the Maine Youth Action Network.

**Every aspect of the service delivery is trauma-informed, from the environment to intake assessment to evaluation.** This includes reaching out to everyone from the facilities staff at the agency or department to those working directly with children, youth, and families. THRIVE aims to ensure that the entire system of care has a basic understanding of trauma and its effects before selecting a treatment modality or implementing evidence-based care.

**Have the support of the community.** To sustain change, THRIVE leaders believe in community support. They have already garnered the backing of faith-based organizations, law enforcement, and other community and culturally-specific organizations such as the African American Association.

**Give training in trauma-informed practice to staff at all collaborating agencies.** To support such a foundational change, THRIVE contracted with Roger Fallot, a leader in trauma-informed system development. Dr. Fallot conducted the first wave of trainings on trauma-informed service delivery with project staff, child welfare personnel, provider agencies and case management staff. A series of follow-up trainings are planned. Initial trainings included a panel of youth and young adults who shared their experiences in the child welfare system. In a recent training, approximately 90 child protective workers were taught reflection, self-assessment skills, and simple ways to minimize trauma for children, youth, and families when providing services. For example, removing a child from home can be traumatic, but child protective workers should minimize the trauma with gestures such as allowing the child to have a toy from home and providing as much information as possible for the child to understand what is happening. The reach of these systemic changes can be seen in THRIVE's growing relationships with service providers. Currently, the initiative has official memoranda of understanding (MOUs) with four case management services.

**Take family and youth voices seriously.** Family and youth voice is taken very seriously and THRIVE's project staff work continually to make sure that participation is genuine. The two-fold approach for family and youth participation involves workforce development and advocacy. Workforce development means providing support and education to mental health providers to allow them to better serve families and youth. Advocacy is focused on empowering youth and family voice to enable a better model of "doing business". As such, youth representatives assisted in the preparation of a federal document on behalf of the initiative, represented the state of Maine in regional youth conferences, and will attend a national youth leadership conference.

**Be culturally sensitive about family, community, and institutional differences.** THRIVE also recognizes the need to be culturally sensitive. Cultural difference is not only endemic to the sphere of race, religion, or ethnicity, but also in spheres of institutional differences. Cultural differences even exist within individual families. THRIVE has achieved a broader understanding of such cultural differences that has enabled it to bridge information gaps, especially at the management level. Thus, there is now a uniform awareness of trauma across various stakeholders involved in the initiative and a consensus among THRIVE partners that screening, assessments, and diagnostic tools should be culturally sensitive.

**Use assessment tools to improve services.** Often, children, youth, and their families are retraumatized as a result of contact with the mental health system. They sometimes confront complex processes and experience limited access and inconsistent care. Often, families are required to retell their stories repeatedly, which further contributes to retraumatization and revictimization. To attain more positive outcomes, THRIVE introduced a uniform system assessment tool designed to engender trust and promote safety in the service delivery environment. Other benefits of a uniform tool include greater consistency in case management and less use of out-of-home placement.

## Program Challenges

The THRIVE Initiative anticipates several positive outcomes, including decreased trauma and revictimization, reduced school drop-out rates, and eliminating or lessening stigma related to mental health. Additional improvements in child and family outcomes are expected, including reductions in health risk behaviors and improvements in health status (such as, reduced obesity, diabetes, and cardiovascular disease).

But some challenges loom large for THRIVE. The first is ongoing provider buy-in. As one stakeholder noted, territorial issues pose obstacles to collaboration. Additionally, despite strong ties to state government, THRIVE leaders anticipate hurdles as a result of the upcoming introduction of a Medicaid managed care carve-out. The initiative also struggles to have substantive inclusion of all relevant agencies. Although there is an observable integration at the local level between child welfare and children's behavioral health, other child-serving agencies with equal stake in the project do not always reflect equal interests due to time and resource constraints. Lastly, sustaining the initiative beyond six years and guaranteeing its financial and programmatic efficacy is a significant concern.

## Lessons Learned

One of the most important lessons thus far has been engaging family and youth. THRIVE leaders recognize that system of care sites often experience a weakening or elimination of family and youth involvement when grant funding ceases.[4] In order to avoid this pitfall, THRIVE gives incentives for family and youth participation, such as stipends, child care support, and taxi vouchers. Barriers to participation for other parties may be overcome by similar incentives.

Another area deserving attention is cultural competency. With some refugee populations, mental health issues are not always recognized within their cultures. A full-time staff person would be helpful to contact hard-to-reach communities, such as Somali and Sudanese refugees, and create inroads to facilitate outreach and engagement.

Early identification is also key. Currently detection occurs at a later stage through child/family reporting or when a child/family comes into contact with mental health or child welfare agencies. THRIVE believes in partnerships among agencies and hopes to eventually broaden its scope from youth involved with child welfare to other child-serving agencies and organizations in order to provide preventive and effective trauma-informed services.

Lastly, formalization of administrative processes in the early stages of an initiative is vital. For example, a quality assurance mechanism that allows for a grievance and appeals process is needed. Additionally, it is important to define critical issues up front and ensure a smooth decision-making process. Setting priorities would have facilitated the earlier recognition of the need for a finance committee, as well as a full-time clinical director.

## Looking to the Future

THRIVE hopes to feed evaluation results back into the trauma-informed system of care. The results and lessons learned are also to be disseminated statewide and nationally. Among the avenues for development are education for the broader community, increased social marketing efforts to reduce stigma, channeling the youth movement towards service delivery, further workforce development for greater cultural competency, and continuation of provider network building.

## Endnotes

1. U.S. Department of Health and Human Services, SAMHSA's National Mental Health Information Center, Center for Mental Health Services. (2006). *Systems of care a promising solution for children with serious emotional disturbances and their families*. <mentalhealth.samhsa.gov/publications/allpubs/Ca-0030/default.asp> (accessed October 9, 2006).

2. TISOC principles are rooted in the principles of Trauma-Informed Service Delivery proposed by Fallot and Harris that incorporate safety, trustworthiness, choice, collaboration, and empowerment when treating a child or a youth. See Harris, M. & Fallot, R. (Eds.). (2001). *Envisioning a trauma-informed service system: A vital paradigm shift*. San Francisco, CA: Jossey-Bass.

3. Under the direction of Dr. James Yoe, the research was conducted by the Maine DHHS Office of Quality Improvement.

4. Manteuffel, B. (2007). *Implementing effective systems of care: What have we learned from the national evaluation?* Presentation to 20th Annual Conference. A System of Care for Children's Mental Health: Expanding the Research Base, March 5, Tampa, Florida.

CASE STUDY #4

# Disseminating Trauma-Informed Best Practice: Promoting Trauma-Informed Practices, National and State Initiatives

## Lessons from the "Knowledge-based" Trenches

Sarah Dababnah and Janice L. Cooper prepared this case study with assistance from Parsa Sajid and Marie Wu.

The Institute of Medicine's recent report, *Crossing the Quality Chasm Series: Improving the Quality of Health Care for Mental and Substance Use Conditions*,[1] represents the latest salvo in a decade and a half effort to improve quality in health care. Efforts to translate research on best practices through models, tools, service-based learning, and education form a major component of the quality promotion movement. These efforts are central to creating and strengthening trauma-informed services and systems.

This case study profiles four dissemination strategies for trauma-informed practices and documents major opportunities and challenges faced by those responsible for their adoption on the ground: (1) a large-scale national effort to disseminate evidence-based practices, (2) a state-level dissemination strategy of a specific trauma-informed intervention, (3) a dissemination strategy suited to complex emergencies, and (4) one state's work to implement evidence-based practice in the juvenile justice system. This case study is based on interviews with key informants engaged in making trauma-informed best practices widely available. These experts were, as one interviewee stated, able to "strike when and where the iron was hot." They each seized an opportunity to increase awareness and knowledge of trauma-informed practices and systems.

### National Models—National Child Traumatic Stress Network

The National Child Traumatic Stress Network (NCTSN) was established by Congress in 2000 with the mission "to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States." NCTSN is composed of 70 member centers of 45 current and 25 previous grantees. It is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Health and Human Services.

#### *Program Components*

In an effort to identify and adopt evidence-based practices for work addressing child trauma, NCTSN examined current research, traditional training models, and various methods that were being used by other networks. NCTSN discovered that these trainings were primarily based off-site and were not able to generate sustained, system wide change. These findings led NCTSN to sponsor a Breakthrough Series Collaborative, a methodology that engages all levels of an organization in order to implement a best practice. The Breakthrough Series Collaborative trained teams of six-12 individuals at 12 NCTSN sites on one evidence-based practice: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

NCTSN later modified the Breakthrough Series Collaborative model to incorporate a dissemination strategy called the Learning Collaborative. Unlike the Breakthrough Series Collaborative, the Learning Collaborative engages a wider array of participants who have not had exposure to TF-CBT. Using an approach that integrates organizational, clinical competency, and family/youth components, the Learning Collaborative's targeted, interactive "learning sessions" aim to accelerate the uptake of evidence-based trauma care. Participants learn to value experiential learning as well as knowledge from the field to create an overall shift in organizational structure and an environment of knowledge sharing and innovation across the organization. To date, NCTSN has trained approximately 30 groups of about 35 participants each.

The Breakthrough Series Collaborative and the Learning Collaborative both require senior-level attendance for an organization to participate. They rely on tech-

*"What degree one has should not be a hindrance to knowledge sharing and learning from each others' experience."*

—Jan Markiewicz, Training Director, National Center for Child Traumatic Stress, Duke University

nology and frequent meetings to collaborate and foster knowledge dissemination and skills-building. Between meetings, participants apply their new skills in their organizations and problem-solve with the trainers.

### *Program Successes*

Although preliminary evaluations are still underway, the trainings have already significantly effected the dissemination of trauma-focused care. The collaborations have acted as catalysts to distribute trauma-focused approaches to other sites. For example, a site in Jackson, Mississippi, which recently began using TF-CBT, is now leading a training for a Katrina-affected site. Another site is working with organizations, including faith-based agencies such as Catholic Charities, to change their trauma care system.

**Focus on interventions with strong evidence base.** One significant factor contributing to the success of these initiatives is a focus on interventions with the highest level of evidence. NCTSN's initiatives were able to strike a balance between adapting the model to work in the field and maintaining fidelity to the original model.

**Create partnerships between researchers and community members.** NCTSN attributes some of its success to the focus on partnership between researchers, training faculty, and community members. This strategy helped to overcome some of the challenges in the collaborative approach: steep financial outlays for face-to-face sessions and technology and individuals accustomed to traditional methods of knowledge dissemination. Establishing faculty as partners with individuals in the field led to strong family member/consumer partnerships. It has also led faculty members to adopt a more holistic style rather than focusing solely on clinical competencies.

**Build strong infrastructure, continuous training, and evaluation components.** Still in the early stages of implementation, NCTSN already has learned and improved from many lessons along the way. First, it better understands the cost to build the infrastructure for the programs, including the need for continuous training and a strong evaluation component. Second, the experience with creating a model that gives a voice to participants led to the development and piloting of a Learning Collaborative Toolkit with the faculty members that provides a systematic guide to the program.

NCTSN recently began rolling out additional Learning Collaboratives. Currently, however, there is no funding for additional Breakthrough Series Collaboratives. Organizers hope to evolve to a "core components" model, in which the foundation of trauma-informed care is the primary focus of the program. NCTSN continues to support dissemination of these models to other sites who wish to adopt trauma-based practices in their own organizations and communities through formal evaluations and reports.

## State-Level Efforts—Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET), Connecticut

In 2002, the juvenile justice system in Connecticut (Juvenile Court and Department of Children and Families–DCF) became interested in adopting the program: Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET) program for youth ages 10 to 18. Originally developed in 1999 for adults with serious mental illness, TARGET is a strengths-based, biopsychosocial approach developed by Dr. Julian Ford at the University of Connecticut. It uses a set of 7 practical skills—labeled FREEDOM steps—to counteract the mental confusion, social isolation, and emotional distress caused by chronic trauma.

TARGET has been used to train 30 agencies in the state. In 2002, the results of a SAMHSA-sponsored evaluation grant provided much of the initial evidence to support TARGET. Since then, the intervention has been disseminated to a number of community programs serving youth involved with the juvenile justice

system, juvenile detention centers, and juvenile probation officers. Recently, the National Child Traumatic Stress Network (NCTSN) juvenile justice workgroup adopted TARGET and works with six sites, including clinics, hospitals, and detention centers. Connecticut's Department of Children and Families also will begin a dissemination process to the state's children's psychiatric hospital over the next year and a half. Given the success of TARGET, the University of Connecticut decided to use its research and development corporation to speed up dissemination and take intellectual development to scale.

### *Program Components*

TARGET's dissemination approach is flexible. Many adaptations of the model have been developed to reach various populations. The core elements include one to several days of initial trainings and ongoing in-person or phone consultations. It also includes weekly to biweekly meetings with staff and clinicians and ongoing guidance for at least a year. A training approach has now been developed for trainers. Over 50 agencies have been trained in the United States, Canada, and Israel. More than 500 clinicians and child service workers have been trained and approximately 1,000 have received overview training. TARGET's major partners, along with the State of Connecticut, include several other state agencies, SAMHSA, NCTSN, and faculty from Yale University and other U.S. universities.

The costs of TARGET vary. One-day individual training costs $100, while the expenses for an agency training are $8,000-10,000. A package that includes training and ongoing quality assurance costs about $15,000-35,000 annually. TARGET's own costs are primarily borne by grant funds and contracts. About $4 million has been spent over the past six years on developing the model, evaluating its efficacy, and disseminating it.

### *Program Successes*

Research to evaluate TARGET is ongoing. Initial data suggests the strengths-based way of understanding traumatic stress results in increased hope and reduced stigma. Using practical skills, children and adults report they are better able to manage current situations and symptoms. Parents are more confident about how to help their child and have fewer feelings of failure. A quality assurance protocol will soon be used on a formal basis to complement evaluation efforts.

One of the biggest benefits for family and youth support in communities with TARGET has been bridging interdepartmental and interprogram collaborations. Another factor in TARGET's success lies in the increase of creative, thoughtful problem solving and the decrease in the use of traditional educational tools. Trainers regularly make phone contact with providers and meet with groups. TARGET's success has also been attributed to researchers working side by side with families and youth to promote growth in the program.

### *Lessons Learned*

**TARGET's emphasis on the present may not work for all settings.** One challenge to TARGET dissemination has been its "present-centered" approach and the lack of focus on memories. TARGET works mainly with families that have experienced extreme trauma and children whose care is quite fragmented in multiple systems. The tradeoff for this method is that TARGET cannot be used in all places and is not yet considered "evidence-based." However, despite the lack of a sound empirical base, TARGET has been "real-world informed" through the input of families and consumers.

**Dissemination will be faster if organizations already want to make their services trauma-informed.** In order to bring dissemination to scale, it would cost about a quarter of a million dollars annually for a number of years for technical assistance and training, not including the cost of service delivery. Much of this money could come from existing resources. It would be best to focus efforts on constituents who want to make services trauma-informed, rather than spending time convincing them they should be. As an evidence base is established for TARGET, it will lower the barriers to program adoption.

TARGET is growing quickly and is fast developing a research base as well as a large number of contracts with state agencies and other organizations. Dissemination efforts will continue to build strong bridges linking specific intervention models in the field. In this way, the field will be on its way to ensure that more children's services are trauma-informed in the future.

## Response to Disaster—The Resiliency Program, New York, and Operation Assist, Mississippi and Louisiana

Columbia University's National Center for Emergency Preparedness and the Children's Health Fund support two programs created after traumatic national events. The Resiliency Program was created in response to families impacted by 9/11, especially those who were underserved because of language barriers or lack of resources. Using the same model, Operation Assist was developed after Hurricane Katrina to provide children's mental health services through mobile units in Biloxi, Mississippi and New Orleans, Louisiana.

### *Program Components*

**The Resiliency Program** serves the mental health needs of children and families in New York City post-9/11 through psychoeducational programs, therapy, provider education on trauma services (teacher, social workers, pediatricians, psychologists), and group treatment. The overarching goal is to strengthen the infrastructure in case of another disaster. Therefore, the Resiliency Program concentrated much of its efforts on the classroom and offered training and consultation for teachers. The Resiliency Program also partners with communities to enhance existing community supportive activities by providing specialty services such as case management or legal services. Based on a commissioned survey that found the most severe mental impact was in the Bronx, the Resiliency Program's work is targeted to that borough. To date, the Resiliency Program has worked with 120 partner agencies and provided services to almost 7,000 people throughout New York, including the Department of Health and Mental Hygiene, day care centers, Big Brothers Big Sisters, homeless shelters, hospitals, and the Psychiatric Institute at Columbia University. The American Red Cross is the Resiliency Program's primary funder, and the annual budget is approximately $600,000.

**Operation Assist** uses three mobile units to provide medical and mental health care to children in the Gulf Coast. Operation Assist's formal mental health treatments include psychotherapy, play and group therapy, and parent education. The mobile units set up at different sites throughout the week. In Louisiana, Operation Assist also started a series of trainings to assist school-based mental health centers with Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and other evidence-based treatments. Operation Assist partners with Coastal Family Health in Mississippi and Tulane University and Louisiana State University in Louisiana. Operation Assist also works with many schools, trailer parks, hospitals, pediatricians, and psychiatrists in the area. The program has served the mental health needs of an estimated 2,500 children, youth, and their families. It is funded by the Butler Foundation, the Bush Clinton Foundation, and Newman's Own at an annual cost of approximately $1 million.

### *Program Successes*

Outcome data for the **Resiliency Program** will be finalized by January 2008. Preliminary results show that service providers report increased knowledge and security in performing their duties. In surveys, children, youth, and their families' served report that they were more actively involved in their own treatment plan. While **Operation Assist** lacks a formal evaluation, the program continues to train over 200 people per month and receive positive feedback from the community regarding the services. Both programs focus on underserved populations first, and the success of the work is evident in the increased knowledge base of consumers and providers in the community.

**Know the needs of the community and the cultural sensitivities and make a long-term commitment.** Many factors have led to the success of the Resiliency Program and Operation Assist. First, a needs assessment was conducted at the start of planning. The programs also made a commitment to understand the cultures of the populations served by working with community liaisons. Both projects are committed for the long term to provide services in these communities. Nevertheless, issues with outreach to underserved communities, including access to services and overcoming mental health stigma in the targeted populations, need to be addressed.

**Build in renewable funding sources.** Like many programs, funding remains a critical barrier to maintaining and expanding these initiatives. The Resiliency Program temporarily had to close for a few months when funders and the government did not immediately acknowledge the lasting impact of 9/11 and the need for continued services.

*I would like to see policy support through legislation and funding for evidence-based practices and interventions. Policies that interfere with such implementation should be done away with. [The] field should have a meaningful voice.*

—Case study participant

**Identifying appropriate personnel to provide services can be difficult.** A challenge for **Operation Assist** was hiring the right professionals in the Gulf Coast. Not only was finding individuals with the right clinical expertise a struggle, but Operation Assist staff also had to address the needs of Gulf Coast professionals whose own mental health was at risk. The monumental destruction in this area even resulted in burnout for the mental health professionals arriving from outside of the Gulf Coast.

**Keep the community informed about plans and details of the program, and provide a voice for advocacy.** Both programs learned invaluable lessons as they went into communities following the devastating events of 9/11 and Hurricane Katrina. According to one program director, it is important when working with communities to clearly present the program's goals and staff intentions as well as directly address the program's strengths and limitations. It is also good to offer tangible benefits, state a timeline, and outline a plan, and structure for how resources will be allocated. Disorganized services and failure to honor commitments to the community will have long-lasting negative effects. It is critical to advocate for the people that are being served since they are generally an underrepresented voice in local and national politics.

### *Looking to the Future*

Both the **Resiliency Program** and **Operation Assist** are slated to undergo formal evaluations. Program leaders plan to disseminate the model on a larger scale. Nationally, program leaders hope to demonstrate how to provide appropriate resources to communities after a disaster, and how to build the infrastructure for a strong disaster-prepared medical and mental health service delivery system.

## Evidence-Based Practices in Juvenile Justice—Multisystemic Therapy (MST) in Connecticut

The State of Connecticut began statewide implementation of multisystemic therapy (MST) in 2002. The plan to create an evidence-based culture focused on the juvenile justice population had its roots in Connecticut's 2000 KidCare Legislation and the introduction of an expanded service continuum that included an array of services—from emergency mobile psychiatry to intensive in-home services. External factors drove some of this reform, including two major consent decrees emanating from the juvenile justice and child welfare systems. Both agencies are lead partners in the roll-out of evidence-based practices in the state.

### *Program Components*

In 1999, an in-home model for service delivery began with the development of eight MST-trained teams. Two years later, the Center for Effective Practices became a licensed MST network partner and the hub for knowledge dissemination and supervision for MST work in the state. By 2004, in addition to MST, the state also had begun to adopt other evidence-based practices, including functional family therapy (FFT), multidimensional family therapy (MDFT), and intensive in-home child and adolescent psychiatric services (IHCAPS). That same year, oversight and supervision of MST was transferred to Advanced Behavioral Health, a large nonprofit, multiservice behavioral health organization. Since implementation, over 25 MST teams have been developed statewide.

In 2005, Connecticut Governor Jodi Rell agreed to a settlement that covered the development of empirically-supported clinical capacity, including multidimensional treatment foster care, wraparound home-based behavioral health treatment services (including trauma-focused gender-specific treatment), post-MST treatment, and the use of therapeutic mentors.[2]

Connecticut's move towards an evidence-based culture builds upon an externally driven, but top-down model of commitment to quality and accountability. The state has strong partnerships with its academic centers that house national developers of evidence-based practice models. In addition, it has benefited from an independent policy center whose reports and advocacy informed some of the strategies adapted. The Center for Effective Practices, located in the Child Health and Development Institute of Connecticut, has played an incubator role for the statewide MST initiative. In addition, its advocacy has propelled changes in juvenile justice. Most recently, it called for the adoption of evidence-based screening in detention, with a focus on trauma in juvenile justice.[3] Citing the $30 million cost per year of services to children, the Child Health and Development Institute urged policymakers to identify children early through appropriate timely assessments.[4]

The state's movement toward quality services has not been without challenges. A system that is as heavily resourced as Connecticut's creates the potential for winners and losers in a reform environment. Significant provider disenchantment, data collection problems, and the lack of an infrastructure to support accountability rank high among the initiative's challenges.

### *Program Successes*

**To be successful, engage stakeholders at multiple levels and in the community.** Despite the obstacles along the way, stakeholders in the process have learned important lessons. First, experience has taught them the importance of stakeholder engagement. Strong top-down leadership alone cannot compel change. There is a need for buy-in at multiple levels and to develop external supporters to act as brokers and catalysts for change.

**Pay attention to the pace of change and staff behavior, and ensure steady funding and reasonable reimbursement rates.** Connecticut learned that the pace of change is important. As the initiative grew over five years to 27 evidence-based MST teams, the significant contraction of the provider pool led to resistance. Multiple strategies need to be employed to overcome this resistance. The role of financial incentives in the form of performance contracts or reimbursement enhancement is more in evidence. Any large effort like this must fit into the mainstream of health care financing; the initial lack of third-party reimbursement for the MST initiative was short sighted, and health care plans should establish realistic reimbursement rates. Stakeholders now have a much better understanding of the need to compensate providers for training and to address provider turnover and staff burnout.

## Endnotes


1. Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board on Health Care Services. (2006). *Improving the quality of health care for mental and substance-use conditions. Crossing the Quality Chasm Series: Improving the Quality of Health Care for Mental and Substance Use*. Washington, DC: National Academy Press.

2. Emily J. et al. v. M. Jodi Rell, et al. (2005). United States District Court, District of Connecticut No. 3.93CV1944. Hartford, CT.

3. Williams, J.; Ford, J.; Wolpaw, J.; & Pearson, G. (2005). *Not just child's play: The role of behavioral health screening and assessment in the Connecticut juvenile justice system*. Farmingham, CT: The Connecticut Center For Effective Practice of the Child Health and Development Institute of Connecticut, Inc. (CHDI) <www.chdi.org/files/1262006_11179_1999141_pdf.pdf>.

4. Ibid.

## APPENDIX A: Table 1: Trauma-Informed Specific Services in the States

| State | Screening and assessment | | | | Treatment/services | | | |
|---|---|---|---|---|---|---|---|---|
| | Name or project/program name (if applicable) | Universal vs. selective | Scope[a] | Type(s)[b] | Project/program name (target population) | Scope[a] | Type(s)[c] | SAMHSA funded |
| AL | Trauma and Abuse Policy and Universal Assessment Instrument[1] | Universal | S | SD | | | | |
| AK | Alaska Screening Tool[1] | Selective | S | SD | Alaska Child Trauma Center in Anchorage (ages 3 to 18)[3] | LGA | UK | X |
| | Trauma Symptom Inventory Scale, Psychological Assessment Resources, 1995[1] | Selective | LGA | EB | Insights to Healing Program (Alaska Natives)[3] | LGA | CC | X |
| AZ | 24-Hour Urgent Response (Child Protection Services)[1] | UK | S | SD | Arizona Families F.I.R.S.T. (families with subs. abuse, child abuse and neglect)[1] | S | UK | |
| | | | | | The Arizona Youth Suicide Prevention Project[3] | LGA | UK | X |
| | | | | | The Child and Adolescent Traumatic Stress Services Center of Southern Arizona/NCTSI[3] | LGA | EB | X |
| CA | | | | | San Joaquin County Mental Health Services: trauma-informed case management (transitional age youth)[1] | LGA | CM | |
| | | | | | PROTOTYPES: use of trauma-informed model[1] | LGA | EB, CM | |
| | | | | | Project Pride: residential programs[8] | LGA | UK | X |
| | | | | | Disaster Relief: Crisis Counseling Assistance in response to flooding**[3] | LGA | UK | |
| | | | | | The GIRLS (Gaining Independence and Reclaiming Lives Successfully) project[3] | LGA | UK | X |
| | | | | | Children's Hospital Los Angeles/ NCTSI (runaway and homeless youth)[3] | LGA | EB | X |
| | | | | | Asian and Pacific Islander Youth Services Network (APIYN): Youth Violence Prevention[3] | LGA | CC | X |
| | | | | | San Francisco Wellness Initiative: School-Based Suicide Prevention[3] | LGA | UK | X |
| | | | | | California School-Age Consortium: Youth Violence Prevention[3] | LGA | UK | X |
| CO | Arapahoe House in Metropolitan Denver**[1] | Selective | LGA | STD | | | | |
| | Infectious, Disease, Medical and Behavioral Screen**[1] | UK | S (Mandate) | UK | | | | |
| CT | Screening for trauma history and PTSD**[1] | Selective | S | UK | Disaster Behavioral Health Initiative**[9] | S | UK | |
| | | | | | Clifford Beers Clinic/NCTSI (the most economically-challenged families and children)[3] | LGA | EB | X |
| | | | | | DMHAS. MH and subs. abuse service systems. Best-practice, trauma-specific treatment models **[1] | S | UK | |
| | | | | | TARGET Trauma Affect Regulation: Guidelines for Education and Therapy[1] | LGA | ES | |
| DC | Community Connections: A series of questions related to trauma as part of the standard intake process **[1] | Selective | LGA | UK | Mobile-crisis services (children in public schools)[2] | S | UK | |
| | | | | | Community Connection, Inc.: Trauma-Informed MH & Addiction treatment, HIV and AIDS Psychoeducation **[1] | S | UK | |
| | | | | | Project Hope: DCDMH school-based program (G-TREM groups for adolescent girls and youth)[1] | LGA | EB | |
| | | | | | TeenScreen and School-Based Crisis Intervention (urban, minority youth at risk of suicide, ages 15-21 in public schools)[3] | S | EB, CC | X |
| | | | | | Youth suicide prevention programs (African American females with disabilities, age 14-21)[3] | LGA | CC | |
| DE | | | | | NCTSI: child traumatic stress assessment and community-based trauma-specific treatment (children/youth in public welfare, JJ, and MH systems)[3] | S | EB | X |

## Table 1: Trauma-Informed Specific Services in the States (cont)

| State | Screening and assessment | | | | Treatment/services | | | |
|---|---|---|---|---|---|---|---|---|
| | Name or project/program name (if applicable) | Universal vs. selective | Scope[a] | Type(s)[b] | Project/program name (target population) | Scope[a] | Type(s)[c] | SAMHSA funded |
| FL | State MH Act (Baker Act)[1] | S (Mandate) | S | SD | TRIAD Girls Group model programs (adolescent girls with sub. abuse or violence)[1] | LGA | EB | |
| | Sub. Abuse and MH agencies in a three county area: Integrated BioPsychological Assessment**[1] | Selective | LGA | UK | Project Recovery: disaster relief, MH and subs. abuse supports (hurricane-related trauma)[4] | LGA | CC | |
| | | | | | African American Center of Excellence (AACE): 12-month, 3-phase, court-supervised model with trauma curriculum[3] | LGA | EB | X |
| HI | A brief screening was recommended for those enrolled in the Jail Diversion Program.[1] | Selective | UK | UK | | | | |
| IL | | | | | Chicago DPH, MH Centers of Excellence Pilot Project on trauma and domestic violence at community mental health centers (women and children affected by domestic violence)[1] | LGA | UK | |
| | | | | | Heartland International Family, Adolescent and Child Enhancement Services (refugee-related trauma)[1] | LGA | CC | |
| | | | | | The Marjorie Kovler Center for the Treatment of Survivors of Torture: holistic, community-based services[1] | LGA | UK | |
| | | | | | La Rabida Children's Hospital: trauma-informed interventions (inner-city African American children), NCTSI[3] | LGA | EB | X |
| IN | Screening for Children in Foster Care[1] | Universal[d] | UK | SD | The Crisis Counseling Program for people affected by disasters (disaster-related trauma)**[2] | S | UK | |
| | | | | | DMH and Addiction: trauma-informed WRAP (Wellness, Recovery and Action Plan)**[1] | UK | UK | |
| KS | | | | | MHA of South Central Kansas Target Population Families Services: Youth Violence Prevention[3] | LGA | UK | X |
| KY | | | | | Bio-Terrorism and Emergency Response**[3] | S | UK | X |
| LA | | | | | Louisiana Rural Trauma Services Center (children/youth in rural areas)[3] | LGA | UK | X |
| | | | | | Emergency Response for Hurricane Katrina[3] | LGA | UK | X |
| ME | Children's Behavioral Health Services: Uniform Assessment Tool for Children/ Adolescent MH[1] | Selective | LGA | STD | MHA. Model trauma-informed system of services (rural and semi-rural counties)**[1] | LGA | UK | |
| | Tri-County Community Mental Health Services (MHS). Trauma screening tool adapted for use with youth and children.[1] | Selective | LGA | STD | 24-Hour Trauma Telephone Support Line (adolescents with sexual abuse trauma)[1] | S | UK | |
| | Tri-County Community MHS. TREP (Trauma Recovery and Empowerment Profile) and Self-Awareness and Recovery Profile**[1] | Selective | LGA | EB/STD/ ES | | | | |
| MD | Universal Intake Form for DHMH Mental Hygiene Administration includes questions about trauma.**[1] | Universal | S | UK | DHMH: TAMAR's Children Project (pregnant and post-partum incarcerated women and their babies)[1] | LGA | UK | |
| | DPH Bureau of Subs. Abuse Services: A series of questions related to trauma as part of the standard intake process **[1] | Universal[e] | S | SD | The Kennedy Krieger Family Center (KKFC) Trauma Intervention Clinic: interdisciplinary evaluation and treatment services[3] | LGA | EB | X |
| | Bessel vanderKolk's Trauma Assessment Packet **[1] | Selective | LGA | ES | | | | |
| MA | DMH Universal Trauma Assessment (computerized medical record) applicable to all DMH-operated programs [1] | Universal | S | SD | Nurturing Families Parenting Groups: outpatient subs. abuse treatment (women and children)[1] | S | UK | |
| | DPH Bureau of Subs. Abuse Services: Trauma assessment is required for all programs.[1] | Universal | S | SD | TREM groups in residential treatments for children and family shelter programs[1] | 35 across state | EB | |
| | Boston Consortium of Services for Families in Recovery**[1] | Selective | S | UK | The National Center on Family Homelessness: trauma-related services (homeless children/youth)[3] | LGA | CC | X |

## Table 1: Trauma-Informed Specific Services in the States (cont)

| State | Screening and assessment | | | | Treatment/services | | | |
|---|---|---|---|---|---|---|---|---|
| | Name or project/program name (if applicable) | Universal vs. selective | Scope[a] | Type(s)[b] | Project/program name (target population) | Scope[a] | Type(s)[c] | SAMHSA funded |
| MA | Franklin Medical Center Eastspoke gathers comprehensive information on inpatients' trauma experience, history and needs.**[1] | Selective | LGA | UK | Disaster Management: Post-9/11 counseling provided**[2] | UK | UK | |
| | | | | | Technical Assistance Center for Mental Health Promotion and Youth Violence Prevention[3] | UK | EB | X |
| | | | | | Comprehensive school-based youth violence prevention program (ages 11-14)[3] | LGA | UK | X |
| | | | | | School-Based Youth Violence Prevention[3] | LGA | CM | X |
| | | | | | Justice Resource Institute, Inc/NCTSN: pilot projects to respond to school and community violence[3] | LGA | EB | X |
| | | | | | Commonwealth of MA: Youth Suicide Prevention & Early Intervention[3] | S | UK | X |
| | | | | | Boston Medical Center Corp.: School-Based Youth-Centered Suicide Prevention (YCSP)[3] | LGA | UK | X |
| | | | | | Boston Public Health Commission/Targeted Capacity (trauma-based services) for African-American and Latina women with children[3] | LGA | UK | X |
| MI | The Southwest Michigan Children's Trauma Assessment Center (CTAC): a unique neurodevelopmental trauma assessment[3] | Selective | LGA | UK | The Southwest Michigan Children's Trauma Assessment Center: occupational therapy interventions which are school-based (ages 11-14, grades 6-8)[3] | LGA | ES | X |
| | | | | | Berrien County Health Department: School-Based Suicide Prevention[3] | LGA | UK | X |
| MN | | | | | Anoka-Metro Regional Treatment Center: Ananda Project TIDBT**[1] | LGA | EB | |
| | | | | | Red Lake Band of Chippewa Indians Emergency Response[3] | LGA | UK | X |
| | | | | | Minnesota Child Response Center (MCRC)/ NCTSN: Minnesota Child Response Initiative[3] | S | EB | X |
| MS | Community Mental Health Centers/ CatholicCharities, Inc: Trauma Recovery for Youth (TRY) Project: Strengths-based assessment tool for use with traumatized children and youth[2] | Selective | LGA | UK | Mississippi Trauma Recovery for Youth (TRY) Project (rural and geographically isolated children with refugee, rape, or disaster-related trauma)[2, 3] | LGA | UK | X |
| | | | | | 5 intensive crisis intervention programs[2] | LGA | UK | |
| MO | | | | | Seeking Safety Groups: subs. abuse programs such as CSTAR (women and children)[1] | LGA | UK | |
| | | | | | DMH with private collaboration: The Missouri Youth Suicide Prevention Project[3] | LGA | EB | X |
| | | | | | Univ. of Montana: crisis response services, trauma intervention, PTSD management, CBT (Native American children, ages < 8)[3] | LGA | EB, CC | X |
| MT | | | | | Montana Youth Suicide Prevention and Intervention Project (ages 10-24)[3] | S | UK | X |
| | | | | | University of MT: the delivery of crisis response services, trauma intervention, and PTSD management (Native American children)[3] | LGA | CC | X |
| NH | Manchester MH Centers and admissions to the NH Hospital:Brief trauma history questionnaire**[1] | Selective | LGA | UK | Dartmouth Psychiatric Research Center: relaxation exercise, psychoeducation, and cognitive restructuring**[1] | LGA | EB | |
| | Community MH Center in NH and a Veterans Administration Hospital. Instruments include PTSD Checklist; Trauma History Questionnaire-Revised.**[1] | Selective | LGA | ES | New Hampshire Project for Adolescent Trauma Treatment (adolescents in CMHS with SED and trauma)[3] | LGA | UK | X |
| | Selected inpatient and community mental health settings: Self-administered, computer-assisted interview on trauma history and PTSD symptoms**[1] | Selective | LGA | UK | New Hampshire Youth Suicide Prevention Collaborative Project (YSPCP)[3] | LGA | UK | X |

## Table 1: Trauma-Informed Specific Services in the States (cont)

| State | Screening and assessment | | | | Treatment/services | | | |
|---|---|---|---|---|---|---|---|---|
| | Name or project/program name (if applicable) | Universal vs. selective | Scope[a] | Type(s)[b] | Project/program name (target population) | Scope[a] | Type(s)[c] | SAMHSA funded |
| NJ | | | | | Traumatic Loss Coalitions (TLC) County Crisis Response Networks (CCRN): coordination with school districts for dealing with traumatic events[2] | S | CC | |
| | | | | | University of Medicine and Dentistry of New Jersey: disseminate TF-CBT as its model program[3] | S | EB, CC | X |
| | | | | | NJ International FACES Program: holistic services (refugee trauma)[3] | LGA | CC | X |
| | | | | | Project Phoenix: outreach, psycho-education, individual and group counseling and referral services (people affected by 9/11 disaster) | S | UK | X |
| NM | | | | | EB Practice Model & Illness Management and Recover[1] | LGA | EB | |
| | | | | | School-Based Youth Violence Prevention (public schools in Albuquerque)[3] | LGA | EB | X |
| | | | | | NMDH: Youth Suicide Prevention and Early Intervention (rural youth)[3] | LGA | CM | X |
| | | | | | Emergency shelter assistance[2] | UK | UK | |
| | | | | | DOH-funded youth response hotlines[11] | UK | UK | |
| NY | All state psychiatric centers conduct trauma screening using forms of their own design.[1] | Selective | S | SD | Some state- and locally-operated programs in NY are using DBT.**[1] | LGA | EB | |
| | JBFCS Center for Trauma Program Innovation: trauma-focused assessment[3] | Selective | LGA | UK | JBFCS Center for Trauma Program Innovation: treatment services (children from low-income and racially diverse neighborhoods)[3] | LGA | UK | X |
| | | | | | Children and Adolescents Trauma Services (CATS) Program: TFCBT (children and adolescents affected by 9/11 disaster)[1] | LGA | EB | |
| | | | | | Safe Horizon's Child Traumatic Care Initiative (CTCI) (up to age 21 in NYC)[3] | LGA | EB | X |
| | | | | | Youth Violence Prevention (youth with emotional difficulties involved in JJ system who would otherwise require residential placement)[3] | LGA | UK | X |
| | | | | | City of Syracuse: community-wide coalition for youth violence reduction with MST[3] | LGA | EB | X |
| | | | | | North Shore University Hospital Treatment and Service Adaptation Center/ NCTSN: disaster/terrorism response plan and supporting toolkit[3] | LGA | CC | X |
| NV | | | | | State of Nevada: a pilot project for comprehensive youth suicide prevention in Clark County.[3] | LGA | EB | X |
| NC | Child and Parent Support Services. Forensic assessment[3] | Selective | LGA | STD | Child and Parent Support Services for PTSD in children: child and parent treatment, intensive in-home services, and school-based interventions[3] | LGA | UK | X |
| ND | School-based screening[2] | Universal | LGA | UK | North Dakota Adolescent Suicide Prevention Project[10] | S | EB | |
| OH | ODMH: Columbia TeenScreen[2] | Selective | LGA | EB | NCTSN: group, individual, and family counseling, 24-hour trauma response services (violence-related trauma), TF-CBT for young children[1] | LGA | EB | X |
| | | | | | Red Flags Prevention Program (depression and suicide): school-based[2] | LGA | UK | |
| OK | | | | | At DMH & Subs Abuse- funded sites, children who have been exposed to trauma are provided MH services.[2] | LGA | UK | |
| | | | | | DMH: youth suicide prevention programs[3] | S | EB | X |
| | | | | | Univ of Oklahoma Health Sciences Center/NCTSN: The Terrorism and Disaster Center[3] | UK | CC | X |

## Table 1: Trauma-Informed Specific Services in the States (cont)

| State | Screening and assessment | | | | Treatment/services | | | |
|---|---|---|---|---|---|---|---|---|
| | Name or project/program name (if applicable) | Universal vs. selective | Scope[a] | Type(s)[b] | Project/program name (target population) | Scope[a] | Type(s)[c] | SAMHSA funded |
| OK | | | | | OK Community Treatment and Services Center: Child/adolescent trauma victims in DMH and subs. abuse services, domestic violence related trauma[3] | S | UK | X |
| | | | | | Indian Country Child Trauma Center/ NCTSI (Native Americans)[3] | LGA | EB, CC | X |
| | | | | | Linking Tulsa Adolescents at Risk with Mental Health Services: use of Columbia TeenScreen[3] | LGA | EB | X |
| | | | | | DMH and Sub. Abuse Services. Direct contract with providers on child trauma counseling. Sanctuary Model in 5 sites.[12] | LGA | EB | |
| OR | Legacy Health System Project Network in Portland**[1] | Selective | LGA | UK | Trauma-based Sanctuary Model implemented at Salem General Hospital Acute Psychiatric Inpatient Unit: model universally applicable for all patients**[1] | LGA | EB | |
| | Early Childhood Community Treatment Center CRN/NCTSI; Shared evidence based assessment tools and procedures among child serving agencies for children 0-3[3] | Selective | LGA | UK | Early Childhood Community Treatment Center CRN/NCTSI: identifying, implementing, and adapting EB and research-informed interventions (children ages 0-3 and families)[3] | UK | EB | X |
| | | | | | Willamette Family Treatment Services, Inc./NCTSI: gender-sensitive trauma services (adolescent girls, rural areas, Native American reservations)[3] | LGA | EB, CC | X |
| | | | | | No More Fallen Feathers: traditional spiritual and cultural beliefs with known best practices in youth suicide prevention (Native Americans)[3] | LGA | CC | X |
| | | | | | Youth Violence Prevention (pre-adjudicated youth ages < 14; youth on probation; youth in detention)[3] | UK | UK | X |
| PA | Luzerne County: multiple trauma assessment[1] | Selective | LGA | EB | Women Against Abuse (WAA) Domestic Violence Shelter: trauma-informed system (women and children, domestic violence related trauma)[1] | LGA | UK | |
| | | | | | Luzerne County Human Services: Taskforce on Domestic Violence to develop a coordinated community response to trauma**[1] | LGA | UK | |
| | | | | | Youth Violence Prevention: Quantum Opportunities Program (disadvantaged adolescents)[3] | LGA | UK | X |
| | | | | | Allegheny General Hospital for Traumatic Stress in Children and Adolescents/ NCTSN (children with sexual abuse and physical abuse)[3] | LGA | EB | X |
| | | | | | Disaster Relief: counseling and public education services[3] | LGA | UK | X |
| RI | The Kent Center for Human and Organizational Development: trauma screening**[1] | Universal | LGA | UK | Kent County Center for Human and Organizational Development: trauma-informed services, including crime-related trauma that serves persons without insurance**[1] | LGA | UK | |
| | Warwick Truancy Program for children and youth includes trauma or abuse screening.[1] | Selective | LGA | UK | Kent Center Court Clinic Program: trauma-informed services**[1] | LGA | UK | |
| | | | | | Warwick Truancy Program: trauma-informed services for children and youth (elementary to senior high school students)[1] | LGA | UK | |
| SC | Traumatic Events Screening Inventory (TESIC)[1] | Selective | LGA | EB | Selected MH Centers: Treatment of PTSD is included in therapeutic services. Individual and group therapy follows the trauma-informed, CBT model.**[1] | LGA | EB | |
| | Parent Questionnaire (TESI-P)[1] | Selective | LGA | EB | | | | |
| | Trauma Symptom Checklist for Children[1] | Selective | LGA | EB | National Crime Victims Research and Treatment Center (youth-serving service systems such as schools, JJ programs, MH centers, medical centers, child advocacy centers, and rape crisis centers)[3] | LGA | EB | X |
| | DMH Quality Improvement procedure audits**[1] | Universal | S | SD | | | | |

## Table 1: Trauma-Informed Specific Services in the States (cont)

| State | Screening and assessment | | | | Treatment/services | | | |
|---|---|---|---|---|---|---|---|---|
| | Name or project/program name (if applicable) | Universal vs. selective | Scope[a] | Type(s)[b] | Project/program name (target population) | Scope[a] | Type(s)[c] | SAMHSA funded |
| SD | | | | | Community Treatment and Services Center (ages 3-18 at Pine Ridge Indian Reservation)[3] | LGA | CC | X |
| TN | | | | | DMH and Developmental Disabilities: Youth Suicide Prevention & Early Intervention (ages 10-24)[3] | S | UK | X |
| | | | | | Childhood Trauma Intervention Center: early identification and effective intervention through collaborations with child welfare, law enforcement and public education (highly vulnerable, traumatized children)[3] | LGA | UK | X |
| TX | Depelchin Children's Center/ Child Traumatic Stress Program[3] | Selective | LGA | UK | Child Traumatic Stress Program: case management and mental health services[3] | LGA | CM | X |
| | | | | | Border Traumatic Stress Response project in Webb County. Trauma-informed services (children and adolescents with traumatic stress, age 2-18, Mexican-Americans).[3] | LGA | UK | X |
| | | | | | TXSDH: Youth Suicide Prevention and Early Intervention in pilot sites[3] | LGA | UK | X |
| VT | Universal screening for trauma **[1] | Universal | S | SD | DMH services to traumatized children/ youth: individual/family counseling; case management; community integration skills; crisis and service support[7] | UK | EB, CM | |
| | DMH: Child Behavior Checklist[7] | Selective | LGA | STD | | | | |
| VA | | | | | Virginia Dept. of Health: Youth Suicide Prevention and Early Intervention[3] | LGA | UK | X |
| WA | Center for Traumatic Stress and Sexual Assault: child foster care assessments and placement[5] | Selective | UK | UK | Center for Traumatic Stress and Sexual Assault: outreach; crisis intervention; trauma, MH and subs. abuse counseling.[5] | UK | UK | |
| | Juvenile justice screens for suicidal ideation and trauma[6] | Selective | S | EB | WA Juvenile Rehabilitation Administration Facilities: residential programs and parole aftercare services with CBT, DBT, Functional Family Parole (JJ-involved youth)[6] | S | EB | |
| | | | | | Puyallup Tribal Health Authority Kwawachee Counseling Center[2] | LGA | CC | |
| WV | Columbia TeenScreen[2] | Selective | LGA | EB | Strength Builders/ NCTSN: quality improvement program (children and adolescents with complex trauma)[3] | LGA | UK | X |
| | | | | | Suicide Hotline[2] | S | UK | |
| WI | | | | | MH Center of Dane County: Adolescent Trauma Treatment Programs-NCTSI[1, 3] | LGA | UK | X |
| | | | | | Youth Violence Prevention (ages 5-13, African American, eligible for federally subsidized meals and housing programs)[3] | LGA | UK | X |
| PR | | | | | Crisis Counseling Regular Services Program in response to MH needs of those affected by the impact of 2004 Tropical Storm[3] | LGA | UK | X |
| AS | | | | | Disaster Services: outreach, individual and group counseling, and public education regarding MH effects of disasters**[3] | LGA | UK | X |

## Table 1: Trauma-Informed Specific Services in the States (cont)

Abbreviations:

| | |
|---|---|
| CBT | Cognitive Behavioral Therapy |
| CSTAR | Comprehensive Substance Treatment and Rehabilitation |
| DMH | Department of Mental Health |
| DPH | Department of Public Health |
| DBT | Dialectical Behavioral Therapy |
| NCTSN | National Child Traumatic Stress Network |
| NCTSI | National Child Traumatic Stress Initiative |
| JJ | Juvenile Justice |
| MHA | Mental Health America |
| MST | Multisystemic Therapy |
| PTSD | Post Traumatic Stress Disorder |
| Subs abuse | Substance Abuse |
| TF-CBT | Trauma Focused Cognitive Behavioral Therapy |
| UK | Unknown |

Notes:

a. Statewide (S), Limited Geographical Areas (LGA)

b. Evidence-based (EB), Empirically Supported (ES), State Developed (SD), Standardized (STD), refers to standardized screening/assessment tools)

c. Evidence-based (EB), Empirically Supported (ES), Culturally Competent (CC), Case Management (CM)

d. Only for Children in Foster Care

e. Only for Alcohol and Other Drug Services

** indicates it is not clear whether it includes children/youth as target populations

References:


1. Jennings, A. (2004). *Blueprint for action: Building trauma-informed mental health service systems. State accomplishments, activities and resources: September 2004*. <http://www.annafoundation.org/articles.html> (accessed October 1, 2006).

2. State Mental Health Block Grant Applications

3. SAMHSA. *Grant awards: State summaries FY 2005/2006*. <http://www.samhsa.gov/statesummaries/> (accessed January 1, 2007).

4. Project Recovery. <http://www.dcf.state.fl.us/mentalhealth/prec/index.shtml> (accessed December 1, 2006).

5. SAMHSA National Mental Health Information Center. (2006). *Approaches to trauma-informed transformation in mental health services: Model programs*. <www.mentalhealth.samhsa.gov/media/ken/txt/womenandtrauma/Model_programs.doc> (accessed October 1, 2006).

6. National Center for Mental Health and Juvenile Justice. (2006). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. <http://www.ncmhjj.com/Blueprint/programs/Washington.shtml> (accessed December 2006).

7. Personal Communication with Laurel Omland, Clinical Care Coordinator, Vermont Department of Mental Health, October 12, 2006.

8. East Bay Community Project. <http://www.ebcrp.org/pride.php> (accessed November 2006).

9. Disaster Behavioral Health Initiative. <http://www.dmhas.state.ct.us/disasterbh.htm> (accessed December 2006).

10. North Dakota Adolescent Suicide Prevention Project. (2006). *A blended approach to prevention*. <http://www.ndsuicideprevention.org/> (accessed December 2006).

11. Adelschim, S. (2007). *Primary care-behavioral health linkages in school-based health centers*. Presentation at ACMHA, Santa Fe, March 16, 2007.

12. Personal communication with Julie Young, Oklahoma Department of Mental Health and Substance Abuse Services, August 23, 2006.

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| AL | G-TREM (staff at adolescent residential treatment program)[1] | EB | SSA | SA | Revised policy on S & R for staff to avoid use of S & R[1] | UK | NR | | X[8] |
| AK | Southeast Alaska Regional Health Consortium: TREM (clinicians)[1] | EB | UK | SA | Dept. of Health and Social Services. Trauma Initiative: Bringing staff from the NASMHPD TA Center to AK; S & R regulations (see below); new funding[2] | SLA | X | Total Budget for Early Intervention Trauma Initiative in FY06: $863,200[2] | No plan[8] |
| | TBI assessments and traumatic brain injury effects (all state-supported, BH treatment providers)[1] | UK | S | | | | | Medicaid covers for an extended array of clinical and rehabilitation services.[1] | |
| | | | | | DMH: inpatient quality standards that limits S & R use which are applicable to API as well as other hospitals[5] | SSA | | | |
| | TAPA/GAINS Trauma Assessment and Treatment (all community care alternatives project staff)[1] | ES | SLA | | | | | Children's Justice Act grant funding for "Child Maltreatment Symposium" (FY04).[1] | |
| | Trauma and its impact on child development (residential care centers)[1] | SD | SLA | | | | | | |
| | Risking Connections (staff from regional school and social services systems, hospitals, MH, subs. abuse agencies)[1] | STD | SSA/SLA | | | | | | |
| AZ | DBH Services: extensive training on reducing use of S & R[1] | SD | SSA | NR | State DH Services policy QM2.4 requires reporting the use of S & R and applies to the DBHS staff and institutions[1] | SSA | NR | | No plan[8] |
| CA | Staff development plan with trauma training (staff in LA county DMH and Alcohol and Drug Abuse)[1] | SD | SLA | NR | Chadwick Center at Children's Hospital-San Diego: EB assessment-based therapy in their Trauma Counseling Program.[6] | SLA | NR | Group trauma models funded for MH and subs. abuse services.[1] | No plan[8] |
| | Prototypes: LA County agency-wide trainings on avoiding retraumatization through trauma-sensitive procedures[1] | EB | SLA | | Seclusion and Behavioral Restraint Reduction Initiative: Senate Bill 130 (Chesbro) passed in SFY04-05 and mandated restrictions and data reporting requirements related to the use of S & R[2] | SSA | | Dept. of Social Services provides funding for the development, design and implementation of an EB Practice and Research Clearinghouse for CW Practices: $425,000 for total of 36 months (2004-2006)[7] | |
| | Orientation and continual training (all agency staff to work with co-occurring disorder and trauma)[1] | SD | UK | | | | | | |
| | Seeking Safety and TREM models (MH, key clinicians and subs. abuse counselors in San Joaquin County)[1] | EB | SLA | | | | | | |
| | The Chadwick Center at Children's Hospital-San Diego: EB trauma assessment[6] | EB | SLA | | | | | | |
| CO | Arapahoe House New Directions for families and female subs. abusing offender program: trauma-informed services (community agencies)[1] | EB | SLA | NR | Office of Suicide Prevention, in collaboration with other state agencies: public campaign on suicide prevention & interventions[2] | S | NR | | UK |
| | | | | | Arapahoe House New Directions for Families and Female Substance Abusing Offender Programs: employs trained clinicians[1] | SLA | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| CT | TREM, Seeking Safety, and TARGET (all levels of DMH and Addiction Services)[1] | EB | S | SA | Dept. of Children and Families (DCF): placed staff in 3 girls' detention centers to identify girls' MH needs and trauma histories and to plan services to be recommended to the court[1] | SLA | X (Gender-specialized) | State funding from DMH and Addiction Services for all trainings[1] | UK |
| | Trauma-specific service (state-operated and private non-profit agencies with affiliates, state hospitals)[1] | SD | SSA/SLA | | | | | DCF funds parents or foster parents to work with traumatized children.[1] | |
| | Training on reducing the use of S & R (State hospital staff)[1] | UK | SSA | | State Policy on S & R includes Patient Personal Safety Preferences form and risk assessment and applies to all state-operated facilities (but not to private, non-profits)[1] | SSA | | DCF's cost effective trauma services[1] | |
| | Behavioral Management Strategies (BMS) training program with a trauma unit (all employees in patient care)[1] | UK | SSA | | | | | DCF-funded development of 8 programs for gender-specific and trauma-specific services under multiple state agencies[1] | |
| | DCF: trauma awareness and education training (child protective workers)[1] | UK | SSA | | JJ Intermediate Evaluation: court-ordered, intensive, outpatient, multidisciplinary MH trauma-informed assessment of court-involved children[1] | SSA | | | |
| DC | Community Connections: orientation on trauma issues (DMH staff)[1] | UK | SSA | LA | Community Connections Agency: applied its model of using Trauma Theory to provide safety and avoid re-traumatization[1] | SLA | NR | | X[8] |
| | Project Hope trauma training (school counselors in schools in the DC area)[1] | UK | SLA | | 22A DCMR Chapter 5: sets DMH emergency rules on the use of S & R in hospitals, RTCs and crisis-emergency programs; prohibits use in all other settings[2] | S | | | |
| | NCTSN: staff training and organizational development. Training on TF-CBT. (service providers for trauma treatment for youth in foster care)[2] | EB | SLA | | Spirituality in Trauma Recovery group: addresses spiritual and religious resources for empowerment and recovery[1] | UK | | | |
| FL | TRIAD women's group model (staff and consumers in Subs. Abuse and MH Agencies in 3 counties)[1] | EB | SLA | NR | | | NR | Disaster Relief: $19,352,241 (SAMHSA funded) to 4 CMH programs[3] | No plan[8] |
| | Crisis Intervention Team (CIT) training model: suicide risk assessment and post-traumatic stress disorder (police officers)[2] | UK | SLA | | | | | | |
| HI | GAINS Center: gender and trauma specific (all staff in Hawaii County Jail Diversion Program)[1] | SD | SLA | NR | State conducted 2004 review of violence. Injury Prevention and Control Branch of DH: successfully petitioned the legislature to establish a new Suicide Prevention Program for youth[2] | S | NR | | No plan[8] |
| IL | Domestic Violence MH Policy Initiative (DVMHPI): trauma and domestic violence (Chicago DPH, pilot sites)[1] | UK | SLA | SA | DMH Initiative for a violence and coercion-free hospital environment: reducing the need for S & R and establishing alternative person-centered interventions[2] | S | X-(immigrants) | DMH awarded a grant focusing on alternatives to restraint and seclusion.[2] | X[8] |
| | DVMHPI: Field test several trauma assessment tools, with additional trainings (4 sites of Child IDHS-DMH and Adolescent Network)[1] | SD | SSA | | The Domestic Violence and MH Policy Initiative by DVMHPI: uses the Risking Connection training model with state-funded community agencies[1] | S | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| IL | Child Trauma Core Competency Curriculum and DV-version of Risking Connection (child providers)[1] | UK | SLA | | DMH and DVMHPI: develop screening tools and assessment processes for identifying child exposure to violence and trauma (4 pilots)[1] | SLA | | | |
| | Risking Connection, TREM, TREP, Trauma-Informed Service by DVMHPI (staff teams from domestic violence programs and MH agencies)[1] | EB | SSA | | Chicago DPM and DMH computerized intake forms: includes risk of danger from others and to self. Policy and Procedures Manual incorporates abuse, trauma, domestic violence/safety.[1] | SSA | | | |
| | Child trauma curriculum developed in collaboration with NSTSN[1] | UK | UK | | | | | | |
| | DCFS: workforce training on Parent-Child Relational Therapy, TF-CBT, structured psychotherapy[13] | EB | UK | | | | | | |
| IN | In-service training related to assessment of trauma and PTSD (child service providers)[1] | UK | UK | NR | Children with a situational trauma using services in 2 or more community agencies do not have to meet the duration requirement ofmental illness.[2] | S | NR | | No plan[8] |
| | | | | | At each hospital, patient family education on S & R is conducted at the time of admission and assessment on client's history with trauma S & R is done.[1] | UK | | | |
| | | | | | State specific data on trauma treatment through pre- and post-evaluation (IT)[1] | SSA | | | |
| KY | The Kentucky Dept. for MH and Mental Retardation Services: treatment for children affected by trauma and abuse[2] | UK | SLA | NR | State initiatives to reduce S & R and understand the effects of trauma[2] | S | NR | | |
| LA** | | | | NR | | | NR | Crisis services and education for trauma survivors have expanded through block grants.[2] | UK |
| | | | | | | | | Emergency response to Katrina: $199,373 (SAMHSA-funded)[3] | |
| ME | Dept. of Behavioral and Developmental Services (BDS) Competency Model (all BDS employees)[1] | UK | SSA | SA | BDS: Policy Regarding the Prevention of S & R Informed by the Client's Possible History of Trauma[1] | S | NR | Medicaid now reimburses TREM and DBT services under section 16-17 of state MaineCare regulations.[1] | UK |
| | BDS: special training for trauma telephone support line[1] | UK | SSA | | BDS used criteria from a trauma theory to change universal screening for trauma histories, staff training and consultation, hiring and human resource practices, review of policies/procedures, and modification of existing services[1] | S | | Trauma Clinical Consultation Service: funds available regionally to all providers serving public MH clients, to purchase trauma clinical consultation service as needed on a fee-for-service basis.[1] | |
| | Risking Connection Training Program (direct care, MH and Subs. Abuse staff)[1] | STD | S | | | | | | |
| | Dept. of Human Services and CW Training Institute: parenting abused and neglected children (foster parents); core competency (child protective service staff)[1] | SD | SSA | | Child Mental Health Initiative includes building an infrastructure and implementing an integrated system of care for young people who have experienced trauma (SAMHSA funded)[3] | S with regional focus | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| ME | Trauma-Informed Approach to Human Services Training (senior staff and administration of selected MH agencies)[1] | SD | SSA | | | | | | |
| | Training on trauma-informed service (Tri-County MH Center staff and agencies)[1] | SD | SLA | | | | | | |
| MD | The Essence of Being Real: training on group dynamics and structuring peer support groups (trauma survivors)[1] | STD | UK | LA | Correctional staff is trained in techniques to avoid triggering and retraumatization.[1] | UK | NR | MHA's Office of Special Needs Populations and Dept. of Human Resources: securing entitlements for mothers with babies at the Trauma, Addiction, MH, and Recovery (Tamar's) Children program[2] | No plan[8] |
| | Risking Connection: TAMAR program; Master Trainer Program train the trainer model[1] | STD | SLA | | | | | Multiple sources of funding for trauma services: Maryland Health Partners authorizes individual and group trauma treatment.[1] | |
| | Baltimore County MH System training: G-TREM, TREP[1] | EB | SLA | | | | | TAMAR's children funding sources: State and local agencies' in-kind services, SAMHSA, Residential Subs. Abuse treatment funds and HUD shelter plus care[1] | |
| | | | | | | | | MHA has received a SAMHSA grant to reduce S & R in the child-serving MH facilities[2] | |
| MA | Child-oriented trauma training (child and adolescent acute and continuing care inpatient and intensive residential program providers)[1] | UK | SLA | SA, LA | Adolescent Safety Zone Tool (developed with adolescent clients) and the Safety Tool for Younger Children, a child-friendly tool using age-appropriate strategies for Individual Crisis Prevention[1] | S | NR | DMA and OCCS have funded clinical positions to provide consultation, training and triage for children with PTSD or other early traumas.[2] | X[2] |
| | Child and Adolescent Restraint Reduction Initiative: trauma and collaborative strength-based models of care (providers)[1] | SD | S | | | | | State received $3 million in federal disaster planning funds for public health funding of trauma services.[1] | |
| | | | | | Cambridge Hospital Children's Unit: Ross Greene's collaborative, supportive, strength-based model with resulted int no restraints being used within a month[1] | SLA | | | |
| | Wellness Recovery Action Plan (WRAP) (peer facilitators)[1] | STD | S | | | | | The state is working on a system to bill for subs. abuse services now provided through licensed MH and Subs. Abuse outpatient programs.[1] | |
| | Institute for Health and Recovery (IHR): trauma and trauma related topics (providers)[1] | SD | S | | DMH Licensing and Child/Adolescent Dept.: Restraint and Seclusion Reduction Initiative (since 2001)[2] | SSA | | | |
| | Worcester and Tewksbury State Hospitals: NASMHPD's modules, neuro-biological and psychological effects of trauma, trauma-informed care and tools[1] | UK | SLA | | Child and adolescent restraint reduction/elimination effort resulted in reducing S & R and providers using trauma-sensitive, strengths-based approaches.[1] | S | | MH-licensed providers bill third party payers for services. For clients with a DSM-IV MH diagnosis, MH providers can bill Medicaid for trauma group treatment.[1] | |
| | New England Trauma Services Network (high-, need under resourced communities)[3] | EB | SSA | | New England Trauma Services Network: to expand services of the Trauma Center at Justice Resource Institute (high-need, under-resourced communities)[3] | SSA | | | |
| | | | | | DMH collects statewide S & R data from all licensed, state operated and state-contracted inpatient facilities and intensive residential treatment programs (IT)[4] | S | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| MN | Partially based on Perlman and Saakvitne's Trauma and the Therapist: training for vicarious traumatization of staff to prevent burnout (staff who work with trauma survivors)[1] | UK | UK | NR | Anoka-Metro Regional Treatment Center and the Willmar Regional Treatment Center: separating individuals with histories of trauma from those with known histories of traumatization.[1] | SLA | NR | The SMHA provided funding for assisting the tribal members through the initial trauma as a result of Red Lake Tragedy.[2] | No plan[8] |
| | | | | | Each of the state-operated services and in-patient hospitals implemented a specified plan for reduction of S & R, which resulted in significant decline in S & R[1] | S | | | |
| | | | | | Requirements for implementing ACT team and other EB treatment models[1] | UK | | | |
| MS** | | | | NR | Child Trauma Therapeutic Services Collaborative project: Region 8 CMHC will facilitate the development of an assessment instrument for resilience among youth who have experienced trauma/stress.[2] | SLA | NR | Integration of Wraparound in Comprehensive Crisis Intervention Programs: DMH provides funding to 4 programs in FY 2003-04.[2] | No plan[8] |
| MO | Annual Spring Training Institute: seeking safety and disaster response training in 2004 (800 front line staff)[1] | UK | UK | LA | Department Operation Regulations were rewritten to reduce S & R in state psychiatric hospitals. The new policy requires choosing an instrument to collect information on patients' trauma histories.[1] | SSA | NR | DMH: CSTAR fee-for-service Medicaid pays for individual and group counseling and group education.[1] | No plan[8] |
| | | | | | | | | Seeking Safety Program is financed as group therapy billing under CSTAR/ Medicaid.[1] | |
| | | | | | Missouri Institute of Mental Health with the state DMH has developed a presentation on trauma for distance education via CETV, Continuing Education TV.[1] | SSA | | Billing codes for individual and group trauma counseling added to the state alcohol and drug abuse treatment contract and $5,000 for staff training was provided.[1] | |
| | | | | | | | | $100,000 SAMHSA planning grant to continue development of its statewide mental health response planfor natural and man-made disasters.[2] | |
| NE | Nebraska Disaster BH Conference workshop (psychiatrists, psychologists, social workers, MH care providers, public health officials, nurses, clergy, subs abuse workers, emergency managers and first responders)[2] | UK | SSA/SLA | NR | One of two states chosen by SAMHSA as a pilot site for a training guide entitled Roadmap to a Restraint-FreeEnvironment for Persons of All Ages[1] | SLA | NR | | UK |
| NV | Division of MH and Developmental Services (MHDS) FY2005. S & R, Abuse and neglect (MH employees)[2] | SD | SSA/SLA | NR | S & R Initiative: eliminate the use of S & R in facilities that currently utilize these techniques when clients pose a danger to themselves, others, or both (since 2003)[2] | S | NR | | X[8] |
| | MHDS: Conflict Prevention and Response Training to reduce verbal or physical abuse in FY05 (direct care staff working with persons in MHDS agencies)[2] | SD | S | | | | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| NH | Dartmouth Psychiatric Research Center: Training on PTSD & oriented toward early intervention and treatment through controlled trials (clinicians)[1] | EB | S | NR | NH Bureau of Behavioral Health: sets the reduction and elimination of coercive practices such as S & R as their priorities[2] | SSA | NR | NH DBH has sponsored a number of presentations on the topic of trauma, post-traumatic disorder, and their treatment.[1] | No plan[8] |
| | | | | | New Hampshire Hospital: S & R guidelines[1] | SLA | | | |
| | | | | | Nursing Data Base Assessment (IT)[1] | UK | | | |
| NJ | TREM model (Catholic Charities and Greater Trenton behavioral healthcare staff)[1] | EB | SLA | SA | Reduction of the use of S & R in inpatient settings (since 1995) and revised Children's Crisis Intervention Service annual designation process which monitored the use of S & R[2] | S | NR | Block Grant allocations were used to develop Traumatic Loss Coalitions (TLC) in all rural counties.[2] | UK |
| | 35-County Crisis Response Network[2] | UK | SLA | | | | | In response to the World Trade Center disaster, Project Phoenix was developed using $6.5M from Federal Emergency Management Agency (FEMA) and $3.4 million from SAMHSA.[2] | |
| | Traumatic Loss Coalitions Prevention Training Program (school MH professionals and school staff[2] | STD | SLA | | DMH Services: statewide plan (1999) for the reduction of S & R in the state hospital system[2] | S | | | |
| | NASMHPD/NTAC Curriculum: S & R "kick off" training in 2003 (state children's psychiatric hospital and community based children's crisis intervention services)[2] | STD | SSA | | All state psychiatric hospitals required in 6/2000 to revise their facility-specific S& R policies and procedures to comply with the provisions of the revised Administrative Bulletin[2] | SSA | | | |
| | | | | | Use of S & R in state hospitals is being monitored and a reduction in use of S & R has been shown.[2] | SSA | | | |
| NM | Signs of Suicide-SOS education program (high school teachers and staff)[3] | UK | SLA | NR | State health department sets as one of the priority goals to reduce teen suicide (15-19) by 13.6%.[14] | S | X (Native Indians) | Garrett Smith Suicide prevention funding[16] | No plan[8] |
| | Training programs in suicide prevention in 2003-2005 (primary care providers and social workers in rural school-based health care centers)[16] | UK | SLA | | Strategizing youth-oriented comprehensive suicide prevention education, early identification, treatment and follow-up through inter-agency collaboration and the efficient use of MH care delivery systems[15] | S | | | |
| | | | | | DOH produced video called "REZ Hope" that addresses major youth issues including suicide, domestic violence to increase awareness and promote action among Native American communities.[15] | S | | | |
| | | | | | Expansion of school mental health as part of behavioral health restructuring: expanded screening and early intervention models for suicide prevention[16] | S | | | |
| NY | Office of MH (OMH): Risking Connection train-the-trainer sessions in 2001 (trainers who eventually trained state and local MH staff and recipients; MH staff in JJ programs who provide training to direct care staff)[1] | STD | SSA/SLA | SA/LA | Under the direction and assistance of OMH, all Residential Treatment Facilities throughout NYS are engaged in quality improvement initiatives, which includes trauma sensitive treatment models for children/youth.[2] | S | X | | X[3] |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| NY | OMH Core Curriculum includes a module on trauma treatment (mandatory for all state staff)[1] | SD | S | | New York Trauma-informed S & R policy[1] | S | | | |
| | | | | | Since 9/11/2001 terrorist attacks, OMH promotion activities have focused on the MH impact of terrorism, effective personal coping strategies, and where to get additional help.[2] | S | | | |
| | Satellite Grand Rounds and Dual Disorders teleconference programs feature trauma issues among other topics[1] | UK | SSA | | | | | | |
| | OMH: Clinical training since 1995 on trauma-related topics at statewide, local, and state facility based programs[1] | SD | S | | | | | | |
| | Rockland Children's Psychiatric Center: Risking Connection Master Training Program (frontline MH workers, residential treatment staff, and therapy staff)[1] | STD | SLA | | | | | | |
| | Palladia: comprehensive trauma trainings for domestic violence and shelter programs[1, 11] | STD | SSA/SLA | | | | | | |
| | OMH. Programs to train police officers on mental illness includes services for victims of trauma, victims of sexual abuse (police officers)[2] | UK | SLA | | | | | | |
| | Over 400 clinicians trained in TF-CBT in 2006-07 as part of a state- and federally-funded Evidence-Based Treatment Dissemination Center | EB | S | | | | | | |
| | Community PARTNERS: EB Trauma Services, NCTSN (primary care personnel), SAMHSA funded[3] | EB | SLA | | | | | | |
| OH | Trauma-informed care in summer 2004 (PATH projects-homeless outreach providers)[1] | SD | S | NR | Major revisions completed to in-patient licensure rules that prohibit the use of tasers and pepper spray in private hospitals, and are only available in public hospitals if requested by the hospital CEO.[2] | S | NR | Suicide Prevention Initiative: ODMH is funding start up of the Suicide Prevention Foundation and will pilot a youth suicide prevention instrument assessment.[2] | No plan[8] |
| | Crisis Intervention Training (CIT) (all inpatient staff)[1] | UK | UK | | | | | | |
| | Creating Violence Free and Coercion Free MH Treatment Environments (staff in licensed children's residential programs, private psychiatric hospitals, and state inpatient facilities)[1] | UK | S | | ODMH Policy I-04: Inappropriate Actions by Staff Toward Patients/Clients, including Abuse and Neglect, applies to all ODMH staff effective 3/8/02.[1] | SSA | | 3 SAMHSA-funded child trauma centers and ODMH collaborate to better address the needs of child and adult trauma survivors by promoting trauma-informed care.[2] | |
| | Training procedures and guidelines that focus on injury free resolutions (state operated hospital staff)[1] | SD | SLA | | Administrative Code 5122-26-16: Special Treatment and Safety Measures (for certifying community MH service providers) requires appropriate staff training prior to use of special treatment and safety measures effective 4/01.[2] | S | | | |
| | Columbus: Creating Violence Free and Coercion Free MH Treatment Environments, July 2004[1] | SD | S | | | | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| OH | | | | | Administrative Code 5122-2-17: S & R and Other Special Treatment and Safety Measures Used in BH Care Organizations states the clinical rationale for S & R must indicate that the physician considered its benefits and risks, effective 7/15/02.[2] | S | | | |
| | | | | | Solutions for Ohio's Quality Improvement and Compliance (SOQIC) in the MH system: focus on creation of a standardized clinical documentation forms set[1] | S | | | |
| | | | | | All state-operated facilities with Violence Free and Coercion Free reduction plans with trauma-informed care: initial assessment to identify individuals with greater risks[1] | S | | | |
| | | | | | Suicide Prevention Coalitions: specialized version of consumer and family advocacy groups[2] | SSA/SLA | | | |
| | | | | | ODMH Ad Hoc Task Force on Childhood Trauma[2] | SSA | | | |
| OK | William Steele: Train the Trainer workshop to become trauma specialists (clinicians)[1] | UK | SLA | SA | Sexual Assault Response Team and Nurse Examiners program to reduce the re-traumatization from sexual assault exams[1] | UK | X | The Oklahoma Youth Center has a shared grant award from DHHS to participate in NCTSN.[1] | UK |
| | Children's Conference: "Weaving Effective and Evidence-Based Practices into a System of Care"[1] | STD | SSA | | Red Rock BHS to establish the state's first Children's Crisis Stabilization Center in Oklahoma City in FY2005. OHCA and ODMHSAS collaborated to review rules and reimbursement policies to support this new specialty service.[2] | SLA | | Targeted MH Services for Children Affected by Trauma is a cooperatively funded and monitored program by ODMHSAS.[2] | |
| | Developing a 1-5 year training plan for a trauma-informed workforce (all children's BH services)[1] | SD | SSA | | | | | ODMHSAS received $500,000 in 2004 through state legislative appropriations for outpatient MH services to children with trauma.[2] | |
| | ODMHSAS and University of Oklahoma Health Sciences Center: TFCBT and PCIT (providers)[2] | EB | SLA | | Suicide Prevention Board: created legislatively to create a state plan for suicide prevention[2] | S | | | |
| | ODMHSAS with Dept of Human Services. Office of Juvenile Affairs. Sanctuary Model (*used the adult based models for children MH services)[2] | EB | SSA | | DMH: used the Jennings checklist of criteria for a trauma-informed system of care as a dissemination, training, capacity development and TA tool for contracted agencies.[9] | SSA | | | |
| | Train the Trainers: START model, a systematic training to assist in recovery from trauma[9] | STD | SSA | | Provider support group for providers working with trauma across the age span[9] | SSA | | | |
| | Suicide prevention toolkit training (375 students in 2005)[2] | STD | SLA | | Designated Coordinator for Trauma and Prevention[9] | SSA | | | |
| OR | Trauma-focused trainings, forums and conferences (multi-agency, culturally diverse, and for all ages)[1] | SD | S | SA | Initiative Partnership for Best Environments for Supporting Success in Treatment (BESST): State and Child & Adolescent Residential Psychiatric Program for violence and coercion-free environments (since 1992)[1] | S | NR | | X[8] |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| OR | Vicarious Traumatization and Burnout in Trauma Care (staff at Mid-Valley Behavioral Care Network)[1] | UK | SLA | | Office of MH and Addiction Services: all state and community providers, and those who oversee public MH and addiction services, assess for trauma-related symptoms and problems and offer services in accordance with Oregon Administrative Rules (OARs)[3] | S | | | |
| | SAFE, Inc.: consumer-owned and operated drop-in center with workshop on trauma and re-traumatization[1] | UK | S | | | | | | |
| | OMHAS with CHARPP: reducing the use of S & R[2] | UK | SSA | | OMHAS Quality Assurance and Certification Unit is responsible for certification and licensure of provider organizations to be in compliance with OARs and state laws and includes authorization of the use of S & R for children in approved facilities.[2] | S | | | |
| | Trauma Policy Advisory Committee (TPAC): training and technical assistance (providers)[1] | UK | S | | | | | | |
| | NASMHPD National Technical Assistance Center: regional training on reducing S & R in 8/2003 (state delegation)[1] | STD | SLA | | | | | | |
| | Salem Hospital: eliminated restraint in its facility and provides consultation to other facilities[1] | UK | S | | | | | | |
| | Project Network (program of Legacy Health System in Portland): trauma and motivational interviewing[1] | UK | SLA | | | | | | |
| | S & R Reduction (residential & acute hospital treatment providers)[2] | UK | SLA | | | | | | |
| PA | Drexel University Behavioral Healthcare Education Program (providers and professional specialties)[1] | UK | SLA | NR | State OMHSAS: adapted a non-seclusion/restraint policy for state psychiatric hospitals[1] | SSA | NR | | UK |
| | BH Trauma Training Initiative: Multi-level training on trauma and interpersonal violence (BH and other human services provider staff)[1] | UK | SLA | | | | | | |
| | Luzerne County Domestic Violence Task Force: SAGE (Safety, Affect Management, Grief, Empathy) Model (over 350 social service professionals)[1] | ES | SLA | | | | | | |
| | Public MH organizations: SAGE and Sanctuary model[1] | ES | SLA | | | | | | |
| RI | Sexual Assault and Trauma Resource Center (Kent Center staff)[1] | UK | SLA | LA | | | NR | MHRH: The Intermediate Services grant by MH Emergency and Traumatic Stress Services to address the MH needs of the survivors, families and children impacted by the Station nightclub fire in 2003 for FY04-05.[2] | X[8] |
| | Crisis Prevention and Intervention (CPI): alternative dispute resolution (CPI staff)[1] | UK | UK | | | | | | |
| | Trauma-Informed Model (agency staff)[1] | UK | UK | | | | | Victims of Crime Act (VOCA): provides both counseling and case management to RI residents with no insurance and crime victims who are low income[1] | |
| | Coalition for Abuse Recognition and Recovery: guidelines for consumer friendly programs (clinical and non-clinical staff)[1] | UK | SLA | | | | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| RI | Incident Command System: Training on disaster response, critical incidents, trauma and children, responding to school crises (community staff).[2] | UK | SLA | | | | | | |
| | CW Training Institute: training includes DBT, trauma, sexual abuse (all DCYF staff and community partners)[2] | SD | SSA/SLA | | | | | | |
| SC | State DMH basic training (staff in the system of services, DMH centers)[1] | SD | S | LA | DMH selected a screening tool to assess trauma for children age 9+ in FY03 and a screening tool for children under 9 in FY04.[3] | SSA/SLA with pilot sites | X (African-Americans) | | X[8] |
| | Trauma sensitivity, assessment and treatments (7 of 17 community MH Centers)[1] | SD | LLA | | | | | | |
| | | | | | DMH: Trauma Initiative Task Force[2] | SSA | | | |
| | Treatment model: CBT for PTSD among children/youth (5 centers under DMH)[12] | EB | SSA/SLA | | DMH has worked with representatives of trauma initiatives in other states and hosted a multi-state think tank and conducted surveys of clinicians and trauma services across the state system.[2] | SSA | | | |
| | Trauma-Sensitivity Training (all inpatient staff in five state hospitals)[1] | SD | LSA | | | | | | |
| | ETV series on CBT for children (child clinicians)[1] | EB | S | | | | | | |
| | Trauma debriefing, suicide assessment and intervention (state DMH emergency/ crisis workers)[1] | SD | SSA | | | | | | |
| | Trauma Initiative Task Force: address trauma and coordinate training[2] | N/A | SSA | | | | | | |
| | DMH training curriculum on trauma-sensitive services and avoiding retraumatization of clients (state hospital in-patient staff)[1] | SD | SSA | | | | | | |
| TX | Youth Suicide Prevention & Early Intervention: train health, school and community representatives to identify and refer at-risk youth (SAMHSA funded)[3] | UK | SSA/SLA | NR | | | NR | | X[8] |
| UT | | | | NR | Utah State Hospital: leading the reduction of S & R[2] | SLA | NR | | X[8] |
| | | | | | Youth Suicide Prevention and Early Intervention: enhance the existing infrastructure in 4 geographic pilot areas in the state to become models (SAMHSA funded)[3] | S | | | |
| VT | Agency of Human Service (AHS): pilot on trauma orientation (local human service providers)[1] | SD | SLA | NR | Trauma-Informed Service System throughout AHS[1] | S | X (refugees) | | No plan[8] |
| | Pilot trauma-orientation training (service providers in housing, vocational rehabilitation, welfare, juvenile, corrections, public health, MH, and Subs. Abuse services).[1] | UK | SSA/SLA | | AHS has child trauma working group, which assesses the system of care for children who are traumatized, with plan to adapt ARC model.[10] | S (planned) | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| WA | Trauma trainings (staff and consumers)[1] | UK | SLA | NR | MHD, Dept. of Alcohol and Subs. Abuse, and SDH have implemented improved health and safety standards pertaining to consumer S & R interventions for residential treatment facilities.[2] | SSA | X (native Indians/ Alaska natives) | MHD funding for The Colville Confederated Tribes: 2-day event to address trauma issues of American Indian/Alaska Native community, from young children to adults[2] | X[8] |
| | Specialized training (staff in the Department of Juvenile Rehabilitation Administration)[17] | EB | S | | | | | | |
| | | | | | JRA adopted a trauma-focused approach to the 60% of youth in juvenile justice with mental health problems.[17] | S | | JRA funds trauma-focused services for JJ youth using state funding.[17] | |
| WV | Bureau for BH and Health Facilities: Critical Incident Stress Management Training (MH practitioners and peer support service personnel)[2] | SD | S | NR | WV Council for Suicide Prevention Initiative: selected lawmakers studied the status of mental health services for adolescents in an effort to reduce suicide and delinquency rates and a suicide hotline is in the development stage for the entire state.[2] | SSA | NR | | No plan[8] |
| WI | In-service training (DMH employees and staff of 72 county MH service systems)[1] | SD | SSA/SLA | NR | In 2002, BMHSAS began delivering tools and system development to support Wisconsin's MH and Subs. Abuse providers in recognized trauma symptoms for Wisconsin's youth population.[2] | SSA | NR | New Medicaid benefit reimburses for comprehensive community services; psychosocial case management model; skills building; individual counseling; home support; TREM; and Seeking Safety.[1] | X[8] |
| | Addressing Vicarious Traumatization and Burnout in Trauma Care: Working With Boundaries (clinicians who work with trauma survivors[1] | STD | UK | | | | | | |
| | | | | | Governor's KidsFirst Initiatives (Safe Kids): strategies to prevent child abuse and neglect through a coordinated system of home visits; improved foster care and adoption services; and reduction of family violence[2] | S | | The Wisconsin Office of Justice Assistance funded a grant to cover the costs of developing tools for traumatized youth.[2] | |
| | Sidran Foundation model of trauma symptoms identification and treatment model (JJ pilots and Coordinated Service Team Initiative county sites)[2] | STD | SLA | | | | | | |
| | | | | | | | | DHFS and Dept. of Public Instruction: 6 grants to promote youth suicide prevention efforts in schools around the state, which target PTSD[2] | |
| | Train-the-Trainer Model (individuals and systems in Madison, WI who went through the Risking Connection training to train others within their service systems)[1] | STD | SLA | | | | | | |
| | Risking Connection (state and county subs. abuse workers, frontline staff and therapists)[1] | STD | SSA/SLA | | | | | | |
| | Risking Connections (staff in Wisconsin Council on Developmental Disabilities)[1] | STD | LLA | | | | | | |
| | Cross-systems training using Risking Connection model[1] | STD | S | | | | | | |
| WY | Staff Certification and Recertification: procedures incorporate understanding and sensitivity to trauma[1] | SD | UK | NR | S & R Policy: sensitivity to past and recent trauma is built into all practices and procedures, including S & R.[1] | UK | NR | | UK |
| | Investigating an allegation of mistreatment against a state employee without retraumatizing the consumer (patient advocates)[1] | SD | S | | Screening and assessment at State Hospital includes a Trauma Assessment Form. The emphasis is on sensitivity and basic knowledge of trauma on part of interviewer.[1] | SSA | | | |

## Table 2: Infrastructure/Systems for Trauma-Informed Specific Practices and Services in the States (cont)

| State | Training and job standards | | | | Policy/procedures | | | Finance | State disaster plan for child welfare |
|---|---|---|---|---|---|---|---|---|---|
| | Type of training (target population) | Type(s)[a] | Scope[b] | Clinical practice guidelines available[c] | Description[d] | Scope[b] | Culturally competent (target group) | | |
| WY | Sensitive and empathic services for the consumers' experience of trauma (statewide staff)[1] | SD | S | | All services are trauma-informed. Existing programs such as DBT and other groups incorporate trauma[1] | UK | | | |
| | How to conduct an investigation from a client about abuse by a state employee without re-traumatizing client (statewide staff)[1] | SD | S | | | | | | |

Abbreviations:

| | |
|---|---|
| BH | Behavioral Health |
| CBT | Cognitive Behavioral Therapy |
| DCF | Department of Children and Families |
| DMH | Department/Division of Mental Health |
| DBT | Dialectical Behavioral Therapy |
| JJ | Juvenile Justice |
| MH | Mental Health |
| SDH | State Department of Health |
| Sub. Abuse | Substance Abuse |
| PTSD | Post-Traumatic Stress Disorder |
| TF-CBT | Trauma Focused Cognitive Behavioral Therapy |
| UK | Unknown |

Note: *refers to standardized or manualized training; **anticipates an underreport since Katrina services have been in place.

a. State developed (SD); empirically supported (ES); evidence-based (EB), standardized* (STD); unknown (UK)

b. Statewide (S); Selected State Agency (SSA); Selected Local Agency (SLA)

c. If any clinical practice guidelines related to trauma services mentioned in Jennings (2004) or state plans, SA-state agency, LA-local agency, local providers, NR-not reported in the references

d. Community-based (CB); Information Technology related (IT)

References:


1. Jennings, A. (2004). *Blueprint for action: Building trauma-informed mental health service systems. State accomplishments, activities and resources: September 2004*. <http://www.annafoundation.org/articles.html> (accessed October 1, 2006).

2. State Mental Health Block Grant Applications

3. SAMHSA. *Grant awards: State summaries FY 2005/2006*. <http://www.samhsa.gov/statesummaries> (accessed on October 2006).

4. Oregon Department of Human Services Office of Mental Health and Addiction Services. *Trauma action plan*. (2006). <http://www.oregon.gov/DHS/addiction/trauma.shtml#actionplan> (accessed on October 2006).

5. Alaska Division of Mental Health and Developmental Disabilities. *Inpatient quality standards*. <www.hss.state.ak.us/dbh/doc/Inpatient%20Standards.doc> (accessed on October 2006).

6. Hensler, D.; Wilson, C.; & Salder, B. L. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices. The Findings of the Kauffman Best Practices Project to Help Children Heal from Child Abuse*. San Diego, CA: Children's Hospital-San Diego, Chadwick Center for Children and Families.

7. California Department of Social Services Office of Child Abuse Prevention. (2003). *Request for proposals 03-02: Child Welfare Services Evidence based Practice Clearinghouse*. <www.dss.cahwnet.gov/pdf/RFP03-02.pdf> (accessed October 1, 2006).

8. United States Government Accountability Office. (2006). *Child welfare: Federal action needed to ensure states have plans to safeguard children in the child welfare system displaced by disasters*. <www.gao.gov/new.items/d06944.pdf> (accessed October 1, 2006).

9. Personal communication with Julie Young, Oklahoma Department of Mental Health and Substance Abuse Services, August 23, 2006.

10. Personal Communication with Laurel Omland, Clinical Care Coordinator, Vermont Department of Mental Health, October 12, 2006.

11. Palladia. <http://www.palladiainc.org/html/programs%2Bhousing/special_init/hp_acs.html> (accessed October 1, 2006).

12. Personal Communication with Christopher Wells, SCDMH Trauma Initiative, Charleston/Dorchester MHC-Main Administrative Office, March 23, 2007.

13. Gawron, T. (2007). The transformation of IDCFS into a trauma-informed and trauma-sensitive system. *20th Annual Research Conference: A System of Care for Children's Mental Health Expanding the Research Base*, March 5, Tampa, FL.

14. Grisham, M., et al. (2006). New Mexico Department of Health FY06 quarter three performance report: Face of health. <http://www.health.state.nm.us/pdf/Q3.pdf>

15. New Mexico Department of Health. (2007). *Strategic plan: Fiscal Year 2007*. <http://www.health.state.nm.us/>

16. Adelschim, S. (2007). *Primary care-behavioral health linkages in school-based health centers*. Presentation at ACMHA, Santa Fe, March 16, 2007.

17. National Center for Mental Health and Juvenile Justice. (2006). Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system. <http://www.ncmhjj.com/Blueprint/programs/Washington.shtml> (accessed October 1, 2006).

## APPENDIX B: Meeting Participants

Dee BigFoot, PhD
Director of Indian County Child Trauma Center, Center on Child Abuse and Neglect University of Oklahoma Health Sciences Center
Oklahoma City, OK

Mary Compo, MSEd
School Based Health Community Coordinator
North Country's Children's Clinic
Watertown, NY

Chris Copeland, LCSW
Executive Director
Tri County Mental Health Services
Auburn, ME

Shannon CrossBear
Co-Director of Training and Evaluation
Federation of Families for Children's Mental Health
Grand Portage, MN

Holly Echo-Hawk, MS
Consultant
Echo-Hawk and Associates
Vancouver, WA

Susan Foster, MPH, MSSW
Vice President
National Center on Family Homelessness
Newton Centre, MA

Bob Franks, PhD
Director
CT Center for Effective Practices
Farmington, CT

Sonia Garcia, LCSW, RP
Director of School-Based Programs Public School / Bergen Upper Middle School
Brooklyn, NY

Tim Gawron, MS, MSW, LCSW
Statewide Administrator for Behavioral Health Services
Illinois Department of Children and Family Services
Chicago, IL

Ellen Gerrity, PhD
Associate Director and Senior Policy Advisor
National Center for Child Traumatic Stress
Duke University Medical Center
Durham, NC

Deborah Gorman-Smith, PhD
Professor
Institute for Juvenile Research University of Illinois at Chicago
Chicago, IL

Kimberly Hoagwood, PhD
Professor of Clinical Psychology in Psychiatry Columbia University
Director of Research on Child and Adolescent Services, New York State Office of Mental Health
New York, NY

Gordon Hodas, MD
Statewide Consulting Child Psychiatrist
Pennsylvania Office of Mental Health and Substance Abuse Services, Department of Public Welfare
Harrisburg, PA

Larke Huang, PhD
Senior Advisor on Children
Office of the Administrator
Substance Abuse Mental Health Services Aadministration
Rockville, MD

Mareasa Isaacs, PhD
Senior Consultant
The Isaacs Group
Owing Mills, MD

Perry Jones
Youth Communications Team
San Francisco, CA

Russell Jones, PhD
Professor of Psychology
Department of Psychology
Blacksburg, VA

Deb Painte, MPA
Project Director MMI
Native American Training Institute
Bismarck, ND

Delfy Peñas Roach, LCSW-R
VP Service Systems Relations
Value Options New Mexico
Albuquerque, NM

Parsa Sajid, MPA
Case Study Author
New York, NY

Luanne Southern, MSW
Senior Director, Prevention & Children's Mental Health
Mental Health America
Alexandria, VA

Carole Warshaw, MD
Director
Domestic Violence and Mental Health Policy Initiative
Chicago, IL

Marleen Wong, PhD
Director
LAUSD Crisis Counseling and Intervention Services LAUSD/RAND/UCLA Trauma Services Adaptation Center for Schools
Los Angeles, CA

Jay Yoe, PhD
Director of Quality Improvement
Maine Department of Health & Human Services
Augusta, ME

Julie Young, MS
Coordinator for Trauma & Prevention Services
ODMHSAS Domestic Violence/Sexual Assault Services
Oklahoma City, OK

Hosts:
Jane Knitzer, EdD
Janice Cooper, PhD

Staff:
Yumiko Aratani, PhD
Sarah Dababnah, MPH
Rachel Masi

## APPENDIX C: Case Study Participants

### North Country's Children's Clinic, Watertown, New York

Janice Charles
Executive Director

Nancy Conde
Director of School-based Health

Mary Ellen Compo
School-Based Health Community Coordinator

Jeanne Emery, Psy.D.
Director of Mental Health Services

Erin Cooney, LCSW-R

Deborah Morrell, RN
School Nurse
Watertown School District

Gail Butterfield
Home School Coordinator
Watertown High School

Randy Howard
TriCare

### Medicine Moon Initiative, North Dakota

Jan Birkland
Project Director, Sacred Child Project

Duane Gourneau
Indian Health Services

Deborah Painte, MPA
Project Director, Medicine Moon Initiative

Tanna Beston

Barb Poitra
Queen of Peace

Ina Olsen
Director, Turtle Mountain Children & Family Services

### Project Thrive, Maine Trauma-Informed System of Care

Chris Copeland
Executive Director
Tri County Mental Health Services

Tonya Labbe
Family Coordinator
Tri County Mental Health Services

Brianne Masselli
Youth Coordinator

Arabella Perez
Project Director

Catherine Ryder
Tri County Mental Health Services

Joan Smyrski
Director of Children's Services
State of Maine

Dr. James T. Yoe
Director of Quality Improvement
State of Maine

### Best Practices in Dissemination

Julian D. Ford, Ph.D.
Associate Professor
Department of Psychiatry
University of Connecticut Health Center

Robert P. Franks, Ph.D.
Director
Connecticut Center for Effective Practice
Child Health & Development Institute

Paula A. Madrid, Psy.D.
Director
The Resiliency Program
National Center for Disaster Preparedness
Mailman School of Public Health
Columbia University

Jan Markiewicz
Training, Director
Duke University
National Center for Child Traumatic Stress

NCCP National Center for Children *in* Poverty
Columbia University
MAILMAN SCHOOL OF PUBLIC HEALTH

215 West 125th Street, New York, NY 10027
TEL 646-284-9600 ▪ FAX 646-284-9623
www.nccp.org