Trauma Informed Care for Children and Adolescents

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Mini Plenary
The 30th Annual Rosalynn Carter Symposium on Mental Health Policy
"Celebrating the Past and Shaping the Future"
November 20, 2014

Mini Plenary:
Trauma Informed Care
for Children and Adolescents

- **Presentation Focus:**
  - **What are Child Traumatic Stress and Trauma Informed Care?**
  - **History: Major Milestones**
  - **Present: Key Issues/Different Perspectives**
- **Q/A: Discussion of Future Directions**

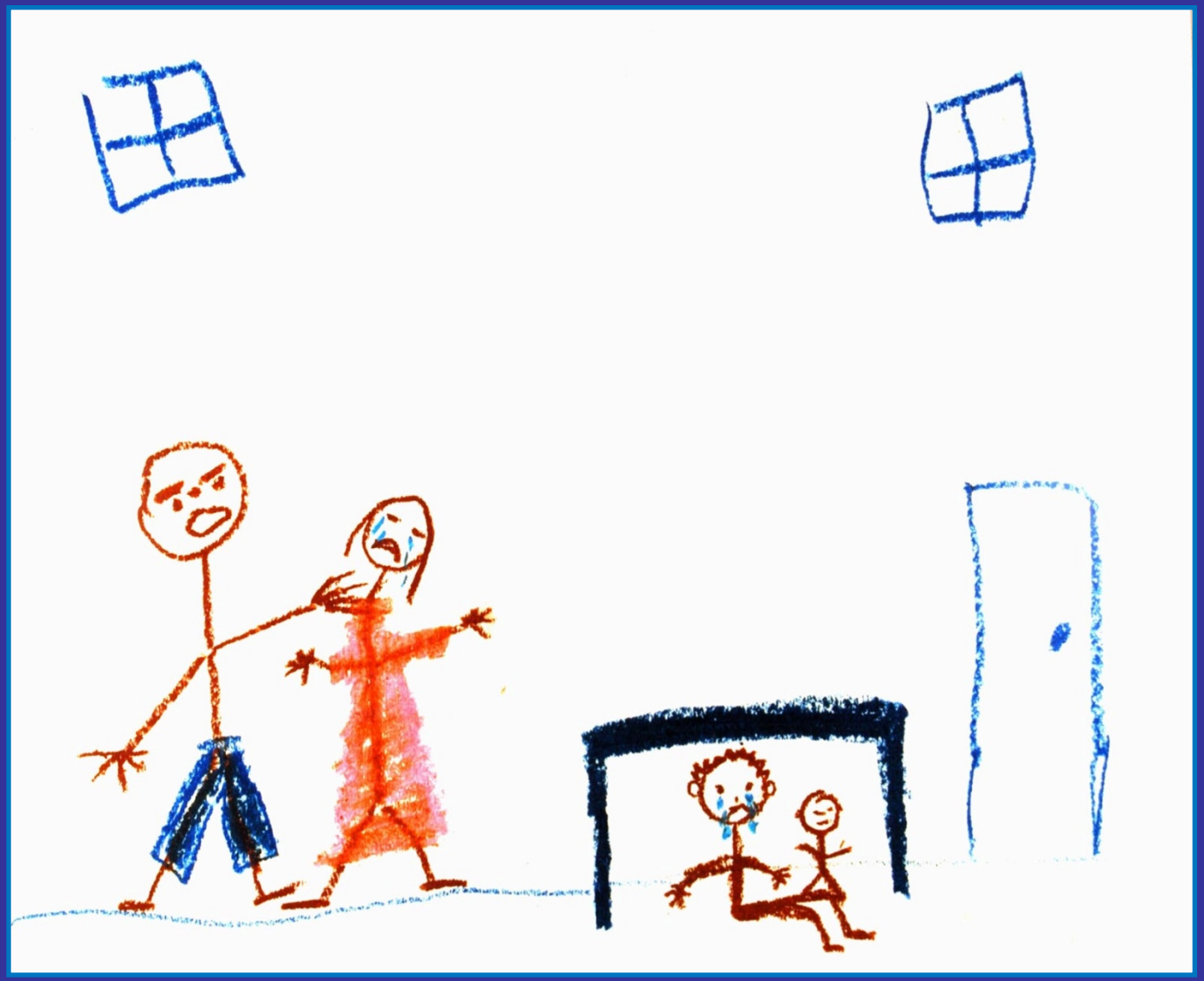
What is Child Traumatic Stress?

Child traumatic stress refers to the physiological, psychological, and behavioral reactions that can be the result of a child's exposure to a broad range of events that overwhelm the child's ability to cope.

- Child Maltreatment
  - Physical/Sexual Abuse/Neglect
- Domestic Violence
- Natural Disasters
- Military Family-related stress (parental loss, injury)
- Traumatic Bereavement
  - Sudden/Violent Loss)
- Medical Trauma
  - Serious accident
  - Life -threatening Illness
- Community and School Violence/Terrorism
- War-Zone Trauma
  - Refugee/War Experiences

"You don't shoot at children."

1985 Great Flood of West Virginia
Parsons, WV



How Big is the Problem?

Two of every three children will witness or experience a traumatic event before the age of 16. Exposure to even low-magnitude stressors result in post-traumatic symptoms. (Copeland et al., 2007; 2010).

3.4 million children reported to child protective services (CPS) in 2012 (CDC/NCANDS, 2014).

A non-CPS study estimated that 1 in 4 U.S. children experience some form of child maltreatment in their lifetimes. (Finkelhor et al, 2013)

How big is the problem? Examples of Key Studies and Reports

The 2011 National Survey of Children's Exposure to Violence (Finkelhor et al., 2013)

- Reinforces numerous previous studies showing that children and youth are frequently exposed to violence, crime, and abuse on an annual basis and over the course of their childhoods.

Report of the Attorney General's Task Force on Children Exposed to Violence , Defending Childhood Initiative (2012)

- Describes exposure to violence as a national crisis that touches the lives of approximately 2 out of every 3 of our children (46 million). In the United States, about 9 children per day (aged 5-18) are lost per day to homicide and suicide.

How complex is the problem? 9/11 studies

New York City, NY Department of Education Study (Hoven et al., 2005)

- At 6 months post 9/11, the prevalence of PTSD was 10.6 % among children, with high rates of other disorders. Over 60% of the children had experienced at least one major traumatic event prior to the attacks.

Mt. Sinai longitudinal studies (Yehuda et al., 2005; Chemtob et al., 2010).

- At 3 years post 9/11. researchers noted the ongoing impact of 9/11 stressors on mothers and their children born soon after the attack. Researchers show the changes in cortisol levels of children whose mothers were in the 2nd or 3rd trimester during the attacks.

How complex is the problem? Child Welfare

Just released Nov. 6, 2014:

Child Welfare Outcomes 2009–2012: Report to Congress

- Focus on safety, permanency, and well-being
- Provides information on national performance as well as the performance of individual states in seven outcome categories.
  - Reduce recurrence of child abuse and/or neglect
  - Reduce the incidence of child abuse and/or neglect in foster care
  - Increase permanency for children in foster care
  - Reduce time in foster care to reunification without increasing reentry
  - Reduce time in foster care to adoption
  - Increase placement stability
  - Reduce placements of young children in group homes or institutions

COST

- The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States is approximately $124 billion (CDC, 2014).

- Measurement challenges: This is a small % of the cost of child maltreatment, and all forms of child trauma.

What is the impact on children?

- Health and mental health effects
- Academic performance
- Substance use/abuse
- Posttraumatic stress and other disorders (depression, anxiety, phobia, panic)
- Cognitive development: IQ and language
- Development: physical, social, emotional
- Capacity to regulate emotion and attention
- Numbness, desensitization to threat
- Re-victimization
- Recklessness and reenacting behavior

Adverse Childhood Experience Studies

- Childhood exposure to 4 or more of 9 risk factors related to child maltreatment and seriously impaired household environments had a 12-fold increase in risk for:

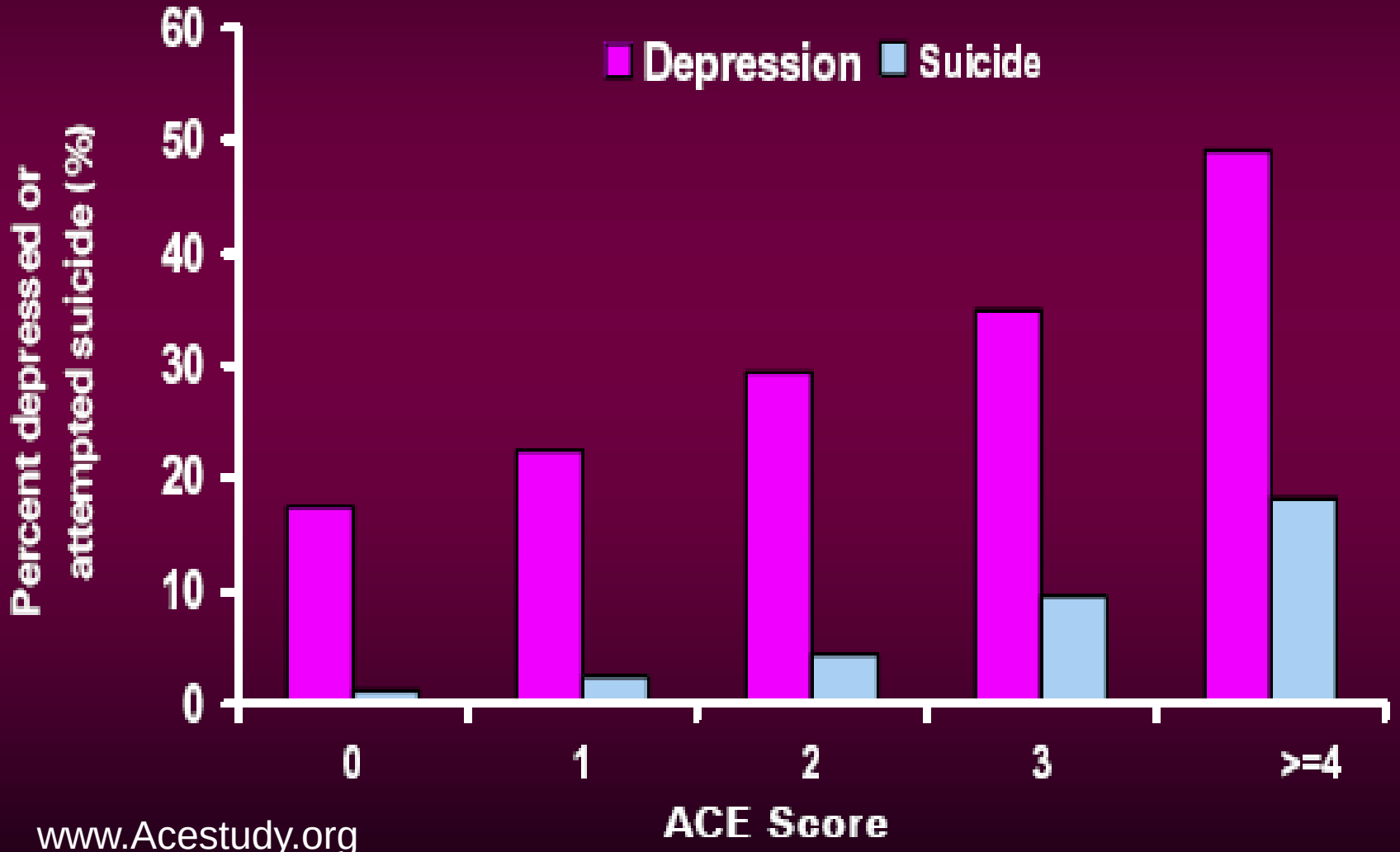
  alcoholism, drug abuse, depression, suicide, and health problems like heart disease.

- Numerous other studies support these findings related to multiple exposures to trauma and their consequences.

What is the long-term impact on children?

- Adverse Childhood Experience Studies (ACES)

The ACE Score and a Lifetime History of Depression or Suicide Attempts



www.Acestudy.org

What is Trauma Informed Care?

Trauma-informed care integrates an understanding of the impact of child traumatic stress on child development, emotions, health, and behavior, into the services (interventions/treatment) and other practices of all child-serving systems.

Includes a focus on key elements:

- Screening
- Evidence-based approach
- Culturally Appropriate
- Trauma-informed Resources and Training
- Continuity of Care Across Systems
- Secondary Trauma Among Caregivers
- Secondary Trauma Among Providers
- Resilience

History:
Selected Milestones

- 1980's establishment of PTSD as adult diagnosis
- NIMH Violence and Trauma Branch includes focus on child trauma (>100 funded grants in adult/child portfolio)
- Surgeon General Reports: Mental Health (1999), Culture and Mental Health (2001); and Youth Violence (2001)
- Growing federal interest in domestic violence, rape, child maltreatment, torture

History:
Selected Milestones

- SAMHSA: Refugees/Women and Violence/NCTSN/Trauma Informed Approach
- DOJ: Defending Childhood Initiative
- ACF : Interest in child welfare and trauma, psychotropic medications issue, integration of trauma in public programs (Note: HHS Guidance letter)
- DSM V: PTSD Diagnosis for Young Children

History:
Selected Milestones

- Adverse Childhood Experience Studies and Advocacy
- Growing Focus on Evidence-Based Treatments, System Change, and Moving Beyond Medical Model
- Mental Health and Addiction Treatment Parity : All Diagnoses
- Affordable Care Act: Integrated Care
- National Child Traumatic Stress Network

History: Selected Milestones

Carter Center Mental Health Symposiums

- 2011 - Building Services and Supports For Children Exposed to Domestic Violence, Child Welfare, and Juvenile Justice
- 2008 - "Unclaimed Children Revisited": Fostering a Climate to Improve Children's Mental Health"
- 2010/Military Families & 2006/Hurricane Katrina
- 1998: Promoting Positive and Healthy Behaviors in Children

The Role of Advocacy

The Power of the People

National Press Club – 1994

Sen. Paul Wellstone - Capitol Hill Briefing - 2001

Mental Health Parity

Parity Rally on Capitol Hill - 2002

House hearing on MH and Addiction Parity 2007

Parity Rally on Capitol Hill - 2008

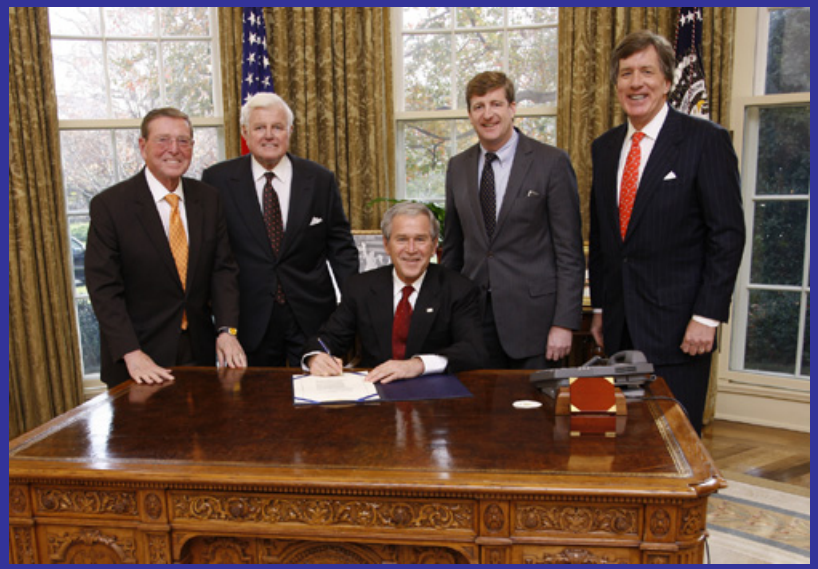
Parity Rally on Capitol Hill - 2008

Parity Rally on Capitol Hill – 2008
The Press

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

- On October 3, 2008, President Bush signed into law the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* as part of the financial rescue package

  (Public Law No. 110-343)



The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

- On November 13, 2013, final regulations were released by HHS for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. The release was announced at the Carter Center Mental Health Symposium by Sec. Sebelius.

Sec. Sebelius, Mrs. Carter, Dave Wellstone, Carter Center, 2013:

Affordable Care Act

- How Does the ACA Benefit Those With Mental Health/Substance Use Disorders? 32 million uninsured people will get coverage
- New benefit in insurance "exchange" and Medicaid managed care plans includes MH/SUD at parity
- Abusive health insurance industry practices are prohibited

National Child Traumatic Stress Network

- Established by Congress in 2000 as part of the Children's Health Act to raise the standard of care and increase access to services for traumatized children, families, and communities.
- Funded through SAMHSA and coordinated by the UCLA-Duke University National Center for Child Traumatic Stress
- Grantees include hospitals, universities, and community based programs that are involved in training, service delivery, product development, data collection and evaluation, and public policy and awareness efforts.

National Child Traumatic Stress Network Centers

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS)

NCTSN The National Child Traumatic Stress Network

Select Key Events Shaping the NCTSN

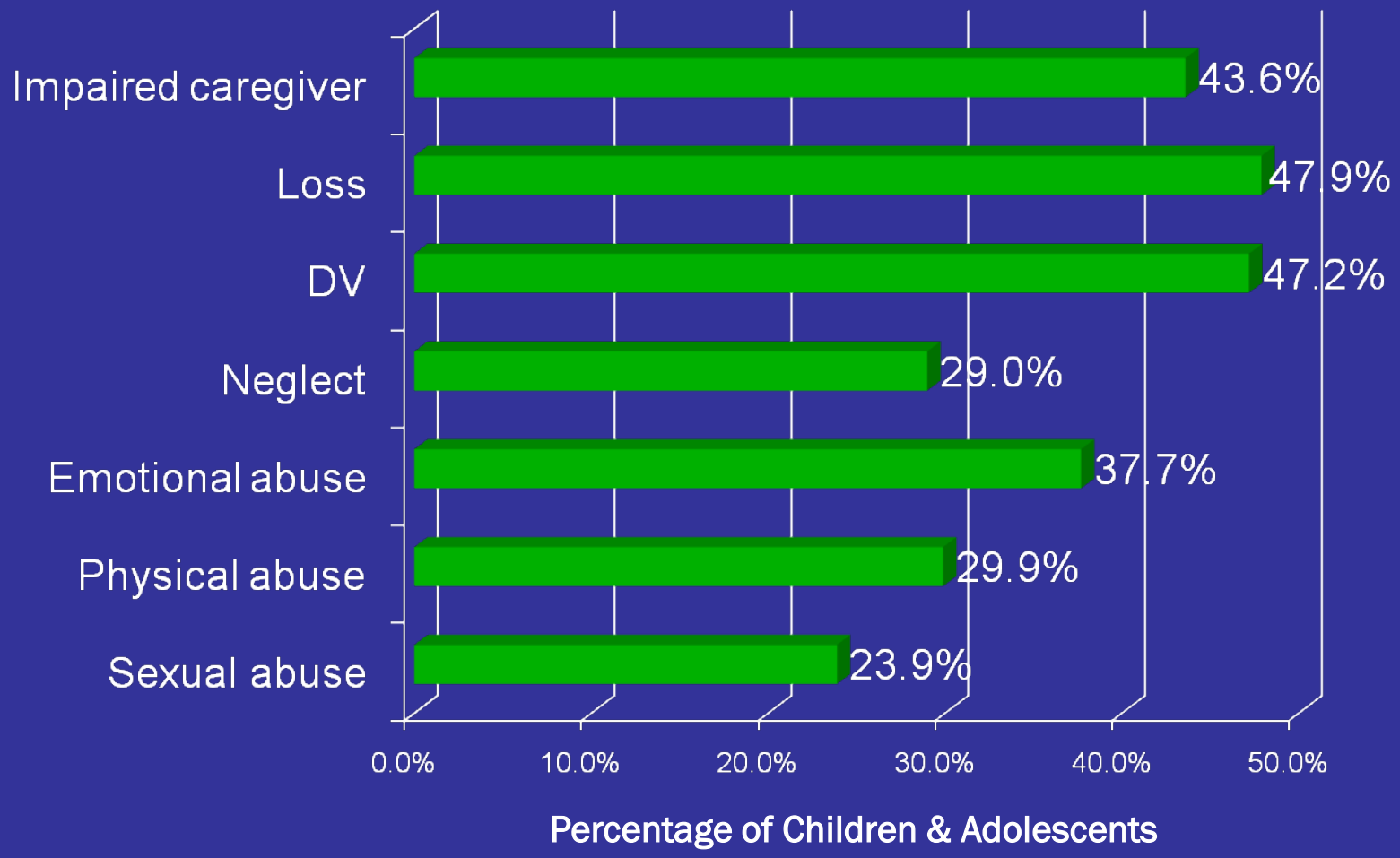
- 1999 Columbine
- 2001 9/11 Terrorist Attacks
- 2001-Present Wars in Afghanistan and Iraq
- 2005 Hurricanes Katrina, Rita, and others
- 2007 Virginia Tech University
- 2012 Hurricane Sandy
- 2013 Sandy Hook Elementary School
- 2014 Shootings and mass disasters

Does the NCTSN make a difference?
NCCTS Core Data Set

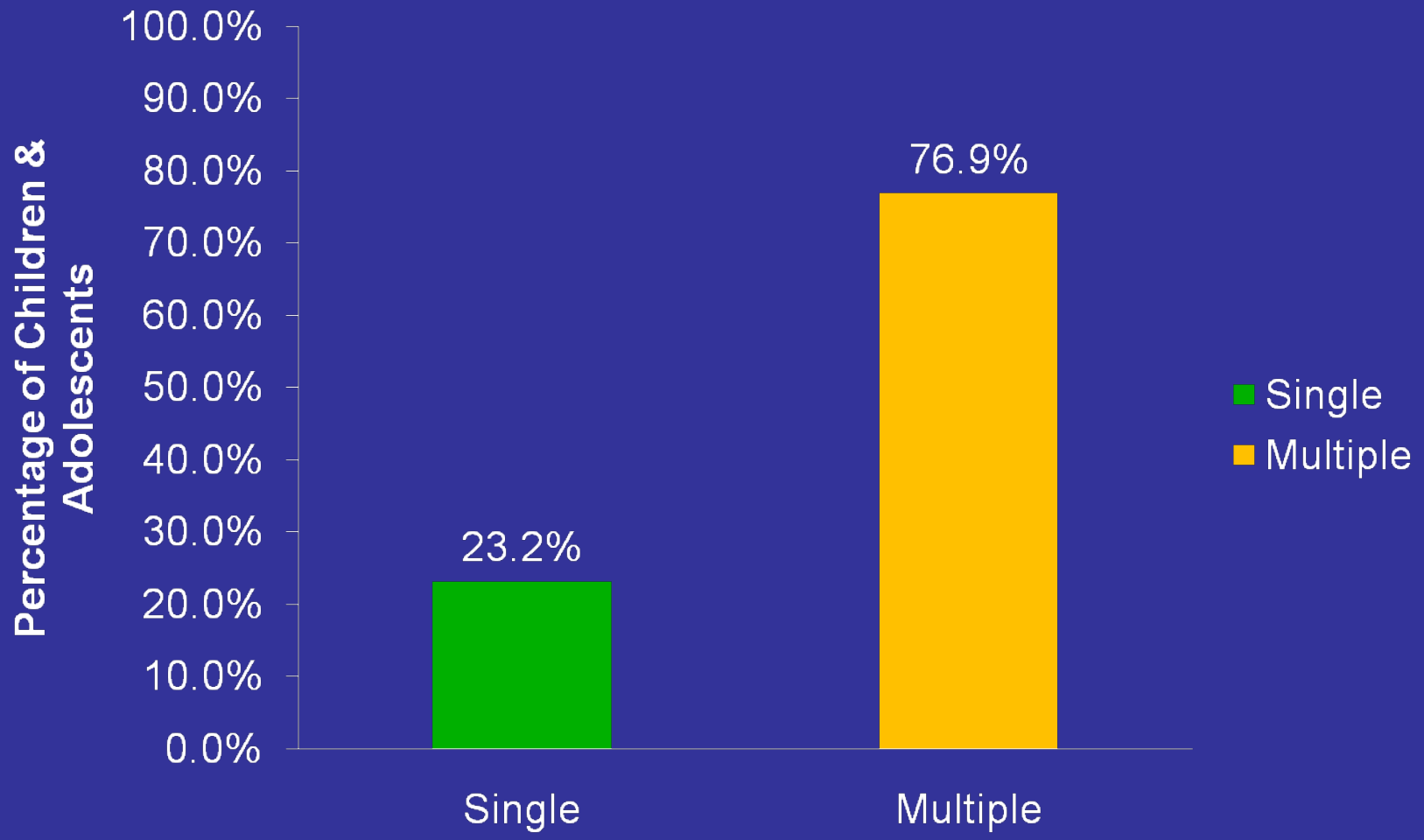
- Data on > 14,000 children

- Demographic and living situation information
- Trauma history and detail
- Indicators of severity
- Clinical evaluation
- Treatment outcome
- Standardized Assessment Measures

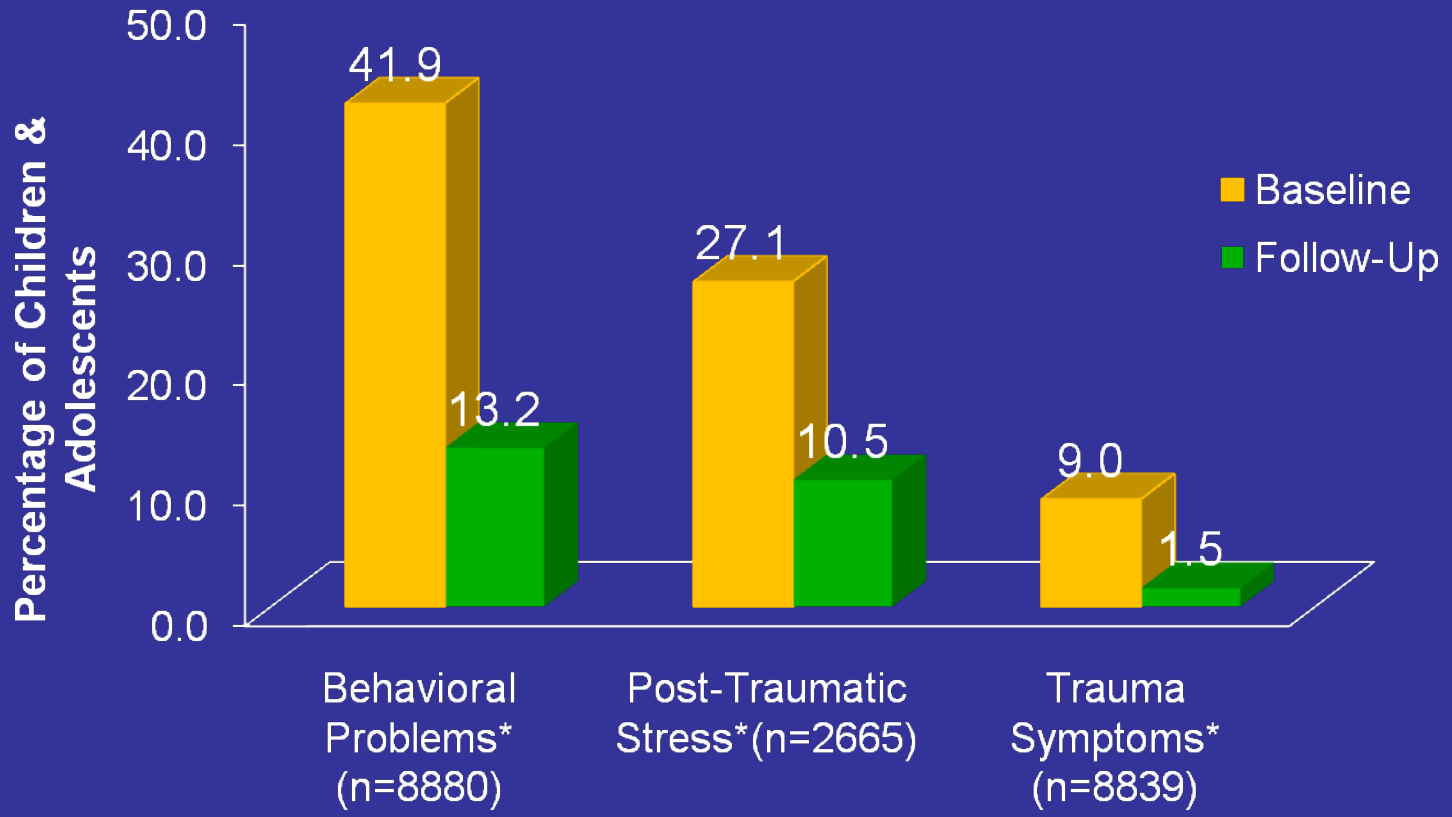
Most Commonly Reported Traumas



Single vs. Multiple Trauma Types



Children & Adolescents in the Clinical Range: Baseline & Last Follow up

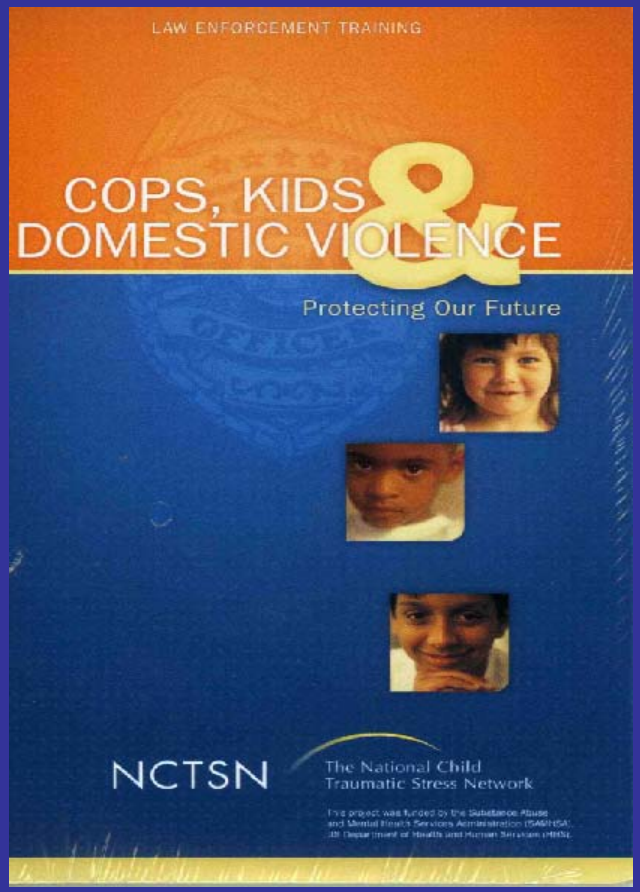


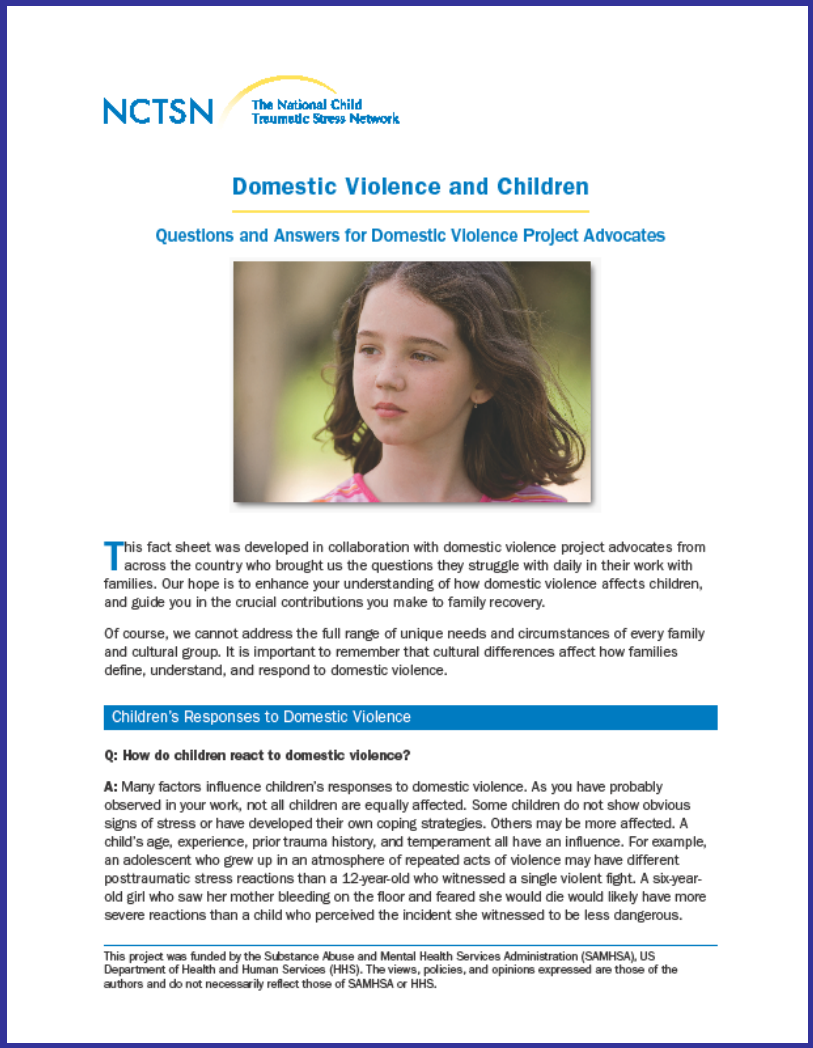
*p ≤.0001

How is NCTSN making a difference?

- Tens of thousands of children served through direct treatment
- Over 1 million professionals trained
- Over 40 evidence-based treatments and promising practices developed
- Over 175 products for parents/caregivers, youth, professionals, general public, policymakers, media
- Network response to national crises

Child Traumatic Stress – Resources
www.nctsn.org





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Domestic Violence and Children

Questions and Answers for Domestic Violence Project Advocates

This fact sheet was developed in collaboration with domestic violence project advocates from across the country who brought us the questions they struggle with daily in their work with families. Our hope is to enhance your understanding of how domestic violence affects children, and guide you in the crucial contributions you make to family recovery.

Of course, we cannot address the full range of unique needs and circumstances of every family and cultural group. It is important to remember that cultural differences affect how families define, understand, and respond to domestic violence.

Children's Responses to Domestic Violence

Q: How do children react to domestic violence?

A: Many factors influence children's responses to domestic violence. As you have probably observed in your work, not all children are equally affected. Some children do not show obvious signs of stress or have developed their own coping strategies. Others may be more affected. A child's age, experience, prior trauma history, and temperament all have an influence. For example, an adolescent who grew up in an atmosphere of repeated acts of violence may have different posttraumatic stress reactions than a 12-year-old who witnessed a single violent fight. A six-year-old girl who saw her mother bleeding on the floor and feared she would die would likely have more severe reactions than a child who perceived the incident she witnessed to be less dangerous.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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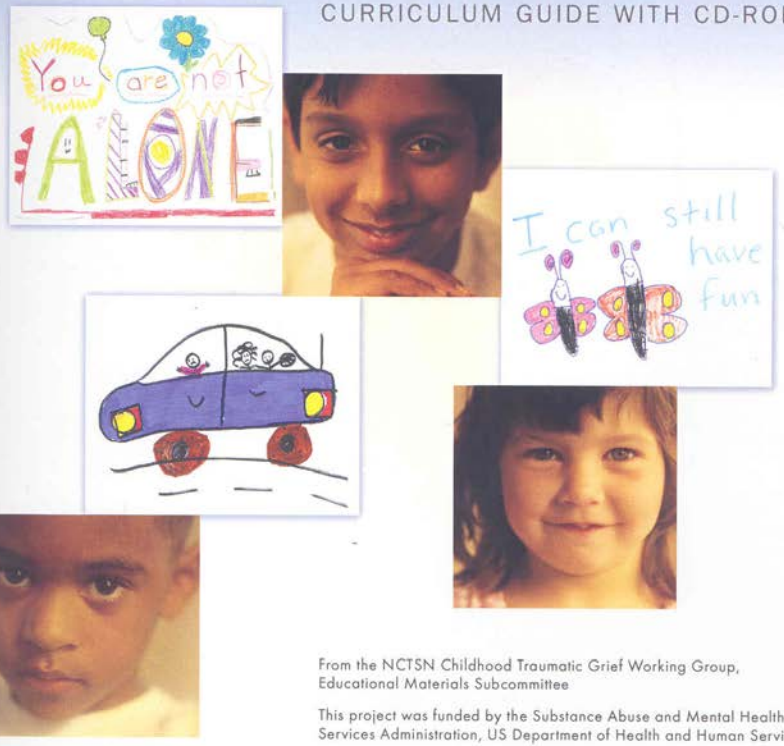
The Courage to Remember

CHILDHOOD TRAUMATIC GRIEF
CURRICULUM GUIDE WITH CD-ROM



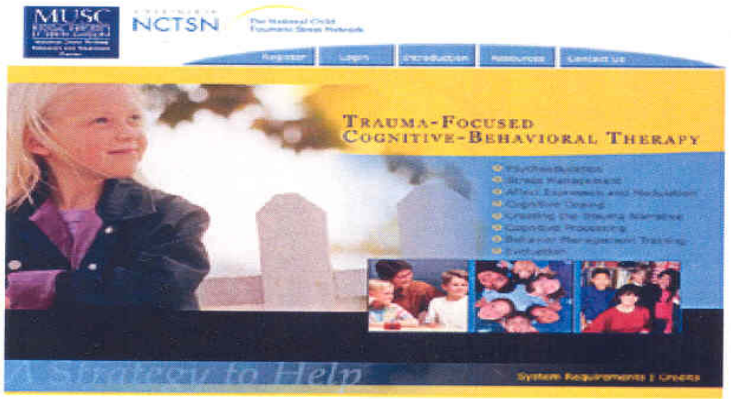
From the NCTSN Childhood Traumatic Grief Working Group, Educational Materials Subcommittee

This project was funded by the Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services

TF-CBT*Web*

A web-based learning course for

TRAUMA-FOCUSED
COGNITIVE-BEHAVIORAL THERAPY



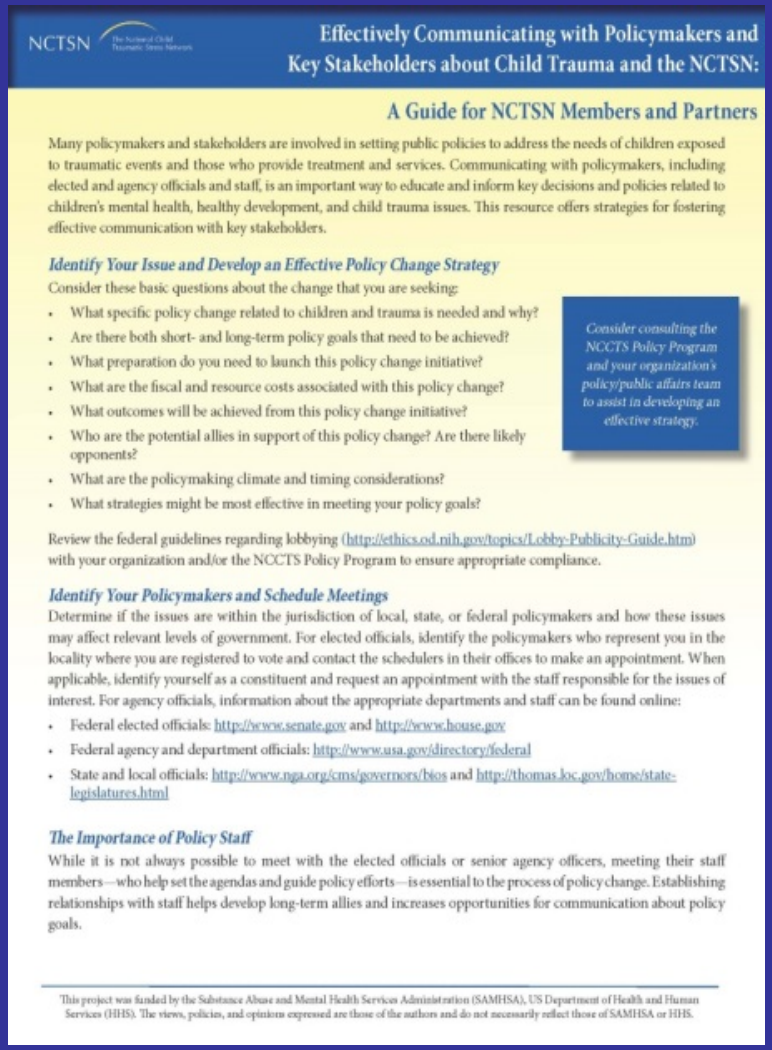
www.musc.edu/tfcbt

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA
National Crime Victims Research & Treatment Center

A PARTNER IN NCTSN The National Child Traumatic Stress Network

Child Traumatic Stress – Resources

www.nctsn.org



NCTSN

Effectively Communicating with Policymakers and Key Stakeholders about Child Trauma and the NCTSN:

A Guide for NCTSN Members and Partners

Many policymakers and stakeholders are involved in setting public policies to address the needs of children exposed to traumatic events and those who provide treatment and services. Communicating with policymakers, including elected and agency officials and staff, is an important way to educate and inform key decisions and policies related to children's mental health, healthy development, and child trauma issues. This resource offers strategies for fostering effective communication with key stakeholders.

Identify Your Issue and Develop an Effective Policy Change Strategy

Consider these basic questions about the change that you are seeking:

- What specific policy change related to children and trauma is needed and why?
- Are there both short- and long-term policy goals that need to be achieved?
- What preparation do you need to launch this policy change initiative?
- What are the fiscal and resource costs associated with this policy change?
- What outcomes will be achieved from this policy change initiative?
- Who are the potential allies in support of this policy change? Are there likely opponents?
- What are the policymaking climate and timing considerations?
- What strategies might be most effective in meeting your policy goals?

Consider consulting the NCCTS Policy Program and your organization's policy/public affairs team to assist in developing an effective strategy.

Review the federal guidelines regarding lobbying (http://ethics.od.nih.gov/topics/Lobby-Publicity-Guide.htm) with your organization and/or the NCCTS Policy Program to ensure appropriate compliance.

Identify Your Policymakers and Schedule Meetings

Determine if the issues are within the jurisdiction of local, state, or federal policymakers and how these issues may affect relevant levels of government. For elected officials, identify the policymakers who represent you in the locality where you are registered to vote and contact the schedulers in their offices to make an appointment. When applicable, identify yourself as a constituent and request an appointment with the staff responsible for the issues of interest. For agency officials, information about the appropriate departments and staff can be found online:

- Federal elected officials: http://www.senate.gov and http://www.house.gov
- Federal agency and department officials: http://www.usa.gov/directory/federal
- State and local officials: http://www.nga.org/cms/governors/bios and http://thomas.loc.gov/home/state-legislatures.html

The Importance of Policy Staff

While it is not always possible to meet with the elected officials or senior agency officers, meeting their staff members—who help set the agendas and guide policy efforts—is essential to the process of policy change. Establishing relationships with staff helps develop long-term allies and increases opportunities for communication about policy goals.

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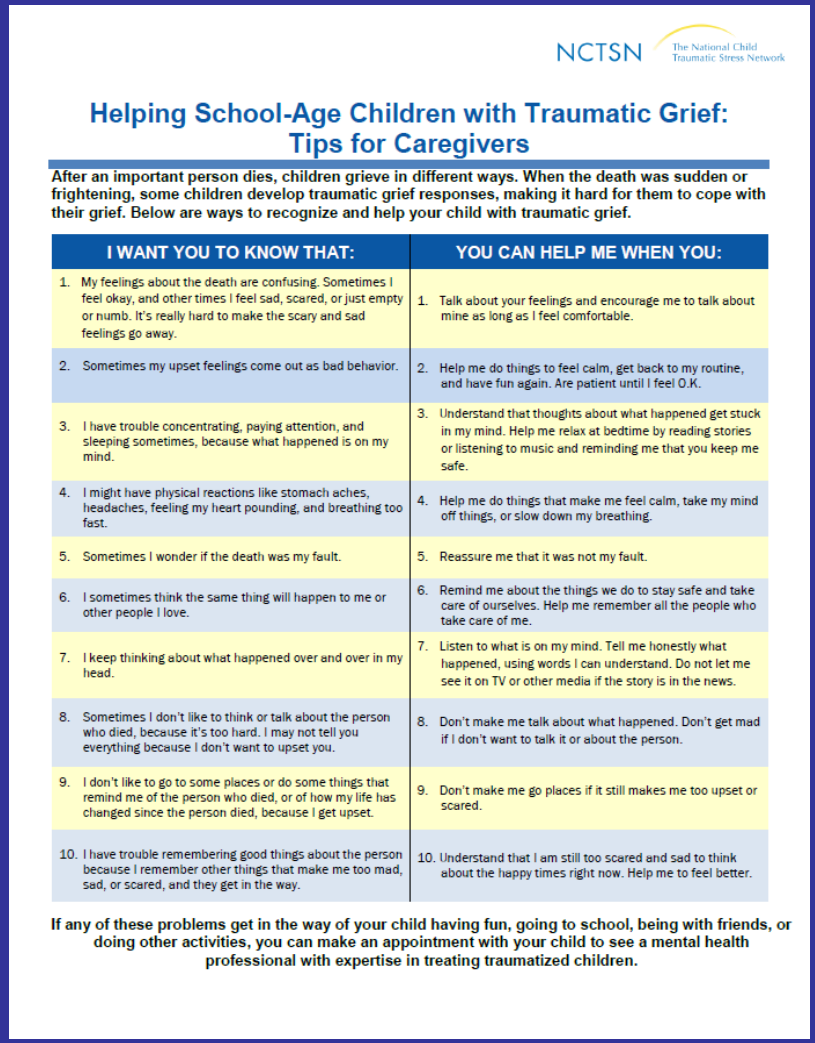

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Helping School-Age Children with Traumatic Grief: Tips for Caregivers

After an important person dies, children grieve in different ways. When the death was sudden or frightening, some children develop traumatic grief responses, making it hard for them to cope with their grief. Below are ways to recognize and help your child with traumatic grief.

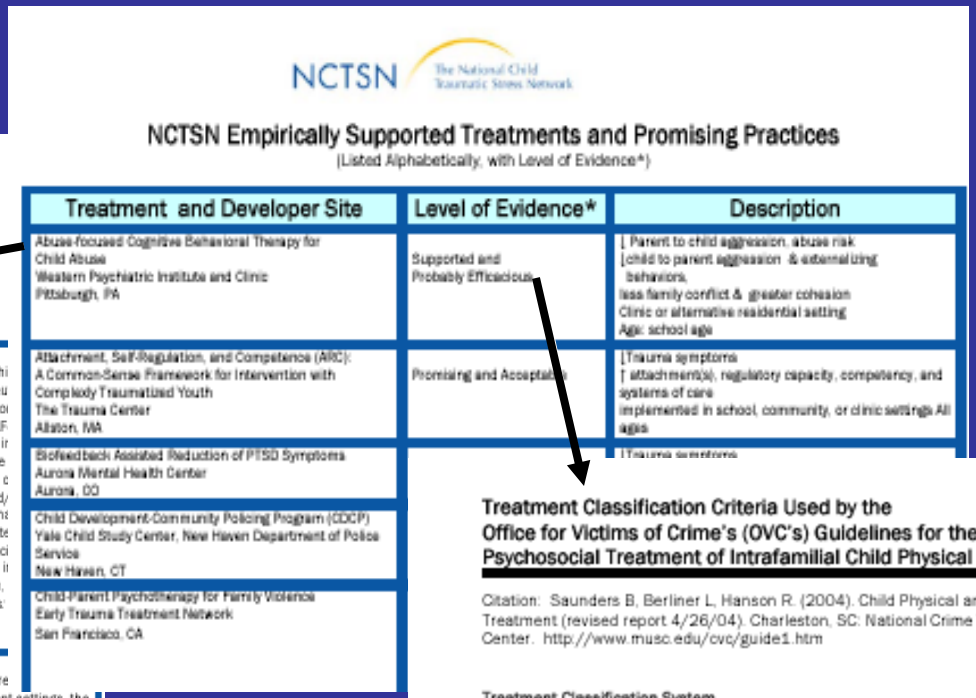
I WANT YOU TO KNOW THAT:	YOU CAN HELP ME WHEN YOU:
1. My feelings about the death are confusing. Sometimes I feel okay, and other times I feel sad, scared, or just empty or numb. It's really hard to make the scary and sad feelings go away.	1. Talk about your feelings and encourage me to talk about mine as long as I feel comfortable.
2. Sometimes my upset feelings come out as bad behavior.	2. Help me do things to feel calm, get back to my routine, and have fun again. Are patient until I feel O.K.
3. I have trouble concentrating, paying attention, and sleeping sometimes, because what happened is on my mind.	3. Understand that thoughts about what happened get stuck in my mind. Help me relax at bedtime by reading stories or listening to music and reminding me that you keep me safe.
4. I might have physical reactions like stomach aches, headaches, feeling my heart pounding, and breathing too fast.	4. Help me do things that make me feel calm, take my mind off things, or slow down my breathing.
5. Sometimes I wonder if the death was my fault.	5. Reassure me that it was not my fault.
6. I sometimes think the same thing will happen to me or other people I love.	6. Remind me about the things we do to stay safe and take care of ourselves. Help me remember all the people who take care of me.
7. I keep thinking about what happened over and over in my head.	7. Listen to what is on my mind. Tell me honestly what happened, using words I can understand. Do not let me see it on TV or other media if the story is in the news.
8. Sometimes I don't like to think or talk about the person who died, because it's too hard. I may not tell you everything because I don't want to upset you.	8. Don't make me talk about what happened. Don't get mad if I don't want to talk it or about the person.
9. I don't like to go to some places or do some things that remind me of the person who died, or of how my life has changed since the person died, because I get upset.	9. Don't make me go places if it still makes me too upset or scared.
10. I have trouble remembering good things about the person because I remember other things that make me too mad, sad, or scared, and they get in the way.	10. Understand that I am still too scared and sad to think about the happy times right now. Help me to feel better.

If any of these problems get in the way of your child having fun, going to school, being with friends, or doing other activities, you can make an appointment with your child to see a mental health professional with expertise in treating traumatized children.

Trauma Specific Evidence-Based Practices

Available at NCTSN.org

Summary Table



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NCTSN Empirically Supported Treatments and Promising Practices

(Listed Alphabetically, with Level of Evidence*)

Treatment and Developer Site	Level of Evidence*	Description
Abuse-focused Cognitive Behavioral Therapy for Child Abuse Western Psychiatric Institute and Clinic Pittsburgh, PA	Supported and Probably Efficacious	[Parent to child aggression, abuse risk [child to parent aggression & externalizing behaviors, less family conflict & greater cohesion Clinic or alternative residential setting Age: school age
Attachment, Self-Regulation, and Competence (ARC): A Common-Sense Framework for Intervention with Complexly Traumatized Youth The Trauma Center Allston, MA	Promising and Acceptable	[Trauma symptoms ↑ attachment(s), regulatory capacity, competency, and systems of care implemented in school, community, or clinic settings All ages
Biofeedback Assisted Reduction of PTSD Symptoms Aurora Mental Health Center Aurora, CO		
Child Development-Community Policing Program (CDCP) Yale Child Study Center, New Haven Department of Police Service New Haven, CT		
Child-Parent Psychotherapy for Family Violence Early Trauma Treatment Network San Francisco, CA		

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Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)

Treatment Description	AF-CBT represents an approach to working with physically abused chi their offending caregivers that incorporates conceptual and therapeu principles/procedures from several areas including learning/behavio family-systems, cognitive therapy, and developmental victimology. AF- integrates several behavior therapy and CBT procedures that target ir and parent characteristics related to the abusive experience and the context in which coercion or aggression occurs. Thus, this approach c address parent and family risks for/correlates of physical abuse and/ sequelae exhibited by children following the abuse. Treatment emphs instruction in specific intrapersonal (e.g., cognitive, affective) and inte (e.g., behavioral) skills designed to promote the expression of prosoci and discourage the use of coercive/aggressive behavior at both the i family levels. For a detailed description, see Kolko, D. J., & Swenson, *Assessing and treating physically abused children and their families: behavioral approach*. Thousand Oaks, CA: Sage Publications.
Target Population	AF-CBT is appropriate for use with physically abusive/aggressive pare school-age children. Although it has been primarily used in outpatient settings, the treatment can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child. This approach is designed for caregivers who exhibit, for example, negative child perceptions, heightened anger or hostility, and/or harsh/punitive/ineffective parenting practices, or for families involved in verbally or physically coercive interactions. Related methods are designed for use with physically abused children who present with externalizing behavior problems, notably aggressive behavior, coping skills/adjustment problems, poor social competence, internalizing symptoms, and developmental deficits in relationship skills. Parents with serious psychiatric or personality impairments (e.g., substance use disorders, major

Intervention Fact Sheets

Treatment Classification Criteria Used by the Office for Victims of Crime's (OVC's) Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse

Citation: Saunders B, Berliner L, Hanson R. (2004). Child Physical and Sexual Abuse: Guidelines for Treatment (revised report 4/26/04). Charleston, SC: National Crime Victims Research & Treatment Center. http://www.musc.edu/cvc/guide1.htm

Treatment Classification System

1. Well-supported, efficacious treatment
2. Supported and probably efficacious treatment
3. Supported and acceptable treatment
4. Promising and acceptable treatment
5. Novel and experimental treatment
6. Concerning treatment

Level-of-Evidence Criteria

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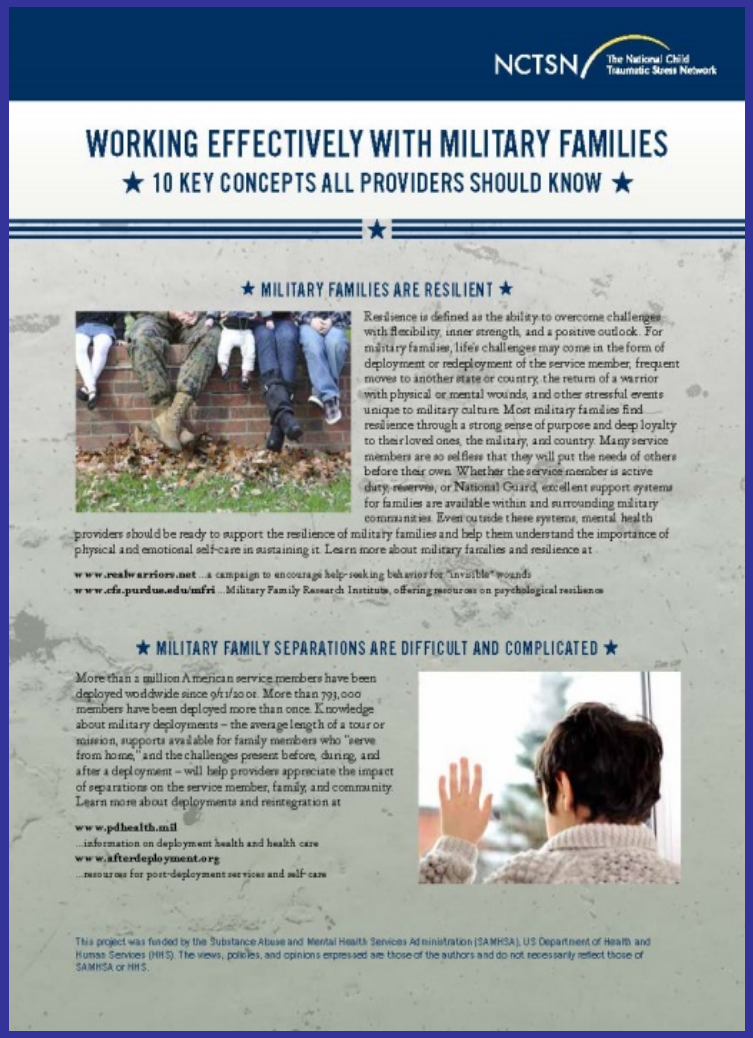
www.nctsn.org



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WORKING EFFECTIVELY WITH MILITARY FAMILIES
★ 10 KEY CONCEPTS ALL PROVIDERS SHOULD KNOW ★

★

★ MILITARY FAMILIES ARE RESILIENT ★

Resilience is defined as the ability to overcome challenges with flexibility, inner strength, and a positive outlook. For military families, life's challenges may come in the form of deployment or redeployment of the service member, frequent moves to another state or country, the return of a warrior with physical or mental wounds, and other stressful events unique to military culture. Most military families find resilience through a strong sense of purpose and deep loyalty to their loved ones, the military, and country. Many service members are so selfless that they will put the needs of others before their own. Whether the service member is active duty, reserves, or National Guard, excellent support systems for families are available within and surrounding military communities. Even outside these systems, mental health providers should be ready to support the resilience of military families and help them understand the importance of physical and emotional self-care in sustaining it. Learn more about military families and resilience at

www.realwarriors.net ...a campaign to encourage help-seeking behavior for "invisible" wounds
www.cfs.purdue.edu/mfri ...Military Family Research Institute, offering resources on psychological resilience

★ MILITARY FAMILY SEPARATIONS ARE DIFFICULT AND COMPLICATED ★

More than 2 million American service members have been deployed worldwide since 9/11/20 or. More than 793,000 members have been deployed more than once. Knowledge about military deployments – the average length of a tour or mission, supports available for family members who "serve from home," and the challenges present before, during, and after a deployment – will help providers appreciate the impact of separations on the service member, family, and community. Learn more about deployments and reintegration at

www.pdhealth.mil
...information on deployment health and health care
www.afterdeployment.org
...resources for post-deployment services and self-care

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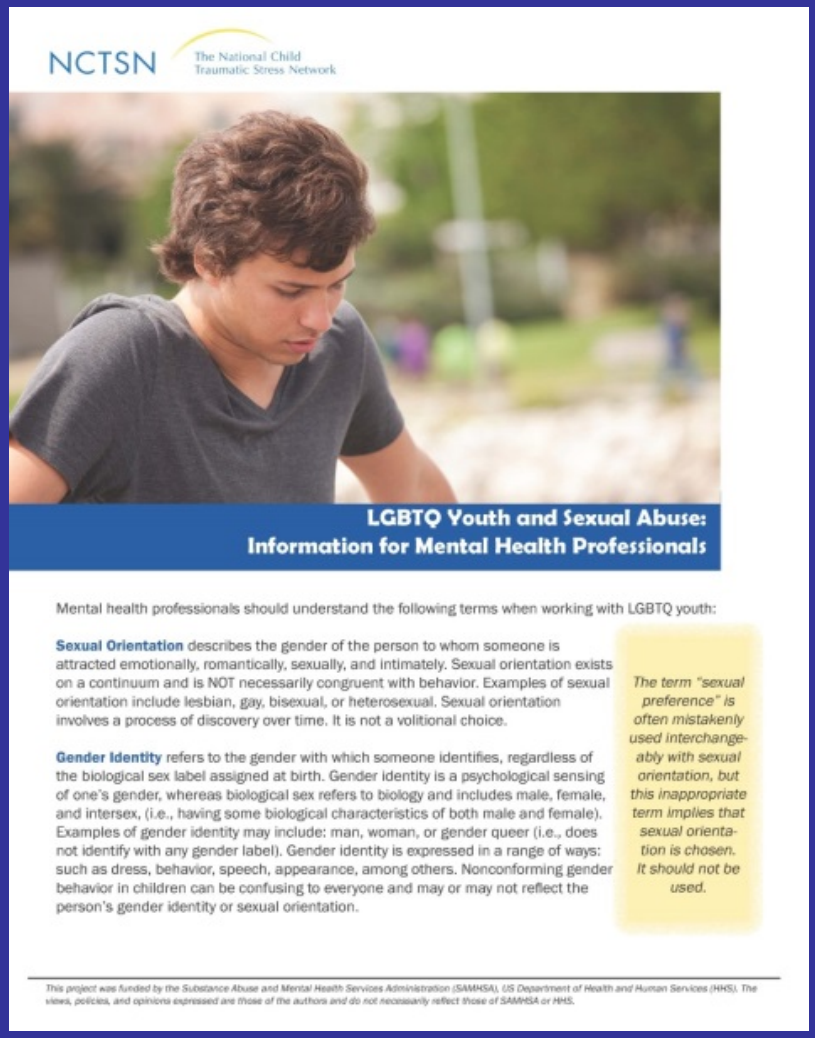

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LGBTQ Youth and Sexual Abuse: Information for Mental Health Professionals

Mental health professionals should understand the following terms when working with LGBTQ youth:

Sexual Orientation describes the gender of the person to whom someone is attracted emotionally, romantically, sexually, and intimately. Sexual orientation exists on a continuum and is NOT necessarily congruent with behavior. Examples of sexual orientation include lesbian, gay, bisexual, or heterosexual. Sexual orientation involves a process of discovery over time. It is not a volitional choice.

Gender Identity refers to the gender with which someone identifies, regardless of the biological sex label assigned at birth. Gender identity is a psychological sensing of one's gender, whereas biological sex refers to biology and includes male, female, and intersex, (i.e., having some biological characteristics of both male and female). Examples of gender identity may include: man, woman, or gender queer (i.e., does not identify with any gender label). Gender identity is expressed in a range of ways: such as dress, behavior, speech, appearance, among others. Nonconforming gender behavior in children can be confusing to everyone and may or may not reflect the person's gender identity or sexual orientation.

The term "sexual preference" is often mistakenly used interchangeably with sexual orientation, but this inappropriate term implies that sexual orientation is chosen. It should not be used.

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Selected Organizations Involved in Child Trauma

- National Federation of Families for Children's Mental Health
- Futures Without Violence
- National Children's Alliance
- Prevent Child Abuse America
- American Academy of Pediatrics
- Child Welfare League of America
- The Carter Center Mental Health Program
- National Center for Cultural Competence
- Hogg Foundation for Mental Health
- Academy on Violence and Abuse
- Office of the Surgeon General

Selected Organizations Involved in Child Trauma

- American Psychological Association
- Mental Health America
- National Military Family Association
- National Council for Behavioral Health
- American Academy of Child and Adolescent Psychiatry
- CHADD (Children and Adults with Attention Deficit Disorder)
- International Society for Traumatic Stress Studies
- American Professional Society on the Abuse of Children
- National Council of Juvenile and Family Court Judges

Selected Organizations Involved in Child Trauma

SO MANY OTHERS....

Future Directions: Broad Issues

- Systems change: Beyond the medical model
- Evidence-Based Treatment/Services
- Reimbursement issues for trauma-related services
- Science
- Cultural Issues: Beyond race and ethnicity
- Consumers
- Public health approach/prevention and reimbursement
- Training: Broad focus

Your Turn:
What do YOU think are important issues for the future?

- Any Topic! Be provocative! Beyond the status quo!

- Possible topics:
  - Integrated Care
  - Child Abuse Within Systems
  - International Collaboration
  - Consumer Advocates
  - Research Topics
  - Role of the Government
  - Role of Caregiver
  - Public Health Approach

.....OR?

Thank You!

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