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.

• 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

Percent depressed or attempted suicide (%)

ACE Score

ACE Score: 0 1 2 3 >=4

Depression
Suicide

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 Symposia

- 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
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
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.
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.
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

- Impaired caregiver: 43.6%
- Loss: 47.9%
- DV: 47.2%
- Neglect: 29.0%
- Emotional abuse: 37.7%
- Physical abuse: 29.9%
- Sexual abuse: 23.9%

Percentage of Children & Adolescents
Single vs. Multiple Trauma Types

Percentage of Children & Adolescents

- Single: 23.2%
- Multiple: 76.9%

NCTSN: The National Child Traumatic Stress Network
CDS September 2010
Children & Adolescents in the Clinical Range: Baseline & Last Follow up

Percentage of Children & Adolescents

<table>
<thead>
<tr>
<th>Category</th>
<th>Baseline</th>
<th>Follow-Up</th>
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<tbody>
<tr>
<td>Behavioral Problems* (n=8880)</td>
<td>41.9</td>
<td>13.2</td>
</tr>
<tr>
<td>Post-Traumatic Stress* (n=2665)</td>
<td>27.1</td>
<td>10.5</td>
</tr>
<tr>
<td>Trauma Symptoms* (n=8839)</td>
<td>9.0</td>
<td>1.5</td>
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*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
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 likely have more severe reactions than a child who witnessed the incident but 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.
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

www.musc.edu/tfcbt
Child Traumatic Stress – Resources

www.nctsn.org

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 policy-making climate and timing considerations?
- What strategies might be most effective in meeting your policy goals?

Review the federal guidelines regarding lobbying (http://ethics.od.nih.gov/topics/Lobby-Publicly/Guide.htm) with your organization and/or the NCTSN 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 agency and department officials: http://www.usa.gov/directory/federal
- State and local officials: http://www.uga.org/cm/d/members/bios and http://tomon.heads.ca.gov/mono/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.

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:

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.
2. Sometimes my upset feelings come out as bad behavior.
3. I have trouble concentrating, paying attention, and sleeping sometimes, because what happened is on my mind.
4. I might have physical reactions like stomach aches, headaches, feeling my heart pounding, and breathing too fast.
5. Sometimes I wonder if the death was my fault.
6. I sometimes think the same thing will happen to me or other people I love.
7. I keep thinking about what happened over and over in my head.
8. Sometimes I don’t think to talk about the person who died, because it’s too hard. I may not tell you about things that happened because I don’t want to upset you.
9. I don’t like to go to some places or do some things that remind me of the person who died, or how my life has changed since the person died, because it gets upset.
10. I have trouble remembering good things about the person because I remember other things that make me sad, scared, or confused, and they get in the way.

YOU CAN HELP ME WHEN YOU:

1. Talk about your feelings and encourage me to talk about mine as long as I feel comfortable.
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. Understand that thoughts about what happened get stuck in my mind. Help me relax at bedtime by reading stories or listening to music and remind me that you keep me safe.
4. Help me do things that make me feel calm, take my mind off things, or slow down my breathing.
5. Reassure me that it was not my fault.
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. 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. Don’t make me talk about what happened. Don’t get mad if I don’t want to talk or about the person.
9. Don’t make me go places if it still makes me too upset or scared.
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.

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Trauma Specific Evidence-Based Practices

Available at NCTSN.org

Summary Table

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<tr>
<th>Treatment Description</th>
<th>Level of Evidence</th>
<th>Description</th>
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<tbody>
<tr>
<td>Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)</td>
<td>Available at NCTSN.org</td>
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AF-CBT represents an approach to working with physically abused children or their offending caregivers that incorporates conceptual and therapeutic principles/procedures from several areas including learning/behavioral family systems, cognitive therapy, and developmental victimology. AF integrates several behavior therapy and CBT procedures that target specific and parent characteristics related to the abusive experience and the context in which coercion or aggression occurs. Thus, this approach addresses parent and family roles for correlates of physical abuse and sequelae exhibited by children following the abuse. Treatment emphasis is on instruction in specific intrapsychic (e.g., cognitive, affective) and interpersonal (e.g., behavioral) skills designed to promote the expression of prosocial and discourage the use of coercive/aggressive behavior at both the family and individual levels. For a detailed description, see Kilko, D. J., & Sweeney, Assessing and treating physically abused children and their families: a behavioral approach. Thousand Oaks, CA: Sage Publications.

Target Population

AF-CBT is appropriate for use with physically abusive/aggressive preschool 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 depression) are not appropriate candidates for this approach.

Level-of-Evidence Criteria


Treatment Classification System

1. Well-supported, efficacious treatment
2. Supported and probably efficacious treatment
3. Supported and accepted treatment
4. Promising and acceptable treatment
5. Novel and experimental treatment
6. Concerning treatment
Child Traumatic Stress – Resources
www.nctsn.org

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

MILITARY FAMILIES ARE RESILIENT ★

Military families are defined as all family members serving, deployed, or retired from the Armed Forces. They face challenges similar to their civilian counterparts, but also face unique challenges such as frequent deployments, separation, and reunion. Military families are resilient in their ability to adapt and cope with these challenges.

www.militaryfamilyresilience.com

MILITARY FAMILY SEPARATIONS ARE DIFFICULT AND COMPLICATED ★

Military family separations can be extremely challenging for both the service member and their family members. They often face long deployments, frequent moves, and the uncertainty of a service member's return. Separation can put a strain on family relationships and lead to feelings of isolation and anxiety.

www.georgiahealth.org

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 assigned at birth. Gender identity is a psychological sense 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.

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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!

Contact:
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www.nctsn.org