Building a Trauma-informed System of Care for Children in Connecticut

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National Prevalence of Trauma Exposure in Childhood

- **By the time they are 15-17 years old, most children are exposed to at least one, and often multiple, traumatic events**
- **71%** of youth up to age 17 reported trauma in past year (most 3+)[1]
  - Child sexual abuse: 17% boys, 28% girls[2]
  - Domestic violence exposure: 20%-40% of all children[3]
- **Most trauma exposure is never reported**

[1]Finkelhor (2005)
[2]Rind, Tromovitch, & Bauserman (1998)
[3]Evans, Davies, & DiLillo (2008)

Prevalence of Children's Trauma Exposure in Connecticut's Systems

- **Outpatient Child Guidance Clinics**
  - 22,344 children served per year
  - **53% report history of trauma**
  - **60-80%** in 22 agencies trained to deliver trauma-focused practices
- **Juvenile Justice System**
  - 10,000 children (0-16) served per year
  - 2,200 admitted to detention
  - >**80% report history of trauma**

- **Total** in these systems alone estimated to be approximately **20,000 children per year in Connecticut**

What are potentially traumatic events?

- Physical Abuse
- Sexual Abuse
- Chronic Neglect
- Life threatening accident or injury
- Chronic illness or painful medical procedures
- Loss of parent, sibling or loved one
- Domestic Violence
- Community Violence
- School Violence
- Dating Violence
- Exposure to natural disasters
- Exposure to war

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What are typical reactions to traumatic events?

- **Overwhelming, unanticipated danger** that cannot be mediated/processed
- Leads to **fight or flight response** (normal methods for decreasing external danger)
- Results in **difficulties in regulating behavior** that compromises affective, cognitive and behavioral responses
- Leads to loss of **internal control** and normal functioning

Post-traumatic symptoms in children: Chronic Symptoms

Four major symptom areas:

1. Re-experiencing the trauma
2. Avoidance & fear
3. Increased arousal
4. Decreased responsiveness, numbing & regression

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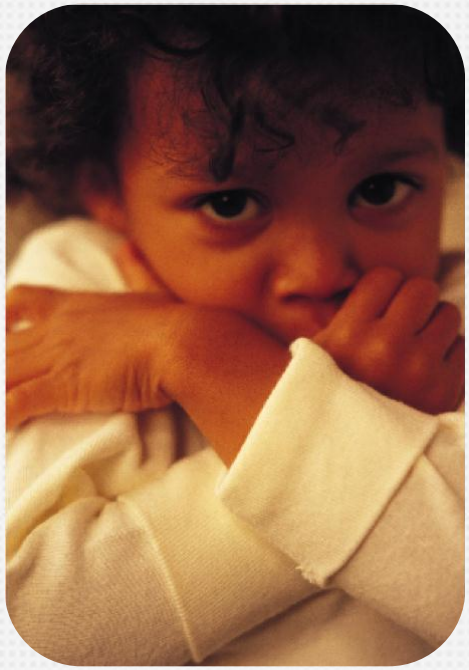
Traumatic Stress in Children: Risk for Misdiagnosis

- Traumatic stress can be a contributing factor and cause of a range of other disorders in children:
  - ADHD
  - Anxiety
  - Depression
  - Bipolar Disorder
  - Oppositional Defiant Disorder
  - Conduct Disorder
  - Specific Phobias
  - Learning/academic difficulties



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Adverse Childhood Experiences (Trauma Exposure)

- **Abuse and Neglect** (e.g., psychological, physical, sexual)
- **Household Dysfunction** (e.g., domestic violence, substance abuse, mental illness)
- **Exposure to Injury or Violence** (e.g., medical trauma, community violence, disaster)

Impact on Child Development

- **Neurobiological Effects** (e.g., brain abnormalities, stress hormone dysregulation)
- **Psychosocial Effects** (e.g., poor attachment, poor socialization, poor self-efficacy)
- **Health Risk Behaviors** (e.g., smoking, obesity, substance abuse, promiscuity)

Long-Term Consequences

Disease and Disability

- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational abuse

Social Problems

- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services

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Data: Felliti & Anda et al, 1998
www.AceStudy.org, www.nasmhpd.org

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Long-term Consequences into Adulthood

Disease and Disability

- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational abuse

Social Problems

- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services

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www.AceStudy.org

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Victimization and Offending
(Kilpatrick et al, 2003)

- **47%** of sexually assaulted boys reported engaging in delinquent acts, compared with only **17%** of those not sexually assaulted.
- **20%** of sexually assaulted girls engaged in delinquent acts, five times higher than the delinquency rate of girls who had not been sexually assaulted **(5%)**
- **47%** of boys who had been physically assaulted had committed a serious offense, compared with **10%** of boys who were not assaulted

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Maltreatment and Offending

- People who experience any type of maltreatment during childhood **are more likely to be arrested later in life**—either as a juvenile or adult.
- Being abused or neglected increased the likelihood of arrest as a **juvenile by 59%** and as an adult by **28%** and for a violent crime by **30%**
- Abused and neglected youth were **younger at first arrest, committed nearly twice as many offenses and were arrested more frequently.**

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Dire Consequences

- Mortality
- In a 2005 study, Linda Teplin found that more that **10% of children** she identified in the juvenile justice system experiencing traumatic stress **were dead 10 years later**.
- In Connecticut, 53% of children in detention screen positive for PTSD.

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Childhood Trauma and Public Health

- Single greatest ***preventable*** cause of mental illness
- Single greatest ***preventable*** cause of drug and alcohol abuse in women
- Single greatest ***preventable*** cause of HIV high-risk behavior (IV drugs, promiscuity)
- Significant ***contributor*** to leading causes of death (heart disease, cancer, stroke, diabetes, suicide)

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OhioCanDo4Kids.Org

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Cost Estimates of Child Maltreatment

United States (in 2007 dollars)

- Direct costs ➔ $33 Billion
- Indirect costs ➔ $71 Billion

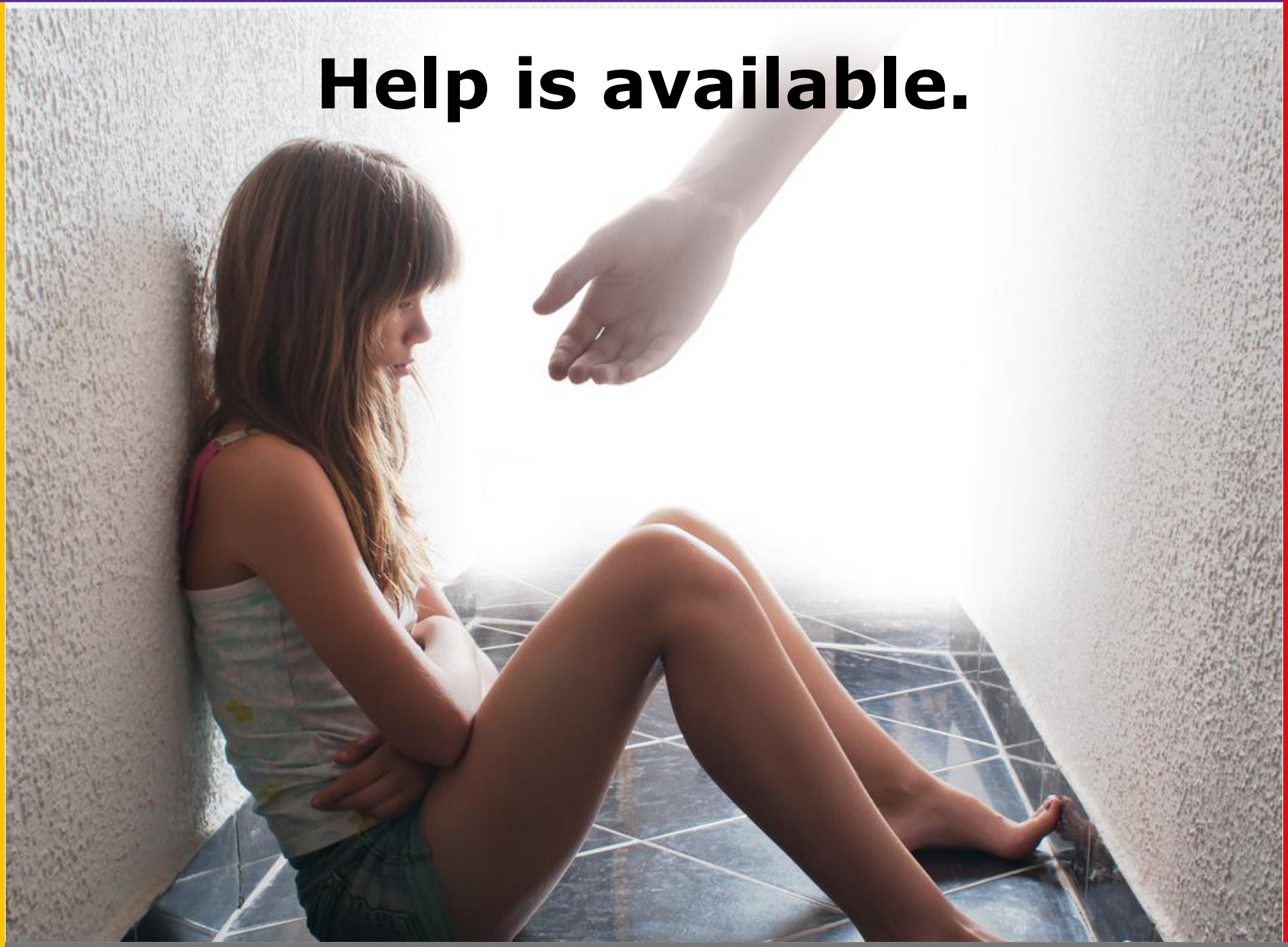
- Total annual costs ➔ **$104 Billion**

Wang & Holton – Economic Impact Study, Prevent Child Abuse America, 2007

Trauma is to Mental Health as Smoking is to Cancer!

Steven Sharfstein, MD
President, American Psychiatric Association

Help is available.



Connecticut History of Trauma-informed System Development

History of in-home evidence-based practices

Growing awareness about child traumatic stress

Desire among key stakeholders to create a trauma-informed system of care

Desire to implement evidence-based practices in outpatient community-based settings

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Major Efforts to Develop Trauma-informed Care for Children

- **Screening and Identification** of at risk children and youth
  - Universal trauma screening in 22 outpatient clinics
  - Universal trauma screening for children in detention
  - Ongoing efforts to screen children in child welfare system
  - Screening in pediatric settings and schools
  - Training of law enforcement
- **Evidence-based practices** disseminated statewide:
  - TF-CBT, TARGET, DBT, CFTSI, CANY
- **Trauma-informed approaches** in milieu settings (TF-CBT, Risking Connection & Restorative Approach)

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Creating a Trauma-informed Child Welfare System

$3.2 million CONCEPT grant, 5 year federal grant awarded to DCF to improve trauma-focused care for children in the child welfare system

① **Workforce development** (trauma-informed care)

② **Universal trauma screening & referrals**
- Screening: by DCF staff
- Assessment & Treatment: by Community Providers

③ **Dissemination of Trauma-focused Treatment**
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Child & Family Traumatic Stress Intervention (CFTSI)

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Funding for the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) was provided by the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #0169

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Trauma Screening, Identification, and Referral

Educating Practices in the Community (EPIC)

- Developed by CHDI
- Utilizes academic detailing model
- Provides training and links to community-based resources

EPIC Trauma Module delivered to:

- 21 Pediatric Offices (392 physicians, nurses, and staff)
- 10 School Districts (728 school nurses, psychologists, social workers and teachers)

Over 1,000 professionals trained in Connecticut to screen for trauma exposure and stress symptoms

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Trauma Screening by DCF

- Through CONCEPT grant, goal is to enhance DCFs capacity to identify and respond to children who have experienced trauma
- To be implemented statewide in 2014
- Required trauma screening of all children ages 4-18 receiving ongoing services in DCF (~14,000 children)
  - Children will be screened using standardized trauma screening tool at time of case plan development and case review
  - Referral to trauma-focused treatment provider if screen positive

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Child and Family Traumatic Stress Intervention (CFTSI)

- Developed by Marans & Berkowitz
- 4-session EBT peritraumatic intervention (Berkowitz, Stover, & Marans, 2011)
- Prevent PTSD/child traumatic stress
- Works with child and caregiver
  - Increase awareness about traumatic stress
  - Develop skills to manage reactions
  - Provide support to family following trauma

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Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

- Developed by Cohen, Mannarino, & Deblinger
- Evidence-Based Treatment: 8+ studies
- Manualized & flexible
- Target population
  - Children/adolescents 3-18 suffering from traumatic stress
  - Goals: Improve child (& parent) symptoms by helping them manage powerful emotions related to traumatic event(s)
- Caregiver involvement in treatment
- Greater improvements in:
  - Child PTSD, depression, anxiety, shame, behavior problems
  - Parent distress, support, parenting practices, depression

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Statewide Dissemination of TF-CBT

- DCF invested in original training and dissemination of model between 2007-2010 training 16 agencies

- Subsequent federal grant from the Administration of Children and Families (CONCEPT) to disseminate TF-CBT to additional 12 agencies and integrate into child welfare system and CFTSI to 8-10 agencies across Connecticut.

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TF-CBT Statewide Dissemination

- 22 agencies trained to date, six more next year
- Any child in Connecticut within one hour drive of agency
- Service reimbursed as outpatient care by Medicaid or private insurance
- Limited capacity and access (especially for children with private insurance)
- Inadequate reimbursement for providers?
- To date 384 clinicians and staff trained across the state
- Highly effective with strong outcomes
- Only 4.8% of children receive TF-CBT in outpatient clinics

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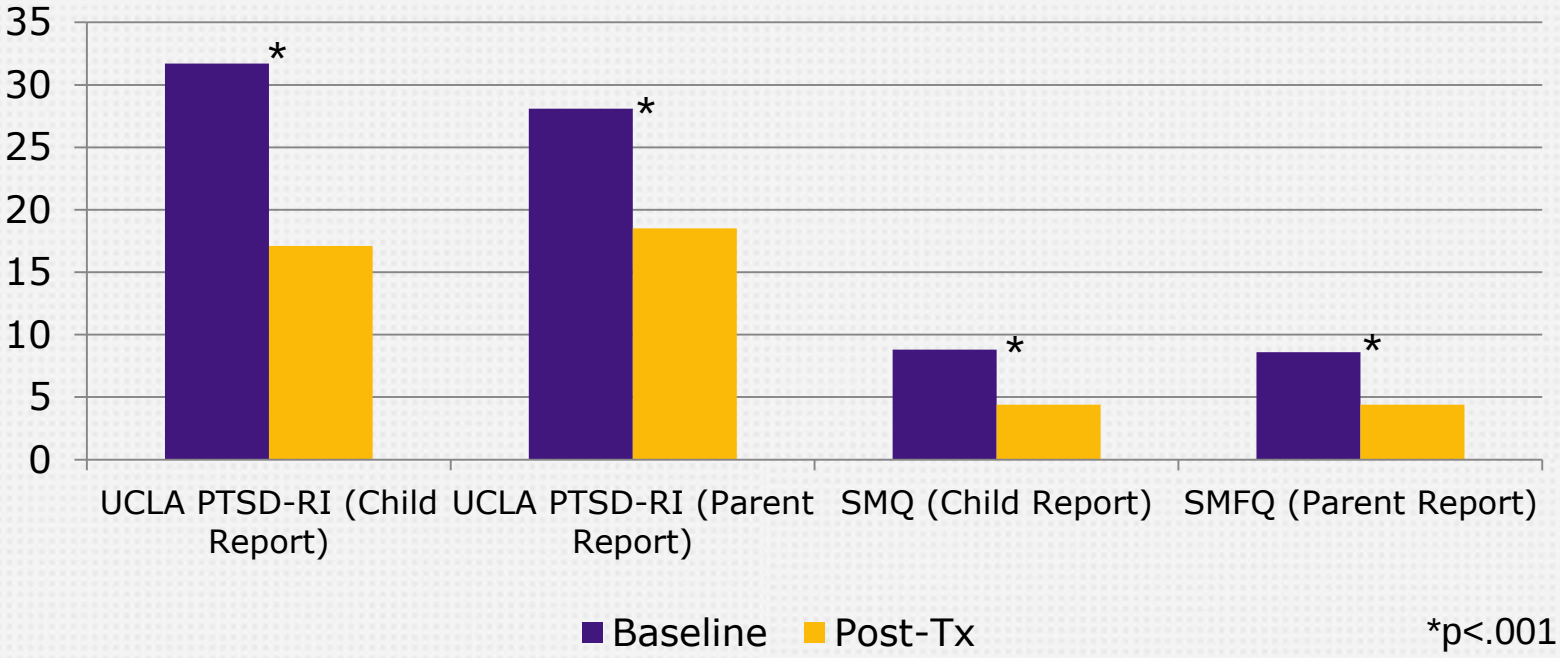
Children Receiving TF-CBT in CT

- **2,369 children served** as of September, 2012
- Average age = **11.5 years old** (range from 3 – 21)
- 60% female
- Living situation:
  - 65% with one or both biological parents
  - 19% in a foster or adoptive home
  - 17% in other settings/unknown
- 14% African American; 27% Latino; 46% Caucasian
- 32% have DCF involvement
- Most common "worst" traumatic events were **sexual abuse, physical abuse/injury, death of a loved one, and separation from caregiver**
- Children report average of **7.8 different types of trauma exposure**

TF-CBT Outcomes in CT (N=391)



***Remission of PTSD diagnosis in 82% of children** with likely PTSD diagnosis at baseline who completed treatment (based on UCLA PTSD-RI Severity)

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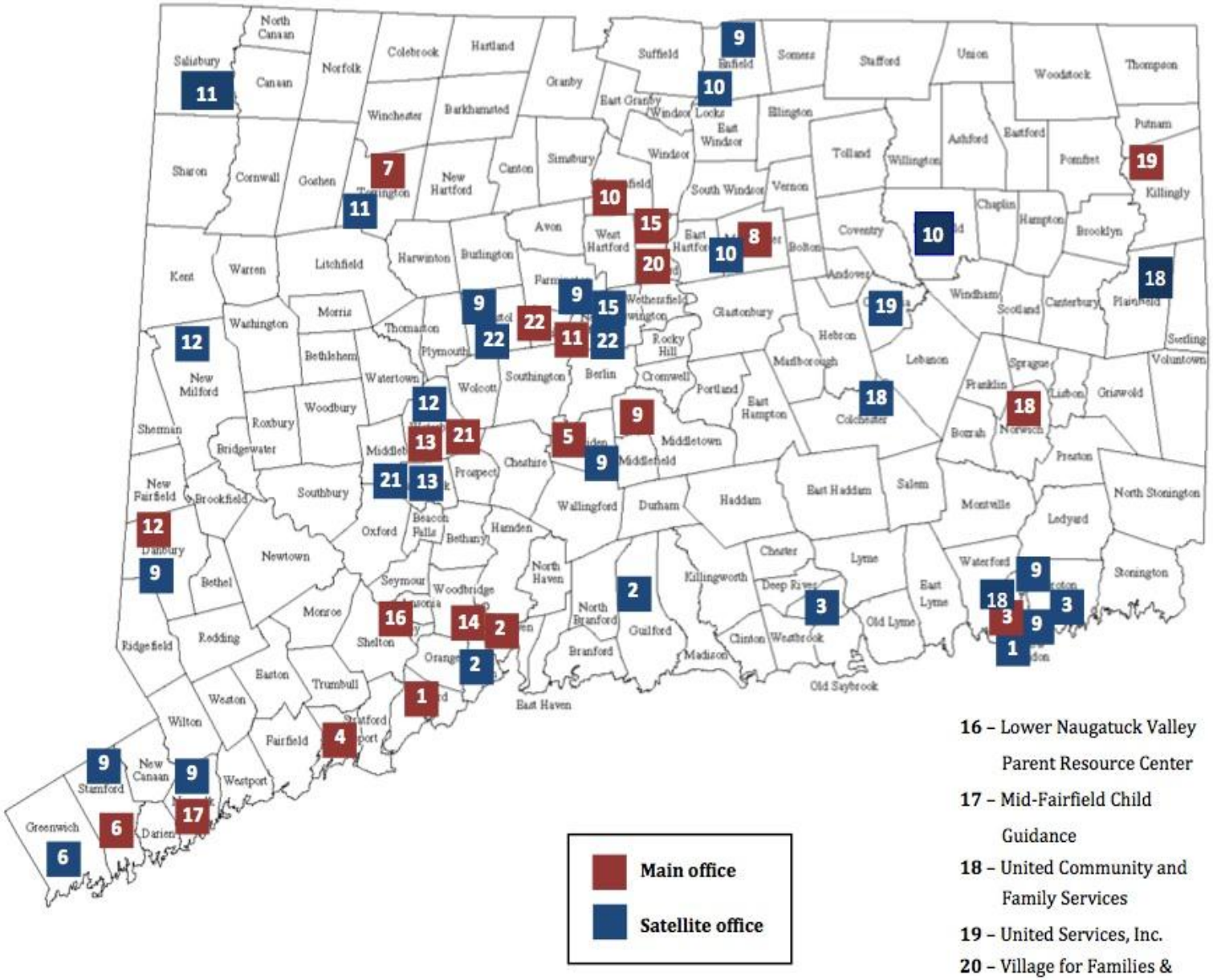
Additional Benefits of TF-CBT Treatment

- Reduced no-show rate
- Increased staff morale
- Shorter length of stay in treatment
- Improved staff attitudes about EBTs
- Likely future cost savings



TF-CBT Agencies

1 – Bridges, A Community Support System

2 – Clifford W. Beers Guidance Clinic

3 – Child & Family Agency of Southeastern CT

4 – Child and Family Guidance Center

5 – Child Guidance Clinic of Central CT

6 – Child Guidance Clinic of Southern CT

7 – Center for Youth and Families/Charlotte Hungerford Hospital

8 – Community Child Guidance, Inc.

9 – Community Health Center

10 – Community Health Resources

11 – Community Mental Health Affiliates, Inc.

12 – Family and Children's Aid

13 – Family Services of Greater Waterbury, Inc.

14 – Hill Health Center Corporation

15 – Klingberg Comprehensive Family Services

16 – Lower Naugatuck Valley Parent Resource Center

17 – Mid-Fairfield Child Guidance

18 – United Community and Family Services

19 – United Services, Inc.

20 – Village for Families & Children, Inc.

21 – Wellmore Behavioral Health

22 – Wheeler Clinic

Summary

1. Trauma exposure and related symptoms are a significant public health concern
2. It is important to screen and identify children early and connect families to appropriate services and supports.
3. Connecticut has a range of available effective services to help children and families.
4. Access to these services is limited and capacity is significant issue.
5. Need for adequate reimbursement for services and ongoing training and quality assurance to ensure good outcomes.

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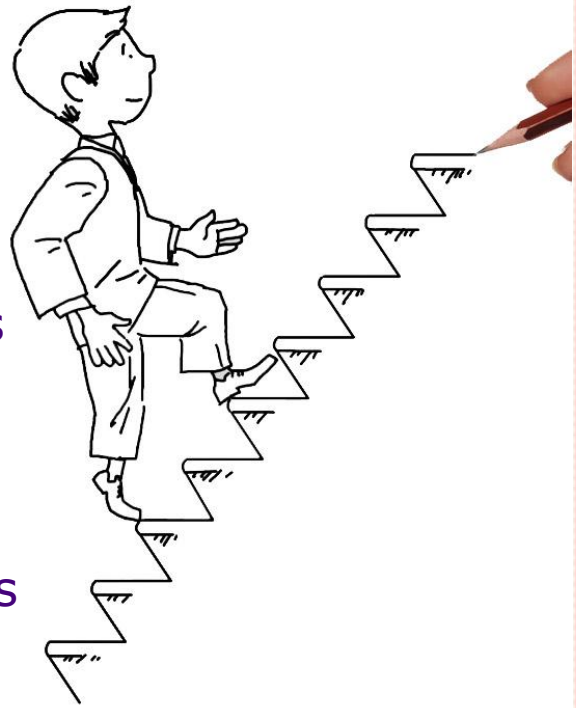
Challenges

- Need for additional training of professionals to screen (especially pediatrics)
- Lack of community-based providers to refer identified children
- Limited capacity of TF-CBT and other trauma-focused providers
- Limited access, especially by those with private insurance
- Limited treatments for young children (ages 0-5) and adults
- Limited to no access in school-based settings
- Extra cost/time to utilize evidence-based treatments and insufficient reimbursement
- Staff turnover
- Ongoing training and quality assurance needs



Recommendations

Build and strengthen a **trauma-informed** system of care across the following systems:

1) Pediatrics
2) Behavioral Health
3) Early Childhood
4) Schools
5) Child Welfare
6) Juvenile Justice

Recommendations

- Increase support for training including:
  - Pediatrics
  - Child Welfare
  - School and early care and education staff
  - Juvenile Justice
  - Community-based Providers
- Identify and train additional providers to deliver trauma-focused services
- Building capacity of existing programs to serve more children
- Ensure equal access to effective trauma-focused services
- Ongoing training and quality assurance for existing programs
- Increased access to trauma-focused services in juvenile justice settings
- Increased the range of evidence-based trauma-focused services available including school-based (e.g., CBITS) and early childhood (e.g., Child FIRST and PCIT)
- Ensuring adequate reimbursements and incentives for providing evidence-based trauma-focused practices for providers
- Collect outcome data to ensure programs are working

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Together we can create a system to build a better future for our most vulnerable children

Contact Information

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Questions & Answers