West Virginia Service Delivery & Development Work Group  
Performance/Best Practice Guidelines – Trauma

I. Target Population

The target population for this workgroup is youth between the ages of 5 and 21 who have experienced traumatic experiences and who are experiencing difficulties in one or more life domains.

II. Desired Outcome

The desired outcome for this workgroup is twofold:

➢ Identify common components of trauma informed care
➢ Identify best practices for trauma specific treatment.
➢ Make recommendations for changes in system and practice in order to create a system of care that is knowledgeable of the impact of trauma and one that can respond to needs in such a way as to foster recovery and minimize retraumatization.

III. Background Information

Trauma Defined: Trauma is defined as “an emotional shock that creates significant and lasting damage to a person’s mental, physical and emotional growth.” Traumatic experiences can significantly alter a person’s perception of themselves, their environment, and the people around them. In effect, trauma changes the way people view themselves, others and their world and can impact the individual’s safety, well-being, and permanence.

Examples of traumatic experiences may include:

<table>
<thead>
<tr>
<th>Loss of a loved one</th>
<th>Abandonment</th>
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<tbody>
<tr>
<td>Accidents</td>
<td>Homelessness</td>
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<tr>
<td>Community/school violence</td>
<td>Bullying, including cyber-bullying</td>
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<td>Domestic violence</td>
<td>Neglect</td>
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<tr>
<td>Physical abuse</td>
<td>Sexual abuse</td>
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<tr>
<td>Emotional/verbal abuse</td>
<td>Man-made or natural disasters</td>
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<td>Man-made or natural disasters</td>
<td>Terrorism</td>
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<td>Refugee and War Zone trauma.</td>
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Types of Trauma: Trauma is characterized in three types, depending of the nature and impact of traumatic experiences.

Acute trauma is a single traumatic event that is limited in time. Examples include:

- Serious accidents
- Community violence
- Natural disasters (earthquakes, wildfires, floods)
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being shot or raped)
• During an acute event, children go through a variety of feelings, thoughts, and physical reactions that are frightening in and of themselves and contribute to a sense of being overwhelmed.

**Chronic trauma** refers to the experience of multiple traumatic events.

• These may be multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse, neglect, or bullying.
• The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact.

**Complex trauma** describes both exposure to chronic trauma—usually caused by adults entrusted with the child’s care—and the impact of such exposure on the child.

• Children who experienced complex trauma have endured multiple interpersonal traumatic events from a very young age.
• Complex trauma has profound effects on nearly every aspect of a child’s development and functioning.

**System induced trauma** can occur as the result of traumatic removal from home, admission to a detention, inpatient or residential facility or multiple placements within a short period of time or over time.

**Prevalence:**

A history of trauma is common among youth (especially youth from diverse cultural backgrounds) and adults who receive services from human services organizations or who are involved in child welfare and criminal justice systems:

• 93.2% of males and 84% of females reported at least one traumatic experience
• Males were most likely to report witnessing violence, while females were most likely to report being victimized by violence (Hennessey et al., 2004)
  ▪ 70-80% of mental health clients have severe trauma histories
  ▪ In state hospitals, estimates range up to 95% of patients have experienced unresolved trauma
  ▪ 90% or more of women in jails and prisons are victims of physical or sexual abuse
  ▪ Up to 2/3 of men and women in substance abuse treatment report childhood abuse or neglect
  ▪ Similar statistics exist for foster care, juvenile justice, homeless shelters, welfare programs, etc
  ▪ Boys who experience or witness violence are 1000 times more likely to commit violence.

**The Adverse Childhood Experiences (ACE) Study:**

The ACE (Adverse Childhood Experiences) Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. The ACE Study is the largest scientific research study of its kind, analyzing the relationship between multiple categories of childhood trauma (ACEs), and health and behavioral outcomes later in life.
The ACE Study was designed to assess what we considered to be “scientific gaps” about the origins of risk factors. These gaps are depicted as the two arrows linking Adverse Childhood Experiences to risk factors that lead to the health and social consequences higher up the pyramid. Specifically, the study was designed to provide data that would help answer the question: “If risk factors for disease, disability, and early mortality are not randomly distributed, what influences precede the adoption or development of them?” The hope was to provide scientific information that would be useful for developing new and more effective prevention programs.

The ACE Study examined the childhood experiences of 18,000 participants has demonstrated that trauma is far more prevalent than previously recognized.

- 50% of study participants reported at least one adverse childhood experience and 25% reported at least two or more untreated trauma underlies a range of health problems and social problems such as prostitution, delinquency and criminal behavior.
- Childhood experiences often underlie suicide attempts (67% of all suicide attempts, 64% of adult suicide attempts, 80% of child/adolescent suicide attempts).
- Adverse childhood experiences are underlying factors for chronic depression, serious and persistent mental health challenges, addictions, victimization of rape and domestic violence, and serious health risks.
- Four or more traumatic experiences shorten life expectancy by 20 years.

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**ACES Pyramid**

![ACES Pyramid Diagram](image-url)
The ACE Study demonstrated the tragic consequences of unaddressed childhood trauma well-being, social functioning, health risks, disease burden, health care costs, and life expectancy. The following graphs outline the correlation between childhood trauma and physical and emotional health problems as identified from the ACE Study.

Challenges to Healing

Despite the fact that there is incontrovertible evidence that trauma can have a profound impact on the functioning and health of individuals, there are a number of challenges to healing, including:

- There is a general lack of understanding of the prevalence and impact of trauma on behavior, development, relationships, and survival strategies.
- The effects of trauma can be seen in both problems directly related to trauma and problems that initially appear to be unrelated.
- Disparities exist in access to services and supports that facilitate healing.
- Individuals most impacted by trauma often have no idea that trauma is at the core of their distress.
- Providers often do not see being trauma-informed as essential to their primary service delivery.
- Many common practices in human service settings (behavioral health, education, juvenile and criminal justice) are experienced as emotionally unsafe and disempowering and retrigger trauma reactions.
Trauma-Informed Care Defined:

Trauma Informed Care is care in which all components have been considered and evaluated in light of a basic understanding of the role that trauma plays in the lives of children/adolescents/adults. Trauma-informed care provides the foundation for a basic understanding of the psychological, neurological, biological, and social impact that trauma and violence have on individuals. It incorporates proven practices into current operations to deliver services that acknowledge the role that trauma plays in the lives of most of the individuals entering our systems. Care is designed to accommodate the vulnerabilities of trauma survivors and is delivered in a way to avoid inadvertent retraumatization and facilitate participation in treatment and recovery.

“A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.” (National Traumatic Stress Network 2012)

A Comparison of Approaches

<table>
<thead>
<tr>
<th>Traditional Approaches</th>
<th>Trauma-Informed Approach</th>
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<tbody>
<tr>
<td>• Problems/symptoms are discrete and separate</td>
<td>• Problems/symptoms are inter-related responses to or coping mechanisms to deal with trauma</td>
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<tr>
<td>• Hierarchical</td>
<td>• Shares power/decreased hierarchy</td>
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<tr>
<td>• Over-diagnosis of Schizophrenia &amp; Bipolar D/O, Conduct D/O &amp; singular addictions</td>
<td>• Recognition of primary/secondary diagnosis of trauma</td>
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<td>• Client behavior is viewed as “manipulative” or “working the system”</td>
<td>• Assess for traumatic histories/symptoms</td>
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<td>• People providing shelter/services are the experts</td>
<td>• Recognition of cultures and practices that are retraumatizing</td>
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<tr>
<td>• Primary goals are defined by service providers &amp; focus on symptom reduction</td>
<td>• Shares power/decreased hierarchy</td>
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<tr>
<td>• Lack of education on trauma prevalence &amp; “universal” precautions</td>
<td>• Client behaviors are viewed as adaptations/ways to get needs met</td>
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<tr>
<td>• Cursory or no trauma assessment</td>
<td>• Families are active experts and partners with service providers</td>
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<tr>
<td>• Reactive – services and symptoms are crisis driven &amp; focused on minimizing liability</td>
<td>• Primary goals are defined by families &amp; focus on recovery, self-efficacy, &amp; healing</td>
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<tr>
<td>• Views clients as broken, vulnerable &amp; needing protection from themselves</td>
<td>• Proactive – preventing further crisis &amp; avoiding retraumatization</td>
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<tr>
<td>• “Tradition of Toughness” valued as best care approach</td>
<td>• Understands providing choice, autonomy &amp; control is central to healing</td>
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<tr>
<td>• “Client-blaming” as fallback position without training</td>
<td>• Caregivers/supporters – collaboration</td>
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<tr>
<td>• Rule enforcing – compliance driven</td>
<td>• Address training needs of staff to improve knowledge &amp; sensitivity</td>
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<tr>
<td>• Closed system – advocates discouraged</td>
<td>• Power/control minimized – constant attention to culture</td>
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<td></td>
<td>• Transparent systems</td>
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Principles of a Trauma-Informed System

The provision of “trauma-informed care” is a seminal concept in emerging efforts to address trauma in the lives of children, youth and adults. In a trauma-informed system, trauma is viewed as “a defining and organizing experience that forms the core of an individual’s identity.”

The following principles reflect the values and practices that characterize the delivery of trauma-informed care. They are not confined to service providers only, but are applicable to all child serving systems, e.g. child welfare, education, behavioral and physical health, and juvenile justice. They advocate respectful, welcoming, safe, and helpful environments that understand the impact of trauma on all aspects of one’s development, functioning, and ability to understand and cope.

A trauma-informed approach involves fundamental shifts in thinking and practice at all levels. Trauma-informed cultures offer the possibility of enhanced collaboration for all participants in the human service system.

Principles of a Trauma-Informed System

- Recovery is possible
- Integrated Care
- Healing happens in relationships/trustworthiness
- Share power, governance, evaluation
- Understand trauma & its impact & minimize retraumatization
- Support empowerment, choice & autonomy
- Ensure cultural competence
- Promote safety, respect, acceptance

Trauma Specific Care Defined:

Trauma specific care is care that is designed to treat the actual psychological and behavioral manifestations of trauma, including grounding techniques that help trauma survivors manage
dissociative symptoms, desensitization therapies that help survivors accept and tolerate painful memories and sensory triggers, and behavioral therapies that teach skills for modulating emotions.

Trauma can result in psychological and behavioral manifestations that impede healthy functioning and require intervention. Trauma specific interventions are designed specifically to address the consequences of trauma and facilitate coping and healing.

Common mental health diagnoses in traumatized individuals include:

1. Mood Disorders
2. Anxiety Disorders
3. Personality Disorders
4. Behavior Disorders
5. Severe and Persistent Mental Illness
6. Eating Disorders
7. Psychotic Disorder
8. Substance Abuse Disorders.

IV. Summary of Current Practice

Trauma S-W-O-C Analysis

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tr>
<td>Recognition of severity of impact of trauma increasing</td>
<td>Lack of understanding of impact of trauma among child serving systems</td>
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<tr>
<td>WVCANS incorporates trauma</td>
<td>Challenge with diagnosis, other trauma misdiagnosed as other psychiatric disorders, including over-diagnosis of RAD</td>
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<tr>
<td>Increasing training on trauma</td>
<td>Lack of trauma specific services, from community-based to residential</td>
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<tr>
<td>Expertise exists</td>
<td>No DSM code for complex trauma in childhood</td>
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<tr>
<td>Strong motivation from State/providers</td>
<td>Tend to try to control youth behaviors without addressing underlying trauma</td>
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<tr>
<td>Better brain technology to detect impact/injuries</td>
<td>Adequate reimbursement for treating trauma (Medicaid &amp; other third party funders)</td>
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<tr>
<td>Good research base</td>
<td>Expensive to obtain certification in trauma</td>
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<tr>
<td>Bridge Program trauma specific residential</td>
<td>Juvenile Justice system lacks knowledge, understanding</td>
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<tr>
<td>DSM revision may include complex trauma as diagnostic category</td>
<td>Lack of knowledge of education personnel, rigid structures</td>
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<tr>
<td>Revised CAPS will trigger specific trauma assessment</td>
<td>Trauma specific assessments not commonly used</td>
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<td>Jacobs Law will drive early assessment &amp; intervention</td>
<td>Lack of understanding of connectedness between trauma, mental health, substance abuse</td>
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<td>Funding often prevents working with families to extent necessary</td>
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<td>Challenge of children testifying in court, lack of preparation, can make poor witnesses</td>
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<td>Lack of collaboration between child-serving systems, agencies, providers, families</td>
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<td>Foster care – not enough, lack of matching, too easy to get kicked out, lack of transition, lack of treatment foster care</td>
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<td>Over-reliance on residential care instead of</td>
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<td>Community-based services</td>
<td>Opportunities</td>
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<tr>
<td>• Lack of family involvement – access to services</td>
<td>• Statewide implementation of trauma informed care among all child serving systems/providers</td>
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<tr>
<td>• Lack of experiential trained therapists (play, art, music, psychodrama, etc.) – lack of reimbursement also</td>
<td>• Implement universal screening of trauma, mental health &amp; substance abuse in all child serving systems</td>
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<td>• SAMS may inadvertently miss trauma or let kids fall through the cracks</td>
<td>• Increase clinical capacity of professionals to provide trauma specific care</td>
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<td>• Lack of understanding of sexually acting out kids (sex offenders vs. abuse reactive vs. normal sexual behavior)</td>
<td>• Work with higher education to better prepare professionals</td>
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<td>• Vicarious trauma/burnout of staff</td>
<td>• Expanded school based health/mental health to include trauma screening/referral</td>
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<td>• MDTs overlooks trauma</td>
<td>• Work with licensure boards to include importance of training in trauma</td>
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<tr>
<td>• Lack of staff trained in forensic interviewing</td>
<td>• Implement trauma assessment in all child-serving systems</td>
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<td>• Increasing disrupted adoptions</td>
<td>• Utilize RCRT to identify trauma as need</td>
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<td>• Child Advocacy Centers</td>
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<td>• Change Medicaid reimbursement to better treat trauma</td>
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<td></td>
<td>• Require trauma informed/specific care for all funding opportunities</td>
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<td></td>
<td>• Incorporate trauma informed care into child care licensing standards</td>
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<td></td>
<td>• Use Building Bridges initiative to utilize/expand expertise/services &amp; reduce duplication</td>
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<td>• Create broad training initiatives &amp; build in consultative/certification opportunities</td>
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<td>• Create blended funding</td>
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<td></td>
<td>• Create support services, e.g. respite, crisis services for foster/biological/adoptive families</td>
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<td>• Revamp foster care system, e.g., develop treatment foster care, better training of foster families in trauma, reimbursement, matching, transitioning, establish respite/crisis, expectations of maintaining youth in foster care</td>
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<td>• Establish outcomes</td>
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<td>• Training of first responders</td>
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<td></td>
<td>• Utilize primary care to identify trauma</td>
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Criteria for Building a Trauma-Informed System of Care (President’s New Freedom Commission on Mental Health’s Achieving the Promise report (2003):

- A designated trauma function and focus in the state mental health department
- State trauma policy or position paper
- Workforce orientation, training, support, competencies and job standards related to trauma
- Linkages with higher education to promote education of professionals in trauma
- Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights
- Trauma policies & services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status
- Systems integration/coordination among systems of care serving persons with trauma histories & including life-space perspective
- Trauma-informed disaster planning & terrorism response
- Financing criteria & mechanisms to pay for best practice trauma treatment models & services
- Clinical practice guidelines for working with people with trauma histories
- Procedures to avoid retraumatization and reduce impacts of trauma
- Rules, regulations, & standards to support access to evidence-based & emerging best practices in trauma treatment
- Research, needs assessments, surveys, data to explore prevalence & impacts of trauma, assess status of services, and support more rapid implementation of evidence-based & emerging best practice trauma treatment models
- Trauma screening & assessment
- Trauma-informed services & service systems
- Trauma-specific services, including evidence-based and emerging best practice treatment models.

V. Trauma Assessment

The impact of trauma is not always recognized. Given the significant impact of trauma, it is crucial that all individuals who enter a human services system be screened for a history of traumatic experiences, and further assessed for post-traumatic sequelae and interaction with other mental health/substance abuse/physical health conditions when appropriate. There are three basic approaches to screening and assessment of trauma and post-traumatic sequelae through tools and instruments:

- Instruments that directly measure traumatic experiences or reactions
- Broadly based diagnostic instruments that include PTSD subscales
- Instruments that assess symptoms not trauma specific but commonly associated symptoms of trauma.

A number of assessments to assess trauma history and/or trauma specific symptoms for both children and adults are outlined below.

Children and Adolescents:
- Trauma Symptom Checklist for Children (TSCC)
- Trauma Symptom Checklist for Young Children (TSCYC)
- Child Sexual Behavior Inventory (CSBI)
- UCLA PTSD Index for DSM-IV
- Chadwick Center Trauma History Checklist
- Achenbach Child Behavior Checklist
- WV Trauma-Informed CANS (Child & Adolescent Needs Strengths Assessment).

Adults:
- Trauma Assessment for Adults (TAA)
- PTSD Checklist for Adults (PCL-A)
- Evaluation of Lifetime Stressors (ELS)
- Trauma History Screen (THS)
- UCLA Adult PTSD Scale
- Traumatic Events Screening Inventory (TESI)
- Trauma History Questionnaire (THQ).

Evidence Based Trauma Specific Interventions:

Research was conducted to identify evidence based clinical practices that can be implemented to mitigate traumatic stress reactions. These interventions include:

- Sanctuary Model
- Seeking Safety
- Trauma Focused Cognitive Behavior Therapy (TF-CBT)
- Parent Child Interaction Therapy (PCIT)
- EMDR
- Multisystemic Therapy
- Dialectical Behavioral Therapy
- Structured Psychotherapy for Adolescents
- Pharmacotherapy
- Alternatives for Families-CBT (AF-CBT).

<table>
<thead>
<tr>
<th>Practice</th>
<th>Target Population</th>
<th>Key Elements</th>
<th>Level of Support</th>
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<tbody>
<tr>
<td>Sanctuary Model</td>
<td>Children ages 4 and up in Residential Setting with emotional &amp; behavioral disturbances &amp; histories of maltreatment or exposure to domestic &amp; community violence</td>
<td>Integrates trauma theories, enhanced therapeutic community, &amp; child treatment strategies</td>
<td>Good</td>
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<tr>
<td></td>
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<td>Fundamental premise is treatment environment as core modality</td>
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<tr>
<td>Seeking Safety</td>
<td>Adults &amp; Adolescents</td>
<td>Manualized</td>
<td>Strong</td>
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<td></td>
<td>Treats trauma/PTSD &amp; substance abuse</td>
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<tr>
<td>Therapy</td>
<td>Population</td>
<td>Description</td>
<td>Strength</td>
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<tr>
<td>TF-CBT</td>
<td>Children, Adolescents &amp; Adults</td>
<td>Recognized as a Model Program by SAMHSA</td>
<td>Strong</td>
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<td>Applicable to treat negative effects of a multitude of traumatic life events (not just abuse)</td>
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<td>Psychoeducation Parenting component Relaxation skills Affect modulation Cognitive coping Trauma narrative Conjoint parent/child sessions Enhancing future personal safety</td>
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<tr>
<td>Parent Child Interaction Therapy (PCIT)</td>
<td>Children ages 2-12 with externalizing behavior problems Physically abusive parents with children ages 4-12</td>
<td>Focuses on improvement in quality of caregiver/child relationship &amp; parenting skills, including positive discipline Adapted for group treatment Live coached behavioral parent training model</td>
<td>Strong</td>
</tr>
<tr>
<td>EMDR</td>
<td>Children, adolescents, adults</td>
<td>Cognitive based; designed specifically for PTSD Requires extensive assessment</td>
<td>Supported &amp; acceptable</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>Children, adolescents, Adults</td>
<td>Cognitive Based; brief &amp; time limited intervention; based on education model Effective in both individual &amp; group settings;</td>
<td>Strong</td>
</tr>
<tr>
<td>Multisystemic</td>
<td>Youth with serious</td>
<td>Targets key factors</td>
<td>Good support</td>
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</table>
Therapy | behavioral difficulties, particularly antisocial within youth’s social ecology that relate to problem behavior
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Dialectical Behavioral Therapy | Children (age 8), adolescents, adults | Basic treatment foci include emotional regulation, distress tolerance, relationship effectiveness and mindfulness. Education focus

Structured Psychotherapy for Adolescents Responding to Chronic Stress | Adolescents ages 12-19 | Mindfulness, Problem-solving, Meaning Making, Relationship Building, Communication Skills, Distress Tolerance

Pharmacotherapy | Children, adolescents, adults | Treat symptoms Good for SSRIs in pediatric PTSD, limited for other medication

Alternatives for Families-CBT (AF-CBT) | School-age children | Cognitive processing of experiences, Affect & management skills, coping skills, social/interpersonal skills, caregiver/parent-directed components, parent-child or family-system directed components

VI. **Recommended Performance/Best Practice Guidelines**

a. Recommendations for Creating Trauma Informed Environments:
   1. Adoption of the Criteria for Trauma Informed Care at State level by all child serving systems.
   2. Assess readiness to implement trauma informed care at system and organizational levels
   3. Use results of readiness at system level to develop plan to increase implementation of trauma-informed care.
   4. Implementation of universal screening of youth for trauma, substance abuse, and mental health in child serving systems.
   5. Revise licensure standards to reflect the principles of trauma-informed care.
   6. Implement state-wide cross-system training initiative.

b. Recommendations for Trauma Specific Care:
   1. Provide and support training on evidence based practices for trauma specific care
   2. Provide opportunities for on-going support/supervision/consultation for clinical staff.

VII. Evidence Based Practice (specific/detailed recommendations):
   a. What is Missing From Our System:
      1. State commitment to implement trauma-informed care in all child serving systems
      2. Strategic plan with comprehensive framework that requires incorporation of principles of trauma informed into all child serving systems
      3. Establish WV System of Care Implementation Team as designated State-level workgroup/committee to oversee implementation of trauma-informed care
      4. Lack of understanding of trauma and its impact by child serving systems, including courts, community, juvenile justice, child welfare, and treatment providers
      5. State policy/reimbursement structures that are based on trauma-informed principles
      6. Coordination of care
         a. Standardized protocols/practice guidelines for screening, assessment, and treatment
         b. Lack of buy-in by State and local child-serving systems
      7. Lack of trauma specific services at community level
      8. Lack of established common outcomes.
   b. What Needs Improved/Further Developed/Increased/Decreased:
      1. Improved
         a. Access to services – particularly youth under 10, youth in parental custody, rural areas
         b. Workforce development for both trauma informed and trauma specific care
         c. Early identification (screening and assessment) of the existence of trauma and trauma related problems, as well as the relationship of trauma to mental health, substance abuse, criminal behavior, physical health, and education problems.
         d. Understanding of the psychological and behavioral manifestations of trauma among child serving systems
         e. Linkage with higher education to promote education of professionals in trauma
         f. Policy and reimbursement support for trauma-informed and trauma specific care.
      2. Further Developed
         a. Use of technology for training
         b. Consistent set of outcomes to be measured and reported by all providers that demonstrate
         c. Workforce development, support, competencies and job standards related to trauma
         d. Practice/performance guidelines
         e. Age/developmentally based interventions (children and adolescents are not little adults)
         f. State level partnerships and commitment to implementation of trauma-informed care.
      3. Increased
         a. Community awareness of the prevalence and impact of trauma
         b. Community based services – less reliance on out-of-home care and increased specialized trauma specific services
         c. Partnerships at State level to support trauma-informed care
d. Training initiatives and support for trauma-informed care and trauma specific care  
e. Implementation of EBP by providers  
f. Use of WV Trauma-Informed CANS  
g. Expand use of revised CAPS process beyond Jacob’s Law population  
h. Performance based contracting and outcomes measurement.

4. Decreased  
a. Over reliance on beds and out-of-home care  
b. Decisions made by courts in absence of clinical input or ignoring recommendations of clinical MDT/review teams  
c. Silos at state level – DHHR bureaus’ decisions without examining impact on the other bureaus, e.g. Medicaid redesign,  
d. Belief by some child serving systems that out-of-state care is better quality than in-state care  
e. Duplication of services caused by state policy or lack of collaboration and coordination among child serving systems.

c. What Needs Continued Support  
1. WV System of Care, including regional clinical review teams and service array  
2. Training initiative for both trauma-informed care and trauma specific care (evidence based practice)  
3. Community-based services  
4. Regional Summits  

d. What Can be Implemented Quickly  
1. Development of standardized outcomes  
2. Establish System of Care Implementation Team as implementation and oversight group for trauma-informed care  
3. Formalize inter-agency partnerships in order to minimize development of duplicate service system, increase access to integrated services, and blend funding. Implementation of standardized assessment protocol  
4. Identify administrative and infrastructure issues related to trauma-informed care and develop recommendations related to those issues.  
5. Undertake policy initiatives at State/funding level that would support trauma-informed care services and systems and provide mechanism for demonstration projects and block grants  
6. Identify technical assistance, training and workforce development needs.  
7. Identify, disseminate and provide technical assistance related to program organization and clinical models for integrated care.  
8. Connect to existing service array initiative to identify service capacity/gaps  
9. Identify established EBP models/curricula  
10. State to provide support/funding for purchase/distribution of EBP models/curricula and training of staff.

VIII. Implementation Strategies/Recommendations
1. Establish WV System of Care Implementation Team as designated State-level workgroup/committee to oversee implementation of trauma-informed care
2. Universal adoption of the criteria for building trauma-informed systems of care at the State level and in all child serving systems. Should be included in all contracts and RFIs for grant funding and adherence should be included in evaluation of programs/services.
3. Provide cross-system training on trauma informed care throughout the State
   a. Establish guidelines/required areas for training
   b. Identify/develop training materials/curricula, including web-based training
4. Use of evidence-based programs/curricula
5. Universal screening of all youth in child serving systems, e.g., DJS, court, Youth Services, etc.
   a. Utilize universal screening tool/protocol for use by non-clinical child serving systems
6. Comprehensive assessment for those who screen positively for existence of substance abuse/mental health/trauma disorder(s).

A. System Level Recommendations

1. Establish WV System of Care Implementation Team as designated State-level workgroup/committee to oversee implementation of trauma-informed care
   a. Coordination of activities and information sharing
   b. Establish cross-training initiative/activities
   c. Develop service agreements for assessment and treatment/support.
2. Universal adoption of the criteria for building trauma-informed systems of care at the State level and in all child serving systems. Should be included in all contracts and RFIs for grant funding and adherence should be included in evaluation of programs/services.
3. State commitment to implement trauma-informed care in all child serving systems.
4. Undertake policy and funding initiatives at State that would support trauma-informed care and trauma specific services and provide mechanism for demonstration projects and grant opportunities.
5. Assist in increasing clinical capacity for provision of trauma specific services.
6. Identify established EBP models/curricula.
7. Work with universities to update curriculum (integrated treatment for co-occurring disorders).
8. State to provide financial support for purchase of EBP curricula/training of staff in the curricula.
9. CBHC Children’s Liaisons focus on trauma, substance abuse, and mental health as co-occurring disorders.
10. State should fund only those services/programs that can demonstrate principles and components of trauma-informed care.
11. Continue to support training initiatives, including opportunities for on-going support, clinical supervision, and consultation.
12. Establish requirement for outcomes measurement
    a. Continued funding contingent on demonstration of positive outcomes.

B. Practice Level Recommendations

1. Implement principles of trauma-informed care at organization/practice level, including orientation of staff, organization policies/practices, implementation of evidence based practices, program monitoring and evaluation.
2. Universal screening for trauma, substance abuse, and mental health and assessment of specific historical experiences and clinical symptoms.
3. Training of clinical staff on trauma specific care and evidence based practices.
5. Outcomes measurement.

C. Training Implications/Recommendations
1. Training State-level stakeholders and policy makers on prevalence and impact of trauma and trauma-informed care.
2. Implement social marketing initiative to increase community awareness of trauma and its impact and decrease stigma.
3. Workforce development
   a. Establish guidelines/required areas for training of staff in all child serving systems in trauma-informed care.
   b. Collaborate with university programs to update curriculum
   c. Improve access to and quality of clinical supervision and support
   d. Provide more opportunities for web and technology based training.

IX. Works Cited


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