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Adolescent Behavioral Health Programs

Adverse Childhood Experiences (ACEs) & Trauma Informed Care

Definition of Trauma

A Working Definition of Trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

SAMHSA, 2013

Types of Childhood Trauma

- Natural Disasters
  - Fires, Floods, Earthquakes, Hurricanes
- Kidnapping
- School Violence
  - Victimization, Threats, Fights, Weapons on Campus
- Community Violence
  - Predatory Violence, Personal Conflicts, Gang Violence, Brutal Acts
- Refugee and War Zone Trauma
  - Exposure to War, Political Violence or Torture
- Terrorism
- Homicide
- Traumatic Grief
- Physical Abuse
  - Experiencing or Witnessing
- Complex Trauma
  - Multiple or Prolonged Traumatic Events
- Sexual Abuse/Assault
- Domestic Violence
  - Experiencing or Witnessing
- Medical Trauma
  - Pain, Injury, Illness, Invasive Procedures or Treatments
- Victim of Crime
- Accidents
- Neglect, Deprivation
- Early Childhood Trauma
  - Ages 0-6

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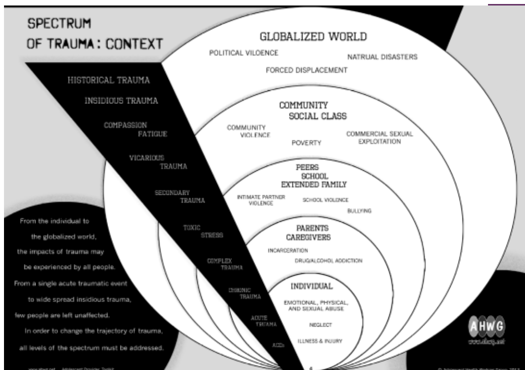

Acute, Chronic and Complex Trauma

Acute Trauma	Chronic Trauma
Single Incident	Repeated
Crime Victim	Prolonged Trauma
Serious Accident	Domestic Violence
	Abuse (Physical or

Complex Trauma
Chronic, Interpersonal Trauma, Varied and Multiple Traumas, Early Onset, Often by Trusted Caregivers

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Prevalence

General Statistics

- **60%** of adults report experiencing abuse or other difficult family circumstances during childhood.
- **26%** of children in the United States will witness or experience a traumatic event before they turn four.
- **Four of every 10** children in American say they experienced a physical assault during the past year, with one in 10 receiving an assault-related injury.
- **2%** of all children experienced sexual assault or sexual abuse during the past year, with the rate at nearly 11% for girls aged 14 to 17.
- Nearly **14%** of children repeatedly experienced maltreatment by a caregiver, including nearly 4% who experienced physical abuse.
- **1 in 4** children was the victim of robbery, vandalism or theft during the previous year.
- More than **13%** of children reported being physically bullied, while more than 1 in 3 said they had been emotionally bullied.
- **1 in 5** children witnessed violence in their family or the neighborhood during the previous year.
- In one year, **39%** of children between the ages of 12 and 17 reported witnessing violence, **17%**reported being a victim of physical assault and **8%** reported being the victim of sexual assault.
- **1 in 3** girls and **1 in 6** boys are victims of sexual abuse

The Relationship Between Childhood Trauma and Justice Involvement

- Identifying children who have experienced trauma is either being done inappropriately or not as often as necessary which may be leaving many of these young people without the services and treatment they need, thus **making them more at risk for future involvement in the justice system.** (Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense. Justice Policy Institute, 2010.)
- Many of the nation's most traumatized youth are found in the juvenile justice system, and a large percentage of adults in the criminal justice system report having experienced trauma in childhood. Illegal behavior is not an inevitable consequence of childhood trauma; however, based on the diverse range of traumatic exposure observed among youth in the juvenile justice system, **trauma can be considered a specific risk factor for future involvement with the justice system.** (Shaffer, J.N., Ruback, R.B. *Violent Victimization as a Risk Factor for Violent Offending Among Juveniles.* Juvenile Justice Bulletin, December 2002, Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.)

Yolo County Juvenile Justice Youth: Exposure to Trauma

Between 2012-2014, of 485 youth with pre-screen assessment:

30% have been a victim of physical abuse

63% have witnessed violence (home, group home, community)

23% had presence of traumatic event

7% reported sexual abuse/rape

16% reported being a victim of neglect

Further assessment of the highest risk youth:

75% have a history of alcohol use

85% have a history of drug use

50% have been a victim of physical abuse

86% have witnessed violence (home, group home, community)

37% had presence of a traumatic experience

14% reported sexual abuse/rape

28% reported being a victim of neglect

Adverse Childhood Experiences (ACEs) Study

Kaiser Permanente and Center for Disease Control, 1998

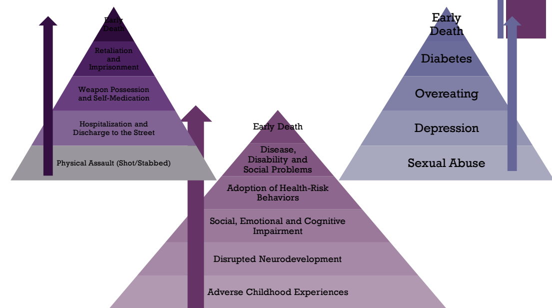
The Study:

- 17,000, mostly white, college-educated, employed adults were screened for 10 prominent childhood traumatic experiences as a part of their routine health care at Kaiser. Participants received one point for each type of trauma.

The Results:

- 70% of the 17,000 people experienced at least one type of trauma resulting in an "ACE score" of one; 87% of those had more than one.
- ACE scores of 4 or more resulted in four times the likelihood of depression, 12 times the risk of suicide.
- ACE scores were also directly correlated with early initiation of smoking and sexual activity, adolescent pregnancy, and risk for intimate partner violence.
- Eighteen States have since conducted ACE surveys with similar results.
- A person with an ACE score of 4 is 260% more likely to have COPD, 240% more likely to have Hepatitis, and 250% more likely to have a sexually transmitted disease than a person with an ACE score of 0.
- A male child with an ACE score of 6 has a 4600% increase in the likelihood of becoming an IV drug user when compared to a child with an ACE score of 0.

ACEs Conceptual Framework



ACES Questionnaire for Youth

ADVERSE CHILDHOOD EXPERIENCES (ACEs) 10 QUESTION SCREENING TOOL

The ACEs 10 Question Screening Tool is an abbreviated version of the ACEs Family Health History Questionnaires and Health Appraisal Questionnaires available at: http://www.cdc.gov/ace/questionnaires.htm

A comprehensive list of validated youth trauma screening and assessment tools are maintained on the NCTSN Measures Review available at: http://www.nctsn.org/resources/online-research/measures-review

FINDING YOUR ACEs SCORE

While you were growing up, during your first 18 years of	Circle	One	If YES Enter 1
1. Did a parent or other adult in the household **often or very often** swear at you, insult you, put you down, or humiliate you? **OR** act in a way that made you afraid that you might be physically hurt?	Yes	No	
2. Did a parent or other adult in the household **often or very often** push, grab, slap, or throw something at you? **OR** ever hit you so hard that you had marks or were injured?	Yes	No	
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? **OR** attempt or actually have oral, anal, or vaginal intercourse with you?	Yes	No	
4. Did you **often or very often** feel that: No one in your family loved you or thought you were important or special? **OR** your family didn't look out for each other, feel close to each other, or support each other?	Yes	No	
5. Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No	
6. Were your parents ever separated or divorced?	Yes	No	
7. Was your mother or stepmother **often or very often** pushed, grabbed, slapped, or had something thrown at her? **OR** sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? **OR** ever repeatedly hit at least a few minutes or threatened with a gun or knife?	Yes	No	
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No	
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No	
10. Did a household member go to prison?	Yes	No	
NOW ADD UP YOUR "YES" ANSWERS. THIS IS YOUR ACEs SCORE.			

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HEALTH RISK BEHAVIORS: MALADAPTIVE COPING STRATEGIES FOR ADVERSE CHILDHOOD EXPERIENCES (ACEs)

SEEKING TO COPE

- Health risk behaviors underlying adult diseases may actually function as effective coping strategies during adolescence.(30)
- Health risk behaviors may not be viewed by youth as the problem, they might be the youth's solution, a way to feel safe, reduce tension, and feel better, OR the youth may be completely unaware of what drives ACE-related behaviors, compulsions, or reactions.
- Dismissing maladaptive coping strategies as "bad habits" or "self destructive" misses their function.
- Maladaptive coping strategies need to be investigated, linked to previous ACEs, and adapted into positive coping strategies and behaviors.

ADVERSE CHILDHOOD EXPERIENCES (ACES) (2)

Abuse of Child Under Age 18
- Emotional Abuse
- Physical Abuse
- Sexual Abuse

Neglect of Child Under Age 18
- Physical neglect
- Emotional neglect

Household Environment
- Alcohol or drug user in home
- Chronically depressed, emotionally disturbed, or suicidal household member
- Mother treated violently
- Imprisoned household member
- Parents separated or divorced

EFFECTS OF TRAUMA AND RELATED HEALTH RISK BEHAVIORS (2)

Neurobiologic Effects of Trauma
- Disrupted neuro-development
- Difficulty controlling anger, rage
- Hallucinations
- Depression
- Anxiety
- Panic reactions
- Multiple (6+) somatic problems
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

Health Risk Behaviors Used to Ease the Pain of Trauma
- Smoking
- Physcial inactivity
- Eating disorders
- Alcoholism
- Drug abuse
- Suicide attempts
- Self injury
- 50+ sexual partners
- Repitition of original trauma
- Perpetrate interpersonal violence

LONG-TERM CONSEQUENCES OF UNADDRESSED TRAUMA (ACEs) (2)

Disease and Disability
- Cancer
- Ischemic heart disease
- Chronic lung disease
- Chronic emphysema
- Asthma
- Liver disease
- Severe obesity
- Skeletal fractures
- Poor self rated health
- Sexually transmitted infections
- HIV/AIDS

Serious Social Issues
- Homelessness
- Commercial sex work
- Delinquency, violence, criminal activity
- Inability to sustain employment
- Re-victimization: domestic violence, rape, bullying
- Long-term use of multiple human service systems
- Compromised ability to parent
- Intergenerational trauma

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Impact of Adverse Childhood Experiences (ACEs)

Important Things to Remember

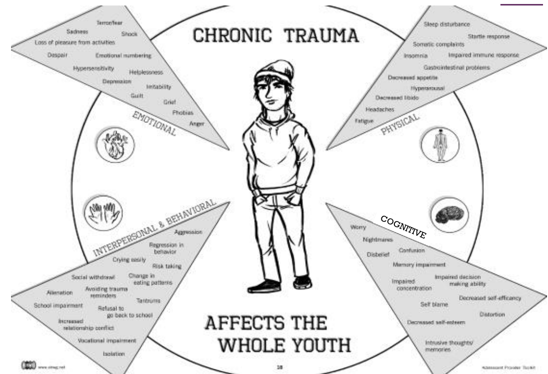
- Not "what's wrong with you" but "what happened to you"
- Symptoms are adaptations
- Violence causes trauma and… trauma causes violence.

SAMHSA, 2013

The Three E's: Events, Experience and Effects

- *Events* and circumstances
- The individual's *experience* of these events or circumstances helps to determine whether it is a traumatic event.
- The long-lasting adverse *effects* on an individual are the result of the individual's experience of the event or circumstances.

SAMHSA, 2013



Impact of Trauma on Development

Cognitive Impact

- Worry
- Nightmares
- Confusion
- Memory Impairment
- Impaired Concentration
- Impaired Decision Making Ability
- Self Blame
- Cognitive Distortion
- Intrusive Thoughts/ Memories

Emotional Impact

- Terror/Fear
- Sadness
- Shock
- Loss of Pleasure from Activities
- Despair
- Emotional Numbing
- Hypersensitivity
- Helplessness
- Depression
- Guilt
- Irritability
- Phobias
- Anger

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Impact of Trauma on Development

Behavioral Impact

- Aggression
- Regression in Behavior
- Self Injury
- Crying Easily
- Risk Taking
- Change in Eating Patterns
- Tantrums
- Refusal to go Back to School
- School Impairment
- Substance Use

Social/Interpersonal Impact

- Social Withdrawal
- Peer Rejection
- Alienation
- Increased Relationship Conflict
- Association with Antisocial Peers
- Lack of Social Problem-Solving Skills
- Poor Boundaries
- Isolation

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Impact of Trauma on Development

Physical Impact

- Sleep Disturbance
- Startle Response
- Somatic Complaints
- Impaired Immune Response
- Gastrointestinal Problems
- Decreased Appetite
- Headaches
- Fatigue

Sense of Self/Others

- Negative View of Self
- Low Self-Esteem
- Expectation of Rejection/Hostility from Others
- Expectation of Others to be Unresponsive/ Unavailable
- Distrust

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SURVIVAL BRAIN VS. LEARNING BRAIN

ALARM SYSTEM: We all have normal alarm systems in our brain/body that lets us know when we are under threat and mobilizes us to fight, flight, or flee threat. When youth experience continuous threats/trauma, the brain/body is put into a chronic state of fear, activating the "survival brain" (mid/lower areas of the brain). This can create an overactive alarm system in the developing brain. A youth's brain/body that develops within the context of trauma can be more easily triggered into "survival brain" by "trauma reminders" or "triggers" even when there is no actual threat. (32,33)

TRAUMA TRIGGERS: Can activate the "survival brain," causing youth to react as though a "there and then" experience (previous traumatic event) is happening "here and now" (in current reality).

Common triggers include:

- Unpredictability
- Sudden changes or transitions
- Loss of control
- Sensory overload
- Feeling vulnerable
- Rejection
- Loneliness
- Confrontation
- Intimacy
- And even praise or positive attention

When youth are in a triggered state, they may not be able to access higher functions of the frontal lobe ("learning brain"). At this time, verbal warnings of consequences, or making demands on the higher "learning brain" (i.e. asking them to explain their decision-making process), may escalate the situation.

DE-ESCALATION: Youth in a triggered state need help to calm down from "there and then" triggers and become more present in "here and now" reality, (in which there may be no actual threat). Feelings of safety and control must be re-established in order for youth to think more clearly.

Strategies include:

- Noticing signs of distress
- Connecting with the youth
- And then re-directing behavior through providing reasonable choices/options for alternative activities/circumstances
- After youth is calm, discussion about what happened can take place and if necessary, consequences can be determined

The long-term goal is NOT to turn off the brain/body alarm system, as the alarm is needed to detect ongoing/real threats. The goal is to increase the alarm's accuracy so that it doesn't turn on unnecessarily.

BRAIN PLASTICITY: Patterned, repetitive activities can help the brain to re-wire and organize itself into more healthy functioning. Activities may include: music, movement, drumming, yoga, deep breathing, mindfulness, and positive, nurturing interactions with trustworthy adults and peers. (32)

NEUROBIOLOGICAL RESPONSE SYSTEMS

STRESS RESPONSE: POSITIVE, TOLERABLE, OR TOXIC (33)

POSITIVE STRESS RESPONSE

- Normal and essential part of healthy development.
- Includes brief increases in heart rate and mild elevations in hormone levels.

Examples: Attending a new school; going out with new friends.

TOLERABLE STRESS RESPONSE

- Activates the mind/body alarm system as a result of more severe, longer-lasting difficulties.
- If activation is time-limited and buffered by relationships with caring adults who help youth to adapt, the brain and other organs may recover from possible damaging effects.

Examples: Loss of a loved one; natural disaster; frightening injury.

TOXIC STRESS RESPONSE

- Can occur when youth experiences strong, frequent, and/or prolonged adversity.
- Without adequate adult support, prolonged activation of the stress response system can disrupt the development of brain architecture and other organs
- Risk for stress-related disease and cognitive impairment is increased well into adulthood.

Examples: Physical or emotional abuse; chronic neglect; caregiver substance abuse or mental illness; exposure to violence; accumulated burdens of severe family economic hardship.

SURVIVAL RESPONSE: FIGHT, FLIGHT, OR FREEZE (34-36)

FIGHT

- Youth struggle to regain or hold on to power, especially when feeling coerced.

Youth often mislabeled as: Non-compliant or combative.

FLIGHT

- Youth disengages or runs away and "checks out" emotionally.

Youth often mislabeled as: Uncooperative or resistant.

FREEZE

- Youth gives in to those in positions of power; does not, or is unable to "speak up."

Youth often mislabeled as: Passive or unmotivated.

Risk Factors for Post Trauma Adjustment Problems

- Severity and Chronicity of Trauma
- Extent of Exposure
- Proximity of Trauma
- History of Other Multiple Stressors
- Preexisting Psychopathology
- Interpersonal Violence
- Personal Significance of Trauma
- Separation from Caregiver
- Extent of Disruption in Support Systems
- Lack of Resources
- High Physical Pain
- Parent/Caregiver Psychopathology/Distress
- Genetic Predisposition
- Close, Familial Relationship to Abuser
- Use of Threat
- Early Onset (Infancy to Preschool Age)
- Multiple Types of Maltreatment
- Lower Cognitive Functioning
- Female
- Passive Coping Style
- Unsupportive Caregiver

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POST TRAUMATIC STRESS DISORDER (PTSD)

Post Traumatic Stress Disorder (PTSD) is the leading diagnosis available in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) for post traumatic symptoms among youth and adults. (37)

PTSD is an important diagnosis, however it is limited by the following: (38)

- Originally developed for and is most relevant to adults, not children/youth.
- More often captures symptoms of single/acute traumatic events, not complex/chronic traumatic events.
- Focuses on the individual.

PTSD A: Stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

PTSD B: Intrusive Recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

PTSD C: Avoidant/Numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g., unable to have loving feelings).
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

PTSD D: Hyper-Arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hyper-vigilance.
5. Exaggerated startle response.

PTSD E: Duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

PTSD F: Functional Significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify If: Acute: If duration of symptoms is less than three months; Chronic: if duration of symptoms is three months or more; With or Without delay onset: Onset of symptoms at least six months after the stressor.

PTSD

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BEYOND PTSD: DEVELOPMENTAL TRAUMA DISORDER

Developmental Trauma Disorder is a proposed diagnosis for the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-V) to capture more developmentally appropriate post traumatic symptoms specific to children/youth. (38)

Developmental Trauma Disorder Includes:
1) Child/youth specific and developmentally appropriate symptoms. 2) Complex/chronic trauma symptoms. 3) Role of impaired caregiving systems.

AFFECTIVE AND PHYSIOLOGICAL DYSREGULATION
Impaired arousal regulation

- Inability to modulate, tolerate, or recover from extreme affect states (e.g fear, anger, shame) including prolonged and extreme tantrums, or immobilization.
- Disturbances in regulation of bodily functions (e.g. sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions).
- Decreased awareness or dissociation of sensations, emotions, and bodily states.
- Impaired capacity to describe emotions or bodily state.

ATTENTIONAL AND BEHAVIORAL DYSREGULATION
Impaired attention, learning, and coping mechanisms

- Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues.
- Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking.
- Maladaptive attempts at self-soothing (e.g. rocking, other rhythmical movements, compulsive masturbation).
- Habitual (intentional, automatic, or reactive) self-harm.
- Inability to initiate or sustain goal-directed behavior.

SELF AND RELATIONAL DYSREGULATION
Impaired sense of personal identity and involvement in relationships

- Intense preoccupation with safety of caregiver or loved ones, or difficulty tolerating reunion with them after separation.
- Persistent negative sense of self (e.g. self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness).
- Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers.
- Reactive physical or verbal aggression toward peers, caregivers, or other adults.
- Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance.
- Impaired capacity to regulate empathic arousal (e.g. lack of empathy for, or intolerance of distress in others, or excessive responsiveness to the distress of others).

FUNCTIONAL IMPAIRMENT
School, family, peer group, legal, health, and work impairments

- **School:** Under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credentials, conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.
- **Family:** Conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within family.
- **Peers:** Isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age inappropriate affiliations or style of interaction.
- **Legal:** Arrests/recidivism, detention, convictions, incarceration, violation of probation/court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.
- **Health:** Physical illness or problems that cannot be fully accounted for, involving digestive, neurological, sexual, immune, cardiopulmonary, proprioceptive, sensory systems, severe headaches (including migraine), or chronic pain/fatigue.
- **Work:** Youth involved in, seeking, or referred for employment, volunteer, or job training show disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

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+ Protective Factors for Post Trauma Adjustment

- A reliable support system (family, friends)
- Access to safe and stable housing
- Timely and appropriate care from first responders
- Self care practices (sleeping, nutrition)
- Using positive coping mechanisms verses negative coping mechanisms
- Parental resilience
- Knowledge of parenting and child development
- Nurturing and attachment

Adapted from: Ally Burr Harris Ph D
Trauma: Impact on Children and Opportunities for Healing

+ Trauma Informed Care

+ What is "Trauma Informed"?

A program, organization or system that is trauma informed realizes the widespread impact of trauma and understands the potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.

SAMHSA, 2013

+ The Three R's: Realizing, Recognizing, and Responding

- A definition of trauma-informed care incorporates three key elements:
  - (1) *realizing* the prevalence of trauma;
  - (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and
  - (3) *responding* by putting this knowledge into practice.

SAMHSA, 2013

Goals of Trauma Informed Care

- Provide the foundation for a basic understanding of the psychological, neurological, biological and social impact that trauma and violence have on many of the individuals we serve by:
  - Avoiding unintentional re-traumatization through agency policies, practices and staff interactions with youth and their families
  - Recognizing the impact of trauma on your clients/students, your staff and YOU
  - Incorporating Trauma Informed Practices in policies and procedures
  - Educating and empowering staff and youth
  - Encouraging self care practices and identifying vicarious trauma

KEY PRINCIPLES OF TRAUMA-INFORMED APPROACHES TO CARE

A trauma-informed approach reflects the adoption of underlying values or principles rather than a specific set of procedures. These values or principles are generalizable across all settings, although language and application may be setting or sector-specific.

1. ***SAFETY:*** Throughout the organization, providers and people served feel physically and psychologically safe; including physical settings and interpersonal interactions.
2. ***TRUSTWORTHINESS AND TRANSPARENCY:*** Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among providers, clients, and family members of those served.
3. ***COLLABORATION AND MUTUALITY:*** There is true partnering and leveling of power differences between providers and clients and among organizational staff from direct care to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
4. ***EMPOWERMENT:*** Throughout the organization and among clients served, individuals' strengths are recognized and validated and new skills are developed as necessary.
5. ***VOICE AND CHOICE:*** The organization aims to strengthen client and family members' experience of choice, and recognizes that every person's experience is unique and requires an individualized approach.
6. ***PEER SUPPORT AND MUTUAL SELF-HELP:*** Are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
7. ***RESILIENCE AND STRENGTHS BASED:*** A belief in resilience and the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, providers, and communities have to offer rather than responding to their perceived deficits.
8. ***INCLUSIVENESS AND SHARED PURPOSE:*** The organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.
9. ***CULTURAL, HISTORICAL, AND GENDER ISSUES:*** Are addressed; the organization actively moves past cultural stereotypes and biases, offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.
10. ***CHANGE PROCESS:*** Is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.

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Trauma Informed System of Care

Trauma Informed	Non-Trauma Informed
Recognition of high prevalence of trauma	Lack of education on trauma prevalence and "universal" precautions
Recognition of primary and co-occurring trauma diagnoses	Over diagnosis of Schizophrenia, Bipolar Disorder, Conduct Disorder, and singular addictions
Assess for traumatic histories and symptoms	Cursory or no trauma assessment
Recognition of culture and practices that are re-traumatizing	"Tradition of Toughness" valued as best care approach
Power/control minimized- constant attention to culture	Keys, security uniforms, staff demeanor, tone of voice

http://www.centerforyouthwellness.org/

Trauma Informed System of Care

Trauma Informed	Non-Trauma Informed
Caregivers/supporters-collaboration	Rule enforcers-compliance
Address training needs of staff to improve knowledge and sensitivity	"Youth blaming" as fallback position without training
Staff understand function of behavior (rage, repetition-compulsion, self-injury)	Behavior is seen as intentionally provocative
Objective, neutral language	Labeling language: "manipulative", "needy", "attention-seeking"
Transparent systems open to outside parties	Closed system- advocates discouraged

http://www.centerforyouthwellness.org/

Best Practices for Intervention

- Many existing trauma-focused interventions overlap in their content and approaches. These areas of overlap are termed "core components". Examples of core components might include:
  - Screening and Triage
  - Systematic assessment, case conceptualization, and treatment planning
  - Psycho-education
  - Addressing children and families traumatic stress reactions and experiences
  - Trauma narration and organization
  - Enhancing emotion regulation and anxiety management skills
  - Facilitating adaptive coping and maintaining adaptive routines
  - Parenting skills and behavior management
  - Promoting safety skills
  - Relapse prevention
  - Evaluation of treatment responses and effectiveness
  - Engagement/addressing barriers to service seeking

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

- TF-CBT is a clinic-based, individual, short term treatment that involves individual sessions with the child and parent as well as joint parent-child sessions. (Treatment is approx. 12-16 sessions.)
- Proved successful with children and adolescents (ages 3 to 18) who have significant emotional problems (e.g., symptoms of posttraumatic stress disorder, fear, anxiety, or depression) related to traumatic life events.
- Treatment can be used with children and adolescents who have experienced a single trauma or multiple traumas in their life. Children or adolescents experiencing traumatic grief can also benefit from this treatment.
- Children and parents learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related traumatic life events; and enhance safety, growth, parenting skills, and family communication.

www.tfcbt.musc.edu

TF-CBT Treatment Modules

- P: Psycho-education about childhood trauma and PTSD &

  Parenting component including parent management skills
- R: Relaxation skills individualized to the child and parent
- A: Affective modulation skills adapted to the child, family and culture
- C: Cognitive coping: connecting thoughts, feelings, and behaviors related to the trauma
- T: Trauma narrative: assisting the child in sharing a verbal, written, or artistic narrative about the trauma(s) and related experiences, and cognitive and affective processing of the trauma experiences
- I: In vivo exposure and mastery of trauma reminders if appropriate
- C: Conjoint parent-child sessions to practice skills and enhance trauma-related discussions/Cognitive Restructuring
- E: Enhancing future personal safety and enhancing optimal developmental trajectory through providing safety and social skills training as needed

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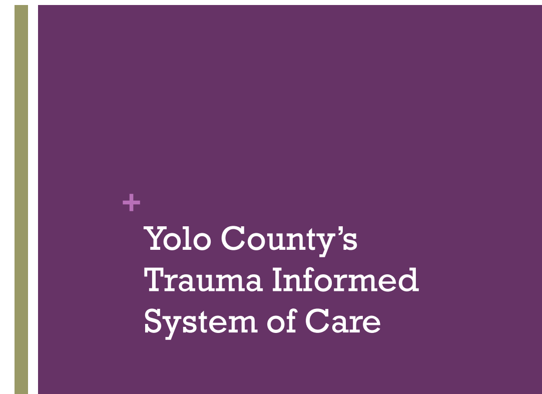
Seeking Safety

- A present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians.
- The treatment was designed for flexible use. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.
- Seeking Safety consists of 25 topics that can be conducted in any order.
  - e.g. , Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding), Life Choices, etc.

www.seekingsafety.org

TF-CBT Providers in Yolo County

- CommuniCare Health Centers
  - 500B Jefferson Blvd West Sacramento, CA 95605
    (916)403-2970
  - 804 Court Street Woodland, CA 95695
    (530)668-2400
  - www.communicarehc.org
- Yolo County Alcohol, Drug and Mental Health
  - 137 N Cottonwood St Woodland, CA 95695
    (530) 666-8650
  - http://www.yolocounty.org/index.aspx?page=59
- Yolo Family Service Agency
  - 455 1st St · Woodland
    (530) 662-2211
  - http://yolofamily.org



The Development of Yolo's Trauma Informed System of Care

- In May 2012, Trauma Focused Cognitive Behavioral Therapy (TF-CBT) training was provided to three local youth serving mental health providers in Yolo County through the support of the Yolo County Department of Alcohol, Drug, and Mental Health and Wrap Reinvestment Funds
- As a part of Yolo's effort to become a trauma informed system of care, the implementation of TF-CBT is an important component.
- The SB163 Wrap Leadership Team's approval of Reinvestment Funds to support TF-CBT implementation is invaluable in this effort.

Yolo County TF-CBT Outcome Data

- Since program implementation in May 2012, over 100 youth have received TF-CBT
- Increase in total number of youth identified as having experienced adverse childhood experiences/trauma
- Increase in accuracy of diagnoses
  - Significant increase in the identification of PTSD in Juvenile Justice Youth
- 100% of youth referred to treatment screened for exposure to trauma and assessed for Post Traumatic Stress Disorder
- 74% of Parents/Caregivers reported positive change from Pre-TF-CBT to Post-TF-CBT (via YOQ)
- 93% of Youth reported positive change from Pre-TF-CBT to Post-TF-CBT (via YOQ-SR)
- 50% of Youth reported positive change in PTSD symptom reduction from Pre-TF-CBT to Post-TF-CBT (via UCLA PTSD-RI)

Development of Trauma Informed Care Workgroup

- Workgroup convened and includes representation from the following agencies:
  - CommuniCare Health Centers
  - Court Appointed Special Advocates (CASA)
  - Juvenile Detention Facility
  - Yolo County Department of Employment and Social Services/Child Welfare
  - Yolo County Probation Department, Juvenile Division
  - Yolo County Department of Alcohol, Drug and Mental Health
- TIC Workgroup Goal Established:
  - Provide the foundation for a basic understanding of the psychological, neurological, biological and social impact that trauma and violence have on many of the youth and families we serve by:
    - Avoiding unintentional re-traumatization through agency policies, practices and staff interactions with youth and their families
    - Recognizing the impact of trauma on our clients, our staff and ourselves
    - Incorporating Trauma Informed Practices in policies and procedures
    - Educating and empowering staff, youth, and families
    - Encouraging self care practices and identifying vicarious trauma

TIC Workgroup's Prioritized Action Steps

- Develop a countywide definition of a trauma informed system of care
- Provide countywide training regarding Trauma Informed Care for Youth
- Implement ACEs screening or other screening tool for exposure to trauma
- Maintain current service delivery structure of Trauma Focused Cognitive Behavioral Therapy
  - (TF-CBT) and support model adherence/fidelity

Trauma Informed System of Care- Definition

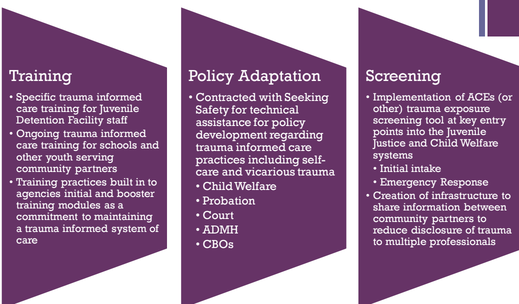
- TIC Workgroup convened to develop a countywide definition of a trauma informed system of care and included representatives from the Yolo County Department of Alcohol, Drug and Mental Health, the Yolo County Probation Department, the Yolo County Juvenile Detention Facility, the Yolo County Department of Employment and Social Services/Child Welfare Services and CommuniCare Health Centers.

"Yolo County as a trauma informed system of care, proactively and strategically recognizes and addresses the impact of trauma on individuals, service providers, and the community as a whole. Our system of care is inclusive of all community sectors and committed to preventing gaps in service."

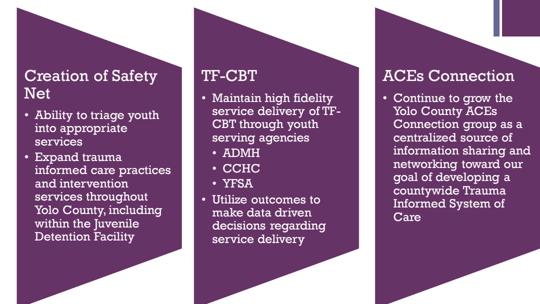
Trauma Informed System of Care Training

- The Yolo County Probation Department contracted with Seeking Safety to provide a total of four, four-hour "Trauma Informed Care for Youth" trainings
- Over 200 attendees across all four sessions with representation from:
  - Yolo County Juvenile Court (Presiding Judge, District Attorneys, Public Defender)
  - Schools throughout the county (Teachers, Counselors, Administrators, School Psychologists, Program Specialists/Advocates, School Nurses, Attendance Liaisons)
  - Court Appointed Special Advocates (CASA)
  - Yolo County Juvenile Probation Officers
  - Yolo County Juvenile Detention Facility Staff and Supervisors
  - Yolo County Alcohol, Drug and Mental Health Department
  - Juvenile Review Board Members
  - Yolo County Department of Employment and Social Services (CWS Social Workers, Employment Specialists,
  - Yolo County Health Department (Outreach Specialists)
  - Community Based Organizations (Clinicians, PN Social Workers, Outreach Specialists, Interns, MHRS, Health Educators, Physician's Assistants, Dentist
  - University of California Davis, School of Education
  - Victim Assistance Network

Accomplishments and Next Steps



Accomplishments and Next Steps



Resources

Resources

- www.nctsn.org
- www.tfcbt.musc.edu
- www.samhsa.org
- www.recognizetrauma.org/statistics.php
- http://freedomnetworkusa.org/wp-content/uploads/2012/05/Trauma_Informed_Care_Powerpoint.pdf
- http://www.ohsu.edu/xd/outreach/occyshn/training-education/upload/TraumaPowerpoint-DrBurrHarris2012.pdf
- http://rodriguezgsarah.files.wordpress.com/2013/05/traumaresbooklet-web.pdf
- http://acestudy.org/
- http://acestoohigh.com
- http://acesconnection.com
- http://centerforyouthwellness.org
- Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense. Justice Policy Institute, 2010
- Shaffer, J.N., Ruback, R.B. *Violent Victimization as a Risk Factor for Violent Offending Among Juveniles.* Juvenile Justice Bulletin, December 2002, Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention