NCTSN The National Child Traumatic Stress Network

Child Traumatic Stress:
What Every Policymaker Should Know

A Guide from the National Child Traumatic Stress Network

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

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Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

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Executive Summary

This guide was written to educate policymakers about the scope and impact of childhood trauma, to offer effective solutions that can be implemented with the support of informed public policy, and to provide information about additional resources. The National Child Traumatic Stress Network (NCTSN) offers this resource for all those who work to develop and implement policies for child- and family-serving systems, including federal, state, and local policymakers, agency and center staff, mental health clinicians, researchers, and service providers, child advocates, and families and consumers affected by trauma.

Child Trauma—A Critical Policy Issue

Everyone pays a price for child trauma. Children, families, neighborhoods, schools, communities, service systems, and—not least of all—taxpayers are all negatively affected when child trauma is left unaddressed.

Untreated child trauma is a root cause of many of the most pressing problems that communities face—problems for which policymakers are held accountable. These include poverty, crime, low academic achievement, addiction, mental health problems, and poor health outcomes. The cost of these problems is felt not only in human terms, but also in dollars and cents. Every year, billions of dollars are spent in the United States to address the inevitable consequences of ignoring childhood trauma.

These negative outcomes are all the more tragic because they are *avoidable*. Successful prevention and intervention programs have been developed, and proven to work. Promising approaches continue to be researched and developed.

However, **such solutions are not possible without the support of public policy.** Policymakers play a critical role in ensuring that the assessment and treatment of child trauma are integrated across systems and programs. Political support of related financing and other resources is also crucial. In short, policy decisions are pivotal in determining whether communities successfully overcome the negative consequences of childhood trauma, or whether caring for traumatized children continues to be simply a "good idea" that is realized in a few discrete places with select populations, while millions of other children and their families are left without the care they need.

Definitions and Developmental Implications

Children are exposed to many kinds of traumatic events, including physical and sexual abuse; domestic violence; community and school violence; loss of loved ones through death or separation; severe accidents or life-threatening illnesses; natural disasters and terrorism; and

experiences in war zones or as refugees. Child traumatic stress occurs when children and adolescents are exposed to traumatic events or situations that overwhelm their ability to cope. Usually such events threaten the life or physical integrity of the child or of someone close to the child, or involve witnessing an occurrence of similar threat happen to someone else. Traumatic events can evoke powerful emotional and psychological reactions such as an overwhelming sense of terror, helplessness, and horror, as well as physical sensations such as racing heart, trembling, dizziness, and loss of bladder or bowel control. In the aftermath of trauma, children may become jumpy and hypervigilant, may struggle with intrusive images related to the traumatic events, may be unable to sleep or have nightmares, and may find it difficult to concentrate or take in new information.

Traumatic events that occur at a particular time and place and are usually short-lived are referred to as *acute traumatic events*. Cases of trauma exposure that occur repeatedly over long periods of time are referred to as *chronic traumatic situations*.

Childhood is a period of intensive emotional and intellectual development, and, because trauma can derail both the neurodevelopment and psychosocial development of children, its impact can last a lifetime. For policymakers, the "take-home" message is simple: **there is no time to wait to address childhood trauma.** Prevention of trauma is, of course, the best route. But when traumatic events cannot be prevented, it is crucial to intervene as early as possible to prevent or minimize the significant damage that can result.

Prevalence, Risk, and Resiliency

Child trauma is a painfully common problem, both domestically and internationally. Although some children are at greater risk of experiencing trauma than others, traumatic events happen to children of all ages, socioeconomic groups, racial and ethnic groups, and geographic regions in the United States. It is well-documented that trauma exposure for children in the United States is widespread (Fairbank, Putnam, & Harris, 2007). Studies of local communities, including subgroups of children, have also found trauma to be pervasive.

Some groups are at particular risk for high rates of trauma and need particular prevention and treatment efforts in order to reduce the negative impact of exposure. At the same time, introducing or supporting protective factors, such as strong social networks, can increase children's resiliency and enable them to successfully handle adversity. Public policies that support the prevention or elimination of risk factors, or that enhance protective factors, can have a positive impact on resilience in children.

Consequences for Individuals, Families, and Communities

Left unaddressed, the lasting effects of childhood trauma place a heavy burden on individuals, families, and communities, and create challenges for virtually all public institutions and service systems. With proper support and intervention, many children are able to overcome traumatic experiences. Unfortunately, too many children go without such support. Research has shown that trauma significantly increases the risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance. Thus, all child- and family-serving systems, especially child welfare, foster care, and juvenile justice, are likely to find that the children they serve have problems related to trauma and need specialized help.

Solutions

Fortunately, solutions exist to reduce the impact of—and, in some cases, even prevent—childhood trauma. What is needed is a system of "trauma-informed care" that effectively recognizes and treats childhood trauma. However, there is no simple formula for achieving such a system. It requires a multi-pronged approach that includes:

- Development and implementation of effective preventive, treatment, and service interventions, including culturally competent practices that reflect the needs of diverse child and family populations
- Strong partnerships and networks, including bonds with families and consumers, to work across service systems and facilitate knowledge exchange

- Training and tools (including data) to help systems effectively identify and address childhood trauma
- Informed public policy that supports and promotes all of these efforts

This guide presents just a few examples of the many proven approaches that can successfully address the needs of children exposed to trauma, as well as their families and communities. (See *Resources,* p. 47, and *References*, p. 53, for sources of information about numerous other successful interventions not profiled here.)

The Role of Policymakers

Policymakers have a central role in determining the fate of children who have been or may be exposed to traumatic events. Implementing effective strategies to address child trauma requires informed public policy, as well as the active involvement of scientists, clinicians, service providers, and all those who work with children and families affected by trauma (Fairbank & Gerrity, 2007). The National Child Traumatic Stress Network (NCTSN) is actively working with policymakers and others who strive to raise the standard of care and increase access to services for traumatized children and their families and communities across the United States.

Introduction:
Child Trauma Is A Critical Policy Issue

Everyone pays the price for childhood trauma. Children, families, neighborhoods, schools, communities, service systems, and—not least of all—taxpayers are all negatively affected when childhood trauma is left unaddressed.

Untreated child trauma is a major contributing factor in many of the most pressing problems that communities face—problems for which policymakers are held accountable. These include poverty, crime, low academic achievement, addiction, mental illness, and chronic medical illnesses. The cost of these problems is felt not only in human terms, but also in dollars and cents. As detailed throughout this report, billions of dollars are spent each year in the United States to address the impact of child trauma.

These negative outcomes are all the more tragic because they are *avoidable*. Successful prevention and intervention programs have been developed, and proven to work. Promising approaches continue to be researched and developed.

All policymakers want to reduce the problems that cause human suffering and increase costs to taxpayers. However, they cannot do so effectively if the role of child trauma is ignored. The purpose of this guide is to educate policymakers about:

- The scope and impact of childhood trauma
- Effective solutions that can be implemented with the support of informed public policy
- Resources for additional information on these topics

Established by Congress in 2000 and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services (HHS), the National Child Traumatic Stress Network (NCTSN) is a collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families and communities across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural and family perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

By providing information, training, and resources, the NCTSN offers support to all child- and family-serving systems (such as education, child welfare, juvenile justice, foster care, mental health,

addiction treatment, emergency and disaster response, and military programs), as well as to many other federal and state agencies that serve children and families. The NCTSN also shares its expertise with all those who develop and implement policies for children and families, including federal, state, and local policymakers, agency directors, mental health clinicians, researchers, and service providers, child advocates, and families and consumers affected by trauma.

Understanding the Problem: The Prevalence and Consequences of Child Trauma

Child traumatic stress is far-reaching in scope and impact. This section of the guide explains what is meant by child traumatic stress, provides statistics on its prevalence, and describes the consequences that may occur when it is left unaddressed.

What Is Child Traumatic Stress?

Child traumatic stress occurs when children and adolescents are exposed to traumatic events or situations that overwhelm their ability to cope. Usually such events threaten the life or physical integrity of the child, or of someone close to the child, or involve the child's witnessing a similar threat to someone else. Traumatic events can evoke powerful psychological and emotional reactions such as an overwhelming sense of terror, helplessness, and horror, as well as physical sensations such as a racing heart, trembling, dizziness, and loss of bowel or bladder control. In the aftermath of trauma, children may become jumpy and hypervigilant, may struggle with intrusive images related to the traumatic events, may be unable to sleep or have nightmares, and may find it difficult to concentrate or take in new information.

Children are exposed to many kinds of traumatic events, including physical and sexual abuse; domestic violence; community and school violence; loss of loved ones through death; severe accidents or life-threatening illnesses; natural disasters and terrorism; and experiences in war zones or as refugees.

Childhood traumatic experiences generally fall into one of two categories: ***acute traumatic events*** or ***chronic traumatic situations.***

An ***acute traumatic event*** occurs at a particular time and place, and is usually short-lived. Acute traumatic events include:

- School shootings
- Gang-related violence in the community

- Terrorist attacks
- Natural disasters (e.g., earthquakes, floods, or hurricanes)
- Serious accidents (e.g., car or motorcycle crashes)
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being beaten, shot, or raped)

In other cases, exposure to trauma can occur repeatedly over long periods of time. In addition to producing some of the same reactions associated with acute traumatic events, these ***chronic traumatic situations*** may result in a range of other responses, including loss of trust in others, guilt, shame, a decreased sense of personal safety, and hopelessness about the future.

They can include:

- Physical abuse
- Sexual abuse
- Domestic violence
- Wars, torture, and other forms of political violence
- Neglect and emotional abuse

Both acute traumatic events and chronic traumatic situations can have serious consequences for children and their families. The examples listed above also illustrate the reality that trauma is embedded in the fabric of daily life. Everyone is at risk of experiencing some form of trauma, and many experience at least one traumatic event during their childhood years.

The Childhood Years: A Period of Growth and Development

Childhood is a period of intensive emotional and intellectual development, and because trauma can derail this development in myriad ways, its impact can last a lifetime. As noted by the US Surgeon General in his 1999 report:

> [C]hildhood and adolescence are marked by dramatic changes in physical, cognitive, and social-emotional skills and capacities. Mental health in childhood and adolescence is defined by the achievement of expected developmental, cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills (USDHHS, 1999, p. 123).

Child traumatic stress interrupts and interferes with this developmental progression in ways that negatively affect a child and reverberate throughout adulthood as well. For example, research has found that child abuse and neglect can negatively affect neurodevelopment (the physical and biological growth of the brain, nervous, and endocrine systems) and psychosocial development (personality formation, including morals, values, social conduct, capacity for relationships with other individuals, and respect for social institutions and mores) (Putnam, 2006). The next section of this guide, *Paying the Price: The Consequences of Child Trauma* (p. 17), illustrates what may occur when these processes are compromised.

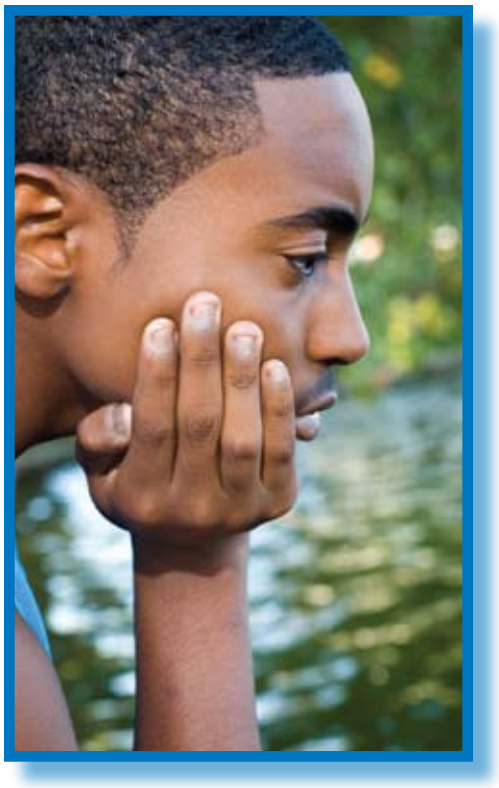
For policymakers, this translates into a simple message: there is **no time to wait** to address child trauma. Prevention of trauma is, of course, the best route. If exposure to trauma cannot be prevented, it is crucial to intervene as early as possible to prevent or minimize the potential for significant damage.

Because childhood is a period of rapid intellectual and emotional development, there is no time to wait to address child trauma.

Prevalence of Childhood Trauma

Child trauma is a painfully common problem both domestically and internationally. Although some children are at greater risk of being exposed to trauma than others, traumatic events happen to children of all ages, from all socioeconomic strata, racial and ethnic groups, and geographic regions in the United States.

It is well-documented that trauma exposure for children in the United States is widespread (Fairbank, Putnam, & Harris, 2007). The national statistics are sobering. For example:



- A study examining the prevalence of violence, crime, and victimization in a nationally representative sample of children and youth aged 2 to 17 found widespread exposure to violence. More than half the children sampled had experienced a physical assault during the study year; more than one in eight had been subjected to some form of child maltreatment (e.g., child abuse or neglect); more than one in twelve had experienced a sexual victimization; and more than one in three had been a witness to violence (Finkelhor et al., 2005).
- The National Survey of Adolescents, sponsored by the National Institute of Justice of the US Department of Justice, estimated that among adolescents aged 12 to 17 in the United States, 5 million had endured a serious physical assault, 1.8 million had experienced a sexual assault, and 8.8 million had witnessed interpersonal violence during their lifetimes (Kilpatrick et al., 2003; Kilpatrick & Saunders, 1993).
- The National Comorbidity Survey (NCS) found that 60.7% of males and 51.2% of females aged 14 to 24 in the United States reported exposure to one or more traumatic events (Kessler et al., 1995).

Studies of local communities that included subgroups of children have also found trauma to be pervasive. The following are just a few examples:

- A study of 160 Head Start preschool-aged children in Michigan found that 78% had been exposed to at least one form of violence; 65.2% had been exposed to at least one incident of violence in the community; and 46.7% had been exposed to at least one incident of mild or severe violence in their family, including child maltreatment and interpersonal violence (Graham-Bermann & Seng, 2005).
- A large study of urban youth aged 10 to 18 years old who were being held pretrial in a juvenile detention center found that 92.5% of detainees had experienced one or more lifetime traumatic events. Eighty-four percent reported multiple (two or more) traumatic experiences, and 56.8% had been exposed to six or more events (Abram et al., 2004).
- A study of New York City public schoolchildren grades 4 to 12 conducted in the wake of the terrorist attacks on September 11, 2001, found that over 60% had experienced at least one significant traumatic event *before* that tragedy. Nearly 25% reported exposure to multiple (two or more) such traumatic events. These events included seeing someone killed

or seriously injured (39%) and seeing the violent and/or accidental death of a close friend (29%) or family member (27%) (Hoven, Duarte, Lucas et al., 2005).

- One study of young adolescent boys from inner-city Chicago found that 68% had seen someone beaten up and 22.5% had witnessed someone shot or killed (NIMH, 2001).
- Childhood trauma is not just an urban problem. A longitudinal study of children residing in the primarily rural western counties of North Carolina found that by age 16, more than 67% reported exposure to at least one traumatic event, such as child maltreatment or domestic violence, traffic injury, major medical trauma, traumatic loss of a significant other, or sexual assault (Copeland, Keeler, Angold, & Costello, 2007).

Did You Know?

Each year, among US children aged 2 to 17:

- Half are victims of a physical assault.
- One in eight experiences child maltreatment.
- One in twelve experiences sexual victimization.
- One in three witnesses violence.

(Finkelhor et al., 2005)

Risk Factors for Trauma

Although exposure to traumatic stress is widespread, most children who receive the support of family and community are resilient, and do not suffer long-term developmental consequences. However, some groups are at particular risk for high rates of exposure to traumatic events, and so need specific prevention and treatment efforts in order to reduce trauma's negative impact (Children's Defense Fund, 2005; Fairbank, Putnam & Harris, 2007). These groups include children who experience:

- Abuse or neglect
- Out-of-home placement
- Exposure to domestic violence

- Poverty
- The violent death of a parent, caregiver, sibling, or friend
- Placement in the juvenile justice system
- Catastrophic accidents or mass casualty events, including those associated with school violence, terrorism, or natural disasters
- Life in countries with major armed conflicts or civil disturbances
- Residential treatment or hospitalization for certain mental health or substance abuse problems, including suicide attempts
- Exposure to violence in their schools and communities
- Chronic and persistent bullying, harassment, and victimization
- Secondary trauma exposure when parents and other caregivers experience trauma and are struggling with their own recovery, as in mass disasters

Lower socioeconomic status has long been associated with an increased likelihood of experiencing undesirable life events (USDHHS, 1999). Racial, ethnic, and cultural groups that are overrepresented among low-income populations are thus placed at a higher risk of experiencing trauma. For example, research indicates that disasters pose particular risks for the mental health of those who face social, economic, and political marginalization, deprivation, and powerlessness. Consequently, children in these populations fare worse in the aftermath of trauma. Their recovery is confounded by these preexisting problems and by the secondary adversities that are more likely to follow traumatic experiences among these populations. Consequently, they experience more severe symptoms for longer

periods of time than other children (NCTSN, 2005b). Some cultural groups endure trauma as a result of historical events, such as war. Becoming a refugee can compound recovery from the original trauma of war and create new trauma exposures (USDHHS, 2001a).
Such demographics underscore the need for culturally competent trauma prevention and intervention programs.

Public policies that prevent or eliminate risk factors or enhance protective factors can increase children's resilience in the face of trauma.

Resiliency and Protective Factors

In responding to traumatic events, some children handle adversity better than others; in other words, they are more resilient. *Resiliency* has been described as the process of, capacity for, or outcome of, successful adaptation despite challenging or threatening circumstances (Masten, Best, & Garmezy, 1990). Protective factors that are associated with resiliency and are correlated with positive outcomes for children (Hughes, Graham-Bermann, & Gruber, 2001; Margolin & Gordis, 2004; Masten & Coatsworth, 1995) include:

- Capacity for cognitive functioning
- Capacity for emotional regulation
- Presence of social supports provided by caring and competent adults
- Holding a positive belief about oneself
- Belief in the safety and fairness of one's situation
- Motivation to act effectively in one's environment

However, even individuals who have multiple protective factors can be overwhelmed by significant levels of trauma. Studies have found that, compared to individuals who have experienced no traumatic events, those who experience multiple traumatic events or circumstances are at much greater risk for a range of serious health problems, including alcoholism, drug abuse, suicide attempts, smoking, poor general health, and sexually transmitted diseases (Felitti et al., 1998). Public policies that prevent or eliminate risk factors, such as poverty or family violence, or enhance protective factors, such as social support, can strengthen resilience in children (Hughes, Graham-Bermann, & Gruber, 2004).

Paying the Price: The Consequences of Childhood Trauma

As the previous examples illustrate, children are exposed to many kinds of trauma and violence, and for some, trauma significantly disrupts development. For these children, the consequences of trauma are profound and long-term.

As will be illustrated in the next section, *Focusing on Solutions* (p. 24), such consequences are not inevitable, and, with proper support and interventions, most children are able to overcome traumatic experiences. Unfortunately, too many children lack such support. Thus, all child-serving systems, especially child welfare, foster care, and juvenile justice, are likely to find that the children they serve have problems related to trauma and need specialized help. Without support, these children are more likely than others to perform poorly in school or drop out, to have difficulty obtaining or maintaining employment, to engage in high-risk behaviors, to suffer or perpetrate violence or abuse, and to have significant mental and physical health problems.

These outcomes are not only painful, but also expensive. For example, one study estimated the annual cost of child abuse and neglect to be approximately $103.8 billion per year in 2007 dollars (Wang & Holton, 2007). This estimate did not fully include indirect medical costs, which are known to be high for victims of child maltreatment (Putnam, 2006). Depression, which is at least three times more prevalent in children who experience abuse than in the general population, has additional costs. In 1998, the direct costs for the treatment of children's mental health problems (emotional and behavioral) were approximately $11.75 billion or $173 per child (Sturm et al., 2000; Ringel & Sturm, 2001). This study included the cost of services provided by health and mental health professionals to treat mental illness. One of the many reasons why national health expenditures for child/adolescent mental disorders are difficult to pinpoint is that mental health and many trauma-related services are delivered and paid for not only in the health and mental health sectors, but also in the education, child welfare, and juvenile justice sectors. No comprehensive national dataset captures all these costs. In addition,

Did You Know?

Child abuse and neglect cost the United States more than $103.8 billion each year.

(Wang & Holton, 2007)

policymakers must also consider the indirect costs associated with mental illness, such as future lost wages as a consequence of lower educational attainment. These are also important parts of the economic burden of child/adolescent mental disorders.

The effects of unaddressed childhood traumatic stress are felt across the spectrum of human experience. As a result, they create challenges for virtually all public institutions and service systems.

Mental Health

The US Surgeon General has noted that exposure to abuse and violence can disrupt the normal development of children and adolescents, with profound effects on mental, physical, and emotional health, and even brain development. In a landmark 1999 review of the mental health research literature, the US Surgeon General found that physical abuse is associated with insecure attachment, impaired social functioning with peers, and psychiatric disorders such as posttraumatic stress disorder (PTSD), conduct disorder, attention-deficit/hyperactivity disorder (ADHD), and depression (USDHHS, 1999).

Psychological maltreatment, sometimes called emotional abuse, can be as harmful as physical abuse. The US Surgeon General's 1999 report on mental health found this form of abuse to be associated with depression, conduct disorder, delinquency, and impaired social and cognitive functioning in children.

(USDHHS, 1999)

Child sexual abuse has been linked to a host of negative psychological outcomes in both childhood and adulthood. For example, studies have found that adult survivors of child sexual abuse are at increased risk for psychiatric disorders including depression, anxiety, substance abuse, PTSD, eating disorders, and suicidality (Al Mamun et al., 2007; Dube et at., 2005; Kendler et al., 2000; Leserman, 2005; Young et al., 2007).

Psychological maltreatment, sometimes called *emotional abuse,* can also be harmful. The US Surgeon General's review found this form of abuse to be associated with depression, conduct disorder, delinquency, and impaired social and cognitive functioning in children. Other findings indicated a relationship between stressful life events, such as parental death or divorce, and the onset of major depression in young children, especially if the events occurred in early childhood (USDHHS, 1999).

Trauma also increases the risk of co-occurring mental health problems. For example, research has demonstrated that PTSD after exposure to a variety of traumatic events (such as family violence, child abuse, disasters, and community violence) is often accompanied by depression. The National Institute of Mental Health (NIMH) recommends that

depression be treated along with PTSD in such cases and that early treatment is best (NIMH, 2001). Studies have also found a high prevalence of trauma exposure and PTSD among those with co-occurring mental health and substance use disorders (NASMHPD & NTAC, 2004).

The outcomes of childhood trauma often reach into adulthood. To further understand the relationship between childhood experiences and adult health, in 1995, the Centers for Disease Control and Prevention (CDC) launched the Adverse Childhood Experiences (ACE) Study. The ACE Study surveyed 17,421 adults at Kaiser Permanente's Department of Preventive Medicine in San Diego, California (Felitti, 2002).

The study found a significant relationship between childhood experiences of abuse and family stress (referred to as "adverse childhood experiences") and a host of negative adult physical and mental health outcomes. Adverse childhood experiences were found to increase the risk of illicit drug use and addiction in adolescents and adults (Dube et al., 2003); adult alcohol abuse (Dube et al., 2002); and adolescent and adult suicide attempts (Dube et al., 2001).

Social Relationships and Behavior

One of the major consequences of significant early exposure to violence can be an impaired capacity for emotional regulation (Fairbank, Putnam, & Harris, 2007). Studies have indicated that traumatized individuals often suffer significant mood swings, anger, irritability, and profound depression. Serious problems with modulating mood and controlling anger can greatly complicate a child's ability to perform in school and to develop healthy peer relations. These problems also increase the risk of a child's self-injury or harm to others (Fairbank, Putnam, & Harris, 2007).

As a group, children exposed to trauma manifest significantly higher levels of emotional and behavioral problems than non-exposed children (Aviles, Anderson, & Davila, 2006). As was noted in Ford et al. (2006, p. 17):

> [W]hen a child's self-respect and sense of control is stripped away—especially if this is done on purpose by trusted persons—this is traumatic victimization. The result of victimization is a child who is likely to resort to 'survival coping'—taking any means necessary to just get by, while feeling damaged, hopeless, distrusting, and empty inside. Survival coping may appear callous and defiant, but it is often a cry for help.

The consequences of this phenomenon are felt at both the individual and community level. For example, studies indicate that at least 75% of youths in the juvenile justice system have been victimized (Ford et al., 2006). Research has found that exposure to violence can increase aggressive behavior (NIMH, 2001).

In addition, the impact of trauma may be carried from one generation to the next. Children exposed to domestic violence are at increased risk of becoming involved in family violence as adults (Widom & Maxwell, 2001). To break the intergenerational transmission of trauma, trauma treatment programs must address not only the needs of the child but also those of the child's parents or caretakers. Effective approaches not only promote the child's recovery but also help parents or caretakers address their own trauma histories. Programs such as Parent-Child Interaction Therapy (PCIT) and Child-Parent Psychotherapy for Family Violence (CPP-FV), which are described in the next section, *Focusing on Solutions* (p. 24), have demonstrated very clearly the benefits of working with both children and their caretakers.

Physical Health

The medical costs of child trauma are significant. In fact, the ACE Study linked child trauma with high-risk behaviors which have been associated with leading causes of death and disability. These behaviors and their outcomes include smoking, heart disease, severe obesity, physical inactivity, depression, suicide attempts, multiple (50 or more) sexual partners, sexually transmitted infections, abuse of alcohol, illicit drug use, and injected drug use (Anda et al., 1999; Dong et al., 2004; Felitti et al., 1998; Felitti, 2002; Hillis et al., 2000).

Child traumatic stress has been linked to serious health problems in children and adults.

The ACE Study also found a link between child trauma and teen pregnancy (Hillis et al., 2004) and paternity in teen pregnancy (Anda et al., 2002). The rate of teen pregnancy among sexually abused girls is approximately four times higher than in non-abused girls. In addition, sexually abused girls are significantly more likely than non-abused girls to have another "rapid-repeat" pregnancy, which interferes with their ability to parent their children (Putnam, 2006).

Experiencing or witnessing violence has been linked to poor school performance.

Other research has found that 30% of abused children have chronic health problems; 3.2% of abused children require hospitalization for serious injuries secondary to child abuse; and that women with histories of sexual abuse are more likely to suffer from obesity, gastrointestinal complaints, chronic pelvic pain, and neurological problems such as headaches and backaches (Drossman et al., 1990; Noll et al., 2007). These are just a few examples of the impact of child trauma on health and medical needs, during both childhood and adulthood.

Cognition and Education

Child traumatic stress can also impair learning. It is well established in the research literature that traumatic stress reactions affect concentration and the ability to take in new information. Experiencing or witnessing violence has been linked to poor school performance in terms of lower grades, increased school absences, and higher dropout and expulsion rates (Hurt et al., 2001; Putnam, 2006).

There is also evidence that maltreatment and early exposure to domestic violence can actually lower children's IQs (Putnam, 2006). The National Clinical Evaluation Study found that:

- Approximately 30% of abused children have some type of language or cognitive impairment.
- Over 50% of abused children have difficulty in school, including poor attendance and misconduct.
- Over 22% of abused children have a learning disorder (Caldwell, 1992).

Trauma can also disrupt the classroom environment, affecting both teachers and students. One study of Head Start teachers who experienced the 1992 Los Angeles riots showed that 7% had severe posttraumatic stress symptoms and 29% had moderate symptoms. Children also were acutely affected by the violence and anxiety around them. They were more aggressive and noisy and less likely to be cooperative or relate well with others (NIMH, 2001).

Some children experience school-related trauma on a regular basis, which affects their attendance. Children who are persistently bullied at school may experience not only physical injury but also serious symptoms of traumatic stress. They may avoid school at all costs to preserve a sense of personal safety. For example, according to the Centers for Disease Control (CDC) a nationwide survey of high school students found that about 6% missed at least one day of school in the previous month because they felt unsafe at school or on their way to or from school (USDHHS, 2004).

The negative effects of child traumatic stress encompass mental and physical health, behavior and social relationships, learning, and academic achievement. Left unaddressed, the lasting effects of child trauma place a heavy burden on individuals, families, communities, and all child-serving systems. Fortunately, solutions exist to reduce the impact of—and in some cases, even prevent—childhood trauma.

Children who are persistently bullied at school may experience serious symptoms of traumatic stress.

Focusing on Solutions: Working Toward Systems of Trauma-Informed Care

As painful as the consequences of child traumatic stress can be, they are not inevitable. There are a number of innovative programs and approaches that clinical experience and research have shown to reduce the impact of child trauma, or even prevent traumatic events from occurring. Promising practices continue to be explored. These approaches not only benefit children and their families but are also felt throughout communities and across service systems.

Such outcomes, however, require a service system focused on "trauma-informed care." Hodas (2006) describes trauma-informed care as multifaceted. A system of trauma-informed care:

- Recognizes the pervasiveness of trauma and makes a commitment to identify and address it early, whenever possible
- Seeks to understand the connection between presenting symptoms and behaviors and an individual's past trauma history, and involves professional relationships and interventions that take into account an individual's trauma history as part of efforts to promote healing and growth
- Provides trauma-specific treatment (developmentally focused, specialized treatments that may be needed to address complex trauma-related consequences) as well as less specialized support services that can be provided in multiple settings by committed professionals who understand trauma
- Applies to multiple systems and settings, including (in the case of children) mental health, juvenile justice, child protection, education, ambulatory care, and community programs
- Entails cross-system coordination that incorporates consideration of trauma in comprehensive service planning

Unfortunately, there is no simple formula for achieving such a system. Instead, it requires a **multi-pronged approach** that includes these four action areas:

- **Effective Interventions.** Development and implementation of effective prevention efforts, treatment, and service interventions, including culturally competent practices that reflect the needs of diverse child populations
- **Strong Partnerships.** Strong partnerships and networks, including working relationships with families and consumers, to work across service systems and facilitate knowledge exchange
- **Tools and Training.** Training and tools (including data) to help systems effectively identify and help those affected by childhood trauma
- **Trauma-Informed Policy.** Informed public policy that supports and promotes all these efforts

The sections that follow describe each of these **four action areas** in more detail and offer examples.

ACTION AREA 1
Effective Interventions

At the core of any trauma-informed system is the provision of effective treatments and services. Many successful trauma prevention and intervention programs have been developed and proven to work. In addition, promising approaches continue to be researched and developed.

> ***Did You Know?***
>
> [Y]outh violence is not an intractable problem. We now have the knowledge and tools needed to reduce or even prevent much of the most serious youth violence, with the added benefit of reducing less dangerous, but still serious, problem behaviors and promoting healthy development.
>
> —US Surgeon General
>
> (USDHHS, 2001b)

Core Components of Interventions

The National Child Traumatic Stress Network (NCTSN) has identified a list of core components that trauma-focused interventions, regardless of their theoretical basis, have in common (NCTSN, 2007). Successful trauma interventions incorporate one or more of the following components:

- Risk screening and triage
- Systematic assessment, case conceptualization, and treatment planning
- Psychoeducation
- Attention to traumatic stress reactions and experiences of children and families

- Trauma narration and organization
- Emotional regulation and anxiety management skills
- Facilitation of adaptive coping and maintenance of adaptive routines
- Enhancement of parenting skills and behavior management
- Promotion of adaptive developmental progression
- Attention to grief and loss
- Promotion of safety skills
- Relapse prevention
- Evaluation of treatment response and effectiveness
- Engagement of families and consumers in improving access to services
- Culturally competent practices

In selecting interventions to implement, NCTSN encourages service providers and other stakeholders to consider: (1) whether and how specific interventions include desired intervention components; (2) how, if included, these components are carried out (e.g., skills acquisition activities, homework, role-playing, games, other approaches); and (3) how well these components fit with the specific needs and preferences of the population served. For example, does the intervention emphasize acquiring appropriate coping skills? If so, are the activities in which skills are acquired appropriate for the developmental level, cultural background, and geographic features of the population served? Interventions that do not include the necessary core components may be inappropriate for the population or may require substantial adaptation in order to be considered appropriate.

The needs, values, and preferences of the people served by an agency or service system should also help determine the type of intervention needed (NCTSN, 2007). Factors to consider include:

- Prevalence of types of trauma and loss to which population has been exposed
- Types and rates of mental distress and associated behavioral and functional impairment

- Cultural background(s) of the clientele and the surrounding community
- Developmental factors, including age, cognitive, and social domains
- Socioeconomic factors
- Logistical and other barriers to seeking help
- Availability of individual, family, and community supports and resources
- Setting in which services are offered (e.g., school, clinic, home, residential setting)

MODEL OUTREACH PROGRAM

Outreach to a Traumatized Community

The Center for Multicultural Human Services in Falls Church, Virginia, offers a model of service to refugee communities. Established in 1982, the center provides services annually in 34 languages to more than 6,000 refugee children and their families.

In 2003, the center identified the Washington, DC–area Sierra Leonean community for outreach. Sierra Leonean refugees come to the United States having survived more than a decade of brutal war and atrocities such as the deliberate amputation of the limbs of children. Many Sierra Leonean children living in the United States are orphans being raised by adoptive or host families.

To reach Sierra Leonean families, the center conducted a systematic outreach that began with regular attendance at community gatherings and co-sponsorship of cultural events. The center made a commitment to serving the immediate needs of the community, hiring "culture brokers" from the community as liaisons. Aware that many Sierra Leonean families would not be receptive to the concept of mental health care, but that family bonds and education are highly valued by the community, the center framed its help in terms of improving family communication and children's academic performance.

As a result of its outreach, the Center for Multicultural Human Services created a strong partnership with the Sierra Leonean community, working together to help Sierra Leonean children build constructively on their pasts so they can create new lives in the United States.

(NCTSN, 2004a)

The Importance of Prevention

Across fields of healthcare, preventive measures are recognized as essential to maintaining and improving public health. Clean water prevents diseases of many kinds, and automobile seatbelts can prevent injuries, disability, and even death. Such preventive measures are much less costly, both in human and financial terms, than treating the diseases caused by people's drinking contaminated water or providing physical rehabilitation for injured people after a car accident.

The same is true in the field of trauma. By supporting the prevention of child trauma due to abuse, neglect, community violence, school bullying, and other harmful events, policymakers can improve and even save the lives of children, ease the burden on public systems, and save significant taxpayer dollars.

The following are **two examples of successful prevention programs** that have benefited children and families:

MODEL PREVENTION PROGRAM

Preventing Trauma Through Early Education: The Upstate New York Shaken Baby Syndrome (SBS) Education Program

The head injuries caused by infant shaking can be devastating, often causing lifelong disabilities or even death. To address this problem, the Upstate New York Shaken Baby Syndrome (SBS) Education Program was established to reduce the incidence of SBS in the region. The SBS Education Program is a hospital-based parent education program designed to educate parents about the dangers of SBS.

Whenever a child is born in the region, the program provides educational materials to both parents who are then asked to voluntarily sign a commitment statement that affirms their understanding of the materials they've received. Participating hospitals return these commitment statements so they can be tracked to determine the effectiveness of the program.

One study of the program found that seven months after signing the commitment statements, over 95% of parents remembered having received the information. Moreover, during the first 5.5 years of the program, there was a 47% decrease in abusive infant head injuries in the region (Dias et al., 2005). To date, parents have returned more than 120,000 signed commitment statements.

(Women's and Children's Hospital of Buffalo, http://www.chob.org/shakenbaby/)

MODEL PREVENTION PROGRAM

Preventing Trauma through Early Intervention: The Nurse-Family Partnership (NFP)

Widely recognized as a model preventive intervention, the Nurse-Family Partnership (NFP) is a nurse home visitation program that seeks to improve the health, well-being, and self-sufficiency of low-income first-time parents and their children. A nurse visits the homes of high-risk women through pregnancy and the first year of the child's life. The nurse adheres to visit-by-visit protocols to help women adopt healthy behaviors and to care responsibly for their children.

A follow-up research study conducted 15 years after the program began found that it had had many positive effects, including preventing and reducing traumatic events. Compared to control groups, the adolescents who had been infants when the program began had experienced a 48% reduction in child abuse and neglect, a 59% reduction in arrests, and a 90% reduction in adjudications as persons in need of supervision (PINS) for problem behavior.

As a result of its documented outcomes, today the NFP program is being implemented in 280 counties in 22 states across the nation. In many states, NFP programs are funded as special projects or through state appropriations.

(NFP, 2007; New Freedom Commission on Mental Health, 2003)

Proven and Promising Practices

Information on specific effective interventions is readily available to policymakers and others. For example, NCTSN maintains a Web-accessible list of empirically supported treatments and promising practices in addressing childhood trauma. Other organizations and agencies have also identified proven and promising practices. A list of some of these sources is provided in the *Resources* section (p. 47).

The following are just a few examples of successful interventions that have benefited children, families, and communities. While this is by no means a comprehensive list of effective approaches, these examples help illustrate the value of implementing best practices.

Overcoming Early Experiences of Domestic Violence: Child-Parent Psychotherapy for Family Violence (CPP-FV)

CPP-FV is a psychotherapy model designed to restore the child-parent relationship and the child's mental health and developmental progression in the wake of domestic violence. The target populations are infants, toddlers, and preschoolers who have witnessed potentially traumatizing levels of domestic violence and/or who display symptoms of violence-related trauma including PTSD, aggression, defiance, noncompliance, recklessness, excessive tantrums, multiple fears, inconsolability, separation anxiety, difficulties sleeping, and social and emotional withdrawal.

CPP-FV involves weekly one-hour sessions, in the home or in clinic settings, for a period of 12 months. Child-parent interactions are the focus of 6 intervention modalities that promote developmental progress through play, physical contact, and language; provide development guidance; model protective behaviors; help parents and children to differentiate reliving traumatic experiences from remembering them; provide emotional support; and offer concrete assistance, case management, and crisis intervention.

CPP-FV has been tested with children and mothers from multi-ethnic, primarily low-income families. For children, outcomes included reductions in symptoms of traumatic stress and in behavior problems. For mothers, outcomes included reductions in symptoms of traumatic stress as well as a decline in avoidance of engagement with their children (NCTSN, 2007).

Helping Children Cope and Recover: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

The goal of TF-CBT is to help address the biopsychosocial needs of children with PTSD or other problems related to traumatic life experiences, and to help their parents or primary caregivers. The target population is children who have significant behavioral or emotional problems related to traumatic life events, whether or not they meet full diagnostic criteria for PTSD.

Developed by Judith Cohen, MD, Esther Deblinger, PhD, and Anthony Mannarino, PhD, TF-CBT combines trauma-sensitive interventions with cognitive behavioral therapy. It is a clinic-based, short-term treatment that includes individual sessions with the child and parent as well as joint parent-child sessions. Through these sessions, children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

TF-CBT has proven to be effective in improving symptoms of PTSD, depression, and anxiety, as well as in reducing externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. In addition, the parental component of TF-CBT increases the positive effects of TF-CBT for children by reducing parents' own levels of depression and emotional distress about their children's traumatic experiences and improving their parenting practices and support of the child.

TF-CBT has been tested with Caucasian, African-American, and Latino children, and is currently being adapted for Native American children and for children in other countries including Zambia, Pakistan, the Netherlands, and Germany (NCTSN, 2007). More information about TF-CBT is available through SAMHSA at http://www.modelprograms.samhsa.gov/pdfs/model/TFCBT.pdf, and online training in TF-CBT is available at http://tfcbt.musc.edu.

Coaching Caregivers: Parent-Child Interaction Therapy (PCIT)

This treatment teaches parents or caregivers skills through teaching sessions and also provides step-by-step play sessions during which the therapist coaches the parent or other caregiver. Generally, the therapist provides coaching from behind a one-way mirror using a transmitter so the child is unaware of the therapist's input. The goal of PCIT is to change negative parent-child patterns of interaction and to improve the quality of the parent-child relationship (or the caregiver-child relationship in residential treatment centers and foster homes); to increase the child's pro-social behaviors and minimize problem behaviors; to increase parenting skills, including positive discipline; and to reduce parental stress.

Studies have shown that PCIT has been very effective. This intervention has reduced the number of re-reports for physical abuse as well as the number of negative parent-child interactions. In a follow-up study three to six years after treatment, mothers reported that their children with oppositional defiant disorder and associated behavior disorders had maintained the improvements in their behavior gained after treatment. Further, the mothers also reported that they had maintained their own improvement in self-control in the years following treatment (NCTSN, 2007).

Working in the Schools: Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)

CBITS provides school-based mental health screening and a standardized brief cognitive behavioral therapy for students who have been exposed to violence. The program is the result of a collaborative effort between the Los Angeles Unified School District (LAUSD), and researchers from the University of California, Los Angeles, and the RAND Corporation.

The ten-week in-school program consists of ten group sessions and one to three individual therapy sessions. It also includes an educational presentation for teachers and group meetings for parents

MODEL SCHOOL PROGRAM

Expanding School-Based Services

Miller Children's Abuse and Violence Intervention Center (MCAVIC) in Long Beach, California, is one example of an NCTSN member center that has increased its presence in schools as a result of its NCTSN grant. MCAVIC serves a culturally diverse, mostly low-income clientele.

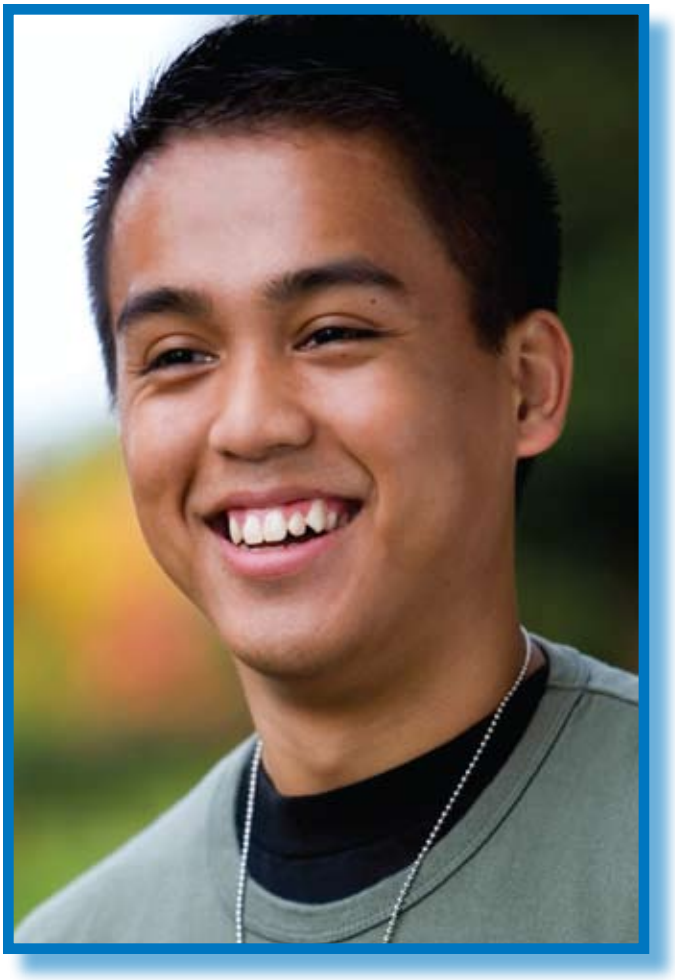
In 2003, the center added a program with Storefront Schools, an educational last resort for adolescents who have been expelled due to violent or disruptive behavior. The center's director noted that Storefront students are "the most severely traumatized adolescents in the school district" but are also the population "least likely to receive services because of people's tendency to regard them as 'bad kids.'"

MCAVIC staff now have an almost daily presence at Storefront and have found that the continuity of contact between students and clinicians is, in itself, therapeutic. As one MHAVIC staff person explained, "These children and adolescents, many of whom have major trust issues as a result of multiple, severe traumas and losses, have never had anyone advocating for them, and are amazed by the experience."

(NCTSN, 2004a)

or caregivers. Designed to be readily implemented by existing school personnel such as school psychologists, counselors, and social workers, the program builds peer and familial support to sustain children once the formal intervention ends.

To test the intervention, a pilot study was conducted in two LAUSD middle schools in largely Latino neighborhoods. Participating children were sixth-graders who had been victims of, or witnesses to, school violence. The results showed the CBITS program to be very effective at alleviating the students' symptoms of PTSD and depression. The CBITS program has been successfully disseminated to other communities and school districts, and adaptations in other settings such as pediatric and adolescent health clinics and community mental health centers are underway (NCTSN, 2004a; Stein et al., 2003).



2 ACTION AREA 2
Strong Partnerships

The negative effects of childhood traumatic stress are far-reaching. They manifest in all areas of children's lives, and thus in all service systems that seek to address children's needs. Solving multi-system problems will require multi-system, collaborative approaches. Strong networks and partnerships are needed at the federal, state, and local levels to work across systems and share knowledge about what does and doesn't work.

The following are just a few examples of how networks and partnerships can improve the assessment and treatment of children who have experienced trauma.

Encouraging Federal, State and Local Collaboration: The Center for Mental Health Services (CMHS) Transformation Agenda

In 2002, the President's New Freedom Commission on Mental Health was created. Its charge was to study the mental health service delivery system for children and adults, and make recommendations to improve it.

In its final report, *Achieving the Promise: Transforming Mental Health Care in America,* the Commission proposed a number of measures to meet this goal. Among the Commission's observations was that mental health services and funding are fragmented across several programs and agencies at all levels of government. The Commission recommended that states develop comprehensive state mental health plans that would "create a new partnership among the Federal, State, and local governments," as well as with mental health service populations and their families (New Freedom Commission, 2003, p. 8).

The Center for Mental Health Services (CMHS), a federal agency under the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services, is working with federal and state agencies to accomplish this and other transformation goals. Through the provision of technical assistance and Mental Health Transformation State Incentive Grants (MHT-SIGs), CMHS is working with states on cross-system planning and infrastructure development (USDHHS, 2006).

A Strong National Partnership: The National Child Traumatic Stress Network (NCTSN)

In 2000, in recognition of the national impact of traumatic events on the nation's children and youth, the US Congress passed the Donald J. Cohen National Child Traumatic Stress Initiative, which established the National Child Traumatic Stress Network (NCTSN). NCTSN is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. NCTSN comprises more than 70 member centers (currently funded grantees and affiliates), and is coordinated by the UCLA-Duke University National Center for Child Traumatic Stress (NCCTS). (For more information about NCTSN, see http://www.netsn.org.)

Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education. NCTSN connects academic and clinical institutions that have specialized knowledge and experience in developing trauma-focused evidence-based treatments with service providers that have community-based experience in providing treatment and services to children and families affected by trauma.

NCTSN centers also work together to develop, disseminate, and implement interventions that will serve the nation's diverse populations of children and adolescents in the full gamut of real-world service settings. Because trauma affects all aspects of families' and communities' lives, the NCTSN extends its reach beyond traditional mental health care settings to schools, medical settings, the juvenile justice system, child protective services, police and other first responders, foster care programs, and many other organizations that interact with children.

Six programs of the National Center for Child Traumatic Stress (**NCCTS**) generate and coordinate ongoing efforts vital to the NCTSN's mission (links to information on specific NCTSN programs are included in the *Resources* section, p. 47):

- The **Data and Evaluation Program**, in conjunction with the Duke Clinical Research Institute (DCRI), at Duke University, provides administrative and scientific leadership as well as technical expertise related to data collection and utilization. This program is responsible for managing the data contributed by all NCTSN centers, for selecting appropriate methods for evaluating treatment outcomes and health service delivery and utilization, and for coordinating the NCTSN response to the federal national evaluation.
- The **Treatment and Interventions Program** promotes the development, evaluation, adoption, dissemination, and adaptation of evidence-based and evidence-informed interventions for diverse populations of traumatized children and their families throughout the NCTSN and beyond, including a training curriculum on the core

concepts, components, and skills considered essential to implementing any best-practice trauma-focused treatment for children and adolescents.

- The **Service Systems Program** works across a wide-range of child-serving systems (e.g., schools, child welfare, or health care) and the general public (e.g., parents, caregivers, and families) to increase awareness about the impact of child traumatic stress and the intersections of culture and trauma. It builds strategic partnerships within and outside the NCTSN, provides education and training, and develops products to address gaps in knowledge and skills across these systems. It increases skills for identifying and triaging traumatized children by providing resources and training to front-line staff and administrators and by promoting strong collaborations between systems and disciplines.
- The **Training Program** promotes a coordinated and systematic effort to develop, support, and provide state-of-the-art, multiplatform, effective training to enhance the quality of clinical assessment, treatment, and services for traumatized children, adolescents, and their families and communities. By combining a broader, organizational approach with a focus on quality improvement , the Training Program works in collaborative partnerships with NCTSN organizations to bring forward and share the most current knowledge from the academic research and clinical practice fields.
- The **Terrorism and Disaster Program** (TDP) works to promote the mental health and well-being of children and families by strengthening the nation's preparedness and response to terrorism and disaster. The TDP's activities, including public education and product development, promote an approach to disaster mental health that is integrated and coordinated within a comprehensive disaster system of care which includes emergency medical services, police, fire and disaster relief personnel, schools, hospitals, and other event-specific essential services and providers. The TDP serves as a national resource for post-terrorism and disaster response, mental health needs assessment, tracking and triage of children and their families, and integration with state and federal preparedness and response plans.
- The **Policy Program** works with federal, state, and local policymakers and with NCTSN members to identify and shape policies within the private and public sectors that affect the care of traumatized children. Through collaborative consultation within and outside the Network, NCTSN members analyze these policies and identify new or alternate policies that will improve the care of children affected by traumatic events. The Network also serves as an educational body to support the work of policymakers and agency officials who direct the activities of the multiple service systems that interact with children and families. The Policy Program develops educational and policy briefs for dissemination within and outside the NCTSN.

Other National Center for Child Traumatic Stress initiatives include important and innovative training opportunities, such as the Breakthrough Series Collaborative (BSC) and Learning Collaborative (LC) programs. In these programs, NCTSN centers work together to share information, to implement training sessions, and to refine proven and promising interventions. For example, one BSC effort was focused on the adoption and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This BSC included teams from 12 NCTSN sites across the country that were committed to providing TF-CBT with sufficient fidelity in order to appropriately serve and improve outcomes for children and families. To accomplish this, each site convened a five- to ten-member team that included clinicians, supervisors, agency administrators, family members, and community partners.

Participating sites committed to testing small, rapid changes that were quickly implemented to accomplish this goal. Sites then shared their adoption and adaptation successes and lessons learned to further accelerate their achievement of improved outcomes.

The NCTSN uses its collaborative structure in a variety of ways, all of which are focused on improving treatment for childhood traumatic stress.

Effective treatment of child trauma requires multidisciplinary teams. These can include mental health clinicians, social workers, teachers, law enforcement personnel, judges, and others. For such teams to function effectively, service systems and provider agencies must be able to collaborate, and to coordinate their efforts. Two community-level collaborations provide excellent examples of what is possible when formerly disparate agencies work together to address the effects of child trauma.

MODEL COMMUNITY PARTNERSHIP PROGRAM

The Louisiana Rural Trauma Services Center (LRTSC)

In the 23rd Judicial District of south Louisiana, which serves three rural parishes, the judge hearing school truancy and juvenile delinquency cases noted that these youths often came from families in which there was substance abuse or parental neglect and that many were involved in child dependency cases for these and other reasons. Fearing that many of these youths might "fall through the cracks" and have continued problems in school and with the law, the judge reached out to the Louisiana Rural Trauma Services Center (LRTSC), an NCTSN center, for help.

Staff from the LRTSC and the 23rd Judicial District began working together in significant ways. To help the court make more knowledgeable and effective decisions in juvenile cases, the LRTSC provided a written summary of the evaluation, including its mental health recommendations. These evaluations were used to determine the types of follow-up interventions, including mental health treatment, that were needed. To address those needs, the partnership expanded beyond the LRTSC and the courts to include the schools, law enforcement, and community agencies.

One result of this collaboration was greater utilization of mental health treatment and support services by youths in the juvenile justice system. By offering evaluations for youths and their families in juvenile court with subsequent treatment and follow-up and by providing related services in the schools, mental health services became less stigmatized for these families.

The availability of better evaluation and treatment plans has resulted in more positive outcomes, including reduced recidivism as well as decreases in the frequency of behavioral problems, truancy, school suspensions and expulsions, for many of these youths.

(Kliebert et al., 2006)

A Cross-System Initiative: The Partnership for Results

This nonprofit agency is dedicated to promoting community-wide collaborations that foster the healthy development of children from infancy through secondary school. The partnership has focused its efforts on the city of Auburn and several nearby communities in rural Cayuga County, New York. It has implemented an innovative, replicable program designed to enhance the multi-agency service delivery system for children and families at risk (Uninsky, 2006; Partnership for Results, http://www.partnershipforresults.org/).

The partnership's goals include increasing school safety and creating educational environments that foster attendance, learning, safety, and appropriate behavior; reducing levels of juvenile violence and addiction; and identifying the target population at the earliest possible moment and providing appropriate services both in and out of school. Its program design involves the collaboration of public education, mental health, human services, health, and local law enforcement agencies as well as community stakeholders including parents, students, and community-based organizations. These organizations work together to provide a continuum of services to children and families that include numerous evidence-based primary and secondary prevention programs.

Based on evaluations over a four- to six-year period, the partnership's approach has had significant positive outcomes. For example:

- Foster care placements declined 43%.
- Youth arrest rates declined 41% for violent crimes and 59% for property crimes.
- Juvenile detention costs decreased by over 50%.
- School safety increased, with a 62% decline in physical fights, a 25% reduction in bullying, and a 59% decrease in crimes against persons on school property.

As noted by one of its architects, the collaborative model of the Partnership for Results program is "overcoming the obstacles that often stand in the way of delivering services that promote the positive social, emotional, and academic development of at-risk children" (Uninsky, 2006).

MODEL PROGRAM

Family and Children's Services: Co-Locating to Provide Trauma Services

Family and Children's Services, an NCTSN center, is a not-for-profit private social service agency in Nashville, Tennessee. Among its many programs and services, the agency provides outpatient mental health counseling to individuals and families, permanency services for foster children, and trauma intervention services for children and their families throughout the greater Nashville area. Through its trauma intervention program, it partners with the Metropolitan Nashville Police Department, the Department of Children's Services, and other agencies to provide direct services to children who have suffered or witnessed violence in their homes or neighborhoods. For example, since 1999, the agency's clinicians have been co-located in two inner-city police substations and in one inner-city school where they are available to provide counseling services to children exposed to violence. Trauma clinicians are on call 24 hours a day, 7 days a week, for the police department and for Child Protective Services, and they begin services on the scene in the immediate aftermath of violence or a traumatic event.

(Gray & Szekely, 2006)

ACTION AREA 3
Tools and Training

While effective interventions and multi-system collaborations can yield tremendous benefits, implementation is rarely a simple process. Tools, including data, are needed to select the right service models and facilitate the implementation process. Training is essential to ensure that agencies and practitioners have the skills and knowledge to replicate successful approaches with fidelity.

The NCTSN is devoted to the development and provision of such tools and training. A few examples:

- The NCTSN is currently implementing the **Core Data Project**, a common set of assessments used to evaluate the services and treatments being delivered to children and families at NCTSN centers. The purpose of the Core Data Project is to integrate formerly fragmented assessment and evaluation information so it can be used successfully by clinicians to improve treatment, by researchers to develop new prevention and intervention strategies, by program administrators to track organizational change, and by lawmakers to formulate national policies for children.
- The **Measures Review Database** is a searchable database containing reviews of measures relevant to the field of child traumatic stress. All reviews were conducted by trauma experts using a uniform review template to allow comparison across measures. The goal is to provide easy access to comprehensive clinical and research information so users can determine whether a measure is appropriate for a specific individual or group, taking into account such important factors as the purpose of the assessment, age, cultural and linguistic group, and trauma type.
- The **Child Welfare Project** develops and disseminates information on trauma-focused, evidence-based interventions for children and families in child welfare systems. A multi-part child welfare training program is among the products and tools for child welfare administrators that have been developed through this project. A Trauma Training curriculum for resource parents is currently in development.
- The NCTSN sponsors **education and training events and teleconferences** including expert presentations on topics such as the developmental impact of child trauma, how to conduct trauma assessments, and culture and trauma. The presentations are open to the public and are available on the Web via video, audiotapes, and transcripts. Professionals targeted for training through the NCTSN programs include:
  - Educators and school administrators
  - Child welfare workers

- Mental health counselors
- Court service personnel
- Family and family court judges
- Guardians *ad litem*
- Law enforcement personnel
- Foster care guardians
- Addiction treatment counselors

- The NCTSN and its members also provide trainings on specific interventions. For example, a Web-based course on Trauma-Focused Cognitive Behavioral Therapy (TF-CBTWeb, see p. 50) is available through the Medical University of South Carolina. This online training was developed by Judith Cohen, MD, Anthony Mannarino, PhD, and Esther Deblinger, PhD, creators of the TF-CBT intervention, and their colleagues.
- The NCTSN also develops and disseminates trauma intervention protocols. For example, together with the National Center for PTSD (NCPTSD, which is under the US Department of Veterans Affairs), the NCTSN has developed an intervention protocol for providing psychological first aid (PFA) to children and families after disasters. PFA can be used to help children and families after traumatic events, including natural disasters, catastrophic school violence, and terrorism. Mental health professionals responding to Hurricanes Katrina and Rita in 2005 used it to conduct triage as they assessed and provided assistance to displaced children, stabilized traumatized children, and began treatment to "patch psychological wounds" (Brymer et al., 2006; NCTSN, 2005).

(For more information on these and other types of tools and trainings, please see *Resources,* p. 47.)

ACTION AREA 4
Trauma-Informed Policy at the Federal, State, and Local Levels

None of the actions so far described here—the implementation of effective interventions, the development of cross-system collaborations, and the provision of tools and training—is possible without the fourth action area: the support of public policy. Policymakers play a critical role in ensuring that the assessment and treatment of child trauma is integrated across systems and programs. Their support of related financing and other resources is also crucial. In short, policy decisions are pivotal in determining whether communities successfully overcome the negative consequences of child trauma or whether trauma assessment and treatment continues to be

simply a "good idea" that is realized in a few discrete places with some select populations while millions of other children and their families are left without the care they need. To change this, all those involved with delivery of services to children and families affected by trauma should work with policymakers, sharing experiences and suggestions, so that the real-life problems of families, consumers, providers and service systems can be considered when policies and regulations are established. This kind of working collaboration can result in better programs and better policies (Fairbank & Gerrity, 2007).

Policy decisions at all levels of government can foster—or hinder—the implementation of solutions. Some examples of related federal policy issues include:

- ***Financing.*** A number of federal funding streams fund, or could potentially fund, child trauma assessment and intervention. These include entitlement programs such as Medicaid and Foster Care (Title IV-E); formula or block grant programs such as the State Children's Health Insurance Program (SCHIP) and the Community Mental Health Services (CMHS) Block Grant Program; discretionary or project grants such as Crime Victim Assistance (CVA) grants, Project SERV (School Emergency Response to Violence) grants, and mental health research grants; emergency or supplemental grant programs such as the Crisis Counseling Assistance and Training Program (CCP) funded through the Federal Emergency Management Agency (FEMA); and grants funded through such legislation as the Violence Against Women Act (VAWA) and the Child Abuse Prevention and Treatment Act (CAPTA) (Folcarelli et al. 2003; Gray & Szekely, 2006).

  Despite the many mechanisms through which trauma funding could and should be provided, public health and social services related to child trauma have been chronically underresourced. In order to ensure that child trauma is effectively addressed in a number of systems and settings, policymakers must support federal, state, and local provisions that enable multiple funding streams to be used for this purpose. They must also support program funding at a level that makes this possible. Trauma programs that are successfully sustained often leverage government dollars with private funding from foundations, businesses, United Way, and other local opportunities, but they also need a reliable commitment from policymakers to strengthen the continuity of such efforts.

- ***Public Education.*** Federal public health programs can provide information to child-serving professions and to the public about child trauma, its signs and symptoms, and where to seek help. Such campaigns have been launched in the past but have tended to focus on specific traumatic events such as the September 11, 2001 terrorist attacks or the 2005 Gulf Coast hurricanes. Although such event-specific campaigns can play a crucial role in helping children and families recover from trauma, it is also necessary to incorporate trauma information more broadly into standard public health and mental health campaigns. Such campaigns could serve as important psychoeducational and preventive tools, helping families and others to understand, prepare for, and support children when they are exposed to traumatic events of all kinds (Gerrity, 2007).

For child trauma to be addressed across systems and settings, policymakers must enable multiple funding streams to be used for trauma services.

- ***Data Collection and Technical Assistance.*** By supporting data collection, training, and technical assistance, federal and state governments play a key role in supporting the replication of best practices and in helping communities adapt those practices to meet individual needs.

- ***Research.*** Continued research is necessary to develop and refine child trauma prevention and intervention efforts. In its recommendations to the president, the New Freedom Commission on Mental Health noted a need to expand the knowledge base to address trauma and its effects on diverse populations. The commission recommended that the federal government undertake a sustained program of research on the impact of trauma on the mental health of specific populations such as women, children, and victims of violent crime, including victims of terrorism. In addition, the commission urged that the National Institutes of Health (NIH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) partner to enhance the evidence base and to evaluate service models for treating PTSD and other trauma-related disorders in public mental health settings (New Freedom Commission, 2003).

State policies also play a crucial role in addressing childhood traumatic stress. For example:

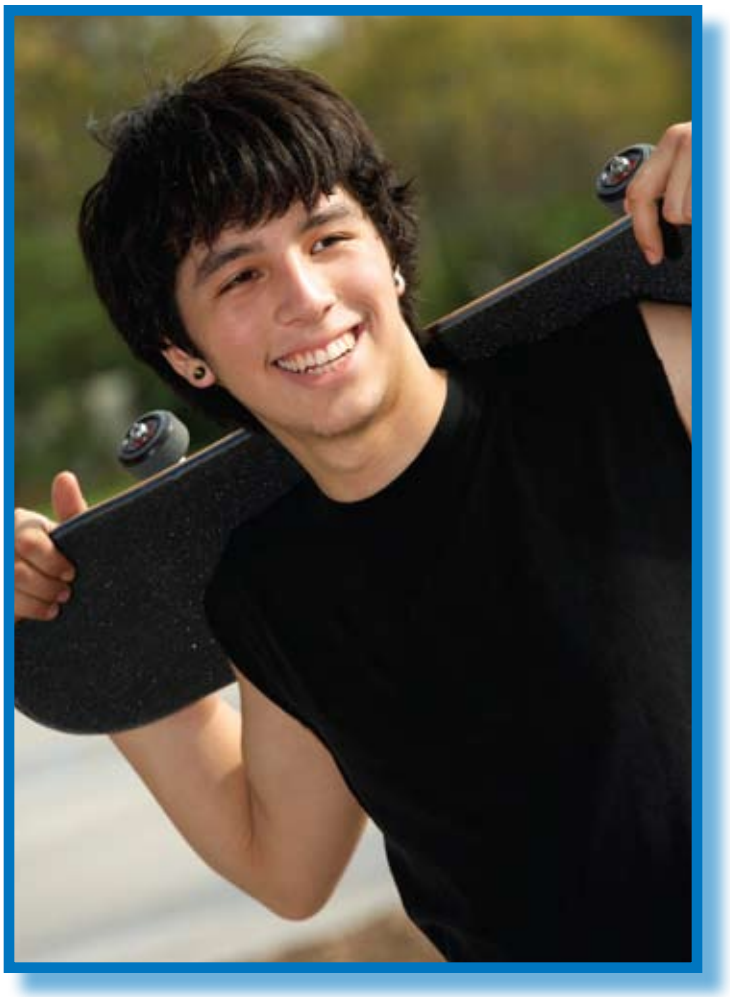
- ***Cross-System Collaboration.*** Transformation of child services can occur through cross-system collaboration. State policies can directly affect the ways in which child trauma services are integrated into child-serving state systems, including child welfare, mental health and addiction services, juvenile justice, and schools. For example, some states (e.g., Ohio,

Oklahoma, and New Mexico) are currently addressing the impact of trauma through federal grants to help transform their mental health systems (Gerrity, 2007).

- ***Financing.*** Some service systems involved in trauma care, such as mental health, are largely financed by state and local funds. As with federal funding, these streams should include provisions for financing of trauma care and should receive funding appropriations adequate to cover these services. Trauma services are also impacted by the degree to which states leverage—or fail to leverage—federal funding to provide them. For example, under the Medicaid program, states are required to fund some mental health services potentially related to trauma treatment, such as in- and outpatient hospital services. However, other crucial services, such as mental health clinic services, rehabilitation services, and case management, are optional under Medicaid, meaning that state Medicaid programs can choose whether or not to cover them (Folcarelli & Law, 1994).

At the **local level**, policy efforts can support trauma-focused partnerships among different child-serving agencies. Such collaborations generally require policy changes at the institutional or agency level. They also require building trust among diverse professional groups and between families and service providers (Gerrity, 2007). Examples of such partnerships that can be developed include working with:

- Disaster and terrorism preparations and response teams at the state and local level
- Prevention/early intervention program staff at mental health centers regarding trauma-informed services
- Public school personnel to enhance awareness and violence prevention efforts



- Law enforcement agencies to develop interventions in domestic violence or child abuse cases
- Homeless shelter agencies to provide training and resources for helping displaced children
- Juvenile court judges and personnel to provide training and resources
- Infant and child development programs and day care center staff to offer information about dealing with trauma

Collaborations also occur through the sharing of resources on program, agency, and governmental websites. The following section provides an annotated listing of specialized trauma-related resources that are available through Internet access.

Finding Information: Resources for Policymakers and Others

Scope and Impact of Childhood Trauma

The following resources provide statistics and research findings on the prevalence of childhood trauma and its effects:

- The **National Child Traumatic Stress Network's** website (http://www.nctsn.org) provides information on child trauma for parents and caregivers, service providers, educators, researchers, and the media.
- The **National Institute of Mental Health** (**NIMH**; http://www.nimh.nih.gov/) provides information on a range of mental illnesses and mental health problems, including PTSD, traumatic stress, and other disorders associated with trauma. From the Home page, click on "Mental Health Topics" under "Health & Outreach."
- The **Substance Abuse and Mental Health Services Administration** (**SAMHSA**; http://www.samhsa.gov), under the US Department of Health and Human Services, provides a range of resources on coping with traumatic events at http://www.samhsa.gov/trauma/index.aspx. You can also find information about the **National Center for Trauma-Informed Care** (**NCTIC**; http://www.mentalhealth.samhsa.gov/nctic/default.asp); a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services.
- The **Centers for Disease Control and Prevention's** website (**CDC**; http://www.cdc.gov) includes a section on emergency preparedness and response (http://www.bt.cdc.gov/), as well as a list of trauma and disaster mental health resources for the public and practitioners (http://www.bt.cdc.gov/mentalhealth/). The CDC also operates the **National Center for Injury Prevention and Control** (http://www.cdc.gov/ncipc/) which houses the **Division of Violence Prevention** (**DVP**; http://www.cdc.gov/ncipc/dvp/dvp.htm). The DVP's mission is to prevent injuries and deaths caused by violence. Its work includes monitoring violence-related injuries; conducting research on the factors that put people at risk or that protect them from violence; creating and evaluating the effectiveness of violence prevention programs; helping state and local partners to plan, implement, and evaluate prevention programs; and conducting research on the effective adoption and dissemination of prevention strategies.
- The **Adverse Childhood Experiences Study** (**ACE**; http://www.acestudy.org/) is a major research project examining the relationship between childhood traumatic experiences and

adult health, including mental health. For more information about ACE publications, please also see the CDC's website (http://www.cdc.gov). From the Home page, put "Ace Study" in the Search box.

- The **American Psychological Association's website** (http://www.apa.org) offers fact sheets, announcements of research findings, clinical information and other resources on the topic of trauma (http://www.apa.org/topics/topictrauma.html).

Effective Interventions

The following resources provide more information on some evidence-based and promising practices in trauma prevention and intervention.

- The **National Child Traumatic Stress Network's website** (NCTSN; http:// www.nctsn.org) includes a list of empirically supported treatments and promising practices in addressing child trauma. The listings for some interventions describe their development or adaptation for diverse cultural groups, or for populations other than those for whom the intervention was originally designed (http://www.nctsn.org/nccts/nav.do?pid=ctr_top_trmnt_prom#q3).

- The **Partnership for Results's** website (http://www.partnershipforresults.org) includes a list of evidence-based and promising practices in the areas of school-based and afterschool programs for children and families as well as enhanced, community-based prevention and intervention for at-risk children and families (http://www.partnershipforresults.org/programs.html).
- The **Substance Abuse and Mental Health Services Administration** (**SAMHSA**) also maintains an evolving **National Registry of Evidence-Based Programs and Practices** (**NREPP**; http://www.nrepp.samhsa.gov/index.htm) in mental health and substance abuse services. To find information on programs which address the impact of childhood trauma, go to http://www.nrepp.samhsa.gov/find.asp, click on "Find Interventions," and use a search term such as "child trauma."
- Quality evidence-based information about what works to improve the lives of children, youth, and families is available at the **Promising Practices Network's** website (http://www.promisingpractices.net), which has been developed and is operated by the Rand Corporation. The website provides information as well as summaries of programs and practices that have been proven to improve outcomes for children. From the Home page, click in the left column on "Programs that Work."

Please see also the full citations in *References* (p. 53) for specific interventions discussed in this paper.

Strong Partnerships and Networks

Following are some resources that describe networks and partnerships focused on systems change and/or knowledge exchange:

- Information about the structure and membership of the **National Child Traumatic Stress Network** (http://www.nctsn.org) can be found at: http://www.nctsnet.org/nccts/nav.do?pid=abt_main
- The components of the **Partnership for Results** (http://www.partnershipforresults.org/index.html), a successful community-wide collaboration to foster the healthy development of children and youth, are described in detail on the program's website.
- Information on the **SAMHSA Mental Health System Transformation** initiative can be found at their website (http://www.gov/matrix/SAP_mh.aspx).
- The **National Center for Trauma-Informed Care** (**NCTIC**; http://mentalhealth.samhsa.gov/nctic/default.asp) assists publicly-funded agencies, programs, and services in making the cultural shift to a more trauma-informed environment that benefits both systems and consumers. Such an environment is more supportive, comprehensively integrated, and

empowering for trauma survivors. The NCTIC website includes a list of trauma-specific interventions based upon psychosocial educational empowerment principles that have been used extensively in public system settings (http://mentalhealth.samhsa.gov/nctic/trauma.asp#intervention).

Tools and Training

In addition to the data sources listed above under *Scope and Impact of Childhood Trauma* (p. 47), other examples of data, education, and training resources include:

- Information on the **NCTSN Measures Review Database** (http://www.nctsnet.org/nccts/nav.do?pid=ctr_tool_searchMeasures)
- NCTSN-sponsored **educational programs, training events, and teleconferences**; open to the public on the Web via video, audiotapes and transcripts. To access archived materials and for schedules of future events (http://www.nctsn.org/nccts/nav.do?pid=ctr_top_train).
- A Web-based training course on **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** (http://tfcbt.musc.edu/)
- "**Psychological First Aid (PFA) Field Operations Guide, 2nd Edition** (http://www.nctsnet.org/nctsn_assets/pdfs/pfa/2/psyfirstaid.pdf)
- "**Listen, Protect, Connect – Model & Teach: Psychological First Aid (PFA) for Students and Teachers,** a print-ready brochure (http://www.ready.gov/kids/_downloads/PFA_SchoolCrisis.pdf)

Trauma-Informed Policy

The documents listed below include policy recommendations, resources, and information:

- *Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma (2007),* an important report by the National Center for Children and Poverty (NCCP) highlighted the role that child trauma plays in the lives of children affected by poverty (http://www.nccp.org/publications/pub_737.html)
- **In 2004, the Johnson & Johnson Pediatric Institute (JJPI)** held a major conference on interventions for children exposed to violence. A chapter from its final report, *Pediatric Round Table – Interventions for Children Exposed to Violence,* "Mobilizing Trauma Resources for Children" by William Harris, Frank Putnam, and John Fairbank can be found on the NCTSN website (http:www.nctsn.org/nctsn_assets/pdfs/reports/HarrisManuscript.pdf).

Conclusion

Child traumatic stress is a real and common problem. Left unaddressed, it carries serious consequences for individuals, families, and communities. This translates into consequences for service systems and the use of taxpayer dollars.

However, such outcomes are not inevitable. Proven prevention and intervention strategies exist that can avert or ameliorate the negative effects of child trauma. This guide provides just a few examples of the many approaches that have been proven to work in addressing the needs of children touched by trauma, as well as their families. It also lists sources of information about the numerous successful interventions not profiled in this paper.

The implementation of effective strategies requires informed public policy. Policymakers have a central role in determining the fate of children who have experienced, or are at risk of experiencing, trauma. The National Child Traumatic Stress Network (NCTSN) stands ready to work with policymakers and others who want to raise the standard of care and increase access to services for traumatized children, their families, and communities across the United States.

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NCTSN The National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.