ADVANCING TRAUMA-INFORMED SYSTEMS FOR CHILDREN

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IMPACT

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Ideas and Information to Promote the Health of Connecticut's Children

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About the Child Health and Development Institute of Connecticut:

The Child Health and Development of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

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INTRODUCTION

Childhood trauma exposure is a significant public health concern. Children are exposed to potentially traumatic events at alarming rates and the negative effects of untreated traumatic stress can last a lifetime. By the age of 17, more than 71% of all children experience a potentially traumatic event – including physical abuse, sexual abuse, violence, or serious accidents.[1] Fortunately, many children are resilient and can recover from trauma exposure with familial and other natural supports. Other children, however, particularly those with chronic or severe trauma exposure and limited support, often experience significant and long-term problems.

Exposure to potentially traumatic events can disrupt brain development and can have lifelong adverse effects on emotional and physical well-being.[2] The risks are especially high for young children who have limited internal resources to understand or cope with trauma and whose developmental trajectory is highly malleable. For example, trauma exposure has been linked to developmental delays, behavioral health problems including posttraumatic stress disorder (PTSD), school problems, delinquency, substance abuse, and suicide.[3] Childhood trauma exposure has been linked to the onset of 28% of all psychiatric disorders in adolescents.[4] The landmark Adverse Childhood Experiences (ACE) study demonstrated that childhood trauma exposure is also associated with chronic health and behavioral health problems across the lifespan, including heart disease, obesity, diabetes, emphysema, and premature death.[5]

The lifetime costs associated with child maltreatment alone have been estimated at $210,012 to $1.8 million per child due to associated health, behavioral health, educational impairments, increased involvement in criminal justice, child welfare, social welfare systems, and lost work productivity.[6,7] Cumulatively, the lifetime costs associated with child maltreatment are estimated at $124 billion to $5.9 trillion nationally for the children maltreated in a single year.[6,7] One study found that 9% of all Medicaid claims for children were associated with child maltreatment.[8]

There is now emerging evidence that investments in trauma-focused services and systems can be recouped through reduced health care costs in as little as one year.[9,10] Preventive services that promote a secure relationship between young children and their caregivers can provide a lasting buffering effect to enhance resiliency and may prevent trauma exposure from occurring in the first place. Early identification of children suffering from trauma exposure and enhancing access to effective trauma-informed services can minimize the consequences of trauma exposure and promote healthy development. Together, these elements comprising “trauma-informed care” have the potential to improve outcomes for all children and to dramatically reduce service and system utilization costs over longer periods of time.

This IMPACT provides a framework for developing a comprehensive and integrated trauma-informed system of care for children. Examples are provided from Connecticut's child-serving systems implementing trauma-informed programs and services. This report is intended to help child serving systems advance trauma-informed care in order to provide more effective and cost-efficient services that result in better outcomes for all children.

BACKGROUND

The call to action to ameliorate the effects of childhood trauma through creation of trauma-informed service systems began more than a decade ago.[11] The goal was, and still is, for systems serving children to work together to prevent, identify and effectively treat childhood traumatic stress. However, a hallmark of trauma is avoidance, where one does not think or talk about trauma because doing so may cause anxiety or distress. Avoidance is common among children, caregivers, and professionals, but systemic avoidance related to addressing trauma has been a barrier to the development of trauma-informed systems.

Recently, the burgeoning research on the prevalence, adverse effects, and costs associated with trauma have led to increasing efforts to make federal, state and local systems more "trauma-informed" and "trauma-sensitive." This interest is leading to a cultural shift among systems from the traditional avoidance-based adage about trauma ("let sleeping dogs lie") to a more explicit focus on addressing trauma directly ("if you don't ask, they won't tell").

For example, a number of federal agencies are promoting trauma-focused systems:

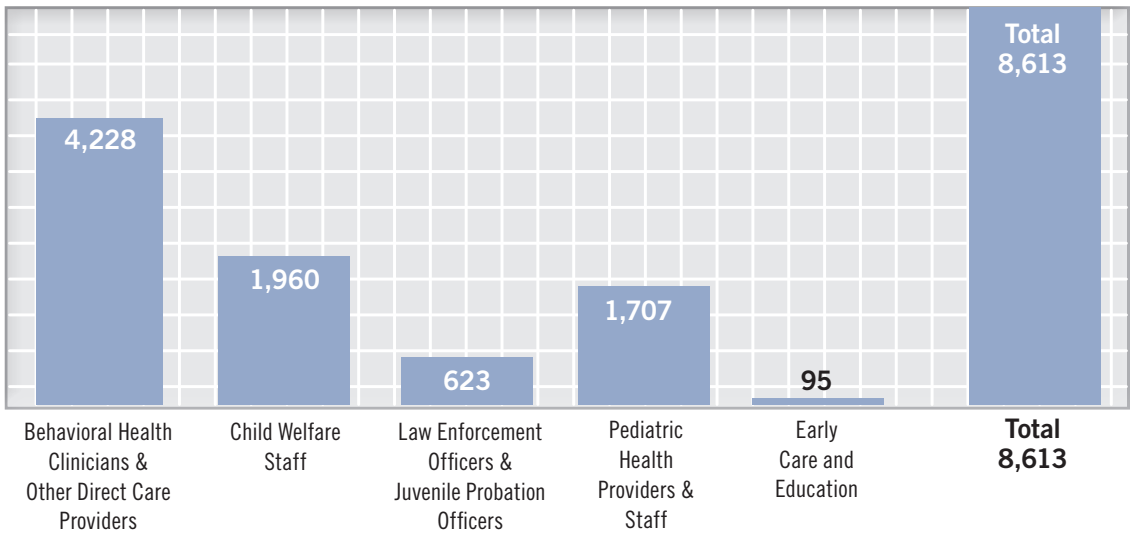
- The Substance Abuse and Mental Health Services Administration (SAMHSA) has funded the National Child Traumatic Stress Network (NCTSN) since 2000 to improve services across the country for child trauma victims and identified trauma as one of its eight strategic initiatives in 2011.[12]
- The Administration for Children and Families has prioritized the development of trauma-informed child welfare systems, including legislation in The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) requiring state child welfare agencies to report how they address trauma experienced by children in foster care.
- Other federal agencies, including the Center for Medicare and Medicaid Services, the Department of Justice and the Department of Education have recognized the impact of child trauma and prioritized trauma-focused systems and programs.

Among states, Connecticut has emerged as a leader in trauma-informed systems through collaborations between state agencies, community-based providers, nonprofit organizations, academic institutions, advocacy groups, families, and others to improve services for childhood trauma victims. Since 2007 in Connecticut:

- more than 8,600 child-serving professionals across multiple sectors have been trained in trauma-informed care (see Figure 1)
- more than 50,000 children have been screened for trauma exposure
- more than 8,700 children have received trauma-focused evidence-based practices (EBPs)

Despite these advances, more work is needed to effectively prevent, identify, and address trauma in Connecticut's children and to develop coordinated, integrated, and effective child-serving systems that support these aims.

Figure 1. Professionals Trained in Statewide Initiatives on Childhood Trauma (2007-2015)*



*Based on known statewide initiatives, not including local or private training efforts.

Basic staff training and awareness about trauma is essential but not sufficient for a system to become trauma-informed.

What is "Trauma-Informed"?

This report focuses on efforts to develop trauma-informed child-serving systems in Connecticut (e.g., behavioral health, child welfare, juvenile justice) and efforts to develop integrated trauma-informed care across systems that serve children and their families. Definitions used in this report related to trauma are shown in Table 1.

Defining a "trauma-informed system" is challenging and various interpretations exist. Basic staff training and awareness about trauma, which is becoming increasingly common, is essential but not sufficient for a system to become trauma-informed. In addition, trauma-informed care is consistent with, but not a replacement for, best practices and standards of care. For example, generally accepted best practices in child-serving systems include prevention, early intervention and care that is culturally competent, family-centered, and strength-based in the least restrictive environment possible.

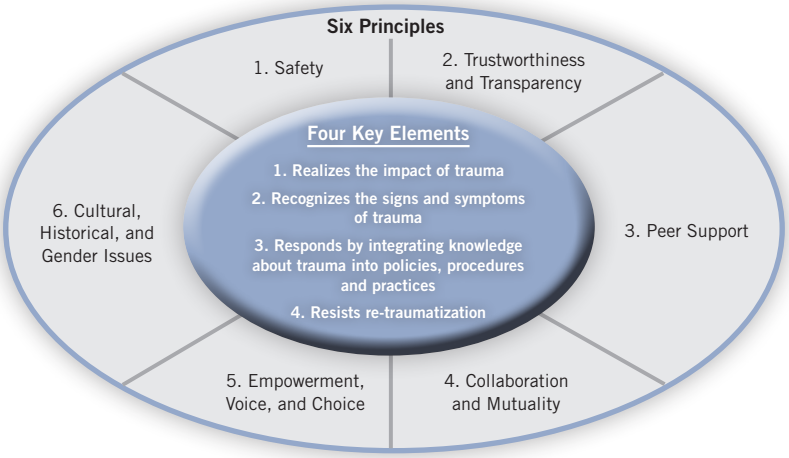
Table 1. Definitions of Terms

Potentially traumatic event	An event that typically involves experiencing or witnessing a serious or life-threatening situation, such as physical abuse, sexual abuse, domestic violence, community violence, accidents, or natural disasters
Trauma exposure	When a child experiences or witnesses one or more potentially traumatic events
Traumatic stress reactions	Short- and long-term physical, emotional, cognitive or behavioral responses following trauma exposure
Childhood trauma	Refers to both trauma exposure and traumatic stress reactions
Trauma-informed	When policies, practices, and interactions with families and colleagues are grounded in knowledge about childhood trauma
Trauma-informed system	A system (e.g., child welfare or education) that demonstrates principles of trauma-informed care

Creating trauma-informed service systems is critical work and plays an essential role in achieving the overarching goal of raising the standard of care and improving access to effective services for children, families, and communities impacted by trauma.

– Carrie Epstein, LCSW-R
Childhood Violent Trauma Center
Yale Child Study Center

Figure 2. SAMHSA's Trauma-Informed Approach[13]



SAMHSA defines four key elements and six principles of a trauma-informed approach, as shown in Figure 2.

In this report, we build upon SAMHSA's definition to define four key elements of a trauma-informed system. These components, Workforce Development, Trauma Screening, Practice Changes and Use of EBPs, and Inter-system Collaboration and Communication are shown in Figure 3.

Table 2 on page 9 describes each of these components in further detail and provides a brief checklist which systems or agencies can use to assess their efforts to become trauma-informed.

Figure 3. CHDI's Key Elements of a Trauma-Informed System

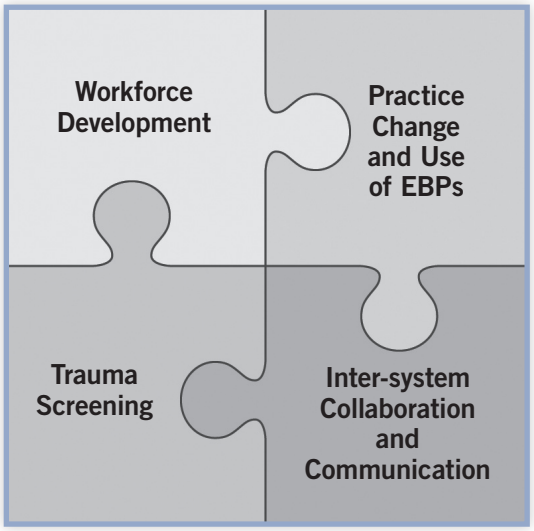


Table 2. Key Elements of a Trauma-Informed System

Workforce Development

- ❑ Staff are knowledgeable about the prevalence and effects of trauma exposure and traumatic stress reactions, and associated health and behavioral health outcomes
- ❑ Staff are knowledgeable about short- and long-term traumatic stress reactions, posttraumatic stress disorder, and misdiagnosis of traumatic stress
- ❑ Staff understand the concept of trauma avoidance and how to discuss trauma with children and families who may be reluctant to do so
- ❑ Staff are knowledgeable about evidence-based trauma-focused assessment and treatment referral options
- ❑ Staff understand how to identify secondary traumatic stress/vicarious trauma and use strategies to promote wellness

Trauma Screening

- ❑ Every child is screened for trauma exposure and trauma reactions at initial system contact and periodically thereafter
- ❑ Children are screened using multiple informants/sources of information
- ❑ Trauma screening information is incorporated into the child's health record

Practice Change and Use of Evidence-Based Practices

- ❑ Development of case plans and services is informed by knowledge about trauma, including the child's trauma history and reactions
- ❑ Agency demonstrates ongoing commitment and funding to supporting evidence-based trauma-focused practices
- ❑ Staff communication and interactions with family are informed by knowledge of childhood trauma and the principles of a trauma-informed approach
- ❑ Staff conceptualize behavioral and emotional concerns from a trauma-informed perspective when appropriate
- ❑ Agency executives and supervisors provide tangible supports and supervision to promote trauma-informed care

Inter-System Collaboration and Communication

- ❑ Staff across systems have a shared understanding about childhood trauma
- ❑ Systems work together to identify youth with trauma exposure and associated symptoms
- ❑ Systems work together to support referrals to, and engagement in, trauma-informed services when appropriate
- ❑ Staff across systems work to align service, treatment and case plans
- ❑ Information about a child's trauma is shared across systems when permitted
- ❑ Staff across systems work to avoid redundant, too many, or contraindicated services

A trauma lens brings an understanding and language for collaboration and joint enterprise across service systems. Trauma-informed care is a shared value that agencies can rally around for integrated care for children, parents, and adults while still recognizing mission diversity.

– Paul Shanley, LCSW
Connecticut Department of Children and Families

Connecticut: An Exemplar of Trauma-Informed System Development

Connecticut has been at the forefront of trauma-informed care for more than a decade, dating to the development of the Child Development-Community Policing (CD-CP) program in the 1990s in New Haven and beginning statewide with the adult behavioral health system in 2001. Table 3 highlights examples of trauma-informed care in Connecticut from 1991 through 2015. Early local initiatives from the Yale Child Study Center, UConn Health, Clifford Beers Clinic, and the Klingberg Family Center increased interest in trauma-informed care in child-serving systems and helped set the stage for the development of statewide efforts to promote trauma-informed care.

In 2007, a statewide Trauma Summit was convened with state and national leaders. The Trauma Summit provided direction to the state's efforts to develop a trauma-informed children's service system, including a plan to bring EBPs for child traumatic stress to community mental health centers across the state. Between 2007 and 2010, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was disseminated to 16 outpatient clinics. In 2011, the Department of Children and Families (DCF) was awarded a five-year federal grant called the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) to further expand trauma-focused EBPs and develop a trauma-informed child welfare system.

Table 3. Timeline of Key Trauma Initiatives in Connecticut

Initiative		Summary
Child Development Community Policing (CD-CP)	1991	Initiative begins in New Haven as a partnership between law enforcement, children's behavioral health, and juvenile justice to support children affected by trauma.
The Consortium for Substance Abusing Women and Their Children (now the Connecticut Women's Consortium)	1998	Originally created in 1990 to support substance abusing women and their children in New Haven, the Consortium expands statewide and begins focus on trauma-informed care.
DMHAS Trauma-informed care initiative	2001	DMHAS begins focusing on trauma-informed care in adult behavioral health, including dissemination of multiple trauma-focused EBPs in community settings.
Trauma Affect Regulation: Guide for Education and Therapy (TARGET) dissemination	2005	Trauma screening and TARGET group treatment model is disseminated into juvenile detention centers and community based juvenile justice programs.
Clifford Beers Clinic receives federal grant for trauma-informed care	2005	Grant award through SAMHSA's National Child Traumatic Stress Network, to promote trauma-informed care for children.
Risking Connection through Klingberg Family Center's Traumatic Stress Institute	2006	Implementation of a staff trauma training model for systems serving childhood trauma victims in any capacity.
Connecticut Trauma Summit	2007	Convened by DCF and CHDI to bring together statewide and national leaders in childhood trauma and behavioral health to develop plans for creating a trauma-informed system.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) dissemination	2007	An evidence-based, trauma-focused outpatient treatment for children, TF-CBT is disseminated to 16 community-based agencies between 2007-2010.
Child First dissemination	2010	Dissemination of an evidence-based, trauma-informed home visiting intervention for children from birth through age 6.
DMHAS Adopts Trauma Services Policy	2010	Trauma Services Policy articulates the importance of, and approaches to, promoting trauma-informed care in adult behavioral health.
Connecticut Collaborative on Effective Practices for Trauma (CONCEPT)	2011	DCF receives five-year CONCEPT grant from the Administration for Children and Families to improve trauma-informed care in the child welfare system.
Educating Practices In the Community (EPIC) Child Trauma Module dissemination	2012	Provides introductory training on child traumatic stress for pediatric providers and their staff using an academic detailing approach.
Connecticut General Assembly passes PA 13-178, An Act Concerning the Mental, Emotional, and Behavioral Health of Youths	2013	Sandy Hook Commission recommends trauma-informed systems; Bill resulting from the tragedy provides additional funding for children's behavioral health services, including trauma-informed services.
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) dissemination	2014	MATCH-ADTC is a modular, evidence-based outpatient treatment for children suffering from anxiety, depression, trauma, and/or conduct problems.
Child and Family Traumatic Stress Intervention (CFTSI) dissemination	2014	CFTSI is a brief, preventive intervention for children who have experienced trauma within the past 45 days.
Cognitive Behavioral Therapy for Trauma in Schools (CBITS) dissemination	2015	CBITS is an evidence-based, trauma-focused group intervention delivered in schools.

"Fifteen years ago, the lack of awareness and training about trauma and its impact in the human services could only be described as system-wide dissociation. Today, the growing movement toward trauma-informed care represents a systemic willingness to KNOW about the pain and suffering caused by trauma and begin addressing it in a holistic way that is healing rather than retraumatizing."

– Steve Brown, Psy.D.
Traumatic Stress Institute
Klingberg Family Centers

Most recently, in response to the tragedy in Newtown, the Connecticut General Assembly called for an extensive study of the children's behavioral health system and opportunities for enhancement (PA 13-178, An Act Concerning the Mental, Emotional, and Behavioral Health of Youths). The final plan recommended allocating funding for trauma-informed services for children and integrating these services across the state's behavioral health, child welfare, juvenile justice, health, and education systems.

The next sections of this report detail ways in which Connecticut is building trauma-informed systems of care across child-serving sectors. Additionally, Appendix I details the implementation of trauma-informed care elements (workforce development, trauma screening, practice change, and collaboration) across child serving systems in Connecticut.

Statewide System Implementation

Connecticut has adopted a range of trauma-informed policies, initiatives, and practices, resulting in a more knowledgeable workforce, earlier identification of trauma through screening, and a rapid expansion of accessible and high quality trauma treatment options for children. The specific strategies used, outcomes achieved, and challenges identified across each child-serving system are followed by a summary of cross-system efforts to promote trauma-informed care in Connecticut. Although the summary below attempts to avoid redundancy, the most comprehensive trauma-informed initiatives include various activities associated with developing trauma-informed systems, and therefore, those initiatives may appear in more than one system.

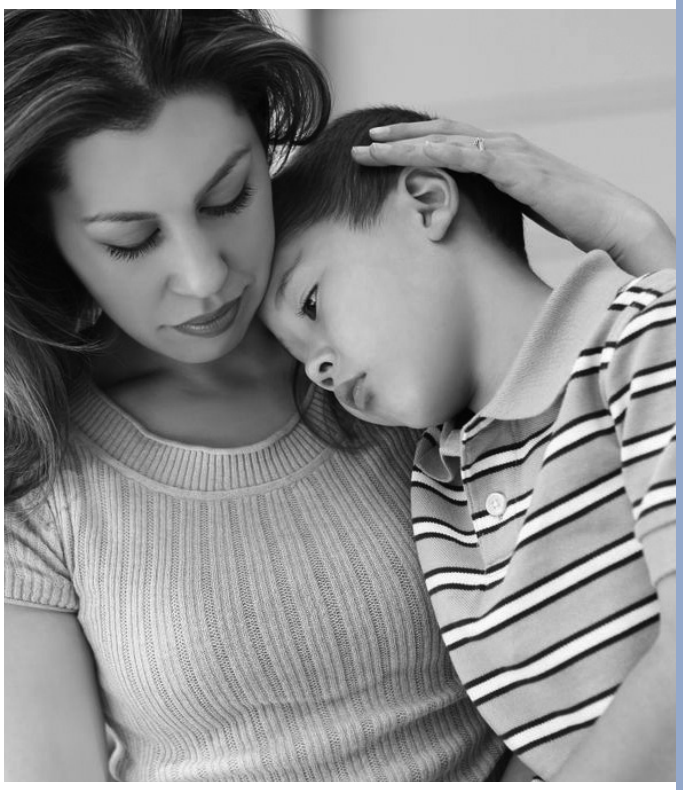
Without proper screening, children suffering from unidentified traumatic stress may be misdiagnosed with other behavioral health conditions and provided unnecessary, ineffective, or even contraindicated interventions that do not address the underlying traumatic stress.

Children's Behavioral Health System

The children's behavioral health system is a critical system for implementing trauma-informed care. DCF has the statutory responsibility for children's behavioral health in Connecticut, although a number of other child-serving state agencies fund and oversee children's behavioral health services for their respective populations. As shown in Appendix I, DCF has taken a primary role with model developers, intermediary organizations, child-serving community behavioral health centers, and others to integrate trauma-informed care into the children's behavioral health system.

Workforce development. To effectively support and treat children exposed to trauma, children's behavioral health professionals must be aware of the prevalence and impact of trauma, how to make referrals for effective trauma treatment, and agency policy and procedures supporting trauma-informed care. Trauma training has been provided to more than 4,000 behavioral health providers in a number of programs across Connecticut including mobile crisis, outpatient services, and congregate care facilities.

Screening. Trauma screening is especially important in behavioral health settings, where children are referred for a wide range of emotional and behavioral concerns and where many clinical services are delivered. Without proper screening, children suffering from unidentified traumatic stress may be

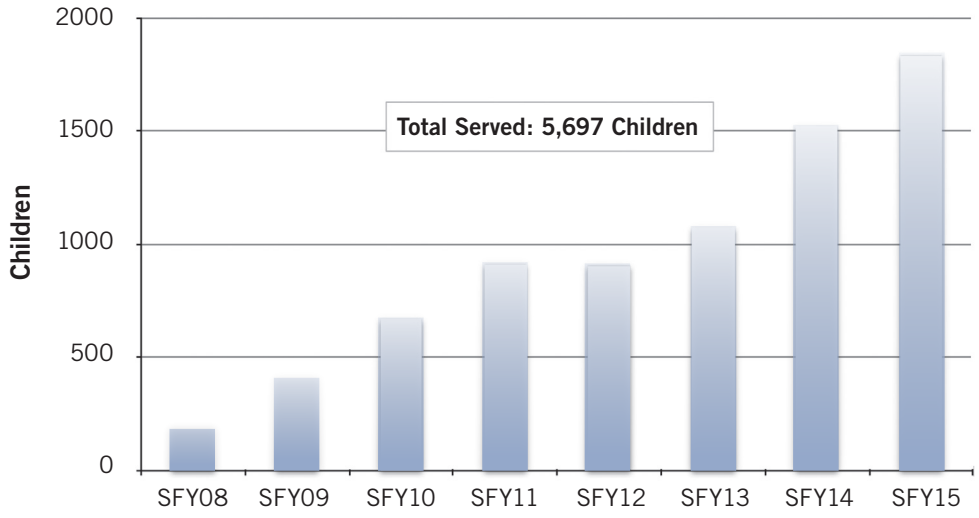


misdiagnosed with other behavioral health conditions and provided unnecessary, ineffective, or even contraindicated interventions that do not address the underlying traumatic stress. Administering trauma exposure screening items are now routine practice for most DCF-contracted behavioral health programs, including outpatient clinics, extended day treatment, mobile crisis, and others. Comprehensive trauma assessments by trained clinicians, using standardized measures, are available at 35 provider agencies serving children at 79 sites across Connecticut.

Practice change and collaboration. Availability of trauma-focused EBPs is an important component of a trauma-informed system. Connecticut has been a national leader in the dissemination of practices for children, beginning with a number of in-home EBPs and more recently with the statewide dissemination of TF-CBT in outpatient clinics. Since 2007, DCF has supported the TF-CBT Center of Excellence at CHDI to disseminate TF-CBT, resulting in more than 5,600 children receiving this treatment (Figure 4). This initiative has utilized the Institute for Healthcare Improvement's Breakthrough Series Collaborative model and the emerging field of implementation science, with the recognition that dissemination of EBPs requires more than standalone clinical training.[15,16,17,18]

Sustainability of EBPs, even after successful implementation, is one of the major challenges to improving children's behavioral health services, yet most agencies do not have the resources to support EBPs alone.[16,17] DCF and CHDI have used economies of scale to expand capacity and

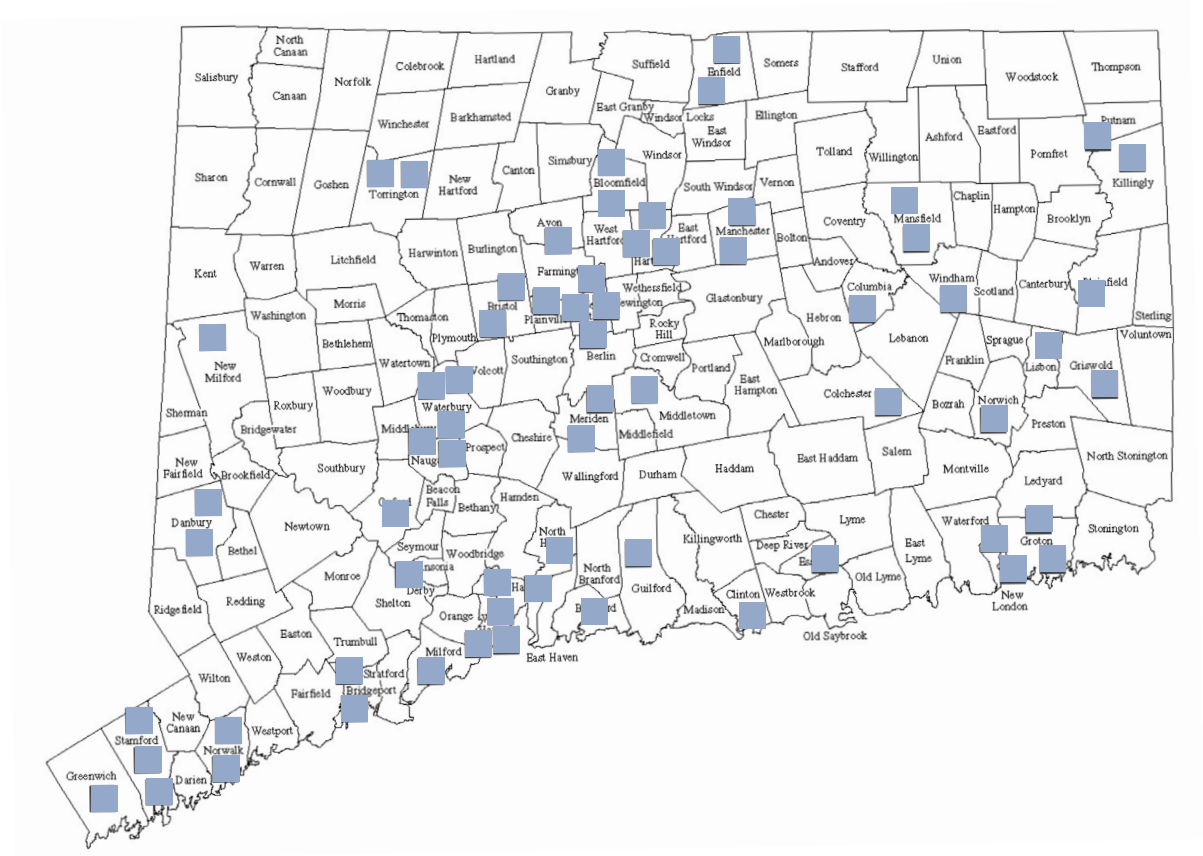
Figure 4. Children Receiving TF-CBT Annually



Note: Children served across multiple years are counted in each year.

DCF and CHDI have used economies of scale to expand capacity and provide ongoing training, data reporting, quality assurance, administration of financial incentives, and credentialing for TF-CBT clinicians through the TF-CBT Center of Excellence.

Location of Providers Offering Trauma-Focused Evidence-Based Practices for Children



provide ongoing training, data reporting, quality assurance, administration of financial incentives, and credentialing for TF-CBT clinicians through the TF-CBT Center of Excellence. As of 2015, TF-CBT is available at 79 locations in Connecticut.

Following the successful TF-CBT dissemination, CHDI and DCF have partnered with model developers to begin disseminating three additional trauma-informed EBPs using learning collaboratives: Child First, the Child and Family Traumatic Stress Intervention (CFTSI), and the Modular Approach for Treatment of Children: Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC). While in the early stages, these models have the potential to dramatically increase access to EBPs and high-quality behavioral health treatment for Connecticut's children over the next several years.

Approximately 85% of children in the child welfare system have been exposed to trauma. Infusion of trauma-informed practice can help child welfare workers understand the potential connections between trauma and a child's behavioral and emotional reactions.

Child Welfare System

Approximately 85% of children in the child welfare system have been exposed to trauma.[19] Infusion of trauma-informed practice can help child welfare workers understand the potential connections between trauma and a child's behavioral and emotional reactions.[20] Addressing trauma can also reduce the problem behaviors that often contribute to multiple placements and the decision to remove children from their homes.[21,22] A trauma-informed system must also support child welfare professionals, who are at high risk of developing secondary traumatic stress, a significant contributor to staff turnover and impaired job performance.[23] As shown in Appendix I, DCF has been a pioneer in this effort, including defining in 2010 "expanding trauma-informed practice and culture" as one of the Department's seven cross-cutting themes.

Workforce Development. Increasing knowledge about childhood trauma and support for a strong, healthy workforce in a state child welfare system of more than 2,000 employees is a major undertaking. As part of the initial implementation of trauma-informed care in 2012, DCF developed a community of "Trauma Champions" who served as local leaders and "early adopters" of trauma-informed care. DCF also began requiring comprehensive trauma training for child welfare workers using the National Child Traumatic Stress Network's (NCTSN) Child Welfare Trauma Training Toolkit; this training is now a pre-service requirement for new staff. Concurrently, DCF is systematically modifying child welfare policy and practice guides to reflect knowledge and best practices about childhood trauma. DCF has also rejuvenated regional staff wellness teams to allow development of local staff wellness plans and resources to support all staff. For example: staff have worked to improve knowledge about recognizing and managing secondary traumatic stress, created quiet spaces for staff to reduce stress and improve well-being following a case crisis, and implemented strategies for preventing and managing secondary traumatic stress.

Screening. Connecticut was among the first states to begin trauma screening in child welfare. CHDI and Yale led an interdisciplinary workgroup that developed and piloted a brief (10 item) child trauma screening measure for this purpose. Now validated, the *Connecticut Trauma Screen* is utilized to screen all children ages 7 and older who are placed into DCF care as part of the Multi-Disciplinary Evaluation. DCF has also required trauma screening of all youth receiving comprehensive, interdisciplinary Intermediary Evaluations following referral by DCF or the court. DCF continues to test strategies for expanding trauma screening to more children involved in the child welfare system.

Practice Change and EBPs. Trauma training has enabled child welfare staff to better discuss the impact of trauma with children and caregivers to foster improved understanding of trauma-related

Trauma Screening: Dante's Story

Dante is a 9-year-old African American male who was referred to the child welfare system after his mother, Trisha, spanked him for getting into trouble at school. He had been suspended in school multiple times for his behavior, which included unpredictable bursts of rage, yelling, and physical aggression. Dante's behavior problems began at age 7 and had recently become so severe that his mother was having great difficulty managing Dante in the home; occasionally his behavior resulted in visits to the hospital emergency department for crisis stabilization. He received therapy focused on his behavior problems in an Extended Day Treatment program until he was discharged because his behavior was not manageable in that setting. Several other clinical and supportive interventions had little or no impact on his behavior. Dante's child welfare worker, James, was concerned that if an effective service wasn't found soon, Trisha might not be able to keep Dante safe at home.

James had completed trauma training through DCF and participated in the TF-CBT Learning Collaborative. He wondered if Dante's behavior could be related to trauma, although no trauma exposure had been reported. James explained the rationale for trauma screening with Trish, who was initially reluctant about yet another clinical service, but agreed to encourage Dante to respond truthfully. Dante did not report any trauma history on the screen with James. However, the next morning, Dante emotionally disclosed to his mother several incidents where Trisha's ex-boyfriend had sexually abused him.

James referred Dante for a trauma assessment at a TF-CBT provider. The assessment resulted in a recommendation for TF-CBT, which Dante and Trish began. Dante was initially reluctant to engage in treatment, but soon found it helpful and appeared relieved to be discussing the sexual abuse. Trish learned how to manage Dante's behaviors at home, and Dante learned coping skills to manage his anxiety and anger about being sexually abused. Dante's school reported that his behavior had improved and he was now making friends. His behavior at home also improved, and Trish felt more confident in her ability to manage Dante when he became upset or angry. She also understood the connection between his past sexual abuse and current emotions and behaviors. Given Dante's and Trisha's progress and Trish's ability to understand and manage Dante's behavior, the family exited the child welfare system successfully.

Names and identifying details have changed.

behaviors, to engage them in trauma-focused services, and to develop trauma-informed case plans that promote safety, permanency, and well-being. Child welfare supervisors and managers can better assist staff with asking children and families about trauma, making trauma-informed decisions about a child's safety, and supporting the well-being of staff, including identifying and ameliorating secondary traumatic stress. The further dissemination of TF-CBT and CFTSI (described previously under Children's Behavioral Health System) has also resulted in increased availability of trauma-focused EBPs for children in the child welfare system.

Approximately 90% of youth in the juvenile justice system have been exposed to trauma, and these youth are at least twice as likely to have PTSD as youth without juvenile justice involvement.

Juvenile Justice System

Connecticut's juvenile justice system, primarily administered through the Judicial Branch's Court Support Services Division (CSSD), has long recognized the importance of trauma-informed care and the link between trauma exposure and delinquency.[20] Approximately 90% of youth in the juvenile justice system have been exposed to trauma, and these youth are at least twice as likely to have PTSD as youth without juvenile justice involvement.[24,25] Childhood trauma exposure is also strongly associated with increased risk of becoming a serious and chronic juvenile offender.[26] In addition, probation officers who are aware of a youth's trauma history are more likely to pursue counseling and supportive services for a court-involved juvenile rather than to rely on disciplinary approaches, which may not address the underlying trauma.[27]

Treatment with Trauma-Informed Evidence-Based Practices: Jose

Jose is a 17-year-old Hispanic male who had extensive involvement with the juvenile justice and child welfare systems. He had been arrested multiple times for substance use and violence, and had been hospitalized several times for suicide attempts. He was referred for a trauma assessment and treatment by his probation officer, who had been trained together with TF-CBT clinicians to identify and refer youth suffering from trauma.

When he was 6, Jose was raped by an adult. At the age of 7, he witnessed his mother attempt suicide. He has been shot at and witnessed severe violence repeatedly, and had abused alcohol and drugs since age 12. Prior to his referral, Jose had received many behavioral health services– including inpatient and outpatient, several intensive in-home EBPs, Therapeutic Foster Home, and Residential Substance Abuse Rehabilitation. Within his family unit there is extensive family history of mental illness, violence, and substance abuse.

At the time of his TF-CBT assessment, Jose's trauma symptoms included upsetting and reoccurring thoughts around his rape, bad dreams and difficulty falling asleep, physical symptoms and a rage that he could not control. His way of coping with his intense feelings was to get high and try to escape. Jose was initially reluctant to engage in treatment, but persisted and attended TF-CBT sessions on his own. His therapist worked closely with Jose's probation officer to ensure that both were consistent about his treatment goals and that the probation officer understood how treatment was progressing.

By the latter part of treatment, after processing his trauma history in TF-CBT, Jose was attending school consistently and following the terms of his probation. He has successfully navigated a DCF placement in a foster home and has remained substance free for more than seven months. He presented as a respectful, insightful young man who engaged in his treatment and learned to understand and manage the feelings associated with his trauma exposure, as well as significant improvements in behavior, drug use, and school functioning.

Names and identifying details have changed.

Trauma-informed care saves lives and builds strong communities by empowering youths, families, and the peers and professionals who are dedicated to helping them with safety, knowledge, skills, and connections to healthy and healing relationships and opportunities.

– Julian Ford, Ph.D.
Department of Psychiatry
UConn Health

Screening. CSSD has been a national leader in screening justice-involved youth for trauma. In 2005, CSSD began screening all youth in detention centers, and more recently expanded trauma screening to other justice-involved youth served by contracted providers. When fully implemented across all ten court districts in 2015, approximately 4,000 youth served annually will be screened for trauma. CSSD also recently began testing trauma screening by juvenile probation officers in several court districts. Cumulatively, full implementation of screening across these services would result in screening nearly all of the 10,000 youth served annually in the juvenile justice system and improved identification of appropriate services for those youth.

Practice Change and EBPs. In addition to expanding trauma screening, CSSD has also sought to improve access to trauma-focused EBPs to which youth who screen positive can be referred. CSSD has implemented Trauma Affect Regulation: Guide for Education and Therapy (TARGET), a group-based EBP for youth suffering from trauma exposure, to make this program available to youth in the juvenile justice system.[28] Beginning in late 2014, TF-CBT was added as another option for youth in the juvenile justice system. Once TF-CBT is available across all court districts by late 2015, CSSD will offer both individual and group trauma-focused EBPs to youth in the juvenile justice system statewide.

Pediatric Primary Care

Pediatric primary care is a critical component of a comprehensive trauma-informed system of care. It is estimated that 75-80% of children with behavioral health concerns do not receive treatment; yet many of these children are seen by pediatric providers.[29] As a result, pediatric practices can serve as primary portals for socio-emotional promotion, trauma screening and referral to behavioral health services.[30] Pediatric primary care is of critical importance because it is often the only setting where very young children are frequently seen, and where preventive services to promote resiliency and reduce the likelihood of maltreatment can occur universally. Despite this, medical providers are least comfortable addressing childhood trauma

when compared to other behavioral health concerns, suggesting the need for workforce development and increased awareness.[31] This is especially important because of the strong links between childhood trauma exposure and physical health, and because traumatic stress reactions may include physiological concerns such as stomachaches, headaches, change in appetite, or sleep disturbances that are typically brought to the attention of medical providers.[5,32]

Workforce Development and Trauma Screening. As an initial step in addressing this knowledge and practice gap, CHDI has disseminated a module for pediatric providers on childhood trauma through its Educating Practices In the Community (EPIC) program. EPIC uses an academic detailing model to provide pediatric practices in Connecticut with information, research, and best practices about a range of topics including developmental screening, autism, and teen driving safety. In 2012, CHDI developed an EPIC module on trauma for pediatricians and other child health care professionals to improve their knowledge about childhood trauma, ability to identify children who may be in need of trauma-focused services, and how to make referrals to trauma-focused EBP providers. More than 1,700 child health providers and related staff have been trained.

When we equip teachers and other school staff with tools to identify and support trauma-exposed students, we not only help those students succeed in school and the community, but we simultaneously promote a safe and supportive learning environment for all students.

– Sharon Hoover Stephan, Ph.D.
Center for School Mental Health
University of Maryland, School of Medicine

Education

Schools are increasingly viewed as a critical setting for the delivery of health and behavioral health services. In fact, the majority of children with emotional or behavioral health needs do not receive services; among those who do, approximately 75% receive services through their schools.[33] The linkages between trauma exposure, physical health, behavioral health and academic functioning underscore the importance of integrating trauma-informed care within educational settings. Children exposed to violence, for example, exhibit lower reading achievement, higher rates of school absence, lower grade point averages, lower graduation rates and are suspended from school more than twice as often as other students.[20,34,35] Youth with histories of trauma can have difficulties regulating emotions and behavior and can be impulsive or disruptive in school settings when experiencing reminders of past trauma.

Common strategies used to address problem behaviors in school, such as a strict focus on consequences for misbehavior, can exacerbate problems with trauma victims if applied in the absence of a trauma-informed lens.[36] For example, knowledge about a child's trauma history, potential triggers of trauma reminders, and a coordinated plan for managing distress can be used to proactively prevent and de-escalate behavioral crises. These approaches do not preclude holding children accountable for misbehavior, but can help to defuse emotional or behavioral outbursts that may otherwise disrupt learning or result in exclusionary discipline practices such as arrest, expulsion, or out-of-school suspension.

Interest in developing trauma-informed schools has recently begun to grow nationally. Schools have been called upon to develop trauma-informed approaches that recognize and address children's behavior from a trauma-informed perspective. In addition, schools have increasingly sought to coordinate in-school services with community-based trauma-informed behavioral health care providers.[37]

Workforce Development. CHDI is working with Connecticut's State Department of Education, CSSD, DCF, and DMHAS to reduce school-based arrests through staff training and skill building, including strategies reflective of trauma-informed care. One program, the School-Based Diversion Initiative (SBDI), works with middle and high schools to reduce their school arrest rates by training school personnel on adolescent behavioral health competencies, crisis de-escalation, restorative practices (e.g., mediation, skill building, peer circles) as an alternative to exclusionary discipline, and enhancing access to trauma-informed and other behavioral health services.

Practice Change and EBPs. DCF and CHDI have recently partnered to expand trauma-focused EBPs in schools through dissemination of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) model. CBITS is a school-based group intervention that has been shown to reduce

Children exposed to violence, for example, exhibit lower reading achievement, higher rates of school absence, lower grade point averages, lower graduation rates and are suspended from school more than twice as often as other students.

PTSD and depression symptoms and psychosocial dysfunction in children who have experienced trauma.[33] Training began in 2015. By 2017 it is anticipated that up to 60 school-based clinicians will be trained to deliver the CBITS model across Connecticut.

Given the nascent stage of trauma-informed care in schools statewide, two promising local examples are worth noting. First, the New Haven Trauma Coalition is a comprehensive effort to address the needs of trauma-exposed children in schools. Begun in 2014, the Coalition is a multi-agency collaboration led by Clifford Beers Clinic to reduce the negative effects of trauma on school-age children in New Haven. The initiative has implemented a tiered approach to trauma services within a school, which includes piloting universal trauma screening, supporting trauma-informed afterschool and in school activities and community partnerships, wrap around care coordination, assessment, and direct services (including CBITS) in six New Haven schools. Thus far, over 685 public school staff have received trauma-focused professional development. Evaluation data are not yet available; however, the comprehensive and collaborative approach embodies the key components of a trauma-informed system and may serve as a model for statewide replication. Second, CHDI has partnered with the Stamford Public School District since early 2015 to enhance their school-based behavioral health services, including an emphasis on trauma-informed care and implementation of CBITS. While still in the early phases, this model may also have potential for replication.

Law Enforcement

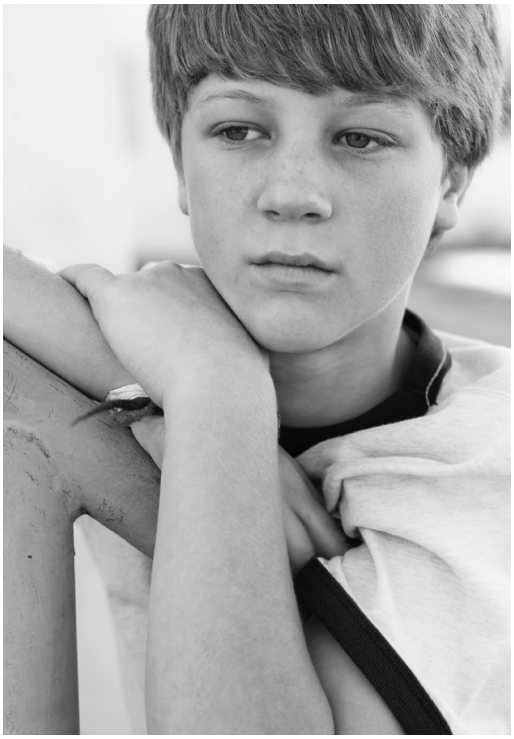
The primary roles of law enforcement are to ensure physical safety and uphold the law; however, this system plays a unique role in serving children and families who may experience abuse, violence, or other forms of trauma. The U.S. Department of Justice has recently emphasized the important role of law enforcement in understanding the impact of childhood trauma and improving collaborative partnerships with other child-serving systems.[37] Law enforcement officers are often the first (and sometimes the only) professionals to intervene with children and families during and immediately following a potentially traumatic event, such as domestic violence, a car accident, or sexual abuse. For example, officers may be able to minimize distress to children following a potentially traumatic event by helping children feel physically safe, by securing the scene and limiting additional exposure to traumatic details, coordinating interviews with the child, and referring the family to trauma-focused crisis or other behavioral health services.

Workforce Development and Practice Change. In Connecticut, thousands of law enforcement officers have been trained to respond to behavioral health crises through the Crisis Intervention Team (CIT) model. CIT is an evidence-based model

that has been shown to reduce arrests, increase law enforcement referrals to behavioral health services, and result in significant cost-savings.[38,39] Although primarily focusing on adult behavioral health, Connecticut's CIT trainings have included content on children's behavioral health and trauma, filling a significant gap in officer training.

Connecticut further expanded law enforcement training through dissemination of the Responding to Children of Arrested Caregivers Together (REACT) model. REACT trains law enforcement officers, Emergency Mobile Psychiatric Services (EMPS) mobile crisis clinicians, and child welfare staff in children's behavioral health and cross-system collaboration using a CIT-Youth curriculum and additional training to understanding trauma and the impact of a caregiver's arrest on children. Although training occurred statewide, the Waterbury and Manchester police departments participated in a more intensive REACT implementation.

Together, these initiatives resulted in more knowledge about childhood trauma among law enforcement and increased communication and collaboration between police, the behavioral health system, and the child welfare system by increasing coordination with the statewide EMPS service.



Although not currently available statewide, the pioneering Child Development Community Policing (CD-CP) program developed at the Yale Child Study Center in New Haven is a promising practice. Begun in 1991, CD-CP is a collaborative model between law enforcement, behavioral health clinicians, and other child-serving systems to support children who are victims of trauma through interdisciplinary case planning and police access to an on-call mobile clinician with expertise in child trauma service.

> **"Child welfare staff and clinicians being trained together provides an opportunity for DCF staff to develop a relationship with a partner agency. By meeting with them on a regular basis we've been able to work together and understand each other's systems..."**
>
> – Child Welfare Manager

Case Example: Local Collaboration

Collaboration between DCF and community partners, such as behavioral health providers, schools and law enforcement is crucial to accomplishing positive outcomes for youth involved with child welfare. One child welfare office established a community-wide collaborative forum to share information about trauma-informed services and to develop and expand collaborative relationships with other community partners. Each quarter, staff meet with colleagues from local behavioral health clinics, health care agencies, law enforcement, and schools to discuss issues related to trauma faced by the children and families they serve. This process has improved communication between systems, resulted in more rapid and successful trauma-focused service referrals, and development of aligned strategies and goals for supporting children and families involved in multiple systems.

Interagency Collaboration & Communication

The information above highlights a number of trauma-related initiatives within child-serving systems including several examples of initiatives that bridge two or more systems. Such initiatives represent a best practice in developing more effective, efficient, and consumer-friendly child-serving systems generally and trauma-informed systems specifically. Strong coordination between child-serving systems has been associated with improved access to services and improved behavioral health outcomes.[40] For example, professionals should understand how families interact with other child-serving systems, have points of contact with colleagues in other systems, and know how to coordinate services, align treatment/case plans, and share information and data about trauma history and traumatic stress when permitted.

At the highest level, legislators and policy makers can support child-serving systems in developing joint planning and memoranda of understanding that support these practices. Through recent legislation and grant support, system integration efforts are increasing. For example, the Children's Behavioral Health Plan articulates a vision for better integrated and trauma-informed child-serving systems. CONNECT is a SAMHSA-funded initiative that is working to integrate behavioral health, juvenile justice, and early childhood systems at the statewide and regional levels. The State Innovation Model (SIM) is a federally funded initiative that aims to support integrated health and mental health practices. In each of these examples of cross-system integration, there is a significant opportunity to explicitly promote trauma-informed practices.

Two promising local examples of systems integration in New Haven are notable. Clifford Beers Clinic's Wraparound New Haven initiative is integrating medical, behavioral health, and community-based services through an interdisciplinary team-based approach. Another

multi-agency initiative in New Haven led by Yale, the MOMS partnership, is working across public health, housing, education, child welfare, and other systems to support new mothers, prevent trauma exposure, and promote resiliency.

Connecticut's EBP dissemination efforts have also begun to include cross-system collaborations. For example, child welfare workers, juvenile probation officers, and Child and Youth Family Service Centers (CYFSC) staff have been full participants in recent TF-CBT dissemination efforts, screening youth for trauma and working with their behavioral health partners to ensure successful referrals and engagement in treatment. The focus on cross-system collaboration has enabled improved communication about children and families and information sharing about youths' treatment and status in the court system. For example, CSSD's primary goal is to reduce criminogenic risk (risk of future criminal behavior), whereas clinicians are often focused on improving behavioral health symptoms and improving functioning. Through cross-system implementation, staff from each system can better understand the others' goals and can understand the complex links between trauma exposure, mental illness, delinquency, and criminogenic risk. Service and treatment plans can be better aligned to support common goals of improved health and functioning, and reduced involvement in the juvenile justice and child welfare systems.

SUMMARY

Childhood exposure to trauma is a pervasive and costly public health problem that affects tens of thousands of Connecticut children. Given the range of associated and life-long impairments in health, behavioral health, and academic outcomes, and increased public systems involvement, childhood trauma has implications for all child-serving systems (as well as adult-serving systems). Fortunately, many children exposed to trauma are resilient and can recover with support from caregivers; socio-emotional promotion and prevention efforts can further strengthen this resilience. However, some children exposed to trauma demonstrate significantly compromised physical and behavioral health outcomes and have difficulties at home, school and in the community. They are at higher risk for involvement with the child welfare and criminal justice systems and are more likely to consume costly behavioral health, medical, and academic services in more restrictive settings. Fortunately, there are highly effective models that can improve these children's lives. Creating trauma-informed agencies and systems that are equipped to identify, serve and coordinate care for these childhood trauma victims – as well as support prevention of additional trauma exposure – is an important component of systems reform.

This report highlights numerous successes on which to build as Connecticut seeks to be a national leader in trauma-informed system development.

Trauma treatment is highly effective and initial results from those who completed treatment in Connecticut demonstrate significant reductions in children's PTSD and depression symptoms.

Progress in Connecticut since 2007

- more than 8,600 professionals have been trained to understand childhood trauma
- at least 35 community agencies or programs at 79 sites have implemented trauma screening
- more than 900 clinicians have been trained through statewide initiatives to conduct trauma assessments and provide trauma-focused EBPs
- more than 50,000 children have been screened for trauma
- more than 8,700 children have received a trauma-focused EBP

Of most importance, these efforts have made a direct and significant impact on children and their families. Trauma treatment is highly effective and initial results from those who completed treatment in Connecticut demonstrate significant reductions in children's PTSD and depression symptoms.[41] In fact, most children with PTSD prior to treatment no longer met criteria for PTSD after completing TF-CBT. More than 95% of caregivers of children completing TF-CBT report satisfaction with their child's treatment. As of 2015, it is estimated that each year more than 20,000 children are being screened for trauma and more than 1,500 will receive a trauma-informed EBP.

FUTURE DIRECTIONS

Despite these improvements, there are still many unserved or underserved children who could benefit from trauma-focused services and trauma-informed systems. Trauma-informed care is just emerging in some Connecticut systems, which provides opportunities for significant advances. For example, the Connecticut Office of Early Childhood, DCF, and the Connecticut Association for Infant Mental Health recently piloted training for 95 early care and education providers that included information about childhood trauma. Expanding trauma-informed care in the early care and education system to provide workforce development for all staff and to include trauma screening, and early intervention services is an important next step. Implementation of trauma-focused EBPs that prevent maltreatment and other forms of trauma exposure and enhance resiliency are especially needed. Pediatric primary care, education, and congregate care facilities are additional systems with great potential for expanding trauma-informed care.

Workforce development in trauma-informed care can be embedded in pre-service training for all professionals in child-serving systems, as well as in graduate training programs and for caregivers. Trauma-informed care can also be incorporated into supervision and quality assurance programs, and opportunities for advanced training and competency or certification should be provided.

While significant progress has been made to implement trauma screening in some systems, the vast majority of Connecticut's 784,000 children are not yet screened for trauma. Very few are screened preventively (e.g., at pediatric well-child visits or school-wide screening) prior to the development of social system involvement or behavioral concerns. When children are screened, screening is not typically conducted using standardized measures with multiple informants in all programs/settings, or at multiple points in time. These strategies are important for identifying children suffering from trauma exposure as early as possible and connecting them with appropriate support and services.

Practice changes to integrate trauma-informed care will vary by professional role and system, but should be supported by supervision, quality assurance, and policy. Access to EBPs can be expanded to ensure they are available to all children in Connecticut, regardless of age, level of care required, insurance status, geographic location, comorbid conditions, or the systems in which they happen to be involved. It is important to ensure appropriate reimbursement for providing EBPs and other high-quality services, including enhanced reimbursement rates or other financing approaches that support the additional time and costs associated with delivering high-quality and cost-effective care, including prevention. There remain significant opportunities to ensure that staff from various child-serving systems closely coordinate and integrate care for children and families across those systems, including sharing information about a child's trauma history and treatment history, when possible.

Additionally, research is needed to understand the benefits of trauma-informed care and the most effective and cost-efficient strategies to implement trauma-informed care in systems. For example, trauma-focused EBPs have been shown to significantly improve child outcomes and reduce health care and social costs, but very little is known about the effects of trauma-informed systems on these outcomes. Research is also needed to understand how the various components of trauma-informed care (e.g., workforce development, screening, practice change and EBPs, and collaboration) are related to child and family outcomes. Comparative evaluation of different methodologies and strategies for implementing these components is needed, particularly given scarce resources.

Finally, efforts to develop trauma-informed systems should be based on the emerging field of implementation science, which examines the most effective methods of implementing best practices.[42] Implementation science addresses systems, organizational, and individual context, may involve structured and innovative strategies for supporting change, and provides an overarching framework for change initiatives such as trauma-informed system development.

RECOMMENDATIONS

Efforts to enhance trauma-informed care in Connecticut will be most effective when the four areas identified in this report are addressed: workforce development; trauma screening; practice change and use of EBPs; and inter-system collaboration and communication. This may prove to be a useful framework for ensuring that all child-serving systems are addressing the need for trauma-informed care in a consistent, integrated, and comprehensive manner.

The following recommendations are provided for consideration by state agencies and other key partners at the state and community level to further improve trauma-informed systems for children and families in Connecticut.

1) System Development and Integration
   a. Create a high-level trauma-informed care position or job function at each state and community system serving children, including state agencies and school systems.
   b. Direct each child serving agency to document, assess, and monitor current efforts related to trauma-informed care.
   c. Create a statewide plan to ensure that development of trauma-informed care is coordinated with current system integration efforts (e.g., in Connecticut, Children's Behavioral Health Plan Implementation, CONNECT, SIM).
   d. Promote culturally competent and family-centered approaches to Trauma-Informed Care.
   e. Utilize implementation science methodology and strategies to develop innovative and efficient systems change approaches.

2) Workforce Development
   a. Require at least introductory trauma training for all staff across child-serving systems including probation officers, guardians ad litem, judges, behavioral health providers, direct care staff, and staff in educational or medical settings.
   b. Develop and implement a trauma competency or certification program to recognize personnel who have demonstrated a high level of competency in child traumatic stress.
   c. Develop and implement a plan for addressing staff wellness and secondary traumatic stress for all staff who interact with children exposed to trauma.

d. Educate birth, foster, adoptive parents and other caregivers about trauma, which will improve their capacity to understand and support children and may prevent more significant problems, placement disruptions, and additional trauma exposure.

3) Screening

a. Routinely screen children for trauma upon entry to any child-serving system, and periodically throughout involvement, using standardized measures.

b. Require or incentivize trauma screening in pediatric primary care, early care and education, and schools, the settings where most children are likely to have contact with trained professionals.

4) Practice Change and EBPs

a. Develop and implement standards for trauma-informed practice change based on professional role (e.g., child welfare worker, pediatrician, teacher).

b. Expand access to trauma-informed EBPs for all children and families, including those who are system-involved youth and those with trauma exposure who are not system involved.

c. Expand trauma-focused services for children under five years old, including access to trauma-focused EBPs.

d. Expand trauma-focused services and EBPs to children in home settings and schools.

e. Expand services to include EBPs that have been shown to prevent trauma exposure, including prevention of abuse, neglect, domestic violence, and community violence.

f. Improve integration of trauma-focused EBPs and substance abuse EBPs given the high comorbidity of trauma and substance abuse.

g. Support centralized dissemination and quality assurance for trauma-focused and other EBPs to support community-based agencies with training, data reporting, and quality monitoring.

5) Funding and Policy

a. Ensure all relevant policies support trauma-informed care.

b. Complete benefit-cost analyses of trauma-informed care in Connecticut to identify and scale up the most cost effective approaches.

c. Identify opportunities for blended funding across child-serving systems for trauma-focused prevention and early intervention services.

d. Provide enhanced reimbursement rates to clinical providers demonstrating high quality implementation of trauma-focused EBPs, as these have been shown to be highly cost-effective.[9,43]

e. Provide funding for trauma screening completed by pediatric and behavioral health providers.

GLOSSARY OF ACRONYMS

Acronym	Full Title
ACE	Adverse Childhood Experience
ACR	Administrative Case Review
CABLE	Connecticut Alliance to Benefit Law Enforcement
CBITS	Cognitive Behavioral Intervention for Trauma in Schools
CD-CP	Child Development Community Policing
CFTSI	Child and Family Traumatic Stress Intervention
CHDI	Child Health and Development Institute
CIT	Crisis Intervention Team
CIT-Y	Crisis Intervention Team-Youth
CONCEPT	Connecticut Collaborative on Effective Practices for Trauma
CONNECT	Connecticut Network of Care Transformation
CSSD	Court Support Services Division
CTS	Connecticut Trauma Screen
CYFSC	Child and Youth Family Service Centers
DCF	Department of Children and Families
DMHAS	Department of Mental Health and Addiction Services
EBP	Evidence-Based Practice
EMPS	Emergency Mobile Psychiatric Services
EPIC	Educating Practices In the Community
JJIE	Juvenile Justice Intermediary Evaluation
MATCH-ADTC	Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems
MDE	Multi-Disciplinary Evaluation
MDT	Multi-Disciplinary Team
NCTSN	National Child Traumatic Stress Network
OPCC	Outpatient Psychiatric Clinics for Children
PTSD	Posttraumatic Stress Disorder
REACT	Responding to Children of Arrested Caregivers Together
SAMHSA	Substance Abuse and Mental Health Services Administration
SBDI	School-Based Diversion Initiative
SIM	State Innovation Model
TARGET	Trauma Affect Regulation: Guide for Education and Therapy
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy

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Appendix I: Statewide Trauma-Informed Care Implementation in Connecticut Child-Serving Systems

Behavioral Health

TIC Component(s)	Initiative	Description	Reach in Connecticut
Workforce Development	EMPS Mobile Crisis Performance Improvement Center	Required training for all EMPS mobile crisis clinicians to recognize and address trauma and how to refer children to trauma-focused services.	204 EMPS mobile crisis clinicians
	Risking Connection milieu-based model	Traumatic Stress Institute of Klingberg Family Centers is disseminating *Risking Connection*, a systems change model that provides foundational trauma training to clinical and non-clinical staff working with traumatized clients.[44] *Risking Connection* has been shown to improve staff knowledge, attitudes, and behaviors to promote a more trauma-sensitive organizational culture.	More than 3,000 clinicians and direct care staff trained; 104 credentialed expert trainers have been designated using a "Train the Trainer" model adopted by 18 agencies and all DCF Statewide Extended Day Treatment programs
	TF-CBT Center of Excellence	Clinical providers trained in childhood trauma through participating in EBP dissemination efforts.	957 outpatient clinicians
Trauma Screening and Assessment	Trauma history questions included in statewide children's statewide behavioral health provider data system	DCF-contracted children's behavioral health providers required to report on four types of trauma exposure at intake across a range of services, including outpatient, mobile crisis, extended day treatment, and others.	15,752 children served annually by DCF-contracted behavioral health providers are screened for trauma history (SFY15) More than 25,000 children screened for trauma
	TF-CBT Center for Excellence & CONCEPT	Enhanced trauma screening is conducted in 35 children's outpatient clinics trained to provide TF-CBT; Modified intake/triage processes to ensure children who screen positive receive trauma-focused assessment by trained clinicians, using standardized measures.	More than 5,000 children age 3-18 assessed for trauma-focused treatment
Practice Change, EBPs, & Collaboration	TF-CBT Center for Excellence	Use of learning collaboratives and training/consultation to create TF-CBT teams in outpatient clinics. Provides implementation support, including training, data reporting, quality assurance, administration of financial incentives, and credentialing. Learning collaboratives include child welfare and juvenile justice staff.	890 clinicians at 35 outpatient clinics, across 79 sites, trained in TF-CBT 37 clinicians have earned either the Connecticut TF-CBT credential or National TF-CBT Certification More than 5,000 children age 3-18 have received TF-CBT
	Child First	Child First is an in-home, dyadic intervention that integrates the trauma-informed Child Parent psychotherapy model with care coordination to serve children birth through six years of age and their caregivers.	Available at 17 agencies in Connecticut
	Child and Family Traumatic Stress Intervention (CFTSI)	CFTSI is a brief, acute, outpatient intervention for children developed at the Yale Child Study Center who have experienced trauma (or disclosure of sexual or physical abuse) within the past 45 days, and has been shown to prevent the development of PTSD and related concerns. Learning collaboratives include multidisciplinary team coordinators and child welfare staff.	Five agencies and 22 clinicians trained; 68 children served
	Modular Approach for Treatment of Children: Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	MATCH-ADTC is an outpatient EBP that was developed by synthesizing common elements found in EBPs for children that each treat a single diagnosis or presenting problem. The model incorporates into a single evidence-based intervention, modules that treat anxiety, depression, trauma, or conduct problems.	Four outpatient clinics and 45 clinicians have been trained in first year; 105 children served

Child Welfare

TIC Component(s)	Initiative	Description	Reach in Connecticut
Workforce Development	CONCEPT	Mandatory training for all staff using the National Child Traumatic Stress Network's (NCTSN) Child Welfare Trauma Training Toolkit; now a pre-service requirement for all new staff.	At least 1,304 frontline staff and 528 supervisors, managers and directors trained
	CONCEPT	DCF is modifying child welfare policy and practice guides to reflect knowledge about trauma.	19 major child welfare policies and practice guides have been modified and disseminated to support trauma-informed care
	CONCEPT	DCF Trauma Champions, from a range of job functions across all offices and facilities, served as early adopters to disseminate information about trauma.	Approximately 45 staff, representing all 14 DCF Area Offices, served as Trauma Champions during the initial rollout of the CONCEPT grant
	DCF/CONCEPT	Regional staff wellness teams support worker wellness and morale, and address secondary traumatic stress.	Over 2,300 DCF staff participated in wellness-sponsored events annually (SFY13)
Trauma Screening	CONCEPT	All children placed in DCF care aged 7 and older are screened for trauma exposure and symptoms as part of the Multi-Disciplinary Evaluation (MDE), a comprehensive interdisciplinary evaluation completed within 30 days of a child entering care.	Approximately 1,950 children in the child welfare system annually will be screened directly
	Intermediary Evaluations	All youth receiving Intermediary Evaluations following referral by DCF or the court are screened for trauma.	Approximately 200 children annually
Practice Change, EBPs, & Collaboration	CONCEPT	Learning collaboratives to disseminate TF-CBT and CFTSI included child welfare staff to build child welfare knowledge of trauma and trauma-specific community resources available to children involved with child welfare and to build collaboration between child welfare and behavioral health. Coordinators of local Multi-Disciplinary Teams (teams made up of LEA, DCF, behavioral health agencies and others involved in cases of child maltreatment work together to ensure child is interviewed once and all services are coordinated) also participated in the CFTSI learning collaborative.	91 DCF staff participated in 2 TF-CBT learning collaboratives; 13 DCF staff and 8 MDT coordinators participated in the CFTSI learning collaborative

Juvenile Justice System

TIC Component(s)	Initiative	Description	Reach in Connecticut
Trauma Screening	CSSD Detention Screening	CSSD began screening all youth in detention for trauma exposure in 2005.	Approximately 2,500 youth screened for trauma exposure annually
	TF-CBT/JJ Learning Collaborative	The CSSD-contracted Child and Youth Family Service Centers (CYFSCs), which provide a range of evidence-based group interventions to youth in the juvenile justice system, began screening youth for trauma in 2014.	When fully implemented across all 10 court districts (expected by 2016), approximately 4,000 youth served by CYFSCs will be screened annually
	TF-CBT/JJ Learning Collaborative	CSSD piloted trauma screening by juvenile probation officers in six court districts.	If fully implemented, approximately 3,500 youth would be screened annually.
Practice Change, EBPs, & Collaboration	TARGET	CSSD has made TARGET, a group-based EBP for youth suffering from trauma exposure, available to youth in detention since 2005 and to youth served by the CYFSCs since 2010.	Between 2010 and 2014, more than 3,000 youth participated in a TARGET group, demonstrating significant improvements in PTSD symptoms and suicide risk[33].
	TF-CBT/JJ Learning Collaborative	CSSD partnered with CHDI and DCF to make TF-CBT available to youth in the juvenile justice system beginning in late 2014.	48 Juvenile Justice-involved youth received TF-CBT

Pediatrics

TIC Component(s)	Initiative	Description	Reach in Connecticut
Workforce Development	EPIC	Childhood trauma module created in 2012 and provided to pediatric practices through CHDI's EPIC program, which uses an academic detailing model to bring research to pediatric practices. Includes information about childhood trauma, screening tools, and availability of trauma-focused EBP providers locally.	43 pediatric practices and 1,707 child health providers and related staff

Education

TIC Component(s)	Initiative	Description	Reach in Connecticut
Workforce Development	SBDI	Program to reduce school-based arrests through staff training and skill building, including strategies reflective of trauma-informed care. Additional childhood trauma module is available.	22 Connecticut Middle and High Schools have participated
Practice Change, EBPs, & Collaboration	CBITS	Dissemination of the evidence-based Cognitive Behavioral Intervention for Trauma in Schools (CBITS) group intervention beginning in 2015.	40 school-based clinicians expected to provide CBITS groups by 2016
Screening, Workforce Development, Practice Change & EBPs, & Collaboration	New Haven Trauma Coalition [local promising practice]	Coalition led by Clifford Beers Clinic, a non-profit organization called *Boost!*, New Haven Public Schools, United Way of Greater New Haven, and the City of New Haven to provide coordinated trauma-informed services across service systems, including screening, assessment, and EBPs.	Initial implementation stage
Workforce Development, Practice Change & EBPs	Stamford Public Schools Consultation [local promising practice]	CHDI and Stamford Public Schools are working to develop a trauma-informed school system including workforce development, policy change, and implementation of CBITS.	Initial implementation stage

Law Enforcement

TIC Component(s)	Initiative	Description	Reach in Connecticut
Workforce Development & Collaboration	Crisis Intervention Team (CIT) and CIT-Youth	CIT is an evidence-based model for law enforcement to respond to and de-escalate behavioral health crises. The Connecticut Alliance to Benefit Law Enforcement (CABLE) has led the state's CIT dissemination since 2003, including integration of child and adolescent behavioral health and trauma. CIT-Youth, which began in Connecticut in 2012, provides additional training and de-escalation skills for law enforcement when working with children and youth.	More than 2,000 Law Enforcement Officers have been CIT-trained. More than 100 have been CIT-Youth trained
	Responding to Children of Arrested Caregivers Together (REACT)	Through a grant from the Institute for Municipal and Regional Policy at Central Connecticut State University, CHDI partnered with CABLE and DCF to develop REACT, which trains law enforcement officers, EMPS mobile crisis clinicians, and child welfare staff to understand and respond to the potential trauma of a caregiver's arrest.	574 law enforcement officers, 92 EMPS clinicians, and 48 child welfare staff were trained
	Child Development Community Policing	Started in 1991, the Child Development Community Policing (CD-CP) program at the Yale Child Study Center is a collaborative model to support children who are victims of trauma between law enforcement, behavioral health, child welfare, and juvenile justice in New Haven[10]. Several other cities in Connecticut and nationally have implemented CD-CP.	Trained 65 law enforcement officers and served 662 children in FY15 in New Haven.

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