TDMHSAS BEST PRACTICE GUIDELINES

Trauma-Informed Care

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Introduction

What is Trauma?

According to the Diagnostic and Statistical Manual (DSM-IV-TR, 2000), trauma is defined as, the **experience** of a real or perceived threat to life or bodily injury **OR** the life or bodily injury of a loved one **AND** causes an overwhelming sense of terror, horror, helplessness and fear. (***Note***: The DSM-5 will include a new chapter titled "Trauma- and Stressor-Related Disorders". However, it is not available in either print or electronic format at the time of this publication.)

Types of trauma. Psychological trauma may include medical issues such as surgeries, living in combat zones, accidents, natural disasters, relational trauma, abuse, neglect, enduring deprivation, and urban violence, all of which involve major losses for children who rely on adults to meet their physical and emotional needs, including connection, safety, support, and soothing (Giller, 1999).The National Child Traumatic Stress Network (NCTSN, n.d.e) divides trauma into the following categories:

- Community and School Violence
- Complex Trauma
- Domestic Violence
- Early Childhood Trauma
- Medical Trauma
- Natural Disasters
- Neglect

- Physical Abuse
- Sexual Abuse
- Refugee and War Zone Trauma
- Terrorism
- Traumatic Grief

What is Child Traumatic Stress?

Blaustein (2010), co-developer of the Attachment, Self-Regulation, and Competency (ARC) treatment model, offers that "traumatic experiences are those that are overwhelming, invoke intense negative affect and involve some degree of loss of control and/or vulnerability." Child traumatic stress takes place when children and adolescents are put in view of traumatic events or traumatic situations, and when this situation overpowers their skills to cope with what they have gone through (NCTSN, n.d.c).

What is Trauma-Informed Care?

The Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.) National Center for Trauma-Informed Care defines trauma-informed care as "an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives" (SAMHSA/NCTIC web site, n.d.). Trauma-informed care focuses on the provision of developmentally appropriate, gender-specific care through the lens of research and evidence of effective practice for children and youth who have experienced events that are psychologically overwhelming (Jennings, 2008).

Impact of Trauma

Prevalence

Trauma exposure prevalence rates vary widely, depending on the community and type of trauma. For example, more than 6 in 10 U.S. youth have been exposed to violence within the past year, including witnessing a violent act, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly 1 in 10 was injured (Finkelhor et al., 2009; SAMHSA, 2009). Nationally, an estimated 772,000 children were victims of maltreatment in 2008 (U.S. Department of Health and Human Services, 2010). Violence exposure rates in urban settings have been well-documented (Stein, Jaycox, Kataoka, Rhodes, & Vesta, 2003), but rural communities are also reporting higher rates of violence exposure (Dean, Wiens, Liss, & Stein, 2007). In a longitudinal general population study of children and adolescents 9-16 years old in western North Carolina, researchers found that one quarter had experienced at least one potentially traumatic event in their lifetime, and 6 percent within the past three months (Costello, Erkanli, Fairbank, & Angold, 2002). In a continuation of the North Carolina study, Copeland and colleagues (2002) found that more than 68 percent of children and adolescents had experienced a potentially traumatic event by the age of 16. Full-blown PTSD was rare, occurring in less than

one half of one percent of children studied. Other impairments—including school problems, emotional difficulties, and physical problems—occurred in more than 20 percent of children who had been traumatized. In those who had experienced more than one traumatic event, the rate was nearly 50%.

Traumatic stress rates also vary and are dependent on a number of variables, including proximity to the event, the number of previous stressors or trauma exposures, trauma reminders or triggers, support system, and resources (La Grecca, Silverman, Vernberg, & Prinstein, 1996). A recent review of research on children exposed to specific traumas found wide ranges in rates of PTSD:

- 20 percent to 63 percent in survivors of child maltreatment.
- 12 percent to 53 percent in the medically ill.
- 5 percent to 95 percent in disaster survivors (Gabbay, Oatis, Silva, & Hirsch, 2004).

These numbers do not reflect the multitude of other consequences of trauma exposure, including physical health issues and other behavioral health consequences. Adverse childhood experiences (e.g., physical, emotional, and sexual abuse; family dysfunction) are associated with mental illness, suicidality, and substance abuse in youth, and with many of the leading causes of death in adulthood (Felitti et al, 1998).

Trauma and Development

Children respond differently to stressors, including traumatic stressors, depending on a number of factors such as: 1) Characteristics related to the individual child (e.g., temperament, cognitive abilities), 2) Characteristics related to the trauma exposure (e.g., proximity, "dose" of trauma), and 3) Post-trauma factors (e.g., supportive caregivers). A critical and ubiquitous factor in how children experience traumatic events and express their subsequent distress, however, depends in large part on the child's age and developmental level. The following paragraphs outline developmental information that can be used as a general guide when providing care for children from a trauma-informed perspective (Adams, 2010; Hodas, 2006; NCTSN, n.d.a, Schwartz& Perry, 1994).

In response to trauma:

Infants might …

- Become irregular in their biological patterns such as sleeping, eating, and voiding
- Become more fussy OR become disengaged (shut down, dissociated)
- Become more difficult to soothe
- Become less adaptive to changes in routine
- Show bodily symptoms (e.g., vomiting, looser stools or constipation)

Preschoolers and young school-age children often…

- Experience feelings of helplessness
- Are uncertain regarding the possibility of continued danger
- Experience generalized fear that extends beyond the specific trauma
- Show their distress through behaviors rather than through words
- Lose (temporarily) previously acquired developmental skills such as toileting and speech
- Generally regressive behaviors such as clinging, thumb-sucking or bedwetting
- Display sleep disturbance (e.g., fear of going to sleep, nightmares, frequent wakening)
- Display separation anxiety and a fear of doing things they once did freely (e.g., playing outside in the yard without a caregiver with them)
- Engage in traumatic play (e.g., repetitious play that is less imaginative than their normal play and may represent the child's continued focus on the trauma)
- Tend to react more to the reaction of the primary caregiver in relation to the trauma than to the trauma itself

School-age children might …

- Develop a persistent concern regarding their own safety and the safety of others close to them and may show signs of separation anxiety
- Become preoccupied with their own actions during the traumatic event, experiencing shame or guilt regarding what they did or did not do
- Experience sleep disturbances
- Experience trouble with concentration and learning in school
- Complain of headaches, stomachaches, or other somatic problems that appear to have no medical basis
- Engage in constant retelling of the traumatic event
- Describe feeling overwhelmed by feelings of fear and/or sadness
- Become more irritable and/or aggressive
- Become withdrawn

Adolescents might …

- Experience heightened anxiety and fear sometimes with flashbacks/intrusive thoughts
- Experience vulnerability that could:
  - lead to behaviors of acting out (aggressive) to gain a sense of control/power
    or
  - lead to avoidance behaviors such as staying at home instead of going to school or out with friends
- Have concern over being labeled "different" or "abnormal" from their peers
- Withdraw/actively avoid reminders of trauma
- Experience sleep disturbance
- Experience feelings of shame and guilt regarding the trauma vis-à-vis what they either did or did not do during the trauma
- Engage in revenge fantasies
- Have depressive symptoms including suicidal ideation

- Experience school/vocational decline
- Have a radical shift in their world-view (e.g., "Nowhere is safe")
- Engage in self-destructive or accident-prone behaviors

Complex Trauma

In contrast to the earlier belief that early trauma had little impact on the child, it is now recognized that early trauma has the greatest potential impact, by altering fundamental neurobiological processes, which in turn can affect the growth, structure, and functioning of the brain. When trauma occurs in a chronic, persistent manner in the context of the young developing brain, the negative effects of such "complex" or "developmental" trauma have been shown to be cumulative, with damage from one stage of development affecting the successful navigation of developmental tasks at the next stage (e.g., van der Kolk, 2003). The majority of brain development is completed during the first five years of life, with the most critical development occurring within the first two years. Brain structures responsible for regulating emotion, memory, relationship security (e.g., attachment) and behavior develop rapidly in the first few years of life and are very sensitive to damage from the effects of emotional or physical stress, including neglect (e.g., Ford, 2009; Nelson, Zeanah, Fox, Marshall, Smyke, & Guthrie, 2007; Perry, Pollard, Blakeley, Baker, & Vigiliante, 1995; Teicher, Anderson, Polcari, Anderson, Navalta, & Kim, 2003). Thus, when thinking developmentally about a child's symptoms across social, emotional, behavioral, somatic, and cognitive domains, it is important to learn as much as possible about the early history of the child with an eye toward traumatic experiences, losses, and most importantly, the early caregiving environment. It is important to ask, "Did the child experience early, multiple, or persistent overwhelming events that might have altered the actual neurochemistry and structure of the developing brain?" If the answer is "yes", the child may have symptoms of complex trauma that will require a more comprehensive treatment approach.

Subtle Psychological Effects of Trauma on Children

While only a minority of traumatized children shows signs of Complex Trauma, many children manifest signs of pervasive *subtle* effects of trauma, and these signs may be missed without careful assessment. Consider the following from Hodas (2006):

> *[Youngsters] "who are required to adapt to dangerous and frightening circumstances, especially within the context of poverty, tend to develop subtle changes in their thinking, beliefs, and values. Such changes lead to attitudes and behaviors that are seen by adults as pathological, even though they may have been adaptive in the past, or in some cases continue being adaptive in the community environment. The subtle psychological effects of trauma on children represent yet another manifestation of the pervasive impact of trauma.... These internal changes and consequent behavioral manifestations, while appearing maladaptive to mainstream adults and child-serving professionals, actually have often been of adaptive benefit to the child, given the need for survival.*

Professionals working with children who have been exposed to trauma often encounter highly guarded individuals, who appear unresponsive to adult efforts to help. Not uncommonly, the trauma goes unrecognized and the child enters, or is at risk of entry into, the juvenile justice system. Many similar children are in Special Education as well. In addition to aggressive behaviors, these children are also at risk of self-injurious behaviors and suicide attempts…"(pp. 24-25).

Resilience

Children who experience trauma display numerous responses, reactions and symptomology. Originally, researchers believed children to be resilient if they possessed a defined list of protective factors and were asymptomatic following a trauma. Recently, the definition has expanded to encompass certain characteristics within each child and his/her environment. Bonanno (2004) suggests resilient individuals are people who remain stable throughout the process of trauma. Resilience continues to be defined "not as immunity or imperviousness to trauma but rather the ability to recover from adverse experiences" (Truffino, 2010, p. 146). Multiple researchers define resilience as a cluster of personal characteristics and/or environmental strengths (Bensimon, 2012; Knight, 2007; Perry, 2006; Truffino, 2012).

Agaibi and Wilson (2005) noted the characteristics of "hardiness, optimism, self enhancement, repressive coping, positive affect and a sense of coherence" as the personal characteristics seen in resilient individuals. Perry (2006) published an article defining four key areas that affect a child's capacity for resilience, child temperament, attuned caregiving, healthy attachments and opportunities for practice. This view of resilience as a personal cluster of symptoms and environmental characteristics fits with what researchers know of development and trauma in children. These clusters explain children growing up in adverse situations being resilient and asymptomatic following a traumatic event. As a best practice for trauma informed care, it is imperative that clinicians assess for and strengthen the resilient characteristics and qualities within families and children. This poses a framework to "support children and families by fostering coping skills that empower them and become protective resources" (Knight, 2007, p. 543).

Assessment

Why Screen for Trauma?

As indicated in previous sections, childhood traumas vary from the sudden loss of parents, siblings, and other loved ones, life-threatening illness, natural disasters, physical and sexual abuse, to community and domestic violence. Though children are resilient, they are also profoundly affected by these experiences. With effective responses from caregivers and the community, they recover and thrive. Without it, trauma's effects can derail childhood and reverberate into adult life. Yet child traumatic stress remains one of our most under recognized public health problems(www.nctsn.org; www.acestudy.org). Youth impacted by trauma often do not receive appropriate mental health care, particularly children who internalize their experience and do not engage in "acting out" behavior. Alternatively, children who engage in disruptive

behaviors may be labeled as defiant or inattentive. In either case, these youth are responding to intolerable feelings impacted by traumatized development in ways that help them cope and survive.

To adequately assess treatment needs for children who have experienced trauma, it is important to assess trauma exposure, posttraumatic stress disorder symptoms (PTSD) and the presence of other psychiatric disorders (Cohen, Mannarino, & Deblinger, 2006). It is also important to note that trauma experience is subjective; therefore, not every child who has endured what may seem to be a difficult situation will have experienced it as trauma. This makes individual assessment even more important. Instruments that measure traumatic experiences or reactions, diagnostic instruments that include PTSD subscales, and instruments that assess symptoms commonly associated with trauma should be considered (Wolpaw & Ford, 2004).

The "gold standard" for evaluating the presence of PTSD symptoms (AACAP, 1998) is the use of a detailed, semi-structured interview. The following self-report instruments have acceptable reliability and validity for clinical use. Because childhood traumatic experiences are typically underreported, routinely asking about traumatic history is recommended. Questions regarding trauma should be part of routine mental health intakes for children and adolescents. Self report, clinician directed questions, culture and developmental level should all be considered for potential impact (Wolpow & Ford, 2004). Whenever possible, screening of younger children should include the involvement of a parent, legal guardian, or involved adult; for an adolescent, a self report is appropriate if or when the collateral information is not available. If trauma screening identifies an area of concern or a need for further assessment, a comprehensive follow-up should occur (Hodas, 2006).

Trauma Exposure Measures

- NSLIJHS Trauma History Checklist and Interview (North Shore-Long Island Jewish Health System, Inc., 2006)
- Trauma History Checklist (THQ) Child Revised (Green, 1996)
- Traumatic Events Screening Inventory-Child Version (TESI-C: Ford et al., 1999)
- Personal Experience Screening Questionnaire (Winters, 1991)
- Childhood Trauma Questionnaire (Bernstein, 1997)
- PTSD simple screening measure (Winston, 2003)

Posttraumatic Stress Disorder Symptoms

- UCLA PTSD Index for DSM IV (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998)
- Child PTSD Symptom Scale (CPSS: Foa, Johnson, Feeny, & Treadwell, 2001)
- Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA: Newman, 2002)
- Trauma Symptom Checklist for Children (TSC-C: Briere, 1996)
- PTSD checklist for Parent (PCL-C/PR: Blanchard, 1996)

Assessing Other Psychiatric Disorders

- Children's Depression Inventory (CDI: Kovacs, 1992)
- Revised Child Manifest Anxiety Scale (RCMAS: Reynolds & Richmond, 2008)
- Child Behavioral Checklist (CBCL: Achenbach, 2001)
- Teacher Report Form (TRF: Achenbach, 2001)
- Diagnostic Interview Schedule for Children (DISC: Shaffer, 2000)
- Diagnostic Interview for Children and Adolescents- Revised (DICA-R: Reich, 1991)
- Parenting Stress Index Short Form (PSI: Abidin, 1995)

Assessing Caregiver Traumatic Stress

Assessing trauma issues in parents is also critical to engaging and tailoring the intervention for the caregiver. Caregivers who are overwhelmed, or for whom traumatic experiences are part of their own history, may have deficits in their ability to manage and modulate strong feelings; in creating, accessing and using strong positive connections when stressed; and in feeling worthy of life. The experience of having a child who has been traumatized often brings with it anger, shame, and embarrassment coupled with feelings of inadequacy. In many cases, access and support for change may be challenges (NCTSN, n.d.b).

Systems Approach to Trauma Informed Care

Overview

Trauma-informed care (TIC) is a systems-focused frame of reference and operating model appropriate in the care of all children and youth. TIC impacts:

- Organizational culture
- Staff practices and approach
- Policy and processes
- Technology (record keeping)
- Screening and assessment
- Staff learning and development in each component of care.

TIC also impacts interfaces among systems. For example, if an educator is not trauma-informed, the tendency to view disruptive behavior from a punitive perspective is stronger. If that educator engages with a trauma-informed behavioral provider, the differences in world views can be challenging. In one community, helping teachers shift their understanding of student behavior reduced suspensions by 85 percent (Stevens, 2012).

Infusing systems of care with trauma-informed knowledge and practice has dramatic results. Systems that become trauma-responsive reduce responses such as seclusions and restraints,

model the post-system responses hoped for in clients, reduce the inevitable secondary or vicarious traumatization of staff, and distribute the responsibility among everyone involved rather than relegating it to mental health staff. Because the impact of trauma can undermine successful intervention, trauma-informed systems that address this impact are more likely to see treatment success.

Why TIC is Critical to Care: Incidence of Trauma

We are increasingly recognizing the importance of implementing trauma-informed care. Williamson, Dutch, & Clawson (2010) offer the following description of why TIC is critical to care:

> Trauma-informed services are a crucial part of a victim's recovery (Clawson, Salomon, & Grace, 2008). In trauma-informed care, treatment is guided by practitioners' understanding of trauma and trauma-related issues that can present themselves in victims. Trauma-informed care plays an important role in service delivery by providing a framework for accommodating the vulnerability of trauma victims. It is not, however, designed to treat specific symptoms or syndromes (Office of Mental Health and Addiction Services, 2008). The treatment of specific mental health symptoms and syndromes requires evidence-based therapeutic and sometimes pharmacological approaches (pp. 3-4).

Trauma is strongly associated with mental and substance use disorders (SAMHSA, 2009). Mueser and colleagues (1998) reported that 90 percent of public mental health clients have been exposed to multiple experiences of trauma. In response, trauma-informed services recognize and avoid coercive interventions that traumatize children, youth, and those who care for them. Organizations providing the new gold standard of care collaborate with those who receive services focusing on the present, identifying and enhancing strengths rather than working only on symptom management. They assume that service recipients do the best they can at every moment, and work to create authentic reconnection, reparation, and healing in the areas impacted (Fallot & Harris, 2006).

Another response to the prevalence of trauma and its context is the awareness that trauma-informed care is inherently relational aware of the impact of the work on all involved. As a result, a key focal point in trauma-informed care is the management of vicarious trauma and self-care for those who receive and provide services to optimize trauma-informed services.

Finally, evidence-informed or evidence-based trauma-specific treatments can be delivered in **any** operating model, whether traditional, medical or trauma-informed. However, the delivery of a trauma-specific treatment in an environment that is **not** trauma-informed may foster cognitive dissonance and confusion for those receiving services because of the dissonance between the environment and the intervention.

Foundational Principles in Trauma-Informed Care for Systems

These principles were identified on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, Reed, Mazelis, & D'Ambrosio, 2003), literature on therapeutic communities (Campling, 2001), and others (Harris & Fallot, 2001; Fallot & Harris, 2002; Saakvitne, Gamble, Pearlman, & Lev, 2000; Bloom & Sreedhar, 2008).

Principles of trauma-informed care in systems include:

- **Understanding Trauma and its Impact.** Trauma impacts body, brain, judgment, frame of reference, beliefs, the ability manage feelings, experience healthy connection, and feel worthy of life; problematic behaviors (symptoms) in the present are adaptive responses to past traumatic experiences (Saakvitne et al., 2000).

- **Promoting Safety.** In trauma-sensitive organizations, provider responses are respectful, consistent, and predictable. The environment pays attention to physical and emotional safety, and to reducing barriers to access.

- **Ensuring Cultural Competence.** This includes understanding how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity within the program, providing opportunities to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

- **Supporting Control, Choice and Autonomy.** Systems of care that are trauma-informed help children and youth (1) regain a sense of choice in their daily lives, (2) develop practical skills in managing feelings, developing internal connections, and feeling worthy of life, correct cognitive errors and develop autonomy (3)provide opportunities for them to make daily decisions and participate in the creation of personal goals, and (4) maintain awareness and respect for basic human rights and freedom.

- **Sharing Power and Governance.** Trauma-informed systems promote equalization of the power differentials. Persons who receive services and in the case of children and youth, their caregivers, are active fully empowered participants in advisory and board capacities.

- **Integrating Care.** Integrating systems of care across body, mind, and spirit is a hallmark of trauma-informed care. For example, a recent research study testing Risking Connection's key principles in low-income healthcare clinics noted improved communication between patients and providers. Sidran Institute has partnered with faith-based communities to support adoption of a trauma-informed rather than stigmatizing perspective in responding to congregants in Jewish, Muslim and Christian congregations. Trauma happens to the body, and the use of interventions such as yoga and mindfulness practices have been used in re-regulation of the brain and body.

- **Healing Happens in Relationship.** Trauma often occurs in relationship. The recovery from all trauma involves relationships, and TIC incorporates establishing safe, authentic, and

positive relationships can be corrective and restorative to survivors of trauma.

- **Recovery occurs.** Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for involvement at all levels of the system, facilitating support from a broad social network, focusing on strength and resiliency, and establishing future-oriented goals are key characteristics in TIC.

A general compare and contrast model for non-trauma informed and trauma informed systems follows (Gillece, n.d.):

Trauma-informed	**Non-trauma informed**
Recognizing high prevalence of trauma	Lack of education on trauma prevalence & "universal" precautions
Recognizing primary and co occurring trauma diagnoses	Over-diagnosis of schizophrenia, bipolar disorder, conduct disorder & singular addictions
Assessing for traumatic histories & symptoms	Cursory or no trauma assessment
Recognizing culture and practices that are retraumatizing	"Tradition of Toughness" valued as best care approach
Minimizing power/control - constant attention to culture	Keys, security uniforms, staff demeanor, tone of voice
Caregivers/supporters– ***collaboration***	Rule enforcers – ***compliance***
Addressing training needs of staff to improve knowledge & sensitivity	"Patient-blaming" as *fallback* position without training
Objective, neutral language	Labeling language: manipulative, needy, "attention-seeking"
Transparent systems open to outside parties	Closed system - advocates discouraged

Specific policy recommendations exist for agencies interested in implementing trauma-informed care, but that is beyond the scope of these guidelines. For more information, please visit the National Center for Trauma-Informed Care website at http://www.samhsa.gov/nctic/default.asp. For a full report of recognized, effective TIC models, see Jennings (2008).

Summary

The adoption of Trauma-Informed Care as an operating standard in the service of improved health in children and youth involves system transformation. This system transformation involves all aspects of the delivery and evaluation of care, including culture change. None the less, at a systems level, the outcomes of successful transformation include greater efficiencies in care provision, recovery of children and youth, and of staff, which in turn result in significant benefit to stakeholders in Tennessee in terms of cost-benefit ratios, improvement of community health, and increases in long-term successes in education, income stability, and health outcomes.

Evidence-Based Practice

As defined by the American Psychological Association (2006), evidence-based practice refers to "the integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (see section on Evidence Based Practice elsewhere in this document for more details). In short, we are focusing on treatment interventions that are backed by solid research and clinical theory that take into account the child and family's culture, community, and beliefs. We start with common components included in evidence-based practices, and then provide a list of specific recommended interventions.

Common Components

With the surge of research into trauma-informed therapy increasing significantly in the past decade, there are a number of interventions for children and youth and many have similar, overlapping components. The National Child Traumatic Stress Network (n.d.c) has outlined the following "core components" of trauma-informed interventions:

- Screening and triage
- Systematic assessment, case conceptualization, and treatment planning
- Psycho-education
- Addressing children and families' traumatic stress reactions and experiences
- Trauma narration and organization
- Enhancing emotional regulation and anxiety management skills
- Facilitating adaptive coping and maintaining adaptive routines
- Parenting skills and behavior management
- Promoting adaptive developmental progression
- Addressing grief and loss
- Promoting safety skills
- Relapse prevention
- Evaluation of treatment response and effectiveness
- Engagement/addressing barriers to service-seeking

Recommended Interventions

The interventions outlined below range from those with more rigorous research (repeated randomized clinical trials) to those considered promising practices or emerging practices. The list is not exhaustive. Before considering which model to use, agencies and providers need to consider not only the evidence behind the model, but whether the model meets the needs of the family and the agency. The NCTSN outlines relevant factors to consider in choosing a treatment model:

- Prevalence of types of trauma and traumatic bereavement to which the population(s) is exposed
- Associated 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 help-seeking
- Availability of individual/family/community strength-based resources
- Setting in which services are offered (school, residential, clinic, home)

In addition to treatment specific models, SAMHSA's National Center for Trauma Informed Care (NCTIC) also lists models for agency transformation and treatments for use in different settings. Below are two tables outlining some of the programs referenced by either the NCTIC or by NCTSN that are either:

1) **Trauma-informed care models** implemented across an agency or system. These models create a coherent container for many different treatment methods, and most focus on frame of reference, processes, policies, physical environment, empowerment and collaboration. In these models, effective treatments and interventions in place will work even better.

2) **Trauma focused treatments** are specific methods or interventions that may be delivered in any model of care, and that are more effective when delivered in a trauma-informed care setting. Unless otherwise noted, the trauma-focused treatment is suitable for male and female children and youth.

Trauma-Informed Care Model	Description/Contact	For
National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings	***All ages***. Assists child, youth, adult, and forensic mental health facilities in reducing the use of seclusion and restraint. Evidence supported (kevin.huckshorn@nasmhpd.org).	systems, agencies
Risking Connection®	***All ages***. Develops optimally helpful responses to trauma survivors of all ages and reduces impact of vicarious trauma on staff. Knowledge and skills acquired support overlaying of additional trauma-specific interventions and treatment modalities as well as change in all organizational areas. Evidence supported. Contact: training@sidran.org.	systems, agencies, specialized contexts
Sanctuary Model	***Age 4 and up*** (no limit). Trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community in which staff are empowered as key decision-makers to influence their own lives and the welfare of their constituents. Requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process (http://www.nctsn.org/sites/default/files/assets/pdfs/sanctuary_general.pdf).	systems, agencies
Sanctuary Model Plus (IRIS Project)	***Children and adolescents placed in residential treatment centers and their families***. Integrates a model of organizational change (Sanctuary®), trauma-informed, training-reorientation curriculum (START), and an activity-based life story approach to rebuilding attachments, establishing permanency, and reprocessing traumas (Real Life Heroes) (http://www.nctsn.org/sites/default/files/assets/pdfs/Sanctuary_Plus_IRIS_2_11_05.pdf).	group, systems

Trauma-Informed Care Model	Description/Contact	For
Using Trauma Theory to Design Service Systems	***All ages***. Step-by-step model systems and agencies to become "trauma-informed." Provides guidelines for evaluating and modifying all system and service components in light of a basic understanding of the role that trauma plays. Contact rwolfson@ccdc1.org.	systems, agencies
Trauma Informed Organizational Self Assessment	***All ages***. Self-Assessment of specific practices necessary for creating a trauma-informed system for the homeless, useful for other agencies. Assesses: supporting staff development, creating a welcoming and safe environment, assessing and planning services, involving service recipients, and establishing policies (http://www.familyhomelessness.org/media/90.pdf).	systems, agencies
Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth	***Ages 2-21***. Males and females, individual and group therapy for children, education for caregivers, parent-child sessions, and parent workshops. Provides a theoretical framework, core principles of intervention, and a guiding structure for providers (http://www.nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf).	individual, family, caregivers, agencies
Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP)	***Ages 0/18***. Incorporates assessment triage and essential components of trauma treatment into clinical pathways. Provides staff with knowledge and skills to incorporate standardized assessments into intake and ongoing treatment processes; provides a treatment model directed by the uniqueness of the child and his or her family, and provides decision making guidelines regarding trauma treatment strategies based upon the child's unique presentation (http://www.nctsn.org/sites/default/files/assets/pdfs/tap_general.pdf).	individual, family, systems

Trauma Focused Treatment	Targeted Populations	For
Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)	***Ages 8-21.*** Adaptation of for youth with developmental disabilities whose lives include a wide range of traumatic experiences, requires standard Dialectical Behavioral Therapy (DBT) training first. Also referenced as "Modified DBT with Developmentally Disabled Children" for children 10-14 (http://www.nctsn.org/sites/default/files/assets/pdfs/dbtsp_general.pdf).	individual
Alternatives for Families - A Cognitive Behavioral Therapy (AF-CBT)	***Ages 5-17***. For physically abused children, offending caregivers. Appropriate for use with physically coercive/abusive parents and their school-age children. Although it has been primarily used in outpatient settings, the treatment can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child (http://nctsn.org/sites/default/files/assets/pdfs/afcbt_general.pdf).	individual, family, group, residential
Child Adult Relationship Enhancement (CARE)	***Children of all ages and their caregivers***. Modification of standard Parent-Child Interaction Therapy (PCIT) model to serve special circumstances and culturally diverse clients. CARE reflects a collaborative co-creation between the Trauma Treatment Training Center (TTTC) and a range of agencies (i.e., battered women shelters, foster care agencies, residential care facilities, medical care settings, homeless shelters) (http://www.nctsn.org/sites/default/files/assets/pdfs/care_general.pdf).	Families; children; all settings
Child and Family Traumatic Stress Intervention (CFTSI)	***Ages 7–18***. Children with their parent or caregiver as an early intervention and secondary prevention model that aims to reduce traumatic stress reactions and posttraumatic stress disorder (PTSD) after a potentially traumatic event (PTE). Children are referred by law enforcement, child protective services, pediatric emergency rooms, mental health providers, forensic settings, and schools (http://www.nctsn.org/sites/default/files/assets/pdfs/CFTSI_General_Information_Fact_Sheet.pdf).	individual, family, systems

Trauma Focused Treatment	Targeted Populations	For
Child Development-Community Policing Program	***Ages 0-18+***. Brings together police officers and mental health professionals for mutual training, consultation, and support so that they may effectively provide direct interdisciplinary intervention to children and families who are victims, witnesses, or perpetrators of violent crimes (http://www.nctsn.org/sites/default/files/assets/pdfs/ChildDevelopment-CommunityPolicingCDCP.pdf).	individual, family, systems
Child-Parent Psychotherapy (CPP)	***Ages 0-6***. For youth who have experienced a wide range of traumas and parents with chronic trauma; examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. Supports and strengthens the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health (http://www.nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf).	individual, family, systems
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	***Ages 10-15***. School-based group and individual intervention designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. For children who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters (http://www.nctsn.org/sites/default/files/assets/pdfs/cbits_general.pdf).	individual, group, family
Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPC-CBT)	***Ages 4-17***. For families with multiple referrals to Child Protective Services (CPS) with no substantiation; families who report using excessive physical punishment with their children; parents with high levels of stress, perceive their children's behavior as extremely challenging, and fear losing their temper with their children (http://www.nctsn.org/sites/default/files/assets/pdfs/cbpcbt_general.pdf).	individual, family, group

Trauma Focused Treatment	Targeted Populations	For
Community Outreach Program - Esperanza (COPE)	***Ages 4-18***. Home and school based treatment program for traumatized children who are presenting with behavior or social-emotional problem. The emphasis is on case management to enable clinicians to offer evidence-based trauma treatments in community settings. Combines TF-CBT, PCIT, and culturally-modified trauma focused treatment (CM-TFT) (http://www.nctsn.org/sites/default/files/assets/pdfs/cope_general.pdf).	individual, family
Culturally Modified Trauma-Focused Treatment (CM-TFT)	***Ages 4-18***. Latino/Hispanic; for youth who have experienced sexual or physical abuse; addresses spirituality, gender roles, familismo, personalismo, respeto, sympatia, fatalismo, folk beliefs. TF-CBT with additional modules integrating cultural concepts throughout treatment (http://www.nctsn.org/sites/default/files/assets/pdfs/cmtft_general.pdf).	individual, family
Family Advocate Program (2005)	***Ages 18-70***. Wraparound services for nonoffending caregivers (95% women) in families reported for sexual/physical abuse or domestic violence (http://www.nctsn.org/sites/default/files/assets/pdfs/FamilyAdvocateProgram_21105.pdf).	family
Forensically-Sensitive Therapy (FST)	***Ages 4-17*** (predominantly female). Used effectively with child sexual abuse victims when criminal and civil court cases are actively pending. FST begins at the end of the investigative process, when abuse has been substantiated and the case is being prosecuted, and the patient is exhibiting symptomatic distress (http://www.nctsn.org/sites/default/files/assets/pdfs/forensic_sensitive_therapy_general.pdf).	individual, family

Trauma Focused Treatment	Targeted Populations	For
Group Treatment for Children Affected by Domestic Violence (DV)	***Ages 5 and up (no upper limit).*** For children and nonoffending parents who have been exposed to DV; predominantly female. Parallel content for children and parents. Includes 11 topic driven modules. (http://www.nctsn.org/sites/default/files/assets/pdfs/GroupTreatmentChildrenDomesticViolence_fact_sheet_3-21-07.pdf).	group, family, systems
Honoring Children, Making Relatives	***Ages 3-7***. For American Indian and Alaska Native children; culturally informed adaptation of PCIT incorporating traditional beliefs about family, face, and non-interference. (http://www.nctsn.org/sites/default/files/assets/pdfs/honoring_children_making_relatives_fact_sheet_032007.pdf).	individual, family
Honoring Children, Mending the Circle	***Ages 3-18***. For American Indian and Alaska Native (AI/AN) children; blending of AI/AN traditional teachings with cognitive-behavioral methods (Trauma Focused Cognitive-Behavioral Therapy [TF-CBT]). (http://www.nctsn.org/sites/default/files/assets/pdfs/HonoringChildrenMending_the_Circle_HCMC_fact_sheet_3-21.pdf).	individual
Honoring Children, Respectful Ways	***Ages 3-12***. For American Indian and Alaska Native children who survive sexual abuse, historical and other traumatic experiences; incorporates American Indian and Alaskan Native world view of wellness, wellbeing, healing, and respect for self and others. (http://www.nctsn.org/sites/default/files/assets/pdfs/HonoringChildrenRespectfulWays_HCRW_fact_sheet_3-20-07.pdf).	individual
Integrative Treatment of Complex Trauma (ITCT-C, ITCT-A)	***Ages 2-21***. Both males and females. For Hispanic-American, African-American, Caucasian, Asian-American; for youth who may have complex trauma histories. (http://www.nctsn.org/sites/default/files/assets/pdfs/ITCT_general.pdf).	individual, family, systems

Trauma Focused Treatment	Targeted Populations	For
International Family Adult and Child Enhancement Services (IFACES)	***Ages 6-18***. For refugee and immigrant children who have experienced trauma as a result of war or displacement and their children. Goal is to meet the mental health needs of all refugee children seeking services, regardless of their background, by providing flexible and comprehensive services (http://www.nctsn.org/sites/default/files/assets/pdfs/ifaces_general.pdf).	individual
Parent-Child Interaction Therapy (PCIT)	***Ages 2-12***. Both males and females, an empirically-supported treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns (http://www.nctsn.org/sites/default/files/assets/pdfs/pcit_general.pdf).	individual, family, systems
Psychological First Aid (PFA)	***Ages 0-120***. For individuals immediately following disasters, terrorism, and other emergencies (http://www.nctsn.org/sites/default/files/assets/pdfs/pfa_general.pdf).	individual
Real Life Heroes (RLH)	***Ages 6-12, plus adolescents (13-19)*** with delays in social, emotional or cognitive functioning. *Real Life Heroes (RLH)* was especially designed for children in child and family service programs who frequently lack safe, nurturing homes and secure relationships with committed, caring adults. The intervention involves six-to-twelve months of weekly therapy sessions (http://www.nctsn.org/sites/default/files/assets/pdfs/rlh_general.pdf).	individual, family, systems
Safe Harbor Program	***Ages 6-21***. Comprehensive program designed to help students, parents, and schools cope with the violence, victimization, and trauma that occurs in their communities. Utilizes a "safe harbor" room in school as a low stigma, easy access entry point to attract distressed children/youth coping with violence. Multi-cultural applications, including LGBT (http://www.nctsn.org/sites/default/files/assets/pdfs/SafeHarbor_fact_sheet_3-20-07.pdf).	individual, group, family, systems

Trauma Focused Treatment	Targeted Populations	For
Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)	***Ages 3-11***. For survivors of sexual abuse exhibiting sexual behavioral problems many of whom have experienced multiple traumatic experiences; to date the model has been effectively used with primarily African-American children; majority of families are low income (http://www.nctsn.org/sites/default/files/assets/pdfs/SMART_fact_sheet_3-21-07.pdf).	individual, family, systems
Skills for Psychological Recovery (SPR)	***Ages 5-120***. Appropriate for both males and females. SPR takes into consideration the reality that many survivors may only be available for one or two contacts (http://www.nctsn.org/sites/default/files/assets/pdfs/spr_general.pdf).	individual, family
Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST)	***Adolescent girls ages 12-21***. For females who have experienced sexual/physical abuse and a range of additional traumas, including community violence, domestic violence, and sexual assault (http://www.nctsn.org/sites/default/files/assets/pdfs/STAIRNST_2-11-05.pdf).	individuals, group
Southeast Asian Teen Village	***Southeast Asian (mostly Hmong) refugee teenage girls***. Helps refugee Southeast Asian girls blend traditional values, beliefs, and customs with expectations of American culture. The program encourages adolescents to find healthy ways to cope with past traumas and bicultural issues, including the use of ceremony and ancestor work (http://www.nctsn.org/sites/default/files/assets/pdfs/SoutheastAsiaTeenVillage_21105.pdf).	group
Streetwork Project	***Ages 13-23***. Homeless and street-involved youth; harm reduction program good with a wide variety of ethnic/racial groups, religious group, and the LGBTQ community (http://www.nctsn.org/sites/default/files/assets/pdfs/StreetworkProject_fact_sheet_3-20-07.pdf).	individuals, group, system

Trauma Focused Treatment	Targeted Populations	For
Strengthening Family Coping Resources (SFCR)	***All ages, from infants to grandparents***. For all family members where complex family trauma exists for multiple traumas related to urban poverty. Uses family rituals, routines and traditions to support family posttraumatic recovery and growth (http://www.nctsn.org/sites/default/files/assets/pdfs/sfcr_general.pdf).	family
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	***Ages 12-21***. Designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning. SPARCS has been used with ethnically diverse populations including LGBTQ (http://www.nctsn.org/sites/default/files/assets/pdfs/sparcs_general.pdf).	family
Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A)	***Ages 10 and up***. Strengths-based approach to education and therapy for trauma survivors who are looking for a safe and practical approach to recovery. Helps trauma survivors understand how trauma changes the body and brain's normal stress response into an extreme survival-based alarm response (http://www.nctsn.org/sites/default/files/assets/pdfs/target_general2012.pdf).	individual, group, family
Trauma and Grief Component Therapy for Adolescents (TGCT)	***Ages 12-20***. For adolescents who have experienced community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist event or traumatic loss. May be delivered in school setting (http://www.nctsn.org/sites/default/files/assets/pdfs/tgct_general.pdf).	individual, group, family, systems
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	***Ages 3-21***. For children with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers (http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf).	individual, family

Trauma Focused Treatment	Targeted Populations	For
Trauma-Focused Coping in Schools (TFC) (AKA: Multimodality Trauma Treatment Trauma-Focused Coping-MMTT)	***Ages 6-18***. For children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control. School based groups and can be offered in clinic settings as well. Multi-lingual (English and French) (http://www.nctsn.org/sites/default/files/assets/pdfs/mmtt_general.pdf).	individual, group
Trauma Systems Therapy (TST)	***Ages 6-19***. For children who are having difficulty regulating their emotions as a result of the interaction between the traumatic experience and the social environment. Community-based program with modules focusing on home-based services, legal advocacy, emotional regulation skills training, cognitive processing, and psychopharmacology (http://www.nctsn.org/sites/default/files/assets/pdfs/tst_general.pdf).	systems

Resources

- Child Trauma Academy (www.childtrauma.org)
- Child Welfare Information Gateway (www.childwelfare.gov)
- National Center for Trauma Informed Care (www.samsha.gov/nctic)
- National Center on Domestic Violence, Trauma & Mental Health (www.nationalcenterdvtraumacenter.org)
- National Child Traumatic Stress Network (www.nctsn.org)

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