

One Year Later

Trauma-Informed Efforts in Eight States



Of the nine states involved in the PRTF Waiver¹ that were funded by CMS to demonstrate the effectiveness of bringing youth out of residential placements, many had begun to build capacity in trauma-informed care prior to the start of their Waivers. These Demonstration Waivers, however, provided a catalyst for their efforts and encouraged them to increase their work at the system and provider levels to become more trauma-informed.

Below are a few examples of how eight of these states worked to make their systems more trauma-informed over a period between initial stakeholder interviews² and a one-year follow-up. Some of the states' accomplishments are highlighted as well.

State and Local System Collaboration: Leadership, Policies, and Successes

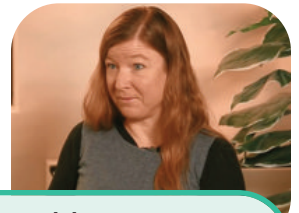
All the states involved³ made efforts to either create or strengthen collaborative efforts to address trauma. In South Carolina, Montana, Mississippi and Maryland, existing state committees or structures with cross-system and family representation have prioritized trauma-related efforts, such as policy development, to increase screening or have combined training for all child-serving systems in trauma-informed care. Jennifer Grant from the



"I plan to be at the table and part of the brainstorming."

– Jennifer

Mississippi Medicaid Office shared her commitment to this process, "I plan to be at the table for these conversations and to continue to support [them] as I can and be part of that brainstorming." Kandis Franklin, the family liaison in Montana's Children's Mental Health Bureau, also described a collaborative effort across systems, "It's exciting to see the shift in the child welfare and juvenile justice systems' adoption of trauma-informed care principles."



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In Georgia, mental health, child welfare and juvenile justice state directors provided leadership to change policies related to trauma assessment and to develop a curriculum for direct care staff in all three systems. As Ursula Davis, Georgia's Child Welfare Director, described it, "Child



"Child welfare has opened its arms to being trauma-informed."

– Ursula

welfare has opened up our arms to being a trauma-informed system." Local communities in Indiana expressed excitement about "Change Teams" with representation from all the child-serving systems, including education, law enforcement, family organizations and others identified in each community. These teams meet on a regular basis and use data to identify areas that need improvement, create and implement plans, then assess whether their plans are working or not.

In Richmond, Virginia, a Trauma-Informed Care Workgroup has attracted many new members over the past year as word of their success has spread. Many members of this workgroup describe a paradigm shift, with everyone talking about trauma and increased awareness of secondary trauma and the importance of self-care.



Capacity Building in Implementing Evidence-Based Treatments within Trauma-informed Systems:

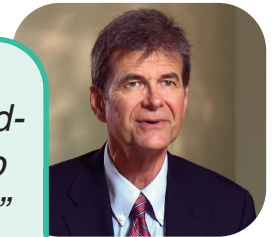
All eight states identified increased efforts to train clinicians in Evidence-Based Treatments (EBTs). The EBTs that seemed to be the most popular were Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), followed closely by Parent-Child Interaction Therapy (PCIT) and Cognitive Behavioral Interventions for Trauma in Schools (CBITS), as well as a few others. All the states reported training large numbers of clinicians. Louise Johnson, the Children's Mental Health Director in South Carolina reported that they have "300 clinicians and 50 supervisors trained and certified in TF-CBT and the overwhelming response was 'We want more.'" Mental health systems were not alone in creating opportunities for clinicians. For example, in Alaska, South Carolina and Georgia, representatives from the juvenile justice system referred to their efforts to train all clinicians in TF-CBT.



"Clinicians said they wanted more training."

– Louise

While all the states recognized that training clinicians in EBTs is essential, they also realized that just training clinicians is not enough. Al Zachik, Deputy Director of Maryland's Behavioral Health Administration, who sits on the Children's Cabinet, elaborated, "There's been an increasing effort to educate all people who work with children and families in the state." Some providers have set goals to train 100 percent of their staff through trauma-informed care sessions offered at orientations for all new hires and regular booster trainings. All employees have been included; for example, secretaries, cleaning staff, foster families, case workers, bus drivers, teachers and executive directors. Statewide conferences on trauma-informed care or trauma "tracks" at larger conferences were used by several states to reach diverse stakeholders that may not typically receive this type of training, such as law enforcement personnel.



"There's been an increasing effort to educate everyone who works with children."

– Al



In addition to ongoing training opportunities, states offered organizational self-assessments to be sure their policies and procedures create welcoming environments that are unlikely to re-traumatize those they serve. In one state, community programs invite state personnel to help with their self-assessment by role-playing people seeking services, so that they could see the organization from the eyes of the consumer. Some identified the need to address policies and practices that can present barriers to hiring individuals with lived experience or to recruiting foster families who may be excellent caregivers but are unable to meet inflexible requirements. Lynne Edwards in Virginia summed it up with her observation, "People are just now beginning to understand the full picture – we have a way to go before we see the major policies and procedures, and protocols change - until it seeps into every aspect of what an organization does."

"We have a way to go until it seeps into every aspect of the organization."

– Lynne

Youth and Family Voice in Policy and Planning and Service Delivery

Every state emphasized the importance of youth and family voice in policy and planning efforts, whether at the local level or at the state level.

Brenda Konradi from Indiana lit up as she said, "I could go on all day about the importance of having consumers at the table, parents at the table; that's always the most



"Having parents at the table is always the most energizing part of our work."

– Brenda



energizing thing of the work we do.” Chanda Aloysius from South Central Foundation in Alaska, serving tribal communities, highlighted the importance of consistency in listening and responding to what families say when developing services:

“When we ask the customer-owners to come and to talk with us and we as an organization are listening to them, they’re sharing their values of their home, their culture, their village...If we didn’t listen after they said, ‘No, you didn’t hear me right,’ then it would probably not be as effective.”



“It wouldn’t be as effective if we didn’t listen when parents share their values.”

– Chanda

Many states also commented on the growing numbers of youth peer support specialists and family peer support specialists with lived experience who provide services reimbursed through Medicaid. The states that have incorporated youth and families into statewide committees and workgroups have noticed the important changes that happen when adults listen and respond to the ideas the youth present. Jackie Chatmon from Mississippi emphasized inclusion of families as co-trainers. Mississippi created two types of peer support specialist toolkits, one for providers to ensure a conducive environment for peer specialists and the other for people who are interested in becoming peer support specialists. When asked about whether there had been progress, Kathy Riley from Indiana said, “I really think as far as trauma-informed, we’ve made leaps and bounds; agencies that I never thought in my life would be interested are all involved now.”

Overall, the states reported an observable culture shift in their journey to become more trauma-informed. Each state has created or strengthened the collaboration they believe they will need in order to keep the effort going as they continue on their way.

Notes

¹Community Alternatives to Psychiatric Residential Treatment Facility Waiver 5-Year Demonstration program; funded by the Centers for Medicare and Medicaid Services, and completed in September 2012 with two years of additional funding to continue to build their capacity to provide “trauma-informed” community-based services.

²Stakeholders participated in interviews beginning in October 2012 and then again one year later ending in June 2014, to relate their progress as they used the resources from the Demonstration in their capacity-building efforts.

³The states are Alaska, Georgia, Indiana, Maryland, Mississippi, Montana, South Carolina, and Virginia.

<http://gucchdtacenter.georgetown.edu/TraumaInformedCare.html>

<http://trauma.jbsinternational.com/traumatool>

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Trauma Informed Care: Perspectives and Resources

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