Implementing Trauma-Focused Cognitive Behavioral Therapy in MN

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Overview

• Traumatic and stressful events
  o Impact on children, adults, and parenting

• Trauma-informed practice
  o Trauma-focused CBT
  o Implementation of TFCBT in Minnesota

• What is a trauma-informed system?
Defining trauma

In its definition of posttraumatic stress disorder, the Diagnostic and Statistical Manual uses this definition of trauma:

An event or events the person experienced, witnessed, or was confronted with that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

Trauma exposure is common

15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime.
Violent Crime in the USA

• USA has the highest level of homicide of any developed country in the world.

• Homicide is the third-leading cause of death for children ages 5-14, the second-leading cause of death for those aged 15-24, and has been the leading cause of death for African-American youth from the early 1980s into the early twenty-first century.
Domestic Violence

• 1.8 to 4 million American women are physically abused each year.
• It is estimated that 7-14 million children witness family violence each year [Edleson et al., 2007].

Child Abuse

• Maltreatment incidence is 12 per 1,000 children, with 899,454 substantiated or indicated cases in 2005.
• Approximately 5,400 children in Minnesota were abused and neglected in 2008, and over 50% were children of color (23% Black; 10% American Indian; 3% Asian and Pacific Islanders; 17% Other). Most children were the victims of multiple maltreatment types.
• Maltreatment rates for under 3s: 16.5 per 1,000 compared with 6.2 per 1,000 for children ages 16 to 17.
The Cycle of Violence

• Both follow-up and follow-back studies have consistently shown a direct link between exposure to violence and subsequent perpetration of violence.

• For example, Widom (2001) reported that child victims of violence and neglect were 59% more likely to be arrested as juvenile, 28% more likely to be arrested in adulthood, and 30% more likely to be arrested for a violent crime.

Challenges in Identifying Traumatized Children

• No way to know about children’s histories of traumatic events
  o Particularly complicated by the shame and stigma associated with many types of trauma

• Identifying ‘invisible’ witnesses
  o E.g. emergency room visits
  o E.g. police reports

• No national surveillance system

• Concerns about formal identification via official statistics leading to government involvement (e.g. CPS)
The Impact of Trauma on Children

Short Term Effects:
Acute Disruptions in Self Regulation

- Eating
- Sleeping
- Toileting
- Attention & Concentration
- Withdrawal
- Avoidance
- Fearfulness
- Re-experiencing /Flashbacks
- Aggression; Turning passive into active
- Relationships
- Partial memory loss

The Impact of Trauma on Children

Long Term Effects:
Chronic Developmental Adaptations

- Depression
- Anxiety
- PTSD
- Personality
- Substance abuse
- Perpetration of violence
Trauma and Developmental Psychopathology

Trauma & Cumulative Risk Overlap
- Risks ‘pile up’ (Rutter, 1985)
- Secondary adversities during trauma events (Pynoos et al., 1996)
- Multi-problem families risk for trauma (Widom, 1989; 1999)
- Other risks contribute to PTSD

Why be concerned with trauma and posttraumatic stress in parents?
- Associations between adult trauma and:
  - Child distress and child PTSD
  - Parenting impairments
- How might parents respond differently to other adults (e.g. service providers) when they are dealing with traumatic stress?
- And most important, how might they deal differently with their children?
Parents who are traumatized may be:

- Suffering from PTSD and related disorders (e.g., depression, anxiety)
- Using drugs to mask the pain
- Disempowered
- Parents of children who have become “parentified” (i.e. responsible beyond their years)

How might parents’ trauma histories affect their parenting?

A history of traumatic experiences may:

- Compromise parents’ ability to make appropriate judgments about their own and their child’s safety and to appraise danger; in some cases, parents may be overprotective and, in others, they may not recognize situations that could be dangerous for the child.
- Make it challenging for parents to form and maintain secure and trusting relationships, leading to:
  - Disruptions in relationships with infants, children, and adolescents, and/or negative feelings about parenting; parents may personalize their children’s negative behavior, resulting in ineffective or inappropriate discipline.
  - Challenges in relationships with caseworkers, foster parents, and service providers and difficulties supporting their child’s therapy.
Trauma history can:

- Impair parents’ capacity to regulate their emotions.
- Lead to poor self-esteem and the development of maladaptive coping strategies, such as substance abuse or abusive intimate relationships that parents maintain because of a real or perceived lack of alternatives.
- Result in trauma reminders—or “triggers”—when parents have extreme reactions to situations that seem benign to others.

Traumatized parents may...

- Find it hard to talk about their strengths (or those of their children)
- Need support in managing children’s behavior
- Have difficulty labeling their children’s emotions, and validating them
- Have difficulty managing their own emotions in family communication
  - When posttraumatic stress symptoms interfere with daily interactions with children, parents should seek individual treatment.
How does adult posttraumatic stress disorder affect parenting?

Growth in fathers’ PTSD is associated with self-reported impairments in parenting one year after return from combat.

PTSD

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.
Criterion A: stressor
The person has been exposed to a traumatic event in which both of the following have been present:

• The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

• The person’s response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

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

• Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

• Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content

• Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.

• Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

• Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
**Criterion C: avoidant/numbing**
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

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

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

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilance
- Exaggerated startle response
Criterion E: duration
Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Trauma Treatment
Trauma-Focused Cognitive Behavior Therapy

- Child trauma treatment with largest body of evidence for its effectiveness
- Developed by Cohen, Mannarino, Deblinger, and tested with various populations (child sexual abuse victims, children exposed to domestic violence, child traumatic grief, etc)
- Targets trauma-related symptoms, not PTSD alone
- Includes parent/caregiver throughout treatment, both together with and separately from the child
Trauma-Focused Cognitive Behavior Therapy

• See http://tfcbt.musc.edu
• Validated for 3-18 year olds
• Essential components:
  o Establishing and maintaining therapeutic relationship with child and parent
  o Psycho-education about childhood trauma and PTSD
  o Emotional regulation skills
  o Individualized stress management skills

TF-CBT cont.

• Connecting thoughts, feelings, and behaviors related to the trauma
• Assisting the child in sharing a verbal, written, or artistic narrative about the trauma(s) and related experiences
• Encouraging gradual in vivo exposure to trauma reminders if appropriate
• Cognitive and affective processing of the trauma experiences
• Education about healthy interpersonal relationships
• Parental treatment components including parenting skills
• Joint parent-child sessions to practice skills and enhance trauma-related discussions
• Personal safety skills training
• Coping with future trauma reminders
Overview

• Defining trauma-informed care
• Care systems serving traumatized children
• Assessment
• Intervention
• Building trauma-informed systems
  o A Minnesota example

Defining Trauma-Informed Care

• What is trauma?
• Trauma-informed care
  o Practitioner knowledge about impact of traumatic events on children, adults, and families
  o Practitioner use of this knowledge in delivering care (skills)
    • E.g. ‘what happened to you?’ vs. ‘why did you do this?’
  o Agency and system use of knowledge in training staff and implementing interventions
Practitioner Knowledge

• How did you learn about trauma?
• What did you learn?
• Examples of trauma curricula
  o National Child Traumatic Stress Network Core Curriculum in Child Trauma
  o Example: Ibrahim

Practitioner Skills

• Trauma assessment
• Delivering
  o Evidence-based trauma treatments
  o Trauma-informed interventions
Notes on the Reporting of Trauma Exposure and Symptoms

- By children
  - Underreporting consistent with posttraumatic symptoms (i.e. denial)
  - Fear of disclosure; shame; stigma
- By their caregivers – underreporting well documented
  - Guilt
  - Denial
  - Concern about child protection involvement
- Discrepancy between parent and child report of both history and symptoms

Benefits of TF-CBT

- TF-CBT is a highly effective treatment for symptoms of traumatic stress in children and youth.
- Over 80% of traumatized children show significant improvement in 12 to 16 weeks.
- Family functioning is improved because TF-CBT encourages the parent to be the primary agent of change for the traumatized child.
Who is TF-CBT for?

• TF-CBT is suitable for many children who have experienced trauma, including children with multiple or compound traumas.
• TF-CBT has been successfully adapted to address the unique needs of several special populations including Latino, Native American, and hearing-impaired families.
• Children as young as three can be treated with TF-CBT.

TRAINING IN TF-CBT: LEARNING COLLABORATIVES IN MINNESOTA
Children with Trauma, Traumatic Stress

Why train providers in TF-CBT?

Training Providers in Trauma-Informed EBPs

Trauma-Informed EBPs for Children

How do you train providers?

Different types of training models available

- Didactic training models: workshops, written materials, presentations, web-based learning
- Competency training models: Role-playing, demonstrations, ongoing consultation, case consultation
- Most successful: Combination
- Most used: Didactic
Training Providers

- Limitations of didactic training
  - Effective for increasing knowledge
  - Doesn’t support change in practice

- In order to change and sustain practice, need to utilize models that support this
  - Combination training

Learning Collaborative (LC)

- Quality improvement model
  - Change and sustain new practice to improve the delivery of care in health care setting
    - Avoid “project mentality”

- Evidence-base for the LC

- NCTSI adaptation
Key Elements of the LC

- Topic Selection
- Faculty Recruitment
- Innovation Teams
- Learning Sessions
- Action Periods
- PDSA Cycles
- Measurement and Evaluation

History of TF-CBT Training

- 2007-2008
  - First TF-CBT Learning Collaborative
  - First Request For Proposals
- 2009 -2010
  - 2 Outpatient Treatment Groups
  - 1 Residential Treatment Group
- 2011-2012
  - 3 Outpatient Treatment Groups
Funding for Providers

Grants pay hourly Medicaid rate for “lost time”

- 10 hours for online training
- 32 hours for classroom training
- 18 hours for consultation calls
- 18 hours for internal supervision
- 36 hours for assessment/fidelity
- 16 hours for follow-up training days
- Travel/lodging costs

Ambit Network’s TF-CBT LC
In-Person Trainings

- Training 1
  - Trauma 101, Trauma-informed assessments, “PRAC”

- Training 2
  - “TICE”, Developing trauma-narrative, Gradual exposure

- Training 3
  - Case presentations, Sustainability after the LC

- Additional topics in Trainings 2 and 3

Consultation Calls

- 18 bimonthly cohort calls
  - Case presentations
- 9 monthly supervisor calls
- Phone conference with web-based component
- Collaboration across agencies and providers
  - “This is how I did it”
Follow-up and Technical Assistance

• “Practicum period” – throughout the LC
  o Scoring clinical assessments
  o Fidelity monitoring
  o Tracking follow-up interviews, assessments
• Purpose of technical assistance
  o Support trainee learning
  o Monitoring implementation
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<th>Session #</th>
<th>Who was present:</th>
<th>Psycho-education:</th>
<th>Parenting Skills:</th>
<th>Relaxation:</th>
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<td>12/2/2010</td>
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<td>Child, Caregiver, or Child + Caregiver</td>
<td>Therapist spent time administering or giving feedback on assessments</td>
<td>Therapist provided psycho-education (e.g. directive education about the traumatic event, normal reactions to trauma, and instills hope)</td>
<td>Therapist explained the physiology of relaxation and instructed on methods of relaxation</td>
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**TF-CBT Fidelity Monitoring**

- Psycho-education
- Parenting Skills
- Relaxation
- Affect Regulation
- Cognitive Coping
- Trauma Narrative
- Injury Desensitization
- Conflict Resolving Session
- Safety
- Problem Solving
- Other

- **Sum**
- **Avg.**
### Summary Information for Client: 3052-0-00616

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<th>TSCC/TSIC</th>
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### Ambit Network

**DATA FROM THE IMPLEMENTATION OF TF-CBT IN MINNESOTA**
Trained Providers in Minnesota

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<tr>
<th>Cohort Name</th>
<th>Number of Trainees</th>
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<td>Alpha</td>
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<tr>
<td>Beta</td>
<td>23</td>
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<tr>
<td>Delta</td>
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<td>Epsilon</td>
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<td>Theta</td>
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<td>Masters in Social Work (MSW)</td>
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Professional License

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<td>Licensed Independent Clinical Social Worker (LICSW)</td>
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<td>Licensed Marriage and Family Therapist (LMFT)</td>
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Certificate

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<td>Registered Play Therapist (RPT)</td>
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Serving Minnesota’s Children

1,555 children screened for trauma

Female 56%
Male 44%

Age of Children Screened for Trauma

- 0-4: 26%
- 5-9: 28%
- 10-14: 42%
- 15-17: 3%
- 18+: 1%

1/30/2013
Race, Ethnicity of Children Screened for Trauma

<table>
<thead>
<tr>
<th>Race</th>
<th>Number</th>
<th>Percent</th>
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<tbody>
<tr>
<td>American Indian/Alaskan Native</td>
<td>100</td>
<td>6.4%</td>
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<tr>
<td>Black/African American</td>
<td>153</td>
<td>9.8%</td>
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<tr>
<td>White</td>
<td>771</td>
<td>49.6%</td>
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<tr>
<td>Asian</td>
<td>7</td>
<td>.5%</td>
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<tr>
<td>Native Hawaiian/Pacific Islander</td>
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<td>.3%</td>
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<td>Multi-racial</td>
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<td>63.7%</td>
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<td>448</td>
<td>28.8%</td>
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Number of Clients Screened, Per Year

![Graph showing the number of clients screened per year from 2007 to 2012.](image)
### Top 10 Behavior Problems Reported

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<th>Somewhat/Very</th>
<th>Total N</th>
<th>% Total Reporting</th>
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<td>Attachment Problems</td>
<td>472</td>
<td>673</td>
<td>70.1%</td>
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<tr>
<td>Behavior Problems, Home/Community</td>
<td>470</td>
<td>674</td>
<td>69.7%</td>
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<tr>
<td>Academic Problems</td>
<td>451</td>
<td>673</td>
<td>67.0%</td>
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<tr>
<td>Behavior Problems, School/Daycare</td>
<td>385</td>
<td>672</td>
<td>57.3%</td>
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<tr>
<td>Other Self-Injurious Behaviors</td>
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<td>673</td>
<td>31.1%</td>
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<tr>
<td>Dev’tally Inapp. Sexual Behaviors</td>
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<td>674</td>
<td>23.9%</td>
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<tr>
<td>Problems Skipping School/Daycare</td>
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<td>673</td>
<td>21.4%</td>
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<tr>
<td>Other medical problems, Disabilities</td>
<td>105</td>
<td>674</td>
<td>15.6%</td>
</tr>
<tr>
<td>Criminal Activity</td>
<td>102</td>
<td>674</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

### Clinical Evaluation

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Probable/Definite</th>
<th>Total N</th>
<th>% Total Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>674</td>
<td>666</td>
<td>86.2%</td>
</tr>
<tr>
<td>Depression</td>
<td>495</td>
<td>659</td>
<td>75.1%</td>
</tr>
<tr>
<td>General Behavioral Problems</td>
<td>432</td>
<td>658</td>
<td>65.7%</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>397</td>
<td>660</td>
<td>57.1%</td>
</tr>
<tr>
<td>Attachment Problems</td>
<td>376</td>
<td>658</td>
<td>44.9%</td>
</tr>
<tr>
<td>Traumatic/Complicated Grief</td>
<td>293</td>
<td>653</td>
<td>44.9%</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>293</td>
<td>657</td>
<td>44.6%</td>
</tr>
<tr>
<td>ADHD</td>
<td>283</td>
<td>655</td>
<td>43.2%</td>
</tr>
<tr>
<td>Dissociation</td>
<td>178</td>
<td>647</td>
<td>27.5%</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
<td>172</td>
<td>639</td>
<td>26.9%</td>
</tr>
</tbody>
</table>
Top 10 Reported Traumas

- Domestic Violence
- Impaired Caregiver
- Emotional...
- Traumatic Loss/Bereavement
- Physical Maltreatment/Abuse
- Neglect
- Sexual Maltreatment/Abuse
- Sexual Assault/Rape
- Physical Assault
- Serious Injury/Accident

Number of Children Reporting

Clinical Outcomes: UCLA

N=396

<table>
<thead>
<tr>
<th>PTSD Overall Score</th>
<th>Baseline Average</th>
<th>Follow-up Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34.43</td>
<td>24.17</td>
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</table>
Clinical Outcomes: TSCC
N=388

<table>
<thead>
<tr>
<th>Condition</th>
<th>Baseline Average Score</th>
<th>Last Follow-up Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>57.68</td>
<td>50.94</td>
</tr>
<tr>
<td>Dissociation</td>
<td>56.77</td>
<td>51.56</td>
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<tr>
<td>Anger</td>
<td>53.96</td>
<td>49.13</td>
</tr>
<tr>
<td>Depression</td>
<td>56.13</td>
<td>50.06</td>
</tr>
<tr>
<td>PTSD</td>
<td>57.9</td>
<td>50.88</td>
</tr>
</tbody>
</table>

THE NEXT FOUR YEARS
The Next Four Years

- Improve access to trauma-informed practices and treatment for traumatized children and families
- Implement and sustain evidence-based trauma treatment models in the Upper Midwest and in particular throughout four targeted regions
- Build and maintain consensus for child trauma

The Next Four Years Learning Collaboratives

- Recently completed a LC in Northwest MN
- Completing a LC Southeast MN
- Initiate two cultural providers LC’s in the metro
- Initiate a second LC for residential treatment center providers
- Initiate a second LC in Central MN
- Initiate a LC in Southwest MN
The Next Four Years
Evaluation and Reporting

• Continue tracking and data collection for LC sites
• Provide evaluation reports for completed cohorts
• Conduct exploratory analysis on fidelity
• Provide TF-CBT booster trainings
• Manage TF-CBT certification process in MN

Systems Integration

• Many child and family serving agencies touch lives following traumatic experiences.
• The way these organizations work together is critically important.
• They can reduce the harmful impact of traumatic experiences OR ...
Systems Integration

• Literature on integrating systems around trauma expertise and responses is scant to nonexistent.

• Survey conducted in 2005 by NCTSN assessed
  o Ways agencies gather, assess, and share trauma-related information
  o Child trauma training that staffs receive

  *Taylor, Siegfried, NCTSN Systems Integration Working Group, 2005.*

Systems Integration

• Findings from the survey across all child serving agencies included:
  o Trauma history rarely follows the child.
  o Many agencies do not conduct standardized trauma screening or assessment.
  o More information is gathered on behavior and problems than duration of abuse, # of episodes, and internalizing symptom.
  o Less than half receive training on trauma treatments and where to refer.
Systems Integration

Recommendations from NCTSN:
• Identify common interests across systems
• Evaluate the benefits of systems integration
• Introduce core training for every child and family serving agency
• Provide trauma-informed interventions early and strategically
• Emphasize interdisciplinary collaboration and relationships

Brymer, Layne, 2008

The Next Four Years
Systems Integration

• Convene Advisory and Families Committees
• Convene a 2-day launch in each region
  ○ Conduct a community needs/readiness assessment
  ○ Facilitate stakeholder dialog
• Convene parents and providers to deliver a NAMI/parent-led training on working with traumatized families
• Deliver training on trauma-informed practice (i.e. NCTSN Toolkit for child welfare providers, and the NCTSN Toolkit for juvenile justice providers)
• Convene quarterly meetings to develop trauma-informed practices (i.e. universal screening protocols, case management and collaboration protocols)
The Next Four Years
Systems Integration

- Convene military stakeholders in parallel launch process
- Two LCs in PTC/ADAPT targeting providers serving military and refugee families
- Year four: further diffuse trauma-informed practice by training school social workers who will then participate in the regional hubs
- Work with each region throughout the grant period on sustainability

The Next Four Years
Number Served

- 400 practitioners trained in EBP Toolkits
- 240 families in parent led trainings
- 115 providers trained in TF-CBT
- 40 providers trained in PTC
- 2450 children screened and assessed
- 1280 children receiving TF-CBT
Contact Information

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