Easy as A-B-C:
Adapting the D-E-F framework to guide trauma-informed assessment and intervention

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4th BIENNIAL TRAUMA CONFERENCE
Addressing Trauma across the Lifespan: Integration of Family, Community, and Organizational Approaches
October 3rd & 4th, 2013

Trauma Training Academy
The Family Center
at Kennedy Krieger Institute

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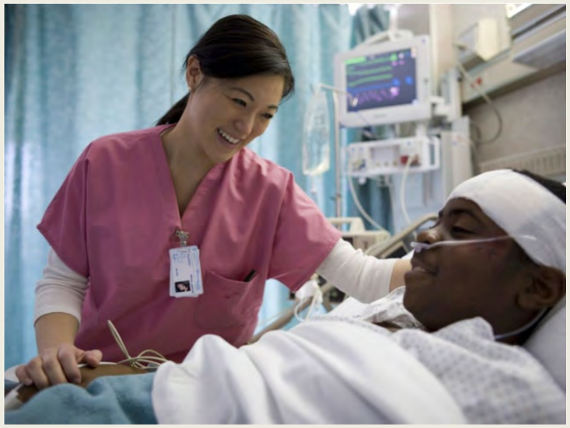


Learning Objectives:

1. **Describe the development of the D-E-F protocol** and its intended function.

2. **Identify commonalities** between trauma-informed assessment and intervention **across diverse child serving systems**.

3. **Discuss cultural implications and other adaptations** that might be required to implement the D-E-F protocol effectively.

4. **Contribute to the adaptation of the D-E-F tool** to guide assessment and intervention for your own work/system.

CONFLICT OF INTEREST:

There is no conflict of interest to disclose among any of today's workshop presenters.

Development of the D-E-F: The Health Care Environment

- 3 Letter model
- KISS
- Needs to fit within THEIR existing framework
- Easy to use

Healthcare Providers' Guide to Traumatic Stress in Ill or Injured Children

•••AFTER THE ABCs, CONSIDER THE DEFs

D	DISTRESS	• Assess and manage pain. • Ask about fears and worries. • Consider grief and loss.
E	EMOTIONAL SUPPORT	• Who and what does the patient need now? • Barriers to mobilizing existing supports?
F	FAMILY	• Assess parents' or siblings' and others' distress. • Gauge family stressors and resources. • Address other needs (beyond medical).

How to Assess: Distress

TRAUMATIC STRESS IN ILL OR INJURED CHILDREN

Pain. Use your hospital's pediatric pain assessment. Ask:

- How is your pain right now?
- What was your worst pain since this happened?

Fears and worries. Ask:

- Sometimes, kids get upset when something like this happens. What has been scary or upsetting for you?
- What worries you the most?

Grief or loss. Ask:

- Was anyone else hurt or ill?
- Have you had other recent losses? (home, pet, etc.)

D

D

How to Help: Distress

TIPS TO HELP FAMILIES OF INJURED OR ILL CHILDREN

1 Provide child with as much control as possible.

- Help the child understand what is happening.
- Allow the child to have a say in what will happen next.

2 Actively assess and treat the child's pain.

- Use your hospital's pain management protocol.
- Teach child and parent basic coping techniques.

3 Provide accurate information, using basic words.

- Ask the child to repeat back explanations.
- Listen carefully and clarify misconceptions.

4 Provide reassurance and realistic hope.

- Describe what is being done to help the child feel better.
- Address the child's concerns or worries.

How to Assess: Emotional Support

TRAUMATIC STRESS IN ILL OR INJURED CHILDREN

What does the child need now?

- Parents: What helps your child cope when upset/scared?
- Child: What helps you feel better when you are upset/scared?

Who is available to help the child?

- Do parents understand the illness/injury or treatment?
- Can they be with their child during procedures?
- Can they help calm/soothe their child?

What are the barriers to mobilizing parent support?

- Do parents' responses make it harder for them to help?
- How confident is the parent in caring for the child?

E

E

How to Help: Emotional Support

TIPS TO HELP FAMILIES OF INJURED OR ILL CHILDREN

1 Listen to parents and encourage their presence.

- Ask parents for their expertise about their child.
- Ask parents about their concerns.
- Encourage them to be with their child.

2 Empower parents to help their child.

- Suggest ways they can help their child.
- Involve them in physical care, as appropriate.
- Help them seek out support if upset/anxious.

3 Encourage child/parent involvement in "normal" activities.

- Suggest activities that fit the child's medical status.
- Find activities that the child and parent can do together.
- Promote contact with the child's friends and teachers.

How to Assess: Family

TRAUMATIC STRESS IN ILL OR INJURED CHILDREN

Assess distress of parents/family members. Ask:

- How is your family coping right now?
- Who is having an especially difficult time?

Gauge family stressors and resources. Ask:

- Are you eating, getting sleep, and taking breaks?
- Do you have friends who can help out at home?

Address other needs (beyond medical). Ask:

- Are there other stressors going on (such as money, job, transportation) that make it particularly difficult right now?

F

F

How to Help: Family

TIPS TO HELP FAMILIES OF INJURED OR ILL CHILDREN

1 Encourage parents' basic self-care.

- Encourage parents to sleep, eat, and take breaks.
- Help them enlist support of friends, family, and community.

2 Remember other family members' needs.

- Involve siblings and explain treatment to them when possible.
- Enlist hospital resources such as chaplain and social work as needed.

3 Be sensitive to the cultural and resource needs of the family.

- Remember that outside issues can impact recovery.
- Be open to involving other healing professionals and customs.

How to Assess: Culturally Sensitive Trauma-Informed Care

…QUESTIONS PROVIDERS SHOULD ASK

LISTEN	**…for variations in understanding. Ask:** • What is your understanding of what's happened? • What is worrying you the most? • What does your family think about it?
BE OPEN	**…to involving other professionals. Ask:** • Who do you normally turn to for support? • Who else should be involved in helping your child? • Are you open to outside referrals and resources?
RESPECT	**…different communication practices. Ask:** • Who typically makes the decisions about your child? • What information should be shared with your child? • Is there anyone else you would like me to talk to?

For the Provider: Working with Traumatized Children and Families

•••ABCs OF PROVIDER SELF-CARE

AWARENESS	• Be aware of how you react to stress (overworking, overeating, etc.). • Monitor your stressors and set limits with patients and colleagues. • Talk to a professional if your stress affects your life or relationships.
BALANCE	• Diversify tasks and take breaks during the workday. • Eat sensibly, exercise regularly, and get enough sleep. • Engage in activities outside of work; use your vacation days.
CONNECTION	• Connect regularly with family, friends, and community. • Use meditation, prayer, or relaxation to connect with yourself. • When not at work, disconnect from professional role and e-mail.

Adapted from Saakvitne & Pearlman, 1996

DEF Worksheet for Trauma Informed Care – Child

Patient ID: **Date:**

TO CHILD: Most kids feel a little worried or upset when they are in the hospital.
Are any of the following things worrying you or upsetting you right now?

Common worries	How to potentially address
☐ Not sure what's happening /no one is telling me much	☐ Find out what child knows / has been told / imagines ☐ Work w/ caregiver to include child in explanations
☐ Worried about or missing friends / family / pets ☐ Worried that I'm missing a lot of things at home / school ☐ Worried about explaining what happened to friends	☐ Encourage more contact with friends / family (talking, texting, face-time, etc.) ☐ Suggest activities that caregiver/child can do together (card games, reading, homework, etc.) ☐ Help child create/tell a story about what happened
☐ Being in pain or worried that pain won't go away*	☐ *Coordinate w/ team re: pain management ☐ Encourage use of distraction activities (TV, movies, computer games, music, etc.)
☐ Worried that I won't look the same / go back to normal* ☐ Feel alone or different from other kids* ☐ Feel like I'm to blame /others are blaming me* ☐ Worried that this might happen again*	☐ Acknowledge worries and provide helpful suggestions without dismissing their "here and now" concerns ☐ Encourage caregiver to provide frequent reassurance ☐ *Consult social work /psychology
☐ Is anything else worrying / upsetting you? *(describe)*	
☐ What helps you feel better when upset? What do you normally do? *(describe)*	

(If indicated a worry): Although you may be upset now, do you think things will be okay for you in the future?
☐ Yes /Probably ☐ Not sure / No* *(*Consult SW/Psych)* Child comments:

Documentation - Education / Coping Plan:

Coping suggestions:

☐ Encourage more contact w/ friends, family	☐ Involve child in explanations / decisions
☐ Encourage more distraction activities	☐ Suggest activities that child/caregiver can do together
☐ Encourage caregiver emotional reassurance	☐ Other:

☐ Provide educational handouts (workbook / activity sheets, etc.):
☐ Provide information or education (about):

Documentation - Team-based Coordination / Consultation

Request Consult: ☐ Social Work ☐ Psychiatry ☐ Psychology ☐ Other:

Coordinate w/ team re: pain management:

Other: ☐ Notified attending physician

Other Documentation:

Completed by: ______________________ Date: ____________ Time: __________

Reviewed by: ______________________ Date: ____________ Time: __________

Comments:

DEF Worksheet for Trauma Informed Care–Caregiver

Patient ID: **Date:**

TO CAREGIVER: The following are common concerns for parents whose children are hospitalized. Please tell us whether these concerns are upsetting or worrying you right now:

Common concerns / reactions	How to potentially address
☐ Seeing my child looking sick, uncomfortable or in pain ☐ Not sure how to comfort or soothe my child	☐ Acknowledge and normalize caregiver reactions ☐ Ask what caregiver knows, believes about child's pain ☐ Suggest ways caregiver can comfort / care for child
☐ Not sure what is happening (prognosis/next steps/discharge) ☐ Feeling overwhelmed by all the medical information ☐ Unsure of how to care for my child medically at home	☐ Find out what caregiver knows/ understands ☐ Provide info in smaller doses / repeat info, if needed ☐ Identify person who can go through info w/ caregiver
☐ Worried about other children or family at home	☐ Have caregiver make list of tasks / help needs ☐ Encourage caregiver to identify / ask others for help (friends, other family, neighbors, etc.)
☐ Feeling guilty or to blame for what's happened ☐ Making decisions alone or under pressure	☐ Acknowledge and normalize caregiver reactions ☐ Connect caregiver w/ someone to talk to (social work, close friend, counselor, clergy member)
☐ Other stresses (time off, medical bills, transportation, etc.)	☐ Consult social work ☐ Identify hospital resources / community referrals

Is anything else worrying / upsetting you? *(describe)*

How would you rate your stress level right now? ☐ A little stressed ☐ Very stressed* ☐ Not stressed at all

Who do you usually turn to for help or support during tough times?

☐ Spouse / Partner ☐ Other family ☐ Friends / Neighbors ☐ People at work ☐ Church Community
☐ No one* ☐ Other: ____________________

Is there any reason that they cannot be helpful to you right now? ☐ Yes* ☐ No If yes: ____________

Are other family members sick, injured or especially upset or worried since this happened? ☐ Yes* ☐ No
If yes, who : ____________

What would help you most right now?

Documentation / Plan:

Provide information /education/instruction:

Encourage use of social support / coping strategies:

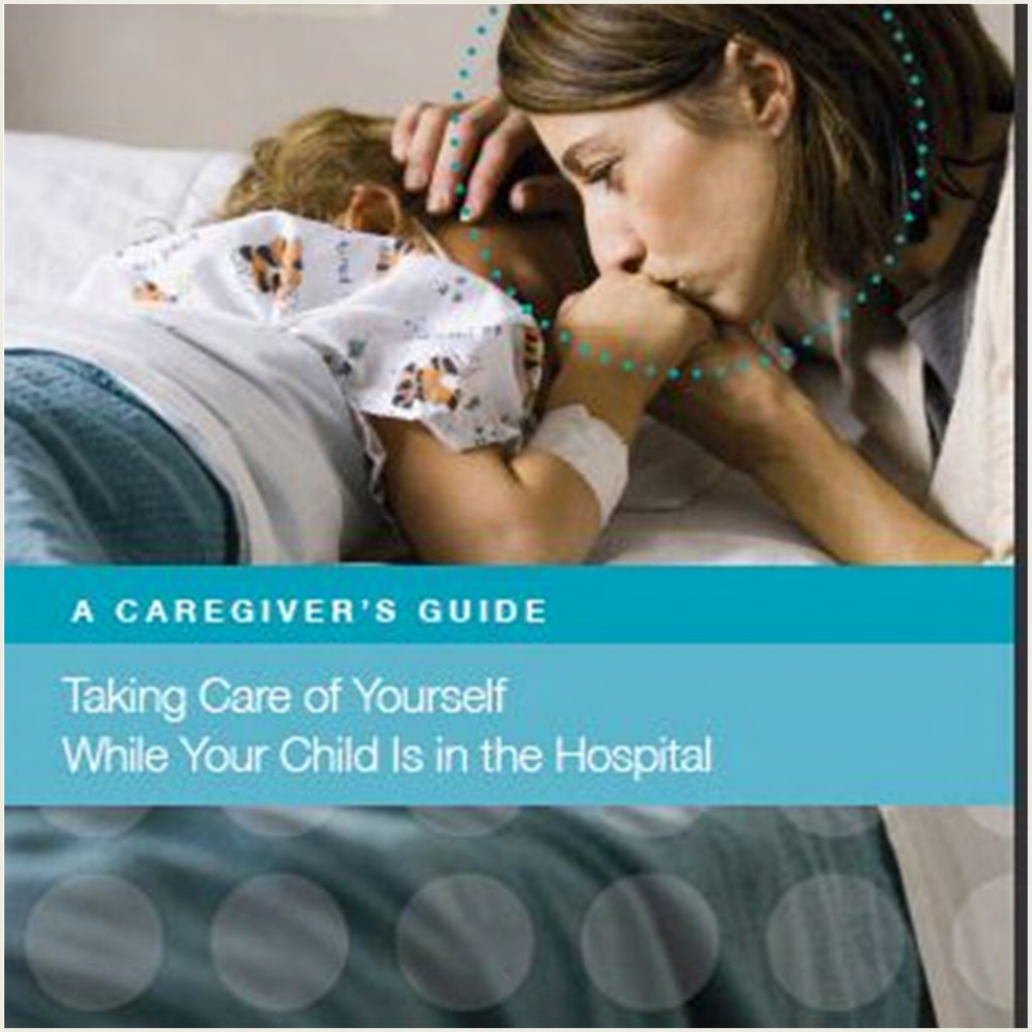
Provide educational handouts/workbooks:

*Consultation / Community Referral: ☐ Social Work ☐ Psychiatry ☐ Psychology / Mental health ☐ Chaplain / Clergy ☐ Community: ☐ Other:

Completed by: ____________ Date: ________ Time: ________

Reviewed by: ____________ Date: ________ Time: ________

Comments:


A CAREGIVER'S GUIDE
Taking Care of Yourself
While Your Child Is in the Hospital

Serious medical events can be traumatic.

No one expects a serious illness or injury to happen to their child. Acute medical events like these are called "medical traumas." When they occur, it is common for children and parents to feel upset, scared, or worried at first.

The sudden nature of the illness or injury, the possible life-threat, and seeing your child go through difficult or painful treatment can cause even more distress to parents and caregivers.

Caregivers and family members react to medical trauma in different ways. These reactions often include thoughts, feelings, and actions that can be upsetting or get in the way of work, school, or life at home.

- Listed below are common reactions that parents may have right after a child's medical trauma:

The hospital can be a scary place, even for adults.

The hospital can be a strange and scary place for children and adults. You may not know where to find things or who to ask for help. The medical staff is here to help, so don't be afraid to ask them questions.

Here are some helpful things to ask about:

- When are visiting hours?
- Who is allowed to visit?
- When does the nurse change shifts?
- Can you show me where things are on the floor?

There may be a lot of strange equipment in your child's room. These machines may make many types of noises and alarms.

Ask your child's doctor or nurse:

- How does each machine help my child?
- What noises should I expect?
- What should I do if a machine is alarming?

Most caregivers feel sad, upset, or guilty the first few times they see their child in a hospital bed, hooked up to machines, or feeling sick. It is common for parents to feel this way.

It is helpful to meet and talk with other parents on the floor about how they have coped. It is also helpful to focus on what you can do to help your child feel more comfortable. If you are unsure, ask your nurse to show you what you can do.

HOSPITAL HERO!

A Story All About Your Stay

YOU ★ ARE ★ AWESOME!

HOSPITAL HERO!

Certificate of Completion

This certifies that

____

has been a true hero in the hospital and at home and has the skills to cope with some pretty tough stuff.

____

____

____

Have your family sign above.

Thanks for sharing your story!

Chapter 5: Talking About What's Worrying You

In the hospital, lots of kids have questions or worries. Here's what some other kids have written in their storybooks:

"I felt alone and missed my friends. It helped when my brother came and played video games with me." – Cole, age 9

"The doctors told me I needed a needle puncture. I heard from other kids that the puncture hurts and I was really scared. I told my nurse and she told me everything that would happen step-by-step. She also helped me come up with things to distract me." – Max, age 13

"I was worried about going back to school. My mom talked to my teacher and found out what I was missing." – Zoe, age 12

Talk to someone.

Is anything worrying you about being in the hospital? Even heroes sometimes need help. There are a lot of people who can answer your questions or calm your worries. All you have to do is ask!

But, talking to someone about what is worrying you can be hard, especially if you haven't done it before. It's easier if you do it step-by-step.

STEP #1: First choose what you want to talk about:

- Is there anything worrying you?
- Is there anything important you don't understand?
- Is there something you really want or need?
- Choose one of these things you want to talk about.

STEP #2: Next, pick who you want to talk to. Someone in your family? Your nurse? Your doctor? Someone else? Think about:

- Who do you usually talk to about your worries?
- Who explains things to you when you don't understand?
- Who listens to you when you really want something?

Put a check in the box next to one or all the people you want to talk to:

- ☐ MOM
- ☐ DAD
- ☐ BROTHER
- ☐ SISTER
- ☐ GRANDPARENT
- ☐ NURSE
  Name:
- ☐ DOCTOR
  Name:
- ☐ FRIEND
  Name:
- ☐ TEACHER
  Name:
- ☐ OTHER
  Name:

There are lots of other ways to take a mini-vacation when you are at the hospital. Check the ones you want to do:

- ☐ Read.
- ☐ Play a video game.
- ☐ Watch a funny movie.
- ☐ Text message friends.
- ☐ Listen to music.
- ☐ Call family and friends.
- ☐ Draw.
- ☐ Visit other kids on the floor.
- ☐ Sing or hum to yourself.

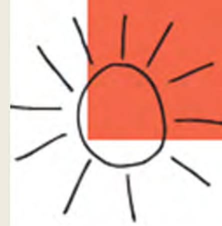
Now that you know what you are good at, DRAW A LINE to match them with things that you have to deal with at the hospital. If you are not sure which ones to use, ask someone for help.

When this happens:

- Something worries me.
- I feel scared.
- I feel mad.
- I feel sad.
- I have to do something I don't like.
- I feel sick or am in pain.
- I see other sick kids.
- I don't feel like getting out of bed.
- I miss my family and friends.
- I have a difficult time walking.
- I feel or look different from other kids.
- I have bad dreams.
- I don't feel like talking.

I can:

- ...make new friends.
- ...tell jokes.
- ...read stories.
- ...ask for help when I need it.
- ...draw or write about myself.
- ...figure out what to do when I have a problem.
- ...try new things.
- ...talk to people I trust.
- ...believe things will turn out OK.
- ...not give up too easily.
- ...talk about how I am feeling.
- ...not stay mad or sad too long.
- Write your own:



Excellent Job!

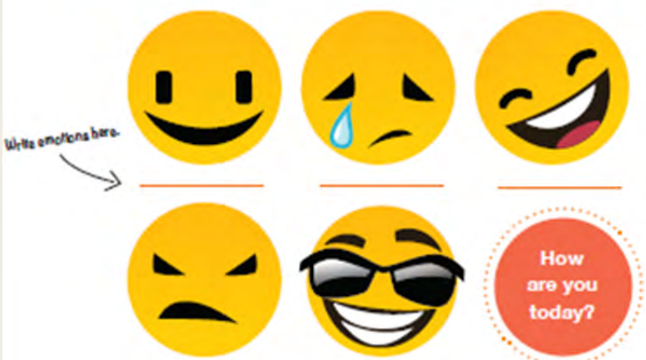
Chapter 8: Know How You Are Feeling

Your face shows how you feel. You know the face your mom or dad makes when they or mad, or the face your friends make when they think something is funny.

Your body can also tell you how you are feeling.

- **When you are sad** – you may feel heavy inside or feel a lump in your throat.
- **When you are mad** – you may feel a lot of pressure in your chest, back or shoulders. You may also feel hot inside or like your body is pulsing.
- **When you are scared or worried** – you may feel tingly in your head, stomach or in your arms and legs. You may also feel sweaty or cold inside.
- **When you are happy or proud of yourself** – you will likely feel warm and relaxed inside. You may also feel like you have a lot of energy inside and want to do things.

Look at each face. Write down what they are they feeling on the outside AND how they are feeling on the inside.



Ask your team members to write here!

Name	What I will do to as a support team member:

It's time to write your own story!

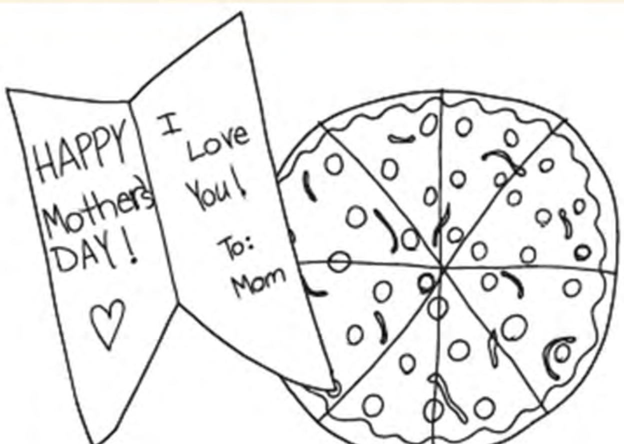
Let's start with an example. Here's a story Tom wrote in his book:

Chapter 1

My name is Tom, I am 10 years old. My favorite food is pizza. I live with my mom, my older brother Tyler, my younger sister Olivia and our cat Mr. Fur. I hate broccoli. My best friend is Matt. My favorite thing to do with my friends is to play soccer.

Chapter 2

My nurse Sara says I'm funny and make funny faces when I don't want to do something. My mom's favorite memory of me is when I made her a card for mother's day. Doctor Rick and I are both left-handed. Oh, and he likes some of the same TV shows that I do.



My at-home coping plan:

I will talk about my feelings with ____________________
(person's name)

and ____________________.
(person's name)

I will ask ____________________
(person's name)

and ____________________ **for help.**
(person's name)

I will spend more time doing ____________________,

____________________, **and** ____________________.
(things that I can still do)

I will remember that I am good at ____________________,

____________________, **and** ____________________.
(things I am good at — see page 25 if you can't think of anything)

Stellar job!

What's next?

- Thoughts on how to assess and address distress, emotional support, and family needs in traumatized children and families across other child serving systems, and their commonalities.

- Opportunity to participate in smaller group work / brainstorming session in Part 2 regarding how you might adapt and use this framework in your work setting.

- Help us think through cultural and other considerations in using an adapted tool with diverse populations.

Some Basic Assumptions About Children in the Child Welfare System

- Everyone (youth *and* families) has been exposed to multiple traumatic events and toxic stress
- The CW system is fragmented, often adversarial and has trouble mobilizing help for youth and families
- CW practitioners and agencies are at high risk for vicarious trauma, which impacts service delivery

Some Basic Assumptions About Children in the Child Welfare System

- Everyone who interacts with youth and families has the opportunity to promote healing but may not do so.
- Families (birth, kinship & foster) are often the vehicle for intervention but often need support to do so and may need healing themselves

An Example
Johnny, age 12

- Feb -Removed from home due to neglect & parental substance abuse. Placed with Maternal Aunt. Changed school.
- Feb-Began having behavior problems referred to OP therapy.
- March-Hospitalized. Returned to Aunt
- May-Hospitalized. Referred to 90 day diagnostic placement. New school, new therapist.
- September – Placed with TFC family. New school, new therapist.

How many people are involved in Johnny's life?

Caregivers

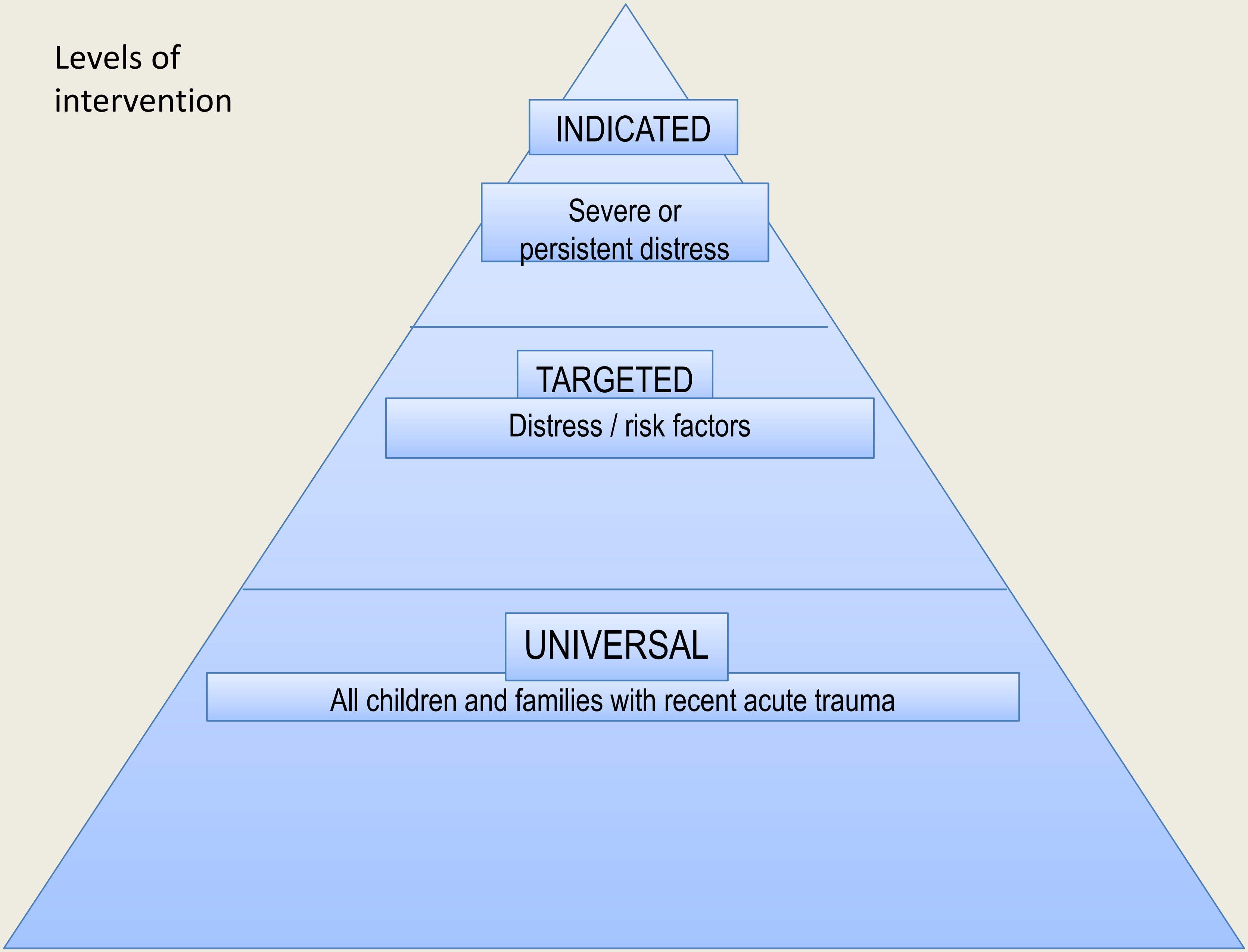
- Mother
- Aunt
- Hospital staff
- Diagnostic Center Staff
- Treatment Foster Parent

Professionals

- CPS worker
- Kinship/Foster Care worker
- 4 Therapists
- 4 Psychiatrists
- Private provider case worker
- 5 teachers
- Doctors?
- Nurses?
- Receptionists?
- Child life staff?

Referring kids to someone else is not sufficient

Levels of intervention



Universal

D: Teach everyone to look for symptoms of trauma
Screen youth and families at entry and at moves

E: Explain what's going on
Strive to provide consistency in your contexts
Be aware of your reactions and responses to youth and families

F: Provide information to all families
Support self-care for all caregivers

The Impact of Trauma on Caregivers

- **Caring for youth who have suffered complex trauma can be very demanding.**
- **Caregivers have many different reactions and feelings. THAT IS OK. You feel what you feel. It is how you respond to those feelings that matter.**
- **Take the time to take care of yourself. Learn to sooth yourself during stressful times and to use down time to care for yourself as**

Symptoms to Look For

If you see the following symptoms, please call the clinic at 410-444-3800 for a follow-up appointment:

- **Preoccupation with the event(s)**
- **Emotional dysregulation**
- **Intense distress**
- **Increase in behavior problems**
- **Problems attaching to/trusting others**
- **School problems**
- **Trouble sleeping**
- **Trouble focusing**

Targeted

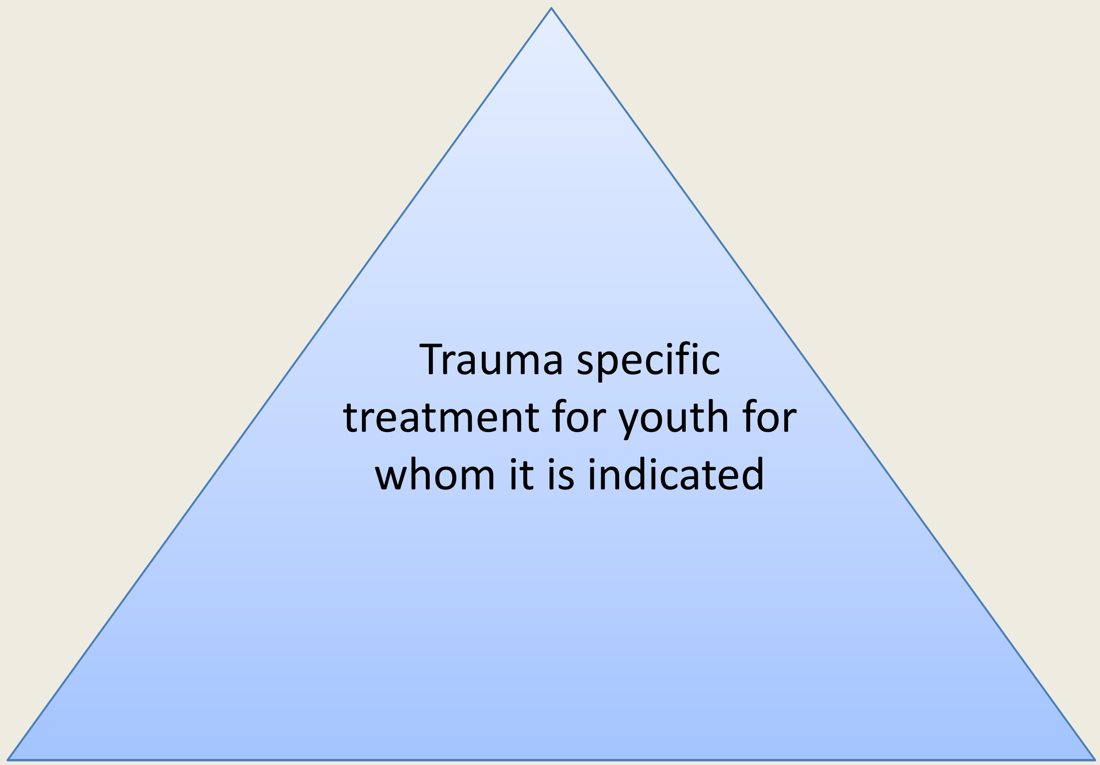
D: Provide comprehensive assessment for youth & families that meet screening criteria

E: Support youth's /family's understanding of being in care

Address any mental health/health/ developmental needs

F: Specific training to meet the child's identified needs

Indicated


Trauma specific
treatment for youth for
whom it is indicated

The DEFs of Trauma in Schools

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OCTOBER 4, 2013

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Child and Adolescent Trauma

- 25% - 68% of American children will experience a traumatic event before graduating from high school
  - Higher in urban and low-income communities
  - Many children experience multiple traumas
- 20-50% of those children will develop significant trauma reactions
  - Children experiencing >1 trauma have more trauma symptoms

The role of schools in managing trauma

What makes school a good place to address trauma?

- Children go to school regularly
- It is a structured, safe environment with trained adults
- Schools draw children and families together
- Can represent a healthy context (relatively) unaffected by a child's specific trauma

Guiding Principles for School-Based Trauma Response

- Need active involvement of multidisciplinary team
- Care must span the multiple systems in which children live – home, school, activities, medical team etc.
- Must involve careful assessment of need – match amount/intensity of service with need

The DEFs of School-Based Trauma

A sequential set of three ordered goals/priorities:

1. Support all students by preventing and preparing for trauma. Universal Care

2. Support students at risk by screening and having automatic systems to handle emergencies. Selected Level Care

3. Support students with significant trauma reactions. Targeted Care

The DEFs of Universal Care

Distress	Emotional Support	Family Support
Goals: Support safety, predictability, responsivity of environment Develop resilience of all students		
Resilience programs – social skills, emotion regulation, problem-solving		

The DEFs of Universal Care

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Develop resilience of all students</td></tr>
<tr><td colspan="2">Resilience programs – social skills, emotion regulation, problem-solving</td><td></td></tr>
<tr><td colspan="2">Student/behavior management programs to increase perceived safety</td><td></td></tr>
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The DEFs of Universal Care

Distress	Emotional Support	Family Support
Goals: Support safety, predictability, responsivity of environment Develop resilience of all students		
Resilience programs – social skills, emotion regulation, problem-solving		
Student/behavior management programs to increase perceived safety		
Clear safety and emergency plans		

Clear Safety and Emergency Plans

- Specific, well-implemented plans for small scale safety issues
  - Suicide and threat assessment plans
  - Mandated reporting/responding to maltreatment
  - Prevention activities in school
- Plans to manage large-scale crises
  - Crisis plans in place
  - Coordination with outside agencies
  - Practices/drills
  - Attention to safety issues

The DEFs of Universal Care

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<tr><td colspan="2">Clear safety and emergency plans</td><td></td></tr>
<tr><td colspan="2">Train school personnel – clear roles</td><td></td></tr>
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Training School Personnel

- Clear roles and responsibilities
  - Prevent under- and over-response to trauma

- Increase staff competence
  - What does trauma look like in school?
  - How should school teams screen for trauma?
  - What plans are in place

Challenges to Recognizing Distress in Schools

- Lack of clarity and specificity of symptoms
  - Trauma reactions have no definitive unique signs
  - Some reactions may be invisible
  - Many trauma symptoms may also be signs of other difficulties
- Developmental challenges
  - Children have limited abilities to report accurately
    - May not verbalize trauma accurately or specifically
    - May not connect trauma event to current distress
  - Trauma will look different at different developmental levels

Recognizing Distress: Re-experiencing Symptoms

Children

- Fearful, anxious
- Regressed language →reading problems
- Inconsistent – emotional outbursts
- Regressed behavior, loss of milestones
- Absenteeism/school refusal
- Irritability/oppositionality

Adolescents

- Rumination
- Revenge fantasies
- Somatic complaints
- Sleep problems
- Decreased achievement
- Risky, confrontational, antisocial behavior (truancy, substance, promiscuity)
- Inconsistent emotionality

Recognizing Distress: Avoidance Symptoms

<u>Children</u>

- Sad, frozen, unresponsive
- Fear-based avoidance
- School refusal
- Social withdrawal – sit alone at recess, refuse play dates
- Restricted affective engagement

<u>Adolescents</u>

- Truancy
- School refusal
- Withdrawal from activities
- Unable to imagine future → no planning for post-secondary education
- Can look like depression

Recognizing Distress: Arousal Symptoms

- Jumpy
- Tantrums, emotional dysregulation
- Sleep problems
- Sleepiness, lack of concentration
- Irritability/distractibility
- Hypervigilance
- Hyper sleep (in adolescents)

Behavioral Signs of School-Based Distress

- Frequent illness or school absence
- Somatic complaints
- School refusal
- Difficulties with emotion regulation, acting out
- Increased withdrawal
- Decreased achievement
- Increased distractibility
- Self-injury, suicidal ideation
- Substance use

Screening for Distress in Schools

Training for School Teams

- Attention to privacy
- Pacing – don't rush
- How to increase child comfort
- Concrete, simple language
- Open-ended questions, leading to more specificity
- Practice interviewing
- Increase adult comfort hearing horrifying stories
- Guidance on how to collaborate with outside teams

The DEFs of Universal Care

<table>
<tr><th>Distress</th><th>Emotional Support</th><th>Family Support</th></tr>
<tr><td colspan="3">Goals: Support safety, predictability, responsivity of environment
Develop resilience of all students</td></tr>
<tr><td colspan="2">Resilience programs – social skills, emotion regulation, problem-solving</td><td></td></tr>
<tr><td colspan="2">Student management programs to increase perceived safety</td><td></td></tr>
<tr><td colspan="2">Clear safety and emergency plans</td><td></td></tr>
<tr><td colspan="2">Train school personnel – clear roles</td><td></td></tr>
<tr><td></td><td colspan="2">Build family-school partnerships</td></tr>
</table>

Family Support: Building Family-School Partnerships

- Increase family-school activities
- Target outreach to higher-risk families
- Focus on positive communication and positive involvement at school
- Identify and address barriers to keep families out
- Cultivate respect for families
- Open doors to other community events at school

The DEFs of Selected Care – Responding After a Potentially Traumatic Event

Distress	Emotional Support	Family Support

Goals: Support mastery of the trauma and a movement toward the path of adaptive development. (Selected Care)

Provide resources to remediate trauma symptoms (Targeted Care)

Distress – Recognize and Respond

- Provide basic psychological first aid
  - Provide child as much control as possible
  - Highlight safety, provide basic information
  - Link child to caring adults

- Actively assess – and reassess – child's psychological pain
  - Observe
  - Interview – child and others

Provide Emotional Support

- Teach basic coping skills
  - Groups, individual
- Provide interventions for the child's unique set of symptoms
  - Address worries, academic issues
  - Develop school reintegration plan, if appropriate
- Encourage normal routine
- Link to supportive resources outside of schools
  - Parents/family
  - Peer/community

Provide Family Support

- Assess family needs, resources
  - Is family traumatized?
  - Can family meet basic needs: eating, sleeping, etc.
  - Consider pre-existing vulnerabilities
- Link family to resources
  - Encourage connection to supportive others
  - Provide referrals to formal resources
- Include family in plan to provide support for children

Trauma-Informed Materials for Lawyers Developed Through the U.S. Dept. of Justice (OJJDP) – Howard Davidson

Identifying Polyvictimization and Trauma Among Court-Involved Children and Youth: *A Checklist and Resource Guide for Attorneys and Other Court-Appointed Advocates*[1]

By Lisa Pilnik, JD, and Jessica R. Kendall, JD, Child & Family Policy Associates

Informational Memorandum from HHS
ACYF-CB-IM-12-04 Issued 4/17/12

Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services

"…2011's *Child and Family Services Improvement and Innovation Act* requires States to include in their health care oversight plans a description of how they will screen for and treat emotional trauma associated with maltreatment and removal for children in foster care (section 422(b)(14)(A)(ii) of the Social Security Act). Identifying the trauma-related symptoms displayed by children and youth when they enter care is critical for the development of a treatment plan. **It is also important to have a complete trauma history for each child.**"

December 2012 Report Recommended…

… Launching a national initiative to promote professional education and training on children exposed to violence

… Ensuring that every professional/advocate serving children exposed to violence and psychological trauma ***learns and provides trauma-informed care and trauma-focused services***

… Ensuring that professional societies develop, adopt, disseminate, and implement principles, practices, and standards for comprehensive evidence-based treatment of children exposed to violence or psychological trauma

… Training defense attorneys who represent children to identify and obtain services for clients who have been exposed to violence

New ABA Project for U.S. Department of Justice Office for Victims of Crime:

Action Partnerships for National Membership/ Professional Affiliation Organizations (2013-14)

RESPONDING TO CHILD POLYVICTIMIZATION

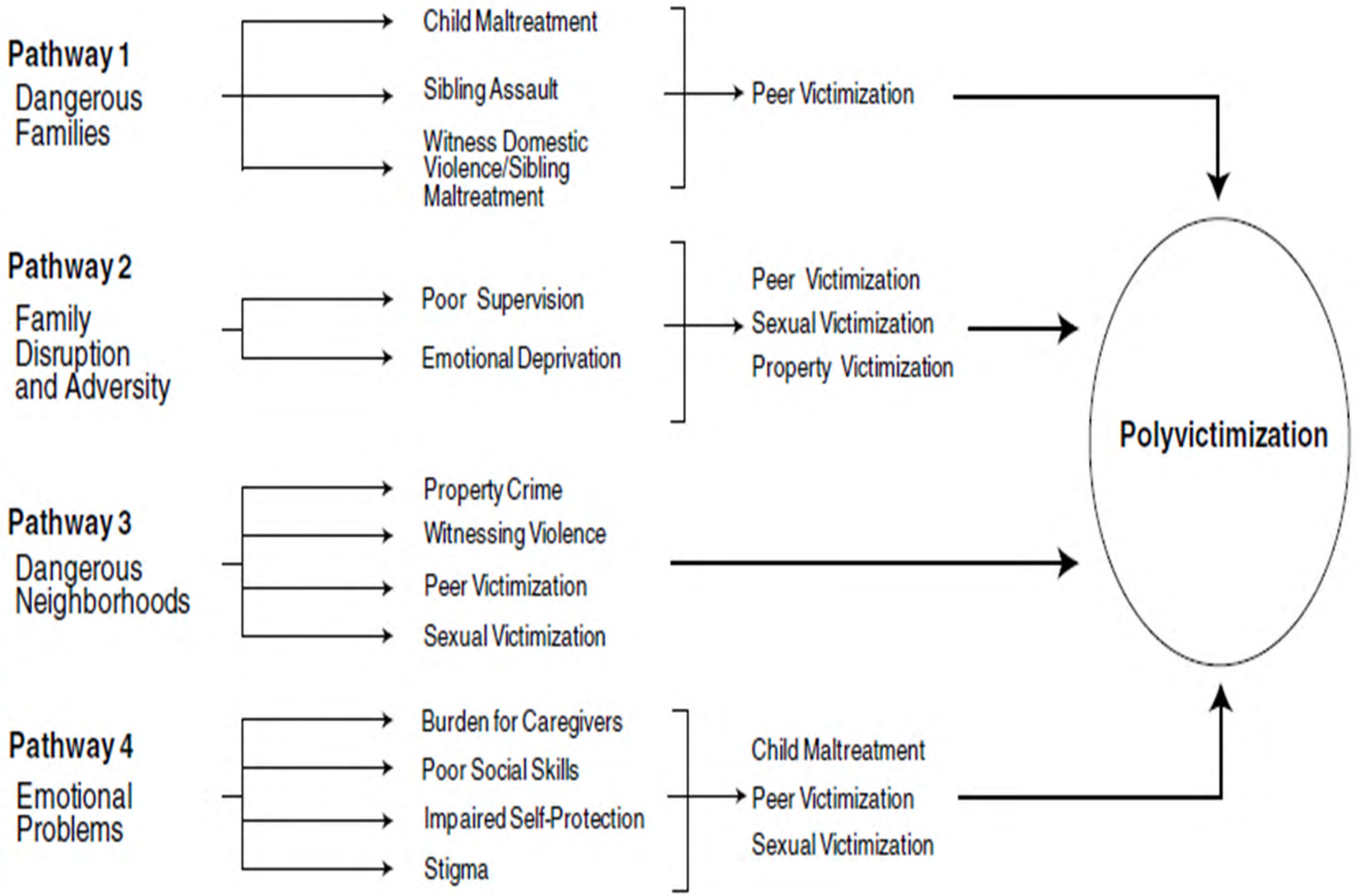
- Convene new ABA Consortium to guide staff work
- Consider new ABA policy resolutions on this topic
- Do new programming on child victimization
- Develop a related training curriculum
- Conduct CLE webinars based on the curriculum
- Create online "self-study" CLE on child victimization
- Publish relevant articles in ABA Child Law Practice and new Website materials
- Create child victimization legal response "best practice" guidelines

For more information: Eva.Klain@americanbar.org

Polyvictimization

- 8% of all youth in NatSCEV sample had 7 or more different kinds of victimization or exposure to violence, crime, and abuse in the past year
- Likely to start at entrance to grade school and high school (ages 7 and 15)
- Associated with 4 pathways:
  - Living in a violent family
  - Living in a distressed and chaotic family
  - Living in a violent neighborhood
  - Having preexisting psychological symptoms

Figure 6: Conceptual Models of Pathways to Polyvictimization



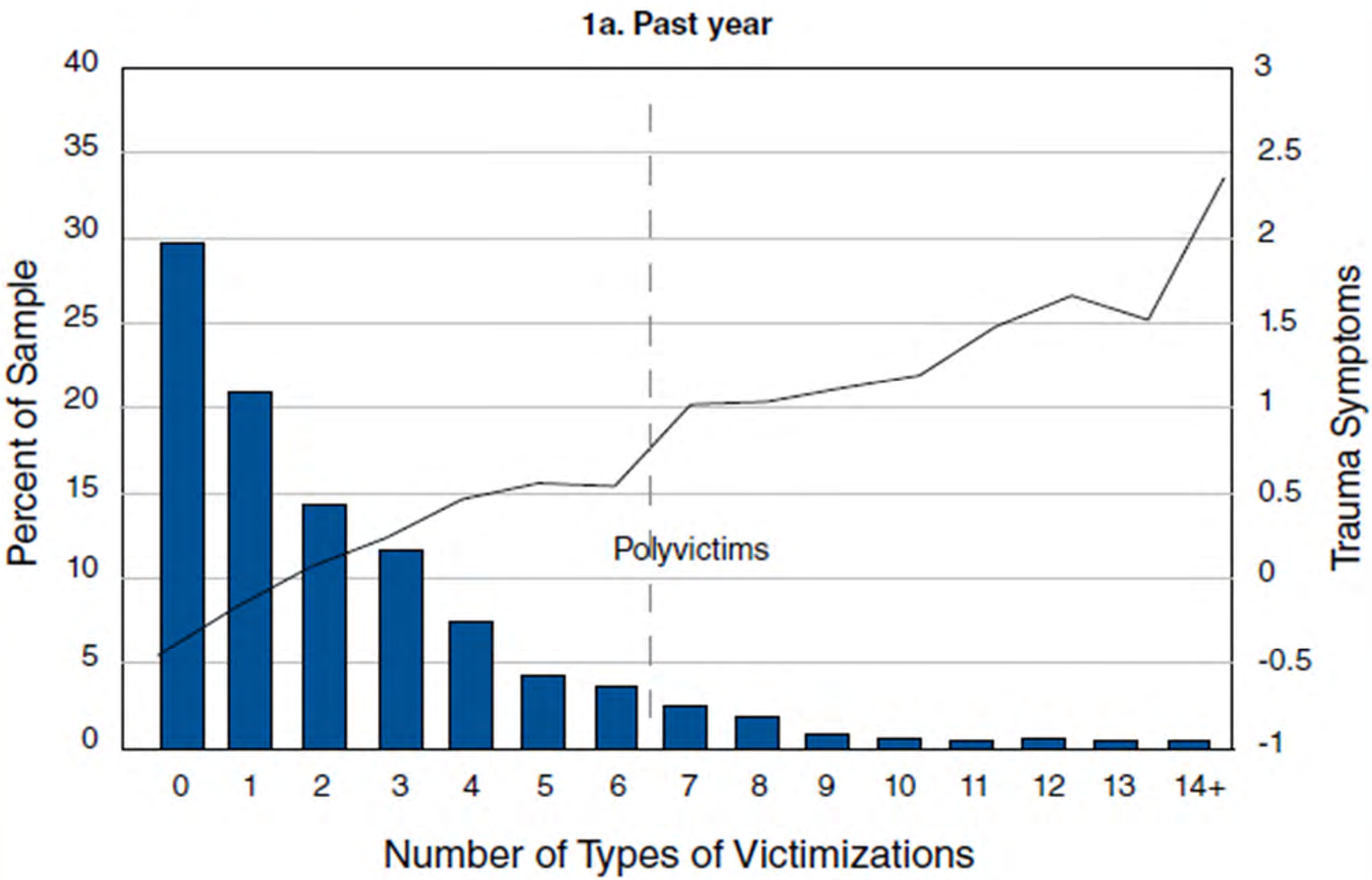
Polyvictims experience . . .

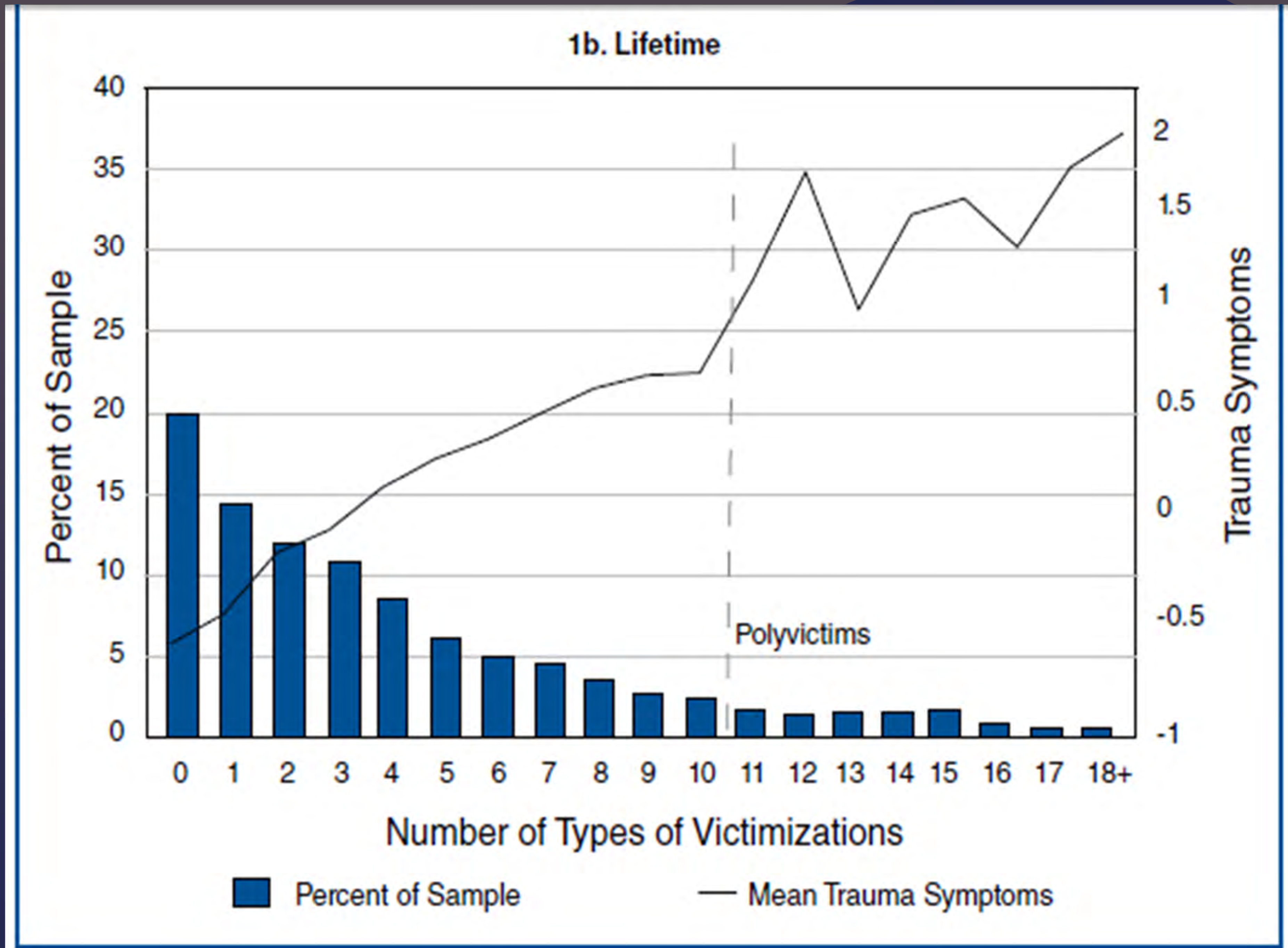
- Cumulative adversity: especially intense and long-lasting effects occur when problems aggregate, especially in childhood
- Complex trauma
- Incidence of serious victimizations (4 to 6 times greater)
- Exposure to multiple domains of victimization (58% in 5 or more domains); relatively few areas of safety for them

Lifetime Adversities and Levels of Distress among Polyvictims

- Like ACE's, more likely to have had other lifetime adversities (average of 4.7 compared to 2.1):
  - Illnesses
  - Accidents
  - Family unemployment
  - Parental substance abuse
  - Mental illness
- High levels of distress measured by indicators of anxiety, depression, anger, and PTSD
- More distressed than those who experienced one type of repeated victimization

Figure 1: Relationship Between Multiple Types of Victimizations and Number of Trauma Symptoms: Past-Year and Lifetime Victimizations





1b. Lifetime
Percent of Sample
40
35
30
25
20
15
10
5
0
2
1.5
1
0.5
0
-0.5
-1
Trauma Symptoms
Polyvictims
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18+
Number of Types of Victimizations
Percent of Sample
Mean Trauma Symptoms

Authors' Implications for Practitioners, Policymakers and Researchers

- Assess for more victimization experiences
- Help professionals identify most endangered children and youth, and protect them from additional harm
- Pay particular attention to these polyvictims
- Need more comprehensive assessments
- Appropriate interventions that reflect polyvictimization experiences

- Reduce stigma or traumatic reminders
- Treat underlying vulnerabilities
- Interrupt onset experiences
- Build supervision and protection capabilities of family members, legal guardians, caregivers, teachers, and other adults to stop onset and progression

Identifying Polyvictimization and Trauma Among Court-Involved Children and Youth: *A Checklist and Resource Guide for Attorneys and Other Court-Appointed Advocates*[1]

By Lisa Pilnik, JD, and Jessica R. Kendall, JD, Child & Family Policy Associates

SAFE START

Working Together to Help Children Exposed to Violence

Center on Children and the Law

AMERICAN BAR ASSOCIATION

Child & Family Policy Associates

CTISP

Chadwick Trauma-Informed Systems Project

Moving From Evidence to Action

The Safe Start Center Series on Children Exposed to Violence

Pilnik, L. & Kendall, J.R. (2012). ***Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates***. Moving from Evidence to Action: The Safe Start Series on Children Exposed to Violence, Issue Brief #7. North Bethesda, MD: Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, US Department of Justice. Available at: www.safestartcenter.org

Application of a Trauma Checklist for Children's Attorneys

- Information integration form, **not** a client interview or self-report form
- Not intended to result in numerical score, but to think of clients in more trauma-informed way
- Use with clients of any age
- Complete it several times at regular intervals or after particular milestones/events

- Be mindful of
  - Limits of state confidentiality and ethics rules
  - Role in the case
  - Self-incrimination (youth charged with offenses / unintended negative use)
- Be clear about whom you represent, what you will do with the information, and under what circumstances it might have to be shared

Polyvictimization/Trauma Symptom Checklist

Part A: Past Experiences

Has the child/youth experienced the following types of **victimization/exposure to violence:**	In the past year? (check if Yes)	Over her/his lifetime? (check if Yes)
Physical Abuse in the Home		
Abuse or Neglect in a Foster Home, Residential Placement, or Detention Facility (including by other youth)		
Assault/Battery by a Non-Caretaker (completed or attempted)		
Severe Physical Injury (e.g., requiring hospitalization)		
Sexual Abuse/Assault by a Parent or Relative Caregiver (completed or attempted)		
Other Sexual Abuse/Assault (e.g., by a non-relative caregiver, at school, by a family friend or stranger; completed or attempted)		
Victim of Sex or Labor Trafficking (e.g., being prostituted, forced involvement in sexual performances, photographed for child pornography, involved in domestic servitude or other harmful or exploitative labor)		
Severe Neglect (e.g., young children being left unattended for long periods, serious malnutrition due to lack of adequate food, ongoing failure to provide necessary medical care that results in hospitalization)		
Extreme Emotional/Verbal Abuse by a Parent or Caretaker		
Witnessing Domestic Violence		
Witnessing School Violence		
Witnessing Community Violence		
Witnessing Animal Cruelty		
Chronic or Repeated Bullying or Harassment (e.g., based on race, ethnicity, appearance, gender or sexual identity, learning problems, or poverty)		
Victim of a Hate Crime that was Reported to the Police		
Teen Dating Violence		
Statutory Rape		
Victim of a Property Crime (burglary, robbery)		
System-Induced Trauma (e.g., arrest situations violent enough to leave bruises or injuries, difficult experiences testifying against abuser at trial)		
Permanent or Long-Term Loss of a Parent or Caregiver Due to Illness, Death, or Incarceration		
Disrupted Caregiving (a change of custody among family members or numerous changes in foster care placements)		
Victim of War, Terrorism, or Natural Disaster		
Other Significant (but not necessarily violent) Life Challenges (e.g., homelessness, poverty, having a caregiver who suffered from substance abuse or mental health issues, or a life-threatening illness or injury of the child)		

Part B: Past and Current Symptoms[1]

Has the child/youth exhibited the following **symptoms that may indicate traumatic stress?** (Adapted from the NCTSN *Child Welfare Trauma Referral Tool*)	In the past year? (check if Yes)	Over her/his lifetime? (check if Yes)
Sleep Disturbances (e.g., night terrors, sleeplessness, excessive sleepiness)		
Attachment Problems (e.g., overly affectionate with strangers, consistently avoids eye contact, fails to engage in interactions or conversations appropriately even with people the child knows well, extreme separation anxiety)		
Arousal (e.g., startles easily, trouble concentrating, easily distracted, inattentive or impulsive)		
Regression (stops engaging in age-appropriate behaviors already mastered, e.g., using the toilet, speaking in full sentences, independently completing schoolwork, socializing with same-age or older peers)		
Affect Dysregulation (trouble feeling or expressing emotions other than frustration or impatience or difficulties recovering from emotional distress)		
Somatization (frequent physical complaints with no apparent cause or more severe or resistant to treatment than physically explainable)		
Hypervigilance (overly aware or concerned about potential dangers; uses anger or aggression to protect self/others)		
Re-experiencing (strong reactions to reminders of trauma or loss, nightmares, flashbacks, sensation of reliving the events, working traumatic experiences into play)		
Anxiety (overly tense or worried, to the point of withdrawal from activities, experiencing panic attacks, or needing excessive reassurances)		
Avoidance (avoiding places, people or other stimuli associated with past trauma, refusing to discuss specifics of traumatic experiences)		
Extreme Impulsivity (sudden, strong, even irrational urge to engage in risky behavior without considering consequences first)		
Attention/Concentration Difficulties, leading to trouble forming strong friendships or completing work		
Dissociation (frequent daydreaming, forgetfulness, rapid personality changes, emotional detachment)		
Emotional or Behavioral Problems:[2]		
• **Numbing** (feeling detached, estranged from or "out of sync" with others, limited emotional range, avoiding thinking or talking about the future)		
• **Oppositional** (hostile/defiant) **Behaviors**		
• **Conduct Problems** (physically or verbally aggressive, destroys property or otherwise breaks the law, sexually promiscuous or aggressive)		
• **Substance Abuse**		
• **Sexual Behavior not Typical of Age Group**		
• **Other Risky Behaviors** (e.g., truancy, stealing)		
• **Eating Disorder**		
• **Self-harm** (e.g., cutting)		
• **Suicide Attempt or Discussion or Thoughts of Suicide**		

[1] Note that some of these symptoms could indicate either trauma-related issues or a developmental disorder. An assessment by a mental health professional can determine the underlying cause.
[2] Traumatic stress symptoms may take the form of common emotional or behavioral problems, including the symptoms listed in this section. When these problems are identified, it is important to consider whether they involve (or are exacerbated by) any of the traumatic stress symptoms.

Polyvictimization/Trauma Symptom Checklist

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Abuse or Neglect in a Foster Home, Residential Placement, or Detention Facility (including by other youth)		
Assault/Battery by a Non-Caretaker (completed or attempted)		
Severe Physical Injury (e.g., requiring hospitalization)		
Sexual Abuse/Assault by a Parent or Relative Caregiver (completed or attempted)		
Other Sexual Abuse/Assault (e.g., by a non-relative caregiver, at school, by a family friend or stranger; completed or attempted)		

Part B: Past and Current Symptoms[5]

Has the child/youth exhibited the following **symptoms that *may* indicate traumatic stress?** (Adapted from the NCTSN *Child Welfare Trauma Referral Tool*)	In the **past year?** (check if Yes)	Over her/ his **lifetime?** (check if Yes)
Sleep Disturbances (e.g., night terrors, sleeplessness, excessive sleepiness)		
Attachment Problems (e.g., overly affectionate with strangers, consistently avoids eye contact, fails to engage in interactions or conversations appropriately even with people the child knows well, extreme separation anxiety)		
Arousal (e.g., startles easily, trouble concentrating, easily distracted, inattentive or impulsive)		
Regression (stops engaging in age-appropriate behaviors already mastered, e.g., using the toilet, speaking in full sentences, independently completing schoolwork, socializing with same-age or older peers)		
Affect Dysregulation (trouble feeling or expressing emotions other than frustration or impatience or difficulties recovering from emotional distress)		

Emotional or Behavioral Problems:[6] • **Numbing** (feeling detached, estranged from or "out of sync" with others, limited emotional range, avoiding thinking or talking about the future)		
• **Oppositional** (hostile/defiant) **Behaviors**		
• **Conduct Problems** (physically or verbally aggressive, destroys property or otherwise breaks the law, sexually promiscuous or aggressive)		
• **Substance Abuse**		
• **Sexual Behavior not Typical of Age Group**		
• **Other Risky Behaviors** (e.g., truancy, stealing)		
• **Eating Disorder**		
• **Self-harm** (e.g., cutting)		
• **Suicide Attempt or Discussion or Thoughts of Suicide**		

Flowchart on Trauma-Informed Actions

(Adapted from the NCTSN *Child Welfare Trauma Referral Tool*)

Child/Youth Has:	Child/Youth Has:	Child/Youth Has:	Child/Youth Has:
Attempted suicide or expressed a suicidal intent;[7] a severe eating disorder; a substance use problem; or a chronic sleep disturbance	Experienced past severe victimization including sexual assault; severe injury; multiple separations from family or primary caregivers; witnessing chronic severe family violence; or 4 or more different types of victimization **or** Clear symptoms including pronounced reactions to reminders of traumatic experiences; multiple traumatic stress symptoms listed above **or** Exhibited a major change in his or her behavior, emotional state, interests or abilities during or soon after traumatic events, as described by the child or caregiver.	Behavior/ functioning problems without severe or multiple types of victimization	Past victimization with no current behavior/ functioning problems
Child/Youth May Need:	**Child/Youth May Need:**	**Child/Youth May Need:**	**Child/Youth May Need:** No immediate action, but should be monitored for future needs and for signs of system-induced trauma.
Immediate stabilization, including inpatient care or services may be required. Advocate should counsel the client in a developmentally appropriate manner, encouraging him or her to receive treatment and/or services if that is what he or she wants. (If the child is at imminent risk, attorneys should act according to State ethical rules.)	Trauma-specific mental health assessment/ services. Advocate should counsel the client in a developmentally appropriate manner, helping obtain services if that is what the client wants.*	General mental health assessment and related services. Advocate should counsel the client in a developmentally appropriate manner, helping the client obtain services if that is what he or she wants.*	

Polyvictimization: Children's exposure to multiple types of violence, crime, and abuse

www.unh.edu/ccrc/pdf/jvq/Polyvictimization%20OJJDP%20bulletin.pdf

Attorneys for Children Guide to Interviewing Clients: Integrating Trauma Informed Care and Solution Focused Strategies

www.nycourts.gov/ip/cwcip/Publications/attorneyguide.pdf

National Child Traumatic Stress Network Child Welfare Trauma Training Toolkit

www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008

Birth parents with trauma histories and the child welfare system: A guide for judges and attorneys

www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_guide_judges_final.pdf

Unique Issues for Hospitalized Foster Children (What HHS Requires)

- Child welfare agencies must develop, in coordination and collaboration with their Medicaid agency, and *in consultation with pediatricians, other experts in health care*, and experts in and recipients of child welfare services, a **plan** for the *ongoing oversight and coordination of health care services* for any child in a foster care placement, which shall ensure a *coordinated strategy* to identify and respond to the health care needs of children in foster care placements, *including mental health and dental health needs*

…and the state must indicate how it will—

1. Have a schedule for all foster children's initial *and follow-up* health screenings that meet *reasonable standards of medical practice*
2. Assure their health care needs are *identified* through screenings to assure that they will be *monitored and treated,* including the **emotional trauma** associated with a child's maltreatment and removal from home
3. Update medical information on the foster child regularly and have that *appropriately shared,* which may include the development and implementation of an electronic health record

4. Ensure the *continuity of health services*, which may include establishment of a *medical home for every child in care*
5. Oversee *use of prescription medicines*, including protocols for the appropriate use and monitoring of psychotropic medications
6. Actively *consult with and involve physicians* or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for them

7. Steps to ensure components of the required *transition plan development* process (for youth who will be transitioning into adulthood) relate to their health care needs, including:
   - Requirements to include options for health insurance (Note: if the foster youth is transitioning at 18 or later, under Obamacare they are eligible for Medicaid until 26)
   - Information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and provide the child with the option to execute such a document

BRAINSTORMING QUESTIONS…

If you were going to adapt the D-E-F for trauma informed assessment and response in your work site / system…

- **What would you leave in / take out / add?**
  - What core concepts would you most want to address?
  - What key responses would you want to be included?
  - What cultural issues would need to be addressed?

- **How would you make this into a tool?**
  - What would it look like?
  - How would you use it?
  - Who else should have it / use it?