

REPORT FROM THE

TRAUMA SUMMIT

MAY 31, 2007

SPONSORED BY:

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES &

NEW PARTNERSHIPS FOR WOMEN, INC.

PREFACE

In late 2006, planning for an event intended to draft a definition of Trauma and an Action Plan to address trauma was initiated. Board members of New Partnerships for Women, Inc. (NPW) proposed a collaborative effort with Wisconsin DHFS and community stakeholders to draft a *Psychological Trauma Policy* then host an event where a larger group of decision makers would meet to learn and then draft the Action Plan with the goal of providing improved services to residents of Wisconsin who had experienced trauma.

Representatives from the divisions of Wisconsin DHFS, consumers and non-profit agency leaders who work in this field, were organized and met regularly during the first 5 months of 2007. During the planning stage, materials from other states on the development of trauma policy were reviewed. A subcommittee met to draft our *Psychological Trauma Policy* and define key terms used in the policy.

This group collaboratively planned the event, *Trauma Summit*, held on May 31, 2007. The mission of the *Trauma Summit* was to provide the Department and community stakeholders with a vision, which would guide our work in planning services and addressing trauma.

This report provides a brief synopsis of the Trauma Summit, and the results of discussion and brainstorming from each of the four afternoon workgroups. The workgroups had the primary charge of drafting the 'Action Plans'.

Clearly this is only the beginning of the process. While much work is left to do, an important first step has been taken in the process of providing better services to those who have experienced trauma.

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Synopsis of the Trauma Summit

Opening remarks:

Reggie Bicha, Deputy Secretary of the Wisconsin Department of Health & Family Services began the day with an excellent summary of the incidence of trauma and the significant effects it can have on victims or survivors.

Consumer Panel: facilitated by Sinikka Santala, Administrator of the Division of Long Term Care Services.

Individuals who had experienced domestic abuse, sexual assault, incest, natural disaster, bullying and abuse due to disability, physical and emotional abuse due to language differences and ethnicity shared their stories. The panelists also discussed what has been re-traumatizing, what have been barriers to healing and what has promoted recovery. (Note: one panelist who is a former foster youth had to cancel at the last minute).

Triggers or retraumatization includes:

- Sexually explicit materials including advertisements & mass media,
- Parental style of management (victim of abuse from a parent),
- Bad weather (victim of natural disaster),
- Living in the same neighborhood as before the event - seeing it daily yet everything is so different (no mature trees, different houses, loss of neighbors etc.).

What are barriers to healing?

- Trying to get therapy/services and not being believed,
- Services or therapy that did not address my needs- despite my telling them,
- Not feeling I have a voice in planning my services.

What promotes healing?

- Faith,
- Personal resilience,
- Therapist who said she would be there for me, and is,
- Helping others heal.

Synopsis of the Trauma Summit, continued.

Key Speaker:

Roger Fallot, Ph.D.

Dr. Fallot is a clinical psychologist and Director of Research and Evaluation at Community Connections, a private, not-for-profit agency. His professional areas of specialization include the development and evaluation of services for trauma survivors and the role of spirituality in recovery. He is the author of numerous clinical and research articles. He also participated in the development of a men's version of the Trauma Recovery and Empowerment Model (TREM), a manualized group intervention for working with survivors of physical and sexual abuse.

Dr. Fallot discussed the depth and breadth of trauma. He further discussed the difference between *trauma-informed services* and *trauma specific interventions*.

Trauma-informed services:

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing. Treatment programs generally recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery; the interrelation between trauma and symptoms of trauma (e.g. substance abuse, eating disorders, depression, anxiety, etc.); and the need to work in a collaborative way with survivors (and also with family and friends of the survivor) and with other human services agencies in a manner that will empower survivors and consumers.

Why we need Trauma Informed services:

Trauma's impact is pervasive.

It is deep and life shaping.

Often self-perpetuating.

Trauma is insidious and differentially affects the more vulnerable.

It affects how people approach services.

And the service system is often re-traumatizing.

Synopsis of the Trauma Summit, continued.

A trauma informed system is based on an understanding of trauma.

- That traumatic events are not rare.
- The impact of trauma is seen in multiple life domains.
- Repeated trauma is viewed as a core life event, around which subsequent development occurs.
- Trauma begins a complex pattern of actions and reactions which have a continuing impact over the course of one's life.
- The consumer/survivor is seen as an integrated, whole person with problems and resources.
- "Symptoms" are understood not as pathology, but attempts to cope and survive.
- The primary goals of trauma informed services are empowerment and recovery.
- Key is a collaborative relationship between consumer & service provider.
- The consumer is an active planner in their services.
- Safety must be guaranteed (emotional and physical safety).
- The CORE Principles include:
 - Safety: emotional and physical,
 - Trustworthiness, making tasks clear and maintaining appropriate boundaries,
 - Choice: prioritize consumer choice and control,
 - Empowerment: prioritizing skill building and empowerment.
- It involves all aspects of programs from administrative level to service level and all groups including all staff and consumers and their families.

Working Lunch:

Chris Hendrickson, Wisconsin DHFS Planning Administrator, introduced the *Draft Psychological Trauma Policy and Definitions*. The Policy and definitions were discussed during the afternoon workgroups. See appendix for copies of the *Psychological Trauma Policy and Definitions*.

Promising Approaches Panel: facilitated by John Easterday, Interim Administrator, Division of Mental Health and Substance Abuse Services.

- Women's AODA Treatment Program – Susan Gadacz, DHFS, Women's AODA Treatment Coordinator.
- Adolescent Trauma Treatment Program – Jim Van Den Brandt, Director, Adolescent Trauma Treatment, Mental Health Center of Dane County.
- New Partnerships for Women, Inc. – Dianne Greenley, Supervising Attorney, Disability Rights Wisconsin.

Results of the Workgroups

Four facilitated workgroups, 1) Children and Families, 2) Mental Health and Substance Abuse, 3) Public Health and 4) Long-Term Support were charged with the following:

1. Review the Policy and definitions (see appendix for *Psychological Trauma Policy and Definitions*). How do they fit with the mission of agencies and divisions?
2. Share accomplishments. What is working well to address trauma?
3. Where are the gaps and missing links?
4. What can we do to improve and develop trauma-informed services?

Below is a summary of the themes that emerged from their discussions of Question Four 'What can we do to improve and develop trauma-informed services?' These Workgroup Themes can be used in the development of an Action Plan or the next step in the process of addressing trauma issues in Wisconsin health and human service systems.

Following this section of Workgroup Themes, are individual the Detailed Workgroups Responses to the four questions.

The entire group of participants reconvened before the end of the day to share the results of their discussions.

Workgroup Themes: Goals, Objectives and Action Steps

GOALS:

Wisconsin's health and human services shall promote the development of a trauma informed and responsive system that is guided by community input, consumer need and direction, evidence-based and/or best practices and which is based on a trauma sensitive environment or culture.

Wisconsin's health and human service system shall strive to make trauma education available to all community members. This includes the opportunity to learn about the effects of and impacts of psychological trauma, the events and experiences that may cause trauma and the resources available to help individuals recover.

Results of the Workgroups, Themes continued.

OBJECTIVES:

Wisconsin's health and human service systems shall:

1. Build awareness of the issue of psychological trauma through public education and awareness campaigns in order to foster a broader understanding of the issue of trauma and its pervasiveness, to reduce the stigma of the long-term effects of trauma, and to promote prevention and recovery.
2. Identify and seek funding streams to develop a plan, train staff and support the implementation of trauma informed systems throughout Wisconsin.
3. Plan and implement training in trauma informed services for all staff in the health and human service arena.
4. Implement trauma informed services in all health and human service programs.
5. Provide technical assistance and mentoring to agencies as they implement trauma informed systems.
6. Evaluate the implementation of trauma informed services.

ACTION STEPS:

The following are examples of action steps, which were developed by workgroups during the 2007 Trauma Summit.

1. BUILD AWARENESS:
 - a. Plan a public awareness campaign on trauma that includes issues of diversity.
 - b. Work with the community of people with disabilities to 'end the silence' around issues of trauma and create a constituency for change.
 - c. Link with the Wisconsin Lt. Governor's Task Force on Women and Depression and advocate for a stronger trauma focus.
 - d. Develop and market a teleconference on trauma issues to 'first responders'.
 - e. Plan for the incorporation of trauma informed services in all aspects of the vision, planning and development of the new Wisconsin Department of Children and Families.

Results of the Workgroups, Themes continued.

- f. Advocate for laws to be victim or trauma centered.
 - g. Sponsor a Summit on reducing the use of seclusion and restraints and promoting the use of positive behavior supports.
2. FUNDING:
- a. Identify and seek funding streams to train staff and support the implementation of trauma informed systems.
 - b. Advocate for mental health treatment parity to ensure resources are available for treatment of trauma related problems.
3. TRAINING & EDUCATION:
- a. Build trauma issues into trainings for service providers, child welfare workers and child care providers.
 - b. Plan training for service providers from different sectors around a theme of trauma.
 - c. Utilize the Wisconsin Clearinghouse for Prevention Resources to provide training on trauma.
 - d. Advocate for trauma to be included in higher education programs such as: AODA, social work and nursing education.
 - e. Request professional organizations to offer Continuing Education credits on trauma informed care and recovery from trauma.
 - f. Provide education, training and increased awareness of trauma issues for family court, circuit court, Guardians ad Litem and judges.
 - g. Provide a trauma workshop at 2008 Judges Conference.
 - h. When planning training consider:
 - i. Language must be understood by consumers and other participants.
 - ii. Do not use jargon.
4. IMPLEMENT TRAUMA INFORMED SERVICES:
- a. Promote the use of trauma screening & assessments in all health and human services.
 - b. Add trauma as a domain to person-centered plans.
 - c. Using the 'strength-based assessment',
 - i. Ask 'what has happened to you during your life? Or 'what has been important in your life?'
 - ii. Ask 'What are you doing to cope with it?'
 - iii. Prepare staff to know what to do when a participant discloses a trauma history.

Results of the Workgroups, Themes continued.

- d. Ensure that agency policies, procedures, and rules are all trauma informed; evaluate existing practice and procedure and make needed changes
- e. Ensure that there is an understanding of trauma issues in the Family Care network.
- f. Request MA-HMOs to identify trauma informed services as a target during the Quality Improvement process.
- g. Build language into contracts with agencies providing services on behalf of Wisconsin DHFS that references the provision of trauma informed services.
- h. Identify trauma as an assessment item in the Division of Quality Assurance.
- i. Continue to maintain a high-level of review for the use of restrictive measures.
- j. Identify program outcomes that are specific to trauma. Provide closer scrutiny of provider policy and procedures as an educational tool
- k. Provide trauma informed services at the new Women's Treatment Program at the Wisconsin Resource Center.
- l. Promote the use of the Family Treatment model in AODA treatment.
- m. Foster interagency collaborations:
 - i. Pull consortia (such as the Coordinated Community Response Teams) together and link with local public and private mental health services for improved consumer services.
 - ii. Link cultural programs (i.e. Refugee Assistance Program) with mainstream systems that provide similar services.
 - iii. Link Sensitive Crimes Units with agencies providing mental health and psychological trauma services for improved victim services.
 - iv. Seek common language across systems and departments.
 - v. Develop collaborations between the new Wisconsin Department of Children and Families and the Wisconsin Department of Health Services for trainings and service delivery.
 - vi. Collaborate with the Wisconsin Department of Public Instruction to foster an understanding of the need for trauma informed services.
 - vii. Host a quarterly listserv, discussion board or meeting of organizations that provide or are interested in providing trauma informed care.

Results of the Workgroups, Themes continued.

5. TECHNICAL ASSISTANCE & MENTORING:
 - a. Provide technical assistance to agencies during the implementation of trauma informed services.
6. EVALUATE PROGRESS:
 - a. Identify best practices, evidence based practices and recognize societal changes.
 - b. Learn from other states that are already using trauma informed systems.

Detailed Workgroup Responses

QUESTION 1, How do the Trauma Policy and Definitions fit with the mission of agencies and divisions?

Children and Families Workgroup

1. We need to include 'family' as well as the individual in the definition.
2. We need to ensure that family means 'family of choice' as many LGBT (lesbian, gay, bi-sexual and transsexual) individuals and former foster youth have other supportive adults in their lives that they consider family.
3. We need to include sexual orientation in the list in the Trauma Sensitive Environment definition.

Mental Health & Substance Abuse Workgroup

1. The definition of trauma-informed services is in accord with solid principles of treatment in psychotherapy and social work.
2. The policy as drafted will promote quality care.
3. How will the policy be made known to the consumer?
4. We need to create buy-in from each county and provide educational opportunities for them.

Results of the Detailed Workgroup Responses continued.

Public Health Workgroup

1. Fits in well with our advocacy mission.
2. The mission of the Wisconsin Division of Public Health includes protecting people by being knowledgeable. Poverty has not necessarily been thought of as a public health issue.
3. Suggestions:
 - a. Build a link into all aspects of our work, do not segregate 'trauma'.
 - b. Prepare emerging providers.
 - c. 'Awareness' of trauma issues does not equate with sensitive services.
 - d. Incorporate trauma concepts in critical incident debriefing and self care.
 - e. Link the mental and physical health together.

Long-Term Support Workgroup

1. DQA (Division of Quality Assurance) regulators need to be aware of the need for trauma informed services in the state long term care facilities.
2. Our community based placements should also be more trauma informed.
3. Regarding Medicaid: we should remove the barriers to trauma treatment by adding provider codes so that a person does not need a mental health label to receive treatment.
4. Policy makers and service providers need to incorporate trauma issues into new programs, such as Family Care.
5. Sometimes we fail to imagine what has happened to some vulnerable persons.
 - a. People with developmental disabilities are not always believed.
 - b. They may not effectively communicate when they have been abused.
 - c. We need to screen for trauma.
 - d. We need to consider and plan for the cost of doing this.
 - e. Ineffective services cost more.
6. Secondary trauma responders: do we need to respond differently when an older adult perhaps with cognitive issues is victimized?
7. Add cognitive capacity to the last sentence in the definition of Trauma Sensitive Environment.
8. Add 'change in living situation' (such as an eviction or to a nursing home) to the list in the definition of Psychological Trauma.
9. Add war, to armed conflict.

Results of the Detailed Workgroup Responses continued.

QUESTION 2, What is working well to address trauma?

Children and Families Workgroup

1. The use of Coordinated Services Teams, (for example, Dane County's Children Come First) and integrated services plans.
2. Wrap around services with the consumer as active participant and the whole family involved. Using this concept the healing work of the family is accelerated. Still, it could incorporate more training on trauma.
3. The Quality Service Reviews of county child welfare systems operates on the same core principles that Dr. Fallot described for trauma informed services.
4. Bureau of Milwaukee Child Welfare has a new medical director who included issues of trauma in her work.
5. The new Mental Health Screening tool for child welfare workers is trauma-informed and will be piloted in 10 Wisconsin counties. Training will be provided on how to use the tool.
6. There is a growing recognition within the child welfare system that the safety of the child and the safety of the protective parent (usually mom) are intertwined with domestic violence issues.
7. Peer Support services work well.
8. The Violence Against Women grant is working to increase collaboration between the alcohol and other drug abuse systems, mental health systems and the domestic abuse systems. It is operated by Disability Rights Wisconsin, with Wisconsin Coalition Against Domestic Violence and Wisconsin Coalition Against Sexual Assault.

Results of the Detailed Workgroup Responses continued.

QUESTION 2 continued, What is working well to address trauma?

Mental Health & Substance Abuse Workgroup

1. The use of the 'systems of care' approach in both child and adult settings. Systems of care philosophy and values incorporate trauma informed values.
2. Consumer run services. For example: Grassroots Empowerment Project and New Directions Information Center. Recovery is best enhanced by ownership.
3. Increasing access to 'evidence based practices' and 'best practices'.
4. Victim advocacy programs, especially during and immediately after the trauma occurs.
5. Consumer and professional partnerships in training helps recovery.
6. There is a spread of the recovery paradigm through the state.
7. Comprehensive Community Services has concepts built in (e.g. recovery, person centered, across the lifespan).
8. Bureau of Mental Health & Substance Abuse providing good training and technical assistance at conferences. Keep it up.
9. There is a lot of information available (especially on women's trauma) on the Substance Abuse and Mental Health Services Administration website.
10. Much more is known now through research about clinical interventions for trauma treatment.

Results of the Detailed Workgroup Responses continued.

QUESTION 2 continued, What is working well to address trauma?

Public Health Workgroup

1. Madison has some good treatment such as is offered at Oasis, Rainbow Project and the Hancock Center for Movement Therapies.
2. Substance abuse, domestic violence and Crisis Response teams funded through the Department of Justice.
3. Advocacy groups.
4. Infant death services available in urban areas focus on grief and loss.
5. Sexual Assault Nurse examiners.
6. Violence Against Women Act- some federal awareness of trauma issues.
7. Community support for the use of experiential treatment programs with trauma survivors. Neurological research on trauma supports this treatment, but it is not well understood or accepted.

Long-Term Support Workgroup

1. Chapters 55 & 46.90 have been revised.
2. Working with practitioners who understand trauma.
3. A value system not necessarily introduced with trauma in mind can incorporate the same core principles.
4. In the developmental disability arena, we're better at addressing health disparities. Better at considering all aspects of health including trauma.
5. There are protocols now for responding to elder sexual assault in facilities.
6. There are already some systems in place in nursing homes.
7. Intermediate Care Facilities (for people with cognitive disabilities) have had a culture change and now offer a more person-centered approach.
8. We're moving more towards managed care and 'pay for performance'. Trauma informed service could be a performance measure.
9. Intermediate care facilities have a policy in place to reduce the use of restraints. They are finding other ways of dealing with behavior and it is being extended to community settings.
10. More entities and services are beginning to work together. (e.g. Brown County)

Results of the Detailed Workgroup Responses continued.

QUESTION 3. Where are the gaps and missing links?

Children and Families Workgroup

1. Continue to need more coordination between mental health and child welfare system.
2. Some things we do re-traumatize - e.g., removing kids from a home.
3. Each system operates under different requirements and time constraints.
4. There is a lack of understanding of 'deprivation trauma' caused by poverty and lack of basic supports.
5. We need to increase awareness among systems regarding trauma and trauma-informed services. There is a lack of understanding of the impact of trauma and how it's manifested, especially among adolescents.
6. Some people who are providing the services have their own unresolved trauma or experience trauma because of their jobs. There's a lack of understanding of 'compassion fatigue'.
7. Caregivers and foster parents need help in understanding the behavior of their kids who have experienced trauma.
8. Restraints used in institutions/treatment facilities can cause re-traumatization.
9. There is a lack of collaboration at the local level. Cross-system work is really cross-cultural work.
10. There is a lack of cross-cultural solidarity, not just cross-cultural competency.
11. Schools have a limited understanding of trauma and often don't have the staff to work with the kids. This often results in kids being expelled for behavioral issues.
12. Lesbian, gay, bi-sexual and transgender kids are examples of kids who don't even realize that they're victims of trauma.

Results of the Detailed Workgroup Responses continued.

QUESTION 3 continued. Where are the gaps and missing links?

Mental Health & Substance Abuse Workgroup

1. The medical model, which is often used, is deficit and diagnosis based.
2. We need to make a better funding connection (e.g. for promising practices) and fund services for as long as the survivor needs them.
3. Mental health service parity is needed.
4. We need a state match for community mental health services
5. Children's services are not comparable to adult services.
6. Children experience trauma in areas such as, schoolyard, street, and through bullying.
7. We need to train and educate other providers, such as medical and educational personnel, first responders, private sector service providers and foster parents.
8. We need to focus on the culture and the environment where the individual lives.
9. We need mental health liaisons at primary care clinics and women's health clinics, as they are often the first stop for trauma victims.
10. Trauma informed services need to start early.
11. Trauma support needs to be revisited and followed up. As trauma is addressed, things often resurface.
12. We need to educate other systems we work with, such as, probation and parole, schools, faith communities, health care and juvenile justice.
13. The criminal justice system and courts often don't understand trauma issues and retraumatization.
14. We need better community education to better identify trauma.
15. Foster care providers need education and information regarding the child's trauma history.
16. Trauma is not included in the curriculum of formal secondary education programs, such as social work and counseling.
17. The MA system is tied to diagnosis. HMO's do not support ongoing treatment and support.
18. Caseworkers may focus on control rather than support.
19. Services for men's trauma is almost non-existent.
20. Trauma is often seen as a conduct disorder in male youth.
21. There is a difference in how genders are diagnosed. (i.e. Men may receive a diagnosis of PTSD. Women often receive a diagnosis of Borderline Personality Disorder).
22. There is too much forced treatment and seclusion and restraint.

Results of the Detailed Workgroup Responses continued.

QUESTION 3, continued. Where are the gaps and missing links?

Public Health Workgroup

1. There is too much disparity between black and white population statistics, such as, death rate, teen birth rates, sexually transmitted diseases of youth/young adults and the rate of sexual assault.
2. We need resources, financial, social, economic, cultural and spiritual to effect change.
3. We see victims as an individual, not recognizing the family, friends and community that are also affected.
4. Insurance companies limit treatment and do not recognize the impact on all family members.
5. Funding for sexual assault treatment for adults is very limited.
6. We need to create broad linkages with other systems.
7. We focus too much on measurement, like infant mortality.
8. A holistic view is needed (e.g. we often focus on females and not males in sexual assault treatment).
9. Our language is not inclusive.
10. We need to treat perpetrators.
11. We need to consider the cumulative impact of institutional racism.
12. We need community and cultural partnerships to be effective.
13. After the abuser is gone, women are more likely to live in poverty.

Results of the Detailed Workgroup Responses continued.

QUESTION 3 continued, Where are the gaps and missing links?

Long-Term Support Workgroup

1. During the assessment stage we don't ask about trauma and that affects the care plan.
2. Trauma may be implied, but is not directly addressed in some assessments. Trauma screening and assessment is needed.
3. Facility staff doesn't always recognize or accept that elders are experiencing trauma. When they are aware, they don't always take appropriate action.
4. There is a lack of education about trauma. Today was very helpful. It should be repeated for a broader health care audience.
5. After treatment is completed, such as in a long term care facility, we need to ensure resources are available and secured in the community to maintain or improve the same level of health.
6. Regarding Managed Care - much of trauma informed services fits into the managed care paradigm.
 - a. Do we have the tools to influence protocols in a managed care system?
 - b. How do we influence clinical practice?
 - c. How do we measure?
7. Regarding those with developmental disability: trauma has other dimensions beyond the core team. Other staff that work closely with consumers may be perpetrators or may chose not to believe and act on reports of trauma.
8. Others need to understand trauma too, such as law enforcement.
9. There is a gap in language between systems. We need a common language and understanding of each other's terms.

Results of the Detailed Workgroup Responses continued.

Question 4, What can we do to improve and develop trauma-informed services?

Children & Families Workgroup

1. Identify and seek funding to support the infusion of trauma-informed services in systems, including addressing the gaps identified in question three.
2. Build trauma issues into training for child welfare workers.
3. Include language in contracts with agencies providing services on behalf of the Wisconsin Department of Health and Family Services that reference the provision of trauma-informed services.
4. Provide technical assistance and consultation to agencies on how to become trauma-informed.
5. Recognize that single event trainings don't change practice. It has to be an on-going process with consultation, agency readiness, implementation plans and follow up technical assistance available.
6. Promote the use of evidence-based tools and best practices (i.e. The National Child Traumatic Stress Network).
7. Learn from other states, e.g., California, Illinois, that are already using trauma-informed services.
8. Advocate for the incorporation of trauma-informed services in all aspects of the vision, planning and development of the Wisconsin Department of Children & Families.
9. Develop collaborations between the new Wisconsin Department of Children and Families & the Wisconsin Department of Health Services for the purpose of trainings and planning for service delivery.
10. Collaborate with the Wisconsin Department of Public Instruction to foster understanding for the need for trauma informed services with our school aged children and youth.
11. Ensure that childcare providers are well informed about trauma and its impact on children's behavior.
12. Improve trauma assessments in the Division of Quality Assurance.

Results of the Detailed Workgroup Responses continued.

Question 4 continued, Children and Families Workgroup

13. Utilize the Wisconsin Clearinghouse for Prevention Resources to provide training on trauma.
14. Education is needed for family court, circuit courts, GALs, and judges. Provide trauma workshop at upcoming Judges Conference in 2008.

Other thoughts:

1. There are lots of kids wrap-arounds services, e.g. runaway services. Volunteers and others who work with kids need to understand trauma.
2. Trauma needs to be understood as a public health issue.
3. Many items mentioned can be incorporated in other Wisconsin DHFS systems, collaborations, RFP's, technical assistance, development of outcomes, trainings etc. can be included in Family Care.
4. What happens as kids age out of the children's systems? Lose insurance? Extending Badger Care to age 21, but then what? See Illinois and other states that have already extended the age to 21 or 23.

Results of the Detailed Workgroup Responses continued.

QUESTION 4 continued, What can we do to improve and develop trauma-informed services?

Long Term Support Workgroup

1. Work with community of people with disabilities to 'end the silence' & create a constituency.
2. Advocate and plan training for service providers that is organized around a theme of 'trauma' for a period of time.
3. Identify program outcomes that are specific to trauma.
4. Incorporate trauma training into current training program.
5. Ensure that there is an understanding of trauma issues in the Family Care network.
6. Continue to maintain a high level of review for restrictive measures.
7. Using a 'strength-based' assessment, ask questions such as:
 - 'what has happened to you in your life?'
 - 'what has been important?'
 - 'how are you coping with it?'
 - Be prepared to know what to do when a participant discloses a trauma history.
8. Add trauma as a domain to person-centered planning.
9. Provide closer scrutiny of provider policy and procedures. Use this as an educational piece.
10. Provide information and referrals for mental health services. Make better use of mental health services.
11. When planning training consider the following:
 - a. Ensure that language is understood by consumers/participants. Do not use jargon.
 - b. Develop clear protocols to include trauma issues such as the Resource Allocation Determination process.

Results of the Detailed Workgroup Responses continued.

QUESTION 4 continued, What can we do to improve and develop trauma-informed services?

Mental Health & Substance Abuse Workgroup

Who's responsible?

1. Sponsor a summit on reducing seclusion and restraint and promoting positive behavior supports. Joyce Allen

2. Make formal recommendation to Wisconsin Technical schools and Universities to include trauma in the curricula for substance abuse counselor training and Social Workers. Lori Kinnard, Dianne Greenley, Mary Neubauer

3. Request that MA-HMO's target trauma informed care as a Quality Improvement Process target. Joyce Allen-BMHSA, Michael Witkovsky

4. Request professional organizations offer Continuing Education Credits on trauma informed care and recovery from trauma. Rod Miller, Ellen S.

5. Market a teleconference on trauma to first responders. Crisis Network, NAMI- Jennie Lowenberg, Mary Beth Forsythe, Ellen S.

6. Host quarterly listserv, discussion board or meetings of organizations that provide trauma informed care. Michael Witkovsky

7. Link specific cultural programs (i.e. Refugee Assistance Program) with mainstream systems that need those services. Mai Zong Vue

8. Pull consortia (such as Coordinated Community Response) together and link with mental health for information sharing. Laura Parker

9. Promote the use of the Family Treatment model for support and treatment. Sue Gadacz, Lisa Roehl, Francine Fienberg.

10. Link with Lt. Governor's Task Force on Women, Depression workgroup and advocate for stronger trauma focus. Dianne Greenley, Donna Erickson.

11. Make Women's Treatment Program at Wisconsin Resource Center trauma informed. Tom Speech.

Results of the Detailed Workgroup Responses continued.

QUESTION 4 continued, What can we do to improve and develop trauma informed services?

Public Health Workgroup

1. Advocate for trauma to be included in higher education disciplines, such as nursing programs, social work preparedness etc.
2. Advocate for cultural competency training in all disciplines, at all levels. An example suggested was a public awareness campaign promoting the value of diversity and cultural differences.
3. Policy, procedures, rules & regulations must become trauma informed. All aspects of programming and administrations must be evaluated, changed and implemented.
 - a. Incorporate practice into bureaucracy and systems.
 - b. Never stop asking the consumer.
 - c. Continually evaluate programs. Consider 'best practices, evidence based practices & better outcomes, and recognize societal changes.
 - d. Always ask the consumer in lay terms.
 - e. Collaborate with other Departments & agencies to further trauma-informed care.
 - f. Seek common language across systems and departments. For example; Public Health, Child Welfare, CDC.
4. Educate/Advocate for laws & practices to be victim/trauma centered.
 - a. Educate lawmakers to change law.
 - b. Apply trauma sensitive culture to laws and Chapter 48.
 - c. Advocate for a stop to the insensitive questioning of victims by DA's.
5. Advocate for mental health treatment parity.
6. Pair natural partners, those with commonalities in outcomes.
7. Identify funding sources.

Ideas for creating change:

- Think about culture & attitude and how to create change.
- Key ownership? Find/establish leadership. Depends on more than one person.
- Do what is needed to bring the right people to the table and practice. Develop materials/tools for what you can do. And do it.

APPENDIX A: DRAFT PSYCHOLOGICAL TRAUMA POLICY AND DEFINITIONS

PSYCHOLOGICAL TRAUMA POLICY

Wisconsin health and human services shall promote the development of a trauma informed and responsive system that is guided by community input, consumer need and direction, evidence-based and/or best practices and which is based on a trauma sensitive environment or culture.

Wisconsin's health and human service system strives to make trauma education available to all community members. This includes the opportunity to learn about the effects of and impacts of psychological trauma, the events and experiences that may cause trauma and the resources available to help individuals and families recover.

DRAFT DEFINITIONS

Psychological Trauma

Psychological trauma refers to the individual's (or family's) perception of significant events or circumstances, past or present.

These events or circumstances may result in a cluster of symptoms, adaptations, and reactions that interfere with the functioning of an individual.

The events or circumstances may be the result of, but are not limited to witnessing, experiencing or exposure to:

- Violence in the home, workplace, school, community or relationships,
- Maltreatment or abuse; emotional, verbal, physical or sexual,
- Exploitation; sexual, financial or psychological,
- Change in living situation such as eviction or move to nursing home,
- Neglect,
- Deprivation,
- Physical or psychological injury, either intentional or unintentional,
- War or armed conflict,
- Natural or human caused disaster.

Trauma Informed & Responsive System

A trauma informed and responsive system provides services that are not specifically designed to treat symptoms or syndromes related to sexual, physical abuse or other trauma, but is informed about, and sensitive to, trauma related issues. A trauma informed and responsive system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking health and human services. Health and human service staff are knowledgeable of the prevalence of trauma history as a frequent co-existing condition in individuals who receive services. A trauma informed and responsive system delivers services in a way that avoids inadvertent re-

traumatization and facilitates consumer participation. Our programs, policies and services are designed to work respectfully and collaboratively with the person who has experienced trauma to promote healing and recovery. Core principles of a trauma informed and responsive system are the provision of an environment of safety, trustworthiness, choice, collaboration and empowerment. It also requires, to the extent possible, closely knit collaborative relationships with public and private sector service systems for treatment referral and to secure resources.

Trauma Sensitive Environment

An environment or culture in health and human services in which all individuals feel physically, psychologically, socially and morally safe; where members manage their emotions appropriately, acknowledge and deal with loss and grief and focus on creating a positive future so individuals do not have to disclose a trauma history to receive services in a healing environment. It is respectful of gender, sexual orientation age, race, disability, cognitive capacity, ethnicity, sexual orientation, socioeconomic status, religious affiliation, etc. of all members.

Trauma Specific Services or Interventions

Trauma specific services or interventions are *designed specifically to address the consequences of trauma in the individual or family and to facilitate healing.*

Trauma specific treatment or interventions are often treatment programs that take place in a trauma sensitive environment. They are designed to work respectfully and collaboratively with the person who has experienced trauma to promote healing and recovery. They recognize the individual's need to be informed, connected, and hopeful regarding their own recovery. They recognize the interrelation between trauma and symptoms of trauma or co-occurring psychological or physical problems and the need to work in a collaborative way with survivors and in collaboration with other concerned and involved agencies and individuals in a manner that will empower survivors and consumers. Trauma specific services or interventions should be based on current research and should use evidence based or promising practice approaches, including peer support.

APPENDIX B: LETTER OF INVITATION

May 8, 2007

Dear Colleague:

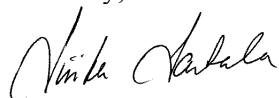
We are writing to you to invite you to a Summit on psychological trauma in Madison on May 31, 2007. Over the past several years' providers of mental health and substance abuse services, long term care services for the elderly and people with disabilities, child welfare services and public health have become increasingly aware of the high prevalence and long-term effects of psychological trauma. Experience and research also indicates that this critical issue needs to be addressed from many angles.

One area of work has been a collaborative effort by WISCONSIN DHFS staff and community partners to promote state-wide leadership in the development of a 'Psychological Trauma Action Plan' for Wisconsin. We believe this 'Action Plan' can provide a vision to WISCONSIN DHFS and its divisions as well as our partner agencies including, counties, tribes and community providers.

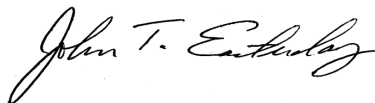
This Summit provides an opportunity to educate and provide leadership in the development of 'best practices' in the health and human services field statewide. The goal of the Summit is to present information about the impact of psychological trauma on the people we serve, discuss proposed language for a trauma policy, take stock of activities that we have already undertaken, and develop action steps that we can take with the resources available.

We are inviting you to this Summit because of your involvement with services and systems that serve people who have experienced psychological trauma. Your participation will help us review and discuss a policy statement for human service and public health program areas. If you cannot attend the full day, please consider attending part of the day or send a representative.

Sincerely,



Sinikka Santala
Administrator
Division of Long Term Care
Services



John Easterday
Interim Administrator
Division of Mental Health & Substance Abuse



Bill Fiss
Interim Administrator
Division of Children & Family Services



Sheri Johnson, Ph.D.
Administrator and State Health Officer
Division of Public Health

Attachment

Report from the TRAUMA SUMMIT May 2007

What: A Summit on Psychological Trauma
When: May 31, 2007
Time: 8:30 a.m. to 3:30 pm
Location: American Family Insurance Headquarters in Madison
6000 American Parkway, Auditorium, Training Center

Goals for this Trauma Summit are:

1. Understand the extent of trauma among the people that we serve and the impact of the experience or history of trauma.
2. Review and discuss the draft trauma policy and definitions
3. Understand activities and actions to address trauma from other states
4. Become familiar with activities undertaken and underway by WISCONSIN DHFS and its key partners
5. Develop action steps for each of the following areas: public health (including sexual assault), children and families, mental health and substance abuse, services to seniors and people with disabilities.

The day's agenda will include:

- Consumer Panel discussing their experiences
- Roger D. Fallot, Ph.D.: Implementing Trauma Informed Human Services

Roger Fallot has consulted with several states on the implementation of trauma informed services. He will describe trauma informed services, why they are needed and what other states are doing to implement trauma informed services. He is a clinical psychologist and Director of Research and Evaluation at Community Connections, a private, not-for-profit agency. His professional areas of specialization include the development and evaluation of services for trauma survivors and the role of spirituality in recovery. The author of numerous clinical and research articles and a founding Board Member of the National Trauma Consortium, Dr. Fallot was Principal Investigator on the District of Columbia Trauma Collaboration Study. He and a group of clinicians at Community Connections have developed a men's version of the Trauma Recovery and Empowerment Model (TREM), a manualized group intervention for working with survivors of physical and sexual abuse.

- Discussion of Wisconsin's current activities, accomplishments and promising approaches
- Working lunch
- Review and discussion of draft definitions of:
 - Psychological Trauma
 - Trauma Informed Services

Report from the TRAUMA SUMMIT May 2007

- Trauma Sensitive Environment
 - Trauma Responsive Services
- Workgroups to develop action plans

Please RSVP & request accommodations by May 21:

Annette Felice

New Partnerships for Women, Inc.

npw@choiceonemail.com

608-831-3735 Map Info:

<http://www.mapquest.com/maps/map.adp?email=1&mapdat>

APPENDIX C: TRAUMA SUMMIT PARTICIPANTS

Betsy Abramson	Chris Lenske
Reggie Bicha	Jo Lettner
Yolanda Bohorquez	Sharon Lewandowski
Fredi Bove	Joe Liggett
Lynn Brady	Jennie Lowenberg
Marci Brost	Gretchen MacDonald
Ted Bunck	Ellen Magee
BethAnn Burazin	Donna McDowell
Molly Cisco	Jennifer Meinholz
Bonnie Cleveland	Peggy Michaelis
Rebecca Cohen	Rodney Miller
Kevin Coughlin	Linda Morrison
Hugh Davis	Mary Neubauer
Dianne Dorlester	Bill Orth
Janet Eakins	Jane Ottow
John Easterday	Laura Parker
Jude Edmonds	June Paul
Donna Erickson	Jane Raymond
Roger Fallot	Lisa Roehl
Annette Felice	Sandra Rowe
Francine Fienberg	Jackie Rueden
MaryBeth Forsythe	Sara Schaefer
Kristine Freundlich	Ellen Schimmels
Susan Gadacz	Kelsy Schoenhaar
Claude Gilmore	Sinikka Santala
Lorie Goeser	Sue Schroeder
Dianne Greenley	Sherrill Sellars
Linda Hale	Tom Speech
Linda Hall	Grace Valentine
Linda Harris	Jim Van Den Brandt
Sue Helgesen	Phyllis Varsos
Chris Hendrickson	Mai Zong Vue
Bonnie Hill	Diane Waller
Harry Hobbs	Wendy Warren
Theresa Hoefft	Michael Witkovsky
Sally Jackson	Tekla Wlodarczyk
Kate Johnson	Laura Wojciuk
Martha Johnson	Christine Wolf
Jennifer Jones	Carol Wright
Amy Judy	Charity Yoder
Robert Kneepkens	Sue Uttech
Lori Kinnard	
Sue LaFlash	
David LeCount	

APPENDIX D: AGENDA

8:30 - 9:00 am	Registration and refreshments	LOBBY
9:00 - 9:30	Opening remarks: Reggie Bicha	AUDITORIUM
9:30 - 10:30	Consumer Panel: Sinikka Santala, Facilitator Yolanda Bohorquez, Jo Lettner, Peg Michaelis, Samaria Vance, Joe Liggett, Sue Helgesen.	
10:30 - 12:00	Roger Fallot, Ph.D. “Trauma Informed Human Services”	
12:00- 1:15	Working Lunch Psychological Trauma Policy & Definitions: Chris Hendrickson Promising Approaches: John Easterday, Facilitator	LUNCH ROOM
1:15 - 3:00	Facilitated Workgroups	
	CHILDREN & FAMILIES:	AUDITORIUM
	PUBLIC HEALTH:	AUDITORIUM
	LONG TERM SUPPORT:	A2151
	MENTAL HEALTH & SUBSTANCE ABUSE	A3142

WORKGROUP DISCUSSION QUESTIONS:

- 1. How do the Trauma Policy and Definitions fit in with what you do?**
- 2. What currently exists to support good trauma informed services?**
- 3. Where are critical gaps and missing linkages to having good trauma informed services?**
- 4. What realistic things can we do to improve and develop trauma informed systems?**

3:00 - 3:30	Outcomes of the Summit, workgroup reports.	AUDITORIUM
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Adjourn

Thanks to the following for contributions to the planning and support of this event:

Bureau of Milwaukee Child Welfare, Disability Rights Wisconsin, Grassroots Empowerment Project, Mendota Mental Health Institute, Mental Health Wisconsin, Mental Health Center of Dane County, National Alliance on Mental Illness, Wisconsin, Wisconsin Association of Children and Families Agencies, Wisconsin Coalition Against Sexual Assault, Wisconsin Coalition Against Domestic Violence, Wisconsin Women’s Veterans Task Force.

Thank you to American Family Insurance Corporation for the use of this facility.

Psychological Trauma Fact Sheet

Events That May Lead to Psychological Trauma

During 2005 Wisconsin's Child Protective Services reported 8,148 substantiated cases of child maltreatment and an additional 2,590 cases where it was found that abuse was likely to occur. There were 3,576 substantiated cases of sexual abuse, 3,255 cases of neglect, 1,271 cases of physical abuse and 46 cases of emotional abuse. 60% of the victims were female. Boys and girls were victimized at approximately the same rate until age 12; thereafter girls were victimized at approximately 3 to 4 times the rate for boys. 80% of the sexual abuse cases involved girls, the majority of whom were over the age of 12.

As part of Wisconsin's Quality Service Review process, 194 families involved in county child welfare services were interviewed. Of the parents in these 194 families, 40% had mental illness; 40% had AODA issues; 25% had experienced trauma; 11% had developmental disabilities; and 48% were living in poverty. Of the children in these families, 25% had experienced trauma. (WI DHFS, 2005)

In Wisconsin there were 5,628 sexual assaults reported to law enforcement agencies in 2004; the U. S. Department of Justice estimates that only one third of sexual assaults are reported. Of those reported in Wisconsin, 84.7% of the victims were female; 70.1% of the victims were under the age of 15; in cases where the relationship to the victim was reported, 88.9% of the victims knew their assailants; 48% of the assaults were for forcible fondling, 20.2% for forcible rape, 18.4% for statutory rape.

(WI Office of Justice Assistance, 2005)

In Wisconsin there were 28,293 domestic violence incidents reported to law enforcement in 2004 (excluding Racine Co.); approximately 73% of the victims were female; approximately 43% of the victims were under the age of 30. There were 31 domestic homicides involving adults as victims and 14 children killed as the result of a domestic situation. In 2005, 8,021 children were served by Wisconsin's domestic abuse programs.

(WI Dept of Justice, 2004)

National studies suggest that between 3.3 and 10 million children are exposed to domestic violence annually.

(Strauss, 1992)

In the five years spanning 2000-2004, a total of 168 people were killed in 158 domestic violence homicide incidents in Wisconsin. 29 of the victims (17%) were age 50 or older.

(WI Coalition Against Domestic Violence, 2006)

During 2005 Wisconsin's elder abuse system reported 4,234 cases of elder abuse; of these 2,136 were substantiated. 1,305 substantiated cases were for self-neglect, 358 for financial exploitation, 164 for emotional abuse, 155 for neglect by others, and 154 for physical abuse. In 63.5% of the reported cases the victims were female; approximately 80% were over the age of

70.

(WI DHFS, 2005)

During 2002-2004 150,276 Wisconsinites were hospitalized due to injuries; the majority were due to falls by persons age 65 and older; however, 14,539 were for self-harm, 18,402 due to motor vehicle and other transportation related injuries, and 5,671 for poisoning. There were 1,924 suicides and 532 homicides.

(WI DHFS and Children's Health Alliance of WI, 2006)

The Adverse Childhood Experiences (ACE) Studies have found in a sample of over 17,000 individuals participating in a Kaiser Permanente Plan in San Diego, CA that 28.3% experienced physical abuse as children; 20.7% experienced sexual abuse; 14.8% experienced emotional neglect; 10.6% emotional abuse; 9.9% physical neglect. Other adverse childhood experiences included: household substance abuse - 26.9%; parental divorce or separation - 23.3%; mental illness in the household - 19.4%; mother treated violently - 12.5%; and incarcerated household member - 4.7%. Thirty-six percent of the sample experienced no adverse childhood experiences; 26% one ACE; 15.9% 2 ACEs; 9.5% 3 ACEs; and 12.5% 4 or more ACEs.

(CDC, 2006)

In a large national study 52% of American women said they were physically assaulted either as a child or an adult; 18% said they experienced a completed or attempted rape at some time in their lives; overall 55% of women had experienced either physical or sexual abuse in their lifetime. In the same study 66.4% of men reported physical assaults in their lifetime; 80% of these assaults occurred while they were children or adolescents.

(Tjaden & Thoennes, 1998)

60% of women in military reserve units stated they experienced some sort of Military Sexual Trauma (sexual assault while serving in the military); 1.5% of these women sought care from the VA for that trauma.

(Kaiser, 2007)

Long Term Consequences of Psychological Trauma

Mental Health and Substance Abuse Problems

A Dane County, Wisconsin study of women who had used publicly funded mental health and/or substance abuse treatment services found that 83% had experienced physical abuse, 64% sexual abuse, and 89% had experienced either form of abuse. For persons with co-occurring mental illness and substance abuse problems the numbers were even higher - 92% physical abuse; 77% sexual abuse; 95% either form of abuse.

(Newmann and Sallmann, 2004)

ACE studies found that 9.5% of women with no abuse history were positive for a mental health disorder compared with 11.9% of women with histories of childhood sexual abuse, 13.7% of women who witnessed maternal battering, and 17.8% of women who experienced childhood physical abuse. 20% who had experienced all three forms of abuse had a mental health disorder and 18.9% who experienced both physical and sexual abuse had such a disorder. Emotional abuse associated with these other forms of abuse further increased the likelihood of an adult mental health disorder.

(Edwards et al., 2003)

National studies have found that women with a history of physical victimization were more than 2 times as likely as women without such a history of reporting a chronic mental health condition; women with a history of sexual victimization were one and a half times more likely to report a chronic mental health condition.

(Thompson et al., 2002)

A study focused on the psychological impact of financial exploitation found that of the 77 victims studied, 29% suffered a major depressive episode after the crime compared to 2% of a control group. Five victims developed suicidal ideation, while 45% had a generalized anxiety disorder and depressed characteristics. 48% of those having a depressive episode continued to have depression 6 months later.

(Granzini et al., 1990)

“Traumatic stressors such as childhood sexual abuse, adult sexual assault, and male partner violence are consistently linked to higher rates of depression, other psychiatric disorders, and physical illness in women.”

(Office of the Lt. Governor, 2006)

An analysis of 212 cases of sexual assault involving female victims ranging in age from 15 to 87 identified that 37% had a history of psychiatric difficulties and that psychological difficulties appear to be more likely among mid-age and the oldest victims. Approximately 20% of the eldest victims also demonstrated a cognitive disability.

(DeBove et al., 2005)

81% of adults diagnosed with Borderline Personality Disorder and 90% of adults with Dissociative Identity Disorder were sexually and/or physically abused as children.

(Herman et al., 1989; Ross et al., 1990)

In Wisconsin 80% of women in treatment for substance abuse disorders have experienced a traumatic event over their lifetimes.

(BMHSAS Data, 2003-2005)

Up to two-thirds of both men and women in substance abuse treatment report childhood abuse or neglect.

(CSAT, 2000)

Seventy-five percent of women in treatment programs for drug and alcohol abuse report having been sexually abused.

(SAMSHA 1994)

In the ACE studies it was found that individuals with 4 or more ACEs had a 500% increase in alcoholism as compared to those with no ACEs and the relationship is graded according to the number of ACEs.

(Felitti, 2003)

30-57% of all females with substance abuse disorders meet the criteria for PTSD; this is 2-3 times higher than for males with substance abuse disorders; the increased risk is due to higher

incidence of childhood physical and sexual abuse for females.
(Najavits *et al.*, 1997)

Physical Health Problems

The ACE studies have found increased incidence of heart disease, cancer, emphysema, fractures, and liver disease for those with higher numbers of ACEs; other studies have found a relationship between childhood abuse and irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, and chronic pain syndromes.
(Felitti *et al.*, 1998; Springer *et al.*, 2003)

The Wisconsin Longitudinal Study found a positive relationship between childhood physical abuse and increased number of medical diagnoses, physical symptoms, depression, anger, and anxiety.
(Springer *et al.*, unpublished paper)

A National Institute on Aging funded study found that: “Even when adjustments were made to account for chronic diseases, social factors and other conditions associated with increased death rates among the elderly, mistreated older persons were three times more likely to die than older persons who were not mistreated.”
(Lachs *et al.*, 1998)

Adult Criminal Justice

94% of incarcerated women reported they had experienced at least one physical or sexual act of violence against them during their lifetime.
(Browne *et al.*, 1999)

A Wisconsin study of women prisoners found that 58% reported a history of childhood sexual abuse; 42% extreme repeated childhood physical abuse; 65% had been the victims of repeated domestic abuse.
(Saviano, 1999)

Homelessness

97% of homeless mentally ill women have experienced severe physical and/or sexual abuse, and 87% experienced this abuse as both children and as adults.
(Goodman *et al.*, 1997)

One study found that 92% of homeless mothers have experienced physical and/or sexual assault. Another study found that 66% of homeless mothers have experienced severe physical violence at the hands of a caretaker; 43% had been sexually molested during childhood; 63% have been victims of domestic violence.
(Bassuk *et al.*, 1996; Browne *et al.*, 1997)

More than 40% of women on welfare were sexually abused as children. They often are unable to hold a job and become homeless.
(DeParle, 1999)

Children and Adolescents

A Massachusetts study of adolescents and children in inpatient and intensive residential treatment found 82% had a history of trauma.
(Heuberger, 2001)

A study found that 86% of adolescents in a psychiatric hospital gave consistent reports of physical abuse and 71% gave consistent reports of sexual abuse.
(Lipschitz et al., 1999)

Adolescents with alcohol dependence are 6-12 times more likely to have a childhood history of physical abuse and 18-21 times more likely to have a history of sexual abuse than those without substance abuse problems.
(Clark et al., 1997)

In one study of juvenile detainees, 93.2% of males and 84% of females reported a traumatic experience with 18% of females and 11% of males meeting full criteria for PTSD. Males were most likely to report witnessing violence, while females were most likely to report being victims of violence.
(Hennessey et al., 2004)

A recent study of low-income pre-school children in Michigan found that nearly half (46.7%) of the children in the study had been exposed to at least one incident of mild or severe violence in the family. Children who had been exposed to violence suffered symptoms of post-trauma stress disorder, such as bed wetting or nightmares, and were at greater risk than their peers of having allergies, asthma, gastrointestinal problems, headaches, and flu.
(Graham-Bermann and Seng, 2005)

People with Disabilities

Research consistently shows that women with disabilities regardless of age, race, ethnicity, sexual orientation, or class are assaulted, raped, and abused at a rate two times greater than women without disabilities.
(Sobsey, 1994; Cusitar, 1994)

The risk of being physically assaulted for an adult with developmental disabilities is 4-10 times higher than for other adults.
(Sobsey, 1994; Cusitar, 1994)

Research by the National Center on Child Abuse and Neglect found that children with any kind of disability are more than twice as likely as children without a disability to be physically abused and almost twice as likely to be sexually abused as children without a disability.
(Crosse et al., 1993)

Childhood violence is a significant causal factor in 10-25% of all developmental disabilities.
(Sobsey, 1994; Valenti-Hein and Schwartz, 1995)

Adult Victimization

Females sexually abused during childhood are 2.4 times more likely than non-abused females to be re-victimized sexually as adults.
(Wyatt et al., 1992)

Females who experience violence during childhood are 3-4 times more likely to be raped than those who do not experience violence.
(Brown, 1992)

Females subject to childhood incest are twice as likely to become victims of domestic violence.
(Russell, 1986)

Psychological Trauma Fact Sheet References

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<http://www.doj.state.wi.us/cvs/documents/DAR/2004DAR/ExSumm.pdf>

Wisconsin Office of Justice Assistance. (December 2005). *Sexual Assaults in Wisconsin 2004*.

<http://www.oja.state.wi.us/docview.asp?docid=1165&locid=97>

Wyatt, G.E. et al. (1992). Differential effects of women's child sexual abuse and subsequent sexual revictimization. *Journal of Consulting and Clinical Psychology*, 60, pp. 167-73.

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APPENDIX F: RESOURCES AND WEBSITES

Some Helpful Resources and Websites

Children

Helping Children in the Child Welfare Systems Heal from Trauma: A Systems Integration Approach. The National Child Traumatic Stress Network.

http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/A-Systems_Integration_Approach.pdf

Traumatic Stress/Child Welfare. Focal Point, Winter 2007. Portland Research and Training Center on Family Support and Children's Mental Health.

<http://www.rtc.pdx.edu/pgFPWO7TOC.php>

Children, Families, and Workers: Facing Trauma in Child Welfare. Best Practices, Next Practice, Winter 2002. The National Child Welfare Resource Center of Family-Centered Practice.

<http://www.hunter.cuny.edu/socwork/nrcfcp/downloads/newsletter/BPNPWinter02.pdf>

Hodas, G. Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care, 2006. <http://www.nasmhpd.org/ntac.cfm>

National Child Traumatic Stress Network. <http://www.nctsn.org>

Mental Health and Substance Abuse

Sidran Institute. <http://www.sidran.org>

Saakvitne, K. et al. Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse

Vermilyea, E. Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress

Healing Self-Injury. <http://www.healingselfinjury.org>

Community Connections. <http://www.communityconnectionsdc.org>

Harris, M. Trauma Recovery and Empowerment: A Clinicians Guide for Working with Women in Groups

Men's Trauma Recovery and Empowerment Model (M-TREM): A Clinician's Guide for Working with Male Survivors in Groups

Copeland, M.E. and Harris, M. Healing the Trauma of Abuse: A Women's Workbook

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National Association of State Mental Health Program Directors.
<http://www.nasmhpd.org/ntac.cfm>

Jennings, A. The Damaging Consequences of Violence and Trauma: Facts, Discussion Points and Recommendations for Behavioral Health Systems (2004)

Blanch, A. Developing Trauma-Informed Behavioral Health Systems (2003)

the anna institute. <http://www.annafoundation.org>

Jennings, A. Blueprint for Action: Building Trauma-Informed Mental Health Service Systems. State Accomplishments, Activities, and Resources (2004)

National Center for Trauma-Informed Care. <http://mentalhealth.samsha.gov/nctic>

National Center for Post Traumatic Stress Disorder. <http://www.ncptsd.va.gov>

Women, Co-occurring Disorders and Violence Study. <http://www.prainc.com/wcdvs>

New Partnerships for Women. Journey of Self-Discovery: A Study Guide for Trauma Survivors.
(2007)

Covington, S. Beyond Trauma: A Healing Journey for Women.
<http://www.stephaniecovington.com>

Najavits, L. Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.
<http://www.seekingsafety.org>

Sexual Assault

National Sexual Assault Coalition Resource Sharing Project.
[Http://www.resourcesharingproject.org](http://www.resourcesharingproject.org)

National Sexual Violence Resource Center. <http://www.nsvrc.org>

Domestic Violence

National Coalition Against Domestic Violence. <http://www.ncadv.org>

Domestic Violence and Mental Health Policy Initiative. <http://www.dvmhpi.org>

Elder Abuse

National Center on Elder Abuse. <http://www.elderabusecenter.org>

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National Clearinghouse on Abuse in Later Life. <http://www.ncall.us>

Multiple Trauma Issues

Accessing Safety Initiative. <http://www.accessingsafety.org>

Adverse Childhood Experiences Study. <http://www.cestudy.org>

Centers for Disease Control and Prevention, Injury Center.
<http://www.cdc.gov/InjuryViolenceSafety>

National Center for Victims of Crime. <http://www.ncvc.org>

National Trauma Consortium. <http://www.nationaltraumaconsortium.org>
<http://www.cdc.gov/InjuryViolenceSafety>

Victims of Crime with Disabilities Resource Guide.
<http://wind.uwyo.edu/resourceguide/default.asp>

Violence Against Women - VAWnet. <http://www.vawnet.org>

Witness Justice. <http://www.witnessjustice.org>

Information compiled by Dianne Greenley, Disability Rights Wisconsin, May 2007.