Van Buren Transformational Health Initiative Project
2013-2016

Implementation Manual

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Building a Comprehensive Trauma-informed System of Care in Rural Counties

Introduction:

The Transformational Grant (TG) project sponsored by the Michigan Department of Community Health (MDCH) (now part of Michigan Department of Health and Human Services [MDHHS]) provided a unique opportunity for a well established, respected university-based children's trauma assessment center to impact multiple systems in a rural county (Van Buren County) in Southwest Michigan by building a trauma-informed system to better serve at-risk / traumatized youth across Van Buren County.

The Children's Trauma Assessment Center (CTAC) at Western Michigan University (WMU) began operations in early 2000. The interdisciplinary team (social work, occupational therapy, speech pathology and audiology, nursing, and medicine) at CTAC has now assessed over 3500 traumatized children and adolescents involved in the child welfare, mental health, and judicial systems referred from across Michigan.

Since 2008, CTAC has been extremely active in multi-agency systems change (child welfare, mental health, schools, courts, and medical) through a series of federally-funded grant projects that resulted in the creation of 11 trauma assessment centers across Michigan, and facilitated ongoing efforts to institute universal trauma screening and assessment for all children being served by multiple systems throughout Michigan.

One component of systems change efforts, especially in rural communities, has been to bring a trauma-informed medical perspective to all agencies involved while always keeping the primary care healthcare community as a priority. One striking commonality across communities was the relative isolation of many primary care practices. This was clearly not purposeful, and was not solely due to the medical sector (the "silo factor" has been well described in all agencies serving youth) but this isolation did clearly impact the needs of complex children who were being served by multiple agencies. This observation has fueled our project: how can we optimally strengthen connections between primary care providers in Van Buren and schools, public / private mental health agencies, and the local health department?

This TG project was CTAC's first medical grant project. It was our sincere hope to bring lessons learned from our extensive clinical experience, many previous CTAC trauma-informed grant projects, and ongoing national collaboration with the National Child Traumatic Stress Network (NCTSN – www.nctsn.org) and blend this with ongoing guidance from TG leadership in Lansing as we sought to build a grassroots trauma-informed system to impact a large number of complex at-risk / traumatized youth in Van Buren.

Another essential piece of this project has always been sustainability. This implementation guide will hopefully serve as the embodiment of these sustainability efforts as we sincerely hope that you will be able to replicate and improve upon our efforts to bring trauma-informed practice to all individual professionals and agencies serving at-risk and traumatized youth in Van Buren County.

Essential Elements of This Project:

Introduction:

When seeking to build a rural trauma-informed system, it is obviously necessary to include as many relevant agencies and organizations as feasible. However, it is easy to become overwhelmed by this step.

Each CTAC-led rural county trauma-informed project presented a unique set of circumstances: the local multiple agencies and organizations typically naturally stratify into an ecological hierarchy largely based on power and influence. This hierarchy, of course, is unwritten but usually quite well known to multiple county professionals.

For example, in one county project, we quickly observed that the probate / family court system clearly was the most influential in that county and one powerful veteran judge was driving that entire process. This resulted in a fragile collaborative balance of multiple agencies that essentially collapsed soon after the "alpha" judge retired.

Key Initial Questions:

- Who is/are the prospective ***primary champion(s)*** of the project, what agency do they represent, and what is their position within that agency?

- Another key early question**: What youth population will you serve?**

- Will this be a ***preventive*** project involving at-risk young children and adolescents that are not yet in the child welfare / judicial systems?

- Or… will it be more ***comprehensive*** (e.g., trauma-informed community model) and involve the preventive component as well as addressing the unique and complex needs of children and adolescents already in the system?

These questions are not meant to exclude key agencies but should help early organizational efforts to focus collective efforts and energies in the proper direction.

For example, if the decision is made for the project to focus on at-risk children, then efforts would naturally be directed toward primary care providers, early childhood education leadership / staff, and trauma-informed mental health service providers directed at improving relationships between parent and child and optimizing child development by reducing external risk factors.

If project leadership decides to focus on trauma prevention as well as traumatized children and adolescents involved in the child welfare system, then it would be paramount to have key planning committee representation from child welfare and the courts.

Local trauma champions pondering these critical questions should refer to Addendum 1 for a visual representation of our conceptual model and additional information.

Initial Logistic Steps:

Assembling the Planning Committee:

We always recommend that the prospective primary champion(s) quickly assemble an interdisciplinary / interagency planning committee that consists of potential trauma champions within each organization. This planning committee does not have to be represented by all the agencies listed below but it is strongly recommended that formal invitations be sent to all possible "players".

Obviously, the selection of planning committee members is critical and can be an early stumbling block in any trauma-informed project. It often helps if there are two or three prospective primary champions to discuss / decide who should be named to the planning committee.

In rural areas, there is often a limited repository of qualified committee members in each representative agency or organization, which can make selection more difficult. Additionally, rural agency directors are usually extremely busy and often won't have adequate time to devote to an ambitious novel local endeavor. It does make sense to connect with busy agency directors that decline the invitation to participate and get their personal recommendation for the "best fit" from their agency.

Below is a list of the essential committee "players" (in no particular order):

- **Medical:** Primary healthcare practice / area hospital (hospital CEO, Chief Medical Officer, prominent influential primary care practitioner, passionate local respected primary care provider [hopefully with interest / expertise in behavioral medicine issues]

- **Public Mental Health**: Community mental health partner (Director, and/or Director of Children's Services, and/or Medical Director [typically a general or child & adolescent psychiatrist)

- **Private mental health** agency (e.g., owner / supervisor of large influential mental health practice)

- **School** representative(s) (preferably from both the general education sector (public school principal is ideal) and the special education sector (best option is often the Director of Special Education of the local county Intermediate School District)

- Local **health department** representative (e.g., Director / Health Officer, Nursing Director, Medical Director

- **Child welfare** representative (DHHS Director or high-level supervisor or DHHS Health Liaison Officer)

- **Court** representative (e.g., court administrator, judicial referee, probate /family court judge)

Confirming the Primary Champion(s):

Another caveat of this initial planning stage: the primary trauma champion needs to be formally and mutually confirmed at the initial formal meeting. This should be done even in counties where the primary champion is obvious to all.

This primary trauma champion must be widely respected in the county for their professional expertise, have strong relatedness skills, be energetic and passionate, be organized and structured (or have a talented executive assistant!), and finally, must keep the child's best interest at the center of every step of this process.

Some examples of primary trauma champions in our systems change work at CTAC:

DHHS Director	DHHS Supervisor	CMH Director/Supervisor
Private MH Agency Director/Supervisor	Intermediate School District (ISD) Superintendent	ISD Supervisor
ISD Early Childhood	ISD School Psychologist	Probate/Family Court

Director		Judge
Juvenile Probation Officer	Private Practice Pediatrician	Private Practice Physician Assistant or Nurse Practitioner
University-based Nursing School Faculty	Health Department Director	Private Practice Trauma Therapist

Barriers & Challenges:

Another caveat during the early planning stages: The planning committee must quickly and nimbly identify true champions who will continue their efforts and energy despite expected barriers and pitfalls. We have seen counties lose critical momentum by misjudging the intent / ability of planning committee members to provide long-term commitment and contribution.

Also, planning meetings can quickly become inefficient and unwieldy, especially if they are too large. Action-oriented committees fare far better and trauma-informed action plans are obviously critical to the success of any trauma-informed community project.

Funding Issues:

Another key step in the early planning stages involves securing some **funding** for the project. We have seen several of our well meaning and talented county projects falter due to lack of funding.

A small local foundation can be an ideal source for start-up funding. We began CTAC operations with a $15,000 local foundation grant. Another of our projects was created with a $40,000 donation from a local family court. This funding issue needs to be addressed very early and is typically the chief reason that even passionate and talented individuals and agencies withdraw from promising county projects.

We were fortunate to have an established state and nationally recognized trauma-informed entity (CTAC) driving this project, with substantial state-funded grant funding available for 3+ years.

A large grant is not essential for success of your project, but project funding has to come from somewhere. In-kind commitments (essentially donation of a professionals time [e.g., 0.1 FTE] by a participating agency) are often available but are not frequently explored. This in-kind support is typically short-lived and needs to be followed with some sort of reimbursement plan from the project (i.e., state-funded reimbursement for trauma assessment of children in the child welfare system, and or grant support).

Trauma-Informed Training and Consultation for your Project:

Finally, we feel that each trauma-informed project needs to seek and develop outside trauma-informed training and consultation resources. CTAC has obviously provided this service for many years to many counties across Michigan and the US. We have used two basic models to provide this trauma-informed training and consultation service:

1) CTAC uses federal grant funds to provide comprehensive training and consultation services for the selected county. These CTAC - individual county relationships have typically been developed prior to the grant proposal being accepted and funded. The level of support and the specific nature of the services to be provided is negotiated before the grant is written and submitted

2) CTAC has also had multiple inquiries originating from counties or individual agencies to provide trauma-informed training and / or consultation services. This scenario typically involves the county or agency securing a limited amount of funding from a local foundation, an anonymous local donor, or internally (for example, an agency director or department head earmarking general funds to be used for trauma-informed training and consultation).

   Many agencies using this model will inquire to CTAC: "How much training and consultation can we secure for $10,000?"

It is imperative to now discuss the importance of budgeting for ***ongoing consultation*** from the trauma-informed expert (In other words, initial trauma training is not enough). We have repeatedly seen trauma-informed projects falter after strong starts due to not having formal ongoing consultation from the collaborative trauma expert.

Organizational Readiness:

One of the initial challenges in any trauma-informed project is delineating an individual organization or agency's readiness to participate in a novel trauma-informed project and to implement any / all trauma-informed recommendations.

At CTAC, during our quest to assist in the start-up of multiple regional trauma assessment centers around the state, we developed an evidence-based model (Richardson 2012) to engage countywide interest and identify potential trauma champions and resident experts across different agencies and organizations.

Understanding Each Other:

The daunting task of building a truly trauma-informed countywide rural system of care for at-risk / traumatized youth is centered on the cumbersome and inefficient structure and function of essentially all involved systems and agencies currently serving youth. Additionally, it has become clear in our systems change work at CTAC

that there is a surprisingly limited understanding of each silo's role by many/most members of other silos.

This relative unfamiliarity is particularly true of the primary care medical community. The typical primary care provider may have a fundamental lack of understanding of the inner workings of child welfare agencies, public mental health agencies, schools, courts, and health departments. More importantly, there is often a general unawareness by the primary care community of this knowledge deficit re other agencies.

The medical community is certainly not alone in this problem of "knowing what you don't know". There are multiple examples of this basic misunderstanding re individuals working at every level (from the trenches to the director's office) in each silo. Any trauma-informed community project must recognize these cross-agency misunderstandings and address them early in the project planning stages.

Unique medical issues:

Building on this silo unfamiliarity issue, the primary champion(s) (especially if they are not in the medical sector) must understand unique and oft not well-understood aspects of medical sector readiness:

- There is often a major disconnect between high-level medical administration and the primary care community (most primary care providers now work for a larger medical entity) and in some areas, there is a fair amount of internalized bitterness from the primary care community: "They don't understand us…"

- The list of unfunded mandates (coming from state and national "motherships" like the American Academy of Pediatrics) confronting primary care physicians (especially pediatricians) is growing and has caused an inordinate amount of stress and angst

- Examples of these unfunded primary care mandates:

    - M-CHAT screen for autism at 18 and 24 months for all patients
    - Post-partum depression screen for all mothers at the 1-month well child examination
    - Depression screening for all 12-year olds

- Because of this, any collaborative inquiries from "the trauma system" that sound like more unfunded mandates may not be well received from the primary care community (even if the planning committee has buy-in from hospital administration)

- Understanding this back story should improve overall planning efficiency for individuals that wish to include the medical sector in any trauma-informed community plans

Trauma-informed is not enough: Understanding the Trauma Continuum

The term "trauma-informed" has become quite fashionable in recent years and reflects the considerable and ever-accumulating scientific evidence base that has clearly established that chronic traumatic stress in childhood has deleterious impacts on multiple body systems and multiple developmental streams in the developing child. Further, it is now clear that these childhood traumatic impacts, if left unaddressed, directly impact the health and well being of adults.

However, it is also clear that being "trauma-informed" (either at an individual level or agency level) is not sufficient for true and lasting systems change. One or two trauma trainings do not guarantee that an individual or agency will change their daily practice to best serve at-risk/traumatized youth.

A trauma continuum better explains the stages of trauma readiness:

Trauma-unaware ➔ Trauma-aware ➔ Trauma-informed ➔ Trauma-ready (to implement) ➔ trauma-implemented

I recommend using this line of thinking to make many trauma-informed organizational readiness decisions.

Sanctuary Model highlights:

Another key principle re organizational readiness for trauma-informed system change comes from the Sanctuary Institute in New York (www.sanctuaryweb.com). The *Sanctuary Model* is a trauma-informed method for creating, sustaining, or changing an organizational culture.

There is now a large body of epidemiological information demonstrating that exposure to trauma, adversity, and chronic stress are universal experiences that affect individuals, families, **organizations, and entire systems** in a wide variety of ways – some that are creative and that insure growth… others that produce dangers to our physical, psychological and social well-being.

A favorite statement from Sanctuary Institute leadership is: "A fish rots from its head". This is intended to convey a strong message that if an agency or organization being considered for inclusion in any trauma-informed community project does not have leadership that are clearly and wholeheartedly committed to this new trauma-informed project, there is little chance of that agency / organization becoming a viable member of that trauma-informed project.

Building Resiliency in Children, Families, and the Workforce:

It is also clear that any approach to establishing a trauma-informed community model must have **resiliency** deeply embedded in its core. Building resiliency in at-risk / traumatized youth as well as in the professional workforce is a critical step for any trauma-informed community project. All participants in any trauma-informed collaborative projects from the trenches to the "penthouse" must embrace the well-researched concepts of resilience in both children and adults.

Resiliency contextualizes adversity… meaning a child's obvious strengths must be weighed against early and ongoing adversity. Contrary to popular belief, children are not automatically resilient creatures that will "get over" / survive their traumatic stress. Three key resiliency concepts need specific mention: 1) **self-efficacy** (the ability for a child to impact his world with his thinking or behavior); 2) **relatedness** (the ability to successfully connect emotionally and socially with peers or supervisory adults); and 3) **affect regulation** (the ability to self-regulate emotion and behavior in a variety of settings). The first two resiliency concepts are protective factors and the third concept is risk factor. All three of these concepts must be identified, fully delineated, and supported and/or enhanced.

WMU CTAC has developed an evidence-based trauma-informed organizational readiness tool (*Trauma-Informed System Change Instrument, 2nd Edition* – Richardson, et al, 2012) to help planning committees make these critical readiness decisions. (See Addendum 2 to inspect CTAC's *Trauma-informed System Change Instrument, 2nd Edition*).

Implementation Details:

Implementation Steps - Common to all Agencies:

The WMU CTAC systems change-training model was utilized for VB-THIP. The primary components are discussed below.

Trauma-informed Training:

Implementation of trauma-informed strategies is always the rate-limiting step while building trauma-informed systems. This implementation process always begins with **didactic cognitive training** for all involved professionals to help them see complex childhood behavioral issues through a different trauma-informed lens. Another cognitive training principle that is equally important here involves the deleterious impact of prenatal exposure to stress, drugs, and alcohol on the developing brain. The combination of mental health genetic risk combined with prenatal exposure and post-natal traumatic toxic stress exerts a synergistically negative impact on the developing brain and results in problematic emotional and behavioral regulation, impaired social development and performance, and suboptimal academic performance.

Following this "Trauma 101", "prenatal exposure 101" training, and training re the interaction of both trauma and prenatal exposure with genetic mental health risk via epigenetic mechanisms, individuals involved in trauma-informed systems change are then trained to use specific trauma-informed tools to accomplish trauma screening / trauma assessment, and trauma-informed case planning / treatment for all at-risk and traumatized youth encountered.

Trauma Screening:

Typically, we begin specific tools training with the CTAC trauma-screening instrument. It was developed in 2008 during our second SAMHSA grant and has been used with over 10,000 children and adolescents across Michigan and the US. Formal psychometric validation has been completed through Colorado State University.

The CTAC trauma screen (See Addendum 3) has two iterations based on the age of the child (0-5 years, and 6-18 years), and is divided into two sections. It is completed by a professional reasonably familiar with the child and family (e.g., teacher, counselor/therapist, caseworker, primary care provider). The top section reviews known or suspected exposure to various forms of trauma (similar to the Adverse Childhood Experiences (ACE) questionnaire). The bottom section lists various behaviors associated / linked with trauma.

Trauma Assessment:

The next step in trauma-informed implementation involves customized trauma assessment. Ideally, trauma assessments are conducted for all children and adolescents that screen positive on the CTAC trauma screen.

The trauma assessment developed in 2000 at WMU CTAC is a comprehensive assessment with cognitive/developmental; relational; psychosocial; and medical components. We have long since realized that this comprehensive trauma assessment is not universally feasible due to varying levels of system capacity in various locations. CTAC now recommends customized assessment based on the capacity of the agency.

Trauma-informed Case Consultation:

A mainstay of our work at CTAC is trauma-informed case consultation. It began with our trauma-informed consultation work in a federally-funded trauma-informed drug court grant and was so well received we have instituted it wherever possible in all of our grant work.

Customized case consultation involves a trauma-informed discussion re a behavioral problem case brought to the table by the agency receiving the trauma-informed services. This discussion is customized according to the agency / organization involved in the consultation. Early in the process, the behavioral cases brought to the discussion are not always recognized by the involved agency / organization (especially primary care facilities or schools) as being trauma-related

cases. One of the stronger aspects of the case consultation model is the trauma-informed consultant's ability to subtlely shape the discussion of a behavioral case into a trauma dialogue. This situation often has lasting trauma-informed impact for those involved in the discussion and can help them see trauma impact sooner when subsequently dealing with other behavioral cases in their practices.

Trauma-informed Interventions:

Trauma screening and assessment should naturally lead to trauma-informed interventions in all phases of the child's life. There has been an explosion of evidence-based trauma-informed interventions in the past decade. For example, there are currently over 100 evidence-based trauma-informed psychotherapy interventions officially registered at the evidence-based clearinghouse at California State University-Northridge.

Unfortunately, many of these therapies are not locally available and also many traumatized children and adolescents have significant regulatory issues, which prevent them from fully participating in evidence-based psychotherapy.

This led CTAC to begin the development of a brain-based trauma-informed therapeutic conceptual model that seeks to stage treatment based on assessment findings. Regulatory-focused treatment modalities are being sought and tested on different age groups (e.g. early childhood, adolescents) in different clinical and ecological settings (school, daycare, respite, residential, detention).

These regulatory-focused and physiologically-based treatment modalities include sensory-focused trauma-informed occupational therapy, trauma-informed music therapy, art therapy, and brain-based trauma-informed psychotropic medication treatment.

Conclusion:

This systems change model was clearly a good fit for this rural southwest Michigan county. The primary care focus of this project was a new yet required twist for us at CTAC. It demonstrated, for example, how a few simple yet key personnel changes in a primary care pediatric practice can create a trauma-informed truly integrated primary care team that is central to strengthening connections between primary care and multiple local agencies and organizations.

We strongly feel that this model is replicable (with moderate additional financial support) in other rural and suburban counties across Michigan and the US, and will actually increase overall system efficiency and improve workforce resiliency, which is truly essential to sustain meaningful changes in multiple systems when dealing with at-risk / traumatized children and adolescents.

This model also is clearly centered on keeping the child and family in the center of each collaborative agency / organization. During our systems change work at WMU

CTAC, we have been taught many essential and amazing things by our complex children and by our hard working collaborative child welfare, mental health, and medical organizations.

Here is a favorite that will nicely summarize our collaborative work on this transformational project:

It does not require any funding for individuals to *think differently* about traumatized child and families.

When a few individuals serving as trauma champions in a rural county ignite the passion of many others working alongside them in their respective agencies / organizations, great things can happen: and those great things will ultimately build resiliency in our wounded yet valiant children and their families and will ultimately be transformational in their healing.

Addendum 1: Trauma-informed Healthcare Models

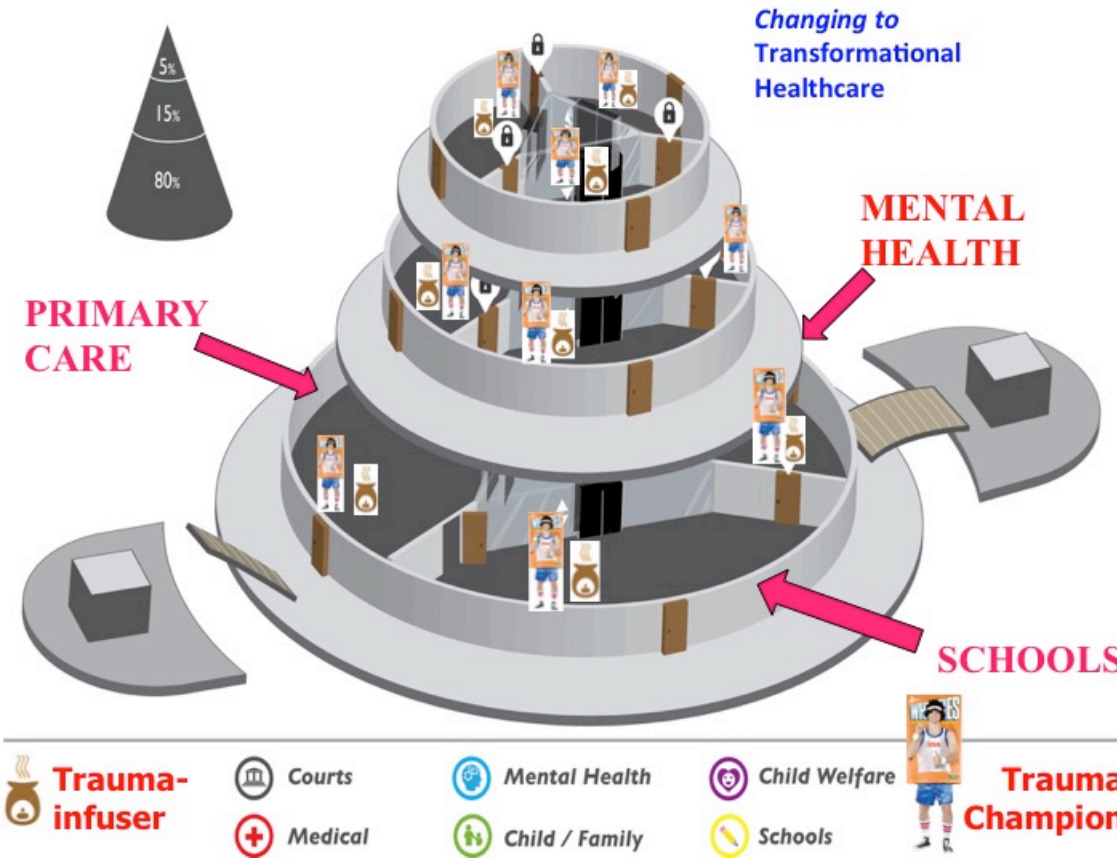

Figure 1: The Tiered Model for Transformational Healthcare. This figure represents all three tiers of integrated behavioral service provided to children by the three primary systems: health care, mental health, and education. Each sector on each tier must have trauma-informed champions to allow true transformational health practice to occur. See further explanation in the text. See each tier highlighted individually in Figures 2 through 4

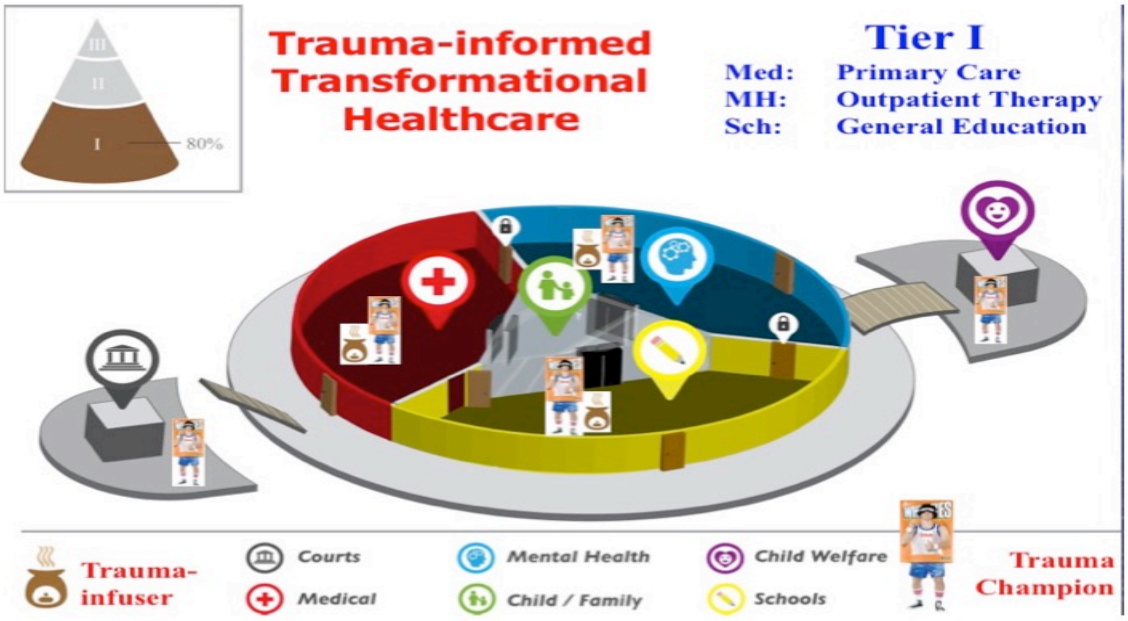

Figure 2: Tier I examined in detail.
The three primary sectors (schools/mental health /medical) are ideally interconnected (represented by the doors) yet each sector has their own space to provide their unique services to at-risk / traumatized children. The child and family are situated in the center of these three sectors and are clearly visible to all three. Approximately 85% of children are serviced in Tier 1.

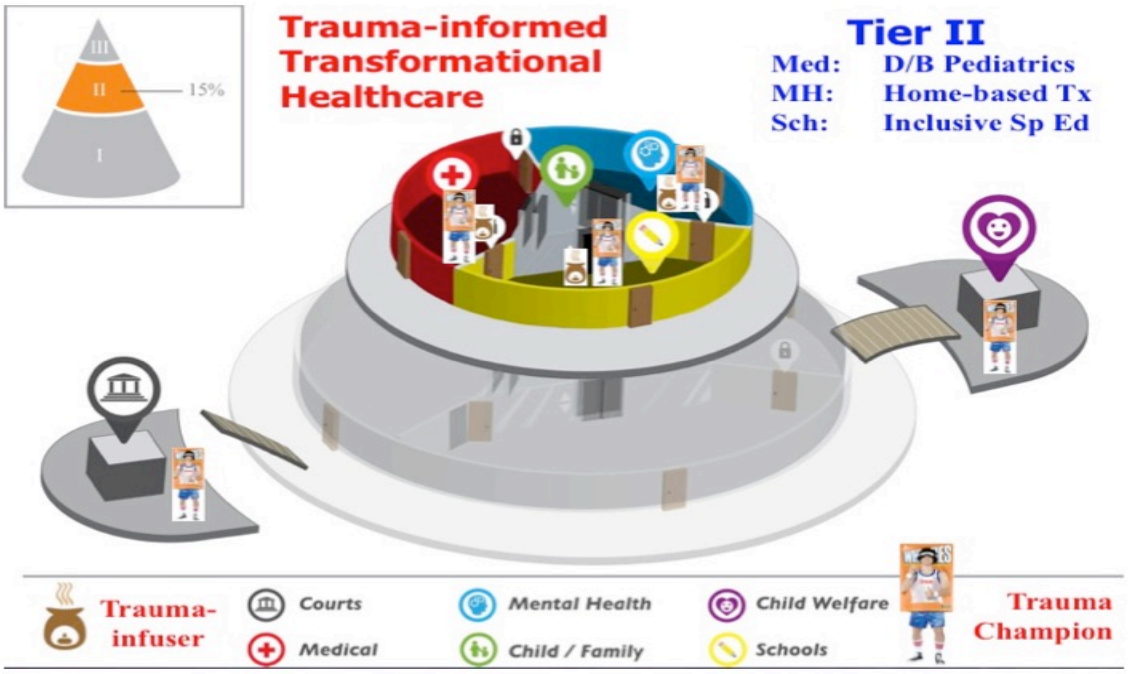

Figure 3: Tier II details Tier 2 is a pivotal transitional zone as it represents those children with relatively more severe behavioral issues but often do not rise to the level of requiring Tier III services and interventions. In the medical sector, Tier II represents children with significant behavioral issues but who do not typically qualify for psychiatric services. Trauma-informed training and consultation have frequently resulted in many primary care providers becoming more comfortable managing these Tier II children and adolescents…thus improving capacity.

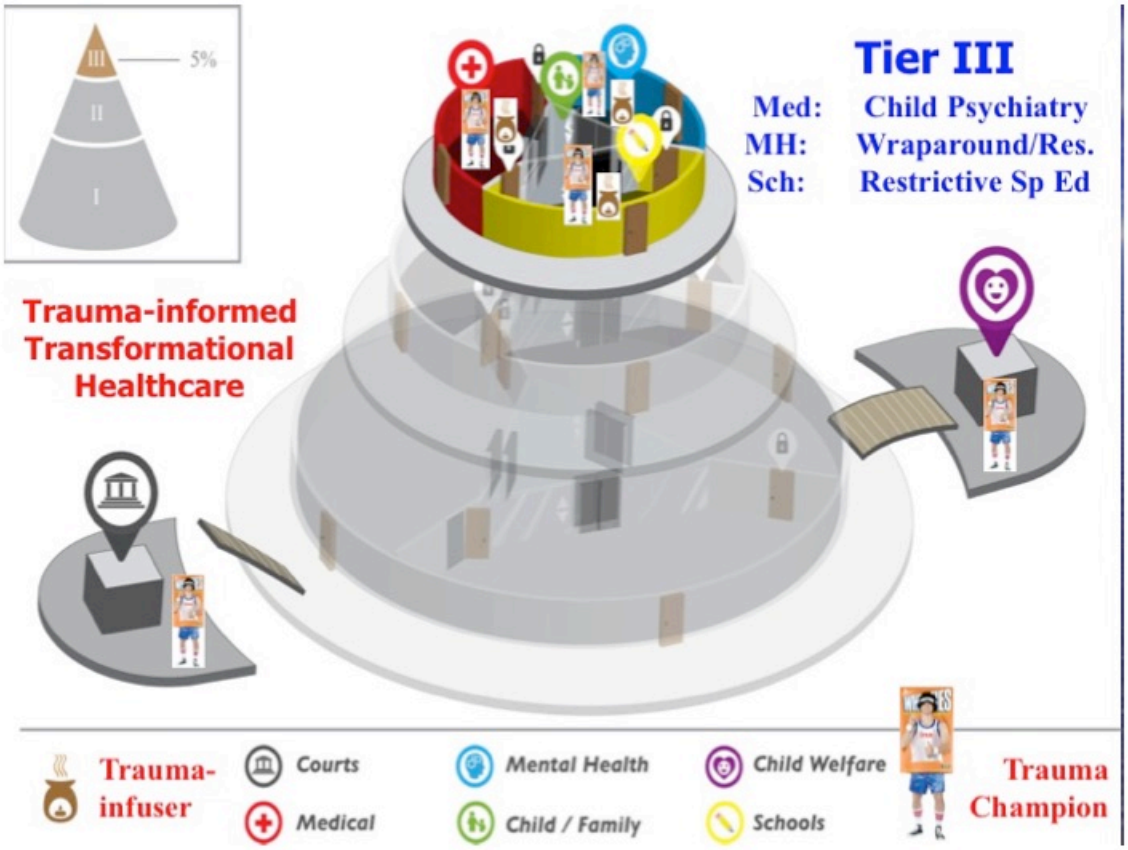

Figure 4: Tier III explained
Tier III children have the most severe behavioral issues and are currently served by the most intensive programs in all three sectors: Child psychiatry management in the medical sector; restrictive special education or alternative school settings in the education sector; intensive outpatient / WrapAround services, or residential programs in the Mental Health sector

Addendum 2: ***Trauma-informed System Change Instrument, 2nd Ed***

Attached as a pdf file….unable to insert in this document…MAS

Addendum 3: WMU CTAC Trauma Screening Checklists

NCTSN The National Child Traumatic Stress Network

Trauma Informed System Initiative

Trauma Screening Checklist: Identifying Children at Risk
Ages 0-5

Please check each area where the item is known or suspected. If history is positive for exposure and concerns are present in one or more areas, a comprehensive assessment may be helpful in understanding the child's functioning and needs.

1. Are you aware of or do you suspect the child has experienced any of the following:

_____ Known or suspected exposure to drug activity *aside from parental use*
_____ Known or suspected exposure to any other violence *not already identified*
_____ Impaired Parenting (i.e. Parent Mental Illness or Parental substance abuse)
_____ Multiple separations from parent/ caregiver, including out of home placement (s)
_____ Frequent and multiple moves or homelessness
_____ Suspected neglectful home environment
_____ Suspected or known Prenatal Exposure to Alcohol/Drugs or Maternal Stress
_____ Physical abuse
_____ Emotional abuse
_____ Exposure to domestic violence _____ Other _____
_____ Sexual abuse or exposure _____
_____ Hospitalization (s) Age? _____

If you are not aware of a trauma history, but multiple concerns are present in questions 2, 3, and 4, then there may be a trauma history that has not come to your attention.

Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. Does the child show any of these behaviors:

_____ Excessive aggression or violence towards self or others
_____ Repetitive violent and/or sexual play (or maltreatment themes)
_____ Explosive behavior (excessive and prolonged tantruming)
_____ Disorganized behavioral states (i.e. attention, play)
_____ Very withdrawn or excessively shy
_____ Bossy and demanding behavior with adults and peers
_____ Sexual behaviors not typical for child's age
_____ Difficulty with sleeping or eating
_____ Regressed behaviors (i.e. toileting, play)
_____ Other _____

3. Does the child exhibit any of the following emotions or moods:

_____ Chronic sadness, doesn't seem to enjoy any activities.
_____ Very flat affect or withdrawn behavior
_____ Quick, explosive anger
_____ Other _____

4. Is the child having relational and/or attachment difficulties?

_____ Lack of eye contact

_____ Sad or empty eyed appearance
_____ Overly friendly with strangers (lack of appropriate stranger anxiety)
_____ Vacillation between clinginess and disengagement and/or aggression
_____ Failure to reciprocate (i.e. hugs, smiles, vocalizations, play)
_____ Failure to seek comfort when hurt or frightened
_____ Other _____

When checklist is completed, please fax to:

Enter Name Here

Child's First Name:_____ Age:_____ Gender:_____
County: _____ Date: _____

Southwest Michigan Children's Trauma Assessment Center

Trauma Informed System Initiative

Trauma Screening Checklist: Identifying Children at Risk
Ages 6-18

Please check each area where the item is known or suspected. If history is positive for exposure and concerns are present in one or more areas, a comprehensive assessment may be helpful in understanding the child's functioning and needs.

1. Are you aware of or do you suspect the child has experienced any of the following:

_____ Known or suspected exposure to drug activity *aside from parental use*
_____ Known or suspected exposure to any other violence *not already identified*
_____ Impaired Parenting (i.e. Parental alcohol/substance abuse or Mental Illness)
_____ Multiple separations from parent or caregiver
_____ Frequent and multiple moves or homelessness
_____ Physical abuse
_____ Suspected neglectful home environment
_____ Emotional abuse
_____ Exposure to domestic violence
_____ Sexual abuse or exposure
_____ Bullying
_____ Prenatal Exposure to Alcohol/Drugs or Maternal Stress
_____Out of Home Placement(s) including Hospitalization/Foster Care Placement
____Other_____
_____

If you are not aware of a trauma history, but multiple concerns are present in questions 2,
3, and 4, then there may be a trauma history that has not come to your attention.
Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. Does the child show any of these behaviors:

_____ Excessive aggression or violence towards self
_____ Excessive aggression or violence towards others
_____ Explosive behavior (Going from 0-100 instantly)
_____ Hyperactivity, distractibility, inattention
_____ Very withdrawn or excessively shy
_____ Oppositional and/or defiant behavior
_____ Sexual behaviors not typical for child's age
_____ Peculiar patterns of forgetfulness
_____ Inconsistency in skills
_____ Other _____

3. Does the child exhibit any of the following emotions or moods:

_____ Excessive mood swings
_____ Chronic sadness, doesn't seem to enjoy any activities.
_____ Very flat affect or withdrawn behavior
_____ Quick, explosive anger
_____ Other _____

4. Is the child having problems in school?

_____ Low or failing grades
_____ Inadequate performance
_____ Difficulty with authority
_____ Attention and/or memory problems,
_____ Other _____

When checklist is completed, please fax to:

Fill Name Here:

Child's First Name:_____ Age:_____ Gender:_____

County/Site: _____ Date: _____