REPORT OF THE COMMISSION ON PSYCHOLOGICAL TRAUMA TO THE VERMONT HOUSE AND SENATE COMMITTEES ON HEALTH AND WELFARE

NOVEMBER 13, 2000

Instead of asking 'what's wrong with you?'
We need to begin asking 'what happened to you?

Report to the Vermont General Assembly on Psychological Trauma: Impact on Vermont Citizens and Recommendations for Public Policy

November 13, 2000

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Executive Summary: Commission on Psychological Trauma

During the 1999-2000 Legislative session it became clear that high quality mental health and support services for people with a history of psychological trauma were not universally available in Vermont. The impact across the Agency of Human Services of not having such services is daunting. Specifically:

- 30 to 70% of persons who are in outpatient treatment for mental health problems and 40 to 72% of those in inpatient treatment have trauma abuse histories
- 70% of all persons who entered substance abuse treatment were victims of physical or sexual abuse
- 72% of women offenders in the Corrections system were abused as children, and 72% were abused as adults
- The Vermont Network Against Domestic Violence and Sexual Assault served 1180 victims of sexual violence, and 7255 victims of domestic violence in FY 1999.

Despite the prevalence of trauma, many clinicians are unfamiliar with effective assessment and treatment of psychological trauma. This lack of knowledge can result in an inaccurate or incomplete diagnosis and often in treatment failure. Further, certain practices such as physical restraint, involuntary medication and housing without privacy also result in re-traumatization for survivors of sexual and physical violence.

Working with trauma survivors can be extremely complex and particularly difficult for therapists and support people. A team approach to treatment is needed and public and private partnerships must include close coordination between providers. Treatment for psychological trauma must be integrated with treatment for other conditions such as substance abuse, medical care, and depression. It is widely recognized that peer support as well as more formal treatment services should be available in the community

The Commission makes three specific recommendations:

Recommendation 1: Appropriate $77,739. to establish a permanent locus of responsibility within the Agency of Human Services for the purpose of developing and overseeing the implementation of a strategic plan that will address the delivery of high quality, respectful services for trauma survivors.

Recommendation 2: Appropriate $548,540. to increase the availability of adult mental health clinical services and supports for survivors, and supervision for treatment professionals. Appropriations should be made in subsequent years based on needs assessments to increase the full array of treatment and support services across the state for all services and individuals of all ages.

Recommendation 3: Appropriate $150,000 for of training for treatment professionals and support workers in the community based and inpatient psychiatric hospital systems.

Purpose and Commission Membership

This commission was formed under Act H. 709, to evaluate and propose a manner to ensure that individualized high quality mental health and support services are provided to individuals who have experienced psychological trauma. The commission is comprised of nine individuals appointed by the Governor, and staffed by the Department of Developmental and Mental Health Services (DDMHS). Please see Appendix A for a complete listing of commission members, staff and their affiliations.

Background: Why this issue?

It is the policy of the State of Vermont to assure that quality mental health and support services are effectively administered to individuals who have experienced psychological trauma. During the 1999-2000 Legislative session it became clear that mental health and support services that were of high quality, timely, effective and respectful for individuals with a history of psychological trauma were not universally available in Vermont's system of care. When one considers the impact across the Agency of Human Services, the ramifications of not having such services is daunting. Specifically:

- 30 to 70% of persons who are in outpatient treatment for mental health problems and 40 to 72% of those in inpatient treatment have trauma abuse histories (Newmann et. al., 1998)
- 70% of all persons who entered substance abuse treatment were victims of physical or sexual abuse (SAMHSA, 2000)
- 72% of women offenders in the Corrections system were abused as children, and 72% were abused as adults (VT DOC, 2000)
- Data shows that traumatic stress responses are associated with an increase use of medical services and a variety of physical health problems (Walker, et. al., 1999)
- The Vermont Network Against Domestic Violence and Sexual Assault served 1180 victims of sexual violence, and 7255 victims of domestic violence in FY 1999.

Testimony

Four one half day and one full day meetings of the commission were held from July to October 2000. Extensive readings were made available to all members, all meetings were open to the public and informal public comment and written testimony was heard throughout the study session. In addition, the following formal testimony was heard:

7/14/00

Anthony Quintilliani, Ph.D., Howard Community Human Services
Margaret Joyal, MA, Washington County Mental Health Services
Stuart Graves, MD, Washington County Mental Health Services

8/24/00

Patricia Watson, Ph.D., National Center for Post Traumatic Stress Disorder
Arlene Averill, Vermont Network Against Domestic Violence and Sexual Assault
Mary Buttitta, MA, Dialectical Behavior Therapy Project Coordinator
Amy Weisman, Vermont Center for Crime Victim Services

9/22/00

Ann Jennings, Office of Trauma Services, Maine Dept. of Mental Health, Mental Retardation and Substance Abuse Services
Patricia Watson, Ph.D. (continuation)
Joseph Hasazi, Ph.D. The Vermont Trauma Institute

Findings

Early in the work of the Trauma Commission, the group decided to target its focus on sub-groups who were most at risk for getting inadequate service. While trauma experiences occur across the entire population, certain people seem to be especially vulnerable in Vermont because of several factors including: lack of insurance coverage, incomplete benefit packages from insurance carriers, and lack of advocacy and leadership for public attention. Groups such as children, people with a severe and persistent mental illness and the elderly clearly need a full range of services and systems development, and the State has begun to address those needs. Adults who do not meet the DDMHS criteria for Community Rehabilitation and Treatment (the program area for people with a severe and persistent mental illness) were selected for focus by the Trauma Commission, and findings and recommendations are oriented toward this group.

Definition of psychological trauma

Psychological trauma is the unique individual experience of an event or enduring stressful conditions, in which:

1. The individual's ability to integrate his/her emotional experience is overwhelmed, or
2. The individual subjectively experiences a threat to life, bodily integrity, or sanity. (Pearlman & Saakvitine, 1995)

An event or stressor creates trauma when it overwhelms a person's perceived ability to cope, and leaves that person fearing death, extreme harm or psychosis. The individual feels emotionally, cognitively and physically overwhelmed. The circumstances of traumatic events often include on-going abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion and/or loss (Giller, 1999).

The Journal of Clinical Psychiatry has published an "Expert Consensus Guideline" for practitioners working with persons who have experienced a traumatic event. The types of extreme stresses that may cause psychological trauma include:

- Sexual assault, including domestic violence
- Childhood sexual or physical abuse, or severe neglect
- Hostage/imprisonment/torture
- Witnessing or learning about a traumatic event for example, witnessing a shooting, war crimes or devastating accident, sudden unexpected death of a loved one.
- Criminal assault, including domestic violence
- Military duty in an active combat theatre
- Serious Accident
- Natural disaster

The definition of "traumatic event" is intentionally broad because no one can determine that an event, in and of itself, will in fact produce debilitating psychological trauma. The effects of exposure to a given event are highly personal and its impact is a subjective and individualized experience. Thus exposure to the same event at that same time may leave one person with a psychological trauma and another with out any long-term disruptions in their ability to cope.

In situations where trauma is ongoing and frequent such as childhood emotional, sexual or physical abuse and domestic violence, the symptoms of psychological trauma can be long lasting and extreme. Oftentimes trauma related responses are diagnosed as psychiatric illness and given labels such as dissociative disorder, borderline personality disorder or posttraumatic stress disorder. For many other persons these symptoms are inaccurately diagnosed and the presence of a recent or past traumatic life event never revealed.

Each of these reactions can be considered a normal response to a stressful event; what differs is the duration, i.e., for how long the person experiences symptoms, and to what degree they interfere with a person's ability to function in their everyday life routines. To be considered a traumatic stress response, the impact of the traumatic event must be extreme, and the person will have experienced intense fear, helplessness or horror. Typically a response of 1 month or less is considered a normal reaction, 1-3 months acute, and 3 months or more chronic (Foa, Davidson, Frances & Ross1999).

The symptoms of psychological trauma can be further exaggerated because they can co-occur with a variety of other disorders (Shalev, Friedman, Foa, Keane 2000). That is, someone experiencing difficulty due to a traumatic event may, at the same time, be experiencing other psychological problems associated with their experience. This co-occurrence makes the psychological trauma particularly difficult to treat. The most common co-occurring disorders are:

- Substance abuse or dependence
- Major depressive disorder
- Medical illness
- Somatization disorders
- Panic disorder/agoraphobia
- Generalized anxiety disorder
- Obsessive compulsive disorder
- Social phobia
- Bipolar disorder
- Eating disorders

Appendix C shows the probable existence of trauma histories for people who have a variety of other mental health diagnoses.

The trauma experience and its impact

Studies report that 30 to 70% of persons who are in outpatient treatment for mental health problems and 40 to 72% of those in inpatient treatment have traumatic abuse histories (Newman, Greenley, Sweeney, Van Dien 1998). Individuals who have a traumatic abuse history are more likely to come into contact with the public service and correctional system. Specifically:

- Adults abused during childhood are more than twice as likely than those not abused during childhood to have a higher prevalence of substance abuse (Stein et. al., 1988)
- 75% of women in treatment programs for drug and alcohol abuse report having been sexually abused (SAMSHA, 1994)
- 80% of women in prison and jails have been victims of sexual and physical abuse (Smith 1998); in Vermont, 72% of women offenders in the Corrections system were abused as children, and 72% were abused as adults (VT DOC, 2000)
- The majority of murderers and sex offenders have histories of childhood abuse (Groth 1979, Seghorn, Boucher & Prentky 1987)
- Children who had experienced multiple exposures to abuse and violence showed an increased prevalence of medical problems as adults, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease (Felitti, et al. 1998 Amer. J Preventive Medicine
- 70% of women living on the streets or in shelters report abuse in childhood (Goodman 1991)
- The Vermont Network Against Domestic Violence and Sexual Assault served 1180 victims of sexual violence, and 7255 victims of domestic violence in FY 1999.

It is commonly recognized that certain other disorders are *"trauma related,"* including dissociative, and borderline personality disorders. These disorders are commonly related to childhood exposure to physical, sexual or severe and prolonged emotional abuse. Approximately 70 % to 75 % of individuals treated for borderline personality disorder have a history of at least one self-injurious act (Clarkin, Widiger, Frances Hurt & Gilmore 1983, Cowdry, Pickar & Davis 1985). These acts can vary in intensity from ones requiring no medical treatments (light scratches and cigarette burns) to ones requiring medical or intensive care hospitalization (overdose, self stabbing, and asphyxiation).

Studies have consistently found a significant relationship between childhood trauma and the development of dissociative disorders (Bernstein & Putnam 1986, Boon & Draijer, 1993: Saxe et al., 1993). The prevalence of dissociative disorders in inpatient mental health settings is approximately 15% (Saxe et.al. 1993). Additionally, psychological trauma has been related to underlying damage to the brain structure and cognitive processes. Preliminary findings with brain scans indicate that language and sensory processes may also be altered by significant trauma (van der Kolk, 1999).

Epidemiological studies have reported that posttraumatic stress is a chronic problem for those experiencing it. In several studies, 33% to 47% of the participants reported experiencing symptoms more that one year after the traumatic event (Davidson, 1991; Helzer, 1987). The National Center for PTSD reports that trauma is associated with an increased likelihood of other psychiatric disorders.

Women are twice as likely (10.4%) as men (5%), to have a posttraumatic stress disorder at some point in their life. Approximately 88% of men and 79% of women in a large-scale study met criteria as having another psychiatric disorder. The most prevalent co-occurring disorders in men were alcohol abuse or dependence (51.9%), major depressive disorder (47.9%),

conduct disorder (43.3%) and drug abuse and dependence (34.5%). For women the disorders most frequently found with PTSD included major depressive disorder (48.5%), simple phobia (29%), social phobia (28.4%) and alcohol abuse/dependence (27.9%).

The impact of inaccurate or incomplete diagnosis

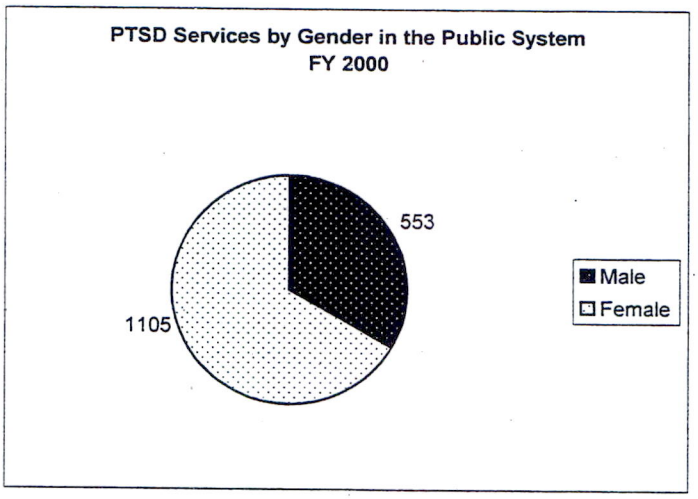
Trauma is an isolating experience. Many people, especially those with childhood abuse histories, have experienced a betrayal of trust, safety and self-worth. Often trauma survivors are reluctant to seek help for fear that their trust and safety will again be betrayed. Intense feelings of shame and self-blame may also conspire to keep individuals from seeking help. At the same time, many clinicians are unfamiliar with effective assessment and treatment of psychological trauma (Rose, Peabody, Stratigeas 1991; Carmen 1995, Jennings 1998). This lack of knowledge inadvertently results in an inaccurate or incomplete diagnosis and often in treatment failure. These treatment failures can reinforce an individuals negative self worth and in effect cause an ongoing re-traumatization for the survivor. Similarly, certain practices such as physical restraint, involuntary medication and the housing without privacy typical of some inpatient settings also result in re-traumatization for victims of sexual and physical violence by recreating the emotional and physical conditions of the original trauma event. Similarly, funding in the public system is based on a medical disease model, hence individuals who seek help are given labels that pathologize what are often normal responses to abnormal events, which may in turn cause additional stigma and devaluation of individuals' self worth.

In addition to the human cost of suffering and further re-traumatization, inaccurate or incomplete diagnosis also results in a financial loss. In a study of 275 patients with severe mental illness in the public mental health system in New Hampshire and Maryland, 43% were found to have a posttraumatic stress response, while only 2% of the patients had this diagnosis in their charts (Mueser et. al, 1998). The prevalence of an undiagnosed or misdiagnosed psychological trauma response suggests that treatment may often times be targeted at the wrong set of symptoms and thus rendered ineffective. In a 1993 study of the Canadian mental health care system Ross and Dua looked at the cost of misdiagnosing dissociative identity disorder in 15 women, prior to accurate diagnosis. It was estimated that these women spent an average of 99 months (8.25 years) in the public system. Following accurate diagnosis the average stay in the system was reduced to 31.5 months (2.6 years) again suggesting that misdiagnosis or incomplete diagnosis can result in resources and funding being targeted at the wrong issue and thus rendered ineffective. Such failures are costly in terms of individual suffering and public system dollars.

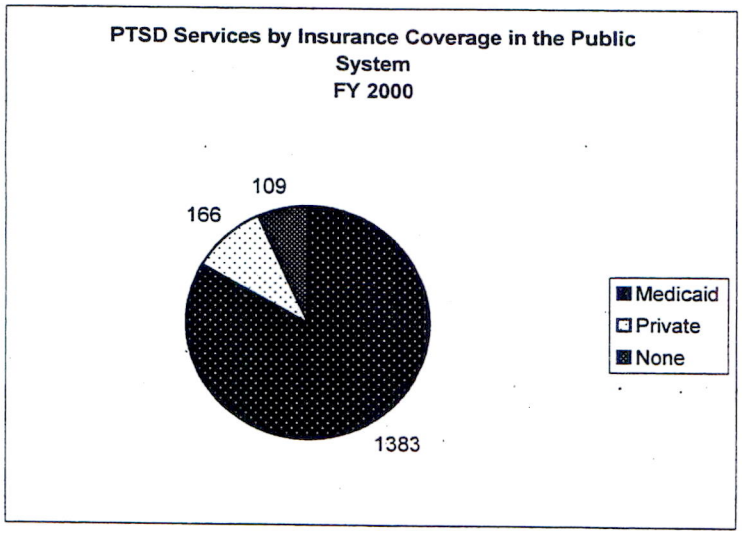
Psychological Trauma Services in Vermont

The Commission explored several aspects of trauma services in Vermont, including clinical mental health services, other community and human services, and resources for training, program development, and public education. With respect to clinical services, caution is necessary in using information based on diagnostic categories. Diagnostic information is often incomplete or misleading because people with trauma related diagnoses are often not assessed for trauma histories. For example, people with a substance abuse diagnosis often have a trauma history, but will not be given a diagnosis of Post Traumatic Stress Disorder. Approximately 1658 people with a stress disorder (PTSD and Acute Stress Disorder)—and an additional estimated 2850 with other diagnoses and probable trauma histories-- are served annually through the public systems of Medicaid/VHAP and CMHCs (see Table 1 in Appendix C).

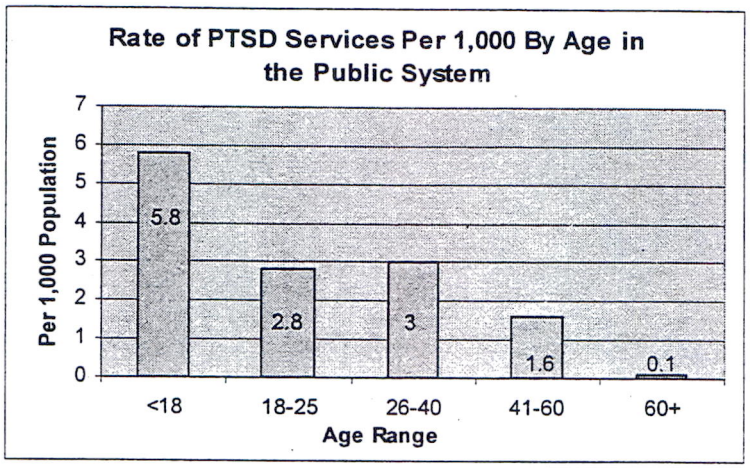
Of those with a stress disorder served in the public system (1658), 33% are men and 67% are women (see Table 2 in Appendix C).



Within public system services for people with stress disorders (1658), 83% are enrolled in Medicaid/VHAP, 10% have commercial insurance, and 7% have no insurance (see Table 2 in Appendix C). [Additional people are served through commercial insurance plans but data is not readily available for inclusion in this report.]



The rate per 1000 for people served in the public system varies considerably by age group. People over age 60 are essentially not served at all, while people under the age of 18 are served at the rate of about 5 per 1000, with adults served at the rate of about 2 per 1000 (see Table 3 in Appendix C).



Expertise and training resources about intervention for psychological trauma exists in several places in Vermont. Examples include:

- The national Post Traumatic Stress Disorder Center at the Veterans Administration in White River Junction contains considerable research, training, and treatment expertise on intervention for and understanding of psychological trauma
- The Vermont Network Against Domestic Violence and Sexual Assault provides training for rape crisis, shelter, law enforcement, and criminal justice programs, and coordinates technical assistance and public education programs statewide
- The LINCS program at Washington County Mental Health is seen as a model treatment intervention program
- The Department of Social and Rehabilitation Services (SRS) has published Guidelines for intervention with children who have experienced trauma, and sponsors several training events each year for SRS staff and other providers
- The Trauma Institute sponsors training in state-of-the art clinical interventions for clinicians treating trauma survivors
- The Addictions Academy on Co-Occurring Disorders, a training program of the Howard Center for Human Services, contains several course entries relating to treatment for trauma survivors

A current training calendar shows 15 separate training events addressing trauma issues scheduled between now and the end of 2001 throughout the public and private human service systems

There is considerable long-standing interest and commitment to improving services to survivors of psychological trauma in Vermont. Two years ago the CMHC Outpatient Program Directors prepared a white paper which included a statement of need for trauma services. The Outpatient Directors have also worked toward developing a model program description, and program entry criteria for survivors. In 1998, the Office of Vermont Health Access hosted a planning effort involving the Medicaid Managed Care health plans and providers to evaluate and recommend reimbursement policies for people who need intensive services in their benefit packages. Trauma survivors have offered to host meetings throughout the state to provide an opportunity for other survivors to have input into the planning process for Vermont's psychological trauma services. It was at the recommendation of trauma survivors, clinicians, and advocates in testimony that the legislature created the Trauma Commission. Finally, an indication of the level of interest is that Trauma Commission meetings typically attracted 20-30 interested persons in addition to Commission members.

Local programs of the Vermont Network Against Domestic Violence and Sexual Assault have been providing crisis intervention, advocacy, shelter and support services to victims and survivors of domestic and sexual violence for more than twenty years in Vermont. These sixteen programs across the state serve thousands of people every year by supporting victims and survivors in coping with the crisis of trauma, to create safety in the aftermath, and to connect with other needed supports and services.

The Trauma Commission found consensus about several critical areas of need for targeted improvement. First, specialized services for trauma victims, such as case management, service coordination and social support, are not always available, due to limited community capacity and to the fact that these services are often not covered by commercial health plans. A survey by the Vermont Crime Victims Center sent to 62 Domestic Violence program, criminal justice and advocate staff (returned by 35%) found that specialized mental health services are "spotty" or unavailable 73% of the time. Even when specialists exist, often waiting lists are a barrier to timely access. Other human services (such as childcare, housing, transportation) are spotty or unavailable 86% of the time (see Appendix B for a complete report of Survey results).

Many critical support services are often not available for trauma survivors. Services such as case management, referral, coordination between treatment and other human services, respite, childcare, transportation, and housing, are not routinely available, and even when such services are available, often the survivor is unable—without assistance—to use such services and supports. Case management services are not usually reimbursed by Medicaid or other carriers, and thus even when specialized "50 minute hour" treatment services are available, the positive effect of treatment is limited by the lack of other critical services.

The gradual weakening of public mental health outpatient services is of particular concern. Over the past decade, federal and state funding for outpatient mental health services has declined; most programs operate at a loss, and several programs are reducing costs by cutting staff. Funding from DDMHS for Medicaid is severely limited, and case management services are not currently included in the benefit package for people eligible through the Vermont

Health Assistance Plan (VHAP). Discussions are underway with the office of Vermont Health Access (OVHA) however, to add service coordination and social support services—key components of case management-- to the VHAP benefit package.

Testimony taken by the Trauma Commission also emphasized several needs in addition to specialized service availability. First, there is need for a coherent, sustainable, locus of statewide leadership to promote on-going training, coordination, public education, and local program development. The Commission was particularly enthusiastic about the model used Maine. The Office of Trauma Services at the Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services in oversees training, public awareness and support regarding the needs of trauma survivors.

Second, on-going training for all human service, criminal justice, law enforcement staff needs to be designed and coordinated at the state level. In particular training which is sensitive to avoiding re-traumatizing survivors, is needed in all inpatient treatment settings. Consistent local/regional needs assessment is seen as the first step in creating needed services, since there are substantial differences in needs among the regions.

Recommended Support and Treatment Services

Considerations in Community Support Services

For individuals who have experienced a psychological trauma, respect and sensitivity are key ingredients to help them understand and recover from their experiences. Often times peer support and advocacy services are vital in providing education and support to the survivor and their family and in helping them understand that they are not alone in their experience. These support services can prove helpful throughout the course of a psychological trauma. They often provide an important first step in prevention of further trauma by helping the individual understand that many of their feelings are normal reactions to a trauma event. For the same reasons, they can also help those individuals who may be struggling with the long-term effects of psychological trauma.

When dealing with psychological trauma it is widely recognized that both peer support and more formal treatment services should be offered in a community-based continuum of care. The continuum should range from prevention to intervention. Because individual reactions to trauma are highly personalized it is important that support and treatment services be culturally competent and respectful of the individual values and belief systems. Community based continuums should include close coordination between support services such as domestic violence programs, peer support and advocacy groups, shelters, refugee services, veterans services, sexual assault/violence services and crisis response services and clinical treatment services such as public and private mental health services. Individuals should have the option of accessing any and all support and treatment services regardless of where they enter the continuum of care.

Considerations in Prevention of Further Trauma

Helping people deal effectively with their immediate reaction to the extreme stressor may help to avoid a psychological trauma altogether or in some cases shorten the duration. Prevention and early intervention strategies include:

- Providing psycho-education

- Normalizing the reaction to the event
- Relieving irrational guilt
- Facilitating emotional recalling and retelling of the event
- Combining techniques above with formal anxiety management, group crisis intervention, cognitive therapy and/or medication if needed.

In addition persons who have experienced childhood trauma can be re-traumatized by practices in the formal mental health treatment system (public & private) and by an inaccurate diagnosis. Treatment and support staff should be well trained and well supervised to assure an accurate diagnosis and heightened respect and sensitivity for those suffering from complex symptoms.

Considerations in Formal Mental Health Treatment (public and private)
It is widely recognized that a phase-oriented treatment model is most appropriate for individuals who are suffering from a psychological trauma. Briefly, the phases include *stabilization* whereby the focus in on stabilizing crisis reactions and strengthening the individual's ability to address the traumatic event. Phase two, *processing* assists the individuals in understanding and coping with the traumatic event. Phase three, *reconnecting* focuses on reconnecting individuals with their internal strengths and unique abilities and external resources and supports (friends, family, work, and daily routines).

Working with trauma survivors can be extremely complex and particularly difficult for therapist and support people. The complexities are two-fold. First, as mentioned earlier many individuals present with co-occurring disorders and symptoms, and second, processing trauma events can cause vicarious trauma in the persons working with the individuals. That is, listening to the extremities of another persons' trauma experience may in effect traumatize treatment and support people. Because of these factors a team approach to providing treatment and support, and experienced staff supervision is always recommended.

In providing a team approach to treatment, public and private partnerships must include close coordination, and psychological trauma treatment must be integrated with treatment for other conditions such as substance abuse, medical care, depression, etc. Additionally for individuals who are long-term sufferers of psychological trauma, disruptions in their daily routines often cause disruptions in their employment, family and living situations. Thus a team approach to treatment and supports in the area of vocational, family relationships, housing and daily living skills may also be employed.

Treatment providers must make a commitment to providing care using treatment strategies which have empirical support and/or have gained clinical consensus in the field of mental health practice. Empirically based refers to practices that have been studied with experimental controls and have been proven effective. Clinical consensus refers to those approaches that are accepted as helpful by practitioners across a profession but either have not yet been tested, been tested in limited studies or cannot be completely tested because of ethical concerns. For example, it would not be ethical to withhold such treatment to one group in order to test its effectiveness in another group. Because researchers are constantly learning more and more about various approaches, treatment practice is constantly evolving. A commitment to on going education is essential for treatment providers. Current approaches to treatment are listed below.

Empirically based strategies are discussed in fuller detail in Appendix D and include:

- Anxiety management
- Cognitive therapy
- Exposure therapy
- Cognitive processing therapy
- Stress inoculation training
- Systematic desensitization
- Dialectical Behavior Therapy
- Medication therapy in conjunction with others mentioned above
- Eye movement desensitization and reprocessing (EMDR)

Treatment approaches that have *clinical consensus* are discussed in fuller detail in Appendix D and include:

- Psychodynamic Psychotherapy
- Debriefing
- Psycho-education
- Peer Counseling
- Marital and family therapy
- Group treatments
- Somatic experiencing

Commission Recommendations

The ramifications of inaction will be felt throughout the Agency of Human Services both in terms of human suffering and the ineffective use of public sector dollars. A comprehensive network should be developed throughout the Agency of Human Services to address the needs of all individuals who have experienced psychological trauma. Similarly, expertise should be available statewide to assist persons suffering from any type of trauma (physical injury, accident, psychological and physical abuse, etc.), recent or past. Specific recommendations are in three goal areas and include:

1. Goal: Leadership to assure that prevention and intervention services and supports across the Agency of Human Services are coordinated and integrated for individuals who experience psychological trauma.

Recommendation 1: Appropriate $77,739. to establish a permanent locus of responsibility within the Agency of Human Services for the purpose of developing and overseeing the implementation of a strategic plan to deliver high quality, respectful services for trauma survivors.

Activities should include the development and identification of:

- An assessment of local system of care needs statewide
- An analysis of resources and gaps across the agency of human services

- Interagency policies and procedures for the coordination, integration and delivery of treatment services, case management and community supports within the Agency of Human Services
- Evaluation of systems outcomes, clinical outcomes and cost outcomes for services and supports
- Annual funding priorities
- A plan to update practices based on empirical research and clinical consensus
- A plan for on-going professional training
- A plan for public education and prevention
- Analysis of statutory changes that may be necessary to ensure that the delivery of high quality and integrated services for trauma survivors is mandated across the agency of human services.

These activities will be undertaken with the following advisors:
- Survivors of trauma
- Public and private sector providers
- State agencies such as DDMHS, DOH, SRS, and the law enforcement and criminal justice systems.

Implementation of Recommendation 1 should include:
- One lead person within the Agency of Human Services with the responsibility for assuring the above activities are implemented in a coherent and coordinated manner
- A group that is given the responsibility of overseeing and advising regarding the development of trauma services
- The group should have at least equal representation of survivors of trauma as compared to public or private sector providers and managers
- The advisory group should hear on going testimony from survivors of trauma, public and private providers and state agencies to assure that services are responsive and of high quality

2. Goal: The available services and supports for trauma survivors should be increased immediately to addresses critical needs, and then increased incrementally over the next few years in accordance with the findings of needs assessment activities in recommendation number one.

Recommendation 2: Appropriate $548,540. to increase the availability of adult mental health clinical services and supports for survivors, and supervision for treatment professionals. Appropriations should be made in subsequent years based on needs assessments to increase the full array of treatment and support services across the state for all services and for individuals of all ages.

Year one service dollars should be allocated within the following parameters:
- Services should be based on empirical practice and clinical consensus
- Services should be delivered in partnership with survivors of trauma
- Services should be co-located in community agencies wherever access may be easiest for survivors of trauma
- Services will include a plan for evaluation of effectiveness

- Medicaid reimbursement policies should be changed to increase the range of services that are billable
- To the extent possible, funds should be matched with federal dollars
- Appropriations should be shared by DDMHS and PATH since both departments incur costs for services
- Support existing programs rather than create new programs
- Utilize public/private partnerships between local mental health and other providers and community services.

Year two allocations and beyond should address:

- The need for a flexible pool of money to allow survivors to receive services outside of the Medicaid or commercial insurance system
- A commitment to public/private partnerships and funding incentives if necessary
- An increase in funding for other community based support services such as sexual assault violence programs, domestic assault violence services, peer support and advocacy groups, shelters, refugee services, veterans services, sexual assault and domestic violence networks and crisis response to provide easy access to services
- Funding in year two and following should be allocated with the same parameters addressed in year one (empirical treatment approach, co-location of services, etc).

3. Goal: To prevent re-traumatization, inaccurate diagnosis and/or harmful treatment practices, the availability of well trained professionals and support workers should be increased.

Recommendation 3: Appropriate $150,000. for training of treatment professionals and support workers in community based and inpatient psychiatric hospital systems

Training initiatives should be coordinated by the designated Agency of Human Service lead and must be delivered with the following parameters:

- A commitment to training models and curriculum that increase awareness and decrease the potential for community re-traumatization in the community service system
- A target of 50,000 be set aside for specific staff training for those persons working in inpatient psychiatric settings, hospital emergency staff and the Vermont state hospital.
- A commitment to empirically based treatment and practices and those that have clinical consensus
- A commitment to on going supervision and support for clinicians and support workers
- Partnerships with research and training facilities in the region (VA National Center for PTSD, Vermont trauma institute, UVM, Vermont Addictions Academy, etc)
- An assessment of local delivery system training needs that includes testimony from survivors of psychological trauma
- Training activities should include on going technical assistance to local practitioners, mental health agencies and community services..

Budget Justification for Recommendations

Recommendation 1: Trauma Services Planning, Management, and Monitoring

Cost		Annual	Total
Coordinator FTE salary and fringe		$56,140.00	
Admin.½ FTE salary and fringe		$19,799.00	
Advisory Committee at $50./day for 6 members for 6 meetings		$1,800.00	$77,739.00

Recommendation 2: Direct Treatment and Support Services

Assumptions

- CMHCs currently serve an estimated 3000 people each year who have trauma histories [40% of Adult Outpatient caseload of 7500]
- Of the 3000, approximately 1350 [45%] are Medicaid eligible
- While treatment, emergency and some social support services are reimbursed by Medicaid in CMHCs, case management [as defined in Medicaid's "Targeted Case Management"] services are not currently reimbursable
- In order to provide case management services [coordination with other community services such as domestic violence, vocational rehabilitation, housing, transportation, child/family services] for current CMHC trauma survivors, it is estimated that 1/3 of clients need 2 hours of service per month, 1/3 need hour of service per month, and 1/3 do not need additional service
- It is assumed that services would be phased in during the first year so that utilization and cost is ½ of tl second, full year, utilization and costs
- Some portion of the CMHC caseload of trauma survivors who are uninsured also need case managemen services
- Some portion of trauma survivors served through commercial insurance plans also need case manageme services

A) Costs for "Targeted Case Management" for current Medicaid eligible trauma survivors at CMHCs

Two hours/mo. for 1/3 of 1350 clients for 6 mos. [12 hrs X 449 people] = 5388 hours
One hour/mo. For 1/3 of 1350 clients for 6 mos. [6 hrs X 449 people] = 2694 hours

Total Hours 8082 hours

X $75.32 / hour

Total Cost = $608,736.

X Medicaid match rate .40

General Fund Cost = $243,494.

B) *Costs for case management for commercially insured and uninsured*

Two hours/mo. for 225 clients for 6 mos. [12 hrs X 225 people]	=	2700 hours
One hour/mo. for 225 clients for 6 mos. [6 hrs X 225people]	=	350 hours
Total Hours		4050 hours
	X	$75.32/hour
General Fund Cost		**$305,056.**

Total General Fund Cost for 1348 Medicaid, Insured, and Uninsured for 6 mos. of case management service **$548,540.**

Total General Fund Cost for Year 2 $1,097,080.

Recommendation 3: Training and Technical Assistance

ACTIVITY	COST
Assessment of Training Needs	
Community Mental Health Practitioners Assessment Consultation (5 days X $500./day)	$2,500.00
Correctional Staff Assessment Consultation (5 days X $500./day)	$2,500.00
Social Services staff Assessment Consultation (5 days X $500./day)	$2,500.00
Travel/meeting expenses	$2,500.00
Targeted Training	
Community Mental Health Practitioners Trainer's fee (20 days X $1500.day)	$30,000.00
Psychiatric Inpatient Practitioners Trainer's fee (20 days X $1500./day)	$30,000.00
Correctional Staff Trainer's fee (5 days X $1500./day)	$7,500.00

Social Services staff Trainer's fee (5 days X $1500./day)	$7,500.00
Room Rent, Meals, Breaks, Facilities for Training events	$30,000.00
Follow up TA/Consultation for Implementing New Practices	
Community Mental Health Practitioners Consultant Fee (30 days X $500./day)	$15,000.00
Psychiatric Inpatient Practitioners Consultant fee (20 days X $500./day)	$10,000.00
Correctional Staff Consultant fee (5 days X $500./day)	$2,500.00
Social Services staff Consultant's fee (5 days X $500./day)	$2,500.00
Travel meeting expenses	$2,500.00
TOTAL FUNDS REQUESTED:	**$150,000.00**