APPENDIX A

MEMBERSHIP LISTING

TRAUMA COMMISSION MEMBERS

NAME & ADDRESS	CATEGORY
Margaret Joyal WCMH 700 No. Main Street Barre, VT 05641	Community Mental Health Center margaretj@wchms.org
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Barbara (Bonnie) Finnigan 35 Dubois Drive So. Burlington, VT 05403	Human Resource Coordinator, Private Sector finnigan@vna-vermont.org

APPENDIX B

Vermont Crime Victims Center Survey

Hello Crime Victim Advocates in Vermont!

A Trauma Commission was formed this past legislative session for the purpose of evaluating and proposing a manner to ensure that individualized, high quality mental health and support services are provided to individuals who have experienced psychological trauma.

In order to assist them in this endeavor, the Commission would like to know your opinion on the scope and quality of services to trauma victims in Vermont. Please take a few moments to complete this brief survey.

Please circle response and/or write in your responses.

1. What is your experience in finding specialized mental health services for trauma victims?

   a) Generally available b) Spotty c) Generally unavailable

Specific comments?

2. Who do you generally refer to?

   a) CMHC b) Private Practitioner c) Other (please specify)

3. What is your experience in finding other human services (i.e. childcare, housing, etc) for trauma victims?

   a) Generally available b) Spotty c) Generally unavailable

Specific comments?

Thank you for taking the time to complete this survey. Please forward your responses to Amy Weisman at the Vermont Center for Crime Victim Services at aweisman@ccvs.state.vt.us.

If you have any questions about the Trauma Commission, please contact John Pierce, Assistant Director, Division of Mental Health at 802-241-2609.

SURVEY CIRCLED RESPONSES

1. What is your experience in finding specialized mental health services for trauma victims?

   a) Generally available - 6

   b) Spotty - 8

   c) Generally unavailable - 8

2. Who do you generally refer to?

   a) CMHC - 7

   b) Private Practitioner - 9

   c) Other (please specify) - 6
   Anyone accepting new clients, Clara Martin Center, hearing counselors who know sign in Northern part of VT, those who are fluent signers and understand deaf culture, Brattleboro Retreat's outpatient services, Northern New England Clinical Associates, UCS, Mountain House.

3. What is your experience in finding other human services (i.e. childcare, housing, etc) for trauma victims?

   a) Generally available - 3

   b) Spotty - 7

   c) Generally unavailable - 11

   *One person responded "Not applicable to date".

SURVEY SPECIFIC COMMENTS

1. What is your experience in finding specialized mental health services for trauma victims?

Specific comments:

- In Rutland County I have found that there is a significant amount of counselors/therapists in practice, however, it is extremely difficult to find someone who is taking new clients. I have had rape victims not be able to find a counselor for months because everyone is so busy.
- We have several good trauma counselors in the area. (Lamoille County)
- Since many of the trauma victims we work with lack adequate health insurance, their only option is mental health. Mental health services in the N.E. Kingdom lack the capacity and resources to serve these victims.
- Some private providers have the training etc. that we look for. We have not had very good responses form NKHS. We are interested in folks with specific knowledge re: domestic violence and sexual assault victimization and sensitivity to the dynamics of such. (N.E. Kingdom)
- Generally it is difficult to locate viable therapists who work specifically with trauma victims in more rural areas. The areas where there seems to be sufficient coverage in this area are Chittenden County and Washington County, otherwise therapists who are comfortable with this issue are unable to take on new clients or are non-existent.
- Rutland Mental Health has been a problem for services for many years. For awhile they were doing better kids services but that part was closed down three years ago. In general they will take as few clients as possible. Always trying to push what should be their clients off onto other agencies.
- Depends on the degree of mental health problems – crisis services available and can be adequate. General counseling or treatment programs can take months for an appointment.
- No services know enough about Deaf Communication and don't hire interpreters.
- It is hard to find therapists who understand deaf culture. There is only a handful in the state.
- Spotty - Especially if the victim has Medicaid and no insurance. In this case, the only option is the community mental health agency (NCSS in Franklin/Grand Isle Counties). Sometimes, even at NCSS, the sliding scale fee is too high.
- Working in a specialized field of traumatization, sexual assault, I find that the community has really identified specific mental health providers who provide very focused treatment. (Chittenden County)

- My children and myself have experienced the effects of PTSD after being involved with the system for five years. We finally came to the knowledge of what was occurring to us and received appropriate assistance toward our recoveries from out of state resources.
- We have extremely limited, if no, mental health services in our area. Will not take adults even with insurance unless "family"/"child" issues. (Windsor County)

2. Who do you generally refer to?

Specific comments:

- Recently we developed a questionnaire for practitioners asking about their fees, the types of patients they serve (adults, teens, kids), their training in DV and SX Assault, their interest in such training and their fee scale. We hope to use the responses we received to compile a referral list. (N.E. Kingdom)
- I generally refer to private practitioners. I would refer to CMHC if I felt that there were individuals who had the experience in this area.
- Anyone we can find who is able to take limited insurance.
- Other community programs.

3. What is your experience in finding other human services (i.e. childcare, housing, etc) for trauma victims?

Specific comments:

- Again, in Rutland County there is an extreme shortage of available resources for trauma or crime victims. There are fee's involved and insurance and Victims Compensation do not cover some of this. There is also the problem of finding an agency/counselor who is available when the crisis is in need of attention.
- This is a huge problem.
- Usually these resources are available, but often due to the trauma, victims may not be able to follow through on their own with paperwork, etc.
- Due to our participation in a HUD grant, housing has become more accessible but is still an issue. Affordable quality childcare is difficult to find and secure, especially for kids who have issues of their own due to witnessing or victimization. (N.E. Kingdom)
- Housing is a big issue as is childcare. Housing is limited, from what I can tell, everywhere. There are huge waiting lists for apartments via VT Housing Authority and immediate emergency placements are becoming increasingly difficult to accomplish. Childcare, again, is an issue. Unless the parent of the child already is somehow served by the system, locating affordable and often unanticipated childcare is difficult. More difficult is locating childcare for children who are experiencing trauma and have behavioral problems as a result.
- Rural area - very limited options and services (Caledonia County)
- All other networking is very good to good. (Rutland County)
- Housing for anyone, especially trauma victims, is very difficult in Vermont, especially Chittenden County. Childcare can take weeks and is expensive. Court cases can also take a long time.
- Housing is impossible these days and childcare. I haven't gotten into that yet.
- It is even more difficult for deaf due to the communication barriers.
- Housing is especially difficult to find in this area (Franklin County).
- Often there are agencies who provide specific needs, however, the waiting list or lack of openings can be a real barrier to expedited services. Lack of funding, also, can be a factor that prohibits certain needs from being met. (Chittenden County)
- During the past six years it has been a continual struggle for the ethical treatment for PTSD sufferers.
- Most human services that I am aware of are through the Department of Social Services and in order to help victims obtain those services,

they need to fill out paper work for assistance and some do not qualify thus losing out on the individual needs they may have. (Bennington County)

- They receive housing priority where there is domestic violence but all resources are limited. (Windsor County)

4. What services that are not available now, would you like to see available for trauma victims?

Specific comments:

- I would like to see counselors who take new clients, without a 2 - 6 month waiting list. Trauma/crime victims are in need of services now, and to put it off does no one any justice. I think that Victims Compensation needs to expand on what they pay for. I realize that they have a specific amount of money, but there are other services that could be paid for, or lend their assistance in. I would like to see a crisis/trauma network set up that would be available for individuals when they need it. This would include counselors, childcare for medical visits and court hearings, and a list of attorney's who would be willing to work pro bono (for a short and limited period of time) to assist victims in trial and depositions.
- Financial assistance.
- More mental health and legal services.
- Free legal services for abuse victims that are challenged by mental health issues. Including training re: mental health issues to such attorneys. Responsive, affordable mental health services specifically for victims of domestic violence and sexual assault. Mandated training to mental health staff re: DV, SX Assault, the dangers of couples counseling where there is abuse, Anger management vs. batterers intervention, etc.
- Transportation and housing are the biggest problems we face in our servicing area. (Randolph)
- Shelter for battered women. (Orange County)
- Increase in viable treatment options. Affordable housing, childcare. Transportation - particularly in rural counties with limited public transportation. Telephone access, again for those individuals in rural areas. Would like to see groups developed to serve victims of trauma who would benefit from group process. Family therapy providers who will work with families on the residual effects of trauma. Outreach workers who would travel to the homes of some trauma victims who have become increasingly isolated as a result of the anxiety and fear they are experiencing. The mental health hotlines could be increasingly useful in more rural areas if trauma victims had access to telephones. More providers who can work in alternative methods of communication for those people who have difficulty expressing their experience verbally. (Art therapy is a very viable option for trauma victims and good for children who have not yet formed strong verbal skills. And finally, the forgotten ones: the elderly

...their years of life might give people the impression that they can buffer trauma, actually it isolates them further and takes a great toll on their health. More outreach and more providers are definitely necessary to work with this population in their own environments.

- Basically no services in place now without calling on resources out of immediate area.(Caledonia County)
- I would like to see better, more compassionate mental health services here in Rutland County.
- Support groups and professionals trained to help these victims. Perhaps those that offer services could work on a sliding scale to help defray costs to victims. Would like to see those that would work with families as a group when there is a trauma that affected the whole family, as well as individual work. Maybe trainings/guidance for family members that are trying to help trauma victim and victim is not receptive to counseling...a way to help other caretakers or friends or family members who are dealing with this situation.
- Housing - transitional and permanent; Transportation - we use bus tokens and taxi vouchers - is limited; Money - for changing locks, phone cards, cell phones, day care, long-term recovery help. (Chittenden County)
- I would like to see 24-hour emergency beeper system for interpreters to be called for from any agencies or shelter Deaf victims.
- I hope that in the future each mental health agency is able to provide specialized services for deaf clients. They may do this hiring a therapist who is a fluent signer and understands deaf culture, or by contracting with another agency (such as VT Center for the Deaf & Hard of Hearing), that is able to provide these services.
- More available therapy - accessible/affordable therapists; more affordable housing; better and more affordable attorney's; more legal aid services.
- There does not seem to be an immediate availability for trauma victims, particularly child victims. (Orleans County)
- Education is essential for the recognition of the appropriate treatment of individuals that have these experiences. Foremost is the understanding to the physiological aspects that are occurring in order not to further re-traumatize individuals, but to support them in their healing. Pharmacological treatments are available, but few individuals understand the biological underpinnings to what is happening for these people. It's my belief that individual civil rights are being overlooked by agencies not handling traumatized people in the correct way and are offering only pharmacological and cognitive treatments. The consciousness and the body seem to be forgotten in these processes. Here are some references: www.trauma-

pages.com/vanderk4.htm, www.healing-arts.org/tir, www.healing-arts.org/children.

- Perhaps more in the way of support groups, which are really accessible, that's within the local area. (Windham County)
- Massage Therapy and other alternative therapies.
- Childcare when court related dates or therapy dates have to be attended. Some Victims do not have telephone access and or/transportation, making communication very difficult, in some cases non-existent. I think that victims need a holistic approach to service. They should have one contact person versus many different people and there should be regular case meetings with those team providers. (Bennington)
- Counseling would be key. A support group could be helpful in Windsor County.
- Counseling and therapy without long waiting lists. (Orleans County)

APPENDIX C

Data Tables: Mental Health Treatment in the Public System

TABLE 1

Services Supported by Medicaid/VHAP and DDMHS		
Diagnosis*	**Clients with Diagnosis**	**Predicted** Number**
Stress Disorders	1658	
Schizophrenia	1520	654
Borderline Personality	101	89
Dissociative Disorders	82	77
Substance Abuse	5891	3888
Major Depressive Disorders	5701	2851

* Diagnoses based on the following DSM IV diagnostic codes:

Stress = Post Traumatic Stress Disorder (30981) or Acute Stress Disorder (30830)
Borderline Personality (30183)
Dissociative Disorders (30012-30015, 30060)
Substance Abuse (30390-30440, 30480, 30500, 30540-30570)

**Based on citations in the literature predicting the likelihood of people with certain diagnoses having a history of trauma.

Schizophrenia	43% (Mueser, 1998)
Borderline Personality Disorder	81% (Herman, 1989)
Dissociative Disorders	94% (Boon, 1993)
Substance Abuse	66% (SAMHSA, 2000)
Major Depressive Disorders	50% (Kessler, 1995)

TABLE 2

Gender and Payer Source of People Served In Medicaid/VHAP and DDMHS

Diagnosis	Gender	Clients With Dx	Insurance Coverage		
			Medicaid	Private	None
Stress Disorders*	Male	553	477	43	33
	Female	1105	906	123	76
Totals		**1658**	**1383**	**166**	**109**
Schizophrenia	Male	821	479	258	84
	Female	699	503	156	40
Totals		**1520**	**982**	**414**	**124**
Borderline Personality	Male	2	2	0	0
	Female	99	90	7	2
Totals		**101**	**92**	**7**	**2**
Dissociative Disorders	Male	15	11	2	2
	Female	67	51	12	4
Totals		**82**	**62**	**14**	**6**
Substance Abuse	Male	3946	1557	1011	1378
	Female	1943	1199	405	339
	Unknown	2			2
Totals		**5891**	**2756**	**1416**	**1719**
Major Depressive	Male	1918	1215	497	206
Disorders	Female	3783	2714	807	262
Totals		**5701**	**3929**	**1304**	**468**

*** Post Traumatic Stress Disorder and Acute Stress Disorder**

TABLE 3

Age of people served by Medicaid/VHAP & DDMHS					
Diagnosis	**Age**	**Clients With Dx**	**Insurance Coverage**		
			Medicaid	**Private**	**None**
Stress Disorders*	<18	812	751	40	21
	18-25	164	115	20	29
	26-40	414	328	56	30
	41-60	259	184	46	29
	60+	9	5	4	0
Totals		**1658**	**1383**	**166**	**109**
Schizophrenia	<18	100	85	1	14
	18-25	133	71	21	41
	26-40	401	259	87	55
	41-60	638	411	214	13
	60+	247	156	91	1
Totals		**1520**	**982**	**414**	**124**
Borderline Personality	<18	4	2	1	1
	18-25	24	21	2	1
	26-40	52	48	4	0
	41-60	20	20	0	0
	60+	1	1	0	0
Totals		**101**	**92**	**7**	**2**
Dissociative Disorders	<18	3	2	1	0
	18-25	8	6	1	1
	26-40	25	16	5	4
	41-60	42	37	4	1
	60+	4	1	3	0
Totals		**82**	**62**	**14**	**6**
Substance Abuse	<18	728	494	157	77
	18-25	1239	390	337	512
	26-40	2296	1086	474	736
	41-60	1498	739	390	369
	60+	130	47	58	25
Totals		**5891**	**2756**	**1416**	**1719**
Major Depressive	<18	938	823	95	20
Disorders	18-25	756	521	144	91
	26-40	1851	1313	353	185
	41-60	1702	1102	456	144
	60+		170	256	28
Totals		**5701**	**3929**	**1304**	**468**
*** Post Traumatic Stress Disorder or Acute Stress Disorder**					

APPENDIX D

Empirically based and clinical consensus treatment approaches

Empirically-Supported Trauma Treatments

The trauma treatment research field is still young, and treatment research can be complicated and difficult to conduct. Because of this, comparisons of different treatments for PTSD are scarce; therefore, when evaluating the literature, lack of empirical evidence does not equate with lack of treatment efficacy. The current process by which trauma experts evaluate treatment options is to study the empirical literature, as well as take into account clinical consensus on treatments which have proven effective in case studies or across clinical settings. The choice of a treatment modality is based on many factors, including unique client life challenges, side / potential negative effects, cost, length of treatment, cultural appropriateness, therapist's resources and skills, client's resources and stressors, co-morbidity of other psychatric symptoms, the fluctuating course of PTSD, fostering resilience, stability and relapse prevention, and legal, administrative, and forensic implications

While there is limited empirical literature for the treatment of trauma-related conditions, there are a number of treatment approaches which have gained solid empirical support. These treatments have shown promising results across a number of different contexts and with different trauma populations, and merit strong consideration when developing a training program for clinicians. Listed below are those treatments which have gained the most empirical support, followed by treatments which have received solid clinical consensus as exhibiting effective results with trauma survivors.

Cognitive-Behavioral Techniques (CBT)

There are more published well-controlled studies on CBT than on any other PTSD treatment (over 30). Effective CBT techniques for trauma include exposure therapy, cognitive therapy, cognitive processing therapy, dialectical behavior therapy (DBT) stress inoculation training (SIT), biofeedback and relaxation (when used in conjunction with other CBT techniques), and assertiveness training. In general, cognitive behavioral techniques have proven very effective in producing significant reductions in PTSD symptoms (generally 60-80%). The magnitude and permanence of treatment effects appears greater with CBT than with any other treatment. The techniques are generally carefully scripted in treatment manuals and are usually 9-16 sessions in length (making it a more easily trainable treatment model). Careful training of the therapist is important, as this treatment is demanding on both patient and therapist.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR has been shown to be more effective than placebo wait list, psychodynamic, relaxation, or supportive therapies. While research comparing EMDR to more standard cognitive behavioral techniques is still young, significantly better results have been obtained with CBT than with EMDR, particularly at three month follow-up, showing greater sustainability of CBT's results. In trying to determine the which components of EMDR are necessary for treatment effects, one study showed same results of EMDR whether eye movements were used or not.

Psychodynamic Therapy

Research on the use of psychodynamic therapy is difficult to conduct, because psychodynamic techniques do not focus on symptom reduction, but rather on more fluid, intra- and interpersonal processes. There is a rich literature on psychoanalytic psychotherapy, which is mostly derived from detailed case histories rather than from controlled clinical trials. To date, there has been only one randomized clinical trial on the efficacy on PTSD symptoms reduction, in which18 sessions of Brief Psychodynamic Psychotherapy was shown to effectively reduce PTSD intrusion and avoidance symptoms by approximately 40%, and improvement was sustained for 3 months. These results were comparable to results with hypnotherapy and systematic desensitization, and significantly greater than a wait list group that received no treatment. While clinicians often support the utilization of psychodynamic techniques in treatment of trauma, particularly more complex trauma, much more research is needed to demonstrate their efficacy for PTSD.

Group Treatments

While various studies have shown beneficial effects of most group treatments with respect to psychological distress, depression, anxiety and social adjustment, there have been few rigorous tests of group treatments in which reduction of PTSD symptoms has been measured. Three studies of **CBT** group treatments (including Cognitive Processing Therapy (CPT), Assertion Training, Stress Inoculation Therapy (SIT)) have been conducted with **women** traumatized by childhood or adult sexual abuse.
All PTSD symptom clusters were reduced 30-60%, and improvement was sustained for six months. One **CBT** group treatment for **combat veterans** showed a 20% reduction in PTSD symptom severity. One study of **psychodynamic** group treatment found an 18% reduction in PTSD symptoms among **women** with PTSD due to childhood sexual abuse. One controlled trial of **supportive** group treatment for **female** sexual assault survivors showed a 19-30% reduction in intrusion and avoidance symptoms, which was maintained for six months.

Inpatient Treatment

There have been no satisfactory studies on inpatient treatment for PTSD and trauma-related conditions. However, clinical consensus agrees that it is appropriate for crisis intervention, relapse prevention, complex diagnosis, and intense procedures.

Marital and Family Therapy

There are no research studies done on the effectiveness of either systemic or supportive marital/family therapy for the treatment of PTSD. However, because of trauma's unique effects on interpersonal relatedness, clinical wisdom indicates that spouses and families be included in treatment for partners, parents, or children with PTSD.

Social Rehabilitative Therapies

While social rehabilitative therapies have been proven effective in chronic schizophrenic and other persistently impaired psychiatric cohorts, they have yet to be formally tested with PTSD clients. Since they appear to generalize well from clients with one mental disorder to another, it is reasonable to expect that they will also work with PTSD clients. Clinical consensus agrees that appropriate outcomes would be improvement in self-care, family function, independent living, social skills, and maintenance of employment.

Treatments for PTSD with Children

To date, there has been very little research on treatment for children with PTSD, partly because it requires identification of the disorder and help-seeking behavior by a caring adult, and partly because traumatic responses are much more difficult to ascertain in children. Additionally, most research with children is related to a one-time event, versus chronic maltreatment. Of the research that has been conducted, the best results are achieved when the family is included in treatment, and school-based treatments may offer the most efficient and effective approach for many children. Clinical consensus agrees that early intervention with children is important, including some components of art or play therapy, cognitive-behavioral techniques, school and/or family intervention, and sensory/motor/learning interventions if necessary.

Hypnosis

While research on the use of hypnosis with trauma survivors indicates very little improvement in trauma symptoms, clinical consensus indicates that it can be helpful as an adjunctive versus a primary treatment, especially with disssociation and nightmares.

Creative Therapies

There is currently no controlled evidence on creative therapies (art, drama, music, body-oriented). The clinical consensus is that it is important in impasses, helpful with breakthroughs, and uniquely designed to address specific somatic manifestations of trauma (i.e., sensory defensiveness, somatic memories, etc.). There is some caution with somatic treatments around physical safety and boundaries, so it is important that therapists be well-trained in this modality.

Preventive Treatment Approaches

While there is no well-controlled empirical support for debriefing as preventive of PTSD and some evidence for harm, there is strong clinical consensus that it is a very important measure following a single-incident trauma. Limited evidence suggests that debriefing may be a sufficient intervention for trauma survivors are not at risk to develop Acute Stress Disorder (ASD) or Post Traumatic Stress Disorder (PTSD), but that those at higher risk are best treated individually with a more intensive treatment model. There has been recent empirical support for brief (five-session) CBT-based treatment as being significantly more preventive of PTSD than supportive treatment (Bryant et. al, 1999).

However, motivation is an important component in treatment success, and there are a number of symptoms which rule out rigorous trauma-focused interventions in early phases post-trauma.