



A Trauma-Informed Guide for Working with Youth Involved in Multiple Systems

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For the briefer version of this product, *Trauma-Focused Supplement for the Crossover Youth Practice Model*, [click here](#). This brief version is designed specifically for users of the Crossover Youth Practice Model.

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The purpose of this guide is to help those working with youth involved in multiple systems (YIMS) and their families to use a traumatic stress perspective and provide trauma-informed care.

This guide was developed by the National Child Traumatic Stress Network (NCTSN) Multisystem Involved Youth Collaborative Work Group and Georgetown University's McCourt School of Public Policy Center for Juvenile Justice Reform.

YIMS are children and adolescents who are under the care or supervision of multiple child and family-serving systems. They include “crossover youth” or “dually involved youth” who are involved in child welfare (CW) and in the juvenile justice (JJ) system. In addition to CW and JJ involvement, YIMS are also often simultaneously involved in an array of other service systems including immigration, legal, education, family services, physical and behavioral health systems and systems designed to serve those with developmental disabilities or who experience homelessness.

YIMS are disproportionately exposed to trauma. Trauma can be the result of maltreatment, family, intimate partner, school, and community violence, war, refugee trauma, hate-based violence, stalking, rape, trafficking, bullying, severe injuries, attachment disruptions, and traumatic deaths or losses of significant others. As a result of implicit and explicit racial bias, historical trauma, and systemic racism, many youth of color are further exposed to psychological trauma due to disparities in access to health-care, economic opportunity, community resources, and education. They are also often subjected to harsh disciplinary measures at school, poor representation in the courts, and confinement and maltreatment when involved with law enforcement and juvenile justice systems. These factors are magnified for youth who are subject to discrimination based on their race, culture, disability, gender identity, sexual orientation, and/or immigration status.



Many YIMS experience severe traumatic stress reactions that take the form of behavioral, emotional, relational, learning, and health problems. Trauma-informed services help YIMS recognize, understand, and cope effectively with these reactions so that they can make developmentally appropriate healthy choices and achieve prosocial goals. A trauma-informed approach involves a supportive collaborative response that is respectful of the youth and a family's race, culture, identity, and personal preferences. This requires providers working with YIMS to be able to:

- accurately identify and respond to youths' needs
- recognize and enhance youth strengths, including those related to cultural identity
- support a system-wide, developmentally appropriate, and racially and culturally responsive approach for all aspects of youth care
- create transparent communication and coordination between youth serving systems
- recognize and manage their own stress reactions effectively

The ultimate goal is to enable YIMS to replace their traumatic stress reactions with healthy and safe ways of living as productive members of society.

To protect privacy, the case vignettes do not describe any single youth or family but instead are composites based on the lives and experiences of many youth and their families. The vignettes will provide real-life examples of key points in each section of this guide.



Joshua:

A Latino youth who was 4 years old when child welfare (CW) removed him from his biological father's care due to physical abuse and neglect. His mother left the family after Joshua's birth and her whereabouts have been unknown since. CW placed Joshua in foster care. When the CW worker initially asked Joshua what he needed, he replied, "Just hugs." After three years of missed opportunities to help Joshua adjust to the separation, heal from abuse, and build resilience, Joshua began outpatient counseling at age 7, following a short-term mental health (MH) hospitalization for self-harming behavior. At age 8, Joshua was expelled from his school after verbally threatening a teacher. For the next several years, providers in the CW, MH, and school systems felt they were doing their best to help Joshua as they moved him through multiple foster homes and, as a result, several different schools.

Service providers attempted to provide Joshua with safety and work towards permanence through his childhood and adolescence, but as a system, failed to create an environment that best served his well-being. When Joshua turned 17, he became involved with the JJ system after he was charged with attempted armed robbery. All he remembered from the incident was waking up in a cell with bruises and feeling "all messed up."

Joshua learned the details regarding his legal charges for the first time while in court in front of the judge and lawyers. During the court appearance, Joshua's CW social worker provided a summary of Joshua's early life. She also discussed Joshua's regular use of alcohol and known experimentation with other drugs. The caseworker described him as distant from his foster family and disconnected from his biological relatives and family/cultural heritage. She did not note Joshua's hospitalizations for mental health issues during childhood and adolescence. There was no mention of Joshua's strengths, hobbies, talents, or his interest in connecting with a mentor. She also did not mention that Joshua's biological grandfather occasionally reached out to the caseworker to ask about his well-being. Based on Joshua's case history provided by the CW worker, the judge decided to send him to a drug rehabilitation program instead of jail. He was not referred for any additional interventions or supports. After Joshua completed the inpatient treatment, he moved to a group home and eventually graduated from high school. CW was planning to keep his case open until his 18th birthday.



Jordyn:

A 16-year-old multiracial female lives with her White mother, two siblings – Jason (age 8) and Jade (age 4) – and her Black father. Her mother works two jobs, and her father is deployed on his fourth tour to Afghanistan. Her mother relies on Jordyn to help with her siblings while she is working. Approximately a year ago, Jordyn met a 30-year-old male named J.P. online. They began to meet in person and although he seemed "nice" at first, J.P. eventually sexually assaulted Jordyn and began commercially sexually exploiting her. Jordyn, previously an honor roll student, was suspended several times during her sophomore year due to skipping school and getting into fights with other girls. A peer reported to a teacher that Jordyn was texting with J.P. to set up a "date" with a man for money. The teacher made a report to CW who began an investigation and found that Jordyn had made a sex tape and was being pressured by J.P. to do another, which Jordyn felt compelled to do because she knew her mother was struggling with money, and she saw it as a way to help her mom with the household finances.

Jordyn witnessed domestic violence between her mother and father on three occasions prior to his current deployment. On one occasion a neighbor called the police, who came to the home but did not arrest or detain either parent. Jordyn's father reportedly had been drinking heavily on each occasion. Jordyn said her father was very different when he returned home from his last combat tour. He seemed jumpy, sad, paranoid, and drank heavily. She said it was hard to see her parents fight, and that one time she went to the hospital with her mother after her mother's eye was injured. One time, her father threatened her mother with a knife and Jordyn said she was afraid that he might kill her if they get into another fight.

Presently, Jordyn describes feeling irritable, has trouble falling asleep, and experiences frequent nightmares. She does not want to think or talk about the sexual assault or exploitation. She feels disconnected from others and cries a lot. She worries that her family will lose their house because of finances. She fears for her mother's safety. She blames herself for allowing J.P. to exploit her and the stress it has caused her family, but says she wants to stay with him because "he really cares about me." She wants her father to get help, but he has refused because he believes that would end his military career. As a result of the problems they face, Jordyn and her family have come to the attention of multiple service systems including school, child welfare, law enforcement, and the military. Unfortunately, these systems have not worked together to coordinate services and provide comprehensive support for Jordyn and her family.

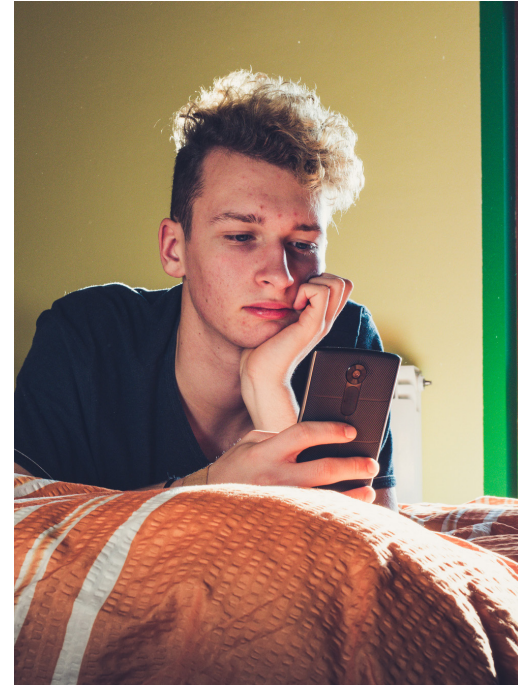
Trauma exposure is a life-altering experience that impacts a child's development, especially for youth who are exposed from an early age and then repeatedly over time; however, YIMS are often resilient in the face of adversity, and trauma-informed services may provide a pathway to recovery that is based on a recognition of both the adverse impact of trauma as well as the resilience and strengths youth have developed to survive.

Psychological trauma has two parts – **exposure** and **reactions**:

- Exposure to traumatic events and victimization, which can lead to
- Traumatic stress reactions, which are cognitive (thoughts/beliefs), emotional and/or behavioral adaptations often designed to help youth deal with threat and injury.

Trauma-exposed youth adapt to real or perceived threats in an attempt to protect themselves and significant others. Without conscious effort, their bodies react with the classic stress response: freeze (e.g., becoming tense, watchful, and on-guard to prepare for danger), fight (e.g., putting up a defense against the actual or potential danger, including fighting back if feeling attacked), flight (e.g., running away, avoiding, and isolating), or shutting down (i.e., mentally and emotionally if there is no other escape). These youths' emotional and behavioral problems can thus be traced back to adaptive attempts to survive trauma.

Trauma reactions can be adaptive in crises, but on an ongoing basis, they take a toll on health, learning, relationships, self-concept, and safety. These reactions may include challenges with relationship development, trust of people and institutions, management of emotion and behavior, addiction, sleep disturbance, and vulnerability to victimization. These challenges can result in trouble at school, at home, with peers, and with law enforcement.



Psychological trauma exposure comes in many forms:

- Family-based traumas such as child emotional, physical, and/or sexual abuse and neglect as well as exposure to intimate partner and family violence.
- School and community-based traumas such as physical or sexual assaults, severe bullying, trafficking, hate crimes, or abuse by authorities.
- Chronic severe environmental adversities such as war, poverty, disasters, forced displacement, racial, ethnic, or other identity-based stigma and discrimination, and homelessness.
- System-induced trauma such as identity-based incarceration, prolonged captivity, isolation, torture, or sudden separation from primary caregivers.
- Historical and intergenerational trauma such as slavery, genocide, and ethnic cleansing.

Traumatic stress reactions experienced by YIMS, like Jordyn and Joshua, can lead to or exacerbate problems with family, peers, and school; substance use; addictive or risky behaviors; sleep, physical health; sexuality; homelessness; or being sexually exploited or trafficked. These problems often escalate—despite efforts by providers in many systems—if the impact of trauma on a youth's behavior goes unrecognized and service providers do not coordinate in providing trauma-informed care. In some cases, the impact of trauma is more difficult to detect because the youth seems to be coping successfully but is actually deeply troubled or severely shutdown. Research shows that high functioning youth who have experienced racial trauma may pay a price for resilience in the form of physical health problems caused by the effort required to adapt and survive trauma.¹

Traumatic stress reactions vary from person to person. Many symptoms develop out of a youth's attempt to survive or cope with their exposure to traumatic events:

- Fear, worry, avoidance of people, places, or things; physiological arousal such as sleep problems, feeling on edge, nervous, chronic physical complaints or health problems
- Depression, isolation, hopelessness, withdrawal, feeling shut down or numbed out, dissociation (“spacing out”), self-harm, suicidality
- Problems forming or maintaining healthy relationships, problems with boundaries, difficulty attuning to other people's emotions, and/or perspective taking
- Distrust, anger, hypervigilance, defiance, negativity, reactive aggression
- Difficulties in school, learning problems, distractibility, poor judgment
- Unhealthy self-concept, alienation, shame, guilt, self-blame, poor self-esteem
- Impulsivity, self-medication, addiction, reckless behavior, early or risky sexual behavior, involvement in gangs or delinquent peer groups, law breaking, running away, trafficking

2

TRAUMA-INFORMED PRACTICE FOR YOUTH INVOLVED IN MULTIPLE SYSTEMS

Recognizing trauma reactions, understanding how they develop and why they persist is a key first step providers, staff, and caregivers can take to help youth recover from the challenges and adversities that have led to multisystem involvement.

Specific recommendations for trauma-informed care of youth involved in multiple systems include:

- Providers must learn to recognize when cognitive, emotional, and behavioral problems are the result of traumatic stress reactions to avoid negatively labeling and stigmatizing YIMS or diagnosing them with psychiatric disorders and failing to help them recover from trauma.
- Providers must acknowledge to youth that the traumas they, their families, and their communities have experienced should not have happened and should not continue. This affirms the challenges that many YIMS are dealing with but may be difficult for youth to relate to or believe, especially if they live in communities where exposure to trauma is an ongoing and expected part of their experience.
- Providers should help YIMS understand that coping strategies they have used to deal with past trauma (e.g., shutting down, using drugs, taking risks) do not mean something is “wrong” or “messed up” with them. Providers should help youth develop ways to use or modify their coping strategies to increase their safety and their ability to achieve the positive goals that they choose for themselves.
- Providers can be great role models and can look for opportunities to demonstrate how to respond to stress, adversity, and discrimination in ways that are consistent with what they expect of youth.
- Providers must recognize that youth of color face systemic racism and implicit biases and may be affected by historical and racial trauma, and that these adversities lead to discrimination and micro and macroaggressions that increase the harm caused by trauma.²
- Providers should show that they are open to hear the youth's and family members' views about trauma, oppression, and systemic racism. This should be done respectfully by learning from what is written or taught by people of color about racism and how it has caused harm to people of color for generations.
- Providers must take responsibility and apologize for any unintentional missteps (e.g., microaggressions) they make in talking about racism and other forms of trauma with youth or family members.
- Providers must recognize that girls involved in multiple systems, especially those of color, have often been victimized and that their system involvement is frequently the result of attempts to cope with trauma (e.g., running away, substance use, risky behavior, reactive aggression).
- Providers must recognize that youth who identify as LGBTQ and gender nonconforming often experience traumatic stress reactions due to exposure to physical and psychological violence in both their homes and community-related biases and stigma.

- Providers must recognize that youth with physical, learning, or developmental disabilities are disproportionately exposed to traumas and that their disabilities often are complicated by traumatic stress reactions they have developed to cope with those traumas.
- Providers should recognize that YIMS and their families often face socioeconomic disparities, such as poverty, homelessness, and living in high-crime neighborhoods that create or exacerbate trauma and lead to traumatic stress reactions.
- Many YIMS live in, or return to, families, schools, or neighborhoods where they are exposed to violence or other forms of trauma. Providers must help youth anticipate and identify accessible supports to cope with crises and emergencies.
- Many YIMS live in, or return to, communities where they are subjected to micro or macroaggressions, exploitation, or other forms of trauma based on their race, ethnicity, culture, sexual identity, gender, age, or other personal characteristics. Providers must help youth develop safe ways to exercise their rights and advocate for themselves and significant others against discriminatory, violent, or oppressive practices in their community.
- Providers must take an active role in creating youth-friendly community resources that prevent trauma and challenge acts of racism.
- Youth and families will benefit when providers engage them as full partners in developing service and treatment plans. This means incorporating goals, priorities, and values as described by the youth and family rather than imposing what the provider feels is best.

In order to accomplish these recommendations, all staff must be knowledgeable about how to recognize traumatic stress reactions. As we describe in the next section, there are a variety of specific approaches to trauma screening, early identification, and assessment.

3

TRAUMA SCREENING AND ASSESSMENT WITH YOUTH INVOLVED IN MULTIPLE SYSTEMS

Trauma-informed screening (TIS) and trauma-informed assessment (TIA) assist providers in identifying youths' trauma histories and traumatic stress reactions. TIS is generally brief and should be initiated soon after a youth enters a system. When a formal screening instrument is used, such as a questionnaire or interview, that instrument should have been research tested and should be selected based upon a goodness of fit with youth and families you serve and the system or program in which you work.

TIS should be routinely done upon every child's first entry into a system of care, and again periodically but with as little duplication as possible, in order to determine whether a youth:

1. Has been exposed to trauma (and if so, when and how), and
2. Is reacting to trauma reminders with traumatic stress reactions.

Research tested means that scientific studies demonstrate that the screening instrument is accurate ("reliable and valid") for youth of similar age, gender, race, ethnicity, culture and language to the youth served by that particular system or program.

TIS should occur in each of the following systems:

- | | |
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| ● Child Welfare Services | ● Pediatric and Family Healthcare Centers |
| ● Schools | ● Family or Social Service Centers |
| ● Juvenile Justice Courts and Services | ● Community Centers and Recreational Programs |
| ● Behavioral Health Treatment Services | ● Programs Serving Youth Experiencing Homelessness or Trafficking |

TIS helps systems determine when and how to provide services that help youth understand and effectively modify traumatic stress reactions, as well as when a youth can benefit from a more in-depth comprehensive trauma assessment (TIA) to guide planning and services. It is never enough to simply conduct a screening; rather, systems must ensure that the results of screening are used to inform decision-making and service planning for each youth. For instance, trauma screening in CW may help staff plan behavioral health and family support services for a maltreated child to ensure they are cared for safely and to help them recover from traumatic stress reactions that may otherwise lead to serious problems in school, relationships, and with the law as the child grows older.

For more information on screening and assessment visit: <https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening>

TIS and TIA should be embedded in a process of care coordination and the information gained should be used to guide services and supports for the youth both within and across systems. For example, information gathered in screening and assessment may be used to determine the best fit for placement, help the foster family or placement facility respond appropriately to a youth's behavior, and assist mental health providers in selecting appropriate treatment interventions. When a youth's traumatic stress reactions adversely impact educational functioning, this information can be used to assist the school in developing an academic plan for appropriate academic support.

“ For example, when Jordyn's teacher made a report to CW because of concern that Jordyn was being sexually exploited, the investigating worker used a trauma history screening interview to sensitively talk with Jordyn about past and current experiences that have been traumatic for her. The worker learned that Jordyn witnessed her father's violence towards her mother when reviewing the trauma screening questions with Jordyn. This helped the worker understand how many of Jordyn's emotional, sleep, and school problems might be posttraumatic stress reactions, and the findings from the trauma screener were shared with her caseworker and led to a referral to a local clinic that provides trauma-focused therapy.

TIA, in comparison to screening, is a more comprehensive examination of a youth's trauma history and traumatic stress reactions. TIA is done by mental health professionals who have specialized training and expertise in doing in-depth assessment of a trauma history and traumatic stress reactions. TIA also involves collecting information from multiple sources to learn about trauma history and traumatic stress reactions and to identify protective factors, including healthy coping strategies and important relationships that support good decision making.

Particularly with YIMS, there are additional considerations to keep in mind for the assessment process. Trauma-informed assessments should assess for signs and risks of potential delinquent behaviors (e.g., school failure, association with delinquent peers). In addition, the effects of witnessing interpersonal violence (e.g., stabbings, sexual assault, domestic violence) should not be underestimated. Providers should strongly consider how such experiences can impact development, important relationships, and the youth's ability to complete tasks related to school, work, and other important life areas. Further, it is critical to remember that child welfare and justice settings can be traumatizing for youth, so providers working with YIMS should also screen and assess for traumatic experiences that may have occurred directly due to involvement in those systems.

“ At the behavioral health clinic where Jordyn was referred, the psychologist who met with her used a valid and reliable trauma assessment questionnaire as an interview guide while getting to know Jordyn. The comprehensive trauma assessment administered by the psychologist included a full social, developmental, and educational history. In reviewing the findings of the assessment with Jordyn, they were able to collaboratively develop a therapy plan and begin to discuss the idea that her emotional, school, and relationship difficulties were likely her attempt to cope with her family violence and sexual exploitation, and not something she should feel guilty about. This new perspective motivated Jordyn to continue in therapy with the psychologist, and recognize the danger caused by her sexual exploitation. Jordyn was able to make the difficult choice to distance herself from J.P because the therapy helped her to explore alternative ways to meet her need for love, affection, and connection as well as to help her mother.

“ In contrast to Jordyn's success story, Joshua's case demonstrates the costs of not conducting careful, timely, trauma screening and assessment. Over the many years in which Joshua received child welfare, behavioral health, school, and developmental disability services, trauma screening was never conducted, and trauma-informed treatment was never provided for him or his biological or foster families. Joshua's involvement with law enforcement and juvenile court as well as the danger that he unintentionally created for others were likely to have—at least in part—been caused by his traumatic stress reactions. These challenges along with his substance use problems (a form of unhealthy coping) may have been avoided or overcome if he had help in understanding how to manage distressing traumatic stress reactions such as anxiety, hypervigilance, and vivid memories of violence. Treatment for traumatic stress reactions

should have been a central part of the kind of inpatient substance abuse treatment that Joshua received, but this would have required careful trauma screening and assessment to ensure that trauma-informed treatment was included as part of that treatment and follow-up care in the community.

Youth and families involved in multiple systems often are overwhelmed by the paperwork and interviews conducted for the purpose of screening and assessment. The information obtained in TIS and TIA is highly personal; therefore, it is essential for providers to treat youth and family members as full partners when obtaining their consent for sharing information about trauma history and traumatic stress reactions.

Trauma screening and assessment can be done differently across systems. Some systems (e.g., schools) do not need to know exactly what has happened (i.e., a detailed trauma history) in order to provide services that reduce the impact of traumatic stress reactions. In some systems, the time or cost required to administer, score, and interpret the results of a TIS questionnaire or a TIA interview may not be feasible. In other systems, detailed personal, family, social, psychological, and/or educational assessments are routinely conducted, and TIS questionnaires or TIA interviews are seamlessly integrated into them.

Additionally, certain types of trauma may be of central importance to services in a particular system. For example, maltreatment or trafficking traumas are crucial to identify in child welfare, while family, school, and community violence are of special concern in school systems. Similarly, certain types of traumatic stress reactions are of high relevance in some systems (e.g., risky “delinquent” behavior in juvenile justice; self-harm and suicidality in behavioral health). TIS and TIA therefore may differ in various systems based on the emphasis each system places on high priority types of trauma exposure or traumatic stress reactions.

In order to avoid duplication and burdening youth and families, whenever possible TIS and TIA information that has recently been gathered in another system or program should be obtained and used in developing trauma-informed services and treatment plans instead of re-administering the same or similar screenings or assessments. Legal and regulatory limits on information sharing may prevent such cross-system/program sharing, but in many cases TIS and TIA findings can be communicated from provider to provider with caregiver and youth consent in order to maximize coordination and trauma-informed care for youth who are involved in multiple systems. It is not unusual for YIMS to be screened multiple times within each system, nor for the findings of these screenings to not be shared or used to develop a coordinated plan. This duplication places an unnecessary burden on youth and on service providers. Youth and families may become frustrated and feel disrespected when presented with the same questions by multiple providers and may be less inclined to provide the information in the future if it is clear that systems are not making efforts to appropriately coordinate care. Properly coordinated trauma screenings and assessments among systems maximizes opportunities to identify contributors to traumatic stress reactions in youth and to collect additional information from trusted adults in a youth’s life about symptoms and coping strategies.

Regardless of the specific approach taken to TIS and TIA, it is essential that they are done using existing or newly acquired information that is accurate and complete for each youth. The goal of TIS and TIA is always to assist in developing and coordinating services that not only meet the goals of the system or program but also those of the youth and family. Doing trauma screening or assessment without a clearly defined “need to know” and the express consent of a youth or their family can feel like a violation of trust and thus could do more harm than good.

Specific recommendations for trauma-informed screening with YIMS include:

Provider Requirements

- Agencies should provide training to both professionals and paraprofessionals from various child-serving systems, especially child welfare and juvenile justice, on how to administer trauma screening, engage youth and family members in the process, and share feedback. It is essential that this includes basic trauma training (e.g. defining trauma, identifying types of traumatic events and the range of traumatic stress reactions that youth can have).
- In addition to training, agencies should offer ongoing support and supervision to those who conduct trauma screenings so that they are able to communicate the results in a manner that is helpful to each youth and to all providers of services who are caring for the youth. Staff should also be taught how to elicit information from frontline providers in a way that will supplement the information collected from youth during screening. Often frontline staff build relationships with youth that provide insight into the youth’s trauma history.

TIS and TIA Instruments and Interviews

- Providers should utilize TIS and TIA instruments or interviews that have been research tested with youth in similar situations and of similar backgrounds to those in their care.
- Although certain forms of trauma or traumatic stress reactions may be of highest priority and may be the focus of the TIS and TIA instruments and interviews used by a particular agency, provision should be made to gather information (i.e., from records of TIS or TIA previously conducted in another system or agency) on the full range of types of trauma, including historical and intergenerational trauma, experienced by the youth and the family.
- Unless already included in the TIS and TIA instruments and interviews being utilized, supplemental screening should be included to explicitly identify youths' experiences of identity-based trauma (e.g., racial, homophobic, or gender-based trauma).

Conducting TIS and TIA

- In order to avoid unnecessary duplication, providers should investigate whether a TIS or TIA has been conducted in another system, and obtain those records in a manner that is consistent with HIPPA and other privacy guidelines. If no TIS is available or information from a prior TIS is outdated (i.e., done more than six months previously), a new TIS (and TIA, if indicated by the screening) should be conducted.
- TIS and TIA should be administered only after the youth has shown a willingness to engage with—at least minimally—the provider administering the screening. The youth's willingness should be verified by obtaining informed assent and parental consent, unless trauma screening is court or legally mandated.
- Staff conducting TIS and TIA should explain the purpose as well as the process that will be used, including how results will be used, and how the youth's confidentiality, legal rights, and best interests are protected. Even when screening or assessment is mandated, it is crucial to explain to the youth (and parent, when involved) that questions about past and current trauma experiences and reactions are going to be asked, and how this information will be used to help the youth to develop ways of coping with reactions effectively. This process is important to gain trust, which is essential to valid screening and assessment.
- If the youth has experienced trauma, but TIS does not indicate any clinically significant traumatic stress reactions or related problems at present, providers should still ensure that the results are shared with other providers and systems with which the youth is involved and provide information to the youth and family about the effects of trauma and ways to cope effectively as a standard practice after TIS.
- TIS should be repeated periodically (without unnecessary duplication), particularly if there are concerns about additional exposure to trauma and/or changes in traumatic stress reactions. Re-screening is also particularly important when a youth denies trauma exposure during a screening process, but providers strongly suspect that the youth may indeed have a trauma history that they are not ready to share. Likewise, traumatic stress reactions may take subtle forms, leading providers to believe that a youth is not impacted by their history when they may be experiencing traumatic stress reactions that are being overlooked.
- When conducting TIAs, providers should collect information from multiple sources about the youth's trauma history and traumatic stress reactions and protective factors including healthy coping strategies and important relationships that support good decision making.
- TIS and TIA should, in design and administration, be sensitive to sociocultural factors such as preferred language, cultural beliefs and practices, gender identity, sexual orientation, developmental/learning capacities, and personal/family strengths and resources.
- TIS and TIA results should be conveyed to caregivers and family members (as appropriate) in non-technical terms and with sensitivity to language and cultural issues.
- Agency or system policies and procedures must protect against misuse of TIS and TIA results including self-incrimination or violation of youths' rights or safety.

Service Coordination

- In order to facilitate coordinated services across systems, results of the TIS or TIA conducted in a given system should be shared in a timely and useful manner with providers in other service systems working with the youth, while considering legal and HIPAA privacy protections and confidentiality regulations.
- Practitioners should integrate TIS and TIA results into every planning process and case, service or treatment plan, with a focus on providing services that help youth understand trauma reactions and adopt healthy coping strategies that work for them.

Information gathered from trauma-informed screening and assessment will inform the development of a comprehensive, trauma-informed case plan (TICP). TICPs for YIMS ideally are structured to integrate an understanding of the impact and consequences of trauma into all interventions and aspects of organizational functioning.³ The TICP includes recommendations to help youth understand the impact of trauma and to develop alternatives to unhealthy trauma reactions that build on their strengths and abilities.

An integral part of the TICP is a Trauma Recovery and Safety Plan (T-RASP), which should be co-created by the youth, family, and providers as a resource to help youth understand and learn to effectively cope with traumatic stress reactions using personal strengths and supportive relationships. A T-RASP integrates screening and assessment information into the TICP in the following steps:

Step 1: Summarize the trauma history, the chronology of traumatic experiences, and adversities in the youth's life. If ongoing or potential future traumas or adversities are identified, staff should work across systems to develop a plan that will protect the youth and do everything possible to prevent further traumatization.

Step 2: Identify trauma reminders, such as stressful or conflictual interactions, smells, sounds, bodily sensations, life transitions, anniversaries, challenges in school or with peers, or even positive experiences.

Step 3: Identify when youth are triggered. Early warning signs are the immediate reactions experienced by a youth when they are exposed to a trauma reminder. Early warning signs can include anxiety, sadness, physical tension, pain, irritability, anger, impulsivity, aggressiveness, guilt, withdrawal, or numbing / boredom. The purpose of identifying early warning signs is to increase awareness for youth and staff and allow for early intervention when a youth is triggered.

Step 4: Identify behaviors, places, people, sensory experiences, such as abdominal breathing, exercise, a safe room, music, healthy touch, or foods or material objects that help the youth to self-soothe, distract, better regulate, and actively cope with stress reactions and feel safe and in control of themselves. Over time, youth may also come to feel comfortable, cared for, relaxed, successful, respected, valued, and/or confident by drawing on these self-regulation skills.

Step 5: Connect youth to opportunities and activities that help them explore and promote their sense of self, including their personal interests and strengths, their culture, and other aspects of their identity.

Step 6: Develop a list of adults and peers who can support the youth. This may include family members, including biological, adoption, foster family members, extended family, neighbors, and/or members of the community. The members of this list can act as bridges for the youth and family across multiple systems. The list should include any adult who has established a healthy connection with the youth. The plan also includes practical ways that the youth can reliably and promptly connect with people on the support list.

Step 7: Refer for trauma-focused mental health treatment, when indicated, to address severe or complicated traumatic stress reactions. See the next section and Appendix A for further information about child and adolescent trauma treatments and ways to access them.

TICPs require communication and coordination of professionals across systems using a multidisciplinary team approach. TICPs enable the multidisciplinary team to create a shared understanding of the risks, needs, and resilience factors that must be addressed in order to prevent deeper system involvement. TICPs also ensure that youths' family, legal, behavioral, emotional, medical needs, and learning challenges can be understood as the result of traumatic stress reactions that can be modified with trauma-informed services.

A case flow management process should be developed to ensure that all multidisciplinary and multisystem providers communicate regularly to monitor and coordinate the services plan. This case flow management process may vary across settings but should always include coordinated recommendations to the court and joint attendance at all court hearings.



Trauma-Specific Treatment

Many behavior management and therapeutic interventions for YIMS (e.g., Cognitive Behavioral Therapy, Multisystemic Therapy, Functional Family Therapy, Motivational Interviewing, Wraparound Services) help youth cope with behavioral and emotional problems, but trauma-specific interventions are also necessary in order to enable youth to recognize, understand, and develop ways of coping with or adaptively modifying traumatic stress reactions.

Three essential elements that trauma-informed treatments use to move beyond standard mental health, educational, and behavioral interventions include:

- An explanation for youth and their adult caregivers about how trauma reactions (e.g., hypervigilance, impulsivity, defensive aggression, avoidance, depression, and an inability to trust) are very common among children and youth who have survived trauma.
- Activities that enable trauma survivors to replace trauma reactions with prosocial ways of being safe and achieving goals (i.e., to reduce reactivity and enhance self-regulation by promoting awareness, self-reflection, and value-based decisions and actions).
- Precautions to ensure that violations of safety and trust that have occurred in each youth's experiences of trauma do not continue to occur in the youth's current life and services.

Trauma-specific treatments range from brief interventions (designed to provide basic trauma education, build skills, and provide support) to intensive long-term treatment. Intensive treatment focuses on addressing the impact of traumatic stress reactions and aims to restore the ability to build healthy relationships, work toward academic goals, and manage ongoing challenges. Often these interventions provide specific skills to help youth identify trauma reminders and to manage intense emotions when trauma reactions occur.

Trauma-specific treatment approaches also include prosocial activities that enable youth to develop, gain recognition for, and achieve personal goals based on their personal strengths, talents, and interests. This includes school, extracurricular, and community activities involving sports, the arts, culture, crafts, commerce, faith/spirituality, socialization, and recreation. It is important that adults who work with youth (e.g., coaches, instructors, employers, faith leaders) understand how trauma can lead to trauma reactions, and how participation in activities can help youth develop the awareness, reflection, and values-based orientation that enable them to replace trauma reactions with effective coping and positive life choices.

Joshua's Trauma-informed Case Plan Coordinated across Multiple Systems

Joshua did not receive trauma-informed services for the first 17 years of his life. The CW caseworker made a crucial difference by putting trauma-informed services into motion when Joshua completed the court ordered inpatient substance abuse treatment.

- Joshua's caseworker initiated contact with Joshua's probation officer so they could exchange what they knew about Joshua's history and current functioning. Together, they identified other key adults in Joshua's life and invited them to be involved as a part of a multidisciplinary team assisting Joshua. This included Joshua's grandfather, caretakers at the group home, and other adults that Joshua identified as important in his life. Through this process, Joshua's grandfather was invited to share his understanding of Joshua's challenges from a cultural and ethnic perspective and suggest cultural traditions and practices which he felt could be helpful for Joshua. He was specifically concerned that Joshua needed to become more integrated in his Latinx community to assist with reclaiming the identity that he felt he lost as a function of the multiple placements from a young age in non-Latinx homes.
- The case worker and the team collected and compiled information to prepare a trauma-informed case plan (TICP) to support Joshua's emancipation. This included collecting previous screenings and current treatment plans. As a group, they met at least quarterly with Joshua to track his successes and prepare him for his transition from child welfare.
- The team petitioned the court to extend Joshua's stay in CW. This option was discussed with Joshua and the benefits that the CW system can provide (e.g., college tuition) were spelled out so that the team, in collaboration with Joshua, could make an informed decision. His grandfather offered to serve as his temporary guardian until he completed the process.

- Joshua was referred for a trauma-informed assessment with a clinical psychologist specializing in child traumatic stress. The referral questions/goals of the assessment included documenting the breadth of Joshua's lifetime trauma exposure and conceptualizing how his past exposure may be contributing to his past and current thoughts, feelings, and behaviors.
- The team highlighted Joshua's strengths and accomplishments, including his completion of the inpatient program and his high school graduation, in their interactions with him and with other providers. The team helped Joshua recognize how traumatic stress reactions have contributed to his problems. However, they also pointed out the many strengths he has developed as a function of the adversity such as courage, determination, caring for others, honesty, and leadership that he can turn into successes. For example, they helped Joshua join a basketball team that promotes Latin American cultural pride. The experience provided an opportunity to help him better understand both his culture and strengths. They also helped him begin to articulate short- and long-term goals regarding education, employment, and housing.
- The assessing psychologist attended a team meeting where she discussed the findings of the trauma assessment with Joshua and other members of the team, helping all of them understand the role that traumatic stress reactions have played in Joshua's survival of years of trauma, but also how they contribute to the challenges that have interfered with his education and led him to be in trouble with the law. The psychologist reframed Joshua's problematic behaviors as common reactions that children who are exposed to traumatic events often use to survive or cope—without excusing the behaviors. Joshua and other members of the team were encouraged to contribute to the conversation with questions or comments throughout.
- The psychologist also acknowledged that many of the providers and staff from different systems working with Joshua are White. She encouraged all staff to approach Joshua and his family with cultural humility—the perspective of curiosity about his life story instead of negatively judging how he has handled traumatic life events. Finally, she encouraged all providers to consider how their implicit biases (i.e., unconscious bias) or having different personal life experiences than Joshua may lead to interactions with Joshua and his family that are non-compassionate or lead to greater distrust for Joshua and his family.
- In follow-up meetings, the team discussed how to assist Joshua in developing healthier coping strategies while understanding his responsibility for past and present choices/behaviors.
- The psychologist has begun trauma-informed treatment with Joshua, including the option of incorporating his grandfather, or another adult of his choice, into the treatment process. This has included the development of a Trauma Recovery and Safety Plan (T-RASP) that Joshua has actively participated in creating, and that has been communicated to all members of the multidisciplinary services team so that they can support Joshua in putting the plan into effect in his daily life. The T-RASP includes psychological and physical safety, and strengths-based, prosocial ways of coping with stressors and trauma reminders that Joshua has committed to use and that are designed to help him achieve his goals.



Providers working with YIMS are affected personally by the hurt that trauma has caused to these youth and their families. These expectable reactions have been described as secondary traumatic stress (STS).⁴ STS reactions can include symptoms of PTSD, including intrusive, avoidant, or hyperarousal symptoms. These symptoms may be intensified as providers help youth with trauma histories navigate multiple systems with divergent goals and poor infrastructure for inter-agency communication. Service providers affected by STS may find themselves re-experiencing memories of their personal traumas. Regardless of whether they have experienced traumas personally, providers may also find themselves feeling anxious, irritable, discouraged, on edge, hopeless, or mentally or physically exhausted. Providers may also grapple with self-doubt, survivor guilt, and sleeplessness. They may struggle with urges to misuse substances or to engage in other addictive activities to cope with their distress. STS can lead to increased conflict, frustration, and impatience with clients and co-workers, as well as with friends and family. STS can undermine the ability to perform one's work effectively and exacerbate challenges in one's personal life. While not all providers will develop STS, it is a predictable consequence of genuinely caring about, and getting to know youth who have experienced trauma and loss in their lives. STS also does not automatically impair work performance or personal quality of life, especially if providers are alert to recognizing signs of STS and can access sources of personal and professional support.

Organizations can assist their staff by identifying the degree to which STS is impacting providers and assessing how well equipped the organization is to respond. Self-report measures such as the Professional Quality of Life Scale provide an opportunity for staff to individually identify levels of STS, burnout, and compassion satisfaction.⁵ Organizational assessments such as the Secondary Traumatic Stress Informed Organization Assessment Tool can provide insight into how well the work group or organization in which services are delivered recognize and respond to STS.⁶ After conducting initial assessments, organizations and staff are better equipped to make targeted efforts toward promoting staff wellness and addressing the impact of STS that are identified by their staff.

Specific strategies that organizations can use to support staff in managing STS include:

- Providing educational sessions to help staff recognize and understand STS and why STS is a frequent reaction when dedicated and compassionate adults work with highly trauma-impacted youth such as YIMS.
- Providing educational sessions that teach staff practical skills for recognizing STS in themselves and in co-workers, and for seeking and providing helpful social support based on understanding STS as the result of compassion and dedication.
- Providing training for supervisors on ways to recognize and nonjudgmentally support staff who are experiencing STS, using tools such as reflective supervision (i.e., form of supervision focused on emotionally processing STS experiences).
- Setting and actively maintaining policies and procedures that support staff in being aware of STS and using their knowledge and skills to cope with STS in healthy ways that serve as a role model for youth and maximize their own wellness and effectiveness.
- Creating spaces that acknowledge the intersection of STS and important personal and professional identities of staff. For instance, staff of color may experience increased distress working with youth of color experiencing trauma or staff who are parents may have particular difficulty working with youth who have been sexually exploited by their parents. Provide opportunities for staff to integrate these discussions into supervision and conversations with colleagues as appropriate.

Addressing STS requires a healthy organizational culture based on acknowledging the impact of working with youth with trauma histories, the impact of systematic racism on staff, and reducing the stigma associated with STS. This can be done in conjunction with ongoing wellness programs for staff. A strategic assessment and planning process is needed to gain buy-in from staff and the organizational leadership. This gives staff ways to contribute to a safer workplace and empowers them to identify trauma-informed approaches (see these examples of organizational self-assessments: [Trauma-Informed Organizational Assessment \(TIOA\)](#) and [Trauma-Informed Juvenile Court Self-Assessment \(TI-CSA\)](#)).

To help supervisors develop effective supervision strategies to address secondary trauma, the NCTSN created the [Secondary Traumatic Stress \(STS\)—Core Competencies for Supervisors](#).

The key principle is that organizational leadership must model and support proactive ways of preventing, reducing, and managing STS, and providers/staff should be educated about the nature of STS and how nonjudgmental awareness of STS can provide opportunities to prevent burnout, and enhance health and sense of accomplishment and satisfaction.

Agencies working with YIMS can accomplish these overarching goals in several specific ways:

- Help all providers/staff understand how their own burnout or STS can impair their relationships with colleagues and negatively impact the youth and families they work with. Staff well-being is essential for promoting empathy for, and building strong working alliances with, YIMS and their families.
- Encourage staff to speak up when they notice colleagues who are suffering from burnout or STS. Open communication about these issues should be promoted in the workplace as a method of prioritizing self-care, not criticizing performance.
- Encourage providers/staff to consider how STS may be playing a role, and can be overcome, when collaboration across systems and between providers does not occur or breaks down.
- Just as we must consider the impact of racial trauma, historical trauma, structural racism, and implicit bias when it comes to caring for youth, organizations must also acknowledge in training, support, and supervision that these experiences also exist for providers/staff.
- Pursue established trauma-informed training programs that have been used successfully in child-serving settings, such as the 2nd edition of the [Think Trauma Curriculum](#), which has a module dedicated specifically to staff care and STS.⁷



Empirically Supported and Emerging Trauma-Informed Interventions for Consideration When Working with Youth Involved in Multiple Systems

Highlighted below are select empirically supported trauma-informed treatment interventions that can be considered when working with YIMS.

Trauma-informed Interventions for Young Children

There are a variety of trauma-informed treatment packages that can be provided to YIMS and their families starting at a very young age. For the purpose of this resource, we refer to these as “early intervention” options. If a youth’s trauma reactions are noticed and treated early in life, this may ultimately prevent youth from becoming system involved.

The following three early interventions for childhood trauma have the most research demonstrating robust long-term benefits for children and their caregivers. Follow-up studies show sustained improvements in child behaviors at six months, two years, and ten years after treatment. Providing trauma-informed interventions to young children and families may well reduce later involvement in multiple systems of care.

Early intervention for trauma that may prevent future multisystem involvement could start with *Child-Parent Psychotherapy* (CPP). This one-year intervention treats preschoolers from infancy through age five and their primary caregivers. It works primarily to rebuild a strong attachment relationship between a child who has experienced trauma and a primary caregiver. One follow-up study at six months showed a sustained improvement in child behavior and reduced maternal distress levels.⁸

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) includes trauma treatment for childhood (3-18) with a strong component for parent-child attachment restoration. It is a phase-based therapy that typically lasts 12-16 sessions, although it can be longer for complex trauma cases. TF-CBT treats sexual behavior problems, disruptive behaviors, and posttraumatic symptoms in children, and includes a strong caregiver component. Follow-up TF-CBT studies at one year and two years show sustained improvements in effective parenting practices and reduced PTSD, depression, and externalizing behaviors in children.⁹ Children also show significant reductions in sexual behavior problems possibly linked to a trauma history compared to children in nondirective treatments.¹⁰

In another intervention, *Children with Sexual Behavior Problems* (CSBP), intervening early with children who have sexual behavior problems has been shown to reduce later justice system involvement as juvenile sexual offenders. CSBP is a 10-session treatment for preschool and school age children that requires parent-caregiver training and separate cognitive-behavioral group therapy for children.¹¹ A 10-year prospective study of this SPB-specific intervention showed that children randomized to the cognitive-behavioral group treatment were no more likely to have future sex offenses than the non-CSPB comparison group when child welfare sex abuse reports and juvenile and adult arrest rates were examined.¹² Children receiving comparison play therapy group had significantly higher future sexual offenses ten years later. CSBP is the most effective treatment for children with sexual behavior problems and has the longest follow-up research documenting sustained gains.¹³

Adolescent Trauma Treatments

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) has been evaluated as a treatment for children who are trafficked, complex trauma victims, and youth in residential treatment.¹⁴ TF-CBT with youth with complex trauma and their caregivers includes multi-disciplinary collaboration that includes safe adults, educators, direct care staff, and others to support and sustain positive treatment outcomes.¹⁵ TF-CBT has also been implemented in residential and juvenile justice facilities.¹⁶

Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) is intended for youth aged 10-18 and, when possible, their caregivers. It can be delivered to individuals or groups in both limited and extended treatments: brief at 4 sessions; limited at 10-14 sessions; and extensive at 26 or more sessions. TARGET-A teaches affect (emotion) and behavioral self-regulation skills summarized by an acronym (FREEDOM), with psychoeducation that enables youth, and adults working with them, to understand how trauma reactions result from automatic adaptations that shift the brain from learning to survival mode. TARGET-A thus provides youth with a new understanding of traumatic stress reactions and practical skills to enable them to stop and think instead of continuing to reactively engage in the extreme behaviors that may have contributed to their involvement with the legal and juvenile justice systems. TARGET-A does not include a trauma narrative component, but it engages youth in the creation of a “Lifeline” that includes all events that the youth considers significant in their life history, including potentially traumatic events but also events that represent successes, resilience, and hope for the youth. When implemented in residential facilities, TARGET-A includes trauma-informed trainings for milieu staff to shift the organizational culture. One TARGET-A study in a large state juvenile justice system for youth in mental health units showed reductions not

A full list of trauma interventions developed by and being used by members of the National Child Traumatic Stress Network, can be accessed here: <https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions>

only in youth depression but also in threats to staff, seclusion, and restraints, in contrast to the youth in the “Treatment as Usual” cohort).¹⁷ In another study, the brief version of TARGET-A was implemented in two Connecticut JJ 14-day detention centers and showed very large reductions in disciplinary incidents for each TARGET-A session in which a youth participated. Post-intervention follow-up at six months showed a significant decline in recidivism for those who participated in TARGET.¹⁸

Trauma and Grief Component Therapy for Adolescents (TGCTA) is intended for youth aged 12-20 and has been delivered in schools, clinics, residential treatment centers, and juvenile justice facilities to youth with trauma and/or loss histories, including not only child abuse and neglect, but also exposure to wartime, community violence, and mass terror.¹⁹ Like TARGET-A, it can be delivered to individuals or groups using both limited and extended schedules. Module I teaches core skills to cope with trauma responses, thus enhancing emotional and behavioral stability; Module II focuses on supporting youth through their trauma narratives; Module III focuses on grief and loss; and Module IV integrates trauma treatment gains while helping youth resume normal developmental progression and future orientation. A study with war survivors showed that using Modules I and IV alone can reduce PTSD symptoms, stabilize behavior, and reduce maladaptive grief, although delivering all four modules showed even greater reductions, with continued symptom improvement at a 4-month follow-up.²⁰ A study with incarcerated youth in several Ohio facilities showed reductions in PTSD and other trauma symptoms as well as reductions in youth threats, seclusion, and restraints when both the brief and lengthy versions of TGCTA were implemented.²¹

Promising Traumatic Stress Interventions

Attachment, Regulation, and Competency (ARC) is both an individual and system-level program for residential programs, schools, and group homes that serve youth from birth to age 21 who have experienced complex trauma. The system itself is a target of intervention, fostering organizational change that can be translated across service systems. ARC includes client-level trauma treatment that can be implemented in combination with system-level programs or on its own. It offers support not only to youth with trauma histories but to all who interact with them, such as caregivers, staff, teachers, administrators, and support personnel. Like Sanctuary (see below), ARC builds in psychoeducation about trauma responses at all levels of an organizational system so that staff and caregivers are aware not only of the trauma-linked “drivers of behavior” among youth but also among themselves. ARC encourages the integration of predictable routines into all aspects of residential programs for youth. ARC evaluations have reported decreases in youth aggressive behaviors, reduced PTSD scores, and more stable placements.²²

Sanctuary. This model focuses on creating trauma-informed, organizational change throughout a single institution such as a residential treatment home or juvenile justice facility. The entire community, including youth and staff, actively work together to create a trauma-informed environment that promotes both safety and recovery from adversity. Sanctuary has been used in residential, juvenile justice facilities, shelters, schools, and community mental health programs.²³

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). SPARCS is a 16-session, manually guided, group intervention that combines role plays, in-vivo practice, and take-home worksheets to assist adolescents with complex trauma histories who continue to live in chaotic (oftentimes violent) environments, and exhibit a range of emotional, behavioral, and social difficulties. SPARCS focuses on the following: 1) the unique developmental tasks of adolescence, and 2) the impact of Complex Trauma (i.e., repeated and/or multiple interpersonal traumas). SPARCS emphasizes a strength-based perspective in conceptualizing the impairments with which many teens who experienced trauma struggle. The “Four C’s” of SPARCS represent the overarching goals of the program and help adolescents develop and strengthen self-regulatory capacities by 1) *Cultivating Awareness* through mindfulness, 2) *Coping Effectively* utilizing distress tolerance and problem-solving skills, 3) *Connecting with Others* by developing sources of support and practicing effective communication, and 4) *Creating Meaning* and purpose by identifying underlying values and making decisions based on those ideals. SPARCS is a present-focused intervention and is not an exposure-based model.

Trauma Systems Therapy (TST) involves a multi-disciplinary team similar to the Crossover Youth Practice Model (CYPM). Legal advocacy is an essential part of TST implementation, as well as psychotherapy, home and community-based therapy, and psychopharmacology. TST addresses social and environmental issues such as poverty, immigration status, community violence, and housing challenges that otherwise may be barriers to treatment engagement by YIMS and their caregivers, TST treatment typically lasts between 7 to 9 months for a youth and family. TST also involves intensive training and consultation lasting 12-24 months for the organizations assembled in multi-disciplinary teams for each case, much longer than the 12-16 week protocols available for many other youth trauma treatment interventions. TST has been widely disseminated and implemented, with clinical and anecdotal evidence showing positive outcomes. These include reported reductions in seclusion and restraints in more than one residential setting, improvements in foster care placement stability, and reductions in hospitalization rates and length of stay for those hospitalized.²⁴



APPENDIX B

NCTSN Resources with Relevance for Youth Involved in Multiple Systems

Trauma-Informed Organizations:

Trauma-Informed Organizational Assessment, TIOA:

<https://www.nctsn.org/trauma-informed-care/nctsn-trauma-informed-organizational-assessment>

Family Involvement in Trauma-Informed Recovery Services:

The Partnering with Youth and Families Committee (PYFC) of the National Child Traumatic Stress Network (NCTSN) has developed guidelines regarding the formation of inclusive advisory boards:

<https://www.nctsn.org/resources/pathways-partnership-tips-developing-effective-advisory-board>

Youth and Family:

Pathways to Partnerships with Youth and Families in NCTSN

<https://www.nctsn.org/resources/pathways-partnerships-youth-and-families-national-child-traumatic-stress-network>

12 Core Concepts for Understanding Traumatic Stress Responses

<https://www.nctsn.org/resources/12-core-concepts-understanding-traumatic-stress-responses-children-and-families-adapted>

Peer-to-Peer Supports for Mental Health and in Trauma-Informed Recovery:

The NCTSN offers guidelines on how to form peer-to-peer support groups:

<https://www.nctsn.org/resources/pathways-partnership-tips-incorporating-peer-peer-support-your-program>

The National Alliance of Mental Illness (NAMI) offers peer-to-peer training for families and people in recovery:

<https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Peer-to-Peer>

The Copeland Institute also offers peer to peer training

<https://copelandcenter.com/wellness-children-youth-and-families>

Historical/Race-Based Trauma:

How Race, Ethnicity, and Culture Impact the Treatment of Trauma

<https://www.nctsn.org/resources/how-race-ethnicity-culture-and-identity-impact-treatment-of-trauma>

Addressing Race and Trauma in the Classroom

<https://www.nctsn.org/resources/addressing-race-and-trauma-classroom-resource-educators>

Immigrant Youth and Families:

Newcomer Youth in Juvenile Justice Court Proceedings: A Trauma-Informed Approach

<https://www.nctsn.org/resources/nctsn-bench-card-newcomer-immigrant-youth>

Addressing the Mental Health Problems of Border and Immigrant Youth

<https://www.nctsn.org/resources/addressing-mental-health-problems-border-and-immigrant-youth>

Complex Trauma:

Complex Trauma in Children and Adolescents

<https://www.nctsn.org/resources/complex-trauma-children-and-adolescents>

What is Complex Trauma: A resource guide for youth and those who care about them

<https://www.nctsn.org/resources/what-complex-trauma-resource-guide-youth-and-those-who-care-about-them>

Child Welfare:

Child Welfare Trauma Training Toolkit

<https://www.nctsn.org/resources/child-welfare-trauma-training-toolkit>

Resource Parent Curriculum

<https://www.nctsn.org/resources/resource-parent-curriculum-rpc-online>

Child Advocacy Center Directors' Guide to Quality Mental Healthcare

<https://www.nctsn.org/resources/child-advocacy-center-cac-directors-guide-quality-mental-healthcare>

Schools:

Creating, Supporting, and Sustaining Trauma-Informed Schools

<https://www.nctsn.org/resources/creating-supporting-and-sustaining-trauma-informed-schools-system-framework>

Juvenile Justice/Legal:

NCTSN Bench Cards for the Trauma-Informed Judge

<https://www.nctsn.org/resources/nctsn-bench-cards-trauma-informed-judge>

Think Trauma: A Training for Staff in Juvenile Justice Residential Settings

<https://www.nctsn.org/resources/think-trauma-training-staff-juvenile-justice-residential-settings>

Trauma-Informed Court Self-Assessment; TI-CSA

<https://www.nctsn.org/resources/trauma-informed-juvenile-court-self-assessment>

Medical:

Helping Foster and Adoptive Families Cope with Trauma

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf>

Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication

<https://pediatrics.aappublications.org/content/pediatrics/145/2/e20193751.full.pdf>

Pediatric Approach to Trauma, Treatment, and Resilience

<https://www.aap.org/en/patient-care/trauma-treatment-and-resilience/>

Implementing Trauma-Informed Integrated Care (Toolkit)

<https://picc.jhu.edu/the-toolkit.html>

Mental Health:

Assessment of Complex Trauma by Mental Health Professionals

<https://www.nctsn.org/resources/assessment-complex-trauma-mental-health-professionals>

Family Resilience and Traumatic Stress: A Guide for Mental Health Providers

<https://www.nctsn.org/resources/family-resilience-and-traumatic-stress-guide-mental-health-providers>

Additional NCTSN resources on screening, assessment and intervention

<https://www.nctsn.org/treatments-and-practices/screening-and-assessment>

Fact Sheets for Trauma Treatment Interventions

<https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions>

Sex Trafficking:

The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families Adapted for Youth Who are Trafficked.

<https://www.nctsn.org/resources/12-core-concepts-understanding-traumatic-stress-responses-children-and-families-adapted>

Military:

Child Maltreatment in Military Families: A Fact Sheet for Providers

<https://www.nctsn.org/resources/child-maltreatment-military-families-fact-sheet-providers>



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