Volume 6, Summer 2016

DCF Credentialing Chronicle

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Fatherhood Initiative of Connecticut

Objectives

The objectives of the initiative are to provide dads with the skills and supports they need to get involved in the lives of their children and stay connected by:

- Promoting public education concerning the financial and emotional responsibilities of fatherhood;
- Assisting men in preparation for the legal, financial and emotional responsibilities of fatherhood;
- Promoting the establishment of paternity at childbirth;
- Encouraging fathers, regardless of marital status, to foster their emotional connection to and financial support of their children;
- Establishing support mechanisms for fathers in their relationship with their children, regardless of their marital and financial status; and
- Integrating state and local services available for families.

For more information, please visit:

http://www.ct.gov/fatherhood/site/default.asp

SEPTEMBER 17, 2016

Statewide Community Awareness Day

BRIDGEPORT
10 am – 12 noon
Beardsley Park

HARTFORD
Bushnell Park

MIDDLETOWN
10 am – 12 noon
Harbor Park

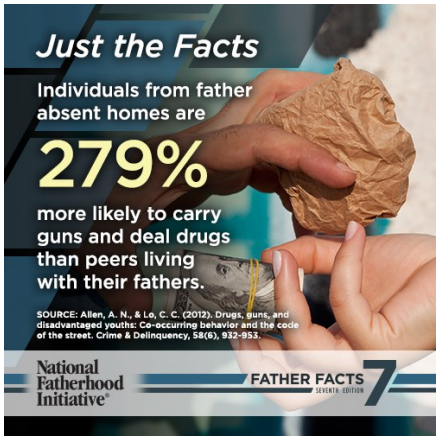
NEW BRITAIN
6:35 pm
New Britain Stadium

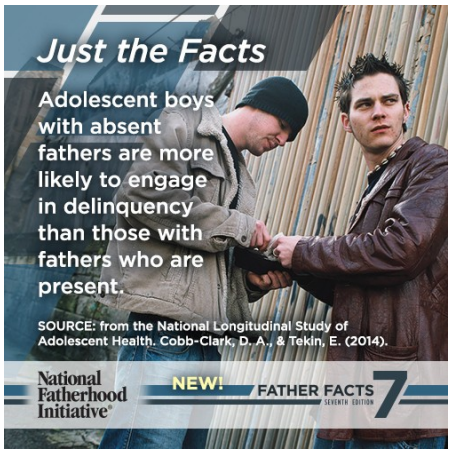
NEW HAVEN
12 noon – 3 pm
Scantlebury Park

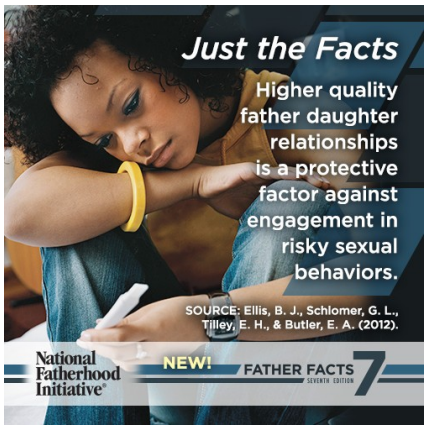
WATERBURY
8 am – 2 pm
Library Park

Father

F A C T S







We Need to Understand How to Provide Trauma-Informed Care

When we think of trauma responses in the simplest form, we think of the "fight-flight-freeze" responses common in traumatized children.

The philosophy of trauma-informed care is becoming more and more embedded in the philosophies and practices of child-serving agencies.

When a child experiences a single traumatic event and is fortunate enough to be surrounded by supportive and nurturing adults, that trauma can generally be assessed and usually treated effectively with the help of parental support. When a traumatized child responds with internalized distress such as sadness, depression or anxiety, our systems appear to understand what that child needs to help in their healing and recovery.

However, when a child has experienced multiple and complex trauma, child-serving professionals, including those in behavioral health, child welfare, juvenile justice and educators, can struggle to see the connection between such histories and other common presentations.

It is not uncommon for children with histories of complex trauma to respond with externalizing behaviors and to be diagnosed with disruptive behavior disorders such as attention deficit hyperactivity disorder, oppositional defiant disorder or conduct disorder. Sometimes children also respond with agitated depression and anxiety. These are the children who may at times rage, fight, argue, refuse to comply, run away, lie and steal.

Why the disconnect between trauma experiences and disruptive behavior disorders? The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) does not yet adequately capture the experiences of trauma in children. Instead, the available diagnoses capture only parts of a child's trauma experiences and presentation.

The problem that I see with this is that an individual diagnosis guides treatment intervention and interventions may or may not include the specific treatment of the trauma. When children are diagnosed with depression or anxiety, it is the depression or anxiety that is targeted in the treatment, rather than the trauma, which is sometimes also the primary issue. When children are diagnosed with disruptive behavior disorders, targeted intervention tends to focus on these behaviors or the secondary symptoms of the trauma, rather than the trauma history itself.

When we think of trauma responses in the simplest form, we think of the "fight-flight-freeze" responses common in traumatized children. The "fight" response can present as verbal or physical aggression; the "flight" response can present as avoidance or refusal, and the "freeze" response can present as dissociation, daydreaming or numbing.

In turn, I see corresponding reactions from child-serving professionals who work with traumatized children. These are the children who can trigger countertransference reactions in the professionals meant to serve them.

The professionals can have a "fight" reaction, which can present as frustration, anger and punitive treatment recommendations; a "flight" response, which can present as child or case avoidance, feeling of hopelessness and referral elsewhere, or a "freeze" response, which can present as a feeling of helplessness or impotence in working with the child or not knowing what to do, so doing nothing.

I see these nontrauma-informed responses toward systems-involved children from both highly trained professionals and those with limited training in behavioral health, child welfare, juvenile justice, and education. Such triggers can elicit our own "fight-flight-freeze" responses to these children presenting with "fight-flight-freeze" reactions to ongoing trauma triggers.

Trauma-Informed Care continued

When a trauma-informed approach is being fully be used, the behaviors of these children should be seen as "normal" secondary reactions to the trauma they have and are still experiencing. An approach that is not fully trauma-informed will view these children's behaviors as volitional, purposeful, manipulative and in need of significant consequences.

That is not to say that children should not receive consequences for their behavior. However, such consequences should be focused on teaching appropriate behavior rather than punishing the behavior, especially by escalated means when initial attempts are not successful.

Not uncommonly, staff serving a child agency are overwhelmed with the numbers of child with significantly complex needs, enormous corresponding paperwork requirements and strict deadlines. These working conditions can make otherwise caring, concerned and patient staff less so. Staff have varying degrees of education, experience and quality of ongoing training and supervision. Thus, it is not unusual when staff are triggered by children who challenge their authority or are not engaged.

Our responses of frustration, anger, avoidance and hopelessness only reinforce the same feelings in traumatized children. There is a saying in the school counseling field: "Those children needing the most love will ask for it in the most unloving ways."

It is easy to react in a trauma-informed manner when a child is responsive and appreciative of our efforts, and treats us with respect. It is harder to respond effectively when that child refuses to talk to us, comply with our requests, tells us off in colorful language or otherwise acts disrespectfully. But these are the children who need us the most.

Luckily, there is training and education available on the neurobiology of trauma. This is the important and emerging research that is connecting the effects of trauma to different domains of a child's functioning. The domains that can be affected include behavioral, cognitive, emotional and relational functioning.

Without understanding the common effects of trauma in a child's functioning, the obvious conclusion is that these children are behaving in volitional and manipulative means. If it is understood that these children have difficulty modulating their impulses and are responding in survival (fight-flight-freeze) mode, this allows for a more patient, respectful and positive intervention.

Understanding that these children's central nervous systems are activated and in need of calming allows us the patience to work with children in calm and respectful ways and reminds us that traumatized children do not "get it" the first, second or third time. Plus, traumatized children do not wake up one day to trust you because you believe you are a trustworthy person. When we understand the effects of trauma, especially pertaining to disruptive behavior, we are better prepared to be with and to help these children.

Most children behave or wish to behave well. Most children want adult respect, love and guidance. Most of those who do not behave well have not yet learned how to behave well and will need lots of time and practice with our guidance.

Our negative responses to disruptive behavior can and do reinforce the misbehavior. In turn, most child-serving professionals like and want to work with children, even if we sometimes do not know how to do so.

Resource:

http://youthtoday.org/2016/07/we-need-to-understand-how-to-provide-trauma-informed-care/

About the author:

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INVOICE SUBMISSION GUIDELINES

The Department of Children and Families has developed an enhanced invoicing system which is an effective and efficient new way to send invoices directly to the Regional Office.

Under this new system providers will now be able to email their invoices directly to one central location.

In addition, a RightFax server has been installed, which is a network fax software application that runs on a Windows platform. This solution will allow the Department to send and receive faxes directly into their desktop computers. The RightFax will be used in the cases where paper invoices are presented or where a provider may not have email capabilities.

To learn more of DCF's invoice requirements and each region's specific invoicing guidelines, please visit:

http://www.abhct.com/News_Resources/DCF_Credentialing/DCF-Invoicing-Requirements/

PROVIDER MARKETING

"How do I market my services?"

The Provider may not utilize any state resources to market the services and/or program it offers. This includes, but is not limited to, utilizing state employee's e-mail address to market any services and/or mentioning in the Provider's own website, brochures or any related information that the Provider is affiliated or approved by DCF.

SAFETY AND SECURITY

The Provider shall have a plan with clear procedures, a consistent, coordinated approach for reporting and managing emergencies to ensure the safety of the child and youth and other parties involved.

The Provider will immediately notify the Department Area Office assigned staff during business hours and the Careline after hours of any emergency or urgent circumstance.

The Provider and its employees shall follow mandated reporting requirements for suspected child abuse and neglect.

The Provider and its employees shall report critical incidences to the DCF Careline and significant events to DCF Risk Management within 12-hours of the incident.

In case you missed last Quarter's Credentialed Provider Meeting...

Credentialing Specialists:

Allison McKenna
860.638.5319
amckenna@abhct.com

Maria Petit-Homme
860.638.5337
mhomme@abhct.com

Director, Credentialing & DCF Services

Sarah Tkacs
860.704.6472
stkacs@abhct.com

213 Court St.,
Middletown CT, 06457
Phone 860.638.5309
Fax 860.638.5302

abhct.com

Credentialed Provider Meeting

If you are a currently approved DCF Provider, you will receive an email invite with an option to register online for the next meeting.

Visit
http://www.abhct.com/Programs_Services/DCF-Credentialing/
for the latest information on DCF Credentialing.

Friday
September 23, 2016

DCF Mandated Reporter Training: REQUIRED

Mandated reporters are required to report or cause a report to be made when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child under the age of 18 has been abused, neglected or is placed in imminent risk of serious harm. (Connecticut General Statutes §17a-101a)

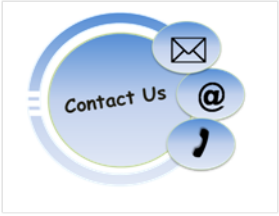
ON-LINE TRAINING Please click here to access the on-line Mandated Reporter Training for Community Providers.

IN-PERSON TRAINING To request to have a trainer come to your organization or facility, please click here and complete the online inquiry form.

Learn What Mandated Reporters Need to Know:
http://www.ct.gov/dcf/cwp/view.asp?a=3483&q=314384

CONTACT US!

Thinking of Moving?
Changed Phone numbers?
New Fax Line?
Expanding Services?
Updating Current Staff Listing?



As an approved DCF Provider you are required to notify ABH if there is a change in your Provider Status.

Visit
http://www.abhct.com/News_Resources/DCF_Credentialing/
and download the Provider Information Change Form.