2015 Pennsylvania State Roundtable Report

Trauma Workgroup

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Creating Trauma Informed and Responsive Dependency Courtrooms

If we save the body, but in so doing, destroy the mind and soul, what good have we really done? ~Justice Max Baer

"I want to thank my Caseworker for all she has done for me." Wouldn't it be wonderful to hear someone say that in a courtroom one day? Right now, those words are regularly spoken in one trauma-informed dependency courtroom.

Families in court have often experienced trauma in their lives. Trauma affects how they communicate, their ability to understand what was decided, and to make changes to address safety issues and work with services. The choices made in the process of conducting the business of the court with individuals who have experienced trauma can make a child's return to his or her parents or being placed in a permanent home more or less likely.

With such significant consequences, court systems and those system partners working with them, recognize the need to understand trauma and its impact on the individuals whom they serve. To be trauma-informed, it is necessary to develop the attitude, orientation, and practices of interacting with others from a "what happened to you" stance. A commitment to infusing the court, both in and out of the courtroom, with a trauma-informed culture will serve everyone well.

Such a commitment begins with an understanding of trauma. The definition of trauma*, in its simplest form, is an "event that threatens someone's life, their safety or their well-being". (NCJFCJ, 2010) Gordon Hodas, M.D., child psychiatrist and consultant for Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) and expert on trauma, identifies maltreatment and witnessing domestic violence as having "the most severe consequences on children and adolescents". (A Primer on Childhood Trauma and Trauma-Informed Care).*

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as

> "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."
>
> *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014*

This series of three "E's", **event**, **experience**, and **effect**, make up the key elements determining if something rises to the level of trauma. Any event, in and of itself, cannot be defined as a trauma. Instead, how the individual experiences that event becomes

*Information about trauma and trauma informed systems can be found in the attachments to this report

crucial. Understanding how someone experiences trauma is a process that requires a trusting, open relationship between two people. The person seeking to understand must have the skills to elicit the trust of a traumatized individual thereby allowing the honest disclosure of information.
Interactions children and parentshave with the child welfare and dependency systems can directly impact their willingness to engage and make timely progress. It is the mission of the Trauma Workgroup to provide information and resources that encourage responsiveness to the needs of those affected by trauma. Becoming trauma-informed benefits everyone. Because it may not be readily apparent who has and who has not been traumatized, it may be more effective to approach everyone as if they experienced trauma than to risk causing further harm.

BACKGROUND:

In 2014, the Psychotropic Medication Workgroup's final recommendation was creation of a workgroup, specifically to examine the issue of trauma. After years of discussion and research, the Psychotropic Medication Workgroup had concluded that the use/overuse of psychotropic medications for foster children was so closely tied to elements of trauma that it was impossible to address one without addressing the other. In agreement, the State Roundtable (SRT) created the Trauma Workgroup (TWG) with the charge of addressing trauma within the courthouse.

Under this broad charge the Workgroup set out to examine system and environmental issues within the courthouse and courtroom that might lend themselves to stressful reactions in traumatized persons. Additionally, the TWG decided to examine courtroom practices with the potential to make the courtroom experience more welcoming and less threatening. Finally, the TWG wanted to provide guidance to judges and legal professionals aimed at fostering safety, empowerment, and trustworthiness, common factors in creating trauma informed systems.

With these charges in mind, the Trauma Workgroup, under the leadership of Honorable Kathryn Hens-Greco, Court of Common Pleas, Allegheny County and Mr. David Schwille, LPC, Department of Human Services Director, Luzerne County, met eight times to organize, develop a plan of action, collect and analyze information related to people's experiences with dependency court.

PRINCIPLES FOR CREATING TRAUMA-INFORMED SYSTEMS

A review of the literature suggests the idea of "trauma responsiveness". This requires all those working within a system to possess the knowledge of both trauma and people's reactions to trauma. Beyond this understanding, trauma responsiveness requires courts, from judges to maintenance staff, knowing how to effectively interact with traumatized individuals who are in stressful situations or experiencing a moment of panic or anxiety. Simple changes to the way one approaches people and the manner in which they speak to them can make a huge difference in the responses people have.

Two well-respected reseachers, Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D. note the incidence of trauma is pervasive; nationally 55% to 90% of Americans have experienced in least one traumatic event. (Creating Cultures of Trauma-Informed Care, 2009). They have developed core values of trauma-informed practice which build the primary framework for many trauma-informed systems throughout the country. An organization's culture, reflecting these five values, recognizes the importance of people, both those being served and those serving. The more ingrained these values, the more attuned the system is to the precept, "do no harm." An infographic of their research and model can be found in the attachments to this report. The five core values are:

- **SAFETY**: create safe spaces
- **CHOICE**: provide options
- **EMPOWERMENT**: notice capabilities
- **COLLABORATION**: make decisions together
- **TRUSTWORTHINESS**: provide clear/consistent information

TWG members were pleased to note that these core values are consistent with the *Mission and Guiding Principles for Pennsylvania's Child Dependency System*. The values exemplify a system whose mission is to protect children and promote strong families and child well-being. When these things are prioritized, timely permanency can be achieved more readily. The values underscore Pennsylvania's strengths-based and family engaged approach. Lastly, they point to the importance of collaboration, not just with those being served, but one system with another; again a principle well-ingrained in our dependency system. As such, the TWG will keep this framework in mind as it develops recommendations and resources for the State Roundtable.

ACTIVITIES:

The TWG began its examination of this issue by completing a "walkthrough of the dependency system". Each point of interaction within the dependency court system was explored. Caseworkers and administrators from several counties, together with youth who had aged out of the system, provided their opinions and feedback about the stress encountered at each juncture. Common themes included:

- Communication: there is a level of uncertainty about what to say, when to say it, and how to convey information in a way that is understandable to all.
- Preparation: because expectations can be unclear, some expressed difficulty feeling well-prepared for questions that may be asked.
- Lack of Understanding: purposes of proceedings and the role of those in the court were not clear and raised anxiety.
- Uninformed: the feeling of not knowing what was happening or what was going to happen next was distracting.

Recognizing that every jurisdiction functions differently, the TWG wondered about the universality of these themes across Pennsylvania. It was decided that a survey was needed to collect a wider variety of responses about trauma and stressors in court.

A trauma survey for professionals was developed and sent out to the lead dependency judge and child welfare administrator in each county. Leaders were asked to take the survey and to send it to their local Children's Roundtable members with instructions to take the survey and pass it along to all of their employees and court-involved contract providers. The survey can be found at: https://www.surveymonkey.com/s/BBDV7ZR.

While the survey is still open, preliminary results show a strong understanding of trauma, its pervasiveness and its relevance to both children and parents. System partners report having received training on trauma while simultaneously wanting more. Full results of the survey will be available in the 2016 SRT report.

After asking professionals for their views and experience with trauma in the dependency system, a survey for parents and a survey for children and youth were created. Copies of this survey can be found as attachments to this report. These surveys are intended to collect information from individuals in the courthouse, either before or after their hearing. Jurisdictions that are interested in understanding the parent and child point of view can use these tools. The TWG is currently soliciting volunteer jurisdictions to administer the parent and child surveys during a one week to one month time period (based on the number of hearings during those timeframes). Each site hosting the survey will need to identify a person or people who are available to provide assistance to individuals and collect the forms once completed. Surveys will be tabulated and aggregate results made available in the 2016 SRT report. If a jurisdiction is interested in receiving the results of their own surveys, they will be provided.

In keeping with trauma-informed core values, Alternate Dispute Resolution (ADR), methods, used in many different sections of the court, was discussed as being a possible way to empower and provide parents and children choice. Information was shared by Venango County, who uses a facilitation model to handle adjudicatory hearings and by Judge Pratt in Fort Wayne, Indiana who provided the genesis of that model. The TWG thought, in light of the ADR practice being used in other areas of the court and its potentially positive impact on a trauma-informed court, further exploration should be done. As part of this exploration, the TWG is seeking the SRT's approval to partner with volunteer jurisdictions to implement and collect data about the practice's usefulness.

Lastly, many counties have expressed difficulty knowing what trauma specific services are available in their communities. The TWG reached out to a number of Behavioral Health Managed Care Organizations asking if they had a system in place to designate or track these providers. Collecting responses is an ongoing task; however, the two that have been received are included in this report's attachments.

CONCLUSION:

The child welfare and dependency systems have an ever increasing awareness of the complex and intricate layers of trauma woven throughout. By becoming trauma-

informed in both culture and practice, these systems have an opportunity to help those whom they serve continue on their journey to health and wholeness. Wanting what is best for children must include the willingness to look at one's own practices through a trauma lens and see what those before you see. Change is hard but areas that cause unintended harm need to change. In the end, all will be better for it.

RECOMMENDATIONS:

The Trauma Workgroup respectfully submits to the Pennsylvania State Roundtable the following recommendations:

1. Develop an electronic resource to highlight innovative and best practices from counties who are becoming Trauma-Informed and Trauma-Responsive so that counties can network and provide peer support for implementation.

2. Work jointly with volunteer counties to obtain parent and child/youth opinions of their court experiences via a survey.

3. Explore the feasibility of the Alternate Dispute Resolution model Facilitation in dependency cases by asking volunteer counties to try the method on a small number of cases and report back on criteria such as implementation, cost and impact on length of hearings.

ATTACHMENTS

1. A series of articles from Children's Mental Health Matters by Dr. Gordon Hodas, M.D., child psychiatrist consultant for the Pennsylvania Office of Mental Health and Substance Abuse Services:
    - A Primer on Childhood Trauma and Trauma-Informed Care, Part 1
    - Childhood Trauma and Trauma-Informed Care, Part 2: From "Trauma-Infirmed" to "Trauma-Informed"
    - System-Induced Trauma What It Is and How to Prevent It
    - The Trauma-Informed Checklist

2. Trauma Infographic

3. Parent Survey

4. Child/Youth Survey

5. Pennsylvania Medicaid Managed Care Organization Directory (Nov 2014)

6. Community Care Behavioral Health Organization Letter

7. Tuscarora Managed Care Alliance Letter

Children's Mental Health Matters

Number 4, October 2012

A Primer on Childhood Trauma and Trauma-Informed Care, Part I

By Gordon R. Hodas, M.D.

Introduction

Over the past decade, there has been increasing recognition of the damaging effects of childhood trauma, in particular childhood maltreatment. Many in the field of human services have also been learning about trauma-informed care. At the same time, the pervasiveness and consequences of childhood trauma remain unclear to many, and efforts to promote trauma-informed care can be misunderstood by some as "pampering" difficult youth who "need to be put in their place."

For the above reasons, I offer a primer on trauma and trauma-informed care. Part I highlights key points about the pervasiveness and impact of childhood maltreatment. This impact is evident in childhood and, all too commonly, continues into adolescence and across the lifespan. Part II will describe trauma-informed care and consider how its consistent implementation can promote resiliency and growth for youth and others. I hope that those who are already familiar with childhood trauma and trauma-informed care will feel validated. For others less familiar, I hope the discussion will promote a sense of curiosity and commitment to learn more.

Pervasiveness of Childhood Trauma and Maltreatment

While there are many types of trauma, maltreatment (neglect, physical abuse, psychological abuse, and sexual abuse) and being a witness of domestic violence often have the most severe consequences on children and adolescents. These forms of trauma tend to create the greatest sense of personal shame and are often inflicted by people whom the child has trusted. In addition, due to personal stigma and at times direct threats by the perpetrator, the child frequently maintains secrecy about the events. The child may mistakenly believe that he or she is responsible for the trauma or may fear being called a liar by their family or others if they speak up.

Unfortunately, childhood maltreatment is not typically a single, isolated event, but instead is part of an ongoing pattern of abuse. Sometimes the abuse is regular and predictable, while at other times the abuse may be intermittent and unpredictable. In either circumstance, the child is likely to experience fear and even terror, and the impact on the child's brain development and emotional functioning can be significant and long-standing.

The percentage of youth in America who have experienced significant trauma is extremely high – up to 80 percent and higher for high-risk youth and those living in urban settings and in poverty – and many of these youth have multiple exposures (Cooper, 2007; Fairbank 2008). Youth at high risk with high rates of trauma exposure include those involved in public systems – child welfare, juvenile justice, drug and alcohol, mental health – and those who are homeless (Cooper 2007).

Impact of Trauma on Children and Adolescents

It is important to understand what happens to the brain development of youth who have experienced severe trauma, particularly repeated maltreatment. The brains of these individuals are typically smaller than the brains of youth who have not experienced abuse. There is less development of the prefrontal cortex – the part of the brain responsible for problem-solving, decision-making, judgment, and self-control. In addition, the corpus callosum, which connects the two hemispheres and therefore facilitates integrated functioning, is also under-developed.

In terms of neurobiology (the chemistry of the brain), youth who have been abused have an increased amount of adrenaline, which along with other

chemicals is responsible for arousal – the so-called fight-or-flight response that occurs when one is in a life-threatening crisis. Hyperarousal occurs frequently in youth who have been abused, even in response to minimal or no discernable threat. The individual gets provoked easily and loses emotional and behavioral control, and then has great difficulty recovering. This loss of control and slow recovery are related to the high level of adrenaline and other chemicals in the brain. Loss of control is also due to the youth's limited skills for dealing effectively with stress, anger, disappointment, and other challenging emotions.

As the child gets older and enters adolescence, the above problems often get worse rather than better. Loss of control occurs more quickly and may appear to be unpredictable. Behavior is often quite impulsive, so that the youth acts without thinking. Explosions of anger upset classmates and frustrate adults. Gaining the youth's trust can also be very difficult – life has taught the youth that he or she is less likely to be hurt by remaining guarded and withholding trust. As a result, the youth may challenge even a caring adult, and "test" the adult to find out if the person perseveres in the relationship or gives up. Such behavior may confuse and alienate many well-meaning adults who could become youth mentors.

Youth who have experienced abuse and maltreatment rarely discuss it, and often try to present themselves as being strong and "in control." As a result, adults may mistakenly believe that inappropriate youth behaviors as described above are intentional and willful, rather than a useful adaptation in response to to past trauma. More likely, instead of feeling in control, the youth is overwhelmed and preoccupied with issues of safety and survival.

Youth who have been maltreated tend to devalue their life and the lives of others. As a result, they may appear to lack empathy. When they act violently, they experience the other person as a threat to their safety rather than as a real person. They may also perceive the person as a symbol of a world that has punished and humiliated them rather than as a real person, further increasing the risk of a violent response.

Impact of Trauma Over the Lifespan

Childhood trauma typically impacts the individual over the entire lifespan, leading to greater vulnerability to negative outcomes in both physical health and behavioral health. Data leading to this sobering conclusion has come in particular from the Adverse Child Experiences (ACE) Study, a longitudinal study that began at Kaiser Permanente in California in 1995. This study involved more than 17,000 middle class adults with private Kaiser Permanente health insurance, who were asked to complete a ten-item questionnaire involving the occurrence of maltreatment and other adversities during their childhood. These same individuals received a comprehensive physical examination, and were also asked extensive questions about their mental and physical health. It was found that, the greater number of adversities experienced by an individual during childhood, the greater the risk-taking that occurred during adolescence and the greater the impairment of mental and physical health status over time. The ACE study is ongoing, with the study group having been followed for nearly 30 years.

Consequences During Childhood and Risk-Taking During Adolescence

In addition to developing symptoms related to trauma, children subjected to maltreatment typically develop impaired attachments to their parents or other caregivers. This impairment can influence the entire developmental process, impacting other relationships and the ability to learn and think critically, develop empathy, and regulate emotions during times of challenge and stress.

During adolescence, youth with a history of maltreatment and adversities are at significant risk of early initiation of smoking, illicit drug use, sexual activity and adolescent pregnancies, and suicide attempts. In addition, such youth often place themselves in dangerous situations and may challenge others with little regard for the potential consequences. Their behaviors may result in violent behavior toward others, as well as personal victimization.

Negative Outcomes in Adulthood

Unfortunately, high risk behaviors and negative patterns persist over the lifespan (Centers for Disease Control and Prevention. 2005). Substance abuse and smoking may be serious problems. Antisocial behavior may result in arrests and incarceration. There may be low levels of educational achievement, under-employment, or unemployment. Divorce is common,

and domestic violence may be perpetrated by males, while females may experience repeated domestic abuse. In addition, nutrition and self-care may be poor, and the need for regular medical and dental care may be disregarded.

These negative patterns affect one's emotional and physical wellbeing, with a variety of negative behavioral and physical health outcomes emerging over the lifespan. *Behavioral health disorders* are more frequent among survivors of abuse than among those not subjected to abuse, and may take many forms. With severe, chronic trauma, post-traumatic stress disorder (PTSD) may emerge. PTSD, which involves the combination of hyperarousal, re-experiencing and avoidance, greatly impairs one's functioning and quality of life. Other potential behavioral health problems include substance abuse, panic attacks, depression and suicide attempts, psychosis, social isolation, negative thinking, and continued risk-taking behaviors.

Physical health disorders may also result from significant trauma exposure, due in part to risk taking and personal disregard of one's health. Adolescent smoking is likely to continue into adulthood, predisposing individuals to many physical health disorders. There is also an increased likelihood of multiple sexual partners and sexually transmitted diseases in adulthood. Physical inactivity and obesity are common. Specific physical health diseases may involve heart disease, chronic lung disease, liver disease, cancer, skeletal fractures, and autoimmune disorders.

Taken together, the net effect of these behavioral and physical health impairments is poor quality of life, often followed by premature death. From a public health perspective, the impact of trauma is an under-recognized factor in the shorter life expectancy of individuals receiving services in the public behavioral health system.

Discussion and Conclusion

The public health impact of childhood maltreatment and trauma on Americans has only recently been recognized in the media and by the public. The ACE study has shown that mind and body are truly linked, with life adversities significantly affecting not just one but both of these domains, and with the consequences typically life-long. Given the stigma associated with trauma and maltreatment, under-reporting is common, and many trauma survivors have little idea how their lives have been affected by their adverse life experiences.

While one might easily become discouraged by the data on childhood trauma and its long-term impact, I suggest withholding judgment, because this is only half of the story. There are ways to respond to trauma and prevent re-traumatization, thereby helping others overcome adverse experiences, become more resilient, and work towards recovery. While some individuals may need specific, clinically-based trauma treatment, many others can benefit from a much less complex public health approach known as trauma-informed care. Part II of this primer will consider what trauma-informed care involves, and how each of us, once informed, has the capacity to make a positive difference. Human relationships can cause harm, but they can also promote healing and recovery. One must never underestimate the power of basic respect and kindness – critical components of trauma-informed care – in helping others overcome the legacy of trauma.

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Children's Mental Health Matters

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Childhood Trauma and Trauma-Informed Care, Part II

From "Trauma-Infirmed" to "Trauma-Informed"

By Gordon R. Hodas, M.D.

Introduction

We have seen that childhood trauma – childhood maltreatment in particular – is a life-altering experience and also a serious public health problem. Childhood trauma is pervasive, and has significant impact on development and health during childhood and adolescence and over the entire lifespan. The previously discussed ACE study has demonstrated a direct correlation between the number of adversities (including maltreatment and loss) experienced by an individual during childhood and the severity of negative mental and physical health over time. Ongoing medical research can now partly explain how trauma impacts brain development and function, thereby connecting epidemiological outcomes with biological pathways.

In response to increased recognition of the impact of trauma on society, various mental health and other human service systems have been learning about "trauma-informed care." However, due to different terminology and different frames of reference, the discussion can be confusing. In addition, amidst the various terms and formulations by experts, the core concept of "trauma-informed care" may be overlooked or obscured.

The goal of this discussion is two-fold: 1) to delineate the concept of trauma-informed care, and 2) to describe its relevance and implementation for high risk youth and for all youth in the community.

Understanding Trauma-Informed Care

Although natural disasters and war both cause hardship, for the most part trauma is caused by specific individuals and is a product of unhealthy relationships. This is especially the case with maltreatment, which results in both adverse physical consequences and equally significant emotional consequences. The latter may involve, for a trauma survivor, a constant sense of endangerment, a sense of bitterness and betrayal, and inability to trust others and oneself.

Individuals who have experienced maltreatment and other interpersonal trauma are at greater risk to experience additional trauma and be re-traumatized. Others who have experienced trauma, although certainly not all, are at risk of themselves inflicting trauma on others. Most people do not actively choose to be victimized or to victimize others. On the contrary, these outcomes often are the result of an out-of-control, spiraling process that may occur in response to severe, chronic trauma that is not effectively addressed. Clearly, there is need to try to interrupt this cycle whenever possible and also to prevent traumatization in the first place. Every one of us is potentially at-risk for trauma, but this is especially the case for individuals living in poverty and those involved in the behavioral health system, other human service systems, and special education. Trauma-informed care, when understood and effectively implemented, can make a difference.

Children's Mental Health Matters is a monthly column to support children, adolescents and their families from the Office of Mental Health Services, Bureau of Children's Behavioral Health Services. It is available online at www.parecovery.org and can be printed and distributed as desired.

Trauma-informed care is a concept and set of practices intended to promote the intentional use of personal relationships and institutional practices to reduce the risk of traumatization and re-traumatization. It is applicable to formal treatment and care settings and to the community at large. Trauma-informed care also seeks to ameliorate the past effects of trauma, so that the individual becomes more resilient and can effectively work towards recovery. Even when incorporated as part of an organization's culture, trauma-informed care is ultimately implemented at the individual, person-to-person level. It is also a core element of a public health approach that seeks to facilitate positive relationships and social policies committed to public safety and non-violence. Within a public health perspective, trauma-informed care can be applicable to all three levels of prevention – *primary* for everyone, *secondary* for youth at risk, and *tertiary* for those needing or receiving mental health treatment.

Building on the work of others, I have previously defined trauma-informed care as follows:

> *Trauma-informed care involves a commitment to relationships, programs and interventions that seek to mitigate the effects of past traumatic experiences, and to prevent new trauma and re-traumatizing experiences, for youth and others. Trauma-informed care thus involves both individual interactions with youth and a public health approach that supports safe, non-violent relationships and settings* (Hodas, 2011).

I further elaborate on the scope of trauma-informed care, when applied to formal treatment and care settings:

> *When used in treatment and care settings, trauma-informed care involves the provision of interventions informed by an understanding of the pervasiveness of trauma and its consequences, and also addresses the symptoms and core deficits related to past trauma and promotes the youth's self-awareness, self-regulation, and healthy functioning* (Hodas, 2011)

An understanding of trauma-informed care requires recognition that it is an attitude, orientation, and set of practices towards others involving humanistic actions. It does not constitute clinical treatment. Clinical treatment for trauma is referred to as "trauma-specific treatment" or "trauma-specific services," and there is a clear distinction made between trauma-informed care or services, on the one hand, and trauma-specific treatment or services on the other. Ann Jennings highlights this distinction in her discussion of trauma-informed services:

> *"Trauma-informed " services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors...*(Jennings, 2004).

Trauma-informed care, as described by Sandra Bloom, operates at two levels: the level of the individual(s) served (the "client(s)"), and the level of agency professionals and the larger system (2012). In the absence of trauma-informed care for staff at the organization level – whereby the same core principles (see below) are adapted and implemented to benefit agency staff – it is highly unlikely that professionals will consistently provide trauma-informed care to youth and their families. All too often, the outcome for staff working in an organizational structure that is not trauma-informed is "burnout" and staff turnover. So, although not the focus of this discussion, trauma-informed care at the systems level for staff also needs ongoing attention.

It is important to appreciate that trauma-informed care is concerned with the *experience* of the individual being served, not the intent of the professional or the rhetoric of the system. The fundamental issue involves whether or not the client, group of individuals in a milieu, or the staff member experiences the support implicit in the concept of trauma-informed care, not what the professionals or administrators intend or claim. The individual served is the arbiter of whether or not a relationship is trauma-informed.

The Core Characteristics of Trauma-Informed Care

There are different models of trauma-informed care. I embrace the compelling simplicity of the model put forth by Roger Fallot (2011). This model identifies "five core principles" of trauma-informed care and of a

system that has embraced trauma-informed care (referred to as a "trauma-informed system"). These core principles are identified, with brief description, below:

- Safety – physical and emotional
- Trustworthiness – built on respect and transparency
- Choice – prioritizing opportunities to make decisions and experience a sense of control
- Collaboration – working together and sharing power
- Empowerment – prioritizing competency, validation, and skill-building

Trauma-informed care helps individuals feel welcomed and respected. Through provision of the five core principles, many of the consequences of past trauma – e.g., feeling unsafe, betrayed, coerced, and disqualified – can be mitigated. While certain individuals with severe, ongoing trauma-related symptoms may require trauma-specific treatment (offered in a trauma-informed setting), the vast majority may benefit from trauma-informed care and non-specialized treatment.

The five core principles need to guide every aspect of a person's experience in an agency, system, or other setting. So within an agency, the individual conduct of all staff and administrators, the mission statement, the policies, procedures and actual agency practices, and the overall culture need to be aligned so that trauma-informed care can be implemented consistently. Although the identified elements of trauma-informed care may seem intuitively sensible, it is important that staff in formal agencies receive training, followed by ongoing supervision and mentoring.

Trauma-informed competencies for direct care staff involve specific knowledge, attitudes and skills (Hodas, 2010). At the skill level, staff need to know how to develop welcoming, trusting relationships with youth, and then how to use these relationships to help youth become more resilient. Modeling and promoting a sense of hopefulness are particularly important here. Staff also need to be able to effectively use de-escalation skills when youth get upset, in order to maintain safety while avoiding the need for restraint and other restrictive procedures. In addition, staff need to work as part of a cohesive team, since mutual respect and collaboration are necessary components of a trauma-informed culture. Finally, staff need to have sufficient self-awareness that they can recognize and manage their own internal reactions appropriately, and identify appropriate goals for professional development.

At the agency level, the underlying culture may be conveyed both verbally and non-verbally. Consider an example offered by Fallot: One drug and alcohol agency greets clients with a banner that states, "*Denial* stops here." A second agency's banner states, "*Hope* starts here." It is not difficult to discern which agency is trauma-informed and which one is not.

Ultimately, trauma-informed care is applicable to every youth in every setting, whether in treatment, care, the home, or the community (the concept of "universal precautions"). I concur with Fallot that trauma-informed care should be implemented by every professional, direct care and otherwise, and by all support staff within a treatment or care setting, and should be experienced by the individual in every interaction and as part of the overall organizational culture. The importance of trauma-informed care is reflected in the fact that trauma-specific treatment, when offered in a setting that is not trauma-informed, is often ineffective. Evidence-based treatments require a trauma-informed context in order to work.

Are We "Trauma-Infirmed" or "Trauma-Informed"?

As a society and within many service systems, we are often more "trauma-infirmed" than "trauma-informed." This unfortunate reality is driven by at least two sets of factors:

1) Deficit-Based Thinking

More of our energy goes into identifying the deficits and "pathology" of an individual than into recognizing and building on the strengths and capabilities. Trauma-informed care is an intrinsically strengths-based approach. The trauma survivor may present as guarded and untrusting, and may behave in challenging ways that frustrate caregivers and professionals. Nevertheless, rather than cataloguing the pathology and assuming a hopeless stance, individuals committed to trauma-informed care presume that the individual's current behaviors have served an adaptive function during earlier, unsafe times. In addition, the trauma-informed professional

seeks to understand the linkages between the individual's earlier trauma exposures, the subsequent adaptations, and the current challenging behaviors. By viewing a person's challenging behaviors as an adaptation, one gains greater respect for that person, and can begin to envision potentially positive future outcomes. Equally important, unnecessary bias and stigmatization can be avoided. Instead of presupposing that the youth's behaviors of concern are "intentional" and "manipulative," the professional is better able to recognize the youth's resilience and the underlying struggles driving negative behavior.

It is well-recognized that youth with significant trauma histories are slow to trust adults. Certainly some of this may be an outgrowth of the youth's traumatic past. However, how much of the absence of trust might be an outcome of some mental health professionals, child welfare workers, juvenile probation officers, teachers and others presuming that the youth in question is unworthy of respect and then acting accordingly?

2) Disempowering Relationships with Youth

The problem with deficit-based thinking is that its impact goes well beyond the domain of internal thinking. The way we perceive others organizes the way we respond to them, and this, in turn, can become part of a negative, self-fulfilling prophecy ("Presuming the Positive," Hodas, 2001). The typical response of an adult to a youth perceived as "manipulative" is to engage in a power struggle and try to put the youth "in his place." Maintaining a deficit-based perspective tends to diminish the professional's sense of empathy and compassion ("Working with Children Who Are Defiant," Hodas, 2001). In addition, what a professional or caregiving adult takes as a personal attack may in fact be the result of the youth's pervasive sense of danger, as well as the automatic responses of a central nervous system organized over time to anticipate and respond to threats to survival.

When professionals disregard, demean, and disrespect the youth and his or her needs, the youth then resorts once again to survival behaviors. The youth's beliefs that adults don't listen and don't care are reinforced, and the youth may conclude that efforts at self-expression are a waste of time. Furthermore, as discussed by James Gilligan, disrespect tends to stimulate compensatory aggression (2001). Even well-meaning staff, by valuing youth "compliance" and strict rule-following rather than youth self-advocacy and appropriate challenges to rules and authority, may unintentionally reinforce the alienation and disempowerment of youth.

How Can We Be Trauma-Informed?

As suggested earlier, trauma-informed interactions and relationships are applicable to all treatment and care settings, and to community living. In formal settings, trauma-informed care helps facilitate specific goals consistent with the mandate of the involved system – e.g., trauma-informed care helps facilitate the recovery of a youth receiving mental health services, the rehabilitation and competency development of a youth in juvenile justice, and the safety, permanency, and well-being of a youth involved with child welfare.

In the community, being trauma-informed involves keeping the five core principles in mind when interacting with youth. Coaches of sports teams can be encouraging and trauma-informed, rather than humiliate youth. Teachers can combine "a pedagogy of kindness" with specific academic coursework. Community leaders and clergy can promote respect and non-violent conflict resolution, and foster community relationships based on mutual learning and the discovery of common interests. Both community activists and academics, including Geoffrey Canada (1998) and James Garbarino (1999), promote trauma-informed relationships based on their life experience and careful observation of others without referencing specific trauma-informed terminology. First responders to crisis try to maintain calm and prevent the individual from being overwhelmed. It is noteworthy that such first-responder programs as Crisis Intervention Teams (CIT) and Mental Health First Aid USA also incorporate trauma-informed ideas without referencing trauma-informed terminology.

Within the family, parents can, and need to be, trauma-informed. Trauma-informed parenting involves being a teacher, supportive coach, mentor, validator, and role model. The goal is to provide safety and predictability for the child on a daily basis, avoiding behaviors that unduly activate the child's hyper-arousal system. Ongoing efforts to help the child feel valued are essential. Trauma-informed parents set limits and impose consequences instructively without anger or loss of control, so that the message can be heard and

the caring relationship preserved. Humiliation and shaming are discarded as motivational tools. Trauma-informed parenting is closely linked to attachment-focused parenting, the latter richly described by Daniel Hughes (2009).

Conclusion

Trauma-informed care is a humanistic, strengths-based concept applicable to everyone, in both formal and informal settings. Since the goal involves preventing traumatization and re-traumatization and ameliorating the impact of past trauma, it is particularly important for youth with a history of severe, chronic trauma and for individuals at high risk of trauma. Whether employed in individual interactions by a direct care worker, as a guiding principle of an agency or system or as a public health concept, the essence of trauma-informed care is that it is intentional and relationship-based.

Without question, it is necessary and important for agencies and systems to screen, assess and ask about trauma, make referrals when indicated, develop the workforce needed to provide trauma-specific treatment for those who need it, and effectively coordinate care within and among systems. All of the above help define a trauma competent system. At the same time, interpersonally-based trauma-informed care as a guide to the daily conduct of professionals and other adults in regular contact with youth, and as a fundamental building block of a trauma-competent system, is important and must not be overlooked. In addition, one can only imagine how much more satisfying our relationships could be if we consistently used trauma-informed principles as a guide to our own daily conduct.

Attitudes and actions within service systems and society as a whole are often far from being trauma-informed, and can instead be regarded as trauma-*infirmed*. However, through individual and collective effort, we can continue the movement towards "trauma-informed care."

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Children's Mental Health Matters

Number 18, December 2013

System-Induced Trauma: What It Is and How to Prevent It

By Gordon R. Hodas, M.D.

Introduction

When we think about childhood trauma, we typically consider maltreatment, community violence, and bullying. Based on what is going on in the country and the world, we may also think about natural disasters and terrorism. There is one type of trauma, however, that we frequently overlook, one that can actually involve us more directly. This type of trauma is known as *system-induced trauma* (National Child Traumatic Stress Network), and it involves actions by mental health and other human service professionals, school staff, and others in a position of authority which cause trauma and harm to individuals for whom they are responsible.

Our focus here is on *youth* (up to age 21) with behavioral health challenges, but system-induced trauma can affect individuals of any age. It can occur in any level of behavioral health care, in both institutions and community-based care, and also in schools, child welfare, juvenile justice, and the legal system. System-induced trauma may occur intentionally or unintentionally. Either way, it causes harm to the individual (*Focus on Trauma*, 2013). System-induced trauma may involve an act of commission (doing something harmful directly to the individual) or an act of omission (failing to respond to an important request or need).

In what follows, we consider examples of system-induced trauma that can occur in behavioral health, and then look at how to prevent it.

Examples of System-Induced Trauma

Some instances of system-induced trauma constitute violations of regulations, ethics, and/or the law. Examples of such egregious system-induced trauma include the following:

- Engaging in any sexual activity with a youth being served or under the responsibility of a person in authority.
- Extorting money from a youth.
- Physically attacking or beating a youth.
- Mocking and making fun of a youth.
- Threatening harm via any of the above actions.
- Lying about the alleged behavior of a youth, or the actual behavior of staff.

Other types of system-induced trauma are harmful without necessarily involving negative intention on the part of the professional. Examples include the following:

- Unnecessary use of seclusion and restraint in institutional settings, whether due to insufficient de-escalation efforts or the convenience of staff (Fox, 2004).
- Using medication to sedate and immobilize a youth ("use of medication as a restraint"), in the absence of a genuine medical emergency (*Pennsylvania Bulletin*, 1999).
- Using unnecessary quantities of ongoing psychotropic medication.
- Denying basic individual rights, such as food, water, and access to the bathroom, under the

false rationale that the youth has not "earned" it.
- Imposing other forms of punishment in the absence of a compelling clinical justification, such as denying the youth contact with his or her family.
- Violating a youth's confidentiality.
- Imposing a rapid succession of consequences on a youth who is upset and out-of-control, rather than trying to help the individual calm down and regain self-control.
- Calling the police on a youth who has lost control, when the purpose is punitive and in the absence of a legitimate need for police involvement to ensure safety.
- Using a points and levels system as a method of coercion and restriction, rather than helping the youth develop coping skills and increased motivation.
- Predicting dire future consequences for the youth who is struggling, rather than supporting the youth and helping him or her to recognize the need and benefits of change.
- Yelling at a youth in response to an incident or action, rather than remaining respectful and professional in one's demeanor (Hodas, 1999).
- Presenting oneself in an unfriendly, intimidating, and even hostile manner.
- Getting into power struggles with the youth, rather than using the situation as a teaching opportunity or at least working to de-escalate the youth.
- Dismissing or minimizing a youth's concerns, because they do not seem significant.
- Shaming and humiliating youth due to loss of control or as a misguided intervention
- Making the provision of respect conditional on receiving respect, rather than unconditional for the youth (Hodas 2013b).
- Failing to provide appropriate information and documents to a youth and family, such as an agency handbook and a list of resources and resource persons potentially available if needed.
- Punishing a youth or family for exercising such rights as submitting an internal or external grievance regarding the quality of care being provided.

There is one final level of system-induced trauma, which is more subtle but not necessarily less harmful to the individual. Examples include the following:

- Failing to establish oneself as a person interested in the youth and his or her life experiences.
- Failing to learn about the role of trauma and loss in the life of the youth (Jennings).
- Failing to maintain a "trauma lens" when interacting with the youth, which focuses on "what happened to you," rather than "what's wrong with you" (NCTIC).
- Failing to ask about the strengths, hopes, and aspirations of the youth (Hodas 2001).
- Failing to point out strengths when they are observed.
- Failing to try to instill a sense of hopefulness for the youth, while still respecting reality of the youth's life to date.
- Failing to acknowledge one's own unintentional mistakes and oversights, as a model for accountability and respect.
- Failing to allow the youth to fully express his or her concerns, due to staff impatience or by focusing on the youth's inappropriate language.
- Failing to recognize the importance of youth self-advocacy, and instead viewing the youth as "oppositional" or "noncompliant."
- Blaming the youth for behaviors out of his or her control, and regarding the youth as "manipulative" or "attention-seeking."

Preventing System-Induced Trauma

Given that some instances of system-induced trauma are unintentional and involve well-meaning staff and agencies, it may not be realistic to prevent all system-induced trauma. Nevertheless, this should be the goal.

To complement good intentions, common sense, and a willingness to respond to feedback, agencies and staff need a set of principles and ethical values to guide them in their work with youth and their families. These principles should take into account basic human needs for respect, as well as the likely impact on the youth of his or her adverse life experiences – in the community and in human service systems (e.g., past system-induced trauma).

Fortunately, such principles have been identified. We recognize them as *trauma-informed principles* (Bloom, Fallot and Harris, 2009; Hodas, 2012).

Below I highlight what I view as the core trauma-informed principles. They are based on the work of Roger Fallot (Fallot and Harris, 2009; Fallot 2011) and the recent formulation of the Substance Abuse and Mental Health Services Administration (SAMHSA), but are less inclusive than the SAMSHA formulation:

- *Safety*

  By prioritizing the physical and emotional safety of youth with whom we work, many of the foregoing examples of system-induced trauma can be avoided. We need to remember that, in the absence of safety, a youth cannot focus on anything other than survival, and trust and empathy cannot develop or be displayed. For youth who experienced significant danger in their lives, it takes time and patience to instill a sense of safety.

- *Trustworthiness*

  Meaningful relationships require mutual trust. Staff need to appreciate the inherent power discrepancy between them and the youth with whom they work. Youth who have experienced repeated disappointment and even betrayal from important adults may be unwilling to trust others, since trust entails allowing oneself to be vulnerable once again. Trustworthiness is conveyed by an adult's manner, not just their words.

- *Collaboration*

  Collaboration involves the intentional sharing of power. Youth cannot collaborate with staff unless they feel safe and experience at least some trust. Youth who have lived in chronic fear do not know how to collaborate. Their focus has been on escaping dangerous situations, fighting back at times, and learning to be strategic in order to avoid harm. This latter coping mechanism may be misinterpreted as "manipulation" by staff unaware of the dynamics of trauma. Sharing power can be very satisfying for staff, when they see changes in the youth.

- *Choice*

  It is human nature to want to have some control in our lives and be able to determine what happens to us. Choice increases one's engagement and motivation to participate in meaningful processes. For many youth with challenges, their opportunity to make choices has been greatly curtailed. At times, making choices may have resulted in punishment and harm. It is important to remember that individuals denied the opportunity to make choices may not be good at it. So try to support youth decision-making and youth-advocacy.

- *Strengths-based*

  Even though being strengths-based has been an implicit trauma-informed principle, its explicit addition by SAMHSA is helpful. Building on strengths enables youth to act constructively. In addition, awareness of personal strengths alters a person's identity, creating a sense of pride and motivation. Staff can be strengths-based by highlighting positive change by the youth. Keep in mind that change is gradual and may appear to be slow. This does not mean that it is not taking place.

- *Empowerment*

  Ultimately, all of the above principles and related interventions can increase the sense of empowerment of youth. If the youth experiences respect and is able to develop genuinely trusting relationships, it is likely that the empowerment will be directed in constructive, prosocial ways. Empowerment does not involve indiscriminately praising a youth irrespective of his or her behavior. It does, however, involve helping the youth identify an inner core of positive intentions. Empowerment also involves modeling positive coping, and assisting the youth in developing effective coping skills.

Discussion:

System-induced trauma, unfortunately, is more common than we may think. Its presence highlights the need at the systems level for strong agency mission and ethics statements, and for effective staff hiring practices, orientation, training, supervision, and performance evaluations. Beyond this, agencies need to do inventories and soul-searching, to learn more about their culture and how their policies and procedures might predispose toward system-induced trauma.

For the individual professional, delineation of the various pitfalls of system-induced trauma is meant to serve as a frame of reference. Understanding and embracing trauma-informed principles can help guide professionals toward healthy interactions with youth, both one-on-one and in groups. Use of a trauma-informed checklist can help operationalize trauma-informed principles for direct care workers and others (Hodas 2013a).

It is important to appreciate that every system-induced trauma is associated with an implicit preventive action. For example, the failure to learn about a youth's trauma and loss can be prevented by asking the youth, at an appropriate time, about such experiences and listening carefully. Behavioral health treatment that does not recognize the impact of trauma on youth will inevitably fall short, frustrating youth and professionals alike. The temptation to blame the youth for challenging behaviors can be prevented by remembering that trauma disrupts normal development, and that youth cannot display coping skills not yet acquired. Such considerations tie in with the need to be strengths-based: Adversity and challenges are real, but each youth also has strengths, and these need to be identified, celebrated, and supported. Strengths will help youth change their lives for the better. Our interventions are best centered on helping the youth recognize what they have already achieved and what, with further effort, may lie ahead.

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Children's Mental Health Matters

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The Trauma-Informed Checklist

By Gordon R. Hodas, M.D.

Introduction

This column focuses on how well-meaning mental health and other human service professionals can assess whether or not they are being trauma-informed in their relationships with *individuals* (primarily referring here to youth and their families). Two earlier columns have described the prevalence and significance of childhood trauma (Hodas, 2012a), and how trauma-informed care represents a public health approach to help prevent re-traumatization and promote healing (Hodas, 2012b).

Professionals who do not recognize and address trauma in their work with individuals may unintentionally engage in what is known as system-induced trauma. The latter involves trauma inflicted by mental health and other human service systems on individuals, which exacerbates their pre-existing trauma (NCTSN). System-induced trauma may result from acts of commission (e.g., inappropriate and unnecessary use of seclusion and restraint) and from acts of omission. One of the prime examples of system-induced trauma by omission involves failure to consider the impact of trauma on the presentation and functioning of the individual. When trauma is not recognized and addressed in individuals presenting with complex challenges, progress is likely to be limited, and harm to the individual may occur (Jennings).

In mental health and human services, professionals need to form *therapeutic relationships* with those with whom they work (Hodas, 2006). This means that relationships need to benefit the individual therapeutically, not that the staff person is doing therapy. In human services, the significance of the therapeutic relationship parallels the importance of important relationships throughout the life cycle. For example, infants cannot survive without a committed, caring parent or caregiver. Students typically cannot learn unless they experience their teacher as being committed to them. Youth need at least one positive role model to effectively navigate the challenges of adolescence. In each instance, the sustaining relationship is not perfect, but is characterized by caring, consistency, and persistence.

Trauma-Informed Care

Trauma-informed care is a vehicle to guide professionals in being respectful and therapeutic with those with whom they work. Trauma-informed care needs to be part of an organization's values and culture, and needs to be offered to agency staff and not just to individuals (Bloom; Fallot and Harris, 2009). At the individual level, trauma-informed care is best understood as involving ongoing interactions between a professional and the individual that are therapeutic in nature, as experienced by the individual. Trauma- informed care is guided by five core principles (Fallot, 2011; Fallot and Harris, 2009): 1) safety (physical and emotional), 2) trustworthiness, 3) choices, 4) collaboration, and 5) empowerment. The latter is promoted via a combination of validation, respectful guidance, and the teaching of specific coping and life skills.

Children's Mental Health Matters is a monthly column to support children, adolescents and their families from the Office of Mental Health Services, Bureau of Children's Behavioral Health Services. It is available online at www.parecovery.org and can be printed and distributed as desired.

The Trauma-Informed Checklist

Delineation of the five core trauma-informed principles is important, but in a practical way how can professionals determine whether or not they are being trauma-informed? In what follows, I offer a "Trauma-Informed Checklist" that professionals can use for self-assessment, one individual at a time. I developed this checklist to assist me in clinical work with youth and families, and to help others in need of a reflective tool to think about trauma-informed care at the individual level (Hodas, 2011).

Below are the questions on the trauma-informed checklist :

- Am I committed to promoting the safety of others? Am I *effective* in promoting their safety?
- Do I want to guide and empower others, or do I want to control them?
- Am I respectful and trustworthy in my interactions with others, even when there is disagreement?
- Do I mostly listen, or do I mostly preach to others?
- Do I use power or threats to gain "compliance," or do I try to engage and motivate others, so that we can work together and collaborate?
- Do I use my hands to restrain others, or to hug them, when appropriate?
- Do I try to understand why a person is struggling, including by considering issues of trauma, or do I focus primarily on their behaviors, "pathology," and diagnosis?
- Can I identify how a person's challenging behavior may have supported their survival in the past, and perhaps may continue to serve this function?
- Am I able to offer hope to others without disqualifying the reality of their life experience to date?
- Am I able to identify strengths in others and help them recognize these also?
- Do I encourage others, consistent with their age and developmental level, to think positively about their life, exercise personal choice, and identify positive goals?
- Do I help others learn to express themselves, advocate for themselves, and develop other important life skills?
- Do I follow the five core TIC principles in my interactions with other professionals and with my colleagues, supervisor, and others?
- Do I model the five core principles in my interactions with parents, guardians, and other family caregivers, to help them learn how to do this with their children?
- Do I know key resources to help the population with which I work, and do I help individuals and families identify and engage natural community supports?
- How do I answer the "Cardinal Question": Do my clients see me as truly being "on their side"?

Discussion

It should be evident that the questions comprising the Trauma-Informed Checklist all build on the five trauma-informed principles identified above. One self-assessment question inquires not about the individual relationship but rather about the professional's relationships with peers and supervisors. While this may seem to involve a different area of inquiry, it is included because one's relationship with individuals depends in part on the quality of one's relationships with other involved staff.

The purpose of the checklist is to stimulate reflection, remind the professional of the broadly-based implications of trauma-informed care at the relational level, and support trauma-informed behaviors by the professional in the individual relationship. These same questions, judiciously selected and rephrased, may also be posed to the individual directly. For example, the professional can ask the youth, "When we talk, do you feel that I listen carefully to what you are saying?" The discussion with the youth, however, will be of greater benefit if the professional has first engaged in his or her own self-assessment. Given that trust and the ability to discuss personal relationships are often difficult for those with significant challenges, the direct use of the checklist with individuals can represent a constructive way to model safe discussion of important issues.

Conclusion

Trauma-informed care, including trauma-informed relationships, needs to be the standard of care in human services. Providing trauma-informed relationships helps the individual overcome some of the adverse affects of past trauma: lack of safety; distrust and possible feelings of betrayal; coercion and absence of choice; uncertainty regarding what will happen next; and disqualification and humiliation in response to efforts at self-assertion and self-advocacy. The Trauma-Informed Checklist can be used for professional growth and quality enhancement, and also serves as a potential catalyst for discussion of the relationship with an individual This tool can help professionals be truly therapeutic, In using the tool, the professional needs to be curious, non-defensive, and open to change. While efforts to provide trauma-informed care are admirable, the professional needs to bear in mind that, ultimately, the effectiveness of trauma-informed care is in the eyes of the beholder.

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When an event is traumatic to children and adults, they may be negatively impacted emotionally, physically and spiritually by these adverse life events.

ITTIC, 2014

Rising from the Ashes...

Trauma - informed care is about ensuring ALL individuals feel physically and emotional safe, are noticed and listened to, and are given a voice.

ITTIC, 2014

The Effects of Trauma

Attachment 2

- Trauma impairs: memory, concentration, new learning, and focus
- Trauma has been correlated to: heart disease, obesity, addiction, pulmonary illness, diabetes, autoimmune disorders, cancer.
- Trauma impacts an individual's ability to: trust, cope, form healthy relationships
- Trauma disrupts: emotion identification; ability to self-soothe or control expression of emotions; one's ability to distinguish between what's safe and unsafeTrauma impacts
- Trauma shapes: a person's belief about self and others; one's ability to hope; one's outlook on life.

RETRAUMATIZATION

WHAT HURTS?

SYSTEM (Policies, Procedures, "The Way Things Are Done")	RELATIONSHIP (Power, Control, Subversiveness)
Having to continually retell their story	Not being seen/heard
Being treated as a number	Violating trust
Procedures that require disrobing	Failure to ensure emotional safety
Being seen as their label (i.e. addict, schizophrenic)	Non collaborative
No choice in service or treatment	Does things for rather than with
No opporunity to give feedback about their experience with the service delivery	Use of punitive treatment, coercive practices and oppressive language

WHAT HELPS?

Creating a Trauma-Informed environment using the following five principles:

SAFETY	CHOICE	EMPOWERMENT	COLLABORATION	TRUSTWORTHINESS
CREATING AREAS THAT ARE CALM AND COMFORTABLE	PROVIDING AN INDIVIDUAL OPTIONS IN THEIR TREATMENT	NOTICING CAPABILITIES IN AN INDIVIDUALS	MAKING DECISIONS TOGETHER	PROVIDING CLEAR AND CONSISTENT INFORMATION

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School of Social Work
University at Buffalo The State University of New York

PARENT SURVEY ON TRAUMA-INFORMED COURTS

Please help us learn about your experience in court so that we can improve things for you and your family. Thank you!

	Yes	No
I have been to court about my child/children only one time.	○	○

These are some statements about court. Please tell us how stressful you think they are:

	Very Stressful	Somewhat Stressful	Not Stressful at All
Getting to court	○	○	○
Knowing when court is	○	○	○
Finding my way around the courthouse	○	○	○
Going through security	○	○	○
Seeing Sheriff Deputies	○	○	○
Waiting for my hearing	○	○	○
Being in the waiting area	○	○	○
Finding someone to take care of my children	○	○	○
Knowing what I'm allowed to do with my children	○	○	○
Remembering my own childhood when I'm at court	○	○	○
Finding food to eat or paying for lunch	○	○	○
Hearing the caseworker talk about me	○	○	○
Speaking in court	○	○	○
Answering questions	○	○	○
Not enough time to talk to my lawyer before court	○	○	○
Understanding court orders	○	○	○

Other: (Please write only on or above the line)

_____

These are some statements about court. Please tell us how helpful you think they are:

	Very Helpful	Somewhat Helpful	Not Helpful
I get to ask questions.	○	○	○
Understanding what I need to do.	○	○	○
Hearing about my strengths and what I'm good at doing.	○	○	○
Having an opportunity to talk to my lawyer when I want to.	○	○	○
The Judge talks to me directly.	○	○	○
The Judge asks me if I understand.	○	○	○
Spending time with my children at court.	○	○	○
Hearing about how my children are doing.	○	○	○
Waiting gives me a chance to talk to other people like me.	○	○	○

Other: (Please write only on or above the line)

_____

These are some statements about court. Please tell us how often these things happen:

	Always	Sometimes	Never
I get to ask questions.	○	○	○
Understanding what I need to do.	○	○	○
I get to hear about my strengths and what I'm good at doing.	○	○	○
I have an opportunity to talk to my lawyer when I want to.	○	○	○
The Judge talks to me directly.	○	○	○
The Judge asks me if I understand.	○	○	○
I get to spend time with my children at court.	○	○	○
I get to hear how my children are doing.	○	○	○
Waiting gives me a chance to talk to other people like me.	○	○	○

The courthouse would be better if: (write your suggestions)

The hearing would be better if: (write your suggestions)

CHILDREN/YOUTH SURVEY ON TRAUMA-INFORMED COURTS

Please help us make court better for you. Thanks!

I am ____ years old.

I am in:

- ○ 1st grade
- ○ 2nd grade
- ○ 3rd grade
- ○ 4th grade
- ○ 5th grade
- ○ 6th grade
- ○ 7th grade
- ○ 8th grade
- ○ 9th grade
- ○ 10th grade
- ○ 11th grade
- ○ 12th grade
- ○ GED classes
- ○ Tech School
- ○ College
- ○ Other

I have been to court only one time.

- ○ Yes
- ○ No

Being at court is: (choose all that apply)

- ○ Fun
- ○ Scary
- ○ Interesting
- ○ Important
- ○ Confusing
- ○ Boring

This is what I like about going to court: (choose all that apply)

- ○ I get to see my parents
- ○ I get to see my brothers & sisters
- ○ There are fun things to do
- ○ I get to play with toys in the courtroom
- ○ There are snacks for me
- ○ I get to talk to the Judge
- ○ There are dogs to play with at court
- ○ I hear good things about my parents
- ○ The Judge tells me I'm doing good
- ○ People listen to me
- ○ I get to talk to my lawyer
- ○ Court makes things get better
- ○ I get to ask for things I need
- ○ Other: ____

This is what I don't like about going to court: (choose all that apply)

- ○ Going through security
- ○ I don't feel safe
- ○ How long it takes for my turn
- ○ Seeing my parents at court
- ○ My parents don't come to court
- ○ I don't know what I'm allowed to do
- ○ I don't get to go into the courtroom
- ○ I'm hungry and there is nothing to eat
- ○ Hearing people talk about me
- ○ Hearing people talk about my parents
- ○ Hearing about what happened to me
- ○ Answering questions
- ○ I don't get to talk to my lawyer
- ○ I don't understand what happened at court
- ○ No one asks me anything
- ○ I can't talk to the Judge privately
- ○ Other: ____

Court would be better if:

PENNSYLVANIA MEDICAID
MANAGED CARE ORGANIZATION (MCO) DIRECTORY
NOVEMBER 2014

Healthchoices Physical Health

Name of Contractor	Contact Information	Service Area
Aetna Better Health		**Lehigh/Cap Zone**
Pharmacy Benefit Mgr: CVS/Caremark Dental Benefit Mgr: DentaQuest	Contact Name/Number: Cibby Abraham (215) 692-9912 Contact Name/Number: Darlene Demore (717)829-2296	
Denise Croce CEO Aetna Better Health L/Cap Zone 2000 Market Street., Suite 850 Philadelphia, PA 19103	Phone: 215-282-3503 Fax: 860-902-7827 CroceD@aetna.com www.aetnabetterhealth.com	Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry and York Counties
MCO Chief Medical Officer: Patricia Guerra-Garcia, M.D.	Phone: 215-282-3539 Guerra-GarciaP@aetna.com	
MCO Contact: Darlene L. DeMore Director, Regulatory Compliance Coventry Health Care, Inc./Aetna Better Health - PA 3721 Tecport Drive Harrisburg, PA 17111	Phone: 717-829-2296 Fax: 717-526-2717 dldemore@cvty.com	DPW Contract Mgr: Liz DeLuca Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: 866-638-1232 TTY: 711 Special Needs Unit: 855-346-9828 TTY: 711 Provider Services: 866-638-1232	
AmeriHealth Caritas Pennsylvania		**Lehigh/Cap Zone**
Pharmacy Benefit Mgr: Perform Rx Dental Benefit Mgr: DentaQuest	Contact Name/Number: Ellan Baumgartner 215-863-5215 Contact Name/Number: Ellan Baumgartner 215-863-5215	
Marge Angello, RN Executive Director, AmeriHealth Caritas Pennsylvania 8040 Carlson Road Harrisburg, PA 17112	Phone: 717-651-3552 Fax: 717-651-3555 mangello@amerihealthcaritas.com	
MCO Medical Director: Eric Berman D.O. AmeriHealth Caritas Pennsylvania 200 Stevens Drive Philadelphia, PA 19113	Phone: 215-863-5804 Fax: 215-937-8114 EBerman@amerihealthcaritas.com	
MCO Contact: Ellan Baumgartner Manager, Regulatory Affairs AmeriHealth Caritas Pennsylvania 200 Stevens Drive Philadelphia, PA 19113	Phone: 215-863-5215 Fax: 215-937-8568 ebaumgartner@amerihealthcaritas.com	DPW Contract Mgr: Charlie Hill Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: 888-991-7200 TTY: 888-987-5704 Special Needs Unit 800-684-5503 TTY: 888-987-5704 Provider Services: 800-521-6007	

Gateway Health — Lehigh/Cap Zone

Pharmacy Benefit Mgr: Argus — Contact Name/Number: Mimi Clavir (412) 255-4173
Dental Benefit Mgr: UCCI — Contact Name/Number: Mimi Clavir (412) 255-4173

Patricia J. Darnley President and Chief Executive Officer Gateway Health Plan®, Inc. Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222	Phone: 412-255-4640 Fax: 412-255-4503 www.gatewayhealthplan.com	Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry and York Counties
MCO Medical Director: Dr. Michael Madden 20th Floor	Phone: 412-255-4640 Fax: 412-255-4503 mmadden@gatewayhealthplan.com	
MCO Contact: Tom Campbell Government Affairs Specialist 21st Floor	Phone: 412-255-4173 or 412-255-7209 Fax: 412-255-4503 TCampbell@gatewayhealthplan.com	DPW Contract Mgr: Alinda Burrell Phone: 717-772-6300 Fax: 717-772-6328
Address for all other GHP staff: Gateway Health Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222	Member Services: Special Needs: Provider Services:	800-392-1147 TTY: 711 800-642-3550 TTY: 711 800-392-1145

UnitedHealthcare Community Plan of Pennsylvania — Lehigh/Cap Zone

Pharmacy Benefit Mgr: Optum Rx — Contact Name/Number: Marion Pardes (973) 297-5537
Dental Benefit Mgr: DBP — Contact Name/Number: Christopher Montanez (443) 896-0769

Sue Schick, President United Healthcare Community Plan of PA The Wanamaker Bldg, Suite 410 100 Penn Square East Philadelphia, PA 19107	Assistant: Patricia Cook: Phone: 215-982-7929 Fax: 215-832-4702 sue.schick@uhc.com	Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry and York Counties
United Healthcare Community Plan of Pennsylvania Unison Plaza 1001 Brinton Road Pittsburgh, PA 15221	Phone: 412-858-4000 Fax: 412-858-4060 www.uhc.com	
MCO Medical Director: Joseph Sheridan, D.O. The Wanamaker Bldg, Suite 400 100 Penn Square East Philadelphia, PA 19107	Phone: 215-832-4505 Joseph.Sheridan@uhc.com	
MCO Contact: Carol Lavoritano Director of Regulatory Affairs &Compliance The Wanamaker Bldg, Suite 400 100 Penn Square East Philadelphia, PA 19107	Phone: 215-832-4534 Fax: 215-832-4702 clavoritano@uhc.com	
MCO Contact: Mark Calla Regulatory Compliance Consultant Unison Plaza 1001 Brinton Road Pittsburgh, PA 15221	Phone 412-545-9474: Fax: 412-457-1364 Mark.calla@uhc.com	DPW Contract Mgr: Pauline Saunders Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs: Provider Services:	800-414-9025 TTY: 711 877-844-8844 TTY: 711 800-600-9007

UPMC Health Plan, Inc./UPMC *for You* — Lehigh/Cap Zone

Pharmacy Benefit Mgr: ESI — Contact Name/Number: Cyril Zibrick 412-454-0947
Dental Benefit Mgr: Avesis — Contact Name/Number: Bob Glass 412-454-7951

John Lovelace, President of Government Programs & Individual Advantage Products UPMC *for You* US Steel Building 600 Grant Street, 55th Floor Pittsburgh, PA 15219	Phone: 412-454-5269 Fax: 412-454-7527 lovelacejg@upmc.edu	Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry and York Counties
MCO Medical Director: Dr. Nicholas Degregorio US Steel Building-11th Floor 600 Grant Street Pittsburgh, PA 15219	Phone: 412-454-7860 Fax: 412-454-7544 degregorion@upmc.edu	
MCO Contact: Jessica Rhodes MA Operations & Government Liaison UPMC *for* You US Steel Building -9th Floor 600 Grant Street Pittsburgh, PA 15219	Phone: 412-454-0949 Fax: 412-454-7544 For correspondence -upmc4qa@upmc.edu For meetings - phillipsjl4@upmc.edu	DPW Contract Mgr: Virginia Perry Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Southwest Lehigh/Cap Special Needs: Provider Services:	800-286-4242 TTY:800-361-2629 866-353-4345 TTY: 800-361-2629 866-463-1462 TTY: 800-361-2629 866-918-1595

Name of Contractor	Contact Information	Service Area

Aetna Better Health — Southeast Zone

Pharmacy Benefit Mgr: CVS/Caremark — Contact Number: Cibby Abraham (215) 692-9912
Dental Benefit Mgr: DentaQuest — Contact Number: Darlene Demore (717) 829-2296

Denise Croce, CEO Aetna Better Health SE Zone 2000 Market Street., Suite 850 Philadelphia, PA 19103	Phone: 215-282-3503 Fax: 860-902-7827 CroceD@aetna.com www.aetnabetterhealth.com	Counties: Bucks, Chester, Delaware, Montgomery, Philadelphia
MCO Chief Medical Officer: Patricia Guerra-Garcia, M.D.	Phone: 215-282-3539 Guerra-GarciaP@aetna.com	
MCO Contact: Darlene L. DeMore Director, Regulatory Compliance Coventry Health Care, Inc./Aetna Better Health - PA 3721 Tecport Drive Harrisburg, PA 17111	Phone: 717-829-2296 Fax: 717-526-2717 dldemore@cvty.com	DPW Contract Mgr: Liz Deluca Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs: Provider Services:	866-638-1232 TTY: 711 855-346-9828 TTY: 711 866-638-1232

UnitedHealthcare Community Plan of Pennsylvania — Southeast Zone

Pharmacy Benefit Mgr: Optum Rx — Contact Name/Number: Marion Pardes (973) 297-5537
Dental Benefit Mgr: DBP — Contact Name/Number: Christopher Montanez (443) 896-0769

Sue Schick, President United Healthcare Community Plan of Pennsylvania (West Location) The Wanamaker Building 100 Penn Square East, Suite 410 Philadelphia, PA 19107	Assistant Patricia Cook: Phone: 215-982-7929 Fax: 215-832-4702 sue.schick@uhc.com	Bucks, Chester, Delaware, Montgomery and Philadelphia Counties

UnitedHealthcare Community Plan of Pennsylvania		Southeast Zone (cont'd)
MCO Medical Director: Joseph Sheridan, D.O. The Wanamaker Building 100 Penn Square East, Suite 400 Philadelphia, PA 19107	Phone: 215-832-4505 Joseph.Sheridan@uhc.com	
MCO Contact: Carol Lavoritano Director of Regulatory Affairs and Compliance The Wanamaker Building 100 Penn Square East, Suite 400 Philadelphia, PA 19107	Phone: 215-832-4534 Fax: 215-832-4702 clavoritano@uhc.com	DPW Contract Mgr: Pauline Saunders Phone: 717-772-6300 Fax: 717-772-6328
MCO Contact: Mark Calla Regulatory compliance Consultant Unison Plaza 1001 Brinton Road Pittsburgh, PA 15221	Phone 412-545-9474: Fax. (412) 457-1364 Mark.Calla@uhc.com	
	Member Services Special Needs: Provider Services:	800-414-9025 TTY: 711 877-844-8844 TTY: 711 800-600-9007

Aetna Better Health		Southeast Zone
Pharmacy Benefit Mgr: ESI Dental Benefit Mgr: DentaQuest	Contact Name/Number: Cibby Abraham (215) 692-9912 Contact Name/Number: Darlene Demore (717) 829-2296	
Denise Croce, CEO Aetna Better Health SE Zone 2000 Market Street., Suite 850 Philadelphia, PA 19103	Phone: 215-282-3503 Fax: 860-902-7827 CroceD@aetna.com www.aetnabetterhealth.com	Counties: Bucks, Chester, Delaware, Montgomery, Philadelphia
MCO Chief Medical Officer: Patricia Guerra-Garcia, M.D.	Phone: 215-282-3539 Guerra-GarciaP@aetna.com	
MCO Contact: Darlene L. DeMore Director, Regulatory Compliance Coventry Health Care, Inc./Aetna Better Health - PA 3721 Tecport Drive Harrisburg, PA 17111	Phone: 717-829-2296 Fax: 717-526-2717 dldemore@cvty.com	DPW Contract Mgr: Liz Deluca Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs: Provider Services:	866-903-0748 TTY: 800-613-3087 866-427-9721 TTY: 800-613-3087 866-903-0748 request provider services

Name of Contractor	Contact Information	Service Area
Health Partners Plans		**Southeast Zone**
Pharmacy Benefit Mgr: Argus Dental Benefit Mgr: Avesis	Contact Name/Number: Kearline D Jones & Pati Gaull (215) 991-4063 or (215) 991-4067 Contact Name/Number: Kearline D Jones & Pati Gaull (215) 991-4063 or (215) 991-4067	
William George, President & CEO Health Partners Plans of Philadelphia, Inc. 901 Market Street, Suite 500 Philadelphia, PA 19107	Phone: 215-991-4044 Fax: 215-849-7097 www.healthpart.com	Bucks, Chester, Delaware, Montgomery and Philadelphia Counties
MCO Medical Director: Dr. Steven Szebenyi, M.D. 901 Market Street, Suite 500 Philadelphia, PA 19107	Phone: 215-991-4027 sszebenyi@healthpart.com	

MCO Contact: Kearline D. Jones Vice President of Government Relations & Compliance	Phone: 215-991-4063 Cell : 267-767-5443 Fax: 215-967-4494 kmjones@healthpart.com	DPW Contract Mgr: Alinda Burrell Phone: 717-772-6300 Fax: 717-772-6328
MCO Contact: Pati Gaull Director of Compliance	Phone: 215-991-4067 Fax: 215-967-9266 pgaull@healthpart.com	
	Member Services: Special Needs: Provider Services:	800-553-0784 TTY: 877-454-8477 866-500-4571 TTY: 215-849-1579 215-991-4350 (Phil. local calls) 888-991-9023

Keystone First — Southeast Zone

Pharmacy Benefit Mgr: Perform Rx Contact Name/Number: Ellan Baumgartner 215-863-5215
Dental Benefit Mgr: Scion Contact Name/Number: Ellan Baumgartner 215-863-5215

Russell Gianforcaro Executive Director Keystone First	Phone: 215-863-5612 Fax: 215-863-5601 rgianforcaro@amerihealthcaritas.com	
MCO Medical Director: Eric Berman, D.O. Keystone First	Phone: 215-863-5804 Fax: 215-937-8114 EBerman@amerihealthcaritas.com	
MCO Contact: Ellan Baumgartner Manager, Regulatory Affairs Keystone First	Phone: 215-863-5215 Fax: 215-937-8568 ebaumgartner@amerihealthcaritas.com	DPW Contract Mgr: Charlie Hill Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs: Provider Services:	800-521-6860 TTY: 800-684-5505 800-573-4100 TTY: 800-684-5505 800-521-6007

Name of Contractor	Contact Information	Service Area

Gateway Health — Southwest Zone

Pharmacy Benefit Mgr: Argus Contact Name/Number: Andrea Maxwell (412) 255-1303
Dental Benefit Mgr: UCCI Contact Name/Number: Andrea Maxwell (412) 255-1303

Patricia J. Darnley President and Chief Executive Officer Gateway Health Plan®, Inc. Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222	Phone: 412-255-4640 Fax: 412-255-4504 www.gatewayhealth.com	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties
MCO Medical Director: Dr. Michael Madden Gateway Health-20th Floor	Phone: 412-255-4640 Fax: 412-255-4503 mmadden@gatewayhealthplan.com	
MCO Contact: REGINA ZEMBAR Government Affairs Specialist Gateway Health-21st Floor	Phone: 412-255-1303 Fax: 412-255-4503 RZembar@gatewayhealthplan.com	DPW Contract Mgr: Alinda Burrell Phone: 717-772-6300 Fax: 717-772-6328
Address for all other GHP staff: Gateway Health Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222	Member Services: Special Needs: Provider Services:	800-392-1147 TTY: 711 800-642-3550 TTY: 711 800-392-1145

Aetna Better Health — Southwest Zone

Pharmacy Benefit Mgr: ESI Contact Name/Number: Cibby Abraham (215) 692-9912
Dental Benefit Mgr: DentaQuest Contact Number: Darlene Demore (717) 829-2296

Denise Croce, CEO Aetna Better Health SE Zone 2000 Market Street., Suite 850 Philadelphia, PA 19103	Phone: 215-282-3503 Fax: 860-902-7827 CroceD@aetna.com www.aetnabetterhealth.com	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties
MCO Chief Medical Officer: Patricia Guerra-Garcia, M.D.	Phone: 215-282-3539 Guerra-GarciaP@aetna.com	
MCO Contact: Darlene L. DeMore Director, Regulatory Compliance Coventry Health Care, Inc./Aetna Better Health - PA 3721 Tecport Drive Harrisburg, PA 17111	Phone: 717-829-2296 Fax: 717-526-2717 dldemore@cvty.com	DPW Contract Mgr: Liz Deluca Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs: Provider Services:	866-903-0748 TTY: 800-613-3087 866-427-9721 TTY: 800-613-3087 866-903-0748 (request provider services)

UnitedHealthcare Community Plan of Pennsylvania — Southwest Zone

Pharmacy Benefit Mgr: Optum Rx Contact Name/Number: Marion Pardes (973) 297-5537
Dental Benefit Mgr: DBP Contact Name/Number: Christopher Montanez (443) 896-0769

Sue Schick, President United Healthcare Community Plan of PA The Wanamaker Bldg, Suite 410 100 Penn Square East Philadelphia, PA 19107	Assistant Patricia Cook: Phone: 215-982-7929 Fax: 215-832-4702 sue.schick@uhc.com	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties
MCO Medical Director: Joseph Sheridan DO United Healthcare The Wanamaker Bldg, Suite 400 100 Penn Square East Philadelphia, PA 19107	Phone: 215-832-4505 Joseph.Sheridan@uhc.com	
MCO Contact: Carol Lavoritano Director of Regulatory Affairs & Compliance United Healthcare The Wanamaker Bldg, Suite 400 100 Penn Square East Philadelphia, PA 19107	Phone: 215-832-4534 Fax: 215-832-4702 clavoritano@uhc.com	DPW Contract Mgr: Pauline Saunders Phone: 717-772-6300 Fax: 717-772-6328
MCO Contact: Mark Calla Regulatory Compliance Consultant United Healthcare 1001 Brinton Road Pittsburgh, PA 15221	Phone: (412) 545-9474 Fax. (412) 457-1364 Mark.Calla@uhc.com	
	Member Services: Special Needs: Provider Services:	800-414-9025 TTY: 711 877-844-8844 TTY: 711 800-600-9007

UPMC Health Plan, Inc./UPMC *for You* — Southwest Zone

Pharmacy Benefit Mgr: ESI — Contact Name/Number: Cyril Zibrick 412-454-0947
Dental Benefit Mgr: Avesis — Contact Name/Number: Bob Glass 412-454-7951

John Lovelace, President of Government Programs & Individual Advantage Products US Steel Building UPMC *for You* 600 Grant Street, 55th Floor Pittsburgh, PA 15219	Phone: 412-454-5269 Fax: 412-454-7527 www.upmchealthplan.com	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties
MCO Chief Medical Officer: Dr. Nicholas Degregorio US Steel Building, 11th Floor 600 Grant Street Pittsburgh, PA 15219	Phone: 412-454-7860 Fax: 412-454-7544 degregorion@upmc.edu	
MCO Contact: Jessica Rhodes MA Operations & Government Liaison UPMC *for You* US Steel Building 600 Grant Street,9th Floor Pittsburgh, PA 15219	Phone: 412-454-0949 Fax: 412-454-7544 For correspondence upmc4qa@upmc.edu For meetings phillipsjl4@upmc.edu	DPW Contract Mgr: Virginia Perry Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: 800-286-4242 TTY: 800-361-2629 Special Needs: 800-463-1462 TTY: 800-361-2629 Provider Services: 866-918-1595	

AmeriHealth Northeast — New East Zone

Pharmacy Benefit Mgr: Perform Rx — Contact Name/Number: Ellan Baumgartner 215-863-5215
Dental Benefit Mgr: DentaQuest — Contact Name/Number: Ellan Baumgartner 215-863-5215

Marge Angello, RN Executive Director, AmeriHealth Northeast 8040 Carlson Road Harrisburg, PA 17112	Phone: 717-651-3552 Fax: 717-651-3555 mangello@amerihealthcaritas.com	
MCO Medical Director: Eric Berman D.O. AmeriHealth Northeast 200 Stevens Drive Philadelphia, PA 19113	Phone: 215-863-5804 Fax: 215-937-8114 EBerman@amerihealthcaritas.com	
MCO Contact: Ellan Baumgartner Manager, Regulatory Affairs AmeriHealth Northeast 200 Stevens Drive Philadelphia, PA 19113	Phone: 215-863-5215 Fax: 215-937-8568 ebaumgartner@amerihealthcaritas.com	DPW Contract Mgr: Charlie Hill Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: 855-809-9200 TTY: 855-859-4109 Special Needs: 888-498-0766 TTY: 855-859-4109 Provider Services: 888-208-7370	

Geisinger Health Plan (Geisinger Family) — New East Zone

Pharmacy Benefit Mgr: MedImpact — Contact Name/Number: Kelly Bonanno (717) 909-3380 or (717) 303-8345
Dental Benefit Mgr: DentaQuest — Contact Name/Number: Kelly Bonanno (717) 909-3380 or (717) 303-8345

Steven R. Youso President & CEO 100 N. Academy Avenue Danville, PA 17822-3220	570-271-8777 sryouso@thehealthplan.com	

Dudley F. Gerow Geisinger Health Plan Chief Government Programs Officer 100 N. Academy Avenue Danville, PA 17822-3220	Phone: 570-271-6714 dfgerow@thehealthplan.com	Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne & Wyoming
David Evans Assistant Vice President State Government Programs Geisinger Family	Phone: 570-271-6836 dlevans@thehealthplan.com	
MCO Medical Director: Chuck Baumgart Geisinger Family	Phone: 570- 214-6113 cbaumgart@thehealthplan.com	
MCO Contact: Kelly Bonanno HealthChoices Program Manager Geisinger Health Plan	Phone: 717-909-3380 klbonanno@thehealthplan.com	DPW Contract Mgr: Terry Carpenter Phone: 717-772-6300 Fax: 717-772-6328
	Member: Provider: Special Needs:	855-227-1302 TTY: 711 800-876-5357 855-214-8100 or 570-214-7570

Aetna Better Health — New East Zone

Pharmacy Benefit Mgr: ESI — Contact Number: Cibby Abraham (215) 692-9912
Dental Benefit Mgr: DentaQuest — Contact Number: Darlene Demore (717) 829-2296

Denise Croce, CEO Aetna Better Health SE Zone 2000 Market Street., Suite 850 Philadelphia, PA 19103	Phone: 215-282-3503 Fax: 860-902-7827 CroceD@aetna.com www.aetnabetterhealth.com	Bucks, Chester, Delaware, Montgomery and Philadelphia Counties
MCO Chief Medical Officer: Patricia Guerra-Garcia, M.D.	Phone: 215-282-3539 Guerra-GarciaP@aetna.com	
MCO Contact: Darlene L. DeMore Director, Regulatory Compliance Coventry Health Care, Inc./Aetna Better Health - PA 3721 Tecport Drive Harrisburg, PA 17111	Phone: 717-829-2296 Fax: 717-526-2717 dldemore@cvty.com	DPW Contract Mgr: Liz Deluca Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs: Provider Services:	866-903-0748 TTY: 800-613-3087 866-427-9721 TTY: 800-613-3087 866-903-0748 (request provider services)

Name of Contractor	Contact Information	Service Area

UPMC Health Plan, Inc./UPMC *for You* — New West Zone

Pharmacy Benefit Mgr: ESI — Contact Name/Number: Cyril Zibrick 412-454-0947
Dental Benefit Mgr: Avesis — Contact Name/Number: Bob Glass 412-454-7951

John Lovelace, President of Government Programs & Individual Advantage Products UPMC *for You* US Steel Building 600 Grant Street, 55th Floor Pittsburgh, PA 15219	Phone: 412-454-5269 Fax: 412-454-7527 www.upmchealthplan.com	Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango & Warren Counties

MCO Chief Medical Officer: Dr. Nicholas Degregorio US Steel Building 11th Floor 600 Grant Street Pittsburgh, PA 15219	Phone: 412-454-7860 Fax: 412-454-7544 degregorion@upmc.edu	
MCO Contact: Jessica Rhodes MA Operations & Government Liaison UPMC *for You* US Steel Building-9th Floor 600 Grant Street Pittsburgh, PA 15219	Phone: 412-454-0949 Fax: 412-454-7544 For all correspondence: upmc4qa@upmc.edu For meeting invites only: phillipsjl4@upmc.edu	DPW Contract Mgr: Virginia Perry Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs Unit: Provider Services:	855-425-8762 TTY:800-361-2629 866-463-1462 TTY: 800-361-2629 866-918-1595
Gateway Health — New West Zone Pharmacy Benefit Mgr: Argus Contact Name/Number: Andrea Maxwell (412) 255-1303 Dental Benefit Mgr: UCCI Contact Name/Number: Andrea Maxwell (412) 255-1303		
Patricia J. Darnley President and Chief Executive Officer Gateway Health Plan®, Inc. Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222	Phone: 412-255-4640 Fax: 412-255-4504 www.gatewayhealthplan.com	Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango & Warren
MCO Medical Director: Dr. Michael Madden Gateway Health-20th Floor	Phone: 412-255-4640 Fax: 412-255-4503 mmadden@gatewayhealthplan.com	
MCO Contact: REGINA ZEMBAR Government Affairs Specialist Gateway Health-21st Floor	Phone: 412-255-1303 Fax: 412-255-4503 RZembar@gatewayhealthplan.com	DPW Contract Manager: Alinda Burrell Phone: 717-772-6300 Fax: 717-772-6328
Address for all other GHP staff: Gateway Health Four Gateway Center 444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222	Member Services: Special Needs Unit Provider Services:	800-392-1147 TTY: 711 800-642-3550 TTY: 711 800-392-1145
AmeriHealth Caritas Pennsylvania — New West Zone Pharmacy Benefit Mgr: Perform Rx Contact Name/Number: Ellan Baumgartner 215-863-5215 Dental Benefit Mgr: DentaQuest Contact Name/Number: Ellan Baumgartner 215-863-5215		
MCO Medical Director: Eric Berman D.O. AmeriHealth Caritas Pennsylvania 200 Stevens Drive Philadelphia, PA 19113	Phone: 215-863-5804 Fax: 215-937-8114 EBerman@amerihealthcaritas.com	
MCO Contact: Marge Angello, RN Executive Director- AmeriHealth Caritas Pennsylvania 8040 Carlson Road Harrisburg, PA 17112	Phone: 717-651-3552 Fax: 717-651-3555 mangello@amerihealthcaritas.com	
MCO Contact: Ellan Baumgartner Manager, Regulatory Affairs AmeriHealth Caritas Pennsylvania	Phone: 215-863-5215 Fax: 215-937-8568 ebaumgartner@amerihealthcaritas.com	DPW Contract Mgr: Charlie Hill Phone: 717-772-6300

200 Stevens Drive Philadelphia, PA 19113		Fax: 717-772-6328
	Member Services: Special Needs Unit: Provider Services:	888-991-7200 TTY: 888-987-5704 800-684-5503 TTY: 888-987-5704 800-521-6007
Aetna Better Health — New West Zone Pharmacy Benefit Mgr: ESI — Contact Name/Number: Cibby Abraham (215) 692-9912 Dental Benefit Mgr: DentaQuest — Contact Name/Number: Darlene Demore (717) 829-2296		
Denise Croce, CEO Aetna Better Health SE Zone 2000 Market Street., Suite 850 Philadelphia, PA 19103	Phone: 215-282-3503 Fax: 860-902-7827 CroceD@aetna.com www.aetnabetterhealth.com	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington & Westmoreland Counties
MCO Chief Medical Officer: Patricia Guerra-Garcia, M.D.	Phone: 215-282-3539 Guerra-GarciaP@aetna.com	
MCO Contact: Darlene L. DeMore Director, Regulatory Compliance Coventry Health Care, Inc./Aetna Better Health - PA 3721 Tecport Drive Harrisburg, PA 17111	Phone: 717-829-2296 Fax: 717-526-2717 dldemore@cvty.com	DPW Contract Mgr: Liz Deluca Phone: 717-772-6300 Fax: 717-772-6328
	Member Services: Special Needs Unit: Provider Services:	866-903-0748 TTY: 800-613-3087 866-427-9721 TTY: 800-613-3087 866-903-0748 (request provider services)

HEALTHCHOICES BEHAVIORAL HEALTH		
Name of Contact	**Contact Information**	**Service Area**
Lehigh/Capital Zone		
Scott Suhring, CEO Capital Area Behavioral Health Collaborative, Inc. 2300 Vartan Way, Suite 206 Harrisburg, PA 17110	Phone: 717-671-7190 Fax: 717-671-7289 ssuhring@cabhc.org	Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties
Behavioral Health Subcontractor – PerformCare		
MCO Contact: James A. Laughman-Executive Director 8040 Carlson Road PO Box 6600 Harrisburg, PA 17112	Phone: 717-671-6500 Fax: 717-671-6546 jlaughman@performcare.org	DPW Staff Liaison: Helen Shuman Phone: 717-772-7226 Fax: 717-705-8386 hshuman@pa.gov
	Member Services:888-722-8646	
Matt Bauder, HealthChoices Administrator Lehigh County Government Center 17 South 7th Street, 2nd Floor Allentown, PA 18101-2400	Phone: 610-782-3526 Fax: 610-820-3689 mattbauder@lehighcounty.org	Lehigh County
Behavioral Health Subcontractor – Magellan Behavioral Health		
MCO Contact: Diane Marciano General Manager One Bethlehem Plaza 17 West Broad Street, Suite 210 Bethlehem, PA 18018	Phone: 610-814-8050 Fax: 610-814-8066 DEMarciano@magellanhealth.com	DPW Staff Liaison: Marcy Rachko Phone: 570-963-4942 Fax: 570-963-3050 mrachko@pa.gov
	Member Services:866-238-2311	
Deborah Nunes, HealthChoices Coordinator Northampton County Dept. of Human Services - HealthChoices Program 2801 Emrick Boulevard Bethlehem, PA 18020	Phone: 610-829-4780 610-829-4775 Fax: 610-997-5808 dnunes@northamptoncounty.org	Northampton County
Behavioral Health Subcontractor – Magellan Behavioral Health		
MCO Contact: Diane Marciano General Manager One Bethlehem Plaza 17 West Broad Street, Suite 210 Bethlehem, PA 18018	Phone: 610-814-8050 Fax: 610-814-8066 DEMarciano@magellanhealth.com	DPW Staff Liaison: Marcy Rachko Phone: 570-963-4942 Fax: 570-963-3050 mrachko@pa.gov

HealthChoices Behavioral Health		
Name of Contact	**Contact Information**	**Service Area**
Lehigh/Capital Zone		
Michelle Hovis, Executive Director York County Human Services York County Government Center 100 West Market Street, 3rd Floor York, PA 17401	Phone: 717-771-9900 Fax: 717-771-9826 mphovis@YorkCountyPA.org	Adams and York Counties
Behavioral Health Subcontractor – Community Care Behavioral Health Organization (CCBHO)		
MCO Contact: James Myers Regional Director 1200 Camp Hill Bypass, suite 100 Camp Hill, PA 17011	Phone: 717-731-3600 Fax: 866-615-9386 myersjb2@ccbh.com	DPW Staff Liaison: Kellie Wayda Phone: 717-772-7471 kwayda@pa.gov
	Member Services:866-738-9849 (Adams County) 866-542-0299 (York County) 866-229-3187 (Spanish Line) Provider Line:888-251-2224	
Edward B. Michalik MH/DD Administrator Berks County MH/DD Program 633 Court Street, 15th Floor Reading, PA 19601	Phone: 610-478-3271 Ext. 6583 Fax: 610-478-4980 emichalik@countyofberks.com	Berks County
Lydia Singley, Program Director Berks County MH/DD Program 633 Court Street, 15th Floor Reading, PA 19601	Phone: 610-478-3271 Ext. 6581 Fax: 610-478-4980 LSingley@countyofberks.com	
Behavioral Health Subcontractor – Community Care Behavioral Health Organization (CCBHO)		
MCO Contact: Jim Myers Regional Director 1200 Camp Hill Bypass, Suite 100 Camp Hill, PA 17011	Phone: 717-731-3600 Fax: 866-615-9386 myersjb2@cchb.com	DPW Staff Liaison: Marcy Rachko Phone: 570-963-4942 mrachko@pa.gov
	Member Services: 866-292-7886 866-229-3187 (Spanish Line) Provider Line:888-251-2224	

Name of Contact	Contact Information	Service Area
Northeast Zone		
James Gallagher-CEO NBHCC 72 Glenmaura National Boulevard Moosic, PA 18507	Phone: 570-344-2005 jgallagher@nbhcc.org	Lackawanna, Luzerne, Susquehanna and Wyoming Counties
Behavioral Health Subcontractor – Community Care Behavioral Health Organization		
MCO Contact: Tina Wydeen, Regional Director 72 Glenmaura National Boulevard, 2nd Floor Moosic, PA 18507	Phone: 570-496-1300 Fax: 866-263-2860 wydeencr@ccbh.com	DPW Staff Liaison: Lynn Wright Phone: 570-963-4941 lynwright@pa.gov
	Member Services:866-668-4696 Provider Line:888-251-2224	
North/Central State Option		
James Gavin, President and CEO Community Care BHO One Chatham Center, Suite 700 112 Washington Place Pittsburgh, PA 15219	Phone: 412-454-2149 Fax: 412-454-8631 gavinjg@ccbh.com	Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren and Wayne Counties
	Member Services: 866-878-6046	DPW Staff Liaison: Scott Liddick Phone: 717:772-7208 Fax: 717-705-8386 scliddick@pa.gov
Southeast Zone		
Mary Beth Mahoney, Acting BHS Director Bucks County Behavioral Health System 600 Louis Drive, Suite 102-A Warminster, PA 18974	Phone: 215-773-9313 Fax: 215-773-9317 mbmahoney@co.bucks.pa.us	Bucks County
Behavioral Health Subcontractor – Magellan Behavioral Health		
MCO Contact: Robert M. Waters, MSSW V.P., Account Management Magellan Behavioral Health of PA 105 Terry Drive, Suite 103 Newtown, PA 18940	Phone: 215-504-3915 Fax: 443-896-1364 rmwaters@magellanhealth.com	DPW Staff Liaison: Scott Ashenfelter Phone: 610-313-5844 Fax: 610-313-5845 sashenfelt@pa.gov
	Member Services:877-769-9784 Chester Member Services: 877-769-9782 Delaware Member Services:888-207-2911 Philadelphia	

Donna Carlson, BH Project Director Department of Human Services 601 Westtown Road, Suite 330 P.O. Box 2747 West Chester, PA 19380-0990	Phone: 610-344-5300 Fax: 610-344-5736 dcarlson@Chesco.org	Chester County
Behavioral Health Subcontractor: Community Care Behavioral Health		
Community Care Behavioral Health One East Uwchlan Avenue, Suite 311 Exton, PA 19341	Member Services: 1-866-622-4228	DPW Staff Liaison: Frank Molina fmolina@pa.gov Phone: 610-313-5844 Fax: 610-313-5845

Southeast Zone		
Name of Contact	**Contact Information**	**Service Area**
Jonna L. DiStefano, Administrator Delaware County Office of Behavioral Health 20 South 69th Street, 3rd Floor Upper Darby, PA 19082	Phone: 610-713-2365 Fax: 610-713-2378 distefanoj@delcohsa.org	Delaware County
Behavioral Health Subcontractor: Magellan Behavioral Health		
MCO Contact: Robert M. Waters, MSSW V.P., Account Management Magellan Behavioral Health of PA 105 Terry Drive, Suite 103 Newtown, PA 18940	Phone: 215-504-3915 Fax: 443-896-1364 rmwaters@magellanhealth.com	DPW Staff Liaison: Scott Ashenfelter Phone: 610-313-5844 Fax: 610-313-5845 sashenfelt@pa.gov
Dr. Arthur Evans, Director Dept. of Behavioral Health/Mental Retardation Services 1101 Market Street, 7th Floor Philadelphia, PA 19107	Phone: 215-685-5400 Fax: 215-685-4151 Arthur.c.evans@phila.gov	Philadelphia County
Behavioral Health Subcontractor – Community Behavioral Health		
MCO Contact: Joan Erney-CEO 801 Market St, 7th Floor Philadelphia, PA 19107	Phone: 215-413-3100 Fax: 215-413-7111 joan.erney@phila.gov Member Services: 888-545-2600	DPW Staff Liaison: Treldon Johnson Phone: 610-313-5844 Fax: 610-313-5845 trejohnson@pa.gov
LeeAnn Moyer, Deputy Administrator of Behavioral Health Montgomery County Behavioral Health Montgomery County Human Svcs. Center 1430 DeKalb Street, P.O. Box 311 Norristown, PA 19404	Phone: 610-292-4575 Fax: 610-278-3683 lmoyer@mail.montcopa.org	Montgomery County
Behavioral Health Subcontractor – Community Care Behavioral Health Organization		
MCO Contact: Robert M. Waters, MSSW V.P., Account Management Magellan Behavioral Health 105 Terry Drive Newtown, PA	Member Services: 1-877-769-9782	DPW Staff Liaison: Scott Ashenfelter Phone: 610-313-5844 Fax: 610-313-5845 sashenfelt@pa.gov

Name of Contact	Contact Information	Service Area
Southwest Zone		
David McAdoo Southwest Behavioral Health Management, Inc. 2520 New Butler Road New Castle, PA 16101	Phone: 724-657-3470 Fax: 724-657-3461 dmcadoo@swsix.com	Armstrong, Butler, Indiana, Lawrence, Washington and Westmoreland Counties
Behavioral Health Subcontractor – Value Behavioral Health of Pennsylvania		
MCO Contact: Dr. Mark Fuller, CEO 520 Pleasant Valley Road Trafford, PA 15085	Phone: 724-744-6301 Fax: 724-744-6303 mark.fuller@valueoptions.com	DPW Staff Liaison: Scott Pino Phone: 412-565-5748 Fax: 412-565-5393 scpino@pa.gov
	Member Services 877-688-5970 Armstrong 877-688-5969 Butler 877-688-5971 Fayette 877-688-5972 Greene 877-688-5973 Indiana 877-688-5974 Lawrence 877-688-5975 Washington 877-688-5976 Westmoreland 877-688-5977	
Don Clark, BH Administrator Allegheny County Dept. of Human Services Human Services Building One Smithfield Street, 3rd Floor Pittsburgh, PA 15222	Phone: 412-350-4280 Fax: 412-350-3880 don.clark@alleghenycounty.us	Allegheny County
Behavioral Health Subcontractor – Community Care Behavioral Health Organization		
James Gavin, President and CEO Community Care BHO One Chatham Center, Suite 700 112 Washington Place Pittsburgh, PA 15219	Member Services: 800-553-7499 gavinjg@ccbh.com	DPW Staff Liaison: Richard Latsko Phone: 412-565-7927 Fax: 412-565-5393 rlatsko@pa.gov
Lisa Ferris-Kusniar, Administrator Fayette County Behavioral Health 215 Jacob Murphy Lane Uniontown, PA 15401	Phone: 724-430-1370 Fax: 724-430-1386 lfk@fcbha.org	Fayette County
Behavioral Health Subcontractor: Value Behavioral Health of Pennsylvania		
MCO Contact: Dr. Mark Fuller, CEO 520 Pleasant Valley Road Trafford, PA 15085	Phone: 724-744-6301 Fax: 724-744-6303	
	Member Services: 1-877-688-5973	DPW Staff Liaison: Ray Jaquette Phone: 412-565-7825 Fax:412-565-5393 rjaquette@pa.gov

Name of Contact	Contact Information	Service Area
Southwest Zone		
Dr. Mark Fuller, CEO Value Behavioral Health of PA 520 Pleasant Valley Road Trafford, PA 15085	Phone: 724-744-6301 Fax: 724-744-6303 mark.fuller@valueoptions.com	Greene County
Member Services: 1-877-688-5973		DPW Staff Liaison: Scott Pino Phone: 412-565-5748 Fax: 412-565-5393 scpino@pa.gov
Gerard Mike, Administrator Beaver County MH/MR Program 1060 Eighth Avenue Beaver Falls, PA 15010	Phone: 724-847-6225 Fax: 724-847-2215 gmike@bcbh.org	Beaver County
MCO Subcontractor: Value Behavioral Health		
MCO Contact: Dr. Mark Fuller, CEO 520 Pleasant Valley Road Trafford, PA 15085 Member Services: 1-877-688-5972	Phone: 724-744-6301 Fax: 724-744-6303 mark.fuller@valueoptions.com	DPW Staff Liaison: Ray Jaquette Phone: 412-565-7825 Fax: 412-565-7825 rjaquette@pa.gov
North/Central County Option Zone		
Pamela Marple, HealthChoices Coordinator Behavioral Health Services of Bedford & Somerset Counties (BHSSBC) 245 W. Race Street Somerset, PA 15501	Phone: 814-443-3621 Ext. 4121 Fax: 814-443-4898 pamm@besmhmr.dst.pa.us	Bedford & Somerset Counties
Behavioral Health Subcontractor – PerformCare		
MCO Contact: James A. Laughman-Executive Director 8040 Carlson Road PO Box 6600 Harrisburg, PA 17112	Phone: 717-671-6500 Fax: 717-671-6546 jlaughman@performcare.org	DPW Staff Liaison: Helen Shuman Phone: 717-772-7226 Fax: 717-705-8386 hshuman@pa.gov
	Member Services: 866-773-7892	
Amy Marten-Shanafelt, Executive Director Blair HealthChoices 1906 N. Juniata Street Hollidaysburg, PA 16648	Phone: 814-696-5680 Fax: 814-695-5132 amshanafelt@blairhealthchoices.org	Blair County
Behavioral Health Subcontractor – Community Care Behavioral Health		
Community Care BHO One Chatham Center, Suite 700 112 Washington Place Pittsburgh, PA 15219	Member Services: 855-520-9715	DPW Staff Liaison: Kellie Wayda Phone: 717-772-7471 Fax: 717-705-8386 kwayda@pa.gov

Name of Contact	Contact Information	Service Area
Tracy Selak, Administrator Cambria county BH/ID Program 411 Main Street Johnstown PA 15901 cc: Ryan Hildebrand, CFO Behavioral Health of Cambria County	Phone: 814-534-4436 Fax: 814-534-4457 tselak@co.cambria.pa.us rhildebrand@bhocc.org	Cambria County
Behavioral Health Subcontractor – Value Behavioral Health of Pennsylvania		
Dr. Mark Fuller, CEO Value Behavioral Health of PA 520 Pleasant Valley Road Trafford, PA 15085	Phone: 724-744-6301 Fax: 724-744-6303 mark.fuller@valueoptions.com	DPW Staff Liaison: Richard Latsko Phone: 412-565-7927 Fax: 412-565-5393 rlatsko@pa.gov
	Member Services: 877-404-4562	
Jeff Hartzell, HealthChoices Coordinator Carbon/Monroe/Pike MH/DS Program 724 Phillips Street, Suite 202 Stroudsburg, PA 18360	Phone: 570-420-1900 Ext. 3711 Fax: 570-421-8295 jhartzell@cmphc.com	Carbon/Monroe/Pike Counties
Behavioral Health Subcontractor: Community Care Behavioral Health Organization		
Beth Pickering, Regional Director One East Uwchlan Avenue, Suite 311 Exton, PA 19341	Member Services: 1-866-473-5862 pickeringba@ccbh.com Phone: 610-594-2800 Fax: 888-588-7567	DPW Staff Liaison: Lynn Wright Phone: 570-963-4941 Fax: 570-963-3050 lynwright@pa.gov
Deborah Duffy Lycoming/Clinton Joinder Board The Sharwell Building 200 East Street Williamsport, PA 17701-6467	Phone: 570-323-6467 Fax: 570-326-1348 dduffy@joinder.org	Lycoming & Clinton Counties
Behavioral Health Subcontractor: Community Care Behavioral Health		
Community Care BHO One Chatham Center, Suite 700 112 Washington Place Pittsburgh, PA 15219		DPW Staff Liaison: Scott Liddick Phone: 717-772-7208 Fax: 717-705-8386 scliddick@pa.gov
	Member Services:	800-553-7499
John DiMattio, DHS Director Erie County MH/MR Program 154 W. Ninth Street Erie, PA 16501	Phone: 814-451-6860 Fax: 814-451-6868 jdimattio@eriecountydhs.org	Erie County
Behavioral Health Subcontractor – Community Care Behavioral Health Organization		
One Chatham Center, Suite 700 112 Washington Place Pittsburgh, PA 15219	Member Services: 1-866-473-5862	DPW Staff Liaison: Ray Jaquette Phone: 412-565-7825 Fax: 412-565-5393 rjaquette@pa.gov

Name of Contact	Contact Information	Service Area
Melissa Reisinger, Executive Director **The Tuscarora Managed Care Alliance** Human Services Building 425 Franklin Farm Lane Chambersburg, PA 17201	Phone: 717-709-4332 mlreisinger@franklincountypa.gov	**Franklin & Fulton Counties**
Behavioral Health Subcontractor: PerformCare		
MCO Contact: James A. Laughman-Executive Director 8040 Carlson Road PO Box 6600 Harrisburg, PA 17112	Phone: 717-671-6500 Fax: 717-671-6546 jlaughman@performcare.org	**DPW Staff Liaison:** **Angela Douglas** Phone: 717-346-5943 Fax: 717-705-8386 andouglas@pa.gov
	Member Services:	866-773-7917
Dave McAdoo, Executive Director **Northwest Behavioral Health Partnership, Inc.** 2520 New Butler Road New Castle, PA 16101	Phone: 724-657-3470 Fax: 724-657-3461 dmcadoo@swsix.com	**Crawford, Mercer, Venango Counties**
Behavioral Health Subcontractor: Value Behavioral Health of Pennsylvania		
Dr. Mark Fuller, CEO **Value Behavioral Health of PA** 520 Pleasant Valley Road Trafford, PA 15085	Phone: 724-744-6301 Fax: 724-744-6303 mark.fuller@valueoptions.com **Member Services:** 1-866-404-4561	**DPW Staff Liaison:** **Scott Pino** Phone: 412-565-5748 Fax: 412-565-5393 scpino@pa.gov

Attachment 6

COMMUNITY CARE
Behavioral Health Organization

Glenmaura Professional Center, 2nd Floor
72 Glenmaura National Blvd.
Moosic, PA 18507
T 570.496.1300
F 866.263.2860
www.ccbh.com

March 10, 2015

Mr. David Schwille, Executive Director
Luzerne County Office of Human Services
111 N. Pennsylvania Blvd., Ste. 110
Wilkes-Barre, PA 18701

Dear David:

In response to your letter received last month on behalf of the workgroup within the Administrative Office of the Pennsylvania Courts, please know that Community Care shares your goal of reducing the trauma experience of children coming before the Court, and consistently seeks opportunities within the communities we serve to promote this clinical competence. Through our partnership with individually licensed clinicians and licensed outpatient clinics that comprise our provider network, we have created a network of providers within the Commonwealth that are credentialed to serve the needs of children and youth, and their families. Our network credentialing process requests each licensed clinician to provide documentation of any specialty Evidence Based Practice (EBP) such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT) at the time of application to each respective network(s). This licensure information is then verified and updated on a routine basis. A listing of Community Care's provider contract regions (Allegheny, Blair, Carbon/Monroe/Pike, Chester, Erie, Lycoming/Clinton, Northeast, North Central, and York/Adams/Berks) can be accessed at www.ccbh.com .

As licensed clinicians enter our respective networks, they are held to the standards of their particular licensing bodies (psychology, professional counselor, social work, etc.) and have access to training opportunities both from Community Care/University of Pittsburgh Medical Center, and other continuing educational opportunities. Trauma informed care, in addition to specific treatment modalities/EBP's, can be accessed via training programs that lead to certification, or through structured supervision models. Although Community Care has not established inclusion criteria to be recognized as a "trauma-certified" clinician, we support the contract specific initiatives that are listed below, and look forward to the continued initiatives designed to expand the clinical expertise within our provider network.

Allegheny County has Trauma Informed Care (TIC) throughout their network, with clinicians trained in Child Parent Psychotherapy (CPP) and TF-CBT. The county holds the TF-CBT training twice a year, and is open to any interested participant. There is also a Center for Traumatic Stress that provides TF-CBT to children and adolescents in their outpatient clinic; and the county received a grant last year for the "Seeking Safety" training for any interested community provider, targeting adults with traumatic histories who are involved with the justice system, offering this two-day training multiple times throughout the year.

Blair County is currently building upon the initiatives begun by child welfare several years ago, focused on increasing the CBT trainings available for providers, and looking for opportunities to systematically make a difference for the children and youth in these systems.

Chester County has rolled out several EBP's, including Trauma Focused CBT. Ensuring fidelity to the models has been a part of the process, including monitoring of providers, and ongoing clinical coaching.

Within Community Care, both Dr. Lyndra Bills and RaeAnn Taylor are expert trainers on this subject. They have presented many resources that could benefit clinicians using a framework to develop a skill set that would allow them to work towards certification or advanced education in the area of trauma informed care. Building on the expertise of Dr. Bills, it is important to remember that the nature of trauma is so complex that the skill set must be flexible, and that the role of Community Care is to support the clinical expertise of our providers to assure that quality care is delivered to our HealthChoices members. With this flexibility in mind, we make resources available to our providers on an ongoing basis to improve the delivery of care. Through this ongoing dialogue, we share the evolving literature related to trauma treatment, and make available the many resources to increase clinical competence within the individual's respective discipline.

Community Care is committed to having a positive impact on this condition and is available to apply the above outlined resources and/or assist in the development of additional capacity to meet the clinical demands of our members. Please feel free to contact me or Tina Wydeen to discuss and identity next steps.

Thank You.

Sincerely,

James G. Gavin
President & CEO

cc: Mr. James Davis, Administrator
Luzerne-Wyoming Counties Mental Health and Developmental Services

Attachment 7

Executive Director
Melissa L. Reisinger
mlreisinger@franklincountypa.gov
Telephone: (866) 646-1060
Human Services Building
425 Franklin Farm Lane
Chambersburg, PA. 17202

Tuscarora Managed Care Alliance

Tuesday, February 18, 2015

Mr. David Schwille, Executive Director
Luzerne County Office of Human Services
111 N. Pennsylvania Blvd., Ste. 110
Wilkes Barre, PA. 18701

Dear David,

I am in receipt of your letter requesting the availability of trauma-based treatment for children in my region. I am the HealthChoices Director for Franklin and Fulton Counties, our subcontracted BHMCO is PerformCare. Currently, we have three certified EMDR (Eye Movement Desensitization and Reprocessing) therapists in three agencies. This evidence based trauma therapy is targeted to older adolescents and adults that have been affected by trauma.

In addition, we also have two agencies with four clinicians trained to conduct Parent Child Interaction Therapy (PCIT) which is listed as an evidence based practice for interpersonal trauma's for children between the ages of 2-8 years of age.

We have also invested in having two specialty Family Based Mental Health Services teams, eight clinicians in OP and RTF and four Case Managers (Mental Health, CYS and JPO), receive certification in the evidence based treatment of Juvenile Sex Offending Counselor Certification Program by the University of Louisville Kentucky School of Social Work Faculty. The curriculum included life review and trauma outcome to address the victimization of the offender.

In June 2015, Tuscarora Managed Care Alliance, in conjunction with the Behavioral Health Services of Bedford and Somerset Counties will be hosting at TF-CBT Training with certification for 20-24 clinicians across both mental health and substance abuse levels of care, (Substance Abuse OP, MH OP, CRR Host Home and Family Based Mental Health Services). The training, and 250 hours of clinical consultation, will allow the clinicians to sit for the certification test. TMCA will have 10 clinicians from five agencies trained for certification. The treatment is targeted to youth 3-18 years that have been affected by trauma.

In regards to network inclusion criteria for declaration of specialty, currently a provider during their credentialing application self declares specialty areas. TMCA and PerformCare recognize the limitations of self-declaration. Moving forward, TMCA and PerformCare in Franklin and Fulton Counties are encouraging competency based certification of clinicians declaring specialty treatment focus.

Please let me know if you have any other information you may need. I did attempt to respond via email, however, received a notification back that delivery had failed.

Sincerely,

Melissa Reisinger
Executive Director
Tuscarora Managed Care Alliance