CRITICAL INCIDENT REPORT

Child Fatalities and Near Fatalities Due to Abuse or Neglect in West Virginia

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
CHILDREN & FAMILIES

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DEFINITIONS

Abused Child: A child whose health or welfare is harmed or threatened by a parent, guardian or custodian who knowingly or intentionally inflicts, attempts to inflict or knowingly allows another person to inflict, physical injury or mental or emotional injury upon the child or another child in the home; or sexual abuse or sexual exploitation; or the sale or attempted sale of a child by a parent, guardian or custodian; and domestic violence. In addition to its broader meaning, physical injury may include an injury to the child as a result of excessive corporal punishment. *(49-1-201)*

Caretaker: The person responsible for the care of a child, including:

a) Parent, guardian, custodian, paramour of parent or foster parent.
b) A relative or any other person with whom the child resides and who assumes care or supervision of the child, without reference to the length of time or continuity of such residence.
c) An employee or agent of any public or private facility providing care for a child, including an institution, hospital, health care facility, group home, mental health center, residential treatment center, shelter care facility, detention center, or child care facility.
d) Any person providing care for a child, but with whom the child does not reside, without reference to the duration of the care. A person who assumes responsibility for the care or supervision of the child may assume such responsibility through verbal or written agreement, or implicitly through the willing assumption of the care-taking role.

CAPTA: The Child Abuse Prevention and Treatment Act (CAPTA) is one of the key pieces of legislation that guides child protection. CAPTA, in its original inception, was signed into law on January 31, 1974 (P.L. 93-247). It was reauthorized in 1978, 1984, 1988, 1992, 1996, and 2003, and with each reauthorization, amendments have been made to CAPTA that have expanded and refined the scope of the law.

CAPTA was most recently reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). The amendment in 2010 added a requirement for states to report child fatalities of children who were known to the agency, defined as having been assessed in the last 12 months or who have received family preservation services in the last 60 months.

Caregiver is Intoxicated (alcohol or other drugs): Report identifies a caregiver who is currently drunk or high on illegal drugs and unable to provide basic care and supervision to a child right now. In order to qualify as present danger, it must be evident in the report that a caregiver who is primarily responsible for childcare is unable to provide care for his/her child right now due to his/her level of intoxication. The state of the parent/caregiver's condition is more important than the use of a substance (drinking compared to being drunk); uses drugs as compared to being incapacitated by the drugs, and if accurate affects the child's safety.

Child: Any person less than 18 years of age. *(49-1-202)*

Child Fatality: The death of a person under the age of 18 that is a result of abuse and/or neglect

Child Maltreatment*:* A caregiver's behaviors and interactions with a child are consistent with the statutory definition of child abuse or neglect.

Critical Incident: A reasonable suspicion that a fatality or near fatality was caused by abuse or neglect or when abuse or neglect has been determined to have led to a child's death or near death.

Critical Incident Review Team: A team of individuals defined by the Commissioner of the Bureau for Children and Families to review critical incidents for the purpose of improving the casework process to prevent future critical incidents.

Crohn's Disease: Crohn's disease is a relapsing inflammatory bowel disease (IBD) that mainly affects the gastrointestinal (GI) tract. It can result in abdominal pain, fever, bowel obstruction, diarrhea, and even the passage of blood in stool.

Drug Affected Infants: Infants born and identified as affected by illegal substance abuse having withdrawal symptoms resulting from prenatal drug exposure, or an infant diagnosed as having Fetal Alcohol Spectrum Disorder.

Federal Fiscal Year (FFY): The federal budget or financial year for the period from October 1 through September 30. It is used by the federal government to report revenue and expenditures.

Glycogen Storage Disease: Glycogen storage disease (GSD) is a rare condition that changes the way the body uses and stores glycogen, a form of sugar or glucose.

Known to the Agency: Refers to a child with an open Child Protective Services or Youth Services case within the last 60 months or who was assessed by Child Protective Services or Youth Services within the last 12 months.

Maltreater: A person is considered to be a maltreater when a preponderance of the credible evidence indicates that the conduct of the person falls within the boundaries of the statutory and operational definitions of abuse or neglect.

Mediport: A mediport is a port placed under the skin to provide medications.

Near Child Fatality: A severe childhood injury or condition caused by abuse or neglect which results in the child receiving critical care for at least 24 hours.

Neglected Child: A child whose physical or mental health is harmed or threatened by a present refusal, failure or inability of the child's parent, guardian or custodian to provide the child with necessary food, clothing, shelter, supervision, medical care or education, when such refusal, failure or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian; or who is presently without necessary food, clothing, shelter, medical care, education or supervision because of the disappearance or absence of the child's parent or guardian. *(49-1-201)*

Opana: An opioid pain medication used to treat moderate to severe pain.

Oxymorphone: An opioid pain medication used to treat moderate to severe pain.

Substance Abuse: An element of the definition of child abuse or neglect in many states. Circumstances that are considered abuse or neglect in some states include the following:

- Prenatal exposure of a child to harm due to the mother's use of an illegal drug or other substance;
- Manufacture of methamphetamine in the presence of a child;
- Selling, distributing, or giving illegal drugs or alcohol to a child; and
- Use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child.

West Virginia Birth to Three: A statewide system of services and supports for children under age three who have a delay in their development, or may be at risk of having a delay, and their family. The Department of Health and Human Resources, through the Bureau for Public Health and the Office of Maternal, Child and Family Health, West Virginia Birth to Three, as the lead agency for Part C of the Individuals with Disabilities Education Act (IDEA), assures that family-centered, community-based services are available to all eligible children and families.

EXECUTIVE SUMMARY

The West Virginia Department of Health and Human Resources (DHHR) is the state agency responsible for Child Welfare as defined in Chapter 49 of the West Virginia State Code. Incidents of abuse and neglect are investigated by Child Protective Services (CPS) located within the Bureau for Children and Families.

The Legislative Audit Report

In the February 2013 Legislative Audit Report, the Performance Evaluation and Research Division (PERD) of the West Virginia Legislative Auditor's Office expressed concern over West Virginia having the highest and second highest incidence of child deaths related to abuse and neglect in the nation for six of the 12 years between 2000 and 2011. PERD also cited the annual Child Maltreatment Report produced by the U.S. Department of Health and Human Services, Administration for Children and Families (ACF), in which West Virginia has a higher recorded rate of deaths per 100,000 children than the national average for eight of the 12 years. The audit found that the information on child fatalities in West Virginia is not well documented; therefore, no statewide performance data were being gathered to determine the state's needs for training, policy, or field improvements that could reduce future child fatalities and near fatalities. In addition, the Legislature and the public were not made aware of the ongoing incidence of child fatalities and near fatalities due to abuse and neglect within the West Virginia child protective system.

Child Fatality Review and Report

A review of child fatalities in West Virginia is conducted by several entities in West Virginia: the Supreme Court of Appeals of West Virginia which is an independent branch of state government, West Virginia Child Fatality Review Team and the Infant Mortality Review Team. The Supreme Court of Appeals of West Virginia analyzes the court system's performance and recommends changes that need to be made. The West Virginia Child Fatality Review Team and the Infant Mortality Review Team are conducted by the Commissioner of the Bureau for Public Health within the Department of Health and Human Resources. The West Virginia Child Fatality Review Team reviews all deaths of children under the age of 18 and the Infant Mortality Review Team examines, analyzes and reviews the deaths of infants and women who die during pregnancy or at the time of birth, and children who die within one year of birth. West Virginia State Code 61-12A-2 establishes both the West Virginia Child Fatality Review Team and the Infant Mortality Review Team and sets forth the requirements of these teams. By state code, both of these teams review and analyze all deaths, ascertain and document the trends, patterns and risk factors and provide statistical information and analysis regarding the causes of certain fatalities. Both teams are required to provide an annual report with recommendations, which goes to the Governor.

Since 2000, the Bureau for Children and Families (Bureau) has submitted information related to child abuse and neglect, including child fatalities as a result of abuse and neglect, to the National Child Abuse and Neglect Data System (NCANDS), which is submitted based on the federal fiscal year (October 1 to September 30). When there is a Child Protective Services history, case level

information, known as the Child File, is collected by NCANDS directly from the West Virginia Statewide Automated Child Welfare Information System (SACWIS) known as the Family and Children Tracking System (FACTS). Additional information about abused and neglected children with no prior history with Child Protective Services is obtained from the Medical Examiner by Bureau staff and submitted to NCANDS in the Agency File. The February 2013 Legislative Audit conveyed the federal Child Maltreatment Report does not address individual state trends, prevention strategies, near fatal incidents of child abuse and neglect; nor does it identify policy related needs. This report is to fulfill the needs of gathering and analyzing this information.

The Critical Incident Review Team

In 2014, the Bureau established an internal child fatality review team to review incidents involving families who have a prior history within the Bureau. During FFY 2014, the team reviewed cases and collected data to develop a review process and to establish baseline data for making the determination on whether or not a child has been abused or neglected in order to address the trends in the data. In FFY 2015, the name of the team changed to the Critical Incident Review Team to encompass critical incidents involving both fatalities and near fatalities. The process and criteria developed by the review team is now used for the systematic review of critical incidents that have occurred in families known to the Bureau or that have come to its attention through the centralized intake assessment process.

The Critical Incident Review Team meets quarterly and is chaired by the Director of the Division of Planning and Quality Improvement (DPQI). Team members are comprised of the Commissioner and Deputy Commissioners for the Bureau for Children and Families, the Regional Directors, and representatives from the Offices of Field Support, Programs and Resource Development, Planning and Research and the Offices of Field Operations. In addition, the Community Services Manager for any district having a history with the child or his/her family is included in the case review for that child. This team reviews all critical incidents resulting in a fatality or near fatality of a child with a known history with the Department in order to make improvements to the process in which critical incidents are reviewed with the intent of reducing the number of fatalities and near fatalities that were the result of abuse and neglect.

The Critical Incident Review process begins when the Bureau is notified of a critical incident through the centralized intake assessment. Child Protective Services assesses the case and takes appropriate actions based on policy. Once the assessment is completed the incident is then assigned to a three-person Field Review Team which consists of a program manager who is a policy expert, a child protective services policy specialist and a specialist from the Division of Planning and Quality Improvement (DPQI) who leads the field review team. To insure an objective review, the members are selected from staff who do not work in the region where the critical incident occurred.

The Field Review Team conducts a case record review of the family history of abuse and/or neglect and the Department's interventions and services provided to the family. Interviews are conducted with Department staff, law enforcement, medical staff and service providers. The DPQI

Specialist presents their findings at the quarterly meetings of the Critical Incident Review Team. A decision is made on each case that the critical incident did or did not result from abuse or neglect as defined in state code and is evaluated for adherence to the Bureau's policy and practice. The Critical Review Team develops a plan for action to enhance the case work practice and improve outcomes for children and families based on the findings and recommendations for the reviews.

The information collected during the review process is aggregated, analyzed, and included in this annual report to the Legislature, as is required by the February 2013 Legislative Audit.

In 2016 policy was changed to expand the review process of the Critical Incident Review team. Prior to 2016, the Department only assessed families in a child fatality to assess the safety of the children remaining in the home. With this policy change, the Department now investigates all child fatality referrals received by the Department in which child abuse or neglect is suspected. This was a decision of the Executive Management Team which consists of the commissioner, deputy commissioners and the Offices of Field Support, Programs and Resource Development, Planning and Research. The purpose of this change was to document in our system findings of child abuse/neglect in the event the family has another child. This change increased the number of investigations for field staff, increased the number of critical incident reviews and increased the number of children being reported for this year.

CHILD FATALITIES

In the federal fiscal year ending September 30, 2014, there were 17 fatal critical incidents resulting from abuse and/or neglect involving children of families who were known to the Bureau. "Known to the Bureau" is defined as having a prior Child Protective Services case or Youth Services case within the last 60 months or an assessment for either Child Protective Services or Youth Services within the last 12 months. Of those fatalities, one was a result of abuse, and seven were a result of neglect. Nine fatalities were attributed to both abuse and neglect.

In the federal fiscal year ending September 30, 2014, several initiatives were put into place as a result of the findings and recommendations of the Critical Incident Review Team. These activities were:

- A policy change requiring that any allegation of substance abuse in the home of a child under the age of one be assessed;
- A review by the child protective policy staff of all screened-out referrals to ensure policy compliance;
- A focus on better safety planning;
- Education for all staff working with families in our county offices on safe sleep; and
- Updated Mandated Reporter Curriculum.

During federal fiscal year ending September 30, 2015, the Critical Incident Review Team determined there were seven fatalities due to abuse and neglect of children known to the Department. The activities that were put into place as a result of the team meetings were:

- Developed and Implemented Critical Incident Training
- Implemented Safe Sleep initiative
- Updated the Drug Affected Infant Policy; and
- Developed and Implemented Mandated Reporter Training

As a result of the expansion in policy to accept the additional cases with no children in the home, a total of 12 cases were reviewed by the Critical Incident Team that would not have been reviewed in federal fiscal year 2015. In federal fiscal year ending September 30, 2016, the Critical Incident Review Team determined there were 13 fatalities due to abuse and neglect of children known to the Department. Of those cases, four were determined to be a result of abuse and/or neglect.

The information below is the data collected from our internal Critical Incident Review Team for FFY 2016.

See **Appendix A** for a narrative of each child fatality for FFY 2016.

Critical Incidents FFY 2014	Critical Incidents FFY 2015	Critical Incidents FFY 2016
Fatality: 17	Fatality: 7	Fatality: 13

Map of Total Child Fatalities due to Abuse and/or Neglect, FFY 2016

WEST VIRGINIA

= County incident occurred
Total Fatalities: 13

Number of Victims in Abuse and Neglect Incidents by Known Cause of Fatality, FFY 2016	
Unsafe Sleep/Drug Use	1
Medical Neglect	1
Overdose/Lack of Supervision	2
Suicide/Failure to Protect	1
Car Accident/Drug Use By Caretaker	1
Gun Shot/Lack of Supervision	1
Child Born Drug-Exposed at Birth/Neglect	1
Drowning/Lack of Supervision	3
Severe Trauma/Physical Abuse	1
House Fire/Drug Use	1

Child Fatality – Demographics of Children, FFY 2016

Number of Victims in Fatal Incidents by Age	
	#
17 Years	3
14 Years	1
10 Years	1
3 Years	2
4 Years	1
2 Years	2
Infant	3

Number of Victims in Fatal Incidents by Race	
	#
White	10
African American	1
More than one race	2

Number of Victims in Fatal Incidents by Gender	
	#
Males	9
Females	4

Child Fatality – Maltreater Demographics, FFY 2016

In the cases below, the numbers do not add up to the 13 cases because in eight cases there were two maltreaters.

Number of Maltreaters in Fatal Incidents by Age	
	#
20-29	7
30-39	10
40-56	4

Number of Maltreaters in Fatal Incidents by Relationship	
	#
Mother	13
Father	5
Mother's Boyfriend	3

Number of Maltreaters in Fatal Incidents by Race	
	#
White	17
African American	2
More than one race	2

Number of Maltreaters in Fatal Incidents by Gender	
	#
Male	0
Female	5
Both Male and Female	8

CHILD NEAR FATALITIES

In FFY 2014, there were five children that were seriously injured due to abuse and/or neglect of families that were known to the Bureau.

In FFY 2015, there were seven children who were seriously injured due to abuse and/or neglect that were known to the Bureau. This is an increase of two children from FFY 2014 to FFY 2015.

In FFY 2016, there were nine children who were seriously injured due to abuse and/or neglect that were known to the Bureau. This is an increase of 2 children from FFY 2015 to FFY 2016.

See **Appendix B** for a narrative of each child near fatality for FFY 2016.

Critical Incidents FFY 2014	Critical Incidents FFY 2015	Critical Incidents FFY 2016
Near Fatality: 5	Near Fatality: 7	Near Fatality: 9

Map of Total Child Near Fatalities due to Abuse and/or Neglect, FFY 2016

WEST VIRGINIA

= County incident occurred
Total Fatalities: 13

Number of Victims in Abuse and Neglect Incidents by Known Cause of Near Fatality, FFY 2016	
Shaken Baby	1
Medical Neglect of a Disabled Child	2
Severe Malnutrition	1
Lack of Supervision/child ingested drugs	1
Lack of Supervision/child overdosed on drugs	1
Abuse/non-accidental trauma	2
Neglect Lack of Supervision/infant had drugs in system	1

Child Near Fatality – Demographics of Children, FFY 2016

Number of Victims in Near Fatal Incidents by Age	
13 Years	1
10 Years	1
2 Years	1
1 Year	1
Infant	5

Number of Victims in Near Fatal Incidents by Race	
White	5
African American	4
More than one race	0

Number of Victims in Near Fatal Incidents by Gender	
Males	4
Females	5

Child Near Fatality – Maltreater Demographics, FFY 2016

In five of the cases, there was more than one maltreater

Number of Maltreaters in Near Fatal Incidents by Age	
16-19	2
20-29	9
30-39	3
40-50+	0

Number of Maltreaters in Near Fatal Incidents by Relationship	
Mother	7
Father	6
Boyfriend	1
Step-Father	0

Number of Maltreaters in Near Fatal Incidents by Race	
White	8
African American	6
More than one race	0

Number of Maltreaters in Near Fatal Incidents by Gender	
Male only	2
Female only	2
Both Male and Female	5

SUMMARY OF 2016 DATA

In 2016, the State of West Virginia experienced on going and increased illegal drug use in our state. A Charleston Gazette article dated December 17, 2016, emphasizes the urgency of the issues being dealt with in West Virginia regarding drug abuse of painkillers. They report that the state's southern counties were "ravaged by a disproportionate number of pain pills and fatal drug overdoses." The article identifies the counties with the highest overdose rates caused by pain pills as Wyoming, McDowell, Boone, and Mingo. Mercer and Raleigh counties rank in the top 10 counties and Logan, Lincoln, Fayette and Monroe in the top 20 counties in the nation. Wyoming County leads the nation in overdose rates caused by painkillers.

In six years, 780 million hydrocodone and oxycodone pills were sent to the state and 1,728 West Virginians fatally overdosed on those two painkillers. Based on West Virginia's population, that is 433 pain pills for every man, woman and child in West Virginia.

With the pressure on restricting the abuse of painkillers, a new drug has emerged in West Virginia: heroin. Heroin creates an additional health risk because of needle sharing, which spreads deadly diseases like hepatitis and HIV. The DHHR figures show heroin-related deaths have increased from 34 in 2010 to 165 in 2015, and 97 as of May of 2016. An example that shows the impact of heroin on West Virginia, on one day in 2016 there were 27 overdoses in the city of Huntington. Huntington encompasses 18.46 square miles with a population of less than 49,000 people.

The review team data for critical incidents reflects the crisis West Virginia is experiencing with drug use. Of the 13 child fatality cases, only one case did not have substance abuse as a factor either in the death or a history with the family. Of the near fatality cases, only two out of nine cases did not have substance abuse issues. The review data showed that two small children ingested illegal drugs during this review period and two overdosed on illegal drugs. In 2016, the team saw three drownings; there were no drownings in 2015. The drownings were a result of neglect and in all three situations it is suspected that there was drug use involved.

In 2016, the team saw an increase in the ages of the children. In 2015, the fatalities and near fatalities were predominately infants. In 2016, ten of the 13 fatality cases were over two years old. The near fatality cases are still predominately infants with five of nine being infants.

In 2015, the team saw three children die as a result of co-sleeping out of seven fatalities; in 2016 that number reduced to one child out of 13 fatalities. The Bureau continues to maintain the activities started in 2015 regarding safe sleep. More details about the training in our Plan for Action are in the next section of the report.

The maltreater data has also changed since 2015 when all of the maltreaters were white and only one child was of more than one race. In 2016 the data is still predominately white, with six maltreaters that were African American and two that were more than one race for fatalities.

The 2016 data shows that the maltreaters in near fatal incidents were predominately younger than those in fatal incidents. In fatal incidents, 14 of the 21 maltreaters where over the age of 30. In

near fatal incidents, three out of 14 maltreaters were over 30. In comparison to 2015 data, six out of nine maltreaters involved in fatal incidents were over age 30, and in near fatal incidents nine of 15 were under the age of 30.

PLAN FOR ACTION

The Bureau for Children and Families has developed a Plan for Action based on the results of the Critical Incident Reviews starting in FFY 2015. The Plan for Action activities are designed to increase awareness, support practice, and improve outcomes in child welfare cases. In 2016, some of the activities in the previous plan have been updated and continue in addition to new activities that have been initiated.

I. Critical Incident Training for Staff to Increase Knowledge and Understanding

Update for 2016:

Critical incident training became a mandatory requirement in new child welfare worker training in January 2016. New workers are required to take this training within in the first year of employment. Findings from the critical incident reviews are also discussed in pre-service training on Initial Assessment. Critical incident training continues to be provided to tenured staff upon request. From October 2015 to November 2016 there were 46 Critical Incident training sessions conducted with a total of 916 participants in attendance.

II. Safe Sleep

Update for 2016:

In 2016, one child died as a result of unsafe sleep that was attributed to abuse and neglect; this number has reduced from three children in 2016. The critical incident reviews shows a continued trend on the need for staff to focus on safe sleep with parents of children under the age of three. In 2016, family assistance staff also provided safe sleep information to families that were applying and receiving benefits that were pregnant or had infants. The Safe Sleep Videos continue to be played in the county offices and Safe Sleep information is available in the county offices. To review the information available and used by staff go to www.safesoundbabies.com. During the next year in addition to continuing the activities above, a subgroup of the critical incident team will be developed to explore the use of a sign off process for parents and updating the information provided to parents on safe sleep with more targeted messaging. The group will also work with Maternal, Child, and Family Health to ensure consistent and up-to-date messaging on safe sleep.

III. Drug-Affected Infant Policy

Update for 2016:

The drug-affected infant policy was changed October 2016. The revision of the policy came from the identification that drug-exposed infants were a trend among child fatalities. The policy was updated to include prescribed medication such as Suboxone, Subutex, Methadone, or any other prescribed medication used to treat addiction. The policy was also updated to include CAPTA, which states that if a child is born and identified as being

affected by substance abuse or withdrawal symptoms of Fetal Alcohol Spectrum Disorder, the family may not leave the hospital with the infant child without a plan of care, which begins with a Protection Plan or Safety Plan. Time frames for seeing the children were changed to immediate. This was revised due to children being released and a plan of care not being initiated. The revised policy on assessing infants exposed to drugs clearly describes how a CPS worker should assess the family's parenting, speak to the family about safe sleep, and assess their preparedness to bring the infant child home. This could include speaking with medical professionals, pertinent collaterals, and gathering hospital records such as toxicology reports, nurses/doctors progress reports, and withdrawal scores.

IV. Mandated Reporter Training

Update for 2016:
The critical incident team determined that mandated reporters not reporting cases of abuse and neglect have not been an issue in 2016. The team decided that the curriculum will be decentralized and made available to the districts if they have a need to provide the training. A workgroup will be developed to update the curriculum and then develop a process to disseminate the information to the field staff.

NEW ACTIVITIES FOR 2016:

Supporting Staff:

a. West Virginia Resiliency Alliance

In 2016 staff involved in assessing critical incidents requested support in dealing with the trauma experienced during the process. The West Virginia Resiliency Alliance (WVRA) initiative was developed several years ago to assist staff for retention purposes, but the initiative has been expanded to assist staff more specifically around the trauma they are exposed to while doing their jobs.

BCF is actively working on establishing a "trauma lens" with our staff. Part of this effort is through the WVRA, among other initiatives such as Safe at Home West Virginia, WVRA's purpose is to help front line staff address the secondary trauma they may experience on the job and is aimed toward improving worker retention and health of staff. Through the WVRA work, with the knowledge and permission of the source, we are using curriculum developed by the ACS-NYU Children's Trauma Institute titled The Resilience Alliance: Promoting Resilience and Reducing Secondary Trauma Among Welfare Staff made available through the National Child Trauma Stress Network. With permission from the source, BCF has adapted the model for use. Resiliency Alliance sessions have been offered by dedicated facilitators in all four BCF regions and also with Centralized Intake staff. We will continue to provide sessions in the regions, as is possible dependent upon availability of facilitators. The ACE (Adverse Childhood Effects) assessment is used and discussed with staff as a part of the WVRA sessions. Currently, the WVRA facilitator

vacancy rate is 50% as only two regions have facilitators. One region is working to rehire a facilitator. The facilitators are retired BCF employees who work these positions as temporary employees.

The WVRA has also developed Traumatic Event Response and will deploy facilitators to districts to respond to Child Welfare and Adult Service work-related traumatic events to assess and recommend trauma-informed referrals for affected staff as indicated. The team has been called upon to respond to several districts related to incidents of child deaths.

Appendix C: WV Resilience Alliance Procedures and Practice Manual
Appendix D: WV Resilience Alliance Traumatic Event Intervention Agenda
Appendix E: Traumatic Stress Handout
Appendix F: The Ten Encouragements

b. Supervisory Consultation:

During the 2016 critical incident reviews reoccurring themes emerged focusing on the quality of assessments:

- Appropriate Collateral Contacts
- Family History Review
- Effective Protection Plans and Safety Plans
- Identifying Appropriate Resources

c. Collateral Desk Guide:

In 2016, the Collateral Desk Guide was redistributed to staff to help improve the use of appropriate collaterals during assessment. In the next year, the Supervisory Consultation Guide will be updated and the supervisory training will be updated to reinforce quality practice during assessment. In addition it will be required that these items will be standing agenda items for monthly unit meetings, quarterly supervisors meetings, and program manager meetings. Meeting minutes will be reviewed by Community Services Managers, Regional Directors and Program Managers to ensure these items are discussed on a regular basis and reinforced with supervisors and staff. The guide can be found at the following link: http://www.dhhr.wv.gov/bcf/policy/Documents/Collateral Contacts Desk Guide 2016.pdf.

d. Substance Abuse Training:

In 2016, BCF began working in partnership with the Bureau for Behavioral Health and Health Facilities (BBHHF) for substance abuse training. BBHHF staff attended a regional supervisor meeting in each BCF region to provide initial training on the substance abuse epidemic in West Virginia and to solicit feedback from supervisors on specific training their staff need on substance abuse. From that feedback, BBHHF developed a full-day training on substance abuse and provided the training two times per region in November and December 2016. The sessions were recorded and the best session will be made available to view online. BBHHF will be working with BCF to develop additional training on more targeted issues in Spring 2017.

In addition to the training being provided by BBHHF, BCF identified a four-hour online training for child welfare professionals on the SAMHSA website. This training was incorporated into the training plan for new workers and is required to be taken within the first year of employment. BCF will also be providing refresher training for all child welfare workers in 2017 in conjunction with BBHHF.

e. Three Branch Institute:

In July 2016, representatives from the WV Department of Health and Human Resources, the Executive Branch, WV Judicial Branch, and WV Legislative Branches attended a 2016 Three Branch Institute to Improve Child Safety and Prevent Child Fatalities. This meeting was sponsored by the National Governors Association, National Conference of State Legislatures, and Casey Family Programs. As a result of the meeting and the support from Casey Family Programs, WV has decided to work on the following intended outcomes over the next two years. They are:

- All children and families at risk have access to evidence-based prevention and early intervention services.
- All children and families are identified at earliest signs of risk. Children under one year old are given high priority.
- The State has a comprehensive, multi-agency plan to prevent child maltreatment deaths.

Appendix A: Abuse and/or Neglect Cases Resulting in Child Fatality
FFY 2016

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
E.C.	Greenbrier	10/15/15	M	14 years	White	Neglect	Mother's boyfriend was supervising the child but was intoxicated. The child died of an overdose of oxymorphone.	Lack of supervision overdose
G.B.	Raleigh	10/7/15	F	5 months	White	Abuse	Mother was intoxicated and rolled over on the child.	Unsafe Sleep
A.H.	Logan	11/26/15	F	4 Years	White	Neglect	The child had glycogen storage disease requiring a feeding tube and a mediport for administering medications. Parents did not provide adequate medical care to the child.	Medical neglect of a disabled child.
D.S.	Monongalia	03/7/16	M	17 Years	White/ African American	Neglect	Mother and mother's boyfriend allowed a party in their home. Child was shot by someone at the party.	Lack of supervision gunshot wound

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
E.G.	Mercer	03/14/16	F	4 months	White/ African American	Neglect	Child was drug exposed at birth, a twin, and premature. Child stopped breathing and when the child was taken to the hospital, there was evidence that the child had not been cared for hours. Child's diaper was full and there was no food in her stomach. She was filthy dirty and there was a bald spot on the back of her head indicating lying for long periods of time.	Failure to provide adequate care to the child.
Z.H.	Mercer	04/7/16	M	17 Years	White	Neglect	Mother and child were doing synthetic marijuana and the child overdosed.	Lack of Supervision drug overdose
C.B.	Grant	04/29/16	M	2 Month	White	Neglect	Child died as a result of a car accident in which his father was driving the car impaired. Mother was in the car at the time of the accident.	Car accident with an impaired driver
T.S.	Webster	06/1/16	M	17 Years	White	Neglect	Mother was aware the child had mental health issues and put the gun in the car where the child had access.	Suicide/ failure to protect

Child's Initials	County	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Fatality
B.N.	Barbour	07/4/16	M	2 Years	White	Neglect	Mother and father were not supervising the child and the child drowned in the river.	Lack of Supervision causing drowning
J.J.	Cabell	07/12/16	M	3 Years	African American	Abuse	Non-accidental trauma by the mother and her boyfriend.	Physical abuse
N.G.	Lincoln	7/25/16	M	3 Years	White	Neglect	Lack of supervision by the mother and the child drowned in a creek. Mother has been charged with child neglect resulting in death.	Lack of Supervision causing drowning.
E.P	McDowell	08/7/16	F	2 Years	White	Neglect	Mother and father were taking a nap and the child got out of the house and drowned in the family pool.	Lack of supervision resulting in Drowning
D.Y.	Mason	08/21/16	M	10 Years	White	Neglect	Family had a house fire the mother had drugs in her system and was unable to get the child out of the house. Child died in the fire.	Lack of supervision resulting in child dying in the fire

Appendix B: Abuse and/or Neglect Cases Resulting in Near Child Fatality

FFY 2016

Below is the summary of cases involving near fatalities. Due to confidentiality, the names of the children cannot be disclosed. Only the names of children involved in a fatality can be disclosed based on CAPTA requirements.

County of Incident	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Near Fatality
Morgan	10/9/15	F	5 Months	White	Neglect	Child had a lung transplant in another state when she was four months old. The parents did not provide follow up medical care for the child.	Medical Neglect
Monongalia	01/22/16	F	1 year	White	Neglect	Child taken to ER unresponsive. It was determined that the child was malnourished and dehydrated.	Severe Malnutrition and Dehydration
Cabell	01/26/16	F	2 Years	White	Neglect	The child ingested a drug (Opana) she found in her father's wallet. Child was taken to the hospital unresponsive. Father was arrested for child neglect causing injury.	Neglect/Drug Ingestion
Kanawha	02/12/16	M	5 Months	African American	Abuse	Non-accidental trauma inflicted by the father.	Abuse/Shaken Baby
Kanawha	01/28/16	M	2 Months	White	Abuse	Non-accidental trauma by the father. Father has been charged with child abuse.	Abuse/Physical Trauma

County of Incident	Date of Incident	Gender	Age	Race/ Ethnicity	Type of Maltreatment	Brief Summary of Incident	Cause of Near Fatality
Marion	04/19/16	F	11 Months	African American	Abuse/neglect	Child left alone by her mother and stopped breathing. It was determined that the child had cocaine in her system.	Lack of Supervision/drug ingestion
Wood	06/01/16	M	7 Weeks	African American	Abuse	Non-accidental trauma both mother and father have been charged.	Abuse/Physical Trauma
Raleigh	06/07/16	M	13 Years	White	Neglect	Child has multiple disabilities and mother failed to provide required medical care and treatment.	Medical Neglect of a Disabled Child
Cabell	07/03/16	F	10 Years	African American	Neglect	Child overdosed on synthetic marijuana, lack of supervision by her parents.	Drug Use Resulting in Injury

Appendix C: WV Resilience Alliance Procedures and Practice Manual

WV RESILIENCE Alliance Procedures and Practice Manual

Name of WVRA Procedure/Practice: WV RESILIENCE Alliance (WVRA) Traumatic Event Response (WVRAPP2)

Traumatic Event Definition: **A traumatic event is an incident that causes physical, emotional, spiritual, or psychological harm. The person(s) experiencing the distressing event may feel threatened, anxious, or frightened as a result. In some cases, they may not know how to respond, or may be in denial about the effect such an event has had. The person(s) will need support and time to recover from the traumatic event and regain emotional and mental stability.** http://www.healthline.com/health/traumatic-events#Overview1

Examples of traumatic events may include:

- child fatality or serious injury to child(ren)
- death of family member, coworker, friend, teacher, or pet
- divorce/loss of significant relationship
- physical pain or injury (e.g. severe car accident)
- serious illness
- war
- natural disasters
- terrorism
- moving to a new location
- parental abandonment
- witnessing a death/homicide/suicide
- rape
- domestic abuse
- prison stay
- child welfare/adult service professional assault, threat, risk, harm

The **WV RESILIENCE Alliance** will respond to Child Welfare and Adult Service ***work-related*** traumatic events and assess and recommend trauma-informed referrals for affected staff as indicated.

Supervisor/Coordinator/CSM will respond to Child Welfare and Adult Service ***personal*** traumatic events and provide appropriate, trauma-informed referrals to affected staff as indicated. (WVRA Facilitators are available to Supervisor/Coordinator/CSM for trauma-response consultation.)

Desired Outcome: To provide a trauma-informed, child welfare/ adult service best practice response to West Virginia's child welfare and adult service professional staff who have experienced a traumatic event and to assist them to regain emotional and mental stability.

Date Procedure/Practice Implemented: May 2016

WVRA Traumatic Event Procedure/Practice:

a. **The WVRA Traumatic Event Response will utilize the SAFER-R - Crisis Response Model (see insert #1 below)**
b. **The Summary Matrix of the 'Tiered' Levels of Traumatic Event Response (see Insert #2 below) will guide the format and structure of the WVRA Traumatic Event Response. The Summary Matrix can also assist the Regional Director (RD)/Deputy Commissioner (DC) in decision-making regarding initiation and the appropriate level of the intervention/ response.**
c. **The PROCESS (see Insert #3 below) to trigger, implement and complete the WVRA Traumatic Event (TE) Response is:**
    1. **CSM determines TE need and Initiates request**
    2. **CSM (or designee) contacts their RD and Deputy Commissioner for consultation**

3. **The RD/Deputy Commissioner authorizes the TE intervention and contacts the WVRA Regional Facilitator with directions to intervene**
4. **The WVRA Facilitator(s) and Traumatic Event Intervention participant(s) will sign a Confidentiality Statement prior to the commencement of the intervention (see Insert #4 below)**
5. **Subsequent to the intervention, the WVRA Facilitator(s) will provide an Informal Participant Evaluation (see Insert #5 below) of the intervention to the TE participant(s) with directions to the participant(s) for returning the completed evaluation to the WVRA Facilitator**
6. **At the conclusion of the intervention, the WVRA Facilitator(s) will provide appropriate (verbal) feedback to the CSM/RD/Deputy Commissioner regarding the intervention**
7. **At the conclusion of the intervention, the WVRA Facilitator(s) will engage in a 'trauma-informed' processing of the intervention with the other WVRA Facilitators**
8. **At the conclusion of the intervention and subsequent to the processing of the intervention, the WVRA Facilitator(s) will provide a Formal, Written Evaluation (see Insert #6 below) of the intervention to the RD/Deputy Commissioner. This evaluation will include assessment of the value, benefits and/or suggested changes to the intervention process and format. It will also recommend any further, trauma-informed assistance which the Facilitator(s) may assess to be necessary to stabilize and 'normalize' the trauma-affected staff.**
9. **WVRA Traumatic Event Intervention Document Management**
   a. **The WVRA Facilitator will create an 'administrative file' which includes any document/form related to the Traumatic Event Intervention in which they participated. The administrative file and its contents should be secured in a locked drawer/cabinet. Any WVRA Facilitator separating from the WVRA, should assure that their administrative file(s) are delivered to the Regional Director (RD) for maintenance and security.**
   b. **The signed Confidentiality Statement(s) (Insert #4 below) should be retained in the administrative file**

c. **The Informal Participant Evaluation of the Intervention completed by the participant(s) (Insert #5 below) should be retained in the administrative file.**
d. **A copy of the Formal, Written Evaluation of the Intervention by the WVRA Facilitator (Insert #6 below) should be provided to both the RD and the DC who initiated the Intervention. The original evaluation should be retained in the administrative file.**
e. **The documents and information contained in the administrative file may be used by the WVRA Facilitators to assist them in their ongoing assessment of the value, benefits and/or suggested changes to the intervention process and format.**

The inserts that are referenced to in this document have not been included and are intentionally missing.

Appendix D: WV Resilience Alliance Traumatic Event Intervention Agenda

WV RESILIENCE Alliance (WVRA)

Traumatic Event Intervention

1. STABILIZE
   A. Introductions – Facilitators and Participants
   B. Explanation of TE Process
      1. Traumatic Event Definition: A traumatic event is an incident that causes physical, emotional, spiritual, or psychological harm. The person(s) experiencing the distressing event may feel threatened, anxious, or frightened as a result. In some cases, they may not know how to respond, or may be in denial about the effect such an event has had. The person(s) will need support and time to recover from the traumatic event and regain emotional and mental stability. http://www.healthline.com/health/traumatic-events#Overview1
      2. Purpose of this Traumatic Event Response
      3. Complete Traumatic Event Intervention Confidentiality Statement with Participants
2. ACKNOWLEDGEMENT
   A. 'Who,' 'what happened,' 'when' of the traumatic event – the 'story'
   B. Listen
3. FACILITATE UNDERSTANDING
   A. 'we have a right to feel whatever we feel'
   B. 'feeling exercise'
4. ENCOURAGE EFFECTIVE COPING
   A. Identify INTERNAL support/coping resources
   B. Identify EXTERNAL support/coping resources
5. RECOVERY AND/OR REFERRAL

Appendix E: Traumatic Stress Handout

Traumatic Stress

How to Recover From Disasters and Other Traumatic Events

The impact of a natural disaster or traumatic event goes far beyond physical damage. The emotional toll can result in a wide range of intense, confusing, and sometimes frightening emotions. Just as it takes time to clear the rubble and repair the damage, it takes time to recover your emotional equilibrium and rebuild your life. There are specific things you can do to help yourself and your loved ones cope with the emotional aftermath of the traumatic event.

www.helpguide.org/articles/ptsd-trauma/traumatic-stress.htm

The emotional aftermath of traumatic events

Natural disasters and other catastrophic events, such as motor vehicle accidents, plane crashes, nuclear meltdowns, and terrorist attacks, are extraordinarily stressful—both to survivors and observers. Such disasters shatter your sense of security, making you feel helpless and vulnerable in a dangerous world. Whether or not you were directly impacted by the traumatic event, it's normal to feel anxious, scared, and uncertain about what the future may bring.

Usually, these unsettling thoughts and feelings fade as life starts to return to normal. You can assist the process by keeping the following in mind:

People react in different ways to disasters and traumatic events. There is no "right" or "wrong" way to think, feel, or respond. Be tolerant of your own reactions and feelings, as well as the reactions and feelings of others. Don't tell yourself (or anyone else) what you should be thinking, feeling, or doing.

Avoid obsessively thinking about the disastrous event. Repetitious thinking about fearful or painful experiences can overwhelm your nervous system trigger making it harder to think clearly and act appropriately.

Ignoring your feelings will slow the healing process. It may seem better in the moment to avoid experiencing your emotions, but they exist whether you're paying attention to them or not. Even intense feelings will pass if you simply allow yourself to feel what you feel—and you'll feel better afterwards.

Talking about what you feel may be difficult, but it will help you heal. Just as you may find it difficult to face your feelings head on, you may also find it difficult to express those feelings to others. But getting them out is essential. Talking with a calm, caring person is best, but expressing your feelings through journaling, art, and other creative outlets can also help.

Common reactions to trauma and disaster

Following a traumatic event, it's normal to feel a wide range of intense emotions and physical reactions. These emotional reactions often come and go in waves. There may be times when you feel jumpy and anxious, and other times when you feel disconnected and numb.

Normal emotional responses to traumatic events

- **Shock and disbelief** – you may have a hard time accepting the reality of what happened
- **Fear** – that the same thing will happen again, or that you'll lose control or break down
- **Sadness** – particularly if people you know died
- **Helplessness** – the sudden, unpredictable nature of natural disasters and accidents may leave you feeling vulnerable and helpless
- **Guilt** – that you survived when others died, or that you could have done more to help or prevent the situation
- **Anger** – you may be angry at God or others you feel are responsible
- **Shame** – especially over feelings or fears you can't control
- **Relief** – you may feel relieved that the worst is over, and even hopeful that your life will return to normal

Normal physical stress responses to traumatic events

The symptoms of traumatic stress are not just emotional—they're also physical. It's important to know what the physical symptoms of stress look like, so they don't scare you. They will go away if you don't fight them:

- Trembling or shaking
- Pounding heart
- Rapid breathing
- Lump in throat; feeling choked up
- Stomach tightening or churning
- Feeling dizzy or faint
- Cold sweats
- Racing thoughts

Disaster recovery tip 1: Seek comfort and support

Natural disasters and other traumatic events turn your world upside down and shatter your sense of safety. In the aftermath, taking even small steps towards restoring safety and comfort can make a big difference.

Being proactive about your own and your family's situation and well-being (rather than passively waiting for someone else to help you) will help you feel less powerless and vulnerable. Focus on anything that helps you feel more calm, centered, and in control.

Reestablish a routine

There is comfort in the familiar. After a disaster, getting back—as much as possible—to your normal routine, will help you minimize traumatic stress, anxiety, and hopelessness. Even if your work or school routine is disrupted, you can structure your day with regular times for eating, sleeping, spending time with family, and relaxing.

Do things that keep your mind occupied (read, watch a movie, cook, play with your kids), so you're not dedicating all your energy and attention to the traumatic event.

Connect with others

You may be tempted to withdraw from social activities and avoid others after experiencing a traumatic event or natural disaster. But it's important to stay connected to life and the people who care about you. Support from other people is vital to recovery from traumatic stress, so lean on your close friends and family members during this tough time.

- Spend time with loved ones.
- Connect with other survivors of the traumatic event or disaster.
- Do "normal" things with other people, things that have nothing to do with the disaster.
- Participate in memorials, events, and other public rituals.
- Take advantage of existing support groups: your church, community organizations, and tight-knit groups of family and friends.

Challenge your sense of helplessness

Trauma leaves you feeling powerless and vulnerable. It's important to remind yourself that you have strengths and coping skills that can get you through tough times.

One of the best ways to **reclaim your sense of power is by helping others**. Taking positive action directly challenges the sense of helplessness that contributes to trauma:

- comfort someone else
- volunteer your time
- give blood
- donate to your favorite charity

Disaster recovery tip 2: Minimize media exposure

In the wake of a traumatic event or disaster, it's important to protect yourself and your loved ones from unnecessary exposure to additional trauma and reminders of the traumatic event.

While some people regain a sense of control by watching media coverage of the event or observing the recovery effort, others find the reminders upsetting. Excessive exposure may be further traumatizing—in fact, retraumatization is common.

- Limit your media exposure to the disaster. Do not watch the news just before bed. Take a complete break if the coverage is making you feel overwhelmed
- Information gathering is healthy, but try to avoid morbid preoccupation with distressing images and video clips. Read the newspaper or magazines rather than watching television.
- Protect your children from seeing or hearing unnecessary reminders of the disaster or traumatic event
- After viewing disaster coverage, talk with your loved ones about the footage and what you're feeling

Disaster recovery tip 3: Acknowledge and accept your feelings

After a traumatic event, you may experience all kinds of difficult and surprising emotions, such as shock, anger, and guilt. Sometimes it may seem like the sadness and anxiety will never let up.

Sadness, grief, anger and fear are normal reactions to the loss of safety and security (as well as life, limb, and property) that comes in the wake of a disaster. Accepting these feelings as part of the **grieving process**, and allowing yourself to feel what you feel, is necessary for healing.

Dealing with traumatic grief and other painful emotions

- Give yourself time to heal and to mourn the losses you've experienced.
- Don't try to force the healing process.
- Be patient with the pace of recovery.
- Be prepared for difficult and volatile emotions.
- Allow yourself to feel whatever you're feeling without judgment or guilt.
- Talk to someone you trust about what you're feeling.

An exercise to help you feel grounded in times of emotional stress and turmoil

Sit on a chair, feel your feet on the ground, press on your thighs, feel your behind on the seat, and your back supported by the chair; look around you and pick six objects that have red or blue. This should allow you to feel in the present, more grounded and in your body. Notice how your breath gets deeper and calmer. You may want to go outdoors and find a peaceful place to sit on the grass. As you do, feel how your bottom can be held and support by the ground.

Source: *Emotional First Aid*, Gina Ross, MFCC, and Peter Levine, Ph.D.

Disaster recovery tip 4: Make stress reduction a priority

Almost everyone experiences signs of stress after going through a traumatic event. While a certain amount of stress is normal, and even helpful, as you face the challenges that come in the aftermath of a disaster, **too much stress** will get in the way of recovery.

Relaxation is a necessity, not a luxury

Traumatic stress takes a heavy toll on your mental and physical health. Making time for rest and relaxation will help you bring your brain and body back into balance.

- Do relaxing activities such as meditating, listening to soothing music, walking in a beautiful place, or visualizing a favorite spot.
- Schedule time for activities that bring you joy—a favorite hobby or pastime, a chat with a cherished friend.
- Use your downtime to relax. Savor a good meal, read a bestseller, take a bath, or enjoy an uplifting or funny movie.

How sleep can reduce traumatic stress

After experiencing a traumatic event, you may find it difficult to sleep. Worries and fears may keep you up at night or disturbing dreams may trouble you. Getting quality rest after a disaster is essential, since lack of sleep places considerable stress on your mind and body, and makes it more difficult to maintain your emotional balance.

As you work through the trauma-related stress, your sleep problems should disappear. But in the meantime, you can **improve your sleep** with the following strategies:

- Go to sleep and get up at the same time each day.
- Limit drinking, as alcohol disrupts sleep.
- Do something relaxing before bed, like listening to soothing music, reading a book, or meditating.
- Avoid caffeine in the afternoon or evening.
- Get regular exercise—but not too close to bedtime.

When to seek help for traumatic stress

As mentioned above, a wide range of emotional reactions are common after a disaster or traumatic event, including anxiety, numbness, confusion, guilt, and despair. In and of themselves, these emotions aren't cause for undue alarm. Most will start to fade within a relatively short time.

However, if your traumatic stress reaction is so intense and persistent that it's getting in the way of your ability to function, you may need help from a mental health professional—preferably a trauma specialist.

Traumatic stress warning signs

- It's been 6 weeks, and you're not feeling any better
- You've having trouble functioning at home and work
- You're experiencing terrifying memories, nightmares, or flashbacks
- You're having an increasingly difficult time connecting and relating to others
- You're experiencing suicidal thoughts or feelings
- You're avoiding more and more things that remind you of the disaster or traumatic event

Helping children cope with traumatic stress

After a disaster or traumatic event, children need extra reassurance and support. Do your best to create an environment where your kids feel safe to communicate what they're feeling and to ask questions.

While you should tailor the information you share according to the child's age, it's important to be honest. Don't say nothing's wrong if something *is* wrong, and don't make promises you can't keep.

Tips for helping children heal after a disaster

- Provide your kids with ongoing opportunities to talk about what they went through or what they're seeing on TV. Encourage them to ask questions and express their concerns. Make it clear that there are no bad feelings.
- If you don't know the answer to a question, don't be afraid to admit it. Don't jeopardize your child's trust in you by making something up.
- The traumatic event or disaster may trigger or bring up unrelated fears and issues in your kids. Acknowledge and validate these concerns, even if they don't seem relevant to you.
- Monitor television watching. Limit your child's exposure to graphic images and videos. As much as you can, watch news reports of the disaster with your children. This will give you a good opportunity to talk and answer questions.
- Remember that children often personalize situations. They may worry about their own safety or that of their family, even if the traumatic event occurred far away. Reassure your child and help him or her place the situation in context.
- Watch for physical signs of stress. The symptoms of traumatic stress may appear as physical complaints such as headaches, stomach pains, or sleep disturbances.

More help for traumatic stress

PTSD and Trauma Help Center: With the right help and coping skills, you can overcome the effects of trauma and move on with your life.

Traumatic stress help

- Post-Traumatic Stress Disorder (PTSD): Symptoms, Treatment and Self-Help for PTSD
- PTSD in Veterans: Helping Yourself Recover from Post-Traumatic Stress Disorder
- PTSD in the Family: Helping a Loved One or Family Member with Post-Traumatic Stress Disorder
- Coping with Grief and Loss: Understanding the Grieving Process
- Supporting a Grieving Person: Understanding the Grieving Process

Common causes of trauma

- Domestic Violence and Abuse: Signs of Abuse and Abusive Relationships
- Child Abuse and Neglect: Recognizing, Preventing, and Reporting Child Abuse
- Attachment and Adult Relationships: How the Attachment Bond Shapes Adult Relationships

Resources and references

General information about emotional and psychological trauma

Common Reactions After Trauma – Guide to the common symptoms, effects, and problems that can result from emotional or psychological trauma. (National Center for PTSD)

What is Psychological Trauma? – In-depth introduction to emotional or psychological trauma, including the causes, symptoms, treatments, and effects. (Sidran Institute)

Emotional Aid (PDF) – Self-help steps to take in dealing with traumatic stress. (Volunteer Today)

Trauma treatment and therapy

How to Choose a Therapist for Post-Traumatic Stress and Dissociative Conditions – Advice on how to choose a trauma therapist. (Sidran Institute)

Trauma is Treated in the Body, Not the Mind – Article by trauma expert Peter Levine on how to heal trauma using a natural, body-based approach. (Somatic Experiencing Trauma Institute)

A Brief Description of EMDR Therapy – Covers the eight phases of EMDR therapy involved in the treatment of trauma. (EMDR Network)

Trauma recovery and self-help

Recovering from Trauma – Article on the necessity of processing emotional trauma in treatment if we are to recover and heal. (Psychology Today)

Dealing With the Effects of Trauma: A Self-Help Guide (PDF) – Guide to the healing journey, including coping strategies, where to find help for emotional trauma, and how to support recovery. (SAMHSA's National Mental Health Information Center)

Trauma in children and adolescents

Helping a Child Manage Fears – Article on helping a child cope with traumatic events. Includes tips for helping your child and a list of common childhood reactions to trauma. (Sidran Institute)

Understanding Child Traumatic Stress – Learn how emotional or psychological trauma in children differs from trauma in adult. Includes causes, symptoms, and recovery factors. (The National Child Traumatic Stress Network)

Delving deeper into psychological and emotional trauma

Trauma, Attachment, and Stress Disorders: Rethinking and Reworking Developmental Issues – Explains the brain-based view of emotional trauma and how it affects child development. (Trauma Resources)

What other readers are saying

"Very useful article for us in this disaster." ~ Nepal

"I am experiencing traumatic stress and am having a very hard time coping. I have given up on [therapy] and doubt that I will ever go to one again. I just found this website this morning and have been looking through it for the past two hours. I already feel a million times better from the things that I have read, watched, and heard. And I am feeling better because of knowing about the numerous resources that are available to me in the future. I don't understand why more mental health professionals do not use these techniques." ~ California

Authors: Melinda Smith, M.A., and Jeanne Segal, Ph.D. Last updated: August 2015.

Appendix F: Three Branch Work Plan

Three Branch Institute on Improving Child Safety and Preventing Child Fatalities West Virginia Team

Team Leader
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Three Branch Institute to Improve Child Safety and Prevent Child Fatalities Action Plan

Intended Outcome	Activities	Expected Completion
All children and families at risk have access to evidence-based prevention and early intervention services. **Chair: Christina Mullins**	• Review referral policies and funding mechanisms for early home visitation programs. • Revitalize Safe Sleep Campaign focusing on flood areas.	October 2016 January 2017
All children and families are identified at earliest signs of risk. Children under one year old are given high priority. **Chair: Linda Watts**	• Research and develop Resource Teams for CPS. • Analyze current data around the effectiveness of parenting classes and other available services. • Research practice models that promote a culture of safety.	February 2017 December 2017 February 2017
The State has a comprehensive, multi-agency plan to prevent child maltreatment deaths. **Chair: Nancy Sullivan**	• Do multi-disciplinary in-depth review and analysis of five years of reports from all organizations tracking child fatalities, including those not known to CPS. • Facilitate judge led regional stakeholder meetings to identify and develop community-based solutions around child safety.	January 2017 March 2017