



**FINAL REPORT OF THE  
VIRGINIA COMMISSION ON YOUTH**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**

# **Trauma-Informed Care**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
2017**

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**MEMBERS OF THE VIRGINIA COMMISSION ON YOUTH**

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**From the Senate of Virginia**

Barbara A. Favola, Chair  
Charles W. Carrico, Sr.  
David W. Marsden

**From the Virginia House of Delegates**

Richard L. Anderson  
Richard P. Bell, Vice Chair  
Peter F. Farrell  
Mark L. Keam  
Daun S. Hester  
Christopher K. Peace

**Gubernatorial Appointments  
from the Commonwealth at Large**

Karrie Delaney  
Deirdre S. Goldsmith  
Christian Rehak Esq.

**Commission on Youth Staff**

Amy M. Atkinson, Executive Director  
Will Egen, Senior Policy Analyst

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## **I. Authority**

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The Commission on Youth is established in the legislative branch of state government. Section 30-174 of the *Code of Virginia* directs the Commission on Youth to "...study and provide recommendations addressing the needs of and services to the Commonwealth's youth and their families." This section also directs the Commission to "...encourage the development of uniform policies and services to youth across the Commonwealth and provide a forum for continuing review and study of such services."

Section 30-175 of the *Code of Virginia* outlines the powers and duties of the Commission on Youth and directs it to "[u]ndertake studies and to gather information and data in order to accomplish its purposes as set forth in § 30-174, and to formulate and report its recommendations to the General Assembly and the Governor."

In fulfilling its duty as set forth in the *Code of Virginia*, the Virginia Commission on Youth, in partnership with the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University, hosted its sixth Family Impact Seminar on May 24, 2017 on the Adverse Effects of Childhood Trauma. This report summarizes the activities of the Commission on Youth related to its work on trauma-informed care.

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## **II. Members Appointed to Serve**

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The Commission on Youth is a standing legislative commission of the Virginia General Assembly. It is comprised of twelve members: six Delegates, three Senators and three citizens appointed by the Governor.

Members of the Virginia Commission on Youth are:

- Senator Barbara A. Favola, Arlington, Chair
- Senator Charles W. "Bill" Carrico, Sr., Galax
- Senator David W. Marsden, Burke
- Delegate Richard L. Anderson, Woodbridge
- Delegate Richard P. "Dickie" Bell, Staunton, Vice Chair
- Delegate Peter F. Farrell, Richmond
- Delegate Mark L. Keam, Vienna
- Delegate Daun S. Hester, Norfolk
- Delegate Christopher K. Peace, Mechanicsville
- Karrie Delaney, Chantilly
- Deirdre S. Goldsmith, Abingdon
- Christian Rehak, Esq., Radford

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### **III. Executive Summary**

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The Virginia Commission on Youth, in partnership with the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University, hosted a Family Impact Seminar on May 24, 2017 on the Adverse Effects of Childhood Trauma. This report summarizes the activities of the Commission on Youth related to its work on trauma-informed care during the 2017 study year. Approximately 160 participants attended the Seminar, including legislators, members of the executive branch, local officials, educators, advocacy groups, service providers, higher education professionals, and stakeholders. Seminar participants learned that youth exposed to trauma have a greater risk of experiencing disease, violence, homelessness, and criminal justice involvement.

As a result of the Seminar and further study on trauma-informed care, the Commission developed draft recommendations that were presented at the September 20, 2017 meeting. After receiving public comment on these recommendations, at the November 8, 2017 meeting, the Commission approved the following recommendations:

#### **Recommendation 1 – Trauma-Informed Care Interagency Workgroup**

Request the Governor to include in the proposed biennial budget, language directing the Office of the Secretary of Health and Human Resources, in cooperation with the Office of the Secretary Education, to create a Trauma-Informed Care workgroup. The workgroup shall include representatives from the Department of Social Services, the Department of Behavioral Health and Developmental Services, the Department of Criminal Justice Services, the Department of Juvenile Justice, the Department of Education, the Office of Children's Services, the Department of Medical Assistance Services, the Virginia Department of Health, the Family and Children's Trust Fund of Virginia, other state agencies as needed, stakeholders, researchers, community organizations and representatives from impacted communities. The workgroup shall (i) develop a shared vision and definition of trauma-informed care for Virginia; (ii) examine Virginia's applicable child and family-serving programs and data; (iii) develop an implementation plan for data-sharing; (iv) develop strategies to build a trauma-informed system of care for children and families across the Commonwealth; (v) identify indicators to measure progress; (vi) identify workforce development opportunities around evidence-based and best practices; and (vii) identify needed professional development/training in trauma-informed practices for all child-serving professionals. In addition, the workgroup shall explore opportunities, including the creation of public/private partnerships to expand trauma-informed care throughout the Commonwealth. The Secretary of Health and Human Resources and the Secretary of Education shall report to the Chairman of the Senate Finance and House Appropriations Committees and the Virginia Commission on Youth by December 15 of each year. Include an appropriation of \$150,000 each year for staff support to coordinate and carry out the duties of the workgroup.

#### **Recommendation 2 – Establish a Small Grants Program**

Request the Governor to include in the proposed biennial budget a General Fund appropriation of \$250,000 to serve as a dollar for dollar match for private, foundation and nonprofit money raised to support a grants program of the Family and Children's Trust Fund (FACT). These dollars shall fund a competitive small grants program to prevent, mitigate or help children ages 0-6 recover from Adverse Childhood Experiences across the state.

### **Recommendation 3 – Virginia’s Tiered Systems of Support**

Request the Governor to include in the proposed biennial 2018 budget, a General Fund appropriation of \$250,000 to increase the existing General Fund appropriation to the Department of Education's Virginia’s Tiered Systems of Supports directing the additional funds to support Title I and Accreditation Denied Schools.

## **IV. Background**

The Commission on Youth received a presentation from Dr. Allison Sampson-Jackson at the October 20, 2016 meeting on how to build trauma-informed communities in Virginia. Using the Substance Abuse and Mental Health Services Administration’s definition, individual trauma results from "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." Dr. Sampson-Jackson outlined the consequences of exposure to violence during childhood. Adverse Childhood Experiences (ACEs) and how ACEs influence health, learning, and unhealthy behaviors later in life were discussed. In addition, Dr. Sampson-Jackson detailed the long-term consequences of ACEs including additional child and adult medical costs, productivity losses, child welfare costs, criminal justice costs, and special education costs. The importance of resilience was discussed in combating the effects of childhood trauma. At the conclusion of the presentation, the Commission agreed to request that Virginia Commonwealth University consider selecting Adverse Childhood Experiences as the topic for next year’s Family Impact Seminar. A letter was sent to Virginia Commonwealth University with this request which received a favorable response.

At the Commission on Youth meeting on May 24, 2017, the Commission, in partnership with the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University, hosted a Family Impact Seminar on the Adverse Effects of Childhood Trauma. Approximately 160 participants attended the Seminar, including legislators, members of the executive branch, local officials, educators, advocacy groups, service providers, higher education professionals, and stakeholders. Seminar participants learned that youth exposed to trauma have a greater risk of experiencing disease, violence, homelessness, and criminal justice involvement.

The Commission members, invited guests, and seminar participants received the following presentations at the Family Impact Seminar. Presentations may be found in the appendix.

The Impact of Adverse Childhood Experiences (ACEs)  
*Allison Jackson, Ph.D., LCSW, CSOTP*  
*Director, System of Care, Magellan of Virginia*

Addressing Trauma’s Medical Impact  
*Michel Aboutanos, MD, MPH, Professor of Surgery, VCU School of Medicine*  
*Chair, VCU Division of Acute Care Surgical Services*  
*Medical Director, VCU Trauma Center, VCU Medical Center*

Sexual Victimization of Children  
*Christina Mancini, Ph.D.*  
*Associate Professor, L. Douglas Wilder School of Government and Public Affairs,*  
*Virginia Commonwealth University*

## Trauma among Youth in Corrections

Hayley Cleary, Ph.D.

*Assistant Professor, L. Douglas Wilder School of Government and Public Affairs, Virginia Commonwealth University*

Seminar participants learned that youth exposed to trauma have a greater risk of experiencing disease, violence, homelessness, and criminal justice involvement. The Family Impact Seminar speakers provided participants with an array of recommendations with the goal of preventing and addressing childhood trauma. Presenters offered suggestions in providing services and supports to children who have experienced trauma; addressing trauma in the medical community; increasing the awareness of sexual victimization of children; and understanding trauma experienced by youth in corrections.

Following the Seminar, the Commission sent letters to members of the Governor's Children's Cabinet highlighting recommendations presented by the seminar speakers. In addition, the Commission requested a presentation from the Children's Cabinet on trauma-related initiatives. Specifically, the Commission requested information on any legislative or budgetary actions that may be necessary to implement strategies in preventing or addressing childhood trauma and its impacts. At the Commission's September 20, 2017 meeting, the Secretary of Health and Human Resources, William Hazel, and the Secretary of Education, Dietra Trent, provided the Commission with an update of the activities of the Children's Cabinet. Their presentation may be found in Appendix E. Following their update, Commission staff presented draft recommendations for trauma-informed care.

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## **V. Findings and Recommendations**

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After presentation of the findings and recommendations at the Commission's September 20, 2017 meeting and receipt of public comment, the Commission on Youth approved the following recommendations at the November 8 meeting:

*Findings:*

*A trauma-informed care interagency workgroup is needed to assist in the development of a trauma-informed system in Virginia. All impacted state agencies, along with stakeholders, researchers, community organizations and representatives from impacted communities should be included in this effort.*

**Recommendation 1**

Request the Governor to include in the proposed biennial budget, language directing the Office of the Secretary of Health and Human Resources, in cooperation with the Office of the Secretary Education, to create a Trauma-Informed Care workgroup. The workgroup shall include representatives from the Department of Social Services, the Department of Behavioral Health and Developmental Services, the Department of Criminal Justice Services, the Department of Juvenile Justice, the Department of Education, the Office of Children's Services, the Department of Medical Assistance Services, the Virginia Department of Health, the Family and Children's Trust Fund of Virginia, other state agencies as needed, stakeholders, researchers, community organizations and representatives from impacted communities. The workgroup shall (i) develop a shared vision and definition of trauma-informed care for Virginia; (ii)

examine Virginia's applicable child and family-serving programs and data; (iii) develop an implementation plan for data-sharing; (iv) develop strategies to build a trauma-informed system of care for children and families across the Commonwealth; (v) identify indicators to measure progress; (vi) identify workforce development opportunities around evidence-based and best practices; and (vii) identify needed professional development/training in trauma-informed practices for all child-serving professionals. In addition, the workgroup shall explore opportunities, including the creation of public/private partnerships to expand trauma-informed care throughout the Commonwealth. The Secretary of Health and Human Resources and the Secretary of Education shall report to the Chairman of the Senate Finance and House Appropriations Committees and the Virginia Commission on Youth by December 15 of each year. Include an appropriation of \$150,000 each year for staff support to coordinate and carry out the duties of the workgroup.

Findings:

*A small grants initiative is need to support communities in developing trauma-informed systems and services.*

**Recommendation 2**

Request the Governor to include in the proposed biennial budget a General Fund appropriation of \$250,000 to serve as a dollar for dollar match for private, foundation and nonprofit money raised to support a grants program of the Family and Children's Trust Fund (FACT). These dollars shall fund a competitive small grants program to prevent, mitigate or help children ages 0-6 recover from Adverse Childhood Experiences across the state.

Findings:

*Schools play a critical role in providing trauma-informed services to students and families. Virginia's Tiered Systems of Supports provides training, technical assistance, and on-site coaching to public school teachers and administrators on the implementation of positive behavioral interventions and supports program. This programming addresses both the academic and behavioral needs of students including students impacted by trauma, improves school climate, and reduces disruptive behavior in the classroom.*

**Recommendation 3**

Request the Governor to include in the proposed biennial 2018 budget, a General Fund appropriation of \$250,000 to increase the existing General Fund appropriation to the Department of Education's Virginia's Tiered Systems of Supports directing the additional funds to support Title I and Accreditation Denied Schools.



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## **VI. Acknowledgments**

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The Virginia Commission on Youth extends special appreciation to the members of the Advisory Group and to the following for their assistance on this initiative:

Integration Solutions

Allison Jackson, Chief Executive Officer

Virginia Department of Behavioral Health and Developmental Services

Stacy Gill, Behavioral Health Community Services Director

Holly Mortlock, Policy Director

Virginia Department of Social Services

Nicole Poulin, Executive Director of Family and Children's Trust Fund of Virginia

Virginia Governor's Children's Cabinet

Daniela Lewy, Executive Director

William Hazel, Secretary of Health and Human Resources

Dietra Trent, Secretary of Education

Voices for Virginia's Children

Emily Griffey, Policy Director



## ***Impact of Childhood Trauma on Health*** ***Adverse Childhood Experiences and Resilience***

Presented by:  
Dr. Allison Sampson-Jackson, PhD, LCSW, LICSW, CSOTP



### ***Defining Trauma***

Individual trauma results from 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 definition 2014



## Adverse Childhood Experiences – A Primer Video

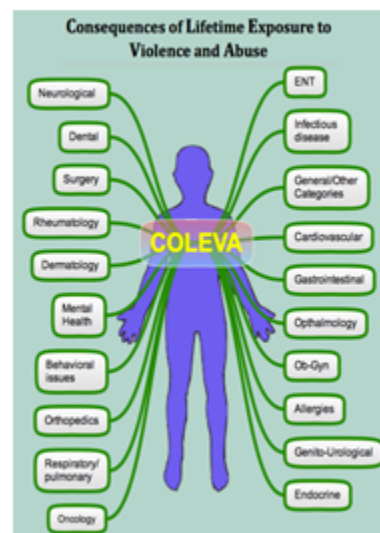
- Emotional abuse
- Physically abuse
- Sexual abuse
- Not loved, not important
- Poverty
- Using drugs/substances
- Separation/divorce
- Mother- interpersonal violence
- Substance abuse
- Mentally health diagnosis
- Prison

\*Remember this is a research tool or for your personal reflection now, not intended to be read to someone and used independently as a screen.

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## Consequences of a Lifetime Exposure to Violence and Abuse

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy



<http://www.coleva.net/>

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## ACEs Score: Adoption of At-Risk Health Behaviors

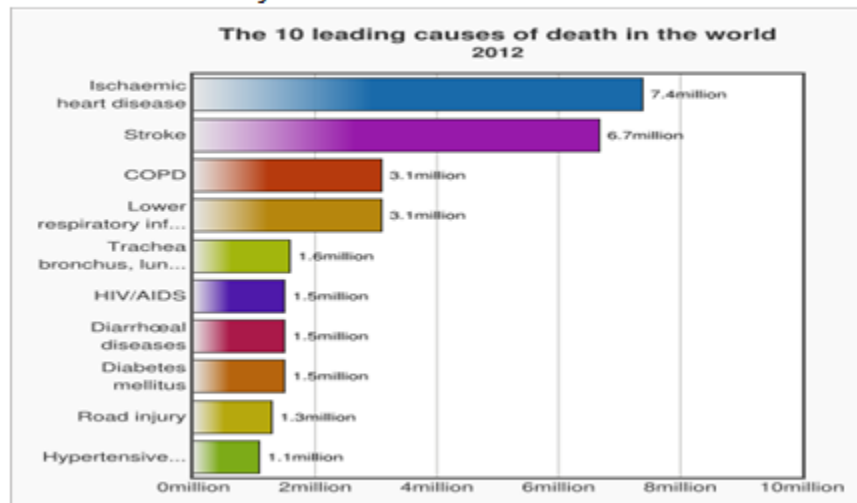
<http://www.iowaaces360.org/impact-of-aces.html>

ACE Score	Risk
4	<ul style="list-style-type: none"> <li>- 260% more likely to develop COPD</li> <li>- 500% more likely to develop alcoholism</li> <li>- Females are 500% more likely to become victims of domestic violence.</li> <li>- Females are almost 900% more likely to become victims of rape</li> <li>- 242% more likely to smoke</li> <li>- 222% more likely to become obese</li> <li>- 357% more likely to experience depression</li> <li>- 443% more likely to use illicit drugs</li> <li>- 1133% more likely to use injected drugs</li> <li>- 298% more likely to contract an STD</li> <li>- 1525% more likely to attempt suicide</li> <li>- 555% more likely to develop alcoholism</li> </ul>
6	<ul style="list-style-type: none"> <li>- 250% more likely to become adult smoker</li> <li>- A male child with an ACE score of 6 has a 4,600% increase in the likelihood that he will become an IV drug user later in life</li> <li>- More likely to die 20 years younger than a person with no ACEs</li> </ul>
7	<ul style="list-style-type: none"> <li>- Adult suicide attempts increased 3,000%</li> <li>- Childhood and adolescent suicide attempts 5,100%</li> <li>- 5,000% more likely to develop hallucinations</li> <li>- Increased the risk of suicide attempts <b>51-fold</b> among children/adolescents</li> <li>- Increased risk of suicide attempts <b>30-fold</b> among adults</li> </ul>

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## ACEs and Leading Causes of Death Linked to 7 out of the 10



<http://www.who.int/mediacentre/factsheets/fs310/en/>

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## Recommendations for Improving Youth and Family Health

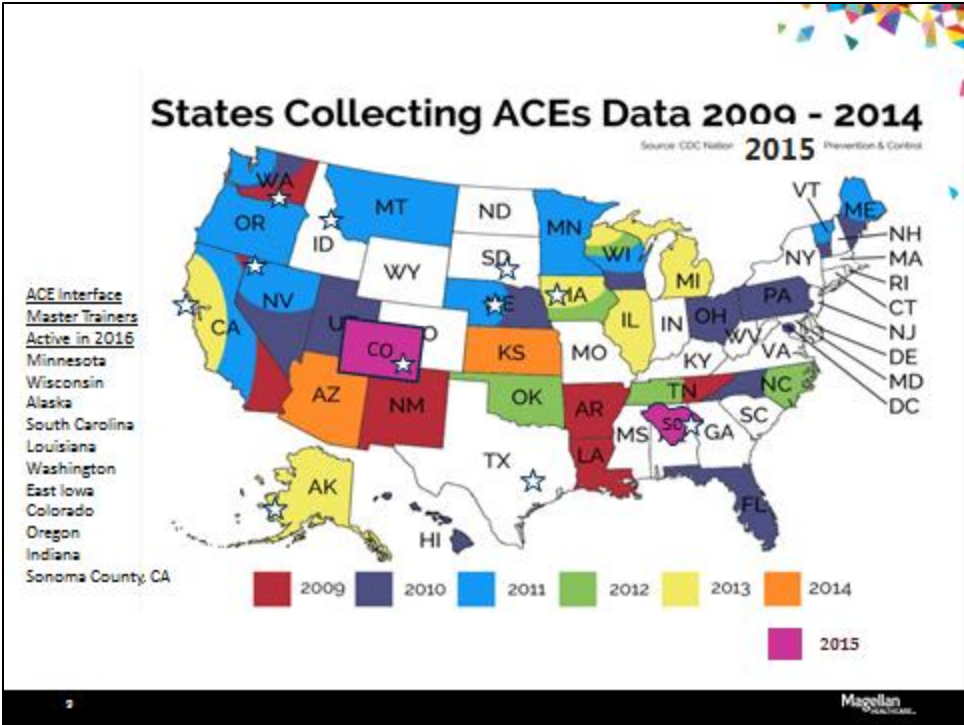
#1 – Get a Baseline on Impact of ACEs in Virginia	VDH- BRFSS added 2016
#2 – Over Sampling of BRFSS in key communities of concern	Norfolk, Petersburg, & Richmond 2017
#3 – Coordinate Cross System Data Collection to Focus Health Response	Lora Porter & Walla Walla WA work
#4 – Integrate ACEs Professional Development Plan across all Health & Human Services Systems	ACEs Interface
#5 – Preventative Strategies for Next Generation Health	Washington NEAR HV Funding
#6 – Engage Hospitals in Preventative HealthCare Approaches	Bounce Back Campaign funding
#7 – Require Pediatricians to Screening for ACEs	CYW-ACEs Q
#8 – Integrate Trauma Informed Care into all 3 tiers of Schools	VTSS and DC model
#9 – Create Responsive HealthCare Systems for Super Utilizers via Enhanced Care Coordination	Camden Healthcare/Dr. Brenner Pilot Funding
#10 – Integrate Trauma Informed Care into Jail Screening and Programs while Enhancing Care Coordination	HARP program replication

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### Recommendation One: Get a Baseline on Impact of ACEs in Virginia

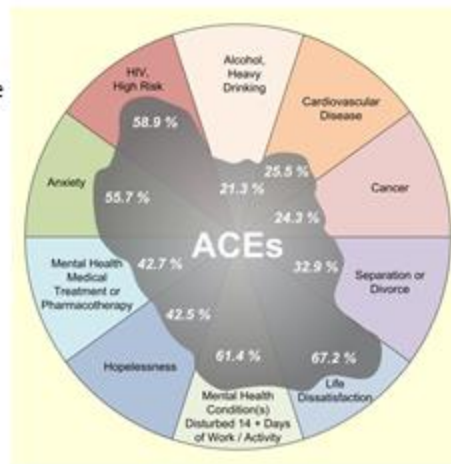


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*Recommendation Two:  
Over Sampling of BRFSS in  
Key Communities of Concern*

## Population Attributable Risk

- A large portion of many health, safety and prosperity conditions is attributable to Adverse Childhood Experience.
- ACE reduction reliably predicts a decrease in all of these conditions simultaneously



Foundation for Healthy Generations .  
(2014-2015). *Health, Safety and Resilience: Foundations for Health Equity* . Seattle: Foundation for Healthy Generations

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## Population Attributable Risk

61%	<b>Incarceration for Adults</b>
22%	Fell $\geq 3x$ in 3 months
31%	Current Smoker
31%	Drinking and Driving
51%	High Risk HIV
15%	Insulin Diabetes
17%	Asthma
69%	<b>Mental Illness</b>
41%	Chronic Depression
67%	<b>Suicide Attempts</b>
65%	<b>Alcoholism</b>
78%	<b>IV Drug Use</b>
54%	Painkillers to get high
14%	Not graduating college or tech
20%	Out of Work $\geq 1$ year
25%	Job Injury (medical)
43%	Interrupted activities $\geq$ of 30 days

Foundation for Healthy Generations .  
(2014-2015). *Health, Safety and Resilience: Foundations for Health Equity* . Seattle: Foundation for Healthy Generations

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## BRFSS Data in Washington Example



### PREVALENCE OF 6-8 ACES AMONG WASHINGTON ADULTS AGE 18-44



<http://www.tulalipnews.com/wp/2014/09/03/adverse-childhood-experiences-aces-chronic-health-and-addiction-in-indian-country/>

**Alignment Legend**  
1 Lowest 6-8 ACE 18-44  
2 Lower than Median  
3 Higher than Median  
4 Highest 6-8 ACE 18-44

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*Recommendation Three:  
Coordinate Cross System Data Collection and  
Thriving Maps in these Areas  
to Focus Health Response*



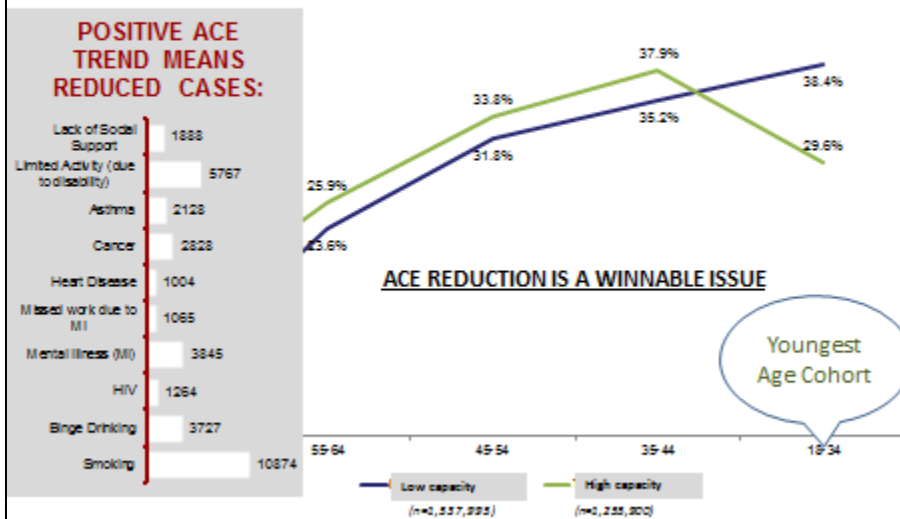
## Building a Trauma Informed Community – Resilience Trumps Aces



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## High Capacity Communities Reduce Percent of Young Adults With ≥ 3 ACEs



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## *Washington Community Capacity Building*

### **Funded Community Networks showed significant improvement in Severity Index**

- Out of home placement
- Loss of parental rights
- Child hospitalization rates for accident and injury
- High School Drop Out
- Juvenile Suicide Attempts
- Juvenile arrests for alcohol, drugs, and violent crime
- Juvenile offenders
- Teen births
- Low birth weights
- No third trimester maternity care
- Infant mortality
- Fourth grade performance on standardized testing

Hall J, Porter L, Longhi D, Becker-Green J, and Drjefus S. (2012) *Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings*, *Journal of Prevention & Intervention in the Community*, 40:4, 325-334. --  
<http://www.tandfonline.com/doi/pdf/10.1080/10852352.2012.707463>

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*Recommendation Four:  
Integrate a ACEs Professional Development  
Plan across all Health and Human Services  
Systems*

## ACEs Interface Master Training

Throughout the nation, people are talking about the ACE Study because study findings reveal this is the largest public health discovery of our time. In any great public health discovery the most important actions in the first decades are:

To tell everyone – share the findings effectively and with fidelity, and  
To change ourselves and promote changes within our spheres of influence.

The ACE Interface *Train the Master Trainer Program* is designed to support rapid dissemination of ACE and resilience science, and promote understanding and application of the science to improve health and wellbeing across the lifespan. In less than a year, *the Master Trainer Program* enables delivery ACE information to diverse communities--with *fidelity to science and concepts*--to tens of thousands of people.

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## *Recommendation Five: Preventative Strategies for Next Generation Health*

## *NEAR Science*

- Neuroscience
- Epigenetics
- Adverse Childhood Experiences
- Resilience

<http://www.healthygen.org/resources/nearhome-toolkit>

<http://www.healthygen.org/resources/laura-porter-keynote-address-near-science-wa-state-resilience-findings>

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## *NEAR: What Help actually Helps ?*

**Support:** Feeling socially and emotionally supported and hopeful

- Social Emotional Competence Building
- Hope and a Sense of Future

**Help:** Having two or more people who give concrete help when needed

- Concrete Supports (not Facebook Friends)

**Community Reciprocity:** Watching out for children, intervening when they are in trouble, and doing favors for one another

- Primary network of protection in your community
- People you see each day and see you

**Social Bridging:** Reaching outside one's immediate circle of friends to recruit help for someone inside that circle

- Asking for help
- Trusting Systems and People outside your circle to respond and be safe

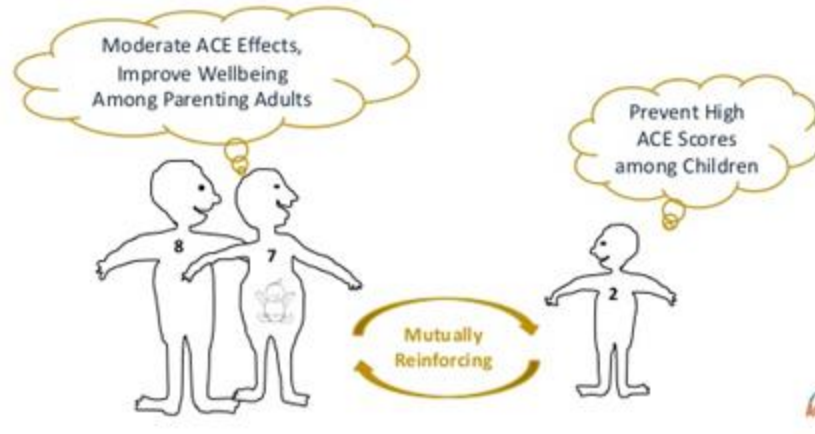
<http://www.healthygen.org/resources/laura-porter-keynote-address-near-science-wa-state-resilience-findings>

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*Creating the Virtuous Cycle*

## Promote Virtuous Cycle of Health




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*Recommendation Six:  
Engage Hospitals in  
Preventative HealthCare Approaches*



*Engage Hospitals, VDH and Health Clinics in  
Statewide Resilience Campaigns*


<http://www.bouncebackproject.org/>

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*Solution Seven:  
Require Pediatricians to Screening for ACEs*



## What's important to know about the ACEs Tool ...

- Important to note that at this time, there are no psychometrically tested and validated ACEs screens for children
- ACEs measure was developed originally as a research tool to gather history from adults 18 years or older
- Dr. Anda and Laura Porter prefer to call it a history gathering tool versus a "screening" tool
- ACEs scores are not predictive at the individual level therefore it should not be used to determine eligibility or diagnosis independent of a comprehensive psychosocial assessment with the use of valid and reliable tools that are shown to help in predicting likelihood of mental health challenges in living

Laura Porter (personal communication 10/16/2016)

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## CYW-ACE-Q Tool Kit Guidance ...

"In the American Academy of Pediatrics (AAP) policy statement, "Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health," the AAP explicitly calls on pediatricians to "actively screen for precipitants of toxic stress that are common in their particular practices" 26."

Burke Harris, N. and Renschler, T.  
(version 7/2015).  
Center for Youth Wellness ACE-Questionnaire  
(CYW ACE-Q Child, Teen, Teen SR). Center for  
Youth Wellness, San Francisco, CA.  
Pg.8

Garner AS, Shonkoff JP, Siegel BS, et al. Early  
childhood adversity ,toxic stress, and the role of  
the pediatrician: Translating  
developmental science into lifelong health.  
*Pediatrics.*  
2011;129(1):e224-e231

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## CYW-ACE Q

SECTION 1 *Ten items assessing exposure to the original ten ACEs*

\* *Population level data for disease risk in adults*

SECTION 2 *Seven or nine items assessing for exposure to additional early life stressors relevant to children/youth served in community clinics*

\* *Hypothesized to lead to disruption in neuro-endocrine-immune axis*

\* *Not yet correlated with population level data about risk of disease*

Burke Harris, N. and Renschler, T.  
(version 7/2015).  
Center for Youth Wellness ACE-Questionnaire  
(CYW ACE-Q, Child, Teen, Teen SR). Center for  
Youth Wellness. San Francisco, CA.  
Page 10

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## Iowa

### 2015

- New patient records for nine month well exams
  - NCCQA Requirements for a Patient-Centered Medical Home
    - Enhance Access and Continuity
    - Identify and Manage Patient Populations
    - Plan and Manage Care
    - Provide Self-Care and Community Support
    - Track and Coordinate Care
    - Measure and Improve Performance
- [www.nccqa.org](http://www.nccqa.org)
- [Created Iowa EPSDT Care for Kids Health Maintenance Recommendations for Pediatricians](#)

### 2016

- Resiliency Toolkit  
<http://www.iowaaces360.org/individuals-and-families.html#resiliency>

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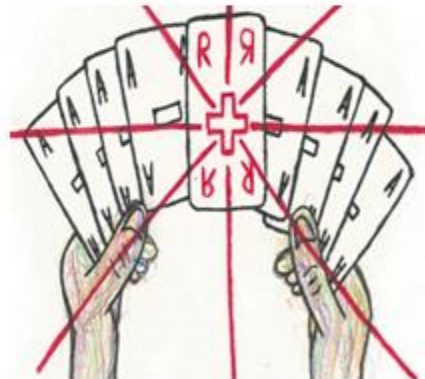
*Recommendation Eight:  
Integrate Trauma Informed Care  
into all Three Tiers of Schools*



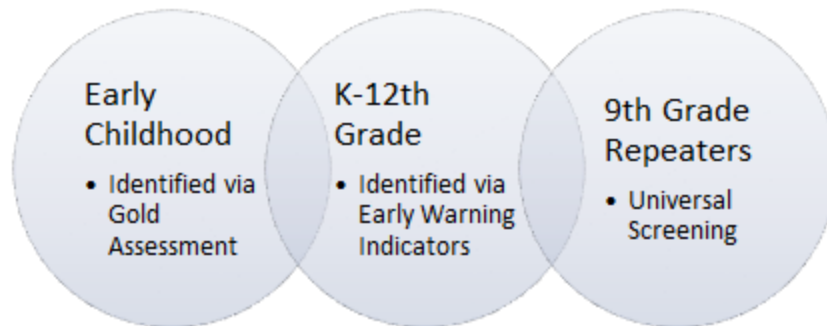
*Be a F.O.R.S.E. in your community*

Image by Lincoln High student Brendon Gilman

**Focus  
On  
Resilience &  
Social-Emotional**



## District of Columbia Trauma Sensitive Process



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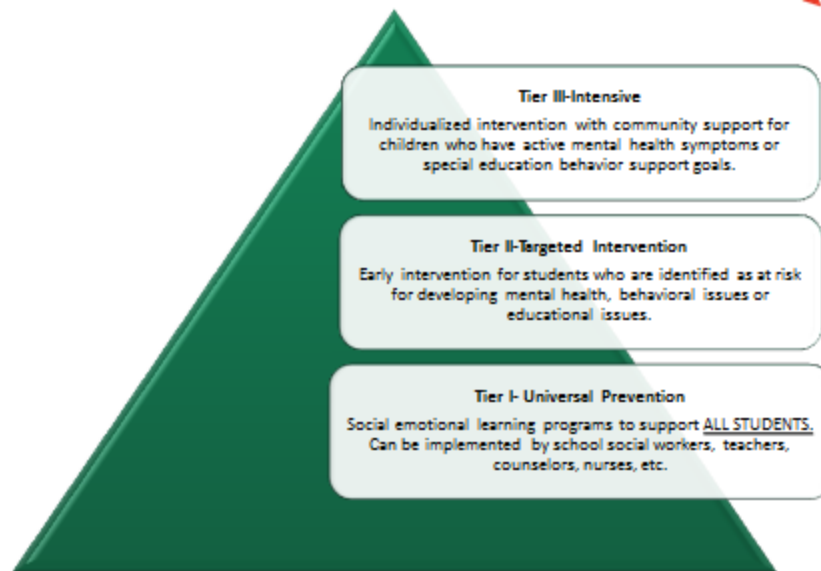
## Early Warning Indicator System Screening for MH and Trauma

Early Warning Indicators	On-Track (Tier I)	Sliding (Tier II)	Off-Track (Tier III)
BEHAVIOR	No Office Discipline Referrals (ODR) or suspensions	2-3 ODRs and/or 1 suspension	3+ ODRs and/or 2+ suspensions
ATTENDANCE	missed < 5% instructional days	missed 2 5-9% instructional days	≥ 10% instructional days
ACADEMICS: READING and Math	Above Proficient or Proficient on interim assessment	Below Proficient	Far Below Proficient

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## Tiered Trauma Sensitive Model



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## Tier One

### Tier I: Universal Prevention/Consultation and Mental Health Promotion:

Social Emotional Support services at this tier are provided universally to the entire student body, school staff, or parents/guardians. These services aim to prevent the development of serious mental health problems and to promote pro-social skill development among children and youth.

#### Examples of interventions at this tier include:

- School-wide PBIS or classroom-based social emotional learning programs, including substance abuse and violence prevention programs (i.e., bullying prevention; Good touch, Bad touch; peer mediation; conflict resolution)
- Staff professional development (i.e., mental health awareness, classroom management)
- Mental health educational workshops for parents/guardians or students
- Mental Health Consultation\*

\*During Tier One: Consultation is focused on increasing the general knowledge base of general education teachers regarding social emotional development, impairments, and the relationship to the curriculum and function in age-appropriate activities.

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## Tier Two

### Tier II: Targeted or Early Intervention/Prevention:

Students who are at elevated risks for developing a mental health problem are offered various early intervention services to target specific risk factors. These interventions are delivered to children and youth who have social emotional challenges, behavioral symptoms and/or mental health needs that may not be severe enough to meet diagnostic criteria or eligibility for special education services.

#### Evidence Based Interventions

- Cognitive Behavior Therapy (CBT-Elementary, Middle and High School)
- Child Centered Play Therapy (CCPT-Elementary School)
- Cognitive Behavioral Intervention For Trauma in Schools (CBITS-Middle and High School)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS-Middle and High School)
- Theatre Troupe/ Peer Education Project (TT/PEP-Middle and High School)
- Cannabis Youth Treatment (CYT-Middle and High School)
- 

#### Additional interventions may include:

- Support groups (e.g., grief and loss, children of divorce, etc.)
- Focused skills training groups (social skills, anger management)
- Crisis management
- Interventions that target specific behaviors, such as aggression, withdrawal, sadness etc.
- Attendance interventions, dropout prevention programs, and training or consultation for families and teachers who work with identified children.
- Mental Health Consultation
- FBA and BIP-Level I

## Tier Two

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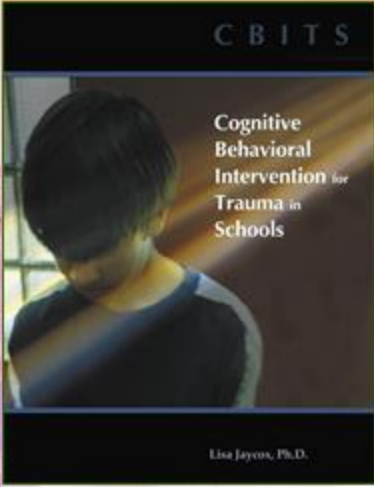
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**LEADING CHANGE  
TRANSFORMING LIVES**

2016 NASW NATIONAL CONFERENCE

**JUNE 22-25, 2016  
WASHINGTON, DC**



**Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**

- School-based intervention
- Delivered by licensed mental health professionals
- Proven effective in research trials
- Visit: [Rand.org](http://Rand.org) OR [cbitsprogram.org](http://cbitsprogram.org)

Lisa Jaycox, Ph.D.

NASW  
National Association of Social Workers

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## Tier Three

**Tier III: Intensive Intervention:**

Students who have active mental health symptoms that meet diagnostic criteria are offered intensive interventions to improve functioning in school and decrease impact on academic achievement. Interventions at this level are appropriate for meeting the needs of students who have specific mental health needs that are impacting their functioning in the school, home, and/or community.

**Evidence Based Interventions**

- Cognitive Behavior Therapy (CBT-Elementary, Middle and High School)
- Child Centered Play Therapy (CCPT-Elementary School)
- Cognitive Behavioral Intervention For Trauma in Schools (CBITS-Middle and High School)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS-Middle and High School)
- Cannabis Youth Treatment (CYT-Middle and High School)

**Interventions at this tier may include any combination of the following:**

- Behavior Support Services on an IEP utilizing evidenced based interventions (listed above)
- Individual and or group counseling
- Psycho-education
- Crisis intervention
- Referral to and Service coordination with community mental health providers

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TRANSFORMING LIVES**

2016 NASW NATIONAL CONFERENCE

**JUNE 22-25, 2016  
WASHINGTON, DC**

**NASW**  
National Association of Social Workers

**Support for Students Exposed to Trauma (SSET) – Modified for Use by Teachers**

- Modified version of CBITS
- Delivered by: Teachers, Graduate Interns and School Counselors
- Proven effective in research trials

PROGRAM MANUAL

Support for Students Exposed to Trauma: The SSET Program

Group Leader Training Manual, Lesson Plans, and Lesson Materials and Worksheets

100% FREE • Author: K. Langley • ©2011 • 2016

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*Recommendation Nine:  
Create Responsive HealthCare Systems for  
Super Utilizers via  
Enhanced Care Coordination*

## *Changes in Healthcare Systems*

### Camden Coalition of Healthcare Providers

#### **A Video from Robert Wood Johnson Foundation**

2003 - Physician Jeffrey Brenner founds the Camden Coalition of Healthcare Providers, an integrated health care system designed to provide preventive and primary care while also addressing patients' social needs.

2011 - Brenner is the subject of a profile in *The New Yorker* that describes his use of data and mapping to identify "hot-spotters"—people with multiple and chronic ailments who are the heaviest users of health care—and respond with a team-based approach to help those patients manage their health, improve their stability and reduce the costs of their care.

Brenner receives a MacArthur "genius" grant for his model of cooperative care, now being replicated by more than ten communities across the country.

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## *Dr. Brenner's Problem Arising From Data*

Nearly half of the city's approximately 77,000 residents were visiting an emergency department or hospital annually—most often for head colds, viral infections, ear infections, and sore throats.

Thirteen percent of the patients accounted for 80 percent of hospital costs;  
20 percent of the patients accounted for 90 percent of the costs.

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## *Process of linking to a Care Management Team*

### **Pro-Actively and as Part of a Readmission Reduction Team**

- The database identifies hospitalized patients with complicated medical and social needs
- A *care management team*—consisting of a social worker, nurse, community health worker and health "coach" (an AmeriCorps volunteer who plans to go into medicine or nursing)—visits the patient in the hospital, reviewing prescribed medications, conferring with doctors and nurses, and helping plan the discharge
- Team members visit the patient at home immediately after discharge and provide ongoing support for two to nine months, including connecting the patient to a primary care doctor, accompanying him or her to appointments, and helping line up needed social services. The goal is to leave patients with the ability to manage their health on their own

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## *Improving Care Can Save Money*

While Brenner's main purpose was to improve care, there is evidence that his model reduces costs.

The first 36 patients averaged a total of 62 hospital and emergency room visits per month before the intervention compared to 37 visits per month afterward.

Their hospital bill total fell from a monthly average of \$1.2 million to just over \$500,000—savings that benefit the federal and state governments in reduced Medicaid spending and the hospitals in reduced charity care costs.

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*Recommendation Ten:  
Enhance Integration of Trauma Informed Care  
into Department of Juvenile Justice Screening  
and Programs while Enhancing Care  
Coordination*

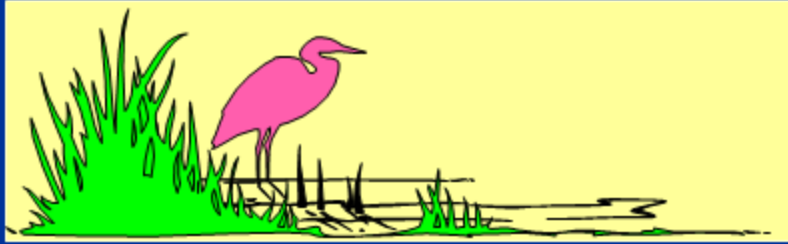
*Trauma and Juvenile Justice Population*

Being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent and as an adult by 28 percent, and for a violent crime by 30 percent. The abused and neglected cases were younger at first arrest, committed nearly twice as many offenses, and were arrested more frequently

(Widom, 1995; Widom and Maxfield, 2001).

- According to NCTSN, each year 2 million children come into contact with the Juvenile Justice System
- The majority of these youth have directly experienced or witnessed trauma
- Trauma informed approaches to their care in the Juvenile Justice System can reduce contact and recidivism

## Crime is a wound



Justice should be healing

## The Balanced Approach

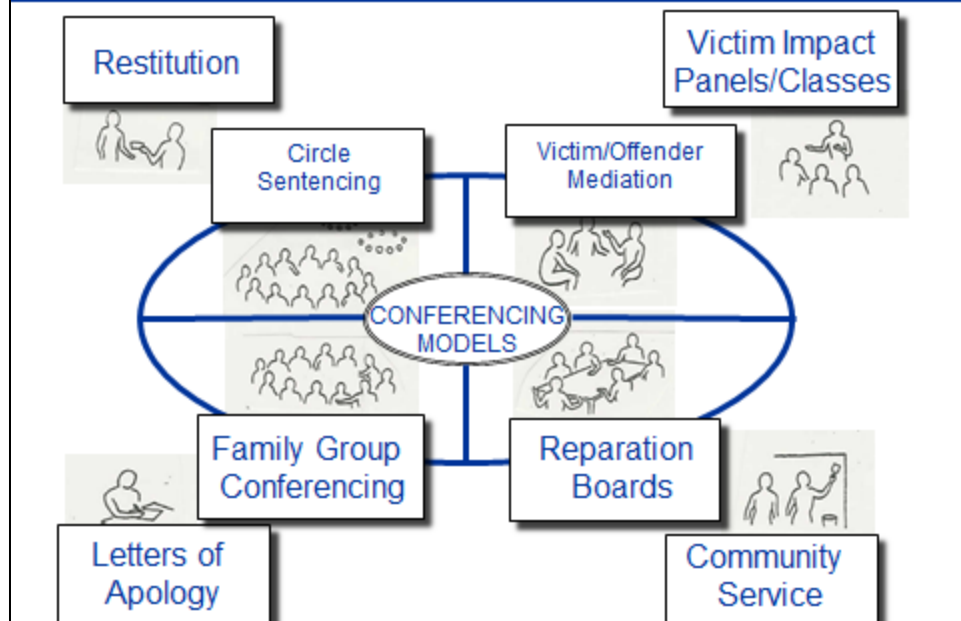
Community  
Safety

Competency  
Development

Accountability

## Restorative Justice Practices at a Glance

OJJDP: Balance and Restorative Justice Training Restorative Justice Foundations Module 1, Slide 68



### *Additional Implementation Suggestions*

- Continued enhancement of Positive Youth Development (PYD) Models focusing on protective factors and assets of youth
- Incorporation of Restorative Practices and Restorative Justice Models across the Department of Juvenile Justice Continuum
- Incorporation of Trauma Informed Organizational Assessments across continuum of services offered

## Implications & Future Directions

### Reduction of ACEs within linked lives context of parents and children

- o Better assessment of factors that serve as mechanisms of stress proliferation, coping and support erosion, disability and health outcomes: Macro, Meso, Micro
- o More data on children's well-being within parental trajectories
- o Main directions of Interventions should be on:
  - o Strengthening "adaptive parental function"
  - o Interrupting stress proliferation and stress embodiment
  - o Resilience cannot thrive at any one level alone: Individual, family, community, structural needed

Paula S. Nurius, University of Washington  
Illustrating NEAR-Related Findings from Surveillance  
Population Data:  
Building Partnership Complementarity





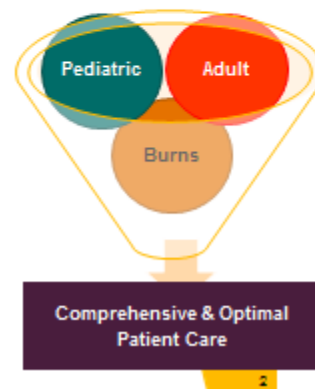
**VCU Medical Center  
A Comprehensive  
Level I Trauma Center**

Michel Aboutanos, MD, MPH  
Chair, Division of Acute Care Surgery

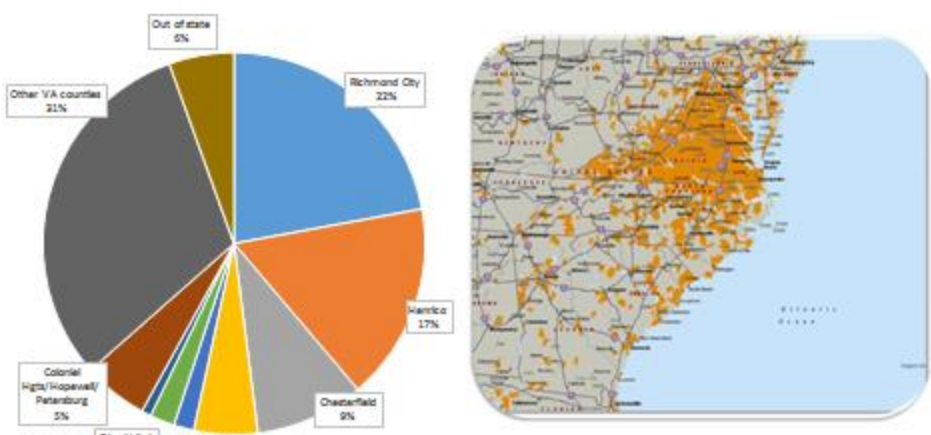


## 30 YEARS OF EXCELLENCE & LEADERSHIP IN TRAUMA CARE

- 1947 Evans-Haynes Burn Center opens as the first civilian burn center in the US
- 1981 First designated Level 1 Trauma Center in VA
- 1984 Center for Trauma and Critical Care Education (CTCCE) launched with the first university affiliated, accredited paramedic program
- 2005 ACS Level 1 Trauma Center verification awarded
- 2010 Panamerican Trauma Society (PTS) headquarters move to VCU
- 2011 Evans-Haynes Burn Center verification
- 2013 ACS Level 1 Pediatric Trauma Center verification
  
- 2014
  - Evans-Haynes Burn Center re-Verification
  - ACS Level 1 Trauma Center re-Verification for the 4<sup>th</sup> time
  - Paramedic Training Center- CoAEMSP Re-accreditation
  
- 2015
  - State redesignation as comprehensive Level I Trauma Center
  
- 2016
  - ACS Level 1 Pediatric Trauma Center re-verification
  - State designation of Pediatric and Burn Programs



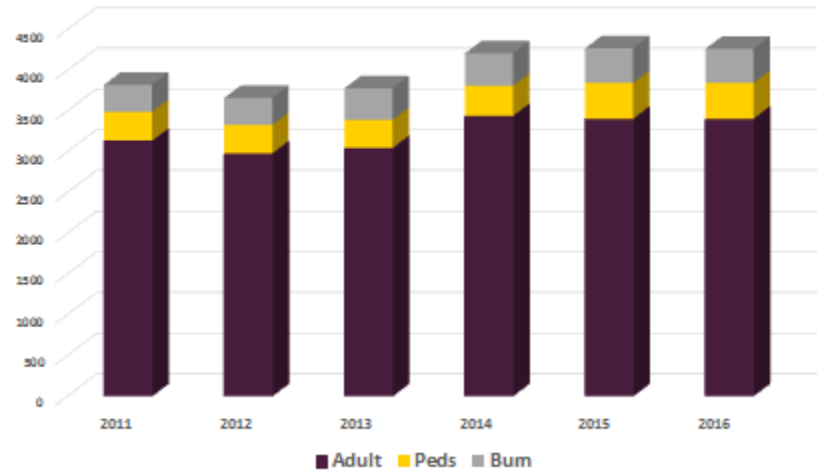
## REGIONAL PROVIDERS



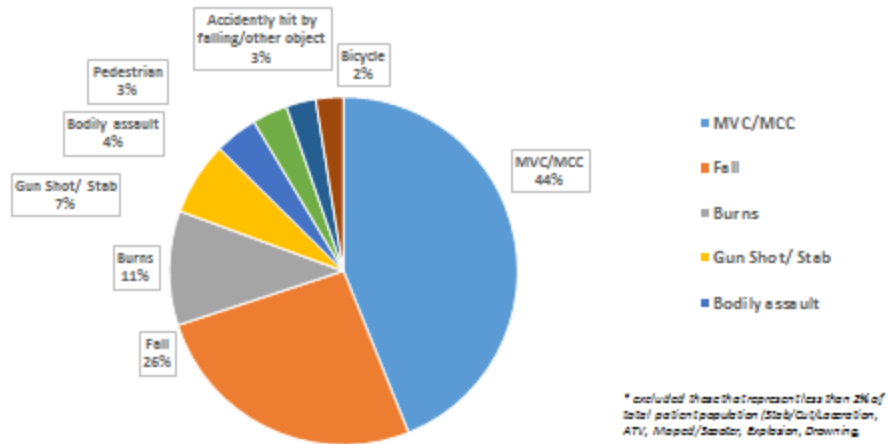
VCU Medical Center trauma serves 70 Virginia counties, D.C., NC and MD



## TRAUMA ADMISSIONS Fiscal Year Trend



## MECHANISMS OF INJURY\*



## Clinical Care-An Orchestrated Process

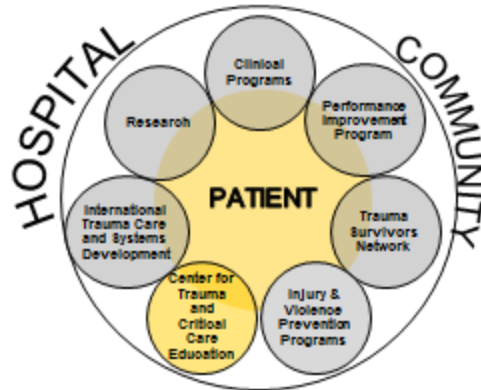
### Multidisciplinary team

- Attending Board Certified physicians
- Nurses
- Nurse practitioners
- Case managers
- Social workers
- Pharmacists
- Dieticians
- Physical therapists
- Occupational therapists
- Speech therapists
- Psychiatrist
- Trauma registry



**Comprehensive, Orchestrated,  
Evidence Based Collaborative Care  
from admission through discharge and  
recovery**

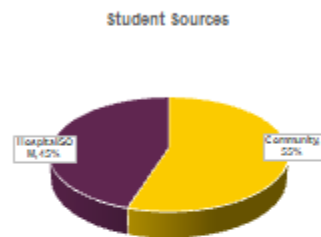
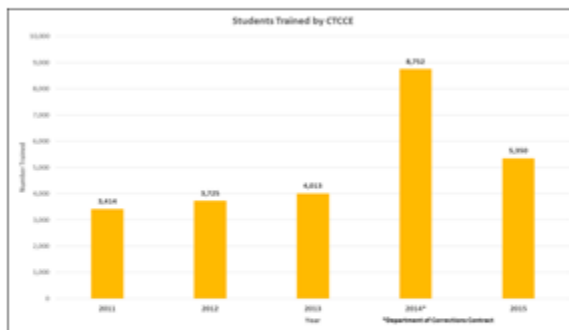
## VCU Level I Trauma Center



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## Center for Trauma & Critical Care Education

- Provides more than 20 different prehospital, trauma, nursing and critical care related courses



- 2015 Rural Trauma Team Development Course
  - Four courses through 2016
- US Airforce Rescue Squadron-Clinical Training
  - University of New Mexico & VCU collaboration

VCU Health.

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## Center for Trauma & Critical Care Education

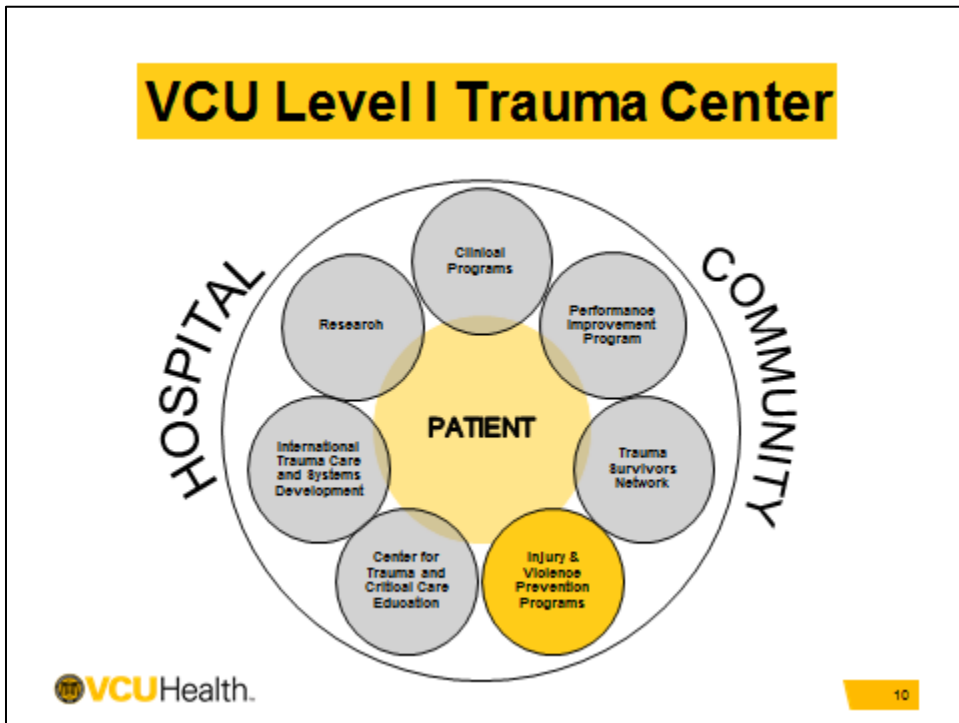
❖ Paramedic programs now extended into to Fairfax, Rockingham, Spotsylvania, Williamsburg

❖ Sponsored students from: Australia, South America, Univ. of New Mexico/SOM/PJ's ( )

❖ Location - Regional Sites for Paramedic Courses & sponsored CE courses ( )

VCU Health.

## VCU Level I Trauma Center



## Trauma Center-Community Partnership Paradigm

Trauma centers active leading role in injury and violence prevention activities, inform and collaborate with their communities, and monitor the effect of prevention & intervention programs

### Trauma Centers

Leadership  
Data registry  
Expertise

- Epidemiology
- Demographics
- Public health

Windows of opportunities



### Community Leaders

Law enforcement  
Government  
Research  
Youth services  
Local businesses  
Funding agencies

*J Trauma* 2004;56:1197-1205.

## Window of opportunity - susceptible moment

When does a gang member ever let any one this close to him

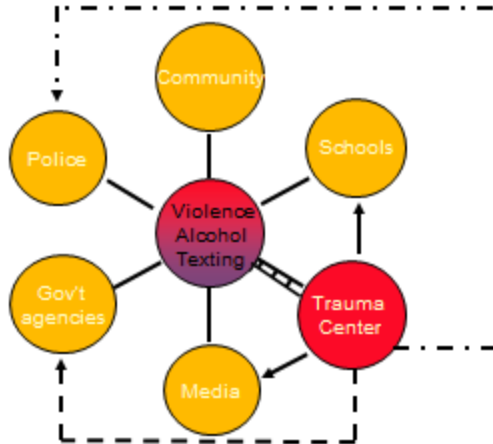


## Injury/Violence-Trauma Center Outreach Model

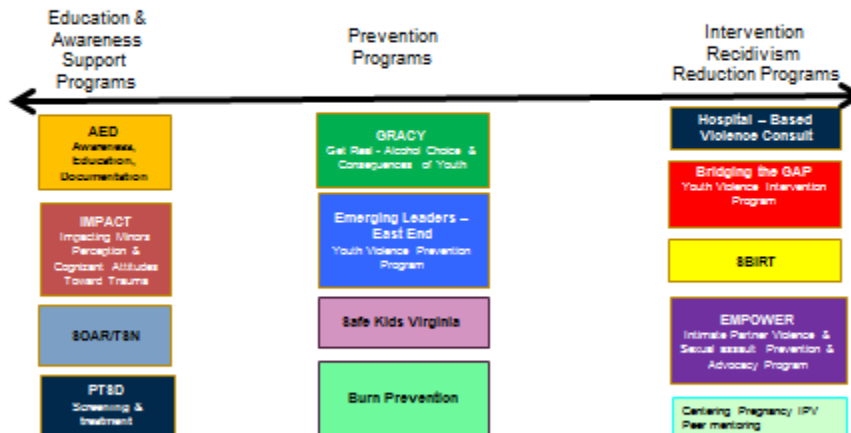
IVPP:  
Community  
2014-16

>60  
collaborative  
workshops

40 educational  
programs.



## INJURY AND VIOLENCE PREVENTION/INTERVENTION PROGRAMS Hospital - Community Based





## BRIDGING THE GAP

In-hospital intervention with community case management

Youth Violence Reduction Program for youth hospitalized with violence related injuries

Intervention program  
 Goal is to reduce recidivism  
 Channel at risk youth into programs promoting safe behaviors



## Legacy Program: Bridging the Gap

In-hospital intervention with community case management

Youth ages 10-24 hospitalized with violence related injuries

Brief Violence intervention

Case management connects at-risk youth with community-based programs

Goal is to reduce recidivism



### Community Services

Substance abuse
Emergency assistance
Recreational
Educational
Vocational
Mental health
Early childhood
Medical assistance
Housing
Workman's comp
Legal
Rehab. Services
Mentoring

What effect does a community-based intervention have when supplemented with a hospital based brief violence intervention to reduce youth violence?



**Reduction with short term risk factors**

- 2.5x less likely to use alcohol
- Significant reduction in Drug use

**Hospital Service utilization**

- Clinic Visit: 3.5x more likely to schedule; (92%) compared to historical control (70%)
- ED visits: 2.5x more likely to have an appropriate ED visit

**Community Service Utilization**

- 2.5 X more likely to access community services at 6 weeks
- 3 X more likely to access community services at 6 months
- > 90% were connected to community service programs within 6 month
- **Recidivism:** < 0.5 % per year (<5 % 2014)

## Conclusion

One of the first hospital-community based violence prevention and intervention program comparing a hospital BVI alone to combination of an in-hospital BVI with community wraparound case management interventions

BVI have a unique role in youth violence prevention, especially in terms of enrollment and rapport building

BVI are not sufficient alone

Trauma centers cannot do it alone

The importance of incorporating the community into risk reduction strategies cannot be overestimated

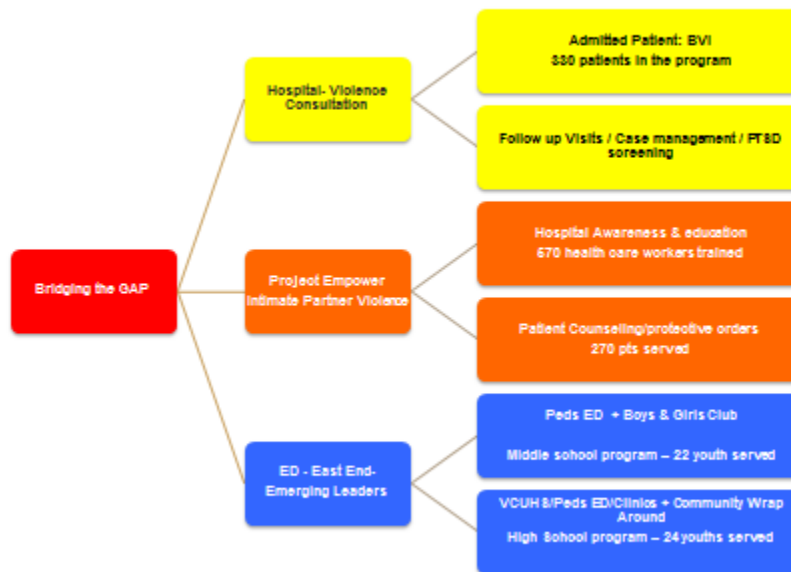
## Follow-up

2007 : 1 patient enrolled  
2010 : 70 patient enrolled  
2016 : 143 patient enrolled

**2014 : BTG became standard of care and all participants were given the BVI + Community Case Management Services!**

**2015: AAST National Best Model for hospital community based youth violence prevention program**

## Increase in Hospital: Community Service Needs Project Expansion

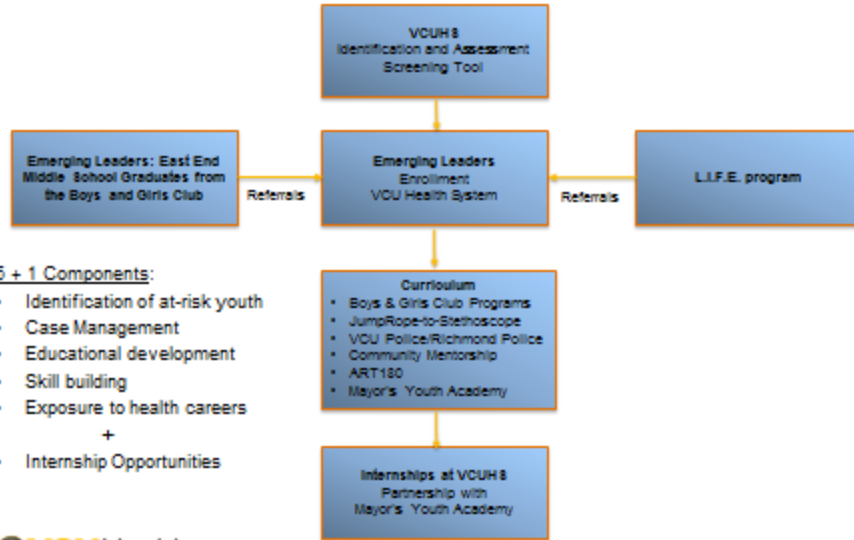




# Emerging Leaders

## High Schoolers - Ages 14-18

YOUTH VIOLENCE PREVENTION – A Hospital-Community Based Program



**5 + 1 Components:**

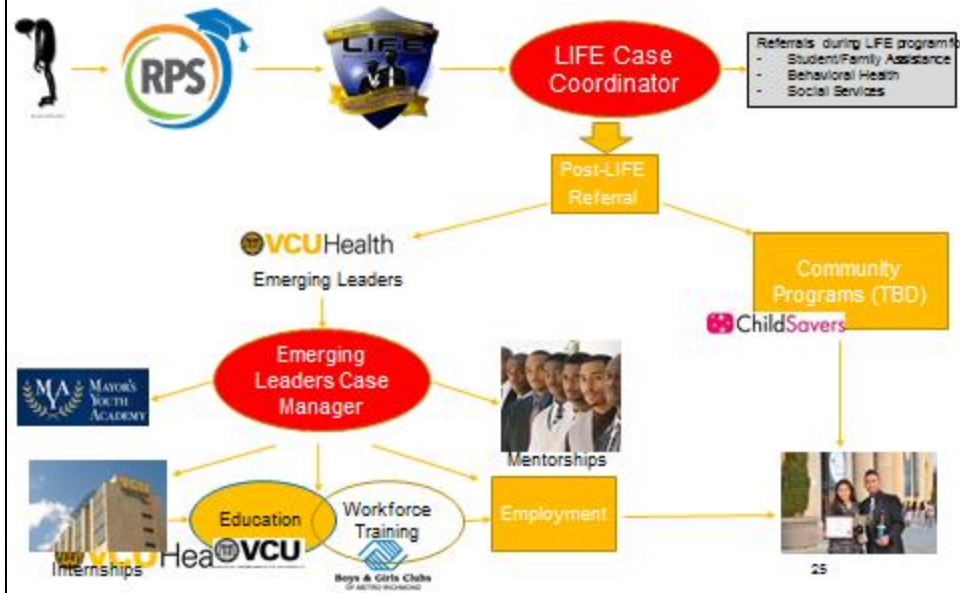
- Identification of at-risk youth
- Case Management
- Educational development
- Skill building
- Exposure to health careers
- +
- Internship Opportunities

Inaugural Class of Emerging Leaders: East End Program

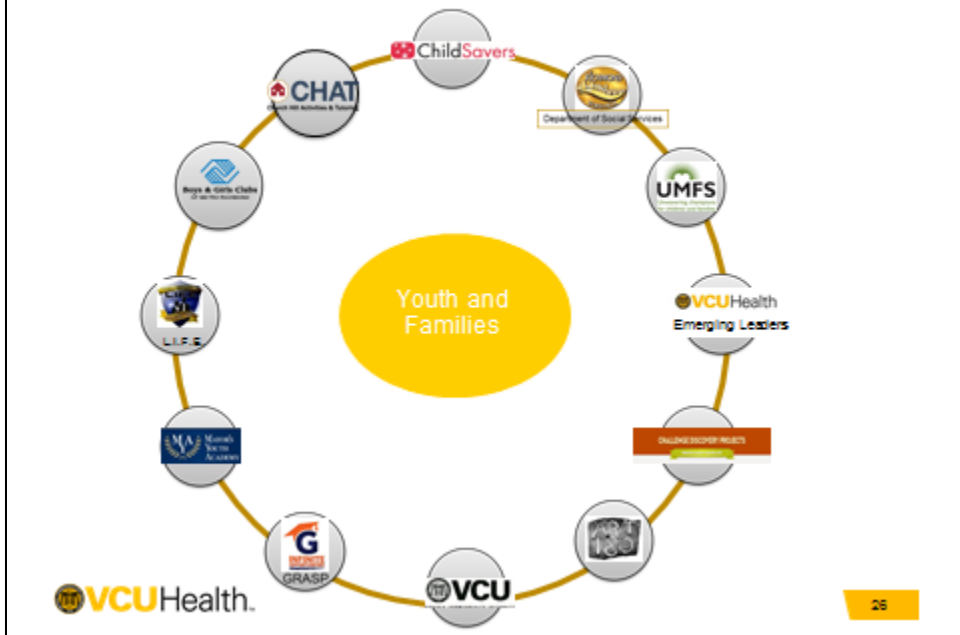


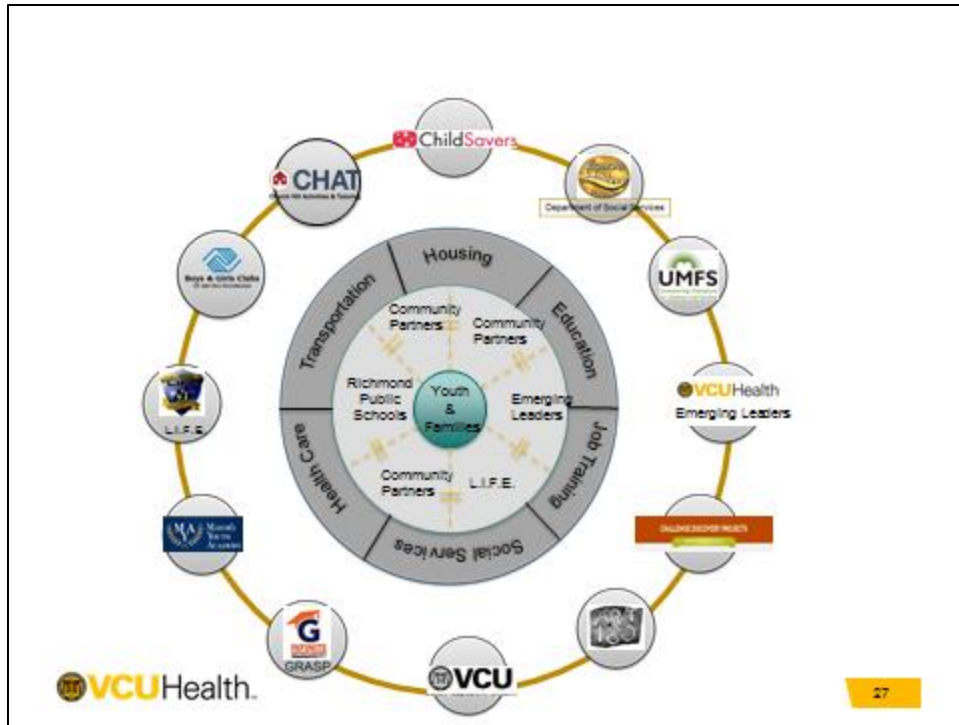


# RVA Alternative Pathways Model



VCU Leadership Role : to help align community programs to establish a coordinated system to support youth and families





## Program Sharing

### Local:

- Hospital-Community wide program awareness initiative
- VCU Medical Center Grand Rounds
- Media / Newsletter / Website/Events

### Regional:

- Virginia Chapter of the American College of Surgery
- Virginia State Trauma Oversight Committee
- 32nd Annual State Pediatric Primary Care Conference

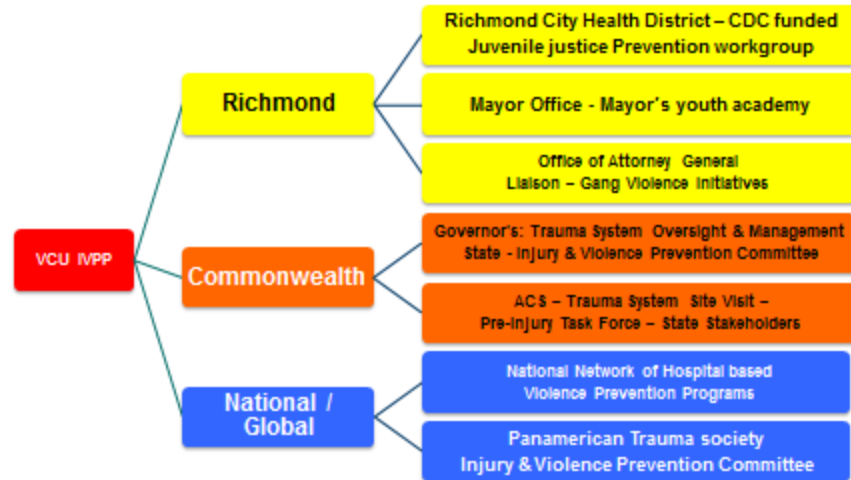
### National:

- American Association for the Surgery of Trauma (AAST) national Congress
- Eastern Association for the Surgery of Trauma (EAST) national Congress
- ATS : American Trauma Society

### International:

- XI Colombian National Trauma Congress, at the Universidad Javeriana de Cali, Cali, Colombia, June, 2010
- Panamerican Trauma Society (PTS) annual Congress
  - Uruguay 2010 ;
  - Paraguay 2011,
  - Colombia 2012,
  - Chile 2013, Panama 2014, Bolivia 2015
- Trauma Brazilian Congress, sao paul Brazil, 2015

## Outreach & IMPACT : “....& who is my neighbor”



### 2009 Inaugural Shining Knight Gala

Recognizing the trauma system at VCU Medical Center & in Central VA

Supports Injury Prevention programs

- All currently grant funded




Supports education and outreach initiatives of the Trauma Center

- Community trauma care

**Sexual Victimization of Children:  
Implications for Families and Society**

**Christina Mancini, Ph.D.**  
**Wilder School of Government and Public Affairs**  
**Virginia Commonwealth University**

 **VCU** Family Impact Seminar on Effects of Trauma on Youth  
May 24, 2017  
VA Capitol Building, House Room 3

## Agenda

- Nature and Extent of Sexual Victimization
- Risk Factors
- Potential Remedies



## Nature and Extent—Prevalence

- Sexual victimization=a broad variety of experiences
- Sexual assault (touching offenses), abuse (“lewd and lascivious”), rape (sexual battery, penetrative crimes), “other” (child pornography offenses)
  - Differing legal statutes
- The harm and extent of these crimes cannot be overstated!



## Nature and Extent—Prevalence

- Lifetime prevalence estimates=surveys
  - Official estimates vastly underreport.
- Among 17 year-olds: 26% of females and 5% of males report sexual abuse/assault (Finkelhor et al., 2014, NatSCEV)
  - For “rape” (penetrative crimes): 6.1%=females, <1%=males
    - Items: “touch your private parts” and “force you to have sex”



## Nature and Extent—Patterns

- Victim-Offender Relationship
  - Most sexual abuse committed by known perpetrator
  - As high as 90% of cases (Greenfeld, 1995)
  - Calls into question “stranger danger” myth



## Nature and Extent—Patterns

- Victim-Offender Relationship
  - NatSCEV: ~17% of females report a peer sexually assaulted them, compared to 11% reporting victimization by adult (Finkelhor et al., 2014)
  - Similar pattern for males
    - 3.1% vs. 1.9%, respectively



## Nature and Extent—Trends

- “The Good”: reports of child sex abuse have been in decline.
  - National Child Abuse and Neglect Data System (NCANDS): Primary data source for sexual victimization trends
    - “quasi-official”
      - Caveats: underreporting, substantiated vs. unsubstantiated; policy changes
    - Rely on this source because surveys have not been regularly conducted to assess trends

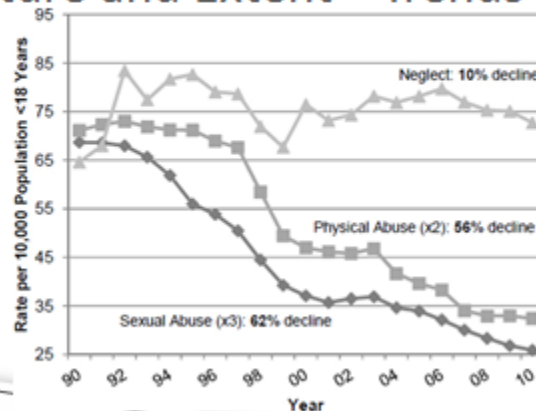


## Nature and Extent—Trends

- Explanations: A genuine decline
  - Mandated reporting
  - Sex offender policies
  - Greater education and awareness
  - Economic changes
    - steepest decline, 1990s, during period of prosperity



## Nature and Extent—Trends



Substantiated Abuse,  
NCANDS, 1990-2010  
(Jones, 2012)



## Nature and Extent—Trends

- Explanations: Artificial?
  - Policy changes?
    - More narrow scope of abuse?
    - More difficult to find “substantiated” cases?
    - Lack of consistent definitions and standards across jurisdictions
    - Investigation resources?



## Nature and Extent—Trends

- The overall consensus concerning the decline in sexual victimization, including offenses involving minors is “about as well established as crime trends can be in contemporary social science”
  - (Finkelhor & Jones, 2012 in a meta-analysis, p. 3; Mancini, 2014, in a review).



## Risk Factors—Family-Level

- Living without one of the biological parents
  - having a step-parent, particularly step-father (20x>likely)
- Family distress, conflict
- Low SES/unemployment in family
  - (Sadleck et al., 2010)



## Risk Factors—Child-Level

- Being female
- Reporting “extremely punitive discipline” or abuse
- Perceived as “quiet,” “passive,” or “lonely” (from perpetrator surveys)
- Witnessing other forms of abuse in the household or across social networks






# Trauma among Youth in Corrections

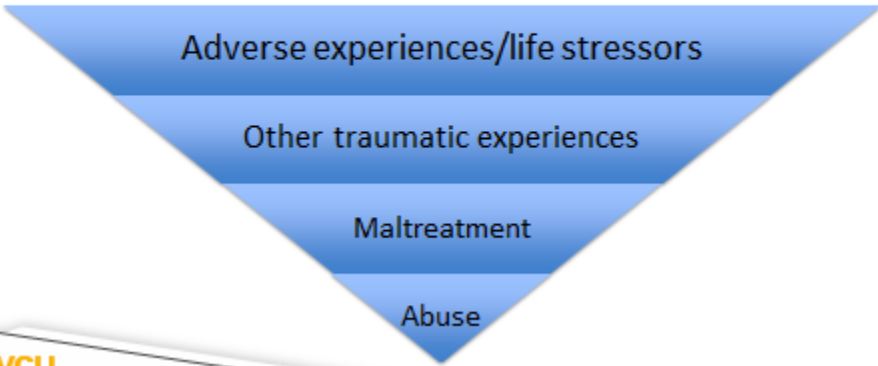
Hayley Cleary, PhD

Virginia Commonwealth University



2017 Family Impact Seminar  
Richmond, VA

## What is trauma?




Adverse experiences/life stressors

Other traumatic experiences


Maltreatment

Abuse



## Trauma rates in the JJ system

- Approximately 75-90% of justice-involved youth have experienced trauma
- PTSD 3x to 10x more prevalent
- Complex trauma history: 35% of juvenile detainees compared to 10-13% among community youth



## Symptoms and manifestations

- Spontaneous memories/flashbacks
- Heightened arousal
- Avoidance behaviors
- Persistent negative thoughts
- Severe negative emotions



## Polyvictimization

### Multiple forms

1. Repeated/continuous traumatic incidents
2. Experiencing multiple types of trauma

### Adapt to survive

- Aggression
- Risk-taking/impulsivity
- Self-medication
- Hypervigilance
- Isolation
- Affiliation with delinquent peers



## Trauma and adolescent development

- The “plastic” brain
- Trauma interferes with self-regulation
  - Focus one’s attention
  - Awareness of environment and own physical/emotional states
  - Learn from the past to adapt to the present
  - Maintain a balanced emotional state



## The costs of poor self-regulation

- Traumatized youth develop mental health problems
  - Conduct disorders (ADHD, ODD, CD)
  - Personality disorders
  - Behavioral dyscontrol disorders (psychopathy, SUD, IED)
- Implications for treatment
  - Traumatized youth are amenable to treatment
  - Treatment of trauma as root cause



## Correctional environments can exacerbate trauma effects

- Mental health triggers
  - Separation from family
  - Strip searches
  - Isolation
  - Physical or sexual abuse
- Inhibit youths' ability to engage in programming



## Special populations: girls

### **Persistent victimization**

- 70-90% of incarcerated girls experienced trauma, often polyvictimization
- Higher rates of abuse, sexual victimization → PTSD, self-harm
- More likely to be "crossover" youth

### **Increased risk for:**

- Substance abuse
- Risky sexual behavior
- Teen pregnancy
- Family/domestic violence
- Unemployment/school failure



## Girls: correctional challenges

- Housing
- Sexual abuse
- Inappropriate/insufficient programming
- Medical health/basic needs



## Special populations: LGBTQ youth

### **Victimization → JJ system**

- Chronic truancy (to escape harassment)
- Running away (abuse at home)
- Survival crimes (e.g., prostitution)

### **Increased risk for:**

- Peer/family rejection and/or abuse
- Homelessness
- Victimization at school



## LGBTQ youth: correctional challenges

- Housing
- Further victimization
- Inappropriate use of solitary confinement



## Practice recommendations

- Clear prioritization of community based treatment
- In institutional placements:
  - Groups, classes, counseling targeted toward self-regulation
  - Focused training for staff and support persons



## Policy recommendation #1

- Screen for trauma and implement procedural protections
  - Screening alone = net widening
  - Screening should match youth to services, not just determine risk
  - Trauma evaluations should not be admissible in court without consent of youth and counsel



## Policy recommendation #2

- Focus resources on the least restrictive environment
  - Fund prevention and early identification programs
  - Support community-based programming (in-home, schools)
  - Community-based setting > residential setting
  - Juvenile facility > adult facility



## Policy recommendation #3

- Scrutinize, then reform or eliminate, procedures that harm youth
  - Removal from community/family
  - Transfer to adult court and corrections
  - Boot camps
  - Prolonged isolation
  - Physical and mechanical restraints
  - Strip searches



## Policy recommendation #4

- Ensure that youths' trauma histories are used as mitigating, rather than aggravating, information
  - Diversion, not punishment, whenever possible
  - Require judges to consider trauma history, future risk in transfer decisions
  - Statutes requiring explicit consideration of trauma in other court processes



## Policy recommendation #5

- Fund evaluations of interventions and respond to findings
  - All programs (community-based or institutional) need to be evaluated for efficacy
  - Measure state's ROI



## Concluding thoughts

### Build on VA's progress!

- Trauma-informed model touches all aspects of system involvement
  - Law enforcement
  - Intake/screening
  - Diversion
  - Secure confinement

### Ultimate (shared) goals:

- Reduce recidivism
- Promote positive youth development
- Create law-abiding, community-engaged citizens



*Thank you for your commitment to  
Virginia's youth*

hmcleary@vcu.edu



## Gender differences

### Girls

- PTSD
- Anxiety
- Depression
- Eating disorders

### Boys

- Aggression
- Delinquency
- Substance abuse



Why should state systems care about trauma?



## Unintended consequences

- Creates risk of harsher treatment
- Can result in youths' self-incrimination
- May lead to stigmatization





## **Children's Cabinet Presentation to Commission on Youth**

William A. Hazel, Jr., Secretary of Health and Human Resources  
Dietra Y. Trent, Secretary of Education  
September 20, 2017



## **Virginia Governor's Children's Cabinet**



## The Leadership



William A. Hazel, Jr.  
Co-Chair  
Secretary of Health & Human  
Resources



Brian Moran  
Secretary of Public Safety &  
Homeland Security



Dietra Y. Trent,  
Co-Chair  
Secretary of Education



Todd Haymore  
Secretary of Commerce &  
Trade



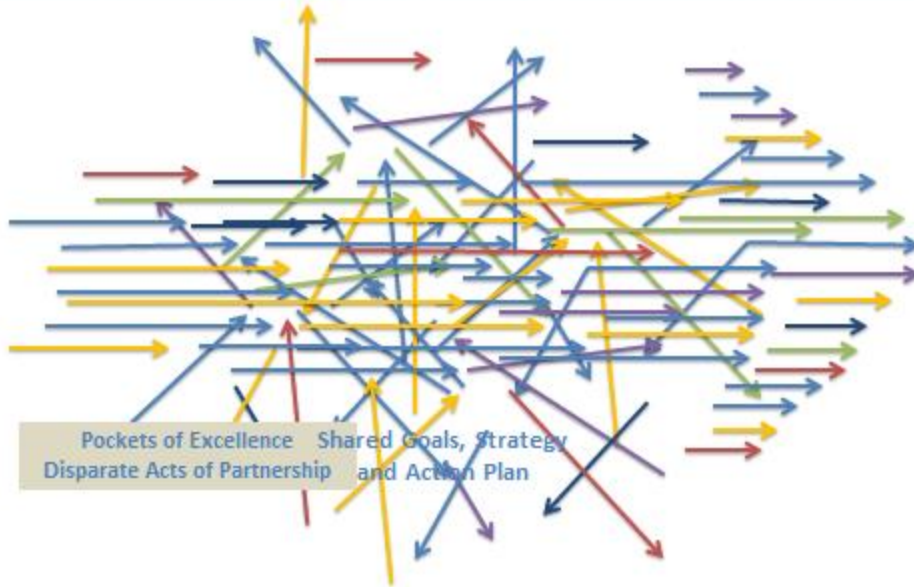
Dorothy McAuliffe  
First Lady of Virginia



Ralph Northam  
Lieutenant Governor of  
Virginia

# The Value

Align children's resources across Virginia



# The Approach

Facilitating Communication, Forging Connections, and Fostering Collaboration



## The Work

### Lead the Challenged Schools Initiative

Enhance educational outcomes and workforce readiness in Petersburg, Norfolk, and Richmond by facilitating a replicable model to improve student achievement through high quality partnerships, including wraparound services

### Lead the Classrooms not Courtrooms Initiative

Reduce student suspensions, expulsions, referrals to law enforcement, and the disparate impact of these practices on minorities and students with disabilities

### Advance policy

Enable greater access to prevention services, high quality physical and behavioral health, nutrition, early childhood programs, stable housing, workforce training, social services, and community supports through schools and other convenient points of service

## The Ability to Convene



Virginia Department of Behavioral Health & Developmental Services



COMMONWEALTH OF VIRGINIA



DEPARTMENT OF JUVENILE JUSTICE



VIRGINIA DEPARTMENT OF EDUCATION



VIRGINIA DEPARTMENT OF SOCIAL SERVICES

**VDH** VIRGINIA DEPARTMENT OF HEALTH  
Protecting You and Your Environment

## Challenged Schools Initiative: Petersburg

- **Summer Feeding:** VDH, VDOE, & Petersburg City Public Schools partnered to make Petersburg Schools a Summer Food Service Program, serving 26,746 meals in 2016 and 27,632 meals in 2017.
- **Out of School Time:** The Petersburg YMCA, library, and public transit collaborated to provide a total of 500 students free access to all of their facilities over the summers of 2016 and 2017 combined.
- **Social Workers:** The Virginia Department of Social Services provided a grant to place 3 social workers in Petersburg City Public Schools to address chronic absenteeism. They received 133 referrals since January, 2017 with improved attendance and discipline for students served.
- **Trauma Informed Care:** 300 community members and 70 students participated in a summit, "Beyond ACEs: Building Community Resiliency" to train Petersburg staff, citizens, and youth on trauma & resiliency.
- **Stable housing:** A pilot has been launched through the Department of Housing and Community Development, Department of Education, and Petersburg City Public Schools to address barriers for high school seniors at risk of being homeless to increase their opportunity to graduate.
- **Resources:** The Children's Cabinet over \$615,000 of additional resources through untapped federal, state, and private dollars to Petersburg.

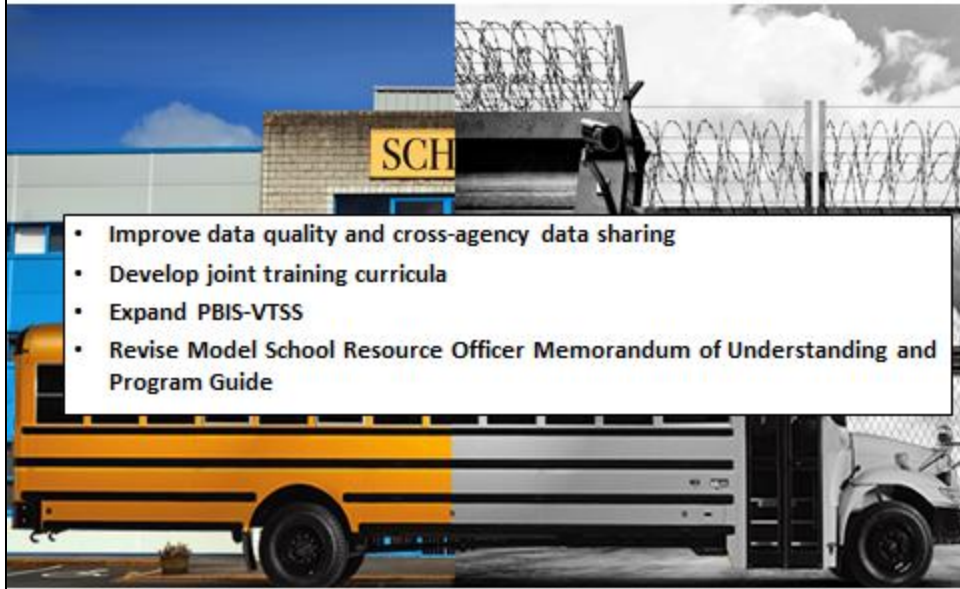
## Challenged Schools Initiative: Richmond

- **Expanding access to high quality Out of School Time opportunities** - exploring how to leverage over \$292,000 in available state grant funds and reduce barriers for families to access existing child care subsidies
- **Meeting the Health/Mental Health needs of more students** - exploring a school division-university partnership with Social Work majors, and accessing over \$500,000 in untapped funding for non-mandated children's services for at-risk youth.
- **Early Childhood Family Engagement** - exploring ways to connect early childhood parent education, state programming, and outreach programs to family involvement efforts in public pre-K programs that can positively impact student behavior and attendance throughout the K-12 continuum.
- **Improving educational opportunities for justice-involved youth** - conducting a process analysis and identifying prevention, educational and policy alternatives that can continue and accelerate individual learning and keep students on track for graduation and success beyond

RICHMOND CITY PUBLIC SCHOOLS



## Classrooms not Courtrooms



## Fiscal Map



## Advance Policy



## Defining Trauma

*Individual trauma results from 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 definition 2014

# Adverse Childhood Experiences

ACEs = ADVERSE CHILDHOOD EXPERIENCES

The three types of ACEs include

## ABUSE



Physical



Emotional



Sexual

## NEGLECT



Physical



Emotional

## HOUSEHOLD DYSFUNCTION



Mental Illness



Incarcerated Relative



Mother treated violently



Substance Abuse



Divorce

# Consequences of a Lifetime Exposure to Trauma

## BEHAVIOR



Lack of physical activity



Smoking



Alcoholism



Drug use



Missed work

## PHYSICAL & MENTAL HEALTH



Severe obesity



Diabetes



Depression



Suicide attempts



STIs



Heart disease



Cancer



Stroke



COPD



Broken bones



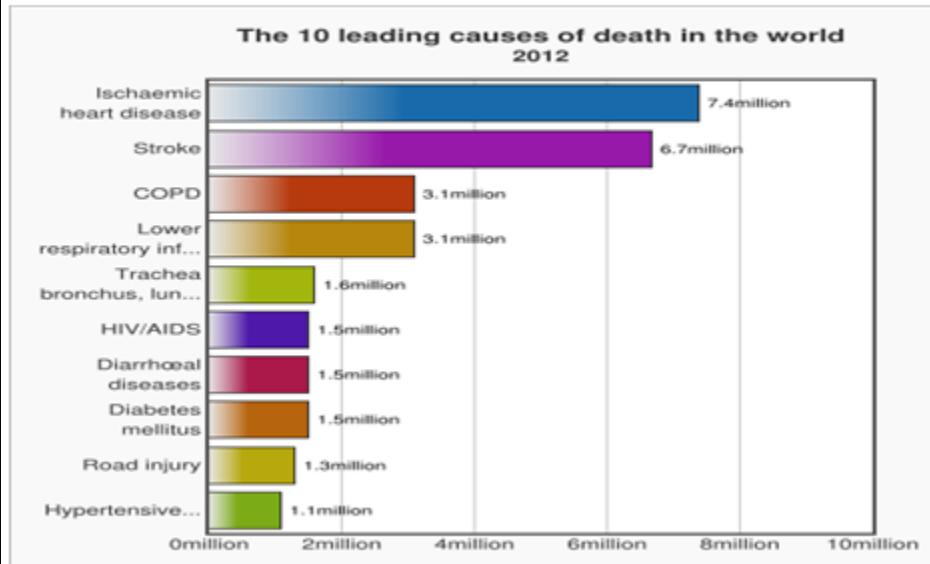
## ACEs Score: Adoption of At-Risk Health Behaviors

<http://www.iowaaces360.org/impact-of-aces.html>

ACE Score	Risk
4	<ul style="list-style-type: none"> <li>- 260% more likely to develop COPD</li> <li>- 500% more likely to develop alcoholism</li> <li>- Females are 500% more likely to become victims of domestic violence.</li> <li>- Females are almost 900% more likely to become victims of rape</li> <li>- 242% more likely to smoke</li> <li>- 222% more likely to become obese</li> <li>- 357% more likely to experience depression</li> <li>- 443% more likely to use illicit drugs</li> <li>- 1133% more likely to use injected drugs</li> <li>- 298% more likely to contract an STD</li> <li>- 1525% more likely to attempt suicide</li> <li>- 555% more likely to develop alcoholism</li> </ul>
6	<ul style="list-style-type: none"> <li>- 250% more likely to become adult smoker</li> <li>- A male child with an ACE score of 6 has a 4,600% increase in the likelihood that he will become an IV drug user later in life</li> <li>- More likely to die 20 years younger than a person with no ACEs</li> </ul>
7	<ul style="list-style-type: none"> <li>- Adult suicide attempts increased 3,000%</li> <li>- Childhood and adolescent suicide attempts 5,100%</li> <li>- 5,000% more likely to develop hallucinations</li> <li>- Increased the risk of suicide attempts <b>51-fold</b> among children/adolescents</li> <li>- Increased risk of suicide attempts <b>30-fold</b> among adults</li> </ul>

## ACEs and Leading Causes of Death

### ACEs Linked to 7 out of the 10



<http://www.who.int/mediacentre/factsheets/fs310/en/>



## Partners in this work



Greater Richmond  
Trauma-Informed Community Network  
Dedicated to supporting & advocating for  
trauma-informed care for all children & families  
in the Greater Richmond area

### FACT

- The Family and Children's Trust Fund (FACT) is a public-private partnership established through legislation in 1986
- Purpose: to raise and distribute funds for the prevention and treatment of family violence across the life span
- Funding provided through license plate sales, state tax check off program and donations
- Governed by a gubernatorial appointed Board of Trustees
- Administrative support provided by the VA Dept. of Social Services
  - Coordinate the Child Abuse and Neglect Advisory Committee formally the Governor's Advisory Committee on Child Abuse and Neglect

