Called to Care

Promoting Compassionate Healing for Our Children

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Rev. Torin T. Sanders, PhD, LCSW

As a child I experienced my parents' separation and divorce. I grew up in a neighborhood where drugs and drug dealing were literally everywhere. Yet, I survived because of caring family members who had high expectations, schools that challenged me, extracurricular activities that occupied me, and an internal sense of my self-worth and possibility. Like many children in New Orleans, I understand the reality of trauma.

In the early 1990s, I had the opportunity to start our city's first program to specialize in serving children who were survivors of homicide victims. We were overwhelmed with cases. It is now 2019—and the need for the work has only grown.

As a pastor, I have buried children taken away by gunfire. I have comforted too many of our youngest citizens who have seen and witnessed extreme acts of violence, have been victims themselves, and are spending their formative years in families and communities unsettled by these events.

This report is overdue. And I am hopeful for what may come as a result of its release. The recommendations listed herein, I pray, will not be received as mere recommendations. If I may use language familiar to my faith, I will say they are "Great Commandments." In other words, our city MUST do these things.

I want to thank the authors of the City Council Resolution, Mr. Jason Williams and Ms. Helena Moreno, who put this process in motion last year. Additionally, this work could not have been done without the wisdom of our co-chair, Dr. Denese Shervington, and the amazing organizational skills of Karen Evans, Executive Director of the Children and Youth Planning Board.

We cannot afford to neglect another generation. Our children are not just the future—they are, in fact, right now. This report is about right now. May we act right now!

For the Children,

Rev. Torin T. Sanders, Ph.D., LCSW

Denese Shervington, MD, MPH

I returned to New Orleans after Hurricane Katrina to live/work the hurricane's disaster. It quickly became evident that the acute traumatic shock of Katrina served as a tipping point for the existing pain emanating from centuries of adversities in the African American community. I knew the work would be challenging, not only because many societies have not been equipped to provide mental health services in a post-disaster recovery and rebuild environment, but also because the potential for resiliency is burdened by the racial, gender, and class inequities deeply entrenched in so many of our systems.

Having previously served as the Medical Director for the Office of Mental Health, I anticipated that the post-disaster needs of children, especially those whose families are under-resourced and underserved, would not be prioritized. Thanks to IWES (Institute of Women and Ethnic Studies) having received a federally funded Teen Pregnancy grant, my team and I were able to employ a citywide trauma-informed approach to allow for the collection of trauma-based data (screening for PTSD, depression, exposure to violence and basic need worries), to provide psychoeducational classes on mental health, and to connect students to whatever mental health services exist.

I am very pleased that this data influenced the adoption of the City Council resolution to create a task force to make recommendations for creating a compassionate and trauma-informed city in which all our children can thrive and flourish. I am honored and deeply humbled to serve as co-chair. I serve on behalf of all our children—especially those without the voice to communicate their pain—many of whom we have turned our backs upon, provided

no resources or protective factors for, and left to wallow in the despair of their traumas, blinded to their resilience. And unfortunately, many of the professionals in the educational and criminal justice systems upon whom children rely for justice and fairness do not understand the deleterious impact of trauma, how it harms our brains and dysregulates our emotions and behaviors. As a result, many of these young people, especially if they are poor, black, and male, have been criminalized, deemed 'untouchables.' As such, the work to serve our children as we should and they deserve, requires retraining, resources, and political resolve.

My devotion to serving as co-chair and playing an integral role in producing this report is based upon my dedication to those 'sad not bad' youth, for whom unfortunately there is a thin line between being victim and perpetrator.

Many thanks to the city council for recognizing that there is much more work to be done to effectively serve and love all our children! It is my hope that this report will serve as the lightening rod.

Sincerely,

Denese O. Shervington

Denese O. Shervington M.D., M.P.H
Institute of Women and Ethnic Studies

Executive Summary

This report, *Called to Care*, was prepared per a Resolution of the New Orleans City Council (No. R-18-344), and adopted on August 9, 2018. That resolution called for the creation of a one-year task force to develop a comprehensive plan to reduce the occurrence and impact of trauma on children and families within the City of New Orleans. This plan is to include strategies for the prevention of trauma, proper assessment of childhood trauma, and effective intervention to help children and families heal.

The task force firmly believes that in order for New Orleans to meet the goals of the resolution, she must become a trauma-informed community. To do so, we as a community must:

A

Acknowledge, recognize, and understand the prevalence of childhood trauma. For example, in 2012 the Institute of Women & Ethnic Studies (IWES) released the first results of a survey of Central City youth. Between then and 2018, over 5000 youth have been screened. The findings were startling:

1 in 5
children had
witnessed murder

1 in 3
children were witnesses to
domestic violence

4 in 10
had seen someone shot,
stabbed or beaten

More than half
had someone close to
them murdered

B

Build and support an infrastructure of organizations, agencies, and schools committed to utilizing evidence-based approaches that will heal both individuals and the community at large, which has been exposed to trauma for generations.

C

Include approaches that acknowledge and address the trauma communities of color face from the history of slavery, segregation, and persistent societal inequities stemming from racism and economic exploitation.

D

Create spaces for all citizens of New Orleans, especially those most impacted by trauma, to have their voices heard and to advance the efforts needed to make and sustain New Orleans as a compassionate, trauma-informed city.

EXECUTIVE SUMMARY

This report represents one in a series of necessary steps forward for New Orleans and all of its residents—particularly the children, youth, and their communities who eagerly await healing, compassion, and care.

Listed below are some of the highlights of the task force recommendations. As a whole, the recommendations address root causes of trauma in New Orleans and includes strategies for implementation and sustainability to ensure that this much needed work is accomplished. Some of the highlights are:

1. **Hear the Voices of Those Affected.** Engage youth, families and communities with lived trauma experience to support the design and implementation of trauma-informed policies.

2. **Conduct Universal Assessment.** Encourage existing service providers to adopt universal assessment practices and tools that promote identifying and responding to childhood trauma.

3. **Increase the "Fun in Place."** Provide needed pro-social outlets and places to go in New Orleans for children and youth.

4. **Training in Evidence-Based Services.** Increase the awareness, knowledge, and skills of the clinical and peer workforce to support the delivery of evidence-based, culturally relevant, and community-supported programming/services in communities that address effects associated with childhood trauma.

5. **Create an Inter-Faith Team.** Engage the faith community to spread the awareness and goals of trauma-informed approaches to helping children and families heal.

6. **Develop Allies in the Workforce and Community.** Provide Childhood Trauma Awareness Training to businesses, nonprofits, and community organizations.

7. **Create of a Children's Budget.** Fund agencies that provide prevention/early intervention and education/awareness programs. This includes funding staff for trauma-informed efforts.

8. **Adopt Alternatives to Standard Punishments.** Establish alternative methods to address poorly behaving children through screening and assessment to understand the root cause of their behaviors followed by wellness-promoting responses.

9. **Create and Maintain a Cross-Sector/Interdisciplinary Team.** Through knowledge building and training in trauma informed approaches, this team will work to advance collective efforts that help to support the healing of children, youth and their families.

10. **Conduct an Annual Summit on Compassion and Resilience.** Track the progress of implementing these recommendations on a yearly basis.

These recommendations are but a few of the more than seven dozen solutions proposed by the task force. The challenge now is implementation. It is the hope of the task force members that just as citizens and policymakers responded to the crisis of Hurricane Katrina 14 years ago, that a similar bold effort on behalf of our city's children will turn the tide from trauma to healing.

Table of Contents

Overview

What is Childhood Trauma?

The National Institute of Mental Health defines childhood trauma as when a child experiences a psychological event that is emotionally painful or distressful and results in lasting mental and physical effects.[1] The roots of research, advocacy, and policy around childhood trauma can be traced to a seminal study conducted by the Centers for Disease Control & Prevention (CDC) and Kaiser Permanente San Diego from 1995 to 1997, which explored the relationship between Adverse Childhood Experiences (ACEs) and adult health outcomes. These adverse events include physical, sexual, and emotional abuse; emotional and physical neglect; violence against mother (domestic violence); and growing up with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned.

Participants in the conventional ACEs study were 72% white, 14% Black and Latinx, middle class, and college-educated persons living in San Diego. In this sample, **12.5% reported ACEs scores greater than four.** A subsequent city of Philadelphia adapted study surveyed a more racially diverse population that was 39% White and 47% Black and Latinx. Researchers in Philadelphia expanded upon the original ACEs questions to include questions about community trauma such as living in unsafe neighborhoods; experiencing bullying, racism, and discrimination; being in foster care, and witnessing violence. In the Philadelphia study, **37% reported ACEs score greater than four.**

STUDY WITH

72%	14%	→	12.5%
White	Black+Latinx		reported 4+ ACES

STUDY WITH

39%	47%	→	37%
White	Black+Latinx		reported 4+ ACES
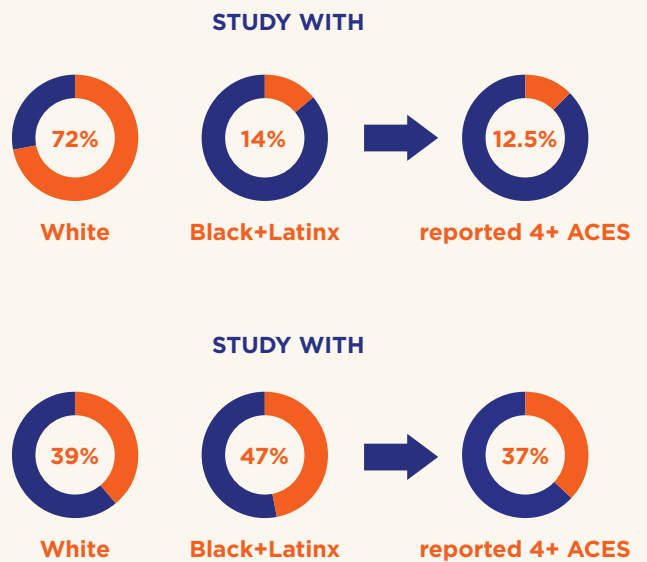
[1]https://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-disasters-and-other-traumatic-events/index.shtml#pub1
[2]Cronholm PF, Forke CM, Wade R, et al. Adverse Childhood Experiences: Expanding the concept of Adversity. Am J Prev Med, 2015: 1-⁹

Significant disparities exist with ACEs scores. According to Child Trends in a 2016 national sample of adolescents, [3] 61% of Black non-Latinx and 51% of Latinx children reported experiencing at least one ACE, compared to 40% of White non-Latinx and 23% of Asian non-Latinx children. In a racially diverse study examining ACEs and behavioral problems in middle childhood, [4] Black children and children of mothers with a high school education or less were the most likely to have been exposed to multiple ACEs. White children were less likely to be exposed to high levels of adversity compared to Black and Hispanic children; however, highly exposed White children were at particular risk for problem behaviors. It was also found that Black children were more likely to have an Attention Deficit Hyperactivity Disorder (ADHD) diagnosis compared to Latinx and White children after exposure to two or more ACEs .

In looking at physical health, the study concluded that there is a "strong graded [cumulative] relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults." These disorders include cancer, ischemic heart disease, liver disease, skeletal fracture, and chronic obstructive pulmonary disease.[5]

More specifically, the study found that persons who had experienced four or more categories of ACEs compared to those who had experienced none, had:

4 in 12x
increased health risks for alcoholism, drug abuse, depression, and suicide attempt

2 in 4x
increase in smoking, poor self-rated health, greater than 50 sexual intercourse partners, and sexually transmitted disease

1.4 in 1.6x
increase in physical inactivity and severe obesity

OVERVIEW

[3] National Child Traumatic Stress Network. About Child Trauma. <https://www.nctsn.org/what-is-child-trauma/about-child-trauma>
[4] Hunt TKA, Berger LM, Slack KS. Adverse Childhood Experiences and Behavioral Problems in Middle School. Child Abuse & Neglect. 2017 May: 67: 391–402. doi:10.1016/j.chiabu.2016.11.005.
[5] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences Study. Am J Prev Med, 1998: 14 (4): 245–258.
[6] Herman JL. Complex PTSD: A Syndrome in Survivors or Prolonged and Repeated Trauma. Journal of Traumatic Stress, 1992; 5(1): 377-391

In terms of mental wellness, the dimensional construct of "complex trauma" is increasingly being used in studies of childhood trauma to describe the experiences of children exposed to "multiple, chronic, prolonged, and developmentally adverse traumatic events."[7] These early life events are frequently interpersonal in nature: a result of sexual or physical abuse, emotional abuse and neglect, as well as witnessing domestic violence, ethnic cleansing, war, and/or community violence.[8] These children usually present with impairments in attachment, cognition, biology, affect regulation, behavioral control, cognition and self-concept, and dissociation (alterations in states of consciousness). Children thus affected are more vulnerable to experiencing other traumas and developing chronic medical illnesses, mental health and addictive disorders, legal, vocational, and family problems along the life-course.[9]

Nobel Prize winning University of Chicago Economics Professor James Heckman identifies ACEs as the single biggest predictor for later problems in adult health and well-being. Heckman's work to identify upstream solutions to the biggest problems facing America concludes, "The short answer is there is general expert consensus that it is somewhere between economically worthwhile and imperative to invest more heavily, as a proportion of both local and national spend, in the very earliest months and years of life."[10]

According to Dr. Ruth Gerson and Dr. David L. Corwin the estimated economic impact of ACEs ranges from $124 billion if considering confirmed child maltreatment cases occurring in one year,[11] to a significantly higher $585 billion when new cases of fatal and nonfatal child maltreatment costs and aggregate lifetime costs for all new child maltreatment cases are considered.[12] It is important to note, that even the projected cost that approaches nearly $600 billion may underestimate the economic impact of childhood trauma because it does not quantify the impact of exposure to domestic violence, parental substance abuse, and other ACEs that significantly affect long-term mental and physical health. For example, depression is comorbid with other post trauma mental health disorders resulting from childhood adversities, and has been found to be the costliest disease in middle- to high-income countries around the world.[13]

Those who advocate for an emphasis on trauma-informed youth care and services are clear that trauma exposed and/or vulnerable children can reach the goals of productivity, connectivity, and civic contribution needed from them for their community's growth if given adequate opportunities to develop positive behaviors. The federal Interagency Working Group on Youth Programs characterizes constructive youth development as a process that engages young people in positive pursuits that help them acquire and practice the skills, attitudes, and behaviors that they will need to become effective and successful adults in their work, family, and civic lives. Positive development in children allows opportunities for future generation to become engaged in their communities, schools, organizations, peer groups, and families in a productive and constructive manner.[14]

[7] van der Kolk, BA. Developmental Trauma Disorder: Towards a Rational Diagnosis for Children With Complex Trauma Histories. Psychiatric Annals, 2005 May: 35(5): 401-408

[8] Cook AC, Spinazzola J, Ford J. Complex Trauma in Children and Adolescents. Psychiatric Annals, 2005 May: 35(5): 390 – 398

[9] van der Kolk, BA. Developmental Trauma Disorder: Towards a Rational Diagnosis for Children With Complex Trauma Histories. Psychiatric Annals, 2005 May: 35(5): 401-408

[10] Heckman, James. <https://heckmanequation.org>11Gerson R, Corwin DL. 2015. Available from: https://www.avahealth.org/resources/aces_best_practices/lifetime-cost.html

[11] Gerson R, Corwin DL. 2015. <https://www.avahealth.org/resources/aces_best_practices/lifetime-cost.html>

[12] Fang X, Brown DS, Florence CS, Mercy JA. The Economic Burden of Child Maltreatment in the United States and Implications for Prevention. Child Abuse & Neglect. Volume 36, Issue 2, February 2012, Pages 156-165.

[13] World Health Organization. The Global Burden of Disease: 2004 Update. Geneva, Switzerland: WHO Press: 2008. <http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/>

[14] Interagency Working Group on Youth Programs, Pathways for Youth: Strategic Plan for Federal Collaboration, December 2016.
<https://youth.gov/sites/default/files/IWGYP-Pathways_for_Youth.pdf>

The competencies that children gain as they develop influence their adult years. Children who master competencies across several domains in their adolescent years are more likely to achieve desirable outcomes including educational and professional success, self-confidence, connections to family and the community, and contributions to society. **Examining some areas of competency shows that unaddressed trauma can potentially handicap young people and diminish their potential for good outcomes as adults:**[15]

Cognitive. Knowledge of essential life skills, problem solving skills, academic adeptness

Social. Connectedness with others, perceived good relationships with peers, parents, and other adults

Physical. Good health habits, good health risk management skills

Emotional. Good mental health, including positive self-regard; good coping skills

Personal. Sense of personal autonomy and identity, sense of safety, spirituality, planning for the future and future life events, strong moral character

Civic. Commitment to community engagement, volunteering, knowledge of how to interface with government systems

Vocational. Knowledge of essential vocational skills, perception of future in terms of jobs or careers

A primary factor that influences how well young people develop these competencies are the overlapping of these three areas:[16]

HIGH COMPETENCY DEVELOPMENT
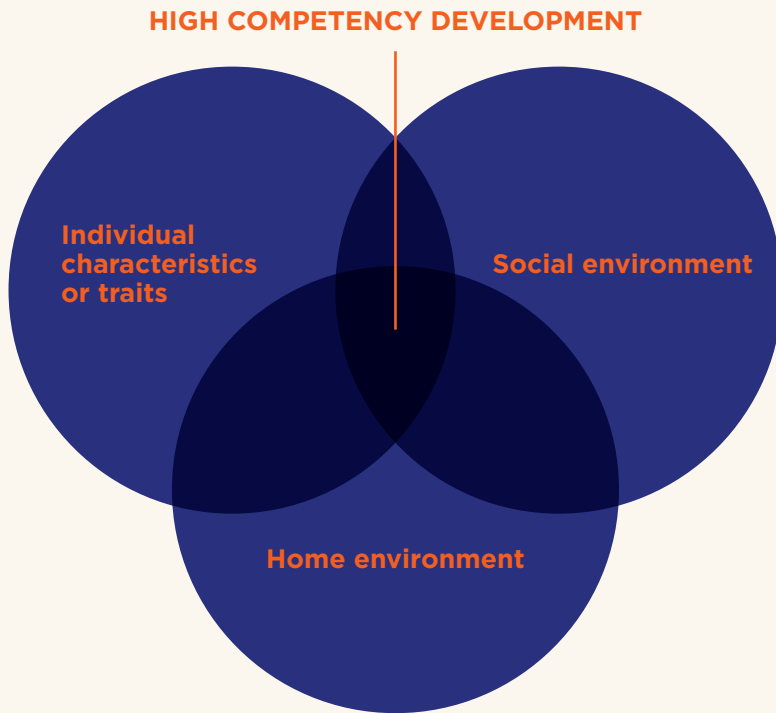
**Individual characteristics or traits. ** Influenced by genetic inheritance and prenatal environment and refers to the characteristics of individuals that influence resilience. Can include social skills, coping strategies, a positive sense of self, and high expectations

Social environment. Encompasses economic conditions, the prevalence of discrimination, educational institutions, and communities serve to reinforce positive behaviors and connectedness to others

Home environment. Includes discord among parents, absence of parents due to health, work or incarceration, and monitoring of children by their parents.

OVERVIEW

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[15] National Research Council, Community Programs to Promote Youth Development. Washington, DC: National Academy Press, 2002, pp. 6-7.
<http://files.eric.ed.gov/fulltext/ED465844.pdf>

[16] HHS, ACF, Family and Youth Services Bureau (FYSB), Understanding Youth Development: Promoting Positive Pathways of Growth, 1997; HHS, ACF, OPRE, Synthesis of Research and Resources to Support at-Risk Youth.

Adolescents who perceive their future in terms of jobs or careers often achieve desirable outcomes. For vulnerable children, poor economic conditions, lingering trauma, and fewer opportunities diminish their outlook on the future. Healthy community's can support children's positive development by reinforcing cultural norms that favor connectedness and responsibility to the whole community and an interest and hope for academic achievement and professional success. Communities can also foster youth development by providing multiple pathways to help them strengthen their competencies via schools, mental health agencies, social services, physical activity, and church and other communal institutions.

These pathways should involve long-term sustainable, transparent and accessible services and programs during the school day and in non-school hours when youth may be more susceptible to risky behaviors.[17] Within schools, the availability of resources for children and their parents such as programs that screen, monitor, and provide relevant support services, can buffer youth from negative community cultures or dysfunctional family situations. Outside of schools, development programs—such as mentoring and leadership programs or physical competitions—emphasize the positive elements of growing up and engage young people in alternatives that counteract negative pressures.

Parental oversight of children and family structure are significant influences on children and their long-term growth and transition to adulthood. Positive adolescent development is facilitated when youth express independence from their parents yet rely on their parents for emotional support, empathy, and advice. However, impoverished, violent, and hopeless families are likely inadequately equipped to provide the prosocial behaviors that assist children in developing a sense of control over their future. Family structures that are unable to promote positive parent-child relationships need resources and interventions to holistically help the young people in the family gain necessary support during childhood, adolescence, and beyond.

[17] Karen Pittman, Merita Irby, and Thaddeus Ferber, Unfinished Business: Further Reflections on a Decade of Promoting Youth Development, The Forum for Youth Investment, 2002.

Overview

How Childhood Trauma Presents in Children

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) seasoned definition of 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."[18] **As discussed previously, these trauma and adverse childhood experience may include:**[19]

- physical and sexual abuse
- neglect
- bullying
- community-based violence
- extreme poverty
- loss of a parent or primary caretaker
- natural disasters

Experiences like these can overwhelm a child's natural ability to cope[20] and can cause stressful reactions in children such as intense fear, terror, and helplessness.[21] Their neurodevelopment can be disrupted, resulting in the impairment of their cognitive functioning or ability to cope with negative or disruptive emotions. **In many children this causes long-term harm to their physical, social, and emotional well-being with potential adverse effects including changes in:**

- emotional responses
- ability to think, learn, and concentrate
- self-image
- attachments to caregivers
- relationships with others
- impulse control

Children who have experienced complex trauma and exhibit these adverse effects are oftentimes misdiagnosed with a multiplicity of psychiatric diagnoses that capture only a limited aspect of the whole child's impairment. Inadequate diagnoses commonly provided for these children include ADHD, behavioral disorders such as Oppositional Defiant Disorder and Conduct Disorder, anxiety disorders, eating disorders, sleep disorders, and communication disorders.[22]

The more categorical and circumscribed diagnosis, Post Traumatic Stress Disorder (PTSD), unfortunately does not capture the full dimension of "complex trauma" and the related developmental impairments, hence a new diagnosis, Developmental Trauma

OVERVIEW

[18]https://store.samhsa.gov/system/files/sma14-4884.pdf
[19] V. Felitti, MD, FACP; R. Anda, MD, MS; D. Nordenberg, MD; D. Williamson, MS, PhD; A. Spitz, MS, MPH; V. Edwards, BA, M. Koss, PhD; and J. Marks, MD, MPH, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," American Journal of Preventive Medicine, Volume 14, Number 4 .1998. p. 245.
[20] U.S. Department of Health and Human Services, Children's Bureau, Child Welfare Information Gateway, Developing a trauma-informed child welfare system. Washington, D.C. 2015.
[21] Vanessa Sacks and David Murphey, Child Trends. The Prevalence of Adverse Childhood Experiences, Nationally, by State, and by Race or Ethnicity. Feb. 12, 2018. <https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity>
[22] Cook AC, Spinazzola J, Ford J. Complex Trauma in Children and Adolescents. Psychiatric Annals, 2005 May: 35(5): 390 – 398

Disorder, is being proposed.[23]

Core components of treatment interventions include:

- establishing safety
- developing competence to manage 'fight or flight' reactions
- dealing with traumatic re-enactments
- managing previously uncontrolled emotions and behaviors
- integration and mastery to achieve equanimity and fun.[24]

In addition to cognitive, functional, and emotional harm, the effects of persistent or unaddressed traumatic experiences on children also have been linked to causing a wide range of health-related conditions including addiction, depression and anxiety, and risk-taking behavior, as well as increasing the likelihood of chronic ill-health conditions such as obesity, diabetes, heart disease, cancer, and even early death.

Children's responses to traumatic events are unique and affected by many factors including their age at the time of the event, the frequency and perceived severity of trauma, and the child's innate sensitivity. Their responses to trauma can also be tempered by their exposure to protective factors such as having positive relationships with healthy caregivers, the child's own physical health, and/or the child's natural coping skills. As such, not all children will experience any or all of these effects while others are predisposed to do so.[25] Researchers have identified multiple groups in the latter category who are at risk of suffering and/or are at risk of experiencing poor outcomes as they enter adulthood.[26] **These groups are not limited to the following:**

- Children/youth in the welfare system[27]
- Youth emancipating from foster care
- Runaway and homeless youth
- Children/youth involved in the juvenile justice system

- Immigrant children/youth and those with limited English proficiency
- Children/youth with physical and mental disabilities
- Children/youth with mental disorders
- Children/youth receiving special education
- Young unmarried mothers
- High school dropouts
- Disconnected (e.g., not in school nor working) youth

Often living in these situations means these children exist without protective factors to help counteract exposure to abuse or neglect, poverty, foster placement, family separation; changes in school placement, neighborhood, and community; as well as fear and uncertainty about the future. Child welfare experts have found that child services systems that use trauma-informed approaches are better able to address children's safety, permanency, and well-being needs.[28]

[23] Carrion VG, Kletter H. Post Traumatic Stress Disorder: Shifting Toward a Developmental Framework. Child Adolesc Psychiatric Clinic N Am 21 (2012) 573-591

[24] van der Kolk, BA. Developmental Trauma Disorder: Towards a Rational Diagnosis for Children With Complex Trauma Histories. Psychiatric Annals, 2005 May: 35(5): 40-408

[25] Child Welfare Information Gateway, Developing a trauma-informed child welfare system. <https://www.childwelfare.gov/pubPDFs/trauma_informed.pdf>

[26] HHS, ACF, Office of Planning, Research, and Evaluation, Synthesis of Research and Resources to Support at-Risk Youth; Wayne Osgood et al., eds., On Your Own Without a Net; and Michael Wald and Tia Martinez, Connected by 25: Improving the Life Chances of the Country's Most Vulnerable 14-24 Year Olds, William and Flora Hewlett Foundation Working Paper, November 2003.

[27] National Center for Homeless Education, Federal Data Summary: School Years 2013-14 to 2015- 16, Education for Homeless Children and Youth (Browns Summit, NC: Dec. 2017); GAO, Child Well-Being: Key Considerations for Policymakers, Including the Need for a Federal Cross-Agency Policy Goal, GAO-18-41SP (Washington, D.C.: Nov. 9, 2017); and Statement of Jack P. Shonkoff, M.D., Director, Center on the Developing Child at Harvard University, before the Energy and Commerce Committee, Subcommittee on Oversight and Investigations, United States House of Representatives, February 7, 2019.

[28] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 17-5014. Rockville, MD: Abuse and Mental Health Services Administration, 2014.

The compounding factors include:

- **Poverty.** Poverty is linked to a number of potential future problems including chronic health conditions, low educational attainment, and engagement in delinquent behaviors.

- **Family Instability.** Children who grow up in two-parent families tend to have better health outcomes and more positive behaviors.

- **Family Dysfunction.** Witnessing violence against their mothers and criminal activity among their family members are the two types of family dysfunction that are particularly detrimental to the future well-being of children.

- **Child Maltreatment.** Abuse and neglect by their parents or other caretakers puts children at risk for outcomes including poor physical and mental health, lower cognitive functioning and educational attainment, and poor social development and behavior.

- **Exposure to Violence in the Community.** Witnessing violence in a community is linked to depression, aggressive behavior, anxiety, posttraumatic stress, psychological trauma, and antisocial behavior.

- **School Resources and Environment.** Schools with fewer resources correlate to children with poor academic outcomes, and schools can create environments with problematic social issues such as bullying and behavioral problems.

- **Community Resources.** Children who live in high-poverty neighborhoods might be less likely than their peers who live in low-poverty neighborhoods to perceive work as a common activity, and therefore are less likely to succeed in school.

- **Residential Mobility.** Children who move frequently may experience negative outcomes such as lower academic performance, high rates of school dropout, emotional and behavioral problems, and engaging in risky sexual behaviors.

- **Minority Status.** Children of color are more likely to live in high-poverty neighborhoods and to attend lower-performing schools compared to white youth. Further, racial discrimination can hinder job opportunities for youth.

Research indicates that children are particularly vulnerable if they experience two or more of these risk factors. In New Orleans, unaddressed frequent long-term exposure to violence, coupled with living in poverty, are two of the prevalent risk factors on this list that the city's children of color regularly endure. The impact of this is not isolated to areas like Central City, but ultimately impacts all within the city limits.

Overview

The Prevalence of Childhood Trauma in New Orleans

Reports on the state of childhood trauma in New Orleans affirmed the heightened prevalence of childhood trauma in the City. It showed its impact causes real damage to children, youth, families, and communities, exposed the lack of infrastructure to stem the damaging trend caused by trauma, and warned that the impact increases generationally and ultimately affects everyone in the city.

Those reports included:

- The screening of *The Children of Central City* documentary.[29] The multi-part special report by Jonathan Bullington and Richard Webster, with photos and video by Brett Duke and Emma Scott, premiered June 13th on www.nola.com and in *The Times-Picayune*. Produced as a project with the USC Annenberg School, it provides an in-depth look at the impact of growing up surrounded by violence in one of New Orleans' most culturally significant and crime-riddled neighborhoods.

- The release of a survey of Central City youth conducted by IWES between 2012-18. The stark and troubling survey revealed that a critical level of traumatic exposure was common in high numbers of the children of Central City. **Amongst the significant data gathered in this survey, this most simplified summary shows the inescapable reality of a crisis brewing:**

- **1 in 5** children had witnessed a murder
- **1 in 3** were witnesses to domestic violence
- **4 in 10** had seen someone shot, stabbed or beaten
- **More than half** had someone close to them murdered

New Orleans' existing environment functions as an incubator for childhood trauma. As reported by *Nola.com-Times Picayune,* Central City is one of New Orleans' most violent communities. It recorded the second highest number of nonfatal shootings and the sixth-highest murder total among 20 local neighborhoods in the first half of 2017 according to New Orleans Police Department (NOPD) statistics.[30] It is also home to roughly 2,900 children and teenagers who often witness these and other crimes such as domestic violence, assault and substance abuse.[31] For many of the boys and girls of Central City, this is a weekly, if not daily occurrence.[32]

Not all vulnerable children experience negative outcomes. Rather social science literature research has identified compounding factors that can influence whether children face negative outcomes in the years up to adolescence or during their transition to adulthood.[33]

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[29] Times Picayune. The Children of Central City: Science of Trauma <https://www.nola.com/children_of_central_city/article_965264d2-992e-11e9-b0af-cbdc34823eb2.html>
[30] https://www.nola.gov/getattachment/Criminal-Justice-Coordination/Reports/2017-Murder-and-Non-Fatal-Shooting-Semiannual-Report.pdf/
[31] https://www.datacenterresearch.org/data-resources/neighborhood-data/district-2/central-city/
[32] https://www.nola.com/living/index.ssf/2018/06/a_brief_history_of_central_city_new_orleans_06132018.html
[33] HHS, ACF, OPRE, Synthesis of Research and Resources to Support at-Risk Youth. The report draws from two reports that synthesize the research literature on risk factors for children: Centers for Disease Control and Prevention (CDC), Adverse Childhood Experiences (ACE) Study, "Major Findings," https://www.cdc.gov/ violenceprevention/acestudy/about.html; and Institute of Medicine (IOM), Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, 2009, http://www.nap.edu/catalog.php? record_id=12480.

To raise awareness of the prevalence of this vulnerability in many of the poor, minority youth in New Orleans and how it presents to the larger society, IWES started a campaign entitled "Sad not Bad." Children who are disruptive or disinterested in class, or appear prone to violence or anti-social tendencies, may be doing so not because they are "bad" kids, but because they have been exposed to traumatic events at an early age and have not received the therapeutic care they need, the institute's President and CEO Dr. Denese Shervington said, "Untreated trauma is the underbelly of violence. If we treat trauma in children, if all communities were socioeconomically equitable and psychologically safe, all children would have a better chance at flourishing and actualizing their potential."

" In New Orleans, unaddressed frequent long-term exposure to violence, coupled with living in poverty, are two of the prevalent risk factors. "

OVERVIEW

Overview

New Orleans Children and Toxic Stress

It is gut wrenching to speak of toxic stress in relation to children rather than responsibility-loaded adults. But that is what far too many New Orleans youth suffer from. Central City is microcosm of this issue—a New Orleans community ravaged by violence.[34] Many of Central City's children have been exposed to so much violence they show evidence of post-traumatic stress disorders in rates higher than soldiers returning from war. The current small-scale and disconnected system of schools, healthcare agencies, and non-profits do not provide enough support and are not trauma based in their approach.

As a result, they neither adequately meet the numbers of children in need nor do they provide a systematic process that can counter the symptoms of the traumatic experiences the children have suffered.

When these children grow up surrounded by crime, their brains can become conditioned to perceive the world as a dangerous place, said Dr. Stacy Drury, associate director of Tulane University's Brain Institute.[35] As a result, the smallest provocation can trigger their "fight, flight, or freeze" instinct. In such moments, marked by high stress and fear, the body releases hormones, including cortisol and adrenaline. These hormones elevate the heart rate and blood pressure, providing a burst of energy needed to ensure survival in times of danger. In optimal situations, these levels return to normal once the threat or perceived threat is no longer present.

This return to normal hormone levels doesn't always happen for children regularly exposed to violence, as they live in a constant state of alarm said Paulette Carter, president and CEO of the Children's Bureau of New Orleans, a nonprofit mental health agency serving more than 3,000 children and their families each year.[36] Living in environments plagued with violence, abuse, and neglect is not optimal. Central City children, like all children exposed to these levels of violence, are continuously triggered and show the physical and mental ramifications of this unhealthy state of arousal.

[34] New Orleans Children Need Help Dealing With Trauma: An Editorial. The Times-Picayune Editorial Board. https://www.nola.com/opinions/article_3c76c7fe-5f59-5be9-8ae2-ea20b7da6387.html

[35] The Children of Central City: Treating Trauma <https://www.nola.com/children_of_central_city/article_bbfe0bb4-992e-11e9-89f8-c79ee8a9a543.html>

[36] The Children of Central City: Treating Trauma <https://www.nola.com/children_of_central_city/article_bbfe0bb4-992e-11e9-89f8-c79ee8a9a543.html>

Some of the impacts of toxic stress include:

- **The Brain.** This constant state of alarm compromises the regions of the brain responsible for memory, emotions, stress response, and complex thought. Per Dr. Drury, this manifests behaviorally as poor anger management, diminished impulse control and struggles processing and retaining information.[37] In environments that are not trauma informed, assessment of these functional issues are often misdiagnosed as attention deficit hyperactivity disorder. With the trauma going untreated, the incorrect focus on the root cause of the issue, and potentially inappropriate mediation provided, results run the gamut from being addressed to being exacerbated.

- **Premature Cellular Aging.** According to a 2014 study of 80 New Orleans-area children by the American Association of Pediatrics, exposure to violence can cause premature cellular aging through the shortening and fraying of the tips at the end of chromosomes or telomeres.[38] According to the research article, "The Association of Telomere Length With Family Violence and Disruption," the erosion of these protective tips, known as telomeres, can lead to cardiovascular disease, obesity, diabetes and mental illness, according to the study. Telomeres are a protective casing at the end of a strand of DNA.[39] Each time a cell divides it loses a bit of its telomeres. An enzyme called telomerase can replenish it, but chronic stress and cortisol exposure decreases that supply. When the telomere is too diminished, the cell often dies or becomes pro-inflammatory. Elissa Epel, PhD, work at the University of California, San Francisco, where she directs the Center for Aging, Metabolism and Emotion shows additional biological links for trauma-exposed children. She says another consistent pattern turning up in clinical and epidemiological samples is a link between early life adversity and shorter telomeres. This relationship was first observed in adults when early adversity was assessed retrospectively, but now it has been observed in young children prospectively. Maltreatment, abuse, severe neglect, and exposure to violence all seem to take a toll on telomere length.

- **Immune System.** When the human body accesses the defensive fight, flight, or freeze mode, parts of the body that are not vital in the moment are shut down to preserve focus on the danger. One of those parts that is shut down is the immune system. Conversely, children who are continuously aroused in a state of alarm, according to the American Psychology Association, are weakened in their ability to fight off diseases due to their immune switches being defensively flipped off.[40]

OVERVIEW

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[37] Neighborhood Stressors Associated With Biological Stress in New Orleans Kids. Tulane University. https://news.tulane.edu/pr/neighborhood-stressors-associated-biological-stress-new-orleans-kids
[38] The Association Of Telomere Length with Family Violence and Disruption
Stacy Drury-Emily Mabile-Zoë Brett-Kyle Esteves-Edward Jones-Elizabeth Shirtcliff-Katherine Theall - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4067635/
[39] The Association Of Telomere Length with Family Violence and Disruption Stacy Drury-Emily Mabile-Zoë Brett-Kyle Esteves-Edward Jones-Elizabeth Shirtcliff-Katherine Theall - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4067635/
[40] http://www.apa.org/pi/families/resources/children-trauma-update.aspx

The Importance of Resiliency and Opportunity

According to the American Psychological Association, resilience means "bouncing back" from difficult experiences. It further adds that research has shown that resilience is ordinary, not extraordinary. Resilience is, or should be, a normal life experience. It's "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems, or workplace and financial stressors."[41] Establishing the importance of resiliency highlights that all people experience difficulty and/or distress. What sets people apart is their ability to overcome emotional distress through behaviors, thoughts and actions that can be learned and developed given healthy environments.

The work being proposed to address childhood trauma in New Orleans can directly inform changes to the children's health system in order to provide all children of New Orleans the opportunity to develop resilience. The types of changes proposed within can ultimately reverse trends that cripple, drain, and suffocate the entire city, but the work begins with identifying and addressing the needs of those who are most directly impacted. Though children in high-risk groups can come from diverse socioeconomic and racial backgrounds, it is children of color and from low socioeconomic backgrounds who tend to be overrepresented in groups showing low resilience trauma. This overrepresentation is a reality for minority communities in New Orleans plagued by high levels of exposure to poverty, crime, and racism, and with little access to systems of care such as health care and vocational assistance.

Asking children to successfully reach productive, engaged, and healthy mental levels of existences without addressing the traumatic environments they live in, their lack of resources to combat these circumstances, and a void of family and community support in

[41]https://www.apa.org/helpcenter/road-resilience

weathering it, then locking them up when they succumb to the mental and physical debilitations of their condition, is a losing proposition for the long-term viability of any community—including New Orleans.

A successful trauma-informed framework includes interventions as well as a change in culture, approach, and operation. Additionally, it builds upon the strengths and assets found within the community, particularly the African American community. Sociologist Dr. Robert B. Hill, sociologist and Senior Research Scientist with WESTAT, identifies five strengths that for African Americans constitute adaptations necessary for survival and advancement in a hostile environment. **Hill lists these strengths in his book, *The Strengths of Black Families*:**
- strong kinship bonds
- strong work orientation
- adaptability of family roles
- high achievement orientation
- religious orientation

Embracing a trauma-informed approach in New Orleans necessitates incorporating knowledge of trauma and its effects into all relevant policies, procedures, and practices.

Effective and efficient trauma-informed care in New Orleans should:
- Offer services to help identify and mitigate the effects of trauma, including screening and assessing children for trauma
- Provide or refer children to services
- Establish systems to keep those not at risk from falling into harm
- Include youth serving organizations, their staff and members of the wider community served through systems. This includes New Orleans Public Schools, New Orleans Recreation Department (NORD), and New Orleans Public Libraries (NOPL).
- Address the family and/or community issues that causes the child the harm or fails to provide protective factors

New Orleans' future depends on a community that is healthy enough to successfully steward its children into young adulthood, and for those young people to eventually leave home and school prepared for college and/or the workforce, ready to take their turn as contributing taxpayers, workers, and participants in civic life. Unaddressed traumatic experiences leave a disproportionate number of children and youth of color at risk of developing problem behaviors that will stymie their ability to make such a healthy transition to adulthood. This vulnerability creates cycles of dysfunction harming their community, themselves, or both.

Currently efforts to combat this rising issue are administered in loosely stitched together programs across agencies that lack the oversight mechanism and funding to coordinate their activities. Many of which do not have the training and capabilities to provide trauma-informed services. And, too many children have no access to this existing programming or have not been screened and identified as dealing with multiple risk factors and potentially suffering from trauma. **Addressing these system-wide gaps is a necessary process for New Orleans to:**
- Engage its younger citizens in positive pursuits
- Heal the hurting and abused amongst them
- Provide stopgaps for those who are at risk of falling into poor mental health

Overview

The Resolution

The call to action issued through The Children of Central City documentary, on behalf of the children and youth of New Orleans, is also a call to heal the entire city and defend its future. The call was responded to on August 9, 2018 when the New Orleans City Council, led by Councilmembers Williams, Moreno and Banks, issued resolution No. R-18-344 indicating two bold actionable items:

1. **The City of New Orleans seeks to become a more compassionate, and trauma-informed City.**

2. **The Children and Youth Planning Board (CYPB) will examine issues surrounding childhood trauma in New Orleans and provide recommendations for a comprehensive approach to the prevention and effective intervention of the negative effects of childhood trauma in New Orleans.**

Resolution NO. R-18-344
CITY HALL: August 9, 2018
BY: COUNCILMEMBERS WLLIAMS, MORENO AND BANKS

A RESOLUTION, requesting that the Orleans Parish Children and Youth Planning Board examine issues surrounding Childhood Trauma and provide recommendations:

WHEREAS, The Times Picayune/NOLA.com series, The Children of Central City shined a light on the plight of thousands of children in New Orleans that grow up with frequent exposure to violence; and

WHEREAS, a survey of Central City youth conducted by the Institute for Women and Ethnic Studies found that 1 in 5 children had witnessed a murder, 1 in 3 children were witnesses to domestic violence, 4 in 10 had seen someone shot, stabbed, or beaten, and more than half had someone close to them murdered; and

WHEREAS, researchers have found that frequent exposure to violence causes children to be in a constant state of alarm, which can result in physical changes in their brains; and

WHEREAS, these effects can be toxic to the brain, particularly in the regions responsible for memory, emotions, stress responses and complex thinking, resulting in difficulties with anger management, impulse control and the processing and retention of information; and

WHEREAS, frequent exposure to violence and other trauma can also result in physical health problems later in life, including cardiovascular disease, obesity, diabetes, and a compromised immune system; and

WHEREAS, problematic behaviors among children, including acting disruptive or disinterested in school, or engaging in violent or anti-social behavior may be a result of exposure to traumatic events at an early age without having received the necessary therapeutic care in response to those experiences; and

WHEREAS, behaviors that arise as a result of trauma can lead to involvement in the juvenile and criminal justice systems, both of which can exacerbate untreated trauma and create new traumas; and

WHEREAS, the systems that children interact with, including schools and the criminal justice system, regularly engage in practices that do not take into account the impact of trauma on behavior, and rely on harsh punishments rather than treatment of the underlying causes; and

WHEREAS, trauma-focused, evidence-based treatments exist and are available to some youth in New Orleans, but sufficient resources are not available to meet the needs of all, due to a lack of local, state, and federal funding to support and expand upon existing high-quality programs; and

WHEREAS, on July 26, 2018 the New Orleans City Council approved Resolution No. R-18-310, calling for the creation and implementation of trauma-informed systems within the Orleans Parish School Board, all charter schools, as well as private and parochial institutions; and

WHEREAS, the city of New Orleans seeks to become a more compassionate and trauma-informed city; and WHEREAS, the Orleans Parish Children and Youth Planning Board was established pursuant to Louisiana R.S. 46:1941.5; NOW THEREFORE BE IT RESOLVED BY THE COUNCIL OF THE CITY OF NEW ORLEANS That the Council hereby requests that the Orleans Parish Children and Youth Planning Board examine issues surrounding Childhood Trauma and provide recommendations; and

BE IT FURTHER RESOLVED, That no later than August 1, 2019, the Orleans Parish Children and Youth Planning Board shall present to the Mayor and City Council recommendations for a comprehensive approach to the prevention and effective intervention of the negative effects of childhood trauma in New Orleans; and

BE IT FURTHER RESOLVED, That the recommendations shall include ways in which existing systems, like the Orleans Parish School Board and Metropolitan Human Services District, can collaborate to build cross-sector partnerships and programming that address, screen for, and alleviate the impact of childhood trauma; and

BE IT FURTHER RESOLVED, That the recommendations shall seek to increase the availability of and access to quality, culturally competent evidence-based services, and to transform the systems which with youth interact, including schools and the justice systems, to ensure they are operating with a trauma-informed lens, thereby promoting youth well-being and rehabilitation, rather than exacerbating the effects of trauma; and

BE IT FURTHER RESOLVED, That the recommendations shall also include pro-social programs that may prevent a child from experiencing trauma, or mitigate the impact of trauma, including early education programs, mentoring and recreation programs, including NORDC programs; and

BE IT FURTHER RESOLVED, That the Orleans Parish Children and Youth Planning Board shall consider strategies to supplement services that are unfunded or underfunded by Medicaid or other federal programs; strategies to increase funding, including the reallocation of resources and/or the creation of new revenue streams; strategies to increase the availability of effective training and implementation support before, during, and after training; and changes to administrative policy and/or municipal code that need to be in place to support the implementation of any of the recommendations.

THE FOREGOING RESOLUTION WAS READ IN FULL, THE ROLL WAS CALLED ON THE ADOPTION THEREOF, AND RESULTED AS FOLLOWS:
YEAS:
NAYS:
ABSENT:
AND THE RESOLUTION WAS ADOPTED.

Overview

The Process

Study — The Task Force's Role

The New Orleans Children and Youth Planning Board launched this work by establishing a CYPB Childhood Trauma Task Force in September 2018. The task force was purposed and populated to complete the recommendations outlined in the New Orleans City Council's Resolution NO. R-18-344, which provided very clear deliverables, albeit with no added resources. The effort was shepherded by Karen Evans, CYPB Executive Director, performing the role of the convening organization, task force facilitator, and project manager over the deliverables.

Immediately, two co-chairs for the task force were identified and successfully recruited: Dr. Denese Shervington, Founder & CEO, Institute of Women and Ethnic Studies, Clinical Professor of Psychiatry at Tulane University School of Medicine and Torin Sanders, PhD., Pastor of The Sixth Baptist Church, Assistant Professor of Social Work, Southern University at New Orleans. The co-chairs partnered with Evans to plan the work of the task force and agreed to equally populate the task force with subject matter experts, those with lived experience (youth and caregivers), and systems leaders/actors. This resulted in a strong, well and differently informed working group of 21 members who met regularly from September 2018—July 2019.

After becoming familiar with each other, the task force charted its objectives and deliverables.

The collectively established objectives of the task force included:

- To examine and understand the issues surrounding childhood trauma in New Orleans and how trauma is experienced by the individual, family, and community.
- To explore local, regional, and national data to learn/understand the impacts of childhood trauma
- To learn/understand the types of trauma prevalent in New Orleans, which can include:
  -Complex Trauma
  -Community Trauma
  -Historical Trauma
  -Intergenerational Trauma
- To determine the root cause(s) of childhood trauma in New Orleans
- To identify/review best practice strategies, evidence-based approaches and national models used by other cities that are seeking to or have become trauma-informed.
- To facilitate cross-sector community engagement/discussions garnering input on approaches to prevention and/or

OVERVIEW

intervention of childhood trauma in New Orleans, and to share thought leadership on approaches to becoming a trauma-informed city.

• To develop a report that shares findings and delivers recommendations for a comprehensive approach to the prevention and/or effective intervention of the negative effects of childhood trauma in New Orleans.

Over the year, task force members participated in problem identification, deep data reviews, studying the types of trauma, and system mapping exercises to yield clarity about the complex issue of childhood trauma in New Orleans. The group researched the best practices framework for becoming trauma-informed as developed through national research conducted by SAMHSA.[42] Adapting SAMHSA's framework, like federal, state and local agencies have throughout the country, as standard guiding assumptions and its principles for establishing efficient and effective trauma-informed processes as the guide for developing recommendations for New Orleans.

The SAMHSA framework establishes four assumptions (4 Rs). A trauma-informed organization, system, or city is one where all its members:

1. **Realize** the widespread prevalence of trauma

2. **Recognize** the signs and symptoms of trauma

3. **Respond** in an understanding, supportive and compassionate manner

4. **Resist** doing any further harm

The six guiding principles that SAMHSA identifies as valid for trauma-informed change processes[43]:

1. **Safety.** Physically and psychologically as defined by the receiver

2. **Trustworthiness and Transparency.** Building and maintaining a relationship of trust and truth

3. **Peer Support.** Mutual self-help; those with lived experience promote healing

4. **Collaboration and Mutuality.** Collective effort, everyone has a role

5. **Empowerment, Voice and Choice.** Individuals, communities + organizations are stakeholders in resilience

and healing promoters of trauma awareness and recovery

6. **Cultural, Historical, and Gender Issues.** Efforts are responsive to racial, ethnic, gender, cultural needs; recognize historical trauma

Additionally, SAMHSA recognizes addressing ten domains that are essential to the implementation of trauma-informed approaches in both organizations and communities. The CYPB Task Force similarly used these domains as a guide for developing recommendations that would be holistically effective in practice across the city.

The SAMHSA 10 Domains:

1. Governance and leadership communicate and support the **vision of a trauma-informed community/city.**

2. **Policy** is reshaped to be trauma-informed.

3. **Physical environment** promotes safety and resilience.

4. **Engagement and involvement of all** citizens and organizations is encouraged; no group is excluded.

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[42] https://store.samhsa.gov/system/files/sma14-4884.pdf

[43] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 17-5014. Rockville, MD: Abuse and Mental Health Services Administration, 2014.

5. Cross-sector collaboration is the norm.
6. **Screening, assessment, and treatment** are in place for identifying and responding to trauma.
7. **Training and Workforce Development** is available for organizations and the general public.
8. **Monitoring and quality assurance processes** are used uniformly to inform and improve services.
9. **Financing mechanisms** make trauma-informed programs and trauma specific services sustainable.
10. **Evaluation data** are collected from a variety of perspectives.

The movement towards implementing trauma-informed agencies and processes is well underway in many parts of the country. Members explored the best and most promising practices from other areas of the country, with a particular focus on the efforts of cities that were reporting success in building resilient and trauma-informed communities. Their processes, outcomes, and lessons learned were reviewed to inform the task force's work toward proposed solutions and recommendations. **The Spotlights of the cities reviewed are listed below and included in the appendix[44]:**

- Philadelphia, PA
- Kansas City, KS/MO
- San Francisco, CA
- Tarpon Springs, FL
- Walla Walla, WA
- Worcester, MA

After much material content review, exploration, study, and discussion, the task force coupled existing examples with the compiled research and knowledge bank of the body's members to identify and began to prioritize its work on the specific needs of New Orleans. Three interrelated systems rose to the top as the crucial areas to focus on to create a path to success for the city. **As such, while other important systems may be mentioned in the report, priority will be given the three systems that the task force determined held the greatest reach and impact on childhood trauma in New Orleans:**

- Education
- Juvenile Justice
- Behavioral Health

With the foundational work completed, task force members worked individually as well as in small, overlapping groups to develop potential recommendations and solutions that would provide a comprehensive approach to the prevention and/or effective intervention of the negative effects of childhood trauma in New Orleans. It is important to note the task force solutions and recommendations were informed by the determined **root cause** of childhood trauma in New Orleans:

- Systemic bias/inequities by design
- Poverty

OVERVIEW

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[44] Substance Abuse and Mental Health Services Administration. SAMHSA Spotlight. A Series on Building Resilient and Trauma Informed Communities. HHS Publication NO. (SMA) 17-5014. Rockville, MD: Substance Abuse and Mental Health Administration, 2017.

The Process

2019 New Orleans Summit on Compassion & Resilience

To enhance the work of the group in speaking accurately for and to respectfully reflect the dynamism of New Orleans, the CYPB Childhood Trauma Task Force created an opportunity to dialogue with the community within its yearlong process. A one-day summit was designed as the medium for this engagement. On June 12th the task force worked, discussed, and brainstormed with over 140 community members representing various sectors across New Orleans at the 2019 New Orleans Summit on Compassion & Resilience: Becoming a Trauma-Informed City.

The 21-member task force viewed the summit as an opportunity to begin the process of cross-collaborative work, transparency, and community engagement that is crucial to the success of a trauma-informed network. Therein, the summit provided the intentional opportunity for the task force to demonstrate one of the six trauma-informed principles in advancing its work:

Empowerment, Voice and Choice Individuals, communities + organizations <u>are</u> stakeholders in resilience and healing promoters of trauma awareness and recovery.

The summit attendees—individuals, community members, and sector actors—participated in a number of sessions with varying formats to enhance discussion, information dissemination, as well as information gathering including:

- Subject expert speakers
- Q&A presentation with trauma-affected youth
- Small table discussions and presentations
- SAMHSA 10-domain focused small group brainstorming
- New data tracking technology demonstration

Each attendee was a critical ingredient to the task force's work—sharing thought leadership in considering recommendations and possible approaches from their respective lens. Their contribution added depth, wisdom, and practicality to the ongoing work of the task force. Their attendance at the summit also provided an opportunity for the task force to publicly declare its purpose and intent and to give these stakeholders the ability to hold the task force and city council accountable for following through on stated goals.

Overview

The Process

Action— The City's Role

In a 2012 study, Briggs-Gowan, et al.,[45] found that **across the United States, 25% of children experience at least one traumatic event by the age of four.** Children who live in poverty are at higher risk of experiencing multiple traumatic events by the age of four.

These lines of national and local data are striking when coupled with work by other researchers who have found that frequent exposure to violence causes children to be in a toxicity-causing constant state of alarm, setting children up for possible chronic, physical issues as well as destructive mental and emotional health.

The statistics following highlight the struggles New Orleans has with violence and poverty and may in turn point to the high levels of juvenile detention, heart disease, high blood pressure, and other stress related physical issues showing high levels in its minority communities.

As stated previously, one striking impetus for the forming the task force was rooted in the release of a survey of Central City youth conducted by the Institute of Women & Ethnic studies which began in 2012 and is ongoing. **To date, over 5000 youth have been screened, and the data has remained consistent over the years:**

- **1 in 5** children had witnessed a murder
- **1 in 3** were witnesses to domestic violence
- **4 in 10** had seen someone shot, stabbed or beaten
- **More than half** had someone close to them murdered

This saddening data gleaned on what Central City youth have experienced is inevitable when coupled the rate of violent crime in New Orleans:

- Based on FBI statistics, Louisiana's murder rate leads the country[46]
- Even if the homicides in the state's largest city are discounted, Louisiana had the nation's highest murder rate for the 29th straight year in 2017 (every year since 1989)[47]
- New Orleans had the nation's 4th highest murder rate (cities 250K+), marking the 30th straight year in the top 5 (not including 2005)[48]

[45]Grasso, Damion, Julian Ford, and Margaret Briggs-Gowan. Early Life Trauma Exposure and Stress Sensitivity in Young Children. Journal of Pediatric Psychology. 2013 Jan. 38(1): 94–103.
[46] https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/home
[47] https://twitter.com/Crimealytics/status/1044185495033565185/photo/1
[48] https://twitter.com/Crimealytics/status/1044185495033565185/photo/1

OVERVIEW

FBI National Murder Rates by City 2017

CITY	2017 MURDERS	RATE
St. Louis	205	66.1
Baltimore	342	55.8
Detroit	267	39.8
New Orleans	157	39.5
Kansas City	150	20.9
Cleveland	107	27.8
Memphis	181	27.7
Newark	77	27.1
Chicago	653	24.1
Cincinnati	70	23.4

FBI National Murder Rates by State 2017

Illinois
7.8

Missouri
9.8

Nevada
9.1

Maryland
9.0

South Carolina
7.8

Arkansas
8.6

Alaska
8.4

Alabama
8.3

Mississippi
8.2

Louisiana
12.4
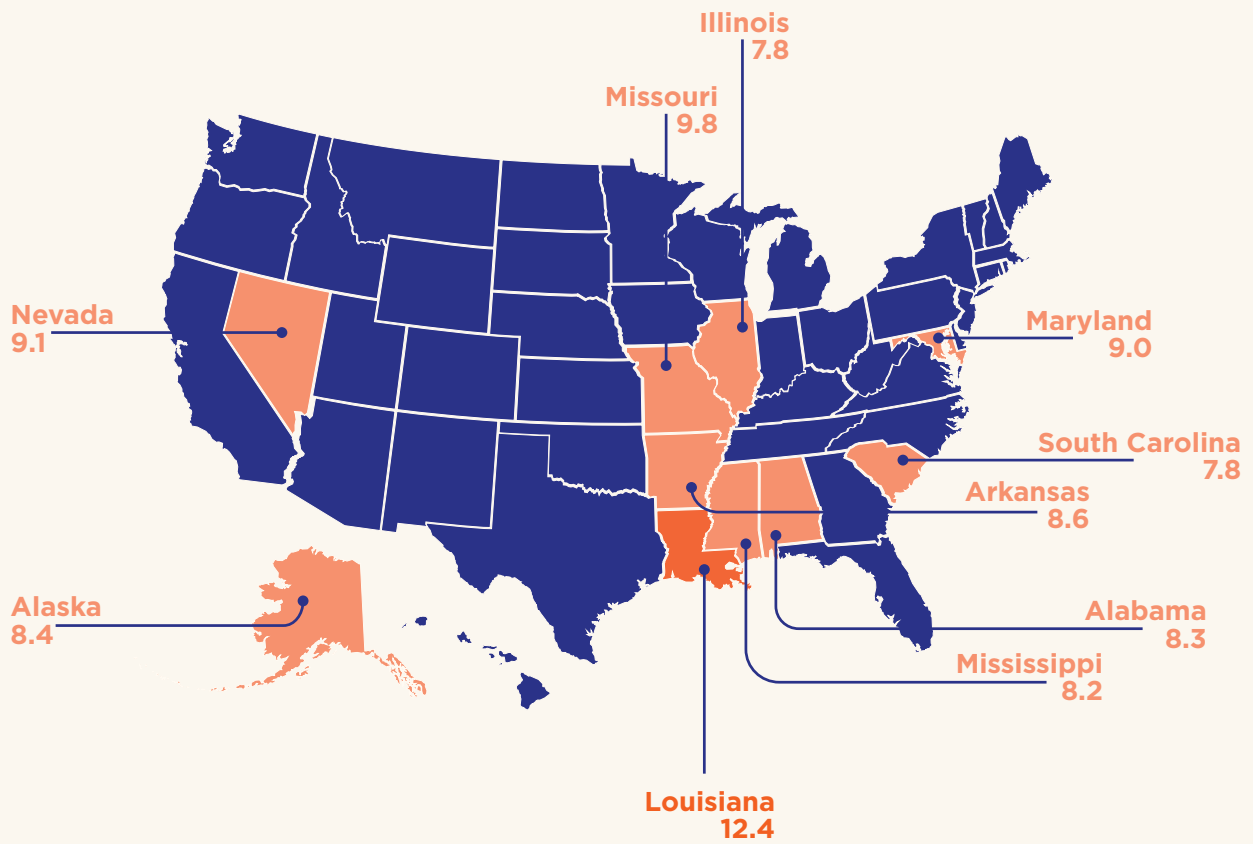
In addition to these discouraging statistics on violence, New Orleans finds itself on failing lists in other areas as well. In their 2019's Best States to Live In survey, WalletHub compared the 50 states based on 51 key indicators of livability.[49] They range from housing costs and income growth to education rate and quality of hospitals—all areas that relate to the levels of protective factors that residents can rely on. Louisiana posted a dismal second to last grade, with health and education showing disturbingly low.

2019's Best States to Live. WalletHub Survey

Overall Rank (1=Best)	State	Total Score	Affordability	Economy	Education & Health	Quality of Life	Safety
1	MA	66.77	43	2	2	3	4
2	MN	66.00	6	11	3	10	12
3	NH	61.21	42	3	4	35	3
4	NJ	61.21	48	35	15	7	1
5...	CO	61.14	25	4	8	12	29
...46	AL	41.91	1	43	48	44	46
47	AR	41.50	9	45	45	43	47
48	NM	39.83	27	50	44	41	48
49	**LA**	**39.79**	**17**	**49**	**49**	**38**	**41**
50	MS	38.67	10	48	50	48	36

[49]https://wallethub.com/edu/best-states-to-live-in/62617/#main-findings

When specific areas were highlighted in depth, Louisiana scored in the bottom percentiles in every category.

Highest percentage of people living below poverty level:
46. Arkansas
47. Kentucky
48. Louisiana
Tie 49. New Mexico
Tie 49. Mississippi

Lowest income growth:
46. Wyoming
47. Delaware
48. Nevada
49. Louisiana
50. New Mexico

Lowest percentage of population 25 y-o and older with high school degree or higher:
46. New Mexico
47. Louisiana
48. Mississippi
49. Texas
50. California

Highest crime rate:
46. Arkansas
47. Tennessee
48. Louisiana
49. Alaska
50. New Mexico

Simply put, as a city New Orleans has many areas that need improvement. And if not addressed within the youth population, as the cycle repeats itself, the consequences of this harm sweeps up additional youth and citizens within its wake and becomes more entrenched in the fabric of the communities, thereby making it harder to counteract.

Overview

The Process

Summary

It is not a coincidence that the New Orleans juvenile delinquency programs and detention facilities house predominantly large numbers of poor black youth for crimes related to the following behavioral issues:

- Inability to focus
- Difficulty being calm/still
- Easily triggered emotions
- Poor management of thoughts and feelings

It is not a coincidence that there are excessively high levels of immune system related illnesses in poor black neighborhoods in New Orleans:

- Asthma
- Hypertension
- Diabetes
- Obesity

The city will be well served by embracing the movement in private and public sectors nationwide to revamp and reestablish the way they have been dealing with youth populations.

Quite simply, young children are being exposed to situations that, left unaddressed and untreated, lead to health and behavioral problems. Amongst these children untreated trauma leads to rising levels of:

- Poor academic accomplishments
- Juvenile delinquency/criminal issues
- Poor societal/familial contributions
- Drug abuse and dependency.

And then, as they age into adulthood, the children perpetuate this dysfunction by raising future generations in further traumatic environments.

A trauma informed community screens, prevents, and treats. Screening for trauma is currently not the norm. It is not routinely or appropriately done by pediatricians, teachers, or service workers—the points of interventions commonly present in the lives of children and the key points where traumatic exposures that are adversely affecting children can be identified. Michelle Alletto reminds us,

"You can physically see someone on dialysis. You can physically see someone in hospice. You can see some physical disability. But it's very hard to show people mental health."

This lies at the heart of the problem in New Orleans where high levels of violence causes a disproportionate number of traumatized poor, black youth. Paulette Carter, President and

CEO of Children's Bureau of New Orleans, a nonprofit that provides trauma-related mental health services to young people and their families, finds that public officials, both past and present, have failed to grasp the seriousness of the psychological injuries suffered by these uncounted victims of violence, in addition to the long-term benefits of providing treatment.

Research conducted in New Orleans looked at the individual and community-wide impact of missed opportunities for intervention. The study looked at 42 children at Lawrence D. Crocker College Prep who screened positive for lifetime PTSD. If those 42 children did not receive adequate treatment, the CDC estimates the cost to society would rise to $8.8 million.[50] James Bueche, deputy secretary for the Office of Juvenile Justice, says that nearly 100 percent of the young people held in state juvenile detention facilities experienced at least one trauma that has resulted in mental health problems. The state spends more than $53,000 a year to incarcerate one minor. Bueche said he would rather see that money go towards prevention

so these boys and girls never reach any of the facilities he oversees.

In New Orleans there are just a handful of organizations, outside of counseling in some schools that provide trauma-focused evidence-based therapies. These include the nonprofit Children's Bureau of New Orleans and the state-run Metropolitan Human Services District. Their efforts, however, are consistently undermined by state budget cuts and a lack of support among local leaders. Nearly a quarter of Metropolitan's budget has been cut over the past eight years, and yet few people have risen to defend the agency's mission, said its executive and medical director, Dr. Rochelle Head-Dunham.

Medicaid and Managed Care Organizations (MCO) are also part of the challenge in bringing much needed care to those in the most need. While Medicaid expansion has absolutely made health insurance possible for many otherwise uninsured, it also challenges providers to provide care for less than it costs to deliver it—an unsustainable approach. MCOs operate similarly but add requirements about the content and length of care delivered that

are often the direct opposite of what a trauma affected child and family need most. Work must be done to develop cost modeling to ensure providers deliver the best practices to advance healing and wellness in a way that doesn't sacrifice provider sustainability.

New Orleans has mental healthcare services for traumatized children that provide care to children under the age of six who have been exposed to violence and are at risk of developing mental illnesses. The program, founded in 2002, also provides support services for their families. Joy Osofsky, professor of Pediatrics and Psychiatry at LSU Health Sciences Center, operates the mental health program in the city that treats children under the age of six. New Orleans is also fortunate to have the Institute of Infant & Early Childhood Mental Health at Tulane University under the leadership of Dr. Charles Zeanah, Executive Director and Mary Peters Sellars-Polchow, Chair of Psychiatry. The Institute of Infant and Early Childhood Mental Health is dedicated to the discovery, dissemination, and application of knowledge to promote social and emotional

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[50] https://www.nola.com/children_of_central_city/article_8d0ea23a-992b-11e9-ac38-7f79c73c19a8.html

competence in young children locally, regionally, nationally and internationally. The Institute's goals include to:

1. Enhance the responsiveness of systems of care to the mental health needs of young children and their families
2. Increase the number of trained infant and early childhood mental health providers
3. Advance the knowledge of infant and early childhood mental health through empirical research

As it stands, New Orleans has been leaving the sick to care for the sick, and incarcerating the failures of that proposition. Jails and juvenile detention facilities further band-aid the root reasons for youth offenders acting out. Not only has the cycle repeated itself till it now approaches critical levels, the current agencies, processes, and systems in New Orleans, lacking a trauma-informed approach, operate without possibility of either preventing recidivism nor decreasing the financial burden of the costs of the penal system and the medical system that are taxed to deal with increasing levels of trauma-ridden citizens.

In adapting a trauma-informed mental health, as well as social, medical, and penal system, New Orleans—a city that greatly needs it—will be joining strong movement in all areas of the country.

- State and federal agencies establish top down policy and processes to address the reality that these traumas are not isolated in their cause and effect. They pay heed to a certainty that everyone will pay the price for ignoring these issues, whether it is increased costs for healthcare, social programs, or mitigating rising criminal activities.
- Schools recognize that successful teaching within the walls of the classroom requires attending to the activities and occurrences outside of the school that affect their ability to successfully impart knowledge and student's capacity to receive it. If only to increase their student body's performance numbers and maintain funding levels, holistic attention to the ability of a child to function is becoming a successful new modus operandi.
- Medical professionals are pushing back against automatic response to health issues and examining the links between pervasive physical issues and the mental stress that is creating the body's breakdown. Identifying and treating root causes outside of the physical realm can provide legitimate healing prescriptions.

Indisputably, addressing childhood trauma will provide significant long-term benefits to all who live within the city's boundary. The potential quality of life benefits include:

- Less crime, New Orleans is a safer city
- Peace and prosperity; children pursue their dreams
- Improved outcomes/social metrics
- City is thriving, not just surviving
- Kids no longer see bodies in the street
- The ability to reallocate funds to other areas of the city will increase due to:
- Less low-income medical services
- Less juvenile and criminal justice services
- Less low-income housing, education and other support services

But most importantly, New Orleans would boast a healthy, productive and vibrant younger generation being raised with the security, opportunities, and capabilities all young children should expect.

Recommendations

Recommendations

Problem Identification

The National Child Traumatic Stress Network (NCTSN) provides this definition of childhood trauma: Childhood trauma occurs when a child experiences an actual or threatened negative event, series of events, or set of circumstances that cause emotional pain and overwhelms the child's ability to cope.[51]

The common types of childhood trauma as identified by NCTSN are:

- Abuse and neglect
- Family violence
- Community violence
- School violence
- Life-threatening accidents and injuries
- Frightening or painful medical procedures
- Serious and untreated parental mental illness
- Loss of or separation from a parent or other loved one (e.g., incarceration, abandonment, death)
- Natural or manmade disasters
- War or terrorist attacks
- Forced displacement or refugee status
- Discrimination
- Extreme poverty

NCTSN's definition and listing of common types of childhood trauma provided the task force with an informed point of reference to examine the presence and prevalence of childhood trauma in New Orleans. The examination was completed with the review of relevant available local data. Examples of the available local data include but were not limited to the following organizations.

- The Institute of Women and Ethnic Studies conducted research into emotional wellness and exposure to violence data from over 5000 New Orleans youth ages 11-15.[52] IWES's Emotional Wellness Screener data shows that New Orleans youth have rates of current and lifetime PTSD **over three times higher than national averages.**

- The impact of Hurricane Katrina, the natural disaster identified as a type of trauma by NCTSN, likely played a substantial role in this disparity; however, research also revealed over 37% of youth have witnessed domestic violence and 54% have experienced the murder of someone close to them. These also appear on the NCTSN list of common types of trauma respectively as family and community violence.

- The Data Center of New Orleans research on New Orleans youth examined the current population size of children 18 years of age and younger living in New Orleans and found there to be approximately 78,000. Of this **39% or 30,498 of the children live in poverty.**[53]

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[51] National Child Traumatic Stress Network. (n.d.) What is Child Trauma. Retrieved November 27, 2017 < https: www.nctsn.org/what-is-child-trauma>
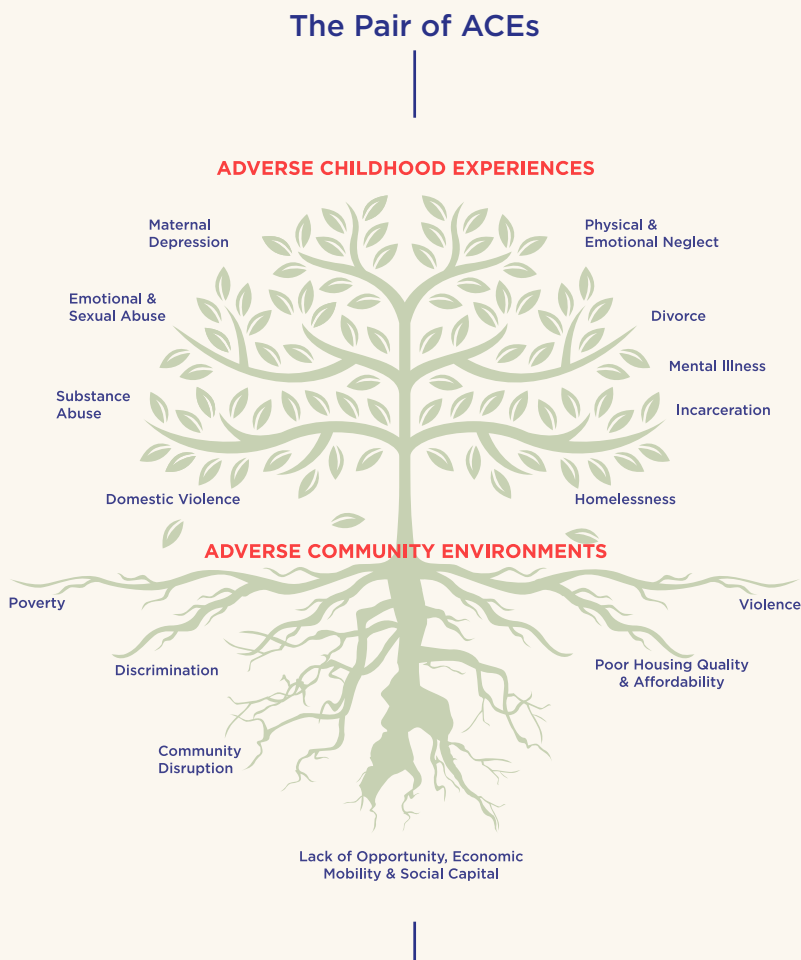[52] IWES Emotional Wellness and Exposure to Violence Report. See Appendix.
[53] The Data Center. (2015). New Orleans Kids, Working Families, and Poverty. <https://www.datacenterresearch.org/reports_analysis/new-orleans-kids-working-parents-and-poverty/>

- The ALICE Report (Asset Limited, Income-Constrained, Employed) issued by United Way of Southeast Louisiana indicates that **53% or 154,355 households** in New Orleans live at ALICE/Poverty levels.[54] **ALICE**, an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed, comprises households that earn slightly more than the Federal Poverty Level but less than the basic cost of living for the state (the ALICE Threshold). Both the DATA Center and the United Way's ALICE report reflect the presence of persistent poverty for children and families in New Orleans, another common type of childhood trauma per the NCTSN listing.

New Orleans has a childhood trauma problem that has persisted over time and has gone under-recognized and untreated. The problem may have formed and been compounded through the combination of ACEs often occurring in adverse community environments.

The Pair of ACEs tree[55] pictured below illustrates the influence of a community environment on the lives of children and families in New Orleans. Specifically, the Pair of ACEs tree depicts the interconnectedness of adverse community environments (ACEs)—the soil in which some children's lives are rooted—and the adverse childhood experiences (ACEs) of their family environment, or branches on which children bud and grow.

The Pair of ACEs

ADVERSE CHILDHOOD EXPERIENCES

Maternal Depression

Physical & Emotional Neglect

Emotional & Sexual Abuse

Divorce

Mental Illness

Substance Abuse

Incarceration

Domestic Violence

Homelessness

ADVERSE COMMUNITY ENVIRONMENTS

Poverty

Violence

Discrimination

Poor Housing Quality & Affordability

Community Disruption

Lack of Opportunity, Economic Mobility & Social Capital

Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

<div style="writing-mode: vertical">RECOMMENDATIONS</div>

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[54] Point-in-Time Data: American Community Survey, 2016. ALICE Demographics: American Community Survey and the ALICE Threshold, 2016. Wages: Bureau of Labor Statistics, 2016b. Budget: Consumer Reports, 2017; U.S. Department of Housing and Urban Development, 2016; U.S. Department of Agriculture, 2016; Bureau of Labor Statistics, 2016a; Internal Revenue Service, 2016; Tax Foundation, 2016, 2017, and Louisiana Department of Education, 2017. Point-in-Time Data: American Community Survey, 2016. ALICE Demographics: American Community Survey and the ALICE Threshold, 2016. Wages: Bureau of Labor Statistics, 2016b. Budget: Consumer Reports, 2017; U.S. Department of Housing and Urban Development, 2016; U.S. Department of Agriculture, 2016; Bureau of Labor Statistics, 2016a; Internal Revenue Service, 2016; Tax Foundation, 2016, 2017, and Louisiana Department of Education, 2017.

[55] Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. 10.1016/j.acap.2016.12.011

Childhood trauma in New Orleans may often be thought of using the standard lens of a medical model that usually focuses on treatments for the patient with the presenting issues. However, the communities of New Orleans are traumatized too and represent a critical part of this city's childhood trauma problem. Traumatized communities are more than a collection of traumatized individuals. Rather, they are communities that have a history of disenfranchisement and oppression and that disproportionately carry the burden of structural violence, which means a social structure that perpetuates inequity and causes preventable suffering or trauma.

The Pair of ACEs tree identifies social structures or systems, as reflected in the soil, that can have a disproportionately negative impact on the lives of people who live in communities suffering from systemic inequities. **Specifically, the social structures or systems can be identified as:**

• Economic
• Educational
• Legal
• Medical
• Political

The George Washington University, School of Public Health Building Community Resilience (BCR) Initiative's research informs the existence of **'Inequity by Design.'**[56] BSR finds that adverse community environments are the result of policies and practices across multiple systems that were perfectly designed for the place-based inequities they produce. New Orleans' poor live in communities of concentrated poverty not by choice, but rather by design—the cumulative result of social and criminal policies enacted over the course of the City's 300-year history. For example, federal policy and lending practices in the real estate industry in the early 20th century supported housing segregation that persists today (e.g., redlining, restricted covenants preventing property transfer based on race, gentrification, sub-prime mortgages, etc.).

These policies combined with the inequitable enforcement of policies across criminal justice (enforcement, mass incarceration, etc.) and public education (funding levels, zero tolerance, decentralization, etc.) also help to explain the place-based differences in who is arrested, the length of incarceration, and

the odds of attending a high-performing school, completing high school, attaining higher education, or entering the skilled trades by way of trade union apprenticeships.

The New Orleans Pair of ACEs tree is planted in soil that is steeped in systemic inequities and dysfunction, robbing it of nutrients necessary to support a thriving community. Adverse community experiences, such as lack of opportunity, limited economic mobility, fear of discrimination, and the associated effects of poverty and joblessness, contribute to—and compound—the adversities that children and families experience.

If the soil is improved through investments in economic development, affordable housing, or educational opportunities, for example, the branches on the tree will grow stronger, yielding healthier leaves. This will translate into improved and measurable outcomes such as increased kindergarten readiness, increased high school graduation rates, lower crime rates, increased economic mobility for children and families, and a sharp decline in the prevalence of childhood trauma.

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[56] Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. 10.1016/j.acap.2016.12.011

Recommendations

The Root Cause

The National Child Traumatic Stress Network concludes that to work towards ending the cycle of trauma and violence it is necessary to acknowledge how both racism and oppression are embedded in our societal layers. Despite shifts in public opinion and attitudes regarding differences in race, ethnicity, age, sex, gender identity, sexual orientation, and disability, systemic bias against marginalized groups persists in the workplace, the housing market, education, health care, and the law. Even mainstream national organizations such as The United Way, in its ALICE report, states that racial bias remains persistent despite research confirming that the gaps in education, income, and wealth that now exist along racial lines in the U.S. have little to do with individual behaviors. Instead, these gaps reflect systemic policies and institutional practices. The following relatively recent examples detail how systemic bias negatively impacts African American families and their children.

In 2008, the Greater New Orleans Fair Housing Center filed a lawsuit that successfully demonstrated that the formula used to calculate awards in the Road Home program, a state-run program designed ostensibly to help homeowners in New Orleans rebuild, was actually discriminatory against African American homeowners. The state of Louisiana settled the lawsuit in 2011. Despite winning the suit, the homeowners adversely affected by the formula were not made whole.

Just last year, Louisiana finally ended a segregation-era practice that allowed for persons to be convicted of a felony with a non-unanimous jury.[57] Not only have criminal justice reform advocates determined that longer, more thoughtful jury deliberations correlate with fewer convictions, non-unanimous juries are documented as a White southern, plantocracy attempt to reestablish political and economic power through convict-leasing—the practice of leasing out prisoners for pay. In order for convict-leasing to work, more people had to be convicted.[58] As a result, until 2018 African Americans on trial in Louisiana had a greater likelihood of being convicted than in other state because only 10 out of 12 jurors were required to vote for conviction.

Michelle Alexander, author of *The New Jim Crow,* civil rights advocate, and visiting professor at Union Theological Seminary, documents how the 1971 initiated "war on drugs" served to further devastate a community already wounded by the infusion of drugs from outside its borders.

[57] https://www.nola.com/news/crime_police/article_cae52b78-3812-57ae-8676-ea4dc3a5d3d0.html
[58] Aiello, Thomas. Jim Crow's Last Stand: Nonunanimous Criminal Jury Verdicts in Louisiana. LSU Press. May 4, 2015.

RECOMMENDATIONS

Coupled with two laws passed later—the 1986 Anti Drug Abuse Act, which established longer sentences for offenses involving the same amount of cocaine and the 1994 Crime Bill, which further provided for harsher sentences for nonviolent offenses—mass incarceration rose rapidly. By the 1980s, while the number of arrests for all crimes had risen by 28%, the number of arrests for drug offenses rose 126%.[59] However, with African Americans persistently profiled and disproportionate recipients of harsher sentences, the US Department of Justice report that "the increasing number of drug offenses accounted for 27% of the total growth among black inmates, 7% of the total growth among Hispanic inmates, and 15% of the growth among white inmates" was inevitable.[60] Even with the national African American population not having been more than 13% of the general U.S. population during that time.

The work of Dr. Joy Degruy, a social work researcher focusing on the intersection of racism, trauma, violence, and American chattel slavery, documents that the traumatic impact of slavery upon African Americans continues systematically to the present day. For example during and post Katrina, the

lack of a community re-building focus, minimal attention paid to the effects of the systemic displacement experienced, and the growth of gentrification that stymied resettlement, prevailed due to the biased system New Orleans has leaned upon since slavery. Other contemporary authors such as Dr. Mindy Fullilove, an American clinical psychiatrist who focuses on the ways social and environmental factors affect the mental health of communities and author of *Root Shock*, agree that the impacts of these massive communal changes continuously tear at the fabric of African American families and generations of their children.

These examples reflect but a few of the systemic policies and institutional practices that create different opportunities for people based on their races and ethnicities. Laws and practices such as these increase the vulnerability of African American families and children and create adverse social conditions that lead to stress and trauma. And, their comprehensive and compounding effects are difficult to understand unless one places them within the historical context of our nation's original sin of slavery, segregation, and the sickness of racism that undergirded them both. To ignore or avoid

addressing the crippling effect this has had on the African American community would render any reparative or transformative work toothless. A critical part of trauma intervention must be about overcoming the taboo against speaking these things and making the unspeakable, speak-able.

There is no quick fix, no one simple solution for the childhood trauma problem in New Orleans. A wide range of strategies will be needed to address the complex issues that cause the prevalence of childhood trauma in New Orleans. Strategies will need to be comprehensive and interconnected, paced and sustained over time, and must address the individual, family/peer relations, community, and societal context in order to promote healing and achieve lasting positive change.

The following recommendations from the task force are provided as a starting point on this extended journey to promote healing, prevention, and intervention of childhood trauma in New Orleans and move the city toward becoming more compassionate and trauma-informed.

[59] Austin J, McVey AD. The 1989 NCCD prison population forecast: the impact of the war on drugs. San Francisco: National Council on Crime and Delinquency, 1989.
[60] https://www.drugwarfacts.org/chapter/race_prison#

Recommendations

The CYPB Childhood Trauma Task Force developed the following mission statement as a guide for creating objectives and recommendations that address childhood trauma in New Orleans and that advances New Orleans in becoming a compassionate and trauma-informed City:

MISSION STATEMENT

The city of New Orleans commits to building capacity in people, organizations, systems, and communities to help us better understand and more effectively serve children and families impacted by stress and adversity.

The task force used SAMHSA's ten implementation domains to organize the recommendations found to be pertinent and of highest necessity for New Orleans. Additionally, the recommendations intersect with the six trauma-informed principles.

Six Key Principles of a Trauma-Informed Approach:

1. **Safety –** physically and psychologically as defined by receiver

2. **Trustworthiness & Transparency –** building and maintaining trust

3. **Peer Support –** mutual self-help, those with lived experience promote healing

4. **Collaboration & Mutuality –** collective effort, everyone has a role

5. **Empowerment, Voice & Choice–** individuals, communities + organizations are stakeholders in resilience and healing, promoters of trauma awareness & recovery

6. **Cultural, Historical, and Gender Issues –** efforts are responsive to racial, ethnic, gender, cultural needs, recognize historical trauma

The SAMHSA 10 Domains:

- Governance and leadership communicate and support the vision of a trauma-informed community/city.
- Policy is reshaped to be trauma-informed.
- Physical environment promotes safety and resilience.
- Engagement and involvement of all citizens and organizations is encouraged; no group is excluded.
- Cross-sector collaboration is the norm.
- Screening, assessment, and treatment are in place for identifying and responding to trauma.
- Training and Workforce Development is available for organizations and the general public.
- Monitoring and quality assurance processes are used uniformly to inform and improve services.
- Financing mechanisms make trauma-informed programs and trauma specific services sustainable.
- Evaluation data are collected from a variety of perspectives.

Recommendations

1
Governance and Leadership

1.1 Shared Vision. Create a citywide vision statement that paints a vivid, aspirational picture of what New Orleans will look and feel like after completing a three-year plan and successfully arrived at becoming a fully compassionate and trauma-informed city.

1.2 Compassion Champion for City. Identify a Champion of Compassion for the City of New Orleans. This person will advance the vision and ensure the recommendations move forward through implementation. The Champion will provide intermittent report and lead celebrations of demonstrated progress.

1.3 Shared Governance and Leadership. Require each city department to craft a vision aligned mission statement that describes what actions the department workforce will undertake to support the City's vision of becoming more compassionate and trauma-informed.

The mission identified should aid in shifting the city culture towards becoming trauma aware.

1.4 People Move Policy and Practices. City of New Orleans creates and funds dedicated staff position to oversee/shepherd trauma-informed efforts throughout the City. Staff will transform recommendations from report into operating plans assigned to key partners with agreed upon timelines and deliverables. This position could exist under the umbrella of the Mayor's Office of Youth and Families and/or through partnership with CYPB.

1.5 Moving Policy into Practice. Direct public facing city departments, especially those that interact with children, youth, and families receiving services and/or with residents as customers, to commit to trauma-informed approaches. This should include:

- Training around applying best interaction practices through a trauma informed lens
- Monitoring the execution of the practices
- Internal and external evaluations/audits conducted to determine progress and needs for improvement

1.6 Day of Recognition + Community Information Sharing. City identifies a day, preferably during National Mental Health Awareness month in May or in alignment with the Annual New Orleans Summit on Compassion & Resilience, to acknowledge the City's commitment to becoming more compassionate and trauma-informed.

Recommendations

② Policy

2.1 State, Local and National Policy Platforms. Align with State of Louisiana as they identify a day and actions to recognize impact of trauma. Connect with events across the state that brings awareness to the impact of trauma. Ensure New Orleans participates in state and national movements to raise awareness of childhood trauma and message the work going forward in New Orleans.

2.2 Policy Audit. Review policies through a trauma-informed lens and modify where needed to reflect the trauma-informed care principles. Focus policy audit in the following areas paying particular attention to practices that may conflict with the six guiding principles that SAMSHA identifies as valid indicators of trauma-informed change (see page 46 of this report):

- New Orleans Public Schools
- NORD
- Orleans Parish Juvenile Court
- Juvenile Justice Intervention Center
- Behavioral Health Providers

2.3 Systemic Inequity. Convene communities to assess policy opportunities that advance equity, reduce disproportionality, and diminish unintended consequences of existing systems. Review systems policies that contribute to inequities (or inequity by design).

2.4 Resolutions to reduce incarceration of juveniles. Establish alternatives to incarceration. Create processes that provide opportunities to understand the "why" of the negative action.

2.5 Prioritize prevention programs through policy change and funding.

Recommendations

3
Physical Environment

3.1 Built Environment Aligns with Vision/Mission. Improve the quality of the built environment and public spaces and maintain minor landscaping on vacant properties across City. It helps prevent further disorganization, violence, and divestment that was signaled by trash-filled, unkempt lots. Remediating abandoned buildings and lots reduces gun violence by 39%, according to 2016 study by the University of Pennsylvania. The study estimates that each dollar spent repairing vacant land yields a direct $26 rate of return to taxpayers. Address neglect and/or deferred maintenance of:
- Parks
- Housing quality
- Transportation

3.2 Physical/Built Environments Worthy of Accountability. Restore Code Enforcement reporting practice to inform status of blight and overgrowth conditions in every district on a bi-monthly basis.

Commit to reducing blight, abandoned buildings, overgrowth by 30% every 4-6 months until completed. Publicly account for progress and needs.

3.3 Engage Voices/Choices in Physical Environment. Host annual information sharing meetings per district to discuss physical/built environments and district pride in the environment; to gather input, ideas and priorities; to provide updates per Code Enforcement reports; and to determine new or next steps.

3.4 Plan in places where population exists. Examine need for place-based resources in neighborhoods with highest population of youth ages birth to 24 years. Work with community members and youth to identify place-based programs that will promote youth opportunity and resilience in place, per developmental stage.

3.5 Increase the Fun in Place. Map the current pro-social outlets for children, youth, and families per community place/district in New Orleans, include type of 'fun', conditions for access (e.g., age, costs, hours, accompanied by adult, etc.) Based on youth population per community place/district, determine how much 'fun' should be accessible within a 2-mile walking radius of the place. Add more fun where needed, per the data, planning with youth and community, fun defined by youth.

RECOMMENDATIONS

Recommendations

4

Engagement and Involvement

4.1 Outreach and Engagement. In partnership with Neighborhood Engagement Office and the Mayor's Office of Youth and Families, create teams of Compassion Champions or Resilience Ambassadors per district to assist with deep outreach/engagement across districts ensuring engagement of as many citizens and organizations as possible per district/across City.

4.2 Another ACE - Information Sharing. Demonstrate support for the plan to de-normalize the prevalence of trauma (it's not normal) with IWES' Advantageous Community Experiences Project. Educate/inform citizens across New Orleans about what is and is NOT normal and what can be done to heal.

4.3 Community/General Public Shared Learning. Partner with local universities to host subject matter experts in key content areas focused on raising awareness, addressing root causes of childhood trauma in New Orleans, examining healing solutions, and prevention strategies for individuals, family and community.

4.4 Voice, Choice and Access. Engage youth, families and communities with lived trauma experience to support the design and implementation of trauma-informed policies.

4.5 Coaches as Leaders. Establish and build capacity of cohorts of NORD Coaches and Sport for Good Coalition Members to lead outreach and engagement efforts informed by their relationships with youth and families across New Orleans.

4.6 Space and Place for Engagement. Spread engagement and involvement opportunities across city and convened locally at neighborhood libraries, parks, and schools.

Recommendations

5

Cross-Sector Collaboration

5.1 Increase Cross-Sector Collaboration Capacity. Sponsor train-the-trainer workshops led by cross-sector collaboration content experts to increase local capacity for advanced cross-sector collaboration informed by a best practices framework. Create a working tool kit of best practice tools for cross-sector collaboration in New Orleans that delivers standards of practice, competence with skills, and tools. Extend practice and use of tool kit to current boards, collaboratives, and working groups across New Orleans.

5.2 Build Expectation for Cross-Sector Collaboration. Define and include cross-sector collaboration as a standing expectation for all pursuing City CEAs, RFPs, Provider Contracts. Request within applications the demonstration of the six trauma-informed care principles through the scope of work. Encourage New Orleans philanthropy community and NOLA Public Schools to align with this trend.

5.3 Allies for Workforce and Community. Provide Childhood Trauma Awareness Training to businesses, nonprofits, and community organizations. Award certificates of completion conferring those who complete the training as 'Trauma Aware' and supporters of the City's vision – compassion, resilience and trauma-informed.

5.4 Understanding Trauma and Why it Matters to the City. Host citywide trainings for all City staff to introduce/inform them of childhood trauma in New Orleans and to increase awareness of trauma: definitions, causes, prevalence, impact, values and terminology of the trauma informed approach. Introduce the City's vision and mission and check-in on alignments with mission for attendee respective departments. Request each individual staff's support in moving the City towards the vision. Lead by example – ensure that every City leader completes the full training and hold a public conferring of the certificates of completion.

5.5 Shared Message. Launch a multi-media campaign requesting that each organization or entity in the city of New Orleans sign on to support the city's Vision of becoming more compassionate and trauma informed. Solicit input on ways organizations/entities can support and deliver actions that could help move New Orleans towards the vision. Repeat new vision related messaging monthly, always seeking demonstrations of support and alignment.

5.6 Agreements. Implement best practice data-sharing agreements across sectors to facilitate effective service coordination, policy alignment and shared accountability to advance the integration of trauma-informed principles.

5.7 Partnerships Locally and at State. Engage Louisiana Department of Health (LDH) and the Office of Public Health (OPH)/Bureau of Family Health as partners in addressing shared priorities regarding population health mandate.

5.8 <u>Clarify Expectations with MOU.</u>
Convene key stakeholders as partners in building out the interdisciplinary team, to craft a comprehensive MOU that incorporates:

- Expectations and scope from each actor
- Common forms and instruments to be used, where applicable
- Mutual opportunities and requirements for trauma training
- Shared decision-making

5.9 <u>Learning together makes New Orleans better.</u> Sponsor learning circles focused on key cross-sector actors and community members learning and applying advanced, best practices that advance the framework for cross-sector collaborations delivering successfully and cooperating as allies. Learning provided by a neutral, skilled content expert applying learning to address a real complex New Orleans issue/problem in real-time, with real success.

5.10 <u>Education and Health Collaborations.</u> Specifically promote and establish collaborations with educational institutes and mental health professionals to better address trauma

5.11 <u>Explore collaboration</u> with Louisiana Office of Public Health's statewide maternal child health neonatal and perinatal collaborative - the 'Louisiana Perinatal Quality Collaborative' that is housed within the Bureau of Family Health.

5.12 <u>Inter-Faith Support.</u> Engage collective of inter-faith leaders across New Orleans to support city launch of healing, compassion, and trauma-informed commitments; recognize providers and organizations that have demonstrated alignment with the City's vision/mission.

Recommendations

6

Screening, Assessment, and Treatment Services

6.1 Interdisciplinary Team. City should require that all health facilities screen for trauma using the Louisiana Department of Health approved instruments and screening standards. Establish an interdisciplinary team to mange this integration. The team will create direction and follow-through on content and process for the use of common/universal tools and other areas that promote readiness in the identifying, understanding, and responding to childhood trauma.

6.2 Universal Assessment. Ensure a respectful screening and assessment process. Encourage existing service

providers to adopt universal assessment practices and ensure appropriate training that promotes the use of using a trauma-informed approach.

6.3 Data Sharing. When possible and within HiPAA guidelines, employ a universal screening tool for organizations to share data within. Provide assistance in developing a new system for data sharing if no adequate one exists.

6.4 "Whole Child" Programming. Establish programming for the "whole child" with connected services inside and outside schools. This is defined by policies, practices, and relationships that ensure each child, in each school, in each community, is healthy, safe, engaged, supported, and challenged.

6.5 Increase Protective Factors. In the school system, increase opportunities for children that can serve as protective factors against experienced trauma:
- More music and art resources in public schools
- More activities for kids during the summer
- Increase child/family advocacy and support in schools
- Create healing centers in school—embedded in school funding

6.6 Trauma-informed Mandate. Promote the importance of trauma-informed care being embedded into all youth-focused organizations. Assist with training and development organizations may need.

6.7 Alternatives to Standard Punishments. Establish alternative methods to address children with challenging behaviors (dysregulated) through screening and assessment to understand the root cause of their behaviors followed by wellness-promoting responses:

- Physical activity prescription in lieu of detention and other disciplinary actions in schools
- Diversion and rehabilitation programs versus incarceration and punitive actions
- Restorative/Transformative justice and contemplative practices implemented in school curriculum

6.8 Holistic Care. Create neighborhood healing centers funded by hospital, entertainment and/or tourism tax to improve the surroundings children exist in outside of the school system. Offer care to all community members.

Recommendations

(7)

Training and Workforce Development

7.1 <u>Training Across Programs/Agencies – Speakers Bureau.</u> Increase the awareness, knowledge, and skills of the entire workforce to deliver services that are: Effective – Efficient – Timely – Respectful – Person-centered. Provide staff in every child-serving, family-serving, and community program trauma-informed training to include:

- Childhood Trauma Awareness
- Signs, Symptoms, Science + Approaches to Healing
- Trauma-informed Principles + Improving Equity, Reducing Disparities
- Workforce Self-Care and Wellness – Understanding Vicarious Trauma
- Integrate same training into City Departments, particularly NOPD, DA, NORD, NOPL.

7.2 <u>Equity, Resilience and Trauma Informed Care.</u> Require trauma training to include education and skills development on cultural competency, language access, implicit bias, equity, and reducing disparities. Assure that training recognizes the inherent resilience and strengths of New Orleans residents who may live in poverty and in communities with high rates of violence.

7.3 <u>Prepare Emerging Workforce.</u> Integrate trauma-informed trainings in the local college and university educational and graduate school preparation, professional development, licensing, and re-certification for child-serving professionals (e.g., health care, early education, K-12 education, social work, courts, police academy, child welfare)

7.4 <u>Data.</u> Use data to identify communities with greatest need. Prioritize community trainings accordingly and in partnership with community.

7.5 <u>Sustain the Workforce.</u> Implement policies, practices, and procedures that build and sustain a trauma-informed workforce.

7.6 <u>Evidence-Based.</u> Increase awareness, knowledge, and skills of clinical and peer workforce to deliver evidence-based, culturally relevant, and community-supported programming/services in communities that addresses effects associated with childhood trauma and that honors principles of trauma-informed approach. Leverage access and cost by pooling training/certification dollars/processes to maximize number of trained providers.

Recommendations

8

Progress Monitoring and Quality Assurance

8.1 <u>**District Cohort/Community Leadership.**</u> Establish Compassion Cohorts per Council District to ensure all childhood trauma healing, prevention, and intervention plans are implemented with relevance and impact per each district's need. Engage Cohort Leaders in Summit on Compassion and Resilience steering/planning committee.

8.2 <u>**Set Benchmark.**</u> Using accessible data, establish priorities and measurable goals.

8.3 <u>**Good Data Dashboards.**</u> Advocate for quality, timely, and consistent data collection and implement a data dashboard (results and indicators) to monitor progress, with attention to race and gender equity and child well-being. Seek youth, community verification of data and need prioritization.

8.4 <u>**Community Feedback.**</u> Engage the youth and community wisdom and voice in monitoring and quality assurance efforts to improve services.

8.5 <u>**Measure.**</u> Using accessible data, establish priorities and measure impact.

8.6 <u>**Assess.**</u> Assess capacity of agencies and organizations serving children based on space available as compared to need/demand for space. Regularly report regularly report service outcomes with attention to race and gender equity in all sectors to promote transparency and accountability. Ensure data is collected and reported to include race, culture, gender, income and zip code.

8.7 Monitor EFFECTIVENESS

8.8 Ensure funding results in real intervention delivered.

8.9 Consider both 'evidence-based' and local/home-grown interventions; include both on care/services continuum:
- Hold quality accountable
- Take a closer look at where funding in practice causes harm

8.10 <u>**Standard Measure.**</u> Agree upon standard measure that specifies what constitutes a trauma-informed organization, e.g. Mental Health Rehab (MHR), NORD Sites, Schools, Extended School Day/After-School Programs, etc.

8.11 <u>**Equity and Inclusion.**</u> Seek data from nontraditional sources. Find the unique and often missed sources. Ensures continued equity and inclusion of communities across race, gender, language and culture, demonstration of trauma-informed principles.

Recommendations

9
Financing

9.1 Call for Resources

9.2 Name and understand all active funding sources

9.3 Acknowledge and address cash flow constraints

9.4 Call out 'hidden' or inactive capital (tax breaks, legacy dedications) and reconsider what could happen if fair taxes, etc. were actually in practice (historical analysis, racial equity analysis)

9.5 Children's Budget. Set aside and make transparent a significant public and private investment that builds a 'children's budget." This budget would help provide funding for:

- Prevention/early intervention + awareness/education of childhood trauma
- Service providers/agencies to deliver direct care

9.6 Advocate for the funding of essential trauma informed services through improvement of MCO provider contracts to address true services needed and sustainable cost reimbursement modeling

Recommendations

10

Evaluation

10.1 Track. Track and monitor progress, analyzing what is and is not working to determine where and how to refocus efforts.

10.2. Truth to Trust. Ensure transparency and continuous quality improvement. Share the story of how things are working, gathering feedback to frame improvements opportunities often and from all perspectives.

10.3 Sample Measure. There are many possible measures to consider when evaluating the progress and impact of a trauma-informed City. Here are possibilities that may be of interest for New Orleans:

- Increased access to behavioral health supports
- Yearly high school dropout rate
- Number of juvenile offenses filed within court system
- Hospitalizations – child injury or accident, suicide attempts

- Structures in place to support consistent trauma informed responses for children and families
- Shared data agreement to look at continuous quality improvement and collective impact across health, academic, and economic outcomes for children and adults
- Increased funding to support trauma-informed city initiatives
- Increase linkage of social services across disciplines

10.4 Shared Learning with Follow-Up/ Progress. Conduct an Annual Summit on Compassion and Resilience to provide space for annual engagement in ongoing efforts, learning and tracking of progress, and collective processing of necessary next steps and timelines.

5. **Celebrate the Success of New Norm.** Recognize advanced cross-sector collaborative results publicly across media platforms. Convene voices of trained collaborators to identify successes, to expose opportunities for improvement and/or refinement in the training and/or practice of collaborating, and to examine the helpfulness of the framework, toolkit and its use. Pursue continuous quality improvement through refinements and updates or advancements to acquired skills.

Implementation Plan

Recommendations without a plan for implementation and accountability run the risk of being forgotten or discarded. The work of the task force and the issue of childhood trauma for the children, youth, and families of New Orleans, as prioritized by the City Council, is too important to submit without plans for next steps. The below implementation plan provides a snapshot of the series of next steps necessary to advance New Orleans on its journey to becoming a more compassionate, trauma informed City.

To become more compassionate and "trauma-informed" involves taking on and attending to a number of scientifically grounded elements that focus on the **six core principles** of the trauma informed approach:

1.
safety

2.
trustworthiness

3.
empowerment

4.
collaboration

5.
peer support

6.
history, gender, culture

The implementation plan aligns with these core principles and identifies the specific principle attended to in the noted focus area.

Implementation Focus Area	Objective	Output for the Year
collaboration	Transform recommendations into action plans to advance coordination, accountability	An Annualized Operating Plan
empowerment	Set the intention with shared co-authored vision	A Citywide Vision
collaboration	Demonstration of sharing the vision across sectors.	A shared vision
trustworthiness; collaboration; empowerment	Create and adopt citywide trauma policy.	Vision informed policy statement
peer support; empowerment; history, gender, culture	Increasing knowledge about trauma informed care; childhood trauma in New Orleans; healing approaches at home and through providers	Increased awareness of ACEs - 10 trainers

Activities	Person(s) Responsible	Schedule
1. CYPB accepts and will perform the function of process holder, facilitating timely follow through on recommendations by way of coordination, accountability and operationalizing recommendations into action plans for persons responsible for deliverables. • Additional staff to be added to lean CYPB operation to ensure delivery of active coordination, accountability efforts. • Link to all other relevant efforts, e.g., Youth Master Plan. • Reconstitute the CYPB Childhood Trauma Task Force to effectively drive continuous efforts.	CYPB Karen Evans + Task Force	Oct. 1 2019 Ongoing
2. City engages subject matter expert (SME) in crafting a process that gathers as many voices as possible in the creation of a City adopted vision statement – "In 3-5 years of trauma informed efforts that take shape extremely well, what could New Orleans look and feel like...New Orleans is..."	Contracted Consultant TBD	Dec. 1, 2019
3. City issues a call to action to all stakeholders, service providers, sector actors/leaders, etc., to join in assisting in executing efforts that advance the citywide vision. Using all media platforms City requests residents, sectors, stakeholders to sign-off (form w/check boxes) as partners in the mission/vision; Also, using Instagram, twitter to creatively demonstrate our shared commitment to becoming a more compassionate, trauma-informed city and why it matters. Top posts can be recognized at City Council.	Contracted Consultant TBD	Jan. 31 2020
4. Guided by the example provided in the Appendix, City engages staff or consultant in crafting an aligned trauma policy statement and encourages other sectors to do the same. See document example in Appendix: See document example in Appendix: Trauma Policy Framework Guide	Contracted Consultant TBD	Jan 31 2020
5. In partnership with LDH, ACE Educator Program, and IWES, launch a **NOLA Cohort of ACE Educators** to be paired with IWES's another ACEs: Advantageous Community Experiences – an assets approach to community capacity building and healing, providing New Orleans specific training and knowledge building. New Orleans ACE Educators Cohort Speakers/Trainers Bureau - Trauma	CYPB Karen Evans Caitlin LaVine ACE Educator Program Dr. Shervington IWES	Nov. 2019

RECOMMENDATIONS

Implementation Focus Area	Objective	Output for the Year
peer support; empowerment; history, gender, culture	Increasing knowledge about trauma in-formed care; childhood trauma in New Orleans; healing approaches at home and through providers	Increased awareness of ACEs • 400+ community members
safety; trustworthiness; empowerment; peer support	Training, development and building capacity across community, sectors, particularly across youth-services	Increased awareness of capacity for various trauma informed care training available in New Orleans. • 200+ staffs

Activities	Person(s) Responsible	Schedule
6. Community Learning/Healing convenings for **community members** across each council district that increases knowledge of both ACEs, heightens awareness of trauma is and what it is not, engagement with neighbors, capacity and skills building for greater self-care and care that can be extended to one another across neighborhoods. All **City Staff** should participate in this learning experience in an effort to ensure common, shared knowledge to advance vision collectively.	CYPB Karen Evans Caitlin LaVine ACE Educator Program Dr. Shervington IWES	Jan. 31 2020, Ongoing
7. Create and sustain a catalogue of the various trauma in-formed care/approaches trainings offered through provid-ers across New Orleans. This will inform common or core content deliverables, targeted audiences reached, training/learning objectives as measured, can certify agreed upon standards for content, processes and outcomes. Can iden-tify, execute delivery of content across sectors, encouraging intersectionality and access. Create collective plan of community training and education opportunities, identifying content as introductory, moderate, or advanced and naming targeted audience. Partners to Include: • New Orleans Youth Alliance (NOYA): Dr. Rashida Govan • IWES: Dr. Denese Shervington • Navigate NOLA: Dr. Danielle Wright • Safe Schools NOLA – 2 CMOs with 6 Schools • Trauma Informed Care Schools Learning Collab. (TICSLC) – 5 Schools in 2019 Cohort + 5 Schools from 2018 Cohort • Teddy McGlynn-Wright, Tulane/TICSLC Project Mgr. • Dr. Deirdre Hayes, Tulane re: Community Learning • Center for Resilience: Liz Marcell Williams • Crossroads NOLA – Anna Palmer • Others (TBD)	CYPB Karen Evans + Task Force Dr. Samantha François, Tulane Others - TBD	Nov. 1, 2019 Ongoing

RECOMMENDATIONS

Implementation Focus Area	Objective	Output for the Year
collaboration	Position New Orleans as a Compassionate, Trauma Informed City among state and national networks.	Links to statewide and national networks • 2+ formal connections
trustworthiness; empowerment; collaboration; peer support; history, gender, culture	Create expectation for community, provider, practice, content and deliverables to be reviewed and built upon.	Annual content, impact and accountability check-in • 100+ attendees
empowerment; peer support	Include healing through faith in the work of trauma recovery for children and families, when and where appropriate.	Increased inclusion of faith communities

Activities	Person(s) Responsible	Schedule
8. Establish and maintain connections with statewide, regional and national ACEs, childhood trauma and trauma-informed city efforts to advance policy positions, access to resources, best/promising practice exchanges, and the broadening of networks of subject matter experts.	CYPB Karen Evans	Jan. 31, 2019 Ongoing
9. Host the Annual New Orleans Summit on Compassion & Resilience as the convening that updates information, knowledge, skills, data sharing and deliverables from prior year – review of report card or dashboard to determine progress toward vision; reset of next steps, next round of deliverables; expand partner matrix to best reflect continuum of trauma informed services across New Orleans; identify gaps, needs and/or issues to inform funding models, celebrate successes and recognize progress leaders.	CYPB Karen Evans + other service, sector partners	May or June Annually
10. City launch of an Annual Day of Well-Being: New Orleans as a City of Compassion and Resilience Engaging all leaders from the Faith Community, all Faiths across New Orleans, to extend thoughts and actions toward the healing of our Children, our neighborhoods, our City on the same day at the same time; sound bites/talking points provided to ensure continuity.	TBD	May or June Annually

RECOMMENDATIONS

Implementation Focus Area	Objective	Output for the Year
*sustainability; collaboration; trustworthiness;	Develop a funding strategy that is well informed by need, costs and desired best practices.	Increased knowledge of funding models + strategies to make changes • 45+ attendees
collaboration	Outreach and engagement of faith community	Broad faith community inclusion and participation in advancing healing across City
collaboration	Engagement in work that aligns with their purpose	Partnership in work that addresses/ reduces systemic bias/ inequity by design across City

Activities	Person(s) Responsible	Schedule
11. Convene 'funding conversations in the round" to launch real discussions around the current disconnect between services, needs, true costs and the expectations for use of evidence-based practices via funding models/reimbursement mechanisms that may not align with practice expectations, needs, and/or costs. Attendees to include: • Philanthropy • City • New Orleans Public Schools • State Medicaid Rep/Subject Matter Expert • State Public Health Department/Population Health • Managed Care Organizations (MCOs) • Behavioral Health Providers • Others (TBD)	CYPB Karen Evans Tap Bui, United Way + other sector partners TBD	Nov. 2019 May or June 2020
12. Engage faith-based organizations and associations in trauma-informed care training and capacity building; enlist support and assistance in raising awareness, expanding knowledge and furthering implementation of the plan. This engagement may include leadership across various denominations to include, but not limited to: • Baptist • Church of God in Christ • African Methodist Episcopal • Archdiocese of New Orleans • United Methodist Churches • Seventh Day Adventist Churches • Lutheran Churches • Episcopal Diocese • Islamic Community • Buddhist Community • Others	CYPB Torin Sanders + Karen Evans	TBD, no later than June 1, 2020
13. Connect with emerging and/or ongoing efforts to identify overlap/shared vision/mission work; strategically leveraging opportunities. This can include, but is not limited to, the following: • New Orleans Human Relations Commission • Louisiana Department of Health (LDH) • Office of Public Health (OPH)/Bureau of Family Health	CYPB Karen Evans + Torin Sanders Others - TBD	TBD, no later than July 1, 2020

Implementation Focus Area	Objective	Output for the Year
history, culture, empowerment	Engage Arts Community with City's vision/mission re: compassion, trauma-informed care	Increased knowledge, awareness and use of the Arts to support healing, well-being.
collaboration	Align with the Mayor's Office of Youth and Families to advance plans and deliverables.	A collaborative work-plan: OYF + CYPB

Activities	Person(s) Responsible	Schedule
14. Engage and partner with the City's Culture Bearers, and Arts Community in learning about and spreading awareness of trauma-informed care approaches, and how Culture Bearers and the Arts Community can help children, youth, families and communities heal.	CYPB Karen Evans + Others TBD	TBD, not later than July 2020
15. In partnership with the Mayor's Office of Youth and Families, build appropriate processes to drive vision, mission, plan and implementation across city, particularly in these departments: • NORDC • NOPL • JJIC	Emily Wolff – OYF Karen Evans – CYPB Others – TBD	TBD, not later than July 2020

RECOMMENDATIONS

Trauma-informed Initiatives In Action

While the task force worked to identify actions that would be of specific benefit to New Orleans, many of the items on the comprehensive list of recommendations provided are exampled around the country as working and effective. Using six states currently engaged in trauma-informed care, here are illustrations of the application of the recommendations and their importance and relevance in creative, effective and efficient mental health care system that focuses on treating the ill effects of trauma. These examples provide templates or directions from which New Orleans can build its own framework. They also indicate resources for ongoing information, support, and/or funding.

The states exampled and their trauma-informed systems[61]:

- Colorado
- Massachusetts
- North Carolina
- Ohio
- Washington
- Wisconsin

State and local child welfare and education agencies in five of the six selected states have developed support systems ranging from providing services to trying to intervene and help children affected by trauma.

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[61] Children Affected by Trauma: Selected States Report Various Approaches and Challenges to Supporting Children. GAO-19-388. <https://www.gao.gov/assets/700/698684.pdf>

Trauma-informed Initiatives In Action

Examples of Trauma-Informed Supportive Systems

- The Colorado child welfare agency, as part of its system of care, uses an evidence- and team-based planning model, referred to as high-fidelity wraparound services, to manage care for children with or at risk of serious emotional disturbance and who are involved in multiple systems, such as the child welfare and juvenile justice systems.[62] As part of these wraparound services, county child welfare staff and local service providers and professionals work with the family to create a plan for them and their children. A coordinator sets up meetings, oversees the plan, and makes sure all team members participate in achieving the plan's goals. In addition to the coordinator, a family advocate provides peer support via weekly visits to parents and caregivers of youth receiving wraparound services.

In addition, depending on the needs of the child, wraparound services may include participating in a support group or meeting with a therapist or grief counselor, among other things.

- In Ohio two counties have a partnership that provides services to children and their families who have experienced trauma because of parents' substance use disorder.[63] As part of the program, children and parents are screened for trauma and may get referred for treatment and services. Families receive wraparound services that are provided by both a caseworker and family peer mentor; the family peer mentor will have personal experiences with addiction and be in recovery.

- Colorado, Washington, Wisconsin and Massachusetts have at least one statewide effort administered by the state education agency to help support all children, including those affected by trauma.

- Colorado, Washington, and Wisconsin encourage schools to implement tiered systems of behavioral support. Tiered systems of support generally consist of three tiers of support:
  - **Tier 1** universal supports that apply to all children
  - **Tier 2** specialized supports for smaller groups of children
  - **Tier 3** supports for individual children who need intensive interventions.

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[62] The Colorado child welfare agency collaborates with the Office of Behavioral Health to implement Colorado's Trauma Informed System of Care, or COACT Colorado. As of February 2019, 17 counties participate in this effort.
[63] Ohio's Sobriety, Treatment, and Reducing Trauma is administered by the Public Children Services Association of Ohio, an organization representing Ohio's county child welfare agencies.

To implement the first tier, school staff supports students in various ways such as interacting with students and setting up a dedicated space in a classroom for students to regulate their behavior.

The second tier may include convening small groups to help children with similar behavioral issues learn how to regulate their emotions, and the last tier may include intensive support for students who need more help, such as developing and implementing wraparound services plans.

- Massachusetts does not use tiered systems of behavioral support, but they help children affected by trauma by employing practices to create safe classroom environments for all students such as developing and building upon relationships and engaging students in structured conversations.

Trauma-informed
Initiatives In Action

Examples of Trauma-Informed Training

The Department of Human Health Services (HHS) offers information and funds training and technical assistance to help state and local agencies support children affected by trauma.[64] The six states being exampled cite the National Child Traumatic Stress Network as an important resource for information, training, or technical assistance.[65]

- Four of the selected states use the NCTSN's Child Welfare Trauma Training Toolkit curriculum to train their staff. The curriculum, designed to be completed in about 13 hours, covers topics such as the essential elements of a trauma-informed child welfare system, the impact of trauma on the brain and body, and the identification of trauma-related needs of children and families.[66]

- Two state child welfare agencies use the Resource Parent Curriculum to train foster parents and others about trauma and another used the Think Trauma curriculum to prepare trainers of group home and residential center staff; both curricula are provided through the NCTSN.[67]

- The NCTSN makes other resources available to state and local communities on its website. For example, NCTSN offers fact sheets about various assessments and treatments as well as two evidence-based treatments for use in school settings.

In addition to information and training provided through the NCTSN, in 2012 HHS's Administration for Children and Families (ACF) issued guidance to encourage state child welfare directors to focus on improving behavioral and social-emotional outcomes for children who have experienced abuse or neglect. In 2013, SAMHSA, in collaboration with ACF and Centers for Medicare and Medicaid Services (CMS), issued joint guidance to encourage the integrated use of trauma-focused screening, functional assessments, and evidence-based practices in child-serving settings.[69] Also, in 2014 SAMHSA, in an effort to help service sectors, such as child welfare, education, and juvenile justice, become more trauma-informed and released *Concept of Trauma and Guidance for a Trauma-Informed Approach.* This document included a framework of key assumptions and principles of a trauma-informed approach. SAMHSA intended that the trauma framework be relevant to its federal partners and their state and local system counterparts, to practitioners, researchers, and to trauma survivors, families, and communities.

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[64] The Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which was enacted on October 24, 2018, directs federal agencies to take several actions related to trauma-informed care. See Pub. L. No. 115-271, §§ 7131-7135, 132 Stat. 3894, 4046-56 (2018).
[65] The NCTSN develops and disseminates interventions and resource materials, offers education and training programs, and engages in data collection and evaluation, among other activities, to help education and child welfare agencies and others support children affected by trauma.
[66] The NCTSN also offers a Child Trauma Toolkit for Educators.
[67] The Resource Parent Curriculum helps foster parents to understand how traumatic events may impact children and to recognize behaviors as symptoms of those experiences.
[68] The two evidence-based treatments, Bounce Back and Support for Students Exposed to Trauma, are aimed at relieving symptoms of child traumatic stress, anxiety, depression, and functional impairment among children, ages 5-11 and 10-16, respectively. See NCTSN fact sheets on Bounce Back and Support for Students Exposed to Trauma.
[69] Enhancing the well-being of children requires a coordinated federal approach that takes into account the interrelatedness of federal actions and policies that aim to improve the lives of children. See GAO-18-41SP.

HHS and Education additionally funds technical assistance centers and makes other resources available to states including:

- SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint offers technical assistance to various publicly-funded systems and organizations on issues relating to trauma education, among other things.

- Education's Readiness and Emergency Management for Schools Technical Assistance Center helps local education agencies before, during, and after emergency situations. Among its various activities, this technical assistance center offers information and technical assistance to local education agencies and others on Psychological First Aid for Schools, which is an intervention model to assist students, staff, and families in the immediate aftermath of an emergency.

- Education's National Center on Safe Supportive Learning Environments as well as its Positive Behavioral Interventions and Supports Technical Assistance Center offer an array of materials about trauma and approaches to supporting children affected by it.

- The ACF, through its Child Welfare Information Gateway website, provides information on building trauma-informed systems, assessing and treating trauma, and addressing secondary trauma in caseworkers. It also offers trauma resources for caseworkers, caregivers, and families, as well as information about trauma training. In some instances, the website directs users to SAMHSA or the NCTSN's website.

State and local child welfare and education agency officials in the six selected states use various further approaches to train staff and birth and foster parents about trauma and its effects on children and families.

- Child welfare officials in Wisconsin and North Carolina use learning communities to train staff, and in some instances, foster parents. For example, North Carolina's child welfare agency used a learning community approach—which included face-to-face training, as well as coaching and practice, over an extended period—to work with child welfare staff in 32 of the state's 100 counties, according to a state official. In a 2016 agency report, state officials reported that the 9- to 12-month learning community process was designed to allow staff the time required to become steeped in trauma knowledge, to learn how to spread that knowledge into skills and practices, and to develop a sustainable program.

- Conversely, state and local education and child welfare officials in three states use

online learning or university coursework to train staff. For example, Wisconsin education agency officials developed a three-tiered training including online modules for educators and school staff. The modules are designed for self-study and, among other things, include guidance on making policies and procedures more trauma-sensitive, as well as information about the characteristics of safe, supportive learning environments.

- In Massachusetts state child welfare officials partnered with three universities to provide trauma-focused courses to child welfare workers, and a local university offers a graduate certificate in trauma and learning to area educators.

- In addition to training staff, state and local child welfare agency officials in four states train clinicians in trauma-focused, evidence-based therapies. For example, Wisconsin clinicians participate in learning communities where they receive training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based therapy. Clinicians participate in 5 days of in-person training, receive 16 consultation calls with a trainer, and complete a 10-hour, self-paced webinar. According to Wisconsin's child welfare website, clinicians who complete the training are eligible for certification as TF-CBT therapists and can be listed on a national website of certified clinicians.

- Similarly, North Carolina's state child welfare agency, in partnership with a nonprofit organization, trains clinicians in four trauma-focused, evidence-based therapies including TF-CBT and Parent-Child Interaction Therapy. Similar to the Wisconsin effort, over the course of a year clinicians learn about these therapies and practice them with children and families.

Trauma-informed Initiatives In Action

Examples of Trauma-Informed Leadership

The reports of officials in all six selected states emphasize the importance of having engaged leadership in establishing and sustaining support for children affected by trauma. They cite a wide range of leaders, including state government officials and managers and supervisors in partner agencies such as schools or nonprofits, who supported these states' trauma efforts. In some cases, those leaders helped establish new trauma initiatives.

For example, Wisconsin's former First Lady launched the work of a statewide, interagency trauma initiative. Additionally, Ohio county child welfare officials found it valuable to obtain management support for their plan to become a trauma-informed organization. In other cases, leaders were seen as important to sustain a trauma

initiative and to ensure its impact. In Massachusetts, university officials found that to ensure the continued availability of evidence-based therapies, they train not only clinicians, but also the individuals who supervise them. Also, a county public health official in Washington, whose agency is implementing trauma initiatives in schools, found their efforts tended to be unsuccessful unless they first engaged school leadership and aligned their health initiatives with the schools' existing efforts.

Federal officials and reports have also cited leadership as an important factor in the implementation of trauma initiatives, with some maintaining that leadership is necessary to support children affected by trauma because of the need to change an organization's culture. In 2013, NCTSN reported on takeaways from a learning collaborative in which nine teams led by child welfare agencies developed, implemented, and tested trauma-informed child welfare practices.[70] Based on the experiences of the teams, the NCTSN report stated that strong and consistent leadership is necessary to implement trauma-informed practice because it requires a shift in organizational culture.

SAMHSA's 2014 guidance for a trauma-informed approach similarly suggests that organizations consider the importance of leadership to initiate a systems- wide change.[71] In addition, HHS officials who worked with states on a series of trauma-related grants awarded between 2011 and 2013 said leadership

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[70] J. Agosti, L. Conradi, J. H. Goldman, and H. Langan, Using Trauma-Informed Child Welfare Practice to Improve Placement Stability Breakthrough Series Collaborative: Promising Practices and Lessons Learned. Los Angeles, CA & Durham, NC: NCTSN, June 2013.
[71] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. <https://store.samhsa.gov/system/files/sma14-4884.pdf>

commitment was important for their grantees in building organizational and worker resiliency, acting upon data and evaluation, and sustaining initiatives.

These documents and statements echo previous Government Accountability Office (GAO) work on organizational transformation; for example, in 2003 GAO reported on key practices found at the center of successful transformation efforts, noting that leadership must set the direction, pace, and tone and provide a clear, consistent rationale that brings everyone together behind a single mission.[72]

In addition to discussing the important role that leadership plays in establishing and sustaining support for children affected by trauma, officials in three states highlighted instances in which a lack of leadership hindered their efforts to support children. The cases they described included delayed, incomplete, or unsuccessful implementation of trauma initiatives.

Delayed implementation.
Officials in one school district said they had developed policies around multi-tiered system of supports in 2009 but did not receive support from political leaders or funding for the initiative until 2016. They said this hindered the initiative's implementation.

Incomplete implementation.
State education officials in that same state said that a lack of leadership hindered their ability to track school districts' implementation of the state's trauma initiatives. These officials said that a lack of requirements for districts to scale up trauma work was a barrier to collecting data on local activities. In another state, there was a county child welfare initiative to implement universal trauma screening that was conducted in partnership with a local university. The university reported that less than half of children with open cases were screened during the project period, which university officials attributed to some supervisors not supporting the screening initiative.

Unsuccessful implementation.
According to officials in a third state, turnover among high-level leaders contributed to difficulties integrating trauma-informed practices at the state's child welfare agency, and the agency was not successful at implementing a trauma screening process.

RECOMMENDATIONS

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[72] GAO, Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations, GAO-03-669 (Washington, D.C.: July 2, 2003). See GAO, Government Reorganization: Key Questions to Assess Agency Reform Efforts, GAO-18-427. Washington, D.C.: June 13, 2018.

Examples of Trauma-Informed Screening

While training staff and parents is important to broaden understanding of trauma and its impact on affected children, identifying these children is also key to helping them receive needed support, including trauma-focused treatment. State and local child welfare and education officials in five of the six selected states screen certain children to determine whether they have experienced trauma, are exhibiting symptoms of trauma, or need to be referred for a trauma-informed mental health assessment.

- In North Carolina and Washington children are screened for trauma when they enter the child welfare system. North Carolina counties that participated in the state's training efforts use two screening tools: one for children under age six and the other for those ages six through 21. The social worker, with input from the caregiver, completes the screening tool for children under age six. Older children are asked questions about their exposure to trauma including physical abuse, domestic violence, sexual abuse, and other traumatic events.

- According to the North Carolina child welfare agency, the trauma screen has a number of benefits for child welfare practice, including informing placement decisions for the youth, prioritizing children who might need to receive treatment quickly, and providing the mental health professional with a better understanding of a child's issues.

- Child welfare officials in Washington also reported integrating trauma screening into the state's child screening program using a 2012 ACF trauma grant.[73] Children and youth are screened within 30 days of placement in foster care if officials expect them to remain in care 30 days or more. With these grant funds, officials in Washington's child welfare agency added a tool to screen for children's trauma symptoms and developed a protocol that rescreens these children every six months.[74]

- In addition, education agency officials from three states report schools have developed processes to identify students who may have experienced trauma. For example, in a Wisconsin school district any staff member, family member, or student can refer a student for screening. The school district formed school-based teams to review information, such as data on suspensions and class disruptions, to identify at-risk students. In addition to the screening process, the school district developed school-based and community mental health service partnerships at 23 schools where therapists provide mental health services.

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[73]ACF awarded trauma-related discretionary grants in 2011, 2012, and 2013. Among the recipients of these grants are university and state government entities in four of the six selected states—Colorado, Massachusetts, North Carolina, and Washington.

[74]Trauma screening tools include the Pediatric Symptom Checklist and Screen for Child Anxiety Related Emotional Disorders. Washington child welfare officials started using the Screen for Child Anxiety Related Emotional Disorders tool to screen for trauma because it is more sensitive than the Pediatric Symptom Checklist to identify symptoms of trauma, such as anxiety and Post-Traumatic Stress Disorder. In addition to these two screening tools, they piloted other trauma screening tools to use for children ages 3-7.

Trauma-informed Initiatives In Action

Examples of Trauma-Informed Program Funding

HHS's ACF and SAMHSA have awarded discretionary grants to states specifically to address childhood trauma. From 2011 to 2013, ACF awarded 20 state and local agencies and other organizations discretionary grants to address childhood trauma totaling about $58 million.[75] Each grantee, including two state child welfare agencies, a county agency, and two universities in officials in five of the six states we selected to review, received up to five years of funding. The grants were used to screen and refer children to treatment, implement or expand trauma-focused, evidence-based treatments, and bridge the gap between child welfare and mental health. According to HHS officials, funding for the last of these grants will end in September 2019.

SAMHSA also awards discretionary grants specifically to address childhood trauma to state and local agencies, universities, and other organizations through an initiative to transform mental health care for children and adolescents affected by trauma. NCTSN, a collaborative network of experts created through the National Child Traumatic Stress Initiative (NCTSI),[76] conducts research on trauma treatment approaches and provides services to children affected by trauma. In fiscal year 2017, SAMHSA received over $48 million for the NCTSN, and it awarded four new grants and supported 82 five-year grant continuations through NCTSI. One state child welfare agency, three universities, and two nonprofits in four of the six state examples received grants through this initiative. Several of these entities used these funds to train clinicians and educate other child serving professionals about trauma and mental health conditions.

In addition to grants that were specifically meant to address childhood trauma, the selected states used other HHS discretionary grants to support children affected by trauma.

- Five state education agencies in the selected states received SAMHSA's Project Advancing Wellness and Resilience Education (Project AWARE) grant.[77] Wisconsin officials also received Education's School Climate Transformation Grant,[78] which was used to create the state's trauma-sensitive schools initiative.
- Washington officials credited SAMHSA's Mental Health Transformation Grant with driving the state's initial trauma-informed work,[79] including its guide about trauma in schools.80
- State agency officials also reported using formula funds, meant for broad purposes like mental health, substance abuse, child welfare, and education, to support their work with children affected by trauma.[81]

- Officials from five agencies in the selected states reported using formula funding from Title IV-E of the Social Security Act to help children affected by trauma.

  - According to Colorado officials, the state's Title IV-E waiver has allowed child welfare workers to screen, assess, and provide interventions that are trauma-informed.

  - In North Carolina, Title IV-E, combined with other funding sources, has helped pay for trauma-informed learning communities to help counties build trauma-informed programming.

- Two states reported using the Substance Abuse and Mental Health Block Grants.

In addition to federal funding, officials in the six selected states reported receiving state funding to support children affected by trauma.

- In 2013 the North Carolina General Assembly appropriated $1.8 million in annually recurring funds to train clinicians in evidence-based trauma treatments.

- In Massachusetts state funding may be used to create and support trauma-sensitive initiatives in schools, among other things.

- In addition to state funding, officials in three of the selected states reported using nonprofit funding to support their efforts.

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[75]These funding opportunities were referred to as: Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service Delivery; Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare; and, Promoting Well-Being and Adoption after Trauma. All three grants were administered under the authority of the Adoption Opportunities Program, see 42 U.S.C. § 5113. As part of its administration of these grants, ACF provided technical assistance to states and convened annual conferences so grantees could share information with each other. Several grantees collaborated to publish articles about their efforts to support children affected by trauma.

[76]NCTSI is authorized under the Children's Health Act of 2000, see 42 U.S.C. § 290hh-1. Established in 2000, the National Child Traumatic Stress Initiative (NCTSI) seeks to improve the quality of community-based trauma treatment and services and increase access to effective trauma-focused interventions.

[77]Through Project AWARE, education agencies may receive funds to increase awareness of mental health conditions among school-age youth, prepare educators and other adults to detect and respond to such conditions, and connect youth with appropriate services. These Project AWARE grants are authorized under the Public Health Service Act, as amended, see 42 U.S.C. § 290bb-32.

[78]Education administers the School Climate Transformation Grant program, which provides competitive grants to state and local educational agencies to develop, enhance, or expand systems of support for schools implementing an evidence-based, multi-tiered behavioral framework for improving behavioral outcomes and learning conditions for all students. These grants are authorized under Title IV-F of the Elementary and Secondary Education Act of 1965, as amended, see 20 U.S.C. § 7281.

[79]The Mental Health Transformation Grant program was intended to support changes in the organization, management, and delivery of public mental health services. Grants were administered by SAMHSA and authorized under the Public Health Service Act, see 42 U.S.C. 290bb-32. The final 5-year grants were awarded in fiscal year 2010, according to HHS officials.

[80]Ray Wolpow, Mona M. Johnson, Ron Hertel, and Susan O. Kincaid, *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success* (WA: Washington State Office of Superintendent of Public Instruction, September 2009), accessed July 23, 2018.

[81]Title IV-E authorizes the large majority of federal funding dedicated to child welfare, with funds chiefly available for specific foster care and adoption expenses. Title IV-E is codified at 42 U.S.C. §§ 670-679c.

[82]HHS was authorized to waive certain Title IV-E requirements to enable states to carry out approved demonstration projects. HHS was authorized to approve new demonstration projects through FY 2014. Demonstration projects are generally limited to five years and may not continue after September 30, 2019. See 42 U.S.C. § 1320a-9.

[83]The Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (Substance Abuse and Mental Health Block Grants) provide funds and technical assistance for substance abuse and mental health services. These grants are administered by SAMHSA and authorized under the Public Health Service Act. See 42 U.S.C. § 300x *et seq.*

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During the ten months of intense meetings, the twenty-one member CYPB Childhood Trauma Task Force, comprised of subject matter experts, youth and caregivers with lived experiences, and systems leaders, examined the issues surrounding childhood trauma in New Orleans. The task force researched and explored efforts advanced by other cities across the nation that have become or are in pursuit of becoming trauma-informed cities. National best, promising practices and processes were reviewed and studied to inform the work of the task force. The work was important, heavy at times, and taken very seriously by this task force's members. Support surfaced in several unexpected places. The support generously extended by several organizations was greatly appreciated, and they are each identified here.

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RECOMMENDATIONS

ACKNOWLEDGMENTS

Appendix

APPENDIX

Further Background on Trauma

The Societal Cycle of Dysfunction

TRAUMA

ADVERSITY

In addition to the biological effects of being in a flight, fight or freeze mode, children also struggle to survive with healthy emotions when they are in homes that do not provide the protective factors of adequate and consistent safety, comfort, and protection.[84] Children in these environments do not learn how to form and maintain healthy attachment relationships. They are not exposed to exchanging emotions in a safe, comforting way, they are hyper aware of the moods and actions of the adults around them, and they may detach or underperform when presented with positive situations for attachment or growth.

Here are some common effects of complex trauma:

Attachment and Relationships

Through relationships with caregivers, children learn to trust others, regulate their emotions, and interact with the world; they develop a sense of the world as safe or unsafe, and come to understand their own value as individuals. When those relationships are unstable or unpredictable, children learn that they cannot rely on others to help them. A child's attachment to a caregiver is the training ground for future healthy relationships with friends and significant others. Children who do not have healthy attachments:

• Are more vulnerable to stress
• Have trouble controlling and expressing emotions
• May overreact or inappropriately react in situations
• May connect poorly with romantic partners or friends
• May respond poorly to authority figures, such as teachers or police officers

Physical Health: Body and Brain

As explored previously, when a trauma exposed child or adult encounters even ordinary levels of stress, their defensive systems may automatically respond as if

the individual is under extreme stress. Stress can impair the development of the brain and nervous system while the absence of mental stimulation in neglectful environments may limit the brain from developing to its full potential. Children with complex trauma histories or adults with histories of trauma in childhood:

• May develop chronic or recurrent physical complaints, such as headaches or stomachaches
• Have more chronic physical conditions and problems.
• Engage in risky behaviors that compound these conditions such as smoking, substance abuse, and poor diet and exercise habits
• Suffer from body dysregulation, meaning they over-respond or under-respond to sensory stimuli.

Emotional Responses

Significant depression, anxiety, or anger is common in children who have experienced complex trauma. They often have difficulty identifying, expressing, and managing emotions. They often internalize and/or externalize stress reactions and as a result their emotional responses may be unpredictable or explosive.

Having learned that the world is a dangerous place where even loved ones can't be trusted to protect

them, children can be vigilant and guarded in their interactions with others and are more likely to perceive situations as stressful or dangerous or alternately, may "tune out" threats in their environment, making them vulnerable to re-victimization.

Difficulty managing emotions is pervasive and occurs in the absence of relationships as well. Having never learned how to calm themselves down once they are upset, many of these children become easily overwhelmed. Children who have experienced early and intense traumatic events also have an increased likelihood of being fearful all the time and in many situations. They are more likely to experience depression as well.

Dissociation

Dissociation is often seen in children with histories of complex trauma. When children encounter an overwhelming and terrifying experience, they may dissociate, or mentally separate themselves from the experience. At its extreme, a child may cut off or lose touch with various aspects of the self.

Although children may not be able to purposely dissociate, once they have learned to dissociate as a defense mechanism they may automatically dissociate during

[84]https://www.nctsn.org/what-is-child-trauma/complex-trauma/effects

other stressful situations or when faced with trauma reminders. Dissociation can affect a child's ability to be fully present in activities of daily life and can significantly fracture a child's sense of time and continuity. It can have adverse effects on learning, classroom behavior, and social interactions. It is not always evident to others that a child is dissociating and at times it may appear as if the child is simply "spacing out," daydreaming, or not paying attention.

Behavior

A child with a complex trauma history may be easily triggered and likely to react very intensely. The child may struggle with self-regulation and may lack impulse control or the ability to think through consequences before acting. As a result, complexly traumatized children may behave in ways that appear unpredictable, oppositional, volatile, and extreme or conversely, may dissociate and seem "spacey", detached, distant, or out of touch with reality. Complexly traumatized children are more likely to engage in behaviors that make it more likely that they will enter the juvenile justice system:

- High-risk behaviors, such as self-harm or unsafe sexual practices

- Excessive risk-taking such as operating a vehicle at high speeds.
- Engage in illegal activities, such as alcohol and substance use
- Assault others, steal, run away, and/or prostitution

Cognition: Thinking and Learning

Children with complex trauma histories may have problems thinking clearly, reasoning, or problem solving. They may be unable to plan ahead, anticipate the future, and act accordingly. When children grow up under conditions of constant threat, all their internal resources go toward survival. Many children who have experienced complex trauma have learning difficulties that may require support in the academic environment.

Self-Concept and Future Orientation

Children learn their self-worth from the reactions of others, particularly those closest to them such as their caregivers. Amongst children suffering abuse and neglect, shame, guilt, low self-esteem, and a poor self-image are common.

To plan for the future with a sense of hope and purpose, a child needs to value him- or herself. Children

surrounded by violence in their homes and communities learn from an early age that they cannot trust, the world is not safe, and that they are powerless to change their circumstances. They have trouble feeling hopeful. Having learned to operate in "survival mode," the child lives from moment-to-moment without pausing to think about, plan for, or even dream about a future.

Long-Term Health Consequences

Traumatic experiences in childhood have been linked to increased medical conditions throughout the individuals' lives. The Adverse Childhood Experiences (ACE) Study results demonstrated the connection between childhood trauma exposure, high-risk behaviors (e.g., smoking, unprotected sex), chronic illness such as heart disease and cancer, and early death.

Economic Impact

The cumulative economic and social burden of complex trauma in childhood is extremely high. Based upon data from a variety of sources, a conservative annual cost of child abuse and neglect is an estimated $103.8 billion, or $284.3 million per day (in 2007 values). This number includes both direct costs—about $70.7

billion—which include the immediate needs of maltreated children (hospitalization, mental health care, child welfare systems, and law enforcement) and also indirect costs—about $33.1 billion—which are the secondary or long-term effects of child abuse and neglect (special education, juvenile delinquency, mental health and health care, adult criminal justice system, and lost productivity to society).

A recent study examining confirmed cases of child maltreatment in the United States found the estimated total lifetime costs associated with child maltreatment over a 12-month period to be $124 billion. In the 1,740 fatal cases of child maltreatment, the estimated cost per case was $1.3 million, including medical expenses and productivity loss. For the 579,000 non-fatal cases, the estimated average lifetime cost per victim of child maltreatment was $210,012, which includes costs relating to health care throughout the lifespan, productivity losses, child welfare, criminal justice, and special education. Costs for these nonfatal cases of child maltreatment are comparable to other high-cost health conditions (i.e., $159,846 for stroke victims and $181,000 to $253,000 for those with Type 2 diabetes).

In addition to these costs are the "intangible losses" of pain, sorrow, and reduced quality of life to victims and their families. Such immeasurable losses may be the most significant cost of child maltreatment.

Trauma — Populations Most at Risk

Some groups of children and families are disproportionately represented among those experiencing trauma. This means that they may be exposed to trauma at particularly high rates or be at increased risk for repeated victimization. For some populations, co-occurring issues and unique adversities can complicate recovery from trauma. Others may face significant challenges related to access to services or require services that are specially adapted for their needs.

1. Trauma and Substance Abuse[85]

There is a strong connection between traumatic stress and substance abuse whether the user is an adolescent or a caregiver. Research studies have shown that adolescents who engage in problematic substance use are more likely to experience traumatic events and develop PTSD, depression, violent behavior, suicide, and other mental health problems compared to those who do not use substances. Additionally, adolescents exposed to traumatic events are more vulnerable to problematic substance use. Psychoactive substances can both dull the effects of stress and place teens at increased risk for experiencing trauma.

Starting even before children are born, parental substance use increases children's risk for later mental health problems and victimization. Children and adolescents with substance-using parents may be exposed to other high-risk situations, such as violence in the home and community.

2. Economic Stress[86]

Economic challenges can affect feelings of safety, the ability to remain calm, relationships with others, and the belief that things will improve. When times are uncertain, people feel frustrated, angry, scared, or hopeless; they may have to plan new ways to overcome obstacles. As children hear, see, and read about what is happening in their homes, communities, and the world, they experience economic stress alongside their parents; when their parents are worried, children begin to worry too.

3. Military and Veteran Families[87]

Children of military and veteran families experience unique challenges related to military life and culture. These include deployment-related stresses such as parental separation, family reunification, and reintegration; disruption of relationships with friends and neighbors due to frequent moves; and adaptation to new schools and new community resources. Added to this, some children face the trauma of a parent returning home from combat with injuries or illness; others must face their parent's death.

4. Intellectual and Developmental Disabilities[88]

Research indicates that youth living with intellectual and developmental disability (IDD) experience exposure to trauma at a higher rate than their non-disabled peers. Children with IDD appear to be at an increased risk for physical abuse, physical

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[85] https://www.nctsn.org/what-is-child-trauma/populations-at-risk/trauma-and-substance-abuse/nctsn-resources
[86] https://www.nctsn.org/what-is-child-trauma/populations-at-risk/economic-stress
[87] https://www.nctsn.org/what-is-child-trauma/populations-at-risk/military-and-veteran-families/nctsn-resource
[88] https://www.nctsn.org/what-is-child-trauma/populations-at-risk/intellectual-and-developmental-disabilities/nctsn-resources

restraint and seclusion, sexual abuse, and emotional neglect. In addition, psychological distress secondary to medical procedures is more common among children living with IDD than their typically developing peers, as they also may have chronic medical problems that necessitate surgeries and other invasive procedures.

5. Homeless Youth[89]

As many as 2.5 million youth per year experience homelessness. Along with losing their homes, community, friends, and routines—as well as their sense of stability and safety—many homeless youth are also victims of violence or other traumatic events. While coming from a variety of backgrounds, research suggests that most of these youth have experienced early and multiple traumas. Their responses to these events have been shaped—at least in part—by age, gender, ethnicity, and sexual orientation. This history of trauma in turn causes significant mental health problems, including depression, anxiety disorders, PTSD, suicidal ideation, attachment issues, and substance abuse disorders. Once they arrive on the street, many youths are re-traumatized. Thus, they struggle to recover from earlier traumatic events at the same time that they are trying to survive in a hostile street environment replete with countless dangers, including an increased likelihood of substance abuse and a vulnerability to being trafficked.

6. LGBTQ Youth[90]

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth experience trauma at higher rates than their straight peers. Common traumas experienced by these youth include bullying, harassment, traumatic loss, intimate partner violence, physical and sexual abuse, and traumatic forms of societal stigma, bias, and rejection. Historically, professionals have failed to recognize and meet the needs of traumatized LGBTQ youth, leading to poor engagement and ineffective treatments that, in some cases, perpetuate the youth's traumatic experiences.

[89] https://www.nctsn.org/what-is-child-trauma/populations-at-risk/homeless-youth/nctsn-resources
[90] https://www.nctsn.org/what-is-child-trauma/populations-at-risk/lgbtq-youth/nctsn-resources

APPENDIX

Trauma — Established Treatments and Approaches

The following are evidence-based trauma treatments that clinicians and therapists can use when working with children and their families that have been accepted and adopted by federal agencies, academic institutions, and community-based treatment centers as standards methods of operation.[91]

Attachment, Self-Regulation and Competency. Includes multiple modalities, such as individual, group and family treatment; parent workshops; and a home-based prevention program. The approach addresses how a child's entire system of care can become trauma-informed to better support trauma-focused therapy.

Child-Parent Psychotherapy. Focuses on the way the trauma has affected the parent-child relationship, and the family's connection to their culture and cultural beliefs, spirituality, immigration experiences, and parenting practices, among other things.

Early Pathways. Focuses on helping caregivers better understand and manage their child's behavior and emotional problems; strengthening the child's prosocial behaviors and setting limits on challenging behaviors; and learning trauma-informed strategies to include safety, calming techniques, and recovery, among other things.

Parent-Child Interaction Therapy. Treats young children exposed to interpersonal violence. It offers concrete, practical parenting skills. The emphasis is on changing negative parent/caregiver child patterns.

Structured Psychotherapy for Adolescents Responding to Chronic Stress. Designed as a group treatment to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault).

Trauma Focused-Cognitive Behavioral Therapy. Focuses on development of skills for regulating behavior; improving relationships; and enhancing safety, trust, parenting skills, and family communication

Recent studies have also shown that trauma-informed approaches infused into the practices and work of child welfare and school staff can help children, their families, and others.

- One study that used child welfare administrative data for about 1,500 children from Kansas found that implementing a trauma-informed approach was associated with improved child well-being and placement stability for children in foster care.[92]
- Another study of two public child welfare agencies that involved 52 children, as well as child welfare staff, mental health providers, and foster parents and kinship

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[91] GAO summaries from National Child Traumatic Stress Network fact sheets. <https://www.gao.gov/assets/700/698684.pdf>
[92] K. Murphy, K. Anderson Moore, Z. Redd, K. Malm, "Trauma-Informed Child Welfare Systems and Children's Well-Being: A longitudinal Evaluation of KVC's Bridging the Way Home Initiative," Children and Youth Services Review, 75. 2017: 23–34.

caregivers, suggests, among other things, that fewer children exited foster homes for negative reasons, such as running away or moving to a group home, when families were trained in a trauma-informed approach.[93]

- A study of 126 female youths residing in two treatment centers in Massachusetts suggests that the youth at the center receiving the trauma-informed approach experienced a reduction in post-traumatic stress disorder symptoms compared with the youth in the residential center that did not offer this approach.[94]

- A study of five schools that adopted a trauma-sensitive approach also reported positive outcomes. For example, the study found a decrease in disciplinary actions, and staff at one school reported that the school felt safer and calmer. School staff also reported improved relations among colleagues and with students, as well as better relations between students and increased parent engagement.[95]

[93] Jessica Dym Bartlett, Berenice Rushovich, Martha Beltz, Esther Gross, and Ann Schindler, *Child Trends, Evaluation of the Implementation of Trauma Systems Therapy-Foster Care in a Public Child Welfare Setting* (Nov. 17, 2017).

[94] T H. B. Hodgdon, K. Kinniburgh, D. Gabowitz, M. E. Blaustein, and J. Spinazzola, "Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework," *Journal of Family Violence*, vol. 28 (2013): 679–692.

[95] Wehmah Jones, Juliette Berg, and David Osher, *Trauma and Learning Policy Initiative (TLPI): Trauma-Sensitive Schools Descriptive Study* (Washington, D.C.: American Institutes for Research, October 2018).

E X A M P L E

TRAUMA POLICY

PURPOSE STATEMENT
The purpose of this policy is to address the trauma in the lives of the children and families served by _____. The policy is promulgated to promote the understanding of trauma and its impact, ensure the development of a trauma informed system and the availability of trauma specific services for (whom).

Purpose statement should include who is impacted by the policy.

DEFINITIONS
Trauma is defined as:
> *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 threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[1]*

Other definitions as applicable for the organization (e.g., secondary trauma, trauma-specific services, trauma-informed services, etc.)

POLICY (Example)
It is the policy of (organization) that (who) shall develop a trauma-informed system for all (population) and shall ensure that the following elements are provided:

I.   *Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.*

II.   *Engagement in organizational self-assessment of trauma informed care*

III.   *Adoption of approaches that prevent and address secondary trauma of staff*

IV.   *Screening for trauma exposure and related symptoms for (whom)*

V.   *Trauma-specific assessment for (whom)*

VI.   *Trauma-specific services for (whom) using evidence based practice(s) (EBPs); or evidence informed practice(s) are provided in addition to EBPs*

VII.   *(who) shall join with community organizations to support the development of a trauma informed community that promotes healthy development of children and reduces the likelihood of adverse childhood experiences.[2] [3]*

Other policy statements?

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[1] Substance Abuse Mental Health Services Administration (SAMHSA), http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx
[2] Substance Abuse and Mental Health Services Administration, Leading Change: SAMHSA's Role and Actions 2011-2012.
[3] SAMHSA's Initiatives, Preventing Substance Abuse and Mental Illness, 2010.

STANDARDS

To ensure a trauma informed behavioral health system, standards have been developed and are required to meet the stated policy.

	Policy		Standards - Requirements
I.	*Adoption of trauma informed Culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.*	*(a.)*	*The (organization) develops and supports a committee to include representatives from (what) services and consumers. The committee's primary focus is to ensure the building and maintaining of trauma informed care within the (organization).*
		(b.)	*The (organization) shall ensure that all staff, including direct care staff, is trained/has ongoing training in trauma informed care.*
			Training needs to be updated on a regular basis due to changes in the research and/or evidence based approaches. Staff trained in trauma informed care should (1.) understand what trauma is and the principles of trauma informed care; (2.) know the impact of trauma on a child's life; (3.) know strategies to mitigate the impact of the trauma(s); and (4) understand re-traumatization and its impact.
		(c.)	*Policies and procedures shall ensure a trauma informed system of care is supported and that the policies address trauma issues, re-traumatization and secondary trauma of staff.*
		(d.)	*The (organization) shall address trauma informed principles hiring practices and staff performance reviews (i.e., interview questions include trauma related questions, etc.).[4]*
II.	*Engagement in organizational self-assessment of trauma informed care*	*(a.)*	*The (organization) conducts an organizational self-assessment to evaluate the extent to which current organization's policies are trauma-informed, identify organizational strengths and barriers, including an environmental scan to ensure that the environment does not re-traumatize.*
			The self-assessment is updated every three (3) years.
		(b.)	*The (organization) shall conduct self-assessment and their self-assessment is updated every three (3) years.*
III.	*Adoption of approaches that prevent and address*	*(a.)*	*The (organization) shall adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to:* • *Opportunity for supervision* • *Trauma-specific incident debriefing*

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[4] Fallot, PhD, Roger, Harris, PhD, Maxine. *Creating Cultures of Trauma Informed Care*. Community Connections, Inc., March 2009. Page 59.

	Policy	Standards - Requirements
	Secondary Trauma of staff	• *Training* • *Self-care* • *Other organizational support (e.g., employee assistance program).*
IV.	***Screening for trauma exposure and related symptoms for each population***	*(a.)* *(Organization) shall use a culturally competent, standardized and validated screening tool appropriate for (whom) during the intake process and other points as appropriate.* *Examples of standardized, validated screening tools are provided on the www.michigan.gov/traumatoxicstress website*
V.	***Trauma-specific assessment for each population***	*(a.)* *(Organization) uses a culturally competent, standardized and validated assessment instrument appropriate for (whom). Trauma assessment is administered based on the outcome of the trauma screening.* *Examples of standardized, validated assessment tools are provided on the www.michigan.gov/traumatoxicstress website*
VI.	***Trauma-specific services for (whom) using evidence based practice(s) (EBPs) or evidence informed practice(s) are provided in addition to EBPs***	*(a.)* *The (organization) shall use evidence based trauma specific services for (whom) in sufficient capacity to meet the need. The services are delivered within a trauma informed environment.* *Examples of trauma specific services are provided on the www.michigan.gov/traumatoxicstress website*
VII.	***(Organization) shall join with other community organizations to support the development of a trauma informed community that promotes healthy development and reduces the likelihood of adverse childhood experiences.***	*(a.)* *(Organization) shall join with community organizations, agencies, faith-based organizations, community collaboratives (i.e, MPCBs) and coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma informed community that promotes healthy environments for children, adults and their families.* *(b.)* *Substance abuse prevention programming is provided using a SAMHSA approved, evidence based and trauma informed approach.*

Federal Support for Trauma-Informed Work

Federal Legislation

Early in 2018, the U.S. House of Representatives passed US House Resolution 443[96] that placed needed emphasis and recognition on the critical need for trauma-informed care in existing federal mental health agencies.[97] The resolution encourages agencies to infuse this approach in to their work and advocates that a trauma-informed approach is "a principle-based, culture-change process aimed at recognizing strengths and resiliency as well as helping people who have experienced trauma to overcome those issues in order to lead healthy and positive lives."

Also in 2018, the Senate passed its own resolution—Senate Resolution 364.[98] The Senate, like the House of Representatives acknowledged that traumas including poverty, violence, natural disaster, adverse childhood experiences and toxic stress are having crippling effects on the individuals nationally. Having federal governing bodies acknowledge the need for a shift in mental health care is as a strong base from which providers and policymakers alike can access their resources and structure and begin to consistent, well-resourced and encompassing best practices.

SAMHSA - Mental Health and Substance Abuse Services

Public health programs for vulnerable youth are concentrated in HHS, ACF and SAMHSA. These programs address youth mental health, substance abuse, teen pregnancy prevention, and support for pregnant and parenting teens.

SAMHSA is organized into four centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Behavioral Health Statistics and Quality (CBHSQ). Collectively, three of the centers administer approximately 13 programs (not all discussed here or in Table A-1) for youth ages 10 to 21 (and up to 25 for some programs). The programs primarily target youth with serious emotional disturbances (SED) and youth at risk of abusing drugs and alcohol.

- CMHS. Youth-focused suicide prevention activities are funded by SAMHSA's Garrett Lee Smith (GLS) Campus Suicide Prevention Grant Program and GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program. The campus grant program funds services for all students (including those with mental health problems and substance abuse that makes them vulnerable to suicide), while the state/tribal program supports statewide and tribal activities to develop and implement youth suicide prevention and intervention strategies.

- The Children's Mental Health Services program supports community-based systems of care for children and adolescents with serious emotional disturbances and their families. The program aims to ensure that services are provided collaboratively across youth-serving systems (such as schools and foster care

[96] https://www.congress.gov/115/bills/hres443/BILLS-115hres443eh.pdf
[97] https://www.networkforphl.org/the_network_blog/2018/09/27/1034/congress_points_to_local_communities_adopting_trauma_informed_approaches
[98] https://www.congress.gov/115/bills/sres346/BILLS-115sres346ats.pdf

placements) and that each youth receives an individual service plan developed with the participation of the family (and, where appropriate, the youth) to meet the mental health needs of that youth. A second program, the National Child Traumatic Stress Network, was created to establish a national network that provides services and referrals for children and adolescents who have experienced traumatic events.

- CSAT. The Juvenile Treatment Drug Courts provide treatment for youth who are drug dependent. This program targets juvenile offenders (preadjudicated or adjudicated status, or postdetention), and provides substance abuse treatment, wrap-around services supporting substance abuse treatment, and case management. A judge oversees the drug treatment program and may allow the youth to avoid (further) penalties for their delinquent behavior.
- CSAP. The Strategic Prevention Framework grants

address underage drinking (among those aged 12 to 20) and prescription drug misuse and abuse (among those aged 12 to 25). These grants are intended to prevent the onset and reduce the progression of substance abuse by incorporating SAMSHA's Strategic Prevention Framework, which emphasizes strategic planning and the implementation of evidence-based prevention. The grants support implementation of a five-step process: (1) conduct a community needs assessment; (2) mobilize and/or build capacity; (3) develop a comprehensive strategic plan; (4) implement evidence-based prevention programs and infrastructure development activities; and (5) monitor process and evaluate effectiveness. CSAP also administers, in cooperation with the White House Office of National Drug Control Policy, the "Drug-Free Communities Support Program."

Community Programming

Local Coordination Grant Program Expands upon SAMHSA's Mental Health Programs of Regional and National Significance by supporting the development of local coordinating and action bodies that help prevent and mitigate the community impacts of trauma by bringing together stakeholders in communities facing high levels of trauma/violence/addiction to identify needs, collect data, build skills and awareness, and develop a strategic community plan. Provides priority grant considerations for communities with high rates of drug overdose and violence. Expands existing authorization by $50 million over 4 years.

Performance Partnership Pilot Creates flexibility for local, state, and tribal entities to pool federal grants from multiple agencies and focus the funding on increasing trauma-informed services for a high-risk population that often receives services across

multiple programs (e.g. Chicago has received funding to braid Head Start and Workforce Innovation and Opportunity Act (WIOA) funding to target at-risk young mothers). This builds on the existing Performance Partnership Pilot focused on "disconnected youth ages 14-24" to now also support younger children and families that have experienced trauma.

Enhancing AmeriCorps Recruitment and Programming Under the Corporation for National and Community Services (CNCS), creates a priority focus of both expanding recruitment from communities facing high levels of trauma/violence/addiction, and prioritizing partnerships with community-based organizations with expertise in addressing such challenges in those communities to enhance service delivery.

Hospital-Based Interventions to Reduce Readmissions Too often, after a patient presents at a hospital after overdosing, attempting suicide, or suffering violent injury, their physical wounds are treated and they are simply discharged without any care management plans—which can result in subsequent re-injury or overdose. Establishes a grant program at the Agency for Healthcare Research and Quality (AHRQ) to test and evaluate hospital-based trauma interventions for patients who present with addiction/suicide attempts/violent injuries to provide counseling services and case management—while someone is in the hands of a health professional—to prevent hospital readmission and improve outcomes.

Expanding Arts Therapy Opportunities Expands existing programs to allow the National Endowment for the Arts to make grants or loans for projects that provide trauma-informed arts opportunities and interventions.

Mental Health Coverage Parity for Infant, Early Childhood, and Youth Services Despite federal requirements and broad coverage eligibility for mental health services, too few children are able to access mental health benefits due to hurdles imposed by insurance companies. Ensures fair treatment, adequate payments, and equitable access to mental health services by providing grants to states to establish guidelines and enforce compliance with parity requirements by health insurance companies.

Streamlining and Coordinating Trauma Funding Building off provisions in the SUPPORT for Patients and Communities Act to create a federal Interagency Task Force on Trauma-Informed Care, directs the Office of Management and Budget to align measurement, reporting, data sharing, and eligibility requirements across relevant federal grant programs to better address trauma.

Measuring Savings from Trauma Interventions Building off provisions in the SUPPORT for Patients and Communities Act to create a federal Interagency Task Force on Trauma-Informed Care, directs the Office of Management and Budget to identify and evaluate trauma-informed interventions and best practices that hold the most promise to reduce long-term costs and estimate the 20-year savings to the federal government for effective implementation of those programs.

The Creating Trauma-Sensitive Schools Conference Led by the nonprofit Attachment and Trauma Network, Inc., this conference grew from 550 attendees in 2018 to 1,200 in 2019, with every state represented at this year's gathering. Cole's group, the Trauma and Learning Policy Initiative, emails guidance on helping traumatized children learn to more than 35,000 teachers and parents across the country and as far away as Pakistan.

Workforce Development & Skills-Building for Professionals

Health Professions Training

Amends HRSA's (Health Resources and Services Administration) Health Professions Training for Diversity Programs (including Scholarships for Disadvantaged Students; Area Health Education Centers Program) to place emphasis on recruitment from communities that have experienced high levels of trauma/violence/addiction.

Increase Authorization to National Health Services Corps (NHSC) due to expanded Eligibility

Building off a provision in the SUPPORT for Patients and Communities Act to add school-based health clinics and certain community locations as eligible settings, authorizes a funding increase for HRSA's National Health Service Corps loan repayment program to enable more behavioral health providers to serve in under-served communities.

Building Infant and Early Childhood Clinical Workforce Leadership

Modeled off of HRSA's LEND program, expands programming within the Maternal and Child Health Bureau to establish statewide training institutes and centers of excellence for infant and early childhood clinical mental health professionals.

Pre-Service Training for Teachers

Improves pre-service training programs to prepare educators to work with students who have experienced trauma by expanding the teacher quality partnership grants under the Higher Education Act to include incentives for curricula focused on building trauma skills related to identification, support, interventions, and discipline.

Tools for Front-line Providers

Directs CDC/SAMHSA to develop toolkits for front-line service providers (e.g., teachers, mentors, faith leaders, kinship caregivers) on identifying and supporting children who have experienced trauma (similar to CDC Guideline for Opioid Prescribing).

Codifying Children Exposed to Violence Initiative

Codifies DOJ's Children Exposed to Violence (CEV) Initiative, which helps prevent violence and support trauma recovery by promoting the awareness and coping skills to support the 2/3 of children who witness or are victims of violence. This program has resulted in the development of the Changing Minds awareness campaign and technical assistance to states to help improve systems and policies to become trauma-informed.

Law Enforcement Coordinating Center Creates

a law enforcement coordinating center under DOJ that will assist law enforcement agencies in sharing information on trauma-informed best practices, improving awareness of child trauma, and training officers on how to interact with children and families with mental illness or who have experienced trauma, including witnessing community violence or overdose. Authorizes at $8M annually for 5 years.

NIH (National Institutes of Health) Study on Trauma

Directs the NIH to study and report on its trauma research agenda, gaps in understanding of trauma, ways to improve coordination, and the effectiveness of existing trauma interventions.

Selected Federal Funding Sources Used to Support Children Affected by Trauma as Cited by Selected State Officials

FEDERAL FUNDING SOURCES	CO	MA	NC	OH	WA	WI
Department of Health and Human Services						
Discretionary Grants						
Administration for Children and Families trauma grants	–	✓	✓	–	✓	–
Mental Health Transformation Grants	–	–	–	✓	✓	–
National Child Traumatic Stress Initiative Grants	–	–	✓	–	–	✓
Project Advancing Wellness and Resilience Education (Project AWARE) Grants	✓	–	✓	✓	✓	✓
Safe Schools, Healthy Students Initiative Grants	–	–	–	–	–	✓
System of Care Expansion Planning Grants	✓	–	–	✓	–	–
Formula Funds						
Medicaid	✓	✓	✓	✓	✓	✓
State Opioid Response Grants	–	–	–	✓	–	–
State Targeted Response to the Opioid Crisis Grants	–	–	–	✓	–	–
Social Services Block Grants	–	–	✓	–	✓	–
Substance Abuse and Mental Health Block Grants	–	–	–		–	
Temporary Assistance for Needy Families	–	–	✓	–	✓	–
Title IV-B of the Social Security Act	–	–	✓	✓	✓	✓
Title IV-E of the Social Security Act	✓	–	✓	✓	✓	✓
Department of Education						
Discretionary grants						
State Personnel Development Grants	✓	–	–	–	–	–
School Climate Transformation Grants	–	–	–	–	–	
Formula funds						
Title I-A of Elementary and Secondary Education Act	–	–	–	–	✓	–

The Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (Substance Abuse and Mental Health Block Grants) provide funds and technical assistance for substance abuse and mental health services. These grants are administered by SAMHSA and authorized under the Public Health Service Act. See 42 U.S.C. § 300x et seq.

- The ACF's Children's Bureau awarded trauma-focused discretionary grants across three cohorts from 2011 to 2013.
- Launched in 1999 as a joint program of the Departments of Education, Health and Human Services, and Justice, the Safe Students, Healthy Schools Initiative has awarded grants to school districts to prevent youth violence and promote healthy development of youth.
- System of Care Expansion Planning Grants are administered by SAMHSA and intended to facilitate adoption of a system of care approach for children and youth with serious emotional disturbances. SAMHSA has not awarded these grants since 2014, according to officials.

- Although the Massachusetts and Wisconsin officials who completed our questionnaire did not mention Medicaid as a source of funding to support children affected by trauma, under the Medicaid program, states are required to provide eligible children under age 21 with coverage for certain health services, which may include mental health services, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, state child welfare officials we interviewed in both of these states talked about using Medicaid to support children affected by trauma. For example, the Wisconsin Department of Health Services and the Department of Children and Families partnered to implement Care4Kids, a program designed to offer comprehensive and coordinated health services for children in foster care. The Care4Kids program creates a "medical home" team for children in foster care, assuring that children receive individualized treatment plans in order to address their specific health care needs, including trauma-related

care.
- State Opioid Response Grants are administered by SAMHSA and aim to address the opioid crisis by increasing provision of prevention, treatment, and recovery activities for opioid use disorder.
- State Targeted Response to the Opioid Crisis Grants are administered by SAMHSA and aim to address the opioid crisis by increasing provision of prevention, treatment, and recovery activities for opioid use disorder.
- Social Services Block Grant goals include, among others, preventing or remedying child abuse and neglect, preventing or reducing inappropriate institutional care, and achieving or maintaining self-sufficiency. Temporary Assistance for Needy Families is a block grant that supports four overarching goals, including providing assistance to needy families so that children can live in their homes or the homes of relatives.
- Title IV-B of the Social Security Act authorizes federal funds to support state child welfare programs and services. In addition to formula grants under the Stephanie Tubbs Jones Child

Welfare Services program and the Promoting Safe and Stable Families program, Title IV-B also authorizes some discretionary grants.

- The Individuals with Disabilities Education Act authorizes federal funds for the State Personnel Development Grants program. The program provides grants to help state educational agencies reform and improve their training and professional development systems for individuals who serve children with disabilities.

- Title I-A of the Elementary and Secondary Education Act of 1965, as amended, provides formula grants to states for their school districts to improve educational programs in schools with high concentrations of students from low-income families.

- Title IV-A of the Elementary and Secondary Education Act of 1965, as amended by the Every Student Succeeds Act, authorizes the Student Support and Academic Enrichment program, which is intended to increase the capacity of state and local education agencies, schools, and local communities to provide all students with a well-rounded education and to improve school conditions and the use of technology.

Federal Children/ Youth Oriented Legislation/ Agencies/Programs

Current federal youth policy has resulted from the piecemeal creation of programs across several areas of social policy. Federal youth policy today also includes recent initiatives to promote positive youth development and increase coordination between federal agencies that administer youth-focused programs. As enacted, the programs are intended to provide vulnerable youth with the opportunities to develop skills and abilities that will assist them in adolescence and during the transition to adulthood.

Congress has allocated funding to these programs for a number of services and activities, including conflict resolution; counseling; crime/violence prevention; gang intervention; job training assistance; mentoring; parental/family intervention; planning and program development; and research and evaluation. The programs differ in size, scope, and funding authorization levels and type (mandatory vs. discretionary).

The list is not exhaustive and may omit programs that serve the targeted youth population. The following sections briefly discuss selected programs under six policy areas—job training and workforce development, education, juvenile justice and delinquency prevention, social services, public health, and national and community service

Job Training and Workforce Development

The federal government funds four major job training and workforce development programs for youth: Job Corps, Youth Activities, YouthBuild, and Youth Conservation Corps. These programs (except for the Youth Conservation Corps) are administered by the Department of Labor (DOL) and target low-income youth ages 14 (or 16) to 24 who require additional assistance in meeting their vocational goals.

The Workforce Innovation and Opportunity Act (WIOA, P.L. 113-128) authorizes the DOL programs through FY2020. The Youth Activities programs fund employment training and academic support services for both in-school youth ages 14 to 21 and out-of-school youth ages 16 to 24. In-school youth includes those who are attending school, low-income, and have a specified barrier to employment. Out-of-school youth includes those who meet certain criteria such as being a high school dropout or being low-income. No less than 75% of funds may be used to serve out-of-school youth.

Job Corps has centers in all 50 states and Puerto Rico where youth live and receive training. Program training consists of career preparation, development, and transition; academic initiatives; and character building.

Created by the Cranston-Gonzalez National Affordable Housing Act of 1992 (P.L. 101-625) and currently authorized under WIOA, YouthBuild has many of the same educational and vocational objectives as those established under the Job Corps and Youth Activities programs. YouthBuild participants ages 16 to 24 work toward their GED or high school diploma while learning job skills by building affordable housing. Finally, the Youth Conservation Corps, established in 1970 by the Youth Conservation Corps Act (P.L. 91-378) and administered by the Departments of Agriculture and the Interior, targets youth ages 15 to 18 of all backgrounds to work on projects that conserve natural resources.

Education

Most federal education programs for vulnerable youth are authorized by the Elementary and Secondary Education Act (ESEA) of 1965 and the Higher Education Act (HEA) of 1965, and administered by the U.S. Department of Education (ED). The ESEA provides the primary source of federal funds to K-12 education programs, with the largest program being Title I-A. The purpose of the Title I-A program, from its original enactment in 1965 to the present, is, in part, to provide supplementary educational and related services to educationally disadvantaged children who attend schools serving relatively low-income areas. The Higher Education Act is the source of grant, loan, and work-study assistance to help meet the costs of postsecondary education. The act also supports programs by providing incentives and services to disadvantaged youth to help increase their secondary or postsecondary educational attainment. Separate legislation authorizes additional education programs serving youth with disabilities and homeless youth.

Programs Authorized by Title I of the ESEA

- Title I of ESEA provides most of the funding for programs that serve disadvantaged youth, and was most recently reauthorized and amended by the Every Student Succeeds Act (P.L. 114-95). Title I-A (Local Educational Agency Grants) is the largest federal elementary and secondary education program.55 Title I-A grants fund supplementary educational and related services to low-achieving and other students attending pre-kindergarten through grade 12 schools with relatively high concentrations of students from low-income families. Title I-A also directs state education agencies (SEAs) and local education agencies (LEAs) to support the enrollment, attendance, and success of homeless children and youth. Title I-C (Education of Migratory Children) provides formula grants to state education agencies (SEAs) for the development of programs targeted to migrant students, and Title I-D (Neglected, Delinquent, or At Risk Children and Youth) gives funding to LEAs and SEAs to meet the special educational needs of youth in institutions and correctional facilities for neglected and delinquent youth, as well as youth at risk of dropping out.

Other ESEA Programs

Titles III and IV of the ESEA also target disadvantaged youth. Title III (Language Instruction for English Learners and Immigrant Students) provides grant funding to states to ensure that limited English proficient (LEP) children and youth, including immigrant children and youth, attain English proficiency. Title IV-B (21st Century Community Learning Centers) provides funding to LEAs for academic and other after-school programs. The purpose of the program is to provide opportunities for academic enrichment, offer students a broad array of additional services, and offer families of served students opportunities for active and meaningful engagement with their children's education.

Programs Authorized Under HEA

The Higher Education Act (P.L. 89-329) authorizes a few programs targeted to vulnerable youth. The primary programs are TRIO, GEAR UP, and the Migrant High School Equivalency program.

- **TRIO Programs** The five programs that make up TRIO are designed to assist students from disadvantaged backgrounds to pursue higher education and to complete their postsecondary studies. These programs are Talent Search, Upward Bound, Educational Opportunity Centers, Student Support Services, and Ronald E. McNair Postbaccalaureate Achievement. Each of these programs is designed to intervene at various points along the education continuum.

- **Talent Search**, authorized under the original HEA legislation, encourages youth who have completed at least five years of elementary education to complete high school and enter postsecondary education; to encourage dropouts to reenter school; and to disseminate information about available postsecondary educational assistance. Upward Bound projects seek to motivate middle school and high school students and veterans to complete secondary education and succeed in postsecondary education through instruction and counseling, among other activities.

- **Educational Opportunity Centers** provide information to prospective postsecondary students regarding available financial aid and academic assistance, and help them apply to college. Student Support Services projects are intended to improve college students' retention and graduation rates, and improve transfer rates from two-year to four-year colleges through instruction; exposure to career options; mentoring; and assistance in graduate admissions and financial aid processes. Finally, the Robert E. McNair Postbaccalaureate Achievement program prepares disadvantaged students for postdoctoral study through seminars, research opportunities, summer internships, tutoring, mentoring, and exposure to cultural events and academic programs.

- **GEAR UP.** Gaining Early Awareness and Readiness for Undergraduate Program (GEAR UP), a program not part of the TRIO array of programs, was added to the HEA by the Higher Education Act Amendments of 1998 (P.L. 105-244). GEAR UP seeks to increase disadvantaged students' secondary school completion and postsecondary enrollment by providing support services. GEAR UP differs from Trio in two key aspects: the program (1) may serve a cohort of students from seventh grade to their first year of college and (2) may assure students of the availability of financial aid to meet college costs. States or partnerships (schools and at least two other entities, such as community organizations and state agencies) are eligible for funding. Any funded state or partnership must provide comprehensive mentoring, tutoring, counseling, outreach, and support services to participating students.

Special Programs for Students Whose Families Are Engaged in Migrant and Seasonal Farmwork.

This program, authorized under HEA, funds institutions of higher education (or private nonprofits in cooperation with institutions of higher education) to recruit and provide academic and support services to individuals who lack a high school diploma and who are or whose parents are engaged in migrant and other seasonal farm work. The purpose of the program is to assist students to obtain a high school equivalency diploma and gain employment, or to attend college or another postsecondary education or training program.

Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) is the major statute that provides federal funding for the education of children and youth with disabilities. Part B of the act includes provisions for the education of school-aged children. As a condition for the receipt of funds states must provide "free appropriate public education" to youth as old as 21. (age may vary depending on state law). This term refers to the right of all children with disabilities to receive an education and related services that meet state curriculum requirements, at no costs to parents. Appropriateness

is defined according to the child's individualized education program (IEP) which delineates the special instruction the child should receive and his or her educational goals.

Education of Homeless Children and Youths Program

The McKinney-Vento Act (P.L. 100-77), as amended by the Every Student Succeeds Act (P.L. 114-95), authorizes the Department of Education to fund local education agencies (LEAs) to provide homeless children and youth comparable education services. LEAs must assist in determining the school that is in the best interest for a child or youth to attend, and implement policies that remove barriers from these students in attending school.

Youth ChalleNGe Program

The Youth ChalleNGe Program is a quasi-military training program administered by the Army National Guard to improve outcomes for youth who have dropped out of school or have been expelled. The program was established as a pilot program under the National Defense Authorization Act for FY1993 (P.L. 102-484), and Congress permanently authorized the program under the National Defense Authorization Act for FY1998 (P.L. 105-85). Currently, 35 programs operate in 28 states, the District of Columbia, and

Puerto Rico. Youth are eligible for the program if they are ages 16 to 18 and enroll prior to their 19th birthday; have dropped out of school or been expelled; are unemployed; are not currently on parole or probation for anything other than juvenile status offenses and not serving time or awaiting sentencing; and are drug free. The program consists of three phases: a two-week pre-program residential phase where applicants are assessed to determine their potential for completing the program; a 20-week residential phase; and a 12-month post-residential phase. During the residential phase, youth—known as cadets— work toward their high school diploma or GED and develop life-coping, job, and leadership skills. They also participate in activities to improve their physical well-being, and they engage in community service.60

Juvenile Justice and Delinquency Prevention

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the Department of Justice (DOJ) coordinates federal activities and administers programs relating to the treatment of juvenile offenders and the prevention of juvenile delinquency. These programs include those enacted under the Juvenile Justice and Delinquency Prevention Act of 1974.

Juvenile Justice and Delinquency Prevention Act

The Juvenile Justice and Delinquency Prevention Act (JJDPA) was first enacted in 1974 (P.L. 90- 415) and was most recently reauthorized in 2002 by the 21st Century Department of Justice Appropriations Authorization Act (P.L. 107-273). Its provisions were authorized through FY2007 and FY2008. The JJDPA as originally enacted had three main components: it created a set of institutions within the federal government that were dedicated to coordinating and administering federal juvenile justice efforts; it established grant programs to assist the states with setting up and running their juvenile justice systems; and it promulgated core mandates that states had to adhere to in order to be eligible to receive grant funding. While the JJDPA has been amended several times since 1974, it continues to feature the same three components. While the JJDPA contains a number of major grants, those currently funded include State Formula Grants, the Juvenile Mentoring Program, and Title V Community Prevention Block Grants.

The JJDPA authorizes OJJDP to make State Formula Grants to states that can be used to fund the planning, establishment, operation, coordination, and evaluation of projects for the development of more effective juvenile delinquency programs and improved juvenile justice systems. The Juvenile Mentoring Program was repealed in 2002 by the 21st Century Department of Justice Reauthorization Act (P.L. 107-273); however, it has continued to receive appropriations each subsequent fiscal year.62 These grants could be awarded to local educational agencies (in partnership with public or private agencies) to establish and support mentoring programs. The Title V Community Prevention Block Grant program authorizes OJJDP to make grants to states, that are then transmitted to units of local government, in order to carry out delinquency prevention programs for juveniles who have come into contact with, or are likely to come into contact with, the juvenile justice system.

Social Services

The major social service programs to assist at-risk youth are authorized under the Social Security Act, as amended, and are administered by the U.S. Department of Health and Human Services.

Foster Care Program and Chafee Foster Care Independence Program (CFCIP)

Title IV-E of the Social Security Act authorizes the federal foster care program.64 Under this program, a state, territory, or tribe may seek federal funds for partial reimbursement of the room and board costs needed to support eligible children who are neglected, abused, or who, for some other reason, cannot remain in their own homes. To be eligible for Title IV-E, a child must be in the care and responsibility of the state and (1) the child must meet income/assets tests and family structure rules in the home he/she was removed from;65 (2) have specific judicial determinations made related to reasons for the removal and other aspects of his/her removal and placement; and (3) be placed in an eligible licensed setting with an eligible provider(s).

Foster youth who reach the "age of majority" (18 years in most states) and who have not been reunited with their parents or placed with adoptive parents or guardians are said to "emancipate" or "age out" of foster care. The Chafee Foster Care Independence Program (CFCIP), created in 1999 (P.L. 106-169) under Title IV-E of the Social Security Act. States, territories,

and tribes with approved plans receive CFCIP funds to provide services intended to help children who are expected to age out of foster care, those who aged out of foster care, and those who left foster care for adoption or guardianship at age 16 or older to make a successful transition to adulthood. Separately, formula funds are authorized for states, territories, and tribes to provide Education and Training Vouchers (ETVs) for CFCIP-eligible youth. ETVs are intended to cover the cost of attending institutions of higher education (e.g., colleges, universities, and job training programs). Only youth receiving a voucher at age 21 may continue to participate in the voucher program until age 23.

Runaway and Homeless Youth Program

The Runaway and Homeless Youth Program, established in 1974 under Title III of the Juvenile Justice and Delinquency Prevention Act, contains three components: the Basic Center Program (BCP), Transitional Living Program (TLP), and Street Outreach Program (SOP).66 These programs are designed to provide services to runaway and homeless youth outside of the law enforcement, juvenile justice, child welfare, and mental health systems. Services include temporary and long-term shelter, counseling services, and referrals to social service agencies, among other supports.

Teen Pregnancy Prevention and Support Programs

The U.S. Department of Health and Human Services administers research and education programs to reduce adolescent pregnancy or to provide care services for pregnant and parenting adolescents. The Title IV-E Abstinence Education Grants program provides competitive grants for abstinence education. States may request funding for the Abstinence Education Grants when they solicit Maternal and Child Health block grant funds (used for a variety of health services for women and children, including adolescent pregnancy prevention activities); this funding must be used exclusively for teaching abstinence.

National and Community Service

The Corporation for National and Community Service (CNCS) is an independent federal agency that administers programs authorized by two statutes: the National and Community Service Act (NCSA, P.L. 101-610) of 1990, as amended, and the Domestic Volunteer Service Act (DVSA, P.L. 93-113) of 1973, as amended.71 The focus of these programs is to provide public service to communities in need through multiple service activities. Although CNCS works to involve a diverse range of individuals in their programs, the agency makes particular efforts to engage disadvantaged youth, either because they enroll these youth to help to carry out the programs (i.e., members or volunteers) or provide services to them through the programs (i.e., beneficiaries). The major CNCS programs are organized into two service streams, AmeriCorps and Senior Corps.

Tom Osborne Federal Youth Coordination Act (P.L. 109-365)

In response to the concerns generally raised by the White House Task Force for Disadvantaged Youth, Congress passed the Tom Osborne Federal Youth Coordination Act (Title VIII of the Older Americans Act, P.L. 109-365), which created the Federal Youth Development Council and specified that it would be chaired by the Secretary of the U.S. Department of Health and Human Services. The Council was authorized for FY2007 and FY2008, but was not ultimately established. Funds were not appropriated for these years (or subsequent years). However, on February 7, 2008, President Bush signed Executive Order 13459 to establish an Interagency Working Group on Youth Programs, discussed in the next section, to improve coordination of youth policy.80

Child Welfare Partnerships

HHS's ACF, the agency that carries out most federal child welfare programs, has partnered with other agencies to focus on the mental health and educational needs of children in foster care. ACF is coordinating with the Centers on Medicare and Medicaid (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), both agencies at HHS, to "support effective management" of prescription medication for children in foster care, and they have called on their state counterparts to do the same.

Separately, HHS has partnered with the Department of Education (ED) in an effort to improve the educational outcomes of youth in foster care.

Shared Youth Vision Initiative

In response to the recommendations made by the Task Force for Disadvantaged Youth, the U.S. Departments of Education, Health and Human Services, Justice, and Labor partnered with the Social Security Administration to improve communication and collaboration across programs that target at-risk youth groups under an initiative called the "Shared Youth Vision." The agencies convened an Interagency Work Group and conducted regional forums in 16 states to develop and coordinate policies and research on the vulnerable youth population. Representatives from federal and state agencies in workforce development, education, social services, and juvenile justice participated in the forums. In FY2014, DOL competitively awarded grants to these states (totaling $1.6 million) for assisting them in developing strategic plans to link their systems that serve youth.

Safe Schools/Healthy Students (SS/HS) Initiative

Since FY2009, HHS, ED, and DOJ have supported the Safe Schools/Healthy Students Initiative to reduce violence and drug abuse at schools (K-12) and in communities. Local education agencies—in partnership with local law enforcement, public mental health, and juvenile justice entities—apply for SS/HS funding. The initiative has sponsored projects in schools and communities that (1) provide a safe school environment; (2) offer alcohol-, other drug-, and violence-prevention activities and early intervention for troubled students; (3) offer school and community mental health preventive and treatment intervention programs; (4) offer early childhood psychosocial and emotional development programs; (5) support and connect schools and communities; and (6) support safe-school policies.

Drug-Free Communities Support Program

The Drug-Free Communities Support Program is administered by SAMSHA and the White House Office of National Drug Control Policy (which has entered into an agreement with OJJDP to manage the program on behalf of the agency). The program awards grants to community coalitions through a competitive grant award process. The program is intended to strengthen the capacity of the coalitions to reduce substance abuse among youth (and adults) and to disseminate timely information on best practices for reducing substance abuse.

State/City Support for Trauma-Informed Work

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Below is a summary of approved laws and resolutions passed in the 50 states, the District of Columbia, and the territories, by legislatures addressing budgets, job growth, health care, immigration, the opioid epidemic, police-community relations, education and others. These actions encourage trauma-informed policies in one or more sectors such as education, criminal justice, or healthcare.

Arizona

Ariz. Rev. Stat. § 8-471: D. The department, in coordination with the Arizona peace officer standards and training board, shall provide child welfare investigators with training. The training shall be, at a minimum, in the following areas: Impact and intervention practices related to adverse childhood experiences, culturally and linguistically appropriate service delivery, domestic violence, family engagement, communication with special populations and trauma informed responses.

Ariz. Rev. Stat. § 8-802: D. All child safety workers shall be trained and demonstrate competency in: Impact and intervention practices related to adverse childhood experiences, culturally and linguistically appropriate service delivery, domestic violence, family engagement, communication with special populations and trauma informed responses.

California

California ACR No. 155 Approved August 18, 2014
"This measure would urge the Governor to identify evidence-based solutions to reduce children's exposure to adverse childhood experiences, address the impacts of those experiences, and invest in preventive health care and mental health and wellness interventions."

Dr. Nadine Burke Harris, a pediatrician appointed California's first surgeon general in January 20__, has identified adversity as America's "greatest unrecognized public health crisis." Starting in 2020, California will screen all children and adults on Medicaid for ACEs.

The city of San Francisco's Department of Public Health's Trauma Informed System Initiative (TIS)[99] provides the critical information necessary for planning and delivery, accountability, resource allocation, and decision making.

The system was used to create a regional trauma-informed Bay Area system of care and improving the ways they understand, respond to and heal trauma. One product of that system is Trauma Transformed, A program of East Bay Agency for Children. The vision for Trauma Transformed[100] began with acknowledging that trauma is pervasive and impacts the health and wellness of Bay Area children, youth and families who rely on our regional public health systems. In response, seven counties — Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara and Santa Cruz — envisioned breaking down silos, coordinating and communicating more effectively across sectors and county lines through a Bay Area Trauma Informed Systems of Care Initiative (BATISC).

Colorado

Trauma Informed System of Care (known as COACT Colorado) Uses an evidence-based and collaborative approach to help families of children and youth with complex needs involved in multiple systems in 17 counties throughout the state. Agencies involved with this initiative include child welfare, juvenile justice, and education. Dedicated staff exists to assist families and provide them with support as children receive services.

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[99] https://www.sfdph.org/dph/hc/HCAgen/HCAgen2016/April%2019/TISFirstYearDataReport.pdf
[100] http://traumatransformed.org/about/

<u>Positive Behavioral Interventions and Supports and Multi-Tiered System of Supports</u>
Encourages the use of Positive Behavioral Interventions and Supports and Multi-Tiered System of Supports as prevention frameworks for improving the outcomes of all students. This occurs through partnerships with families, schools, and communities. It also uses multiple evidence- based practices at the classroom, school, district, region, and state levels.

<u>Boulder County, CO: Integrated Managed Partnership for Adolescent and Child Community Treatment</u>
Consisting of 11 public agencies and nonprofit organizations, including the Boulder Valley School District and a nonprofit organization that provides mental health services, this initiative is an interagency collaborative partnership. The group provides case coordination and ensures participating agencies and organizations have consistent practices and processes for children involved in multiple systems. Services, such as trauma-focused, evidence-based therapies and mentoring for youth in the juvenile justice system, are also available through this effort.

Florida
Chapter 2015-79, Committee Substitute for SB No. 7078

Enacted March 21, 2015
This is a Florida Law to require community-based organizations that provide child protective services for the state to "give priority to the use of services that are evidence-based and trauma-informed."

In Tarpon Springs, Florida, the city crafted a community effort to gather city officials, professionals, and residents to coordinate multiple trauma-informed activities. Multi-sector collaboration is supported by a MOU.

Illinois
Illinois SB 565, Public Act 99-0927 Signed by Governor on January 20, 2017
Legislation to require social and emotional screenings for children as part of the their school entry examinations. https://www.acesconnection.com/...-health-examinations

The University of Illinois at Chicago School of Medicine Comprehensive Assessment and Response Training System improves the quality of psychiatric services provided to youth in foster care, and the University of Chicago Recovery & Empowerment After Community Trauma Initiative supports residents who are coping with community violence.

Kansas City
In Kansas City, schools, including preschools, worked through the Trauma Smart initiative to become trauma-informed communities by providing education and support to children, teachers, and parents. Trauma Smart was created in 2008 by Crittenton Children's Center, a non-profit organization based in Kansas City, Missouri. The purpose of Trauma Smart® (TS)[101] is to help educational organizations (agency) create trauma informed communities that support the needs of young children who have experienced trauma and the caregivers (parents, staff) who love and care for them. TS also helps organizations create environments that support the development of resiliency skills for all students served. Multiple research studies show that early identification and treatment helps mitigate the long-term negative physical and mental health effects of trauma and develops resiliency. Agencies served by TS to date show that approximately 92% of children referred for individual treatment have experienced 1 traumatic event; and 69% of children have experienced 3 or more traumatic events. Research shows that early identification and treatment of children who have experienced trauma helps mitigate these factors.

[101] http://traumasmart.org/uploads/2018-Administrators-Guidebook.pdf

Massachusetts

Child Trauma Project

Provided a series of training and activities organized throughout the state that expanded on inter-agency collaboration to support children affected by trauma. It also created leadership teams focused on trauma in all of Massachusetts' child welfare offices. In addition, it trained clinicians in three trauma-focused, evidence-based therapies, including Trauma- Focused Cognitive Behavioral Therapy.

The Safe and Supportive Schools Grant Program

Helps school districts ensure that a school creates a safe, positive, healthy and inclusive learning environment. This state-funded grant program also makes sure there is use of a system for integrating services and aligning initiatives that promote, among other things:

- Students' behavioral health, including social and emotional learning, and trauma sensitivity
- Children's mental health
- Positive behavioral approaches that reduce suspensions and expulsions

Plymouth County, MA: Brockton Public Schools

Creating trauma-sensitive schools has been Brockton Public Schools' focus. Among other things, the schools create safe and supportive environments by enhancing relationships with students and ensuring educators are aware of students' behavior, according to this same official. In addition, Brockton Public Schools collaborates with the county district attorney's office on two trauma-focused initiatives—the Childhood Trauma Initiative and Handle With Care. The Childhood Trauma Initiative trains educators and law enforcement, among others, about trauma's effects on children's development. Handle With Care allows police officers or caregivers to notify a school that a child may have experienced a traumatic event.

Massachusetts Safe and Supportive Schools No. 4376

Signed by the Governor August 13, 2014, this provision establish a statewide "safe and supportive schools framework" to assist schools to create safe and supportive learning environments "that improve educational outcomes for students." This includes preventive and intensive services and supports depending on students' needs. The Trauma and Learning Policy Initiative is a collaborative effort of Harvard Law School and Massachusetts Advocates for Children, which has championed a policy agenda to nurture trauma-sensitive and trauma-informed schools.[102]

The Massachusetts Department of Mental Health plans to create a venue with peer-to-peer support to engage individuals experiencing trauma more effectively. http://acestoohigh.com/2014/08...med-school-movement/ Update on implementation of the law: https://www.acesconnection.com/...chools-framework-law

Minnesota

Minn. Stat. § 245.4889. Children's Mental Health Grants

The following services are eligible for grants under this section: "(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive Web site to share information and strategies to promote resilience and prevent trauma."

Missouri

Missouri Trauma-Informed Schools Initiative, Missouri statute (2 sections)
Section 161.1050.1 - Initiative established, department duties--definitions
http://www.moga.mo.gov/mostatu...tml/16100010501.html
Section 161.1055.1 - Pilot program established, selection of schools--fund created--definitions.
http://www.moga.mo.gov/mostatu...tml/16100010551.html
"Bills as introduced (House bill Nos. 2565 & 2564) Effective July 1, 2017

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[102] https://traumasensitiveschools.org

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In 2016, Missouri enacted the 'Trauma-Informed Schools Initiative' that requires the Department of Elementary and Secondary Education (DESE), in consultation with the Department of Mental Health and Department of Social Services, to provide information on the trauma-informed approach to all school districts, to offer training on the trauma-informed approach to all school districts, and create a website for schools and parents with information on the trauma-informed approach and a guide for schools to become trauma-informed." The law included developing a pilot program under which five schools would receive intensive training in the trauma-informed approach.

New Mexico
N.M. Stat. § 32A-23B-2
https://www.acesconnection.com/...ountability-act-docx
As used in the Home Visiting Accountability Act: "D. "home visiting" means a program strategy that: (1) delivers a variety of informational, educational, developmental, referral and other support services for eligible families who are expecting or who have children who have not yet entered kindergarten and that is designed to promote child well-being and prevent adverse childhood experiences."

North Carolina
Project Broadcast
Trains county child welfare workers over a 9-12 month period to incorporate an understanding of trauma and its effects into their every day practices. It also trains staff to use two screening tools—one for children 6 and under and one for children ages 6-21—to identify whether they have experienced trauma and refer them for an assessment if needed. Additionally, it trains clinicians on four trauma-focused, evidence-based therapies to treat children's trauma symptoms.

Rowan County, NC: Partnering for Excellence
Consisting of the county department of social services, the county's mental health managed care organization, and private mental health providers, this initiative supports children ages 5-17 and families involved in the child welfare system. Key elements of Partnering for Excellence include screening children for trauma and, if needed, trauma-intensive comprehensive clinical assessments. The initiative also facilitates improved communication, coordination, and monitoring of child and family treatments by ensuring staff train together and participate in ongoing collaborative meetings.

Ohio
Child Welfare Training Program
Provides training on core and specialized competencies for child welfare caseworkers, supervisors, and foster parents. The training program includes courses for the three groups that teach about the effects of trauma on children. For example, caseworkers can take trainings on the impact of emotional abuse and interventions for children who have suffered trauma while caregivers can take trainings on providing discipline that is trauma-informed and dealing with the effects of complex trauma.

Athens County, OH: School Outreach Caseworkers
Placing caseworkers in local elementary schools, the county child welfare agency's initiative supports students, families, and teachers by promoting positive school relationships to enhance student success and strengthen families. Among other responsibilities, caseworkers help coordinate services for individual students and bring outside resources into schools. They also support parents by providing home and school-based services and coordinating parenting classes to help strengthen skills.

Oregon
The state of Oregon passed the first law designed to promote

trauma-informed approaches to decrease rates of chronic school absenteeism, and created a plan to leverage community resources to support youth.

H.B. 4002 (Chapter 68)
Signed by Governor on March 29, 2016
"The law requires two state education agencies to develop a statewide plan to address the problem and provides funding for 'trauma-informed' approaches in schools. https://acestoohigh.com/2016/0...ation-bill-into-law/"

Or. Rev. Stat. § 414.629:
"(2) A community health improvement plan must be based on research, including research into adverse childhood experiences, and must identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan. The plan must also:
(a) Evaluate the adequacy of the existing school-based health resources including school-based health centers and school nurses to meet the specific pediatric and adolescent health care needs in the community;
(b) Make recommendations to improve the school-based health center and school nurse system, including the addition or improvement of electronic

medical records and billing systems;

(c) Take into consideration whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;
(d) Improve the integration of all services provided to meet the needs of children, adolescents and families;

(e) Focus on primary care, behavioral health and oral health; and

(f) Address promotion of health and prevention and early intervention in the treatment of children and adolescents."

Pennsylvania
In Philadelphia, the Mobilizing Action for Resilient Communities (MARC)[103] program brings together 14 sites actively engaged in building the movement for a just, healthy and resilient world. A mix of cities, counties, regions, and states, these communities are all building a culture of health by translating the science of ACEs into practices and policies that foster resilience. MARC is coordinated by The Health Federation of Philadelphia with support from the Robert Wood Johnson Foundation and The California Endowment.

Texas
Texas S.B. 1356, Juvenile Justice trauma-informed training Statute Signed by Governor 6/14/2013 Effective Sept. 1, 2013
"Requires the juvenile justice department to provide trauma-informed care training for probation officers, juvenile supervision officers, and court-supervised community-based program personnel. The training 'must provide knowledge, in line with best practices, of how to interact with juveniles who have experienced traumatic events.'"

Texas H.B. 2789 (https://legiscan.com/TX/text/HB2789/id/1160053)
Trauma-Informed Training for Employees
Passed 9/1/2015, 84th Legislature (2015-2016)
Statute
"Relating to trauma-informed care training for certain employees of state supported living centers and intermediate care facilities. Law (Chapter 161 Human Resources Code) requires the Department of Aging and Disability Services to develop or adopt trauma-informed care training for employees who work directly with individuals with intellectual or developmental disabilities in living centers and intermediate care facilities."

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[103] http://marc.healthfederation.org

Washington State

Child Health and Education Tracking Program

Screens children in five areas, including physical and behavioral health, within the first 30 days of entering the child welfare system. In addition, dedicated staff are trained to use tools to identify children's trauma symptoms, including anxiety and attention problems. One tool includes questions about children's anxiety, such as whether they are scared to go to school. Children are rescreened every six months using these tools.

Compassionate Schools and Social and Emotional Learning

Provides universal supports to all students through these initiatives, which include creating a positive school climate and culture.

- Compassionate Schools support all students and focus on helping teachers understand fundamental brain development, interpret and manage children's behaviors successfully, and engage students, families, and the community.

- Social and emotional learning is the process through which children learn how to understand and manage emotions, set and achieve goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions.

King County, WA: King County Department of Public Health

Beginning in 2017, King County's Department of Public Health implemented changes to become a trauma-informed agency. The agency now has three areas of focus—creating a trauma-informed care training plan and standardized curriculum; awarding mini- grants to agency "champions" who create small projects connected to the agency's trauma-informed care principles, which includes fostering compassionate relationships; and making policy and human resources changes, including the investigation process for internal human resources complaints.

The state of Washington implemented the ACEs Public-Private Initiative (APPI), a collaboration among public, private and community organizations to research and inform policies to prevent childhood trauma and reduce its negative emotional, social and health effects. The APPI is the successor to the Family Policy Council, which implemented the Self Healing Communities Model, which emphasized cultural change and capacity building from 1994 to 2012.

Preventing and Mitigating the Effects of ACEs
Wash. Rev. Code § 70.305.005 et.seq

Washington State HB 1965
Enacted June 15, 2011
"The law established a statutory definition of adverse childhood experiences that is consistent with the ACE study and codified the state's commitment to addressing ACEs in state policy. It also sunsetted two organizations devoted to children and families—Washington State Family Policy Council and the Council for Children and Families—and provided a framework for a private-public initiative to address ACEs."

In Walla Walla, Washington, the city and community members launched the Children's Resilience Initiative to mobilize neighborhoods and Washington State agencies to tackle adverse childhood experiences (ACEs). The city issued proclamations and 2013 and 2017 in support of the resilience initiative.

Wisconsin

Trauma Project

Consisting of three parts, this initiative trains clinicians who treat children affected by trauma in trauma-focused, evidence-based therapies; holds workshops for foster, birth, adoptive, and kinship parents attended by social workers and others to learn about trauma and its effects; and provides learning communities for state and county child welfare staff that infuse an understanding of trauma into staff's every day work.

Trauma Sensitive Schools
Modeled after the Positive Behavioral Interventions and Supports school improvement process, this initiative focuses first on universal practices (Tier 1), followed by strategies for groups of students who need additional support (Tier 2), and intensive interventions for students who require ongoing support (Tier 3).

Waupaca County, WI: Waupaca County Department of Health and Human Services
Beginning in 2012, the Department of Health and Human Services has worked to transition into a trauma-informed agency by incorporating trauma-informed care into its operations. The agency's operating principles include partnering with clients, promoting safety, and earning clients' trust. The agency has become more family-friendly and is more focused on preventing children from entering the child welfare system, according to an agency official. Since becoming trauma-informed, it was reported that staff have had less secondary stress and there has been a decrease in staff turnover.
In 2011 Wisconsin's Fostering Futures initiative was implemented to raise awareness about how childhood trauma can dramatically shape a person's life. This initiative has grown over time to become a collaboration amongst the State of Wisconsin

with tribes, state agencies, county governments, and nonprofit organizations to make Wisconsin a trauma-informed state. "Fostering Futures' vision is that all Wisconsin children and families are thriving in nurturing communities; individuals, communities and government integrate trauma-informed, strength-based principles into their relationships, culture, policies and practices, promoting safe, stable and nurturing relationships."[104]

https://acestoohigh.com/2017/0...sed-on-aces-science/
Wisconsin Senate Joint Resolution 59
Report enrolled 1/17/2014
"Resolved by the senate, the assembly concurring, That policy decisions enacted by the Wisconsin state legislature will acknowledge and take into account the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships, and note the role of early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital."

Brighter Futures in Wisconsin
Wis. Stat. § 48.545

Brighter futures initiative
(2) Awarding of grants. (a) From the appropriations under s. 20.437(1)(eg), (kb), and (nL), the department shall distribute $2,097,700 in each fiscal year to applying nonprofit corporations and public agencies operating in a county having a population of 750,000 or more, $1,171,800 in each fiscal year to applying county departments under s. 46.22, 46.23, 51.42, or 51.437 operating in counties other than a county having a population of 750,000 or more, and $55,000 in each fiscal year to Diverse and Resilient, Inc. to provide programs to accomplish all of the following:

1. Prevent and reduce the incidence of youth violence and other delinquent behavior.
2. Prevent and reduce the incidence of youth alcohol and other drug use and abuse.
3. Prevent and reduce the incidence of child abuse and neglect.
4. Prevent and reduce the incidence of nonmarital pregnancy and increase the use of abstinence as a method of preventing nonmarital pregnancy.
5. Increase adolescent self-sufficiency by encouraging high school graduation, vocational preparedness, improved social and other interpersonal skills and responsible decision making.
(am) From the amounts allocated under par. (a), the department

[104] http://www.fosteringfutureswisconsin.org

may distribute an amount determined by the department to a nonprofit corporation or public agency to provide a program that accomplishes all of the following:

1. Prevents and reduces the incidence of adverse early childhood experiences in children 8 years of age and under and reduces the effects of those experiences through behavioral health and other services.
2. Provides professional development, training, and research in serving children 8 years of age and under for practitioners serving those children.
3. Provides direct services for children 8 years of age and under.
4. Provides child care, including a special care nursery, for children 8 years of age and under that has achieved the top rating provided under the child care quality rating system under s. 48.659.
5. Provides early intervention services under s. 51.44, early childhood education services, in-home treatment services, family services, and outpatient occupational therapy, physical therapy, and speech therapy services for children 8 years of age and under."

Utah
http://acestoohigh.com/2014/08...eduction-resolution/
Utah H.C.R. 10
Signed by the Governor March 22, 2017
"A concurrent resolution to encourage state policy and programs to incorporate ACEs science to address 'severe emotional trauma and other adverse childhood experiences' in children and adults and implement evidence-based interventions to increase resiliency."

Vermont
Chronology of ACEs-related legislation in Vermont 2014-15
"In 2014, the Vermont legislature passed a bill to require the Blueprint for Health (a state-led health care program that includes practices providing healthcare to the majority of Vermonters) to do a study to address 'whether, how, and to what extent' ACE-informed medical practice should be incorporated into Blueprint practices and community health teams. This study was based on legislation introduced by Dr. George Till (H. 762) that also included a provision to require Blueprint practices in the state to use the ACE questionnaire as a tool to assess health care. Only the study authorization was included in the final legislation (S. 596, Act 144, signed by Governor on May 27, 2014).
As the result of that legislation, a report, "Integrating ACE-Informed Practice into the Blueprint for Health," (http://blueprintforhealth.verm...rt-Final-1-14-15.pdf) was issued in January 15, 2015.
In subsequent legislation (H. 481, signed by the Governor on June 5, 2015, Vt. Act 54 of 2015, in Section 56.), the legislature directed the Blueprint for Health to "work collaboratively to begin including family-centered approaches and adverse childhood experience screenings consistent with the report entitled "Integrating ACE-Informed Practice into the Blueprint for Health." Considerations should include prevention, early identification, and screening, as well as reducing the impact of adverse childhood experiences through trauma-informed treatment and suicide prevention initiatives."

Emotional Wellness and Exposure to Violence
Data from New Orleans Youth Age 11-15

IWES's Emotional Wellness Screener data shows that New Orleans youth have rates of current and lifetime PTSD over three times higher than national averages. While the impact of Hurricane Katrina likely played a substantial role in this disparity, research also revealed over 37% of youth have witnessed domestic violence and 54% have experienced the murder of someone close to them.

Youth Emotional Wellness Contextualized

Introduction

Youth in New Orleans inhabit a complex and quickly evolving environment. New Orleans is experiencing what some refer to as an economic renaissance, but many of the city's long-time residents are left out. As of 2013, **39% of the city's approximately 78,000 children live in poverty** (Mack, 2015). Though New Orleans has experienced a significant demographic shift since Hurricane Katrina, including a drop in the population of children (particularly children of color), this child poverty rate is equivalent to pre-Katrina conditions. Challenges include a lack of living wage jobs[1] and access to the transportation that ensures stable employment; in addition, affordable housing has all but disappeared from New Orleans' rental-based market as gentrification of the city pushes people to more remote areas that are even less accessible to employment and transportation (GNOFHAC, 2014).

> Though the murder rate dropped in 2014, every other violent crime rate rose from the previous year, including a **27.5% increase in assault** and a **38.6% increase in rape** (NOPD, 2015).

Lack of social and economic resources, exposure to violence, poverty, and living in unstable neighborhoods can cause anxiety and toxic stress for any population, but the brunt of negative effects is borne by children. **Chronic stress associated with poverty can alter the brain during critical developmental phases and ultimately cause deficits in learning and behavioral problems, as well as lead to an array of negative health outcomes, both mental and physical** (NCCP, 2014). For young people who experienced Hurricane Katrina, this stress may be compounded by untreated trauma associated with the disaster. A recent study found that among African American female adolescents, higher interpersonal stress was associated with increased sexual risk behaviors placing young people at risk for STIs and pregnancy (Hulland, 2014).

In response to these and other salient issues, the **Institute of Women and Ethnic Studies (IWES)** was founded in 1993 in order to address health disparities experienced by communities of color. Over the last twenty years, IWES has developed culturally responsive holistic health programs, activities, and research models for women, their families, and youth of color. By honoring the lived experiences of the people with whom IWES engages, evidence-based health interventions are adapted to address the needs of the community in which IWES is embedded.

> IWES' **Believe in Youth! NOLA!** program, a teen pregnancy prevention program that uses a trauma-informed approach to engage youth based on the belief that emotional wellbeing and stress are contributing factors in sexual decision-making.

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[1] A living wage can be defined as ,"the wage a full-time worker would need to earn to support a family above federal poverty line, ranging from 100% to 130% of the poverty measurement," and varies among localities (Economic Policy Institute, 2002). The current federal poverty line for a family of 4 is $24,250 (DHHS, 2015).

Approach

IWES began implementing the Believe in Youth! NOLA! program in schools, community-based organizations, and faith-based organizations in 2010. Throughout the course of delivering teen pregnancy prevention information, it became increasingly clear that many program participants were experiencing distress in other areas of their lives not directly connected to sexual health. In order to effectively support the young people in the Believe in Youth! NOLA! program, in 2012 IWES designed and began implementing an emotional wellness component as well as an emotional wellness survey with program participants. **The survey was designed to assess symptoms of poor mental health including, depression, PTSD, and suicidality as well as exposure to violence and access to basic needs.** The results are reviewed by an IWES social worker and psychiatrist, who conduct crisis assessments with those students who meet criteria for further intervention and provide referrals to the school social worker or outside resources as necessary. In addition, at the end of each cycle of implementation, IWES staff shares the de-identified results of the emotional wellness survey with school leadership in order to document the needs of their student population and to develop strategies to address those needs.

Though data collection is ongoing, the sample discussed within this report was collected between 2012 and 2015 (**n=1221**). Participants were between the ages of 10-16, **mean age=12.89** years (SD;1.16), 41% male, 58.1% female, and **87.3% of the sample identified as African American**.[2]

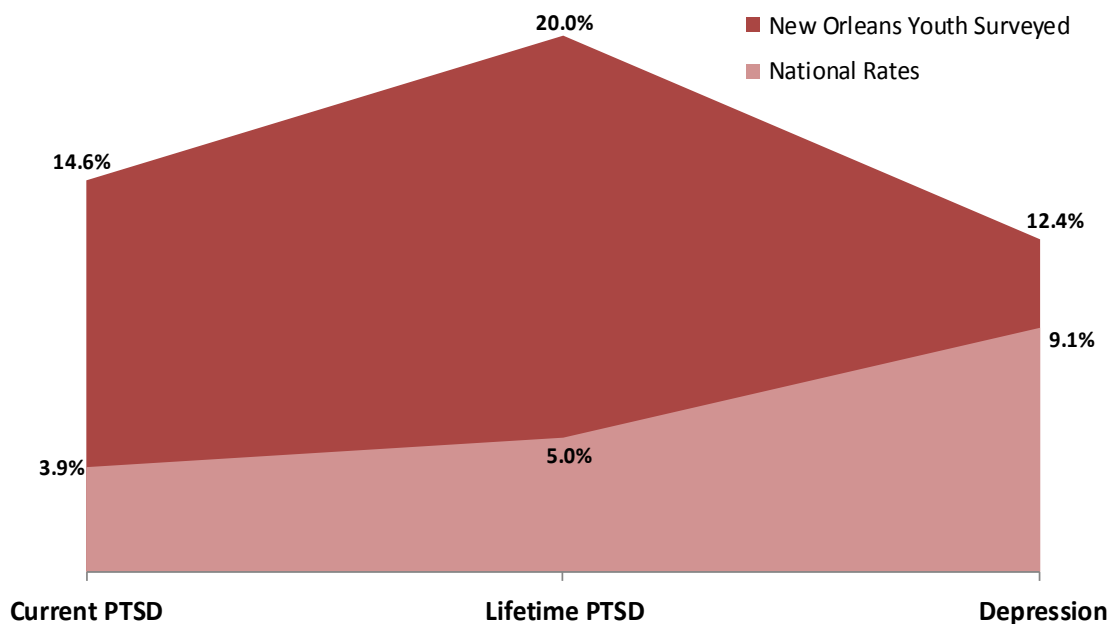## National vs. Local Mental Health Outcomes

Figure 1: Rates of mental health outcomes among New Orleans youth surveyed compared to national rates (Merikang, 2010 and SAMHSA, 2013).

Findings

Key findings from the survey include high levels of reported mental health symptoms and exposures to violence among youth in the sample. Results of the survey show that the prevalence of mental health disorders among youth in New Orleans is extremely high, particularly when compared with the national average.

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[2] Data was analyzed in SPSS to assess overall prevalence of mental health outcomes and frequency of exposure to violence, and the sample was stratified by gender (compared using Pearson's χ^2) in order to gauge potential variations. Logistic regressions were conducted to test the strength of key associations between various exposures and health outcomes.

Exposure to violence among youth surveyed:

37.9% of respondents witnessed domestic violence

39.8% witnessed a shooting, stabbing, or beating

17.9% witnessed a murder

54% experienced the murder of someone close to them

Youth who participated in the program also reported high levels of anxiety related to safety and stability.

14% of respondents reported feeling suicidal

52.2% worry about violence in their neighborhood

16.4% worry about having enough food to eat or a place to live

29.5% worry about not being loved

As shown below in Figure 2, there are stark gender disparities represented in this data. Girls are significantly more likely to meet criteria for symptoms of current PTSD, depression, and suicidality. They are also much more likely than boys to report that they are worried about not being loved.

Gender Disparities

■ Boys ■ Girls ■ Total

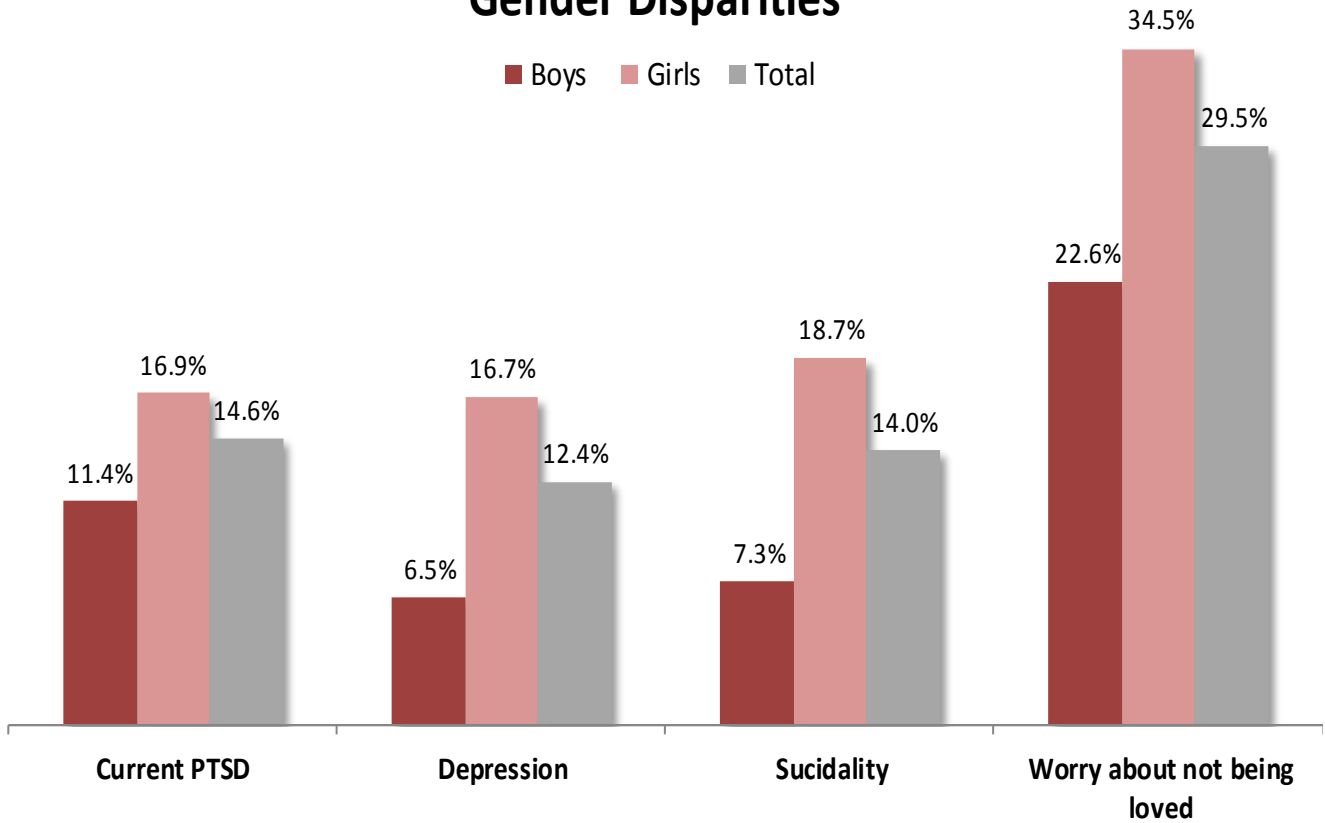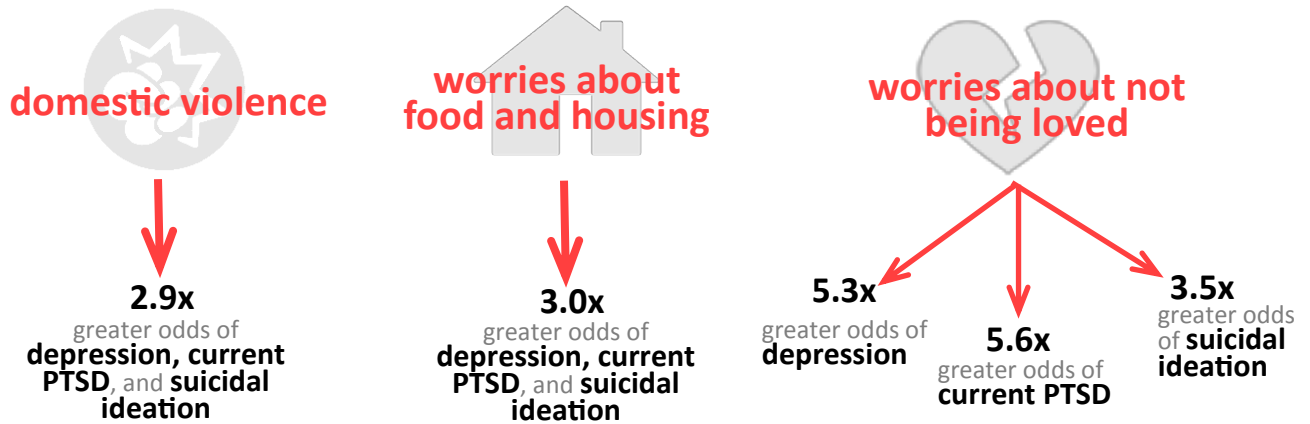|	Boys	Girls	Total
Current PTSD	11.4%	16.9%	14.6%
Depression	6.5%	16.7%	12.4%
Sucidality	7.3%	18.7%	14.0%
Worry about not being loved	22.6%	34.5%	29.5%

Figure 2: Gender disparities among New Orleans youth surveyed as related to mental health and worry.

Findings also indicate that exposures to violence and security-related worries are associated with the mental health outcomes of survey participants. Witnessing violence, worrying about violence, and being forced to commit sexual acts were also strongly associated with negative mental health outcomes.

Youth who reported:

domestic violence	**worries about food and housing**	**worries about not being loved**
↓	↓	↙ ↓ ↘

2.9x
greater odds of **depression, current PTSD**, and **suicidal ideation**

3.0x
greater odds of **depression, current PTSD**, and **suicidal ideation**

5.3x
greater odds of **depression**

5.6x
greater odds of **current PTSD**

3.5x
greater odds of **suicidal ideation**

Meeting the Needs of Youth in New Orleans

These data show that exposure to traumatic experiences is pervasive among young New Orleanians. Though New Orleans residents are likely aware of the high levels of violence in the community as well as persistent resource instability and poverty, previously it was difficult to estimate the associations of these conditions with the health of the city's youngest residents due to a lack of available data. Data collected from this survey demonstrates the impact these issues have on adolescents, and it is clear that their mental health is suffering. **The lack of available, accessible, and affordable mental health resources for the youth in question is troubling and should be a point of advocacy for those interested in the wellbeing of youth in the city.** Additionally, the data suggests that there is a disproportionate impact of mental health problems on girls. As funding and advocacy continues to grow in support of initiatives focused on young men of color, representation of the issues faced by young women of color is also paramount.

Another compelling outcome of this data is the strength of association between exposure to domestic violence and material/emotional instability with negative mental health outcomes. **Though experiencing community violence was also associated with symptoms of mental health problems, the exposures and anxieties most directly experienced in the home appear to have the greatest impact on youth mental health.** These findings are in line with the body of research which shows the protective power of perceived social support from parents and adult caregivers on youth mental health and coping skills (Jain, 2013).

Finally, the origin of this data collection as a component of a teen pregnancy prevention program is particularly relevant when the established links between stress, trauma, and sexual risk-taking behaviors are considered. If the high rates of HIV, STIs, and unanticipated pregnancies in New Orleans are to be lowered, sexual health education should include trauma-informed content that addresses the lived experiences and stressors experienced by youth. In order to address the interlocking factors that contribute to negative health outcomes for youth and their families, IWES continues to use the Social Ecological Model (SEM) as a framework for program design (depicted in Figure 4). This approach recognizes that an individual's behavior both shapes and is shaped by multiple levels of influence including the individual, interpersonal, community and societal contexts. In order to enact sustainable city-wide change, interventions should seek to address issues at multiple levels of the SEM.
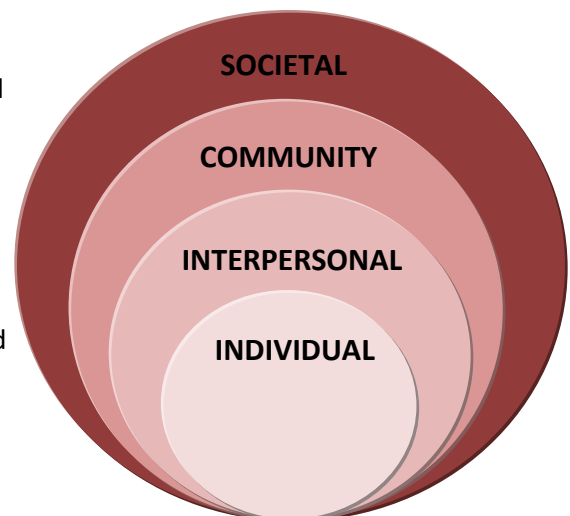
SOCIETAL

COMMUNITY

INTERPERSONAL

INDIVIDUAL

Figure 4: The Social Ecological Model.

References

The Data Center. (2015). *New Orleans kids, working families, and poverty.* New Orleans, Louisiana: Mack. Retrieved from http://www.datacenterresearch.org/reports_analysis/new-orleans-kids-working-parents-and-poverty/

Department of Health and Human Services, (2015). *2015 poverty guidelines*. Washington, DC. Retrieved from http://aspe.hhs.gov/poverty/15poverty.cfm

Economic Policy Institute. (2001). *EPI issue guide: living wage*. Washington, DC. Retrieved from http://epi.3cdn.net/6654f659599ce2fd22_qnm6b9ce8.pdf

Greater New Orleans Fair Housing Action Center. (2014). *Where opportunities knock, doors are locked.* New Orleans, Louisiana. Retrieved from http://www.gnofairhousing.org/wp-content/uploads/2014/11/11-06-14-Where-Opp-Knocks-FINAL.pdf

Hulland E. N., Brown J.L., Swartzendruber A. L.. (2014). The association between stress, coping and sexual risk behaviors over 24 months among African American female adolescents. *Psychology, Health & Medicine, 20 (4), 443-56.*

Jain, S. & Cohen, A. (2013). Behavioral adaptation among youth exposed to community violence: A longitudinal multidisciplinary study of family, peer and neighborhood-level protective factors. *Prevention Science, 14 (6),* 606-617.

Merikangas, K. et al. (2010). Lifetime prevalence of mental disorders in the U.S. Adolescent Comorbidity Survey Replication-Adolescent Sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49, 980-988.

National Center for Children in Poverty, (2014). Child poverty. Retrieved from http://www.nccp.org/topics/childpoverty.html

New Orleans Police Department. (2015). *New Orleans Uniform Crime Reporting (UCR) crime statistics for the year 2014 compared to 2013.* New Orleans, LA. Retrieved from http://www.nola.gov/getattachment/fb8bc501-faf2-493d-bf17-0537723d0ba7/UCR-2014-YTD/

Substance Abuse and Mental Health Services Administration. (2013). *Results from the 2012 National Survey on Drug Use and Health: mental health findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD. Retrieved from http://www.samhsa.gov/data/sites/defaultfiles/2k12MH_Findings/2k12MH_Findings/NSDUHmhfr2012.htm

2019
NEW ORLEANS
SUMMIT ON
COMPASSION
& RESILIENCE

A Convening Report highlighting the insights and recommendations for collectively addressing childhood trauma in New Orleans

NEW ORLEANS CHILDREN & YOUTH PLANNING BOARD

BCM

TABLE OF CONTENTS

"My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor, and some style."

- Maya Angelou

The Summit was convened by the Children & Youth Planning Board and the New Orleans Childhood Trauma Taskforce with funding from Baptist Community Ministries.

We are deeply grateful to the community of stakeholders who offered their full participation in envisioning a trauma-informed New Orleans by generously and authentically sharing their lived experiences, expertise, successes, and challenges.

ACKNOWLEDGEMENTS

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THANK YOU TO XAVIER UNIVERSITY FOR GENEROUSLY HOSTING THE SUMMIT IN THE MCCAFFREY BALLROOM

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SUMMIT OVERVIEW

The 2019 New Orleans Summit on the Compassion and Resiliency was a day-long offering sponsored by the New Orleans Children & Youth Planning Board with funding support from Baptist Community Ministries. The summit aimed to collectively focus on the experiences of New Orleans children and youth, spotlight community initiatives underway, and to gather insights and recommendations on how New Orleans can become a Trauma Informed City.

The 2019 Summit on Compassion and Resilience was held at Xavier University of Louisiana. The event took place in the McCaffery Ballroom on the 3rd floor of the University Center on June 12th, 2019 from 9am to 4pm, and was followed by a reception hosted by the New Orleans Trauma- Informed School Learning Collaborative.

The summit attracted a diverse group of stakeholders from across New Orleans. The attendees included— among many—faith-based groups, non-profits, local culture bearers, and civil servants. The voices and experiences of the participants, as well as the facilitators, expert presenters, and performing artist created a resounding call for this work to move forward as a priority and as a collaborative effort.

The collective made powerful steps towards establishing the knowledge-base and norms of practice that could lead New Orleans on the path to truly becoming a trauma informed city.
The summit resulted in a values and insights for designing a pathway for guiding citizens and residents, partners, providers working to develop trauma informed community systems of care that 1. realize the widespread prevalence of trauma, 2. recognize the signs and symptoms, 3.respond in an understanding and supportive manner, and 4.resist doing further harm.

DAY AT A GLANCE

NETWORKING BREAKFAST

WELCOME

OPENING REMARKS | WISDOM FROM NEW ORLEANS' YOUTH

CHILDHOOD TRAUMA IN NEW ORLEANS: DATA & NARRATIVE

BUILDING A TRAUMA-INFORMED CONTINUUM: PARTICIPATORY ASSET MAPPING & DEVELOPING A PARTNER MATRIX

LEARNING IN ACTION PANEL DISCUSSION

ENVISIONING A TRAUMA-INFORMED NEW ORLEANS

DEEP DIVE DISCUSSION ON TIC DOMAIN

REFLECTIONS AND CLOSING REMARKS

THE DAY IN MOTION

"Everybody needs somebody. Cause most people don't have nobody."

Participants explored what services, resources, and partnerships already exist in the Greater New Orleans area, listened and learned from youth voices, and shared insights into a City Plan on how to individually and collectively make New Orleans a trauma-informed city. After a welcoming by President of Xavier University Dr. Reynold Verret and Karen Evans of the Children and Youth Planning Board, youth voices were brought to the forefront as Iman Shervington facilitated a conversation with three young people on the experience of trauma and the systems perpetuating and remediating that trauma.

The youth panel represented Daughters Beyond Incarceration and Travis Hill NOLA's Welcoming Project. The panel's discussion of systems spanned education, criminal and juvenile justice, social and family support, mental health, and physical health.

The youth panelists were all young women of color, and an issue of particular interest was the experience and practice of disproportionate discipline on black and brown girls. They highlighted issues of trust and feeling safe, including unwillingness to express themselves in the presence of most teachers and fellow students. They also underscored the necessity for places where youth could really be seen and heard.

DATA AND NARRATIVE

Denese Shervington, MD, MPH, led a discussion on the various manifestations of childhood trauma in New Orleans.

MAPPING TRAUMA-INFORMED CAPACITY ACROSS COUNCIL DISTRICTS

Trauma-Informed Provider Map
Greater New Orleans Area

2019 NEW ORLEANS SUMMIT ON COMPASSION & RESILIENCE

Service Providers

Neighborhood Boundaries

Youth Population (0-24 Years)

City Council District
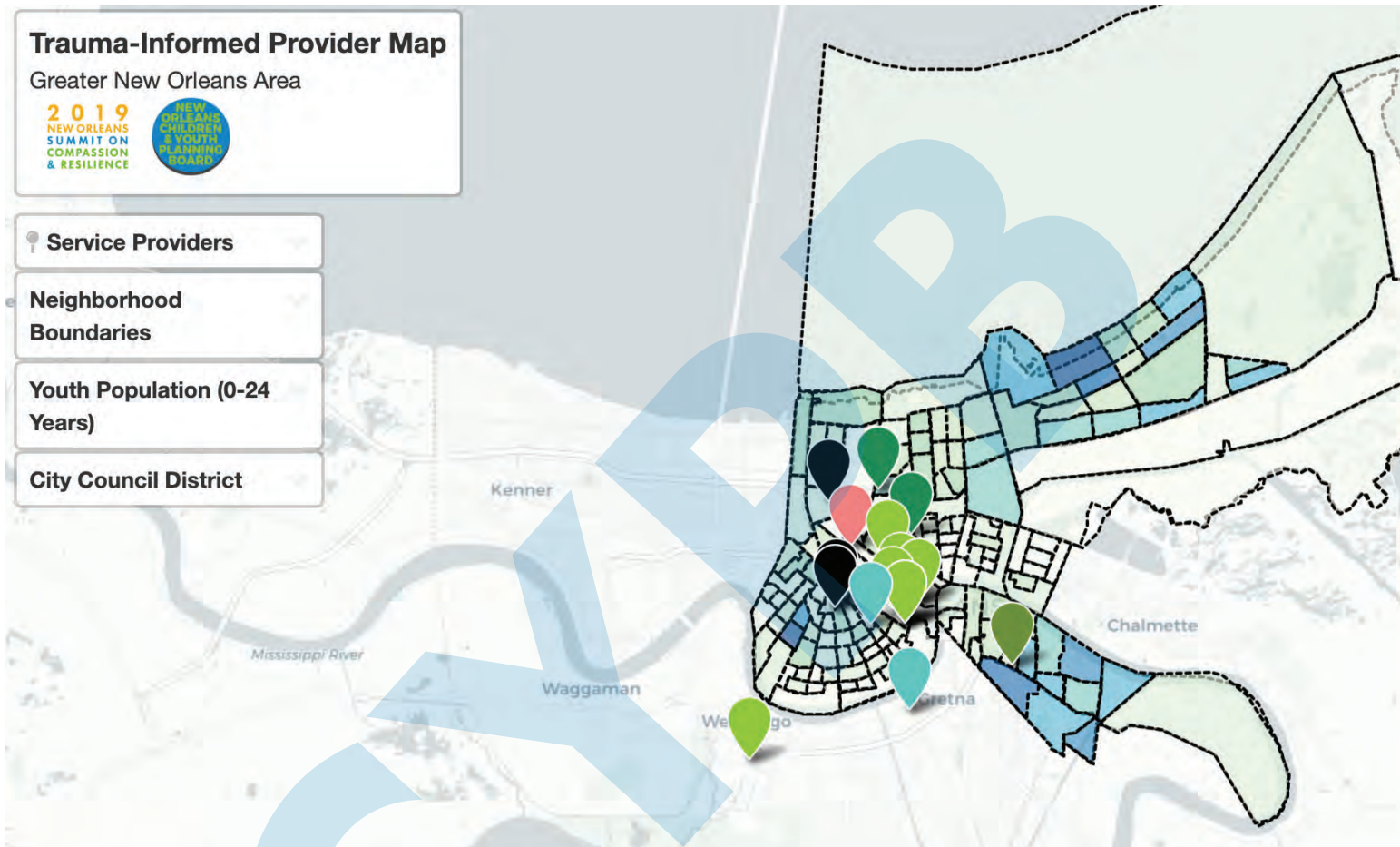
Attendees participated in digital mapping tool exercise, showcased by Maggie Hermann of Central City Renaissance Alliance and Chad Oliver of The Blue House Civic Studio, where participants located existing trauma-informed assets in New Orleans.

PROVIDER INSIGHTS AND EXPERIENCE

Sector leaders from around New Orleans representing the UMC Trauma Center, New Orleans Youth Alliance, Training Grounds, and the New Orleans Children's Bureau, shared their experiences providing services and their take on the changing landscape of trauma awareness.

THREE-YEAR PRACTICAL VISIONING

Facilitator Lolita Ross with SHARED Strategy Group, LLC guided attendees through a three year practical visioning exercise that outlined priorities for becoming a trauma-informed New Orleans.

A WORD FROM THE COUNCIL

Councilman Jason Williams provided final remarks, highlighting the importance of working collaboratively and utilizing long-term visioning.

PARTNER MATRIX

PARTNER

Institute of Women and Ethnic Studies

We are dedicated to improving the mental, physical and spiritual health and quality of life for women, their families and communities of color, particularly among marginalized populations, using community engaged research programs, trainings, and advocacy.

SERVICES

- Sex Ed (trauma-informed)
- HIV Testing and Prevention

- Community Mental Health and Resiliency Training
- Trauma-informed Research across programs
- Trauma-informed Youth Convenings
- Women Recovery Groups (collaboration w/ MHSD)
- Global Mental Health Research

CERTIFICATIONS | DESIGNATIONS

- Licensed Mental Health Staff
- Trauma-informed Yoga
- Training of Trainers
- HIV CTR training (counseling and rapid testing)
- Master level staff in social work, urban education, public health, policy, etc.
- Suicide Risk Assessment/Intervention
- Mental Health First Aid training

VISION FOR BEING PART OF FUTURE EFFORTS

- Supporting advocacy
- Accountability through research
- Training of providers and community members
- Evidence-based, trauma-informed programs (for all!)

OFFICE OF CRIMINAL JUSTICE COORDINATION

PARTNER

Mayor's Office of Criminal Justice Coordination (OCJC)

SERVICES

OCJC fosters system-wide communication and evidence-based policymaking to promote an accountable, coordinated, equitable, and effective criminal and juvenile justice system.

CERTIFICATIONS | DESIGNATIONS

Our staff does not provide frontline services and has no particular trainings or certificates in being trauma-informed.

VISION FOR BEING PART OF FUTURE EFFORTS

- We regularly convene stakeholders and policymakers and can push for systemic changes
- Through a SAMHSA grant, we will train criminal justice professionals (e.g. court staff, probation officers) on how to be trauma-informed in the criminal justice system

- Training
- Convening and Networking
- Resource Development
- Training and Technical Assistance
- Policy and Advocacy

PARTNER

New Orleans Youth Alliance

SERVICES

- NOYA Youth Leadership Fellowship
- New Orleans Youth Program Quality Initiative (NOLA-YPQI)
- Assessments
- Coaching
- Communities of Practice
- Improvement Plans

CERTIFICATIONS|DESIGNATIONS

- Mental Health First-Aid
- Developed training series for youth development professionals

on equity, trauma-informed approaches, healing justice and radical healing: Soul Rebels

VISION FOR BEING PART OF FUTURE EFFORTS

Building a network of trauma-informed, equity focused youth development professionals

- Ad hoc social workers
- Bridge the digital divide
- Enable early literacy

PARTNER

New Orleans Public Library

"Transforming Lives, Enriching Neighborhoods, and Preserving History"

SERVICES

- Supply information and access to resources to citizens of all ages
- Make connections between people and resources
- Support lifelong learning
- Provide free public programming and entertainment to the community
- Serve as a vibrant and evolving community center for our neighborhoods
- One of the largest public-serving umbrellas of city government

CERTIFICATIONS|DESIGNATIONS

- Mandated Reporter Training
- Narcan Administration Training
- Service to Homeless Training—emphasis on empathy
- De-escalation and Conflict Resolution Training

VISION FOR BEING PART OF FUTURE EFFORTS

- More Staff Training
- Develop processed procedures to become more Trauma Informed
- Add social works to staff
- Training on self-care and avoiding burnout and compassion fatigue
- Build a more formal referral process for social services
- Increase mental health materials and programs

Tulane University

PARTNER

Tulane University - NIJ/DOJ Trauma-Informed Schools TIS-LC G.W. Carver

Psychologists, social workers and counselors implementing and researching trauma-informed approaches in schools

SERVICES

- Training and coaching for teachers in evidence-based practices for trauma-informed schools
- Analysis/needs assessment of school-wide systems and trauma informed action planning
- Collecting and analyzing research and process data to assist schools in decision-making

CERTIFICATIONS|DESIGNATIONS

- Nationally recognized psychologists, counselors and social workers involved in organizations such as NCTSN, National Center for School Mental Health and APA
- Scholarly journal publications

VISION FOR BEING PART OF FUTURE EFFORTS

To be leaders in the training and certification of schools

Daughters Beyond Incarceration

PARTNER

Daughters Beyond Incarceration (DBI)

DBI is a 501c3 org that works to enhance the lives of girls with incarcerated fathers. Girls between the ages of 8–18 need a way to bridge the communication with their fathers while he's serving out his sentence. DBI provides this through mentorship, support and education

SERVICES

- Father/daughter workshops to enhance the communication gap between the father/daughter
- Build the daughter's overall sense of wellbeing by supporting her with restorative approaches to dealing with the ACEs
- Partners with clinical psychologists, social workers, and formerly/currently incarcerated persons

CERTIFICATIONS|DESIGNATIONS

Our support staff has graduate degrees in social work, law degrees, criminal justice degrees and most importantly lived experiences. We also are certified in understanding ACEs and building self-healing community. Lived experiences are essential.

VISION FOR BEING PART OF FUTURE EFFORTS

We provide a unique care to girls and their incarcerated fathers. Our program teaches girls self-love and healing from growing up fatherless. DBI envisions a city where every girl growing up fatherless is mentally supported by a group of like-minded individuals who are working to change policies on their behalf.

PARTNER
Adventist Community Services

SERVICES
- Outreach services
- Awareness programs
- Food stamp and medicaid applications
- Disaster preparedness programs

- Mental health and domestic violence youth programs

CERTIFICATIONS|DESIGNATIONS
- A.C.S. (Adventist Community Services)
- American Red Cross
- Baptist Community Services
- Individual Professional certifications/degrees

VISION FOR BEING PART OF FUTURE EFFORTS
- Partnering with other agencies
- Raising awareness
- Community needs assessment
- Wellness programs
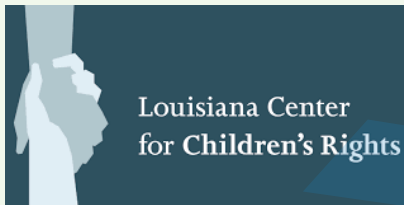
PARTNER
Louisiana Center for Children's Rights

Using direct representation and advocacy we fight to keep children out of the justice system so they can thrive in their homes and communities.

SERVICES
- Juvenile public defense (Orleans Parish)
- Case management
- Assessment
- Post-conviction work/reentry
- Policy advocacy

CERTIFICATIONS|DESIGNATIONS
- We have a range of social workers

with various certifications on staff (LMSW, LCSW-BACS, BSW)
- CBITS
- TFCBT
- Certificate in Forensic Social Work
- CPI
- Psychological First Aid (Lawyers and social workers)
- Traumatic Bereavement (TGCTA)
- Motivational interviewing

Lawyers and other child serving staff have received trainings on:
- ACEs
- Adolescent brain development
- Trauma informed interviewing techniques

VISION FOR BEING PART OF FUTURE EFFORTS
- Utilize a trauma-informed network
- Direct our amazing and vulnerable clients to such services
- Be part of advocacy efforts to create such a network

PARTNER

Orleans Parish School Board

SERVICES

- Authorize schools
- Citywide services
- School support and advocacy, trainings/ professional development
- Truancy Center
- Enrollment
- Student Hearing Office
- Youth Opportunity Center (YOC)
- Case management
- Homeless
- Behavioral health
- Reentry/hospital/ incarceration
- Family support
- School attendance
- Student discipline
- Juvenile justice
- Partnerships
- Transition support at fragile points
- Exceptional Children's Services

Trainings
- Creating trauma-informed schools
- Restorative approaches to discipline
- Trauma-informed collaborative training (in progress)
- Cultural competence training

CERTIFICATIONS| DESIGNATIONS

- Team of licensed social workers at YOC and ECS

VISION FOR BEING PART OF FUTURE EFFORTS

- Helping community partners understand the educational landscape in our city
- Building partnerships with organizations that offer support to schools
- Promoting best practices at our schools around supporting kids who have experienced trauma and providing training, support, information, accountability to ensure school practices are not retraumatizing students

PARTNER

Community Works

- Over 100 enrichment instructors
- 9 site directors
- Over 850 young people participate daily
- 6 person office staff

SERVICES

- Afterschool enrichment programs
- Summer enrichment programs
- In-school residencies/enrichment

CERTIFICATIONS|DESIGNATIONS

- IWES (Innovation Works Series)
- Project Peaceful Warriors (Innovation Works Series)
- YPQI - youth methods trainings
- NOYA - Soul Rebels

VISION FOR BEING PART OF FUTURE EFFORTS

Out of school programs are a great place to recognize, address and heal from trauma. Community Works wants to make sure our youth development workers have the tools to help that healing take place for the over 850 young people we work with every day.

PARTNER

Up2Us Sports

We engage, train, and support coaches to serve at schools/after school programs in NOLA. Coaches are trained in trauma-informed sports based youth development and are encouraged to use those skills to link life skills through sports.

SERVICES

Coach Program
- Capacity building in school and after school
- Year of service (AmeriCorps)
- Living stipend
- Education award
- Trained in trauma-informed strategies

- Professional Development
Training Program
- Variety of trauma-informed sports based youth development trainings offered to coaches and programs.

CERTIFICATIONS | DESIGNATIONS
- Levels 1-4 Sports Based Youth Development Certification
- Safesport Certification

VISION FOR BEING PART OF FUTURE EFFORTS
- Offer all of our programs to schools and community partners
- Recognizing physical activity/sports promotes healing from the effects of trauma
- Sports/Teams supply caring adult and relationships which are credible messengers to connect life skills for healthy decision making through sports

PARTNER

Training Grounds Inc.

A nonprofit organization with parents, caregivers, educators and children (birth–5) to create quality learning experiences to promote healthy Brain Development and improve early childhood outcomes.

SERVICES
- Parent learning opportunities (parenting workshops) The Growing Brain, Child Development, Active Parenting, Triple P.
- Professional Development workshops

- We PLAY Center - Free space where parents and children (0–3) grow and learn together
- Trainings
- Breastfeeding support
- We PLAY Gets Ready For Pre K - Free program to help parents and children (3–5) prepare for the transition to Pre K and K

CERTIFICATIONS | DESIGNATIONS
- Social workers, early childhood educators
- Zero to 3 certified trainers - The Growing Brain
- Pathway Trainers

VISION FOR BEING PART OF FUTURE EFFORTS
- Working with parents
- Conducting workshops
- Providing space where children and parents and caregivers feel safe to PLAY and explore

PARTNER
New Orleans Family Justice Center (NOFJC)

Dual agency that services clients that have been sexually assaulted, domestically abused, or trafficked.

SERVICES
- case management
- childcare
- Lyft
- Alternative healing
- Crime victim rep
- Education GED
- TRO
- SLLS
- Immigration
- DA Office worker

- Clinic - sex and DV forensic exams
- NOPD detectives felony/sex DV
- counciling
- Transitional housing
- Match savings

CERTIFICATIONS | DESIGNATIONS
- Case Management - Intake and then link to services
- Childcare - during working hours for services
- Lyft - sliding scale legal services
- Alternative healing - singing, reiki, ear acupuncture, massage, cardio, yoga, belly dancing, art group, healthy sexuality group, Spanish group
- Education - GED prep, job training, resume building, job placement, one app
- Crime victim rep - 500 emergency fund clients of crime

- TRO - protective orders, sign off, legal advocacy
- Plan B provider - one step for FREE (just come ask)
- Clinic-forensic exam, sex assault, domestic violence, STI testing sliding scale, medicade
- NOPD - domestic violence - officers - felony - sex crimes - officers - felony 4 detective

VISION FOR BEING PART OF FUTURE EFFORTS
- JD's Summit
- Masters in social work
- LSCW/LFMC
- Partnership with Dr. Shervington
- NSAC/Black Women Blueprint
- Women/Vision/Trauma-based
- Trainings listed at NOFJC.org

PARTNER
NORDC

SERVICES
Advance the physical, mental, and social well being of New Orleanians by promoting a safe and welcoming environment for recreational athletic, and cultural experiences

CERTIFICATIONS|DESIGNATIONS
- Mandated reporting
- Developing full training from Harvard Medical School study

VISION FOR BEING PART OF FUTURE EFFORTS
NORDC Parks and Centers provide a safe environment for many things. Though this trauma-free initiative, we provide training for our staff and partners.

ORLEANS PARISH JUVENILE COURT

PARTNER

Orleans Parish Juvenile Court (DPJC)
RISE Initiative

Respect, Invest in, Support, Empower
- VOCA funded initiative at OPJC to
identify youth at risk or victimized by
trauma and human trafficking

SERVICES

- Introduce protocols and policies in
  the court and the intake center for
  identifying and responding to youth
  who are victims of trauma and human
  trafficking
- Provide crisis intervention and case
  management for youth and families
  who are affected by/victims of human
  trafficking
- Create parent support group for

parents/caregivers of human trafficking victims and
youth who are at risk
- Develop and coordinate trainings (as well as
  provide trainings) on ACEs, trauma, human trafficking,
  secondary trauma, reporting and responding to child
  abuse, and resilience for court staff and partners

CERTIFICATIONS|DESIGNATIONS

1 LMSW and 2 MSW students on staff, all with extensive
training in trauma, human trafficking, etc.
- Certified forensic interviews
- CBT/TF-CBT trained
- TBH trauma screen[sic]
- Mental health first aid / suicide risk training

VISION FOR BEING PART OF FUTURE EFFORTS

- Working with court staff and judges to coordinate
  trainings for court to become a more trauma-informed
  system
- Helping to change the narrative around youth in the
  city, particularly youth of color
- Engaging youth and working to involve youth voice in
  decision-making
- Working with and training other systems in human
  trafficking identification and response/treating youth
  as victims opposed to as offenders

WELCOMING PROJECT
EMBRACING OUR OWN

PARTNER

Travis Hill NOLA's Welcoming Project

SERVICES

- Provide mentoring, community support
  services and workforce development to
  system–involved youth (10-23) leaving jail

or juvenile detention in Orleans
CERTIFICATIONS|DESIGNATIONS

General staff certification/designation:
- LPC (MH-related), JD, BA, BS, Teaching
Training:
- Trauma-informed care (ongoing)
- Restorative justice (ongoing)

VISION FOR BEING PART OF FUTURE EFFORTS

We envision continuing advocacy in and outside of the
justice system, education system, state legislature, etc. to
support creation and funding of trauma-informed services
and supports in New Orleans

FAMILY IN NEED OF SERVICES

PARTNER

Families In Need of Services (Orleans Parish Juvenile Court)

Families in need of services is juvenile delinquency prevention program dedicated to the intervention of truancy, ungovernable behavior by juvenile, runaway and other status offenses.

SERVICES

- Case management
- Prevention and Intervention
- Community support
- Advocacy
- Referrals to Community Partners

CERTIFICATIONS |DESIGNATIONS

- Education
- Social Work (MSW)
- Sociology (MS)
- Criminal Justice (MS)
Backgrounds
- DCFS
- Probation/Parole
- Mental Health Rehabilitation
- Education
- Homelessness
- Criminal Justice
Trainings
- TBRI
- Sexual Trauma/Trafficking
- Crisis Intervention
- Substance Abuse
- Title IV E
- Mental Health

VISION FOR BEING PART OF FUTURE EFFORTS

- Continued education
- Focus group
- Community partnerships
- Awareness for families through providing information about what's going on in the community and what is variable

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PARTNER

ATD Fourth World New Orleans

ATD (All Together in Dignity) Fourth World New Orleans
Nonprofit Organizations fighting extreme poverty in the City
- Accompanying/supporting families/ youth and children living in extreme poverty
- Beautification of neighborhood
- Street libraries
- Summer festival of learning etc.

SERVICES

We advocate in overcoming extreme poverty in low income community e.g. Central City, New Orleans East, 7th Ward, River Garden.
- Bring the voices of families living in extreme poverty to other institutions, services, etc. recognizing they are part of the solution.
- Reaching youth incarcerated, lead them to success
- Prevention – bringing books, arts, crafts on the street every Wednesday and Saturday PM
- Building self-esteem, leadership
- Accompanying families children/youth to court, social services, etc.

CERTIFICATIONS|DESIGNATIONS

- Training in social studies work, S. science
- Leadership, Human rights
- Participatory Research approach

VISION FOR BEING PART OF FUTURE EFFORTS

- Bringing other organizations
- Working with youth, children in poverty together

PARTNER

Friends and Families of Louisiana's Incarcerated Children, Black Men Rising, Black Girls Rising

Families and Friends of Louisiana Incarcerated Children (FFLIC) / Black Man Rising Movement
Statewide, grassroots, parent led, multigenerational, organizing, membership organization
We are the truth at being authentic

SERVICES

- Advocate for parents, students, and youth who may be formally incarcerated or at risk or who have issues in the education system.
- Fight for policy change
- Peer-to-peer mentorship
- Juvenile Justice Reform / Education Reform
- Leadership development for youth and parents

CERTIFICATIONS|DESIGNATIONS

We have staff who train staff in trauma informed practices. We are the community. We are the impacted people.

VISION FOR BEING PART OF FUTURE EFFORTS

By continuing to hold systems accountable to the community. Ya heard.

PARTNER

Center for Restorative Approaches

SERVICES

- Provide training, consultation, & facilitation of dialogue circles which improve communication, build relationships, reduce violence, & allow those most impacted by conflict & wrongdoing to use their strengths & assets to develop their own solutions to reporting harm
- Anti-racism training

CERTIFICATIONS|DESIGNATIONS

- Social Work
- Restorative Approaches
- Mediation

VISION FOR BEING PART OF FUTURE EFFORTS - Building organizations & systems capacity to develop/foster/ensure equality
- Provide alternatives to punitive & harmful accountability practices (suspensions, arrests, incarceration)
- Building institutions understanding (and capacity) of the importance of intentionally using relationship building

OUR BIG VISION
For a Trauma-Informed New Orleans

Participants envisioned how a trauma-informed New Orleans looks, sounds, feels, and functions

CHILDREN AND YOUTH LIVE IN POSITIVE ENVIRONMENTS TO THRIVE

MENTAL HEALTH SERVICES FOR FAMILIES

SCHOOL-BASED HEALTH CENTERS ADDRESSING PHYSICAL AND MENTAL HEALTH

SAFE AND SECURE SPACES AND OPPORTUNITIES FOR RECREATION

EVERY CHILD HEARS "YOU ARE IMPORTANT"

KIDS SEE AND HEAR PEOPLE FROM THEIR AREAS THAT HAVE SUCCEEDED

GOVERNANCE, LEADERSHIP, AND COMMUNITY COMMUNICATE & SHARE A VISION

SYSTEMS THAT CHILDREN ENCOUNTER DO NO HARM

ALL RESOURCES ARE ENGAGED TO KEEP KIDS FROM BEING INCARCERATED

YOUTH WORKFORCE DEVELOPMENT FOR TRADE, PROFESSIONAL, AND ACADEMIC

YOUTH-FOCUSED TRANSPORTATION, INCLUDING A SHARED CAR AND SHUTTLE SYSTEM

THREE-YEAR PRACTICAL VISION

WHAT DO WE WANT TO SEE IN PLACE IN THREE YEARS AS A RESULT OF OUR EFFORTS?

COLLABORATION AND COORDINATION

Broader, comprehensive, multi-sector coalition of trauma-informed advocates

By training everyone on trauma-informed principles and practices (city employees, etc.)

And Coordinating systemic efforts including data, funding & policy at every level

A representative community-led collaboration to increase information and resource sharing

Definition of quality services agreed upon by community coalition and transparent and ongoing systems to vet services.

Prioritize prevention programs through funding and policy change

No duplication; no fragmentation

STRATEGY & PRACTICES

Physical activity Rx in lieu of detention and other disciplinary actions in schools

Linkages to T.I. neonatal-perinatal healthcare

Use and implementation of best practices identified in research-based of NOLA

Neighborhood Healing Centers funded by Hospitality, Entertainment, Tourism Tax $$$

All justice systems participation in Trauma-Informed Care

Trauma sensitive school staff/training to display more compassion

Diversion & Rehabilitation Programs vs. Incarceration & Punitive Actions

Recreational Youth Spaces that are Free, Accessible, & Well Kept

Smaller classroom sizes with educators that are compassionate, well trained & held accountable

COMMUNITY ASSETS

Youth-led and elder supported initiatives

Crime reduction = Mental Health Accessibility (decriminalized)

Trauma Based Resources included in Education System – Increased local and national awareness

Civilian Review Board for NOPD (Police accountability)

Healing Centers in school

Embedded in school funding

Transformative Justice and Contemplative Practices implemented in school curriculum

More activities for kids during the summer

Universal screening for trauma in schools

Increase advocacy and support in schools

STANDARDS

Agreed upon standard measure that specifies what constitutes a trauma-informed organization (eg, MHR, NORD facility, after school program., etc.)

Accountability body in existence that has carried out the task forces recommendations in the form of an action plan and does ongoing monitoring of an agreed upon standard.

Agreed upon universal screening tools that organizations will use and share data.

What happened vs. what's wrong --> Recognizing trauma is a law/protocol

FUNDING

Proper funding for agencies and mental health professionals

Resolutions to cease incarceration of juveniles, alternatives to incarceration to understand the "why" of the action

Having collaborations with educational institutions and mental health professionals to better inform of trauma

Collaborate with City Officials and solicit support for trauma-informed services

DEEP DIVES INTO DOMAINS

POLICY IS RESHAPED TO BE TRAUMA-INFORMED

- Identify current policies and compare to the standard. Edit to align to the standard and identify gaps that need to be filled.
- Any trauma-informed policies should demonstrate an understanding of the issues of racism, equity and doing no harm, as well as accountability and promoting well-being
- Policy language should be easily understandable and in common language
- Policy development should include people impacted by the policy and consider intersectionalities
- Implementation and training must be considered in policy development
- Policies must include multiple, varied, and ongoing opportunities for community feedback and engagement, as well as pathways to operationalize feedback
- The community must be engaged beyond policy development, and throughout implementation and monitoring
- Policies must include accountability and oversight mechanisms
- Policies must be aligned across all levels
- Systematic structures are based on racism and power differentials – policy remedies need to address the inequity born from these structures

PHYSICAL ENVIRONMENT PROMOTES SAFETY AND RESILIENCE

Current Reality
- Toxic soil and lead in the water leads to Black homeowners developing cancer
- Bikes getting stolen forces kids to stay inside and creates a risk to going outside
- Kids want to make it out and the mentality is "every man for himself" – there is no focus on going back in
- Not every kid wants to play basketball; teens are too old for camps; no age appropriate jobs or opportunities for pro-social skill building
- Public transportation to recreation sites is lacking
- Nowhere for kids to play; have to carry gun
- Party buses are a cultural experience where kids can have fun - how have the new regulations affected this?
- There is a gap in physical spaces for certain age brackets/gendered activities

Our Vision
- Safe environments for children to play
- Education on who and what is safe
- In New Orleans East, re-develop mindset changes stigma. We can envision re-development.
- Pride in space – not just living space but a sense of self is developed by your space in relation to others' space
- Pro Black Home-ownership in communities (having to LEAVE home to get better contributes to trauma)
- Psychological Safety – kids are allowed healthy psychological development
- Kids can be themselves in spaces that feel safe
- We can communicate through environments that kids are

SCREENING, ASSESSMENT, AND EVIDENCE-BASED, CULTURALLY APPROPRIATE TREATMENTS ARE IN PLACE FOR IDENTIFYING AND RESPONDING TO TRAUMA

Screening and Assessment

- Systems level change alongside treatment
- Currently there is no uniform screening/assessment in place - universal screening assessment is needed
- Screening happens in different places and data is not being shared
- Kids are not being screened because intervention resources are not available
- There is a fear of screening because the next step is connecting individuals to services. This fear needs to be considered when planning for screening/assessment.
- Must include family in conversation around screening

Treatment

- What is "culturally appropriate" and "evidence-based"? Clarify and define for practioners / providers
- Training for providers in evidence based practices – not everyone has access to EBP training. Paths for access are needed.
- How do families with complex issues relate to "evidence-based" practices?
- Must have more community and family buy-in
- Different lenses exist based upon experiences. There are differences in the meaning of "treatment."
- Treatment should go beyond a medical and clinical definition; it needs to include education/activities which contribute to positive relationships where children and youth tap into resilience
- Not every child needs to be "diagnosed"
- Individuals fall through the cracks; there are too many organizations doing the same thing with the same approach and methodology
- Currently there is no plan to the continuum
- We need evaluations of interventions

FINANCING MECHANISMS MAKE TRAUMA-INFORMED PROGRAMS, INNOVATIONS, AND TRAUMA-SPECIFIC SERVICES SUSTAINABLE

Assumptions:

1. Quality is defined
2. There is a shared value framework: we all want this

Recommendations:

A. Promote transparency on COST
   1. Use funder relationships to be clear about real cost to heal
   2. Identify and set a resource floor for all critical spaces for youth

B. Monitor EFFECTIVENESS
   1. Ensure money results in real intervention
   2. Consider both "evidence-based" and local/home-grown solutions
   3. Hold quality accountable
   4. Take a closer look at where money in practice causes harm

C. Call for RESOURCES
   1. Name and understand all active funding sources
   2. Acknowledge and address cash flow constraints
   3. Call out "hidden" or inactive capital (tax breaks, legacy dedications) and reconsider what could happen if fiar taxes, etc. were actually in practice (historical analysis, racial equity analysis)

ENGAGEMENT AND INVOLVEMENT OF ALL CITIZENS AND ORGANIZATIONS IS ENCOURAGED; NO GROUP, SECTOR OR INDIVIDUAL IS EXCLUDED

- Cross-sector collaboration must be the norm
- Meet people where they are at - host convenings and conversations in community spaces and for working people
- NOPL encourages the use of the public library as a space for meaningful convening and collaboration
- Create and maintain pathways for people with lived experience to offer feedback and inform decision-making
- Keep people informed on policies, rules, and activities by convening in community spaces

6. Screening, assessment, and evidence-based, culturally appropriate treatments are in place for identifying and responding to trauma.

FEEDBACK & IMPACT STATEMENTS

WE ASKED: HOW DID WE DO ON ACCOMPLISHING OUR OBJECTIVES FOR THE DAY?

30% of participants shared post-event feedback

86.36% AGREED THAT WE DEFINED CURRENT CONDITIONS OF TRAUMA IN NEW ORLEANS

81.81% AGREED THAT WE BEGAN TO BUILD A FRAMEWORK FORWHAT A TRAUMA-INFORMED NEW ORLEANS WOULD LOOK LIKE

1 OUT OF 2 PARTICIPANTS AGREED THAT WE IDENTIFIED THE CURRENT CAPACITY THAT EXISTS TO RESPOND TO TRAUMA

1 IN 2 PARTICIPANTS AGREED THAT WE DOCUMENTED THE PARTNERS AND RESOURCES AVAILABLE TO SUPPORT EFFORTS TOWARDS BECOMING A TRAUMA-INFORMED CITY

"EXCELLENT LEARNING OPPORTUNITY TO SUPPORT POSITIVE HEALTHY COMMUNITIES"

"THE FRAMEWORK AND PLANNING PORTION WAS SUCH AN AMAZING CONVERSATION, ONE THAT IS USUALLY MISSED WHEN DISCUSSING HOW MUCH TRAUMA THERE IS IN NEW ORLEANS"

"LOVED HEARING YOUTH VOICES!!"

WHAT DID YOU FIND MOST VALUABLE?

- Ability to network
- Info on how to develop resilience to combat trauma
- The information provided
- Excellent learning opportunity to support positive healthy communities
- The exchange of ideas in a well-structured format
- Bringing stakeholders together
- Learning about other organizations providing trauma-informed services to youth
- Learning about the groups doing cool things in the city
- Loved hearing youth voices! Framework and planning portion was such an amazing convo, one that is usually missed when discussing how much trauma there is in New Orleans.
- The envisioning and implementation planning
- Breakout groups
- The information that was presented and the group discussions
- There were many different stakeholders from various organizations and institutions present. Typically these events are more academic – I appreciated the different perspectives.
- Networking with providers
- Hearing speakers talk about how they use their personal experiences to address trauma with the folks they serve
- The panels, hearing the voices of the youth, discussions, collaborative activities
- The kids/students experience and how they view NOLA and their own perceptions of how they are understood/perceived
- Having youth voice present. Would encourage more.
- The framing of the issue with data
- Networking with people whom I wouldn't necessarily get to meet and hear the perspectives from.
- Loved videos from youth.
- The breakout discussions.
- Children voices/ experiences
- Common goals of efforts for the next 3 years
- What can kids do for fun? In the summer?
- Defining trauma and getting into the 10 principles
- Diversity in sectors/providers in attendance
- Meeting other organizations
- Interpersonal connections – dialogue at the end, specifically +3 goals on 3 years activity
- The opportunity to connect and reconnect with other providers doing the work.
- I found it very valuable that so many people came out to push the effort of bettering our community/youth
- I appreciate the attention to asset mapping, data on defining trauma, the voices of the youth
- I found the information valuable
- Knowing there are so many other people in the city doing similar work towards the same goal.   Also, we loved hearing how all of our youth in the panel listed

RECOMMENDATIONS FOR FUTURE CONVENINGS

- Do this again!
- Discussion of deliverables from the preceding summit to give a sense of accomplishment and advancement – changes made to agency goals, new partnerships formed, grants won, etc.
- Give CEUs and CLUs, charge for the event and require that the certificate at the end of the summit
- A more comfortable room with more opportunities for intimate conversation
- Focus on schools, school reform, assess charter, for-profit system's impact.   Equity. Focus on non-punitive approaches (as mentioned) and de-stigmatization of trauma and mental health issues
- Would like access to more of the trauma data
- More time for group work
- Update info + services + treatments – moving forward
- More in-depth discussions on how to move things forward community-wide discussing policies that can help with this (does the policy need to be introduced/overhauled?)
- Infuse opportunities for self-care and mindfulness activities. I like the music that was playing and opportunities for breaks, but I find that discussions about ACES, Attachment, etc. can be triggering or upsetting for some folks.
- Probably should shorten the convening to retain more folks for the evening event
- More opportunities for brainstorming, conversations
- Better marketing/more involvement across states/think local --> act global. Agenda released at minimum of 24 hours before the meeting. Academic research to add to the discussion. People in field adding to discourse.
- Shine light one examples of cities that have done this successfully.
- 30 minutes is not enough time to hear Dr.

Shervington speak!   Wish we could have heard much more about the local research. More time in the planning sessions.
- More public health participants - this is a necessary convo for experts in the field to have. Allergen-free foods. Colleague with dangerous airborne nut allergy had to leave because of Zapps potato chips.
- Possibly a shorter day. It's a lot to go through in one day and stay present.
- Just to do more! This was valuable for me as a TIC practitioner.
- More elected officials at the table, as well as OPSB and NOPD
- The thru-line was not clear and the connection between activities was not always clear
- Programming, jobs, camps, outlets (valuable parks, foundations)
- It is vital to implement physical movement and/ or resilience practices for summit attendees during the summit. The importance of arts/arts sector was not mentioned and that is a critical aspect of becoming a trauma-informed city.
- Make it shorter, too long, too much talking, more videos, more activity
- Having more connections between organizations already doing this work. More introductions to everyone in the room.   I would also like to see action plans and next steps come out of the summit.
- I would like to see more youth, criminal justice systems and educational leaders available at the summit.
- I'd like to see more youth presence and representatives from the Criminal Justice system and Church environment.
- More clear agenda for day in terms of food provided, longer lunch break, healing certified gathering (adequate pacing, offerings)
- Resource info shared ahead of time and/or afterward (not just in discussion or on the fly)

SUGGESTED NEXT STEPS FOR MOVING THE WORK FORWARD

- I have to say this was very visionary, bud did not consider at all funding, in a city that can't pay to fix its potholes. It could stand to be more grounded.
- Bring this summit to the groups that this makes an impact to
- Deliverables to execute
- Provide participants with contact info for other participants to help facilitate easier collaboration
- I would have liked more discussion on the public education component and how we can get people to buy into the work
- Small groups to convene between summits
- Conduct trainings in various professional sectors
- Possibly sending out a questionnaire in 6 months to conference participants to see how they/their organizations are implementing the changes (ie. moving things forward) discussed at the conference.
- Continue to bring stakeholders to the table, include more families and young people
- Get input from impacted people to tell their stories and give solutions
- Really including parents/youth voices in every step of the process
- Continued involvement – a yearly summit to track progress
- N/A
- The conversation must be inclusive of all systems that touch young people
- What are recent research findings about trauma in NOLA?   Both qualitative and quantitative representations would help some of us more data-informed individuals.
- We have numerous of MHRs in this city doing more damage than good and there is not an accurate list of current MH services in the city. It's hard to know where is even open. We should have mandatory registration list for ALL clinics, facilities, and counseling centers.
- There were the first steps of understanding/naming needs and deltas within New Orleans, but I want to actually plan some actionable with task force. We've got lots of work and dismantling to do! Let's make some coalitions with participants!
- For next steps we (also the entire community) can stay updated on everything and put every thought into action
- Contact: laura@dancingrounds or info@dancingrounds.org to help workshop or facilitate art based movement and resilience practices.
- Let's make a cohort (trauma warriors...LOL, possible name)
- I think there could have been a larger emphasis on our edu system. I think schools are an easy place for this work to start since they have access to all of our youth.
- Centralized resource for information shared at the summit
- Youth involvement and increase the participation of the faith communities.
- Sending invitations to churches in the Orleans area making them aware of this service.
- I got many suggestions/ideas for moving work!
- Accountability for influencers – the more that we can get their buy-in the more successful this will be. (so it's top-down and bottom-up work)

LIST OF ATTENDEES

Lynette Adams
Tiffany Aidoo
Mary Alexanderson
Merlin Alexis
Bree Anderson
Lillie Iris Andrews
Caleigh Balsamo
Kristie Bardell
Sharon Barnett-Starks
Troi Bechet
JoAnn Blair
Shawanda Blatcher
Lucy Blumberg
Cozette Boakye
Joy Bruce
Aureal Buckner
Alexander
Deirdre Burrel
Joyce Rabb Butler
Dominique Butler
Lucia Campos
Johanna Canniz-Bright
Paulette Carter
Kaelyn Charbennet
Gabe Christian-Solá
Brenda Clark
Aaron Clark-Rizzio
Kristen Corby
Ranord Darensburg
Mya Ebanks
Sheryl-Amber
Edmondson
Addie Fargason
Jason Foster
Veronica Freeman
Denise Garrison
Wendy Giere Frye
Karen Gilmore
Shametria Gonzales
Rashida Govan
Victoria Grant

Sarah Green
Lyn Hakeem
Torrie Harris
Jesse Hartley
Ava Hernandy
Teddy Houston
Judge Arthur L. Hunter, Jr.
Katie Hunter-Lowrey
Chelsea Hylton
Christina Illarmo
Monique Johnson
Djenaba Jones
Dominque Jones
Kelli Jordan
Jarred Jupiter
Sheetal Kandola
Heather Kindschy
Sam King
Reign Lalour
Keith Lampkin
Caitlin LaVine
Nathan LeJeune
Sarah Lewis
Clara Love
Olivia Mancing
Jesse Manley
Nolan Marshall
Kate Martin
Kenisha Martin
Kate Martin
Kristen McCallum
Peggy Mendoza
Jerita Mitchell
Ajia Mitchell
Nikkisha Napoleon
Melissa Newell
Christopher Nulph
Chandler Nutik
Sarah Omojola
Emily Painton

Vern Plotkin
Alison Poort
Sierra Powell
Leticia Provost
Sarah Quattlebaum
Alexis Reed
Melanie Richardson
Catherine Rieder
Brianna Rock
Christy Ross
Bridgette Ryan-Ortiz
Samantha Sahl
Torin Sanders
Cardinal Seawell
Madorah Sesay
Iman Shervington
Afsoon Shirazi
Amanda Simpkins
Adrienne Strock
Jessica Styons
Hanna Tadevich
Janelle Temple
Monica Turner
Maria Victoire
Kathleen Whalen
Angela Wiggins
Jason Wiliams
Irene Williams
Sombra Williams
Cleanelle Williams
Ty Williams
Paris Williams
Roy Williams

Public Health Partnerships for Trauma Transformation

GETTING STARTED. For many years, Philadelphia has been a leader in developing and implementing trauma-informed approaches. It began in the 1990's, with local and national experts providing trauma training across the city. When Arthur Evans, PhD, became director of the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) in 2004, he made a commitment to developing a Recovery and Resilience Oriented System of Care (ROSC). This commitment set in motion a decade of systems transformation which included adopting trauma-informed approaches as one of the ten core values of the ROSC framework.

Philadelphia has many strengths, including local expertise, strong institutions and visionary leadership. However, the city also faces many challenges. Thirty percent of the population lives below the poverty line and unemployment is close to 20% in some inner city areas. Problems persist across generations, and there are significant disparities in access to services and supports. Philadelphia also has the highest homicide rate of the ten largest American cities.

The Philadelphia model is characterized by a public health approach, partnerships focused on trauma-informed transformation, and a continuum of prevention, treatment, intervention, and continuing care. The Trauma Transformation Initiative, established in 2010, now includes the schools, the police department, housing agencies, the judicial system and academia as well as hospitals and behavioral health agencies.

The *Substance Abuse and Mental Health Services Administration* (SAMHSA) has a long-standing commitment to addressing the impact of trauma on individuals and communities. The *SAMHSA Spotlight Series* highlights different approaches to building trauma-informed, resilient communities. A setting is trauma-informed if the people in that setting *realize* the widespread prevalence of trauma, *recognize* the signs and symptoms, *respond* in an understanding and supportive manner, and *resist* doing further harm.

The goals of the *Spotlight* series are to:
1. Highlight innovative approaches to trauma-informed community change.
2. Provide information to other communities interested in becoming trauma-informed.

POPULATION: 1.5 million

FOUNDED: 1682 by William Penn

Called City of Brotherly Love

History shaped by influxes of European immigrants and African Americans during the Great Migration

Home to 7 Fortune 1000 companies

Site of the first U.S. library, hospital, medical school, stock exchange, business school, and zoo

Home to more outdoor sculptures and murals than any other American city

The first Recovery Walk in 2004 had 425 participants, the 2014 Walk had 23,000

Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

The Change Process

FOCUS ON PROMOTING POPULATION HEALTH BY TRANSFORMING NEIGHBORHOODS

One vibrant example of this collaborative spirit is the *Porch Light Program*, the product of a vision shared by DBHIDS and the Philadelphia Mural Arts Program. This vision centers on using art as a public health strategy, strengthening community engagement, promoting a recovery perspective in behavioral health, and addressing social and economic factors such as poverty, racism, violence and resource disparities.

The Philadelphia model is characterized by a population health approach and partnerships focused on trauma-informed transformation, placing human connection at the heart of wellness and healing.

The *Porch Light Program* is a unique collaboration among local artists, individuals experiencing mental health, substance use and intellectual disability-related challenges, service providers, local funders, and academic partners. Together they co-create public art in neighborhoods across the city, improving morale, building connections, and healing communities by exploring health-related issues. Since 2007, over 20 murals have been created. Each focuses on an issue like substance abuse disorders, spirituality, homelessness, trauma, immigration, war or community tensions. The *Porch Light Program* reduces isolation and invisibility among people with behavioral health challenges and gives voice to individuals and communities that are often excluded.

The impact of the program does not end with the dedication of a mural. Relationships forged during the process often lead to ongoing activities. In one neighborhood, the collaboration led to a yearly conference to address community concerns. Porch Light also has an impact beyond the neighborhoods in which the murals are located. Trolley tours of the project, with trained tour guides and certified Behavioral Health Peer Specialists, provide an opportunity for the public to learn about the artwork as well as the issues illustrated.

There are three basic steps in the program. In the *Engage* phase, trusting relationships are built through a variety of community activities. In the *Create* phase, stakeholders work together to build a visual language and a collective vision for the project. In the final phase, *Generate,* the mural is hand painted by the community members involved in the project.

Photo by Steve Weinik

Personal Renaissance
© 2010 City of Philadelphia Mural Arts Program / James Burns

Spotlight on Implementation

CROSS-SECTOR COLLABORATION. Philadelphia's commitment to a public health approach has resulted in powerful cross-sector collaboration. Efforts to address community violence, for example, include the health care, community education and youth service sectors: a 33-foot vehicle drives around the city with the message "Stop Shooting People," youth leadership and peer mediation help to interrupt gang violence (CeaseFire), and a hospital-based program provides trauma-informed support systems to young men wounded in street violence (Healing Hurt People). The Philadelphia approach involves community-level partnerships, collaboration at the leadership level across the full range of systems, and strong commitment to social justice and equity.

SCREENING/ASSESSMENT/TREATMENT. Current priorities for screening/ assessment/treatment include expanding screening and identification using evidence-based instruments, educating clinicians and intake coordinators on early diagnostic screening and referral for trauma-focused treatment; implementing evidence-based practices for the LGBTQ community and for people with co-occurring disorders, and strengthening clinical supervision and mentorship. DBHIDS also created an online mental health screening tool which can identify mental health and substance abuse challenges, also located at supermarket kiosks around the city.

TRAINING AND WORKFORCE DEVELOPMENT. The DBHIDS Behavioral Health Training and Education Network (BHTEN) provides a framework for infusing the principles of recovery, resilience and self-determination into the behavioral health service system with trainings such as *Toward Trauma-Informed Practice: Support for Recovery and Resilience*. DBHIDS has trained more than 30 providers in trauma-informed organizational change using the Sanctuary Model and trauma-focused practices such as Trauma-Focused Cognitive Behavioral Therapy and Prolonged Exposure Therapy. DBHIDS has also trained over 60 of its own staff in the Sanctuary Model to promote community and to improve policies and practices.

SAMHSA'S IMPLEMENTATION DOMAINS

SAMHSA has identified 10 domains that are essential to the implementation of trauma-informed approaches in both organizations and communities. Domains highlighted in this document are indicated by arrows. For further information, see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

1. Governance and leadership communicate and support the vision of a trauma-informed community.

2. Policy is reshaped to be trauma-informed.

3. Physical environment promotes safety and resilience.

4. Engagement and Involvement of all citizens and organizations is encouraged; no group is excluded.

5. **CROSS SECTOR COLLABORATION** is the norm.

6. **SCREENING, ASSESSMENT, AND TREATMENT** are in place for identifying and responding to trauma.

7. **TRAINING AND WORKFORCE DEVELOPMENT** are available for organizations and for the general public.

8. Monitoring and quality assurance processes are used uniformly to inform and improve services.

9. Financing mechanisms make trauma-informed programs and trauma specific services sustainable.

10. Evaluation data are collected from a variety of perspectives.

Philadelphia Highlights

- The DBHIDS Evidence Based Practice Innovation Center (EPIC) supports and promotes promising practices to improve the quality of services for children and adults

- The Pay for Performance initiative provides incentives for improving quality of clinical care through use of a performance metric.

- The Forensic Diversion Court Initiative provides justice-involved individuals with trauma-informed case management and access to trauma specific treatment services in lieu of incarceration and hefty fines.

- The Philadelphia Urban Ace Study, with support from the Robert Wood Johnson Foundation, conducted a study on the impact of adverse childhood experiences (ACEs) on Philadelphia residents.

- Mental Health First Aid is a public education program that teaches how to help individuals who are experiencing a mental health crisis. Philadelphia has trained over 10,000 Veterans, military families, and individuals from higher education and public safety.

- The DBHIDS Faith and Spiritual Affairs initiative uses a public health approach to reduce the stigma of behavioral health in communities of faith. By partnering with faith and spiritual communities and other stakeholders, DBHIDS expands access to health care in the community.

MOST SIGNIFICANT CHANGE: Among many profound changes, the most significant has been the transformation of the behavioral health system from a traditional medical model of service delivery to a trauma-informed, recovery- and resilience-oriented system of care.

COMMUNITY TO COMMUNITY SHARING. Nationally, Philadelphia has been inspired by The National Council of Community Behavioral Health Services' trauma initiative; Chicago's Cure Violence Program; the President's New Freedom Commission on Mental Health 2003; and SAMHSA. The city has been a catalyst for change in many other communities. In 2008, DBHIDS began hosting study tours for professionals who want to understand how the department's transformation efforts embody the principles of recovery, resilience and self-determination stakeholders. To date, they have hosted 46 tours with representatives from over 35 U.S. cities, states and federal agencies and 8 foreign countries.

FOR FURTHER INFORMATION:

Porch Light Program
http://muralarts.org/programs/porch-light

Behavioral Health Training and Education Network
https://www.bhten.com/

The ACE Survey
http://www.cdc.gov/ace/about.htm

Child Adversity
http://developingchild.harvard.edu

Community Resilience Communities Building Resilience
http://communityresiliencecookbook.org

http://www.creatingcommunitysolutions.org

Prevention of Sexual Assault and Relationship Violence
http://www.preventconnect.org/

Mental Health and Wellness
http://www.preventioninstitute.org/focus-areas/promoting-mental-health-a-well-being.html

A healthy mind is as important as a healthy body

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

A Coalition in the Business of Compassion

GETTING STARTED. The Kansas City metropolitan area spans eight counties in two states. When Marsha Morgan convened the first Trauma Matters KC (TMKC) meeting in February 2012, trauma champions from both sides of the Missouri river joined forces.

Agencies within the two states had followed slightly different paths. In Missouri, the Department of Mental Health had created a statewide group of "early adopters" – community mental health centers, residential programs and other agencies committed to becoming trauma-informed. In Kansas, the Johnson County Trauma-Informed Task Force, with 16 participating agencies organized under United Community Services, provided leadership. By 2012, there was growing support for community-wide action. The city faces significant social challenges, including large income disparities. For example, Johnson County is one of the richest counties in the nation, while Wyandotte County is one of the most economically challenged. In a 2011 needs assessment, pediatricians, nurses, mental health providers, teachers, families and adolescents all identified addressing trauma and building resilience as a priority.

Members from 12 organizations attended the first meeting of TMKC. Since then, the group has developed a mission statement, organized subcommittees, and conducted community trainings and events. Membership currently includes more than 40 organizations and 100 individuals.

The *Substance Abuse and Mental Health Services Administration* (SAMHSA) has a long-standing commitment to addressing the impact of trauma on individuals and communities. The *SAMHSA Spotlight Series* highlights different approaches to building trauma-informed, resilient communities. A setting is trauma-informed if the people in that setting *realize* the widespread prevalence of trauma, *recognize* the signs and symptoms, *respond* in an understanding and supportive manner, and *resist* doing further harm.

The goals of the *Spotlight* series are to:
1. Highlight innovative approaches to trauma-informed community change.
2. Provide information to other communities interested in becoming trauma-informed.

POPULATION: 2.1 million

FOUNDED: in early 1800's by fur traders; grew rapidly after Civil War as center of cattle industry

Spans boundary between Missouri and Kansas

Resting spot for Lewis and Clark expedition

Known for jazz and sports; hosts professional baseball, football, soccer, and NASCAR racing

Boasts more barbecue restaurants than any other city and more outdoor fountains than any city except Rome

Recently named one of top 30 cities for young entrepreneurs

Home to several well-known foundations supporting health and educational research

The Change Process

FOCUS ON SECONDARY TRAUMA: FIRST RESPONDERS AND TEACHERS

First responders and teachers play essential roles in community well-being, and both groups experience significant on-the-job stress. First responders encounter trauma daily, and are known to have high levels of alcohol use, suicide, divorce, and burnout. Teachers can be deeply affected by trauma in the lives

Captain Darren Ivey, Commander of CIT program and coordinator of police trauma training

of their students. In the past two years, TMKC has partnered with police and schools to build resilience in the workforce and to introduce trauma-sensitive practices.

TMKC is working for widespread change, and their goal is to have as many people and groups as possible involved.

The first step for law enforcement was integrating information about trauma into specialized mental health training for Crisis Intervention Teams (CIT). CIT training includes both front line officers and leadership, and is always at full capacity. As part of the new module on trauma, officers evaluate their own Adverse Childhood Experiences (ACE) scores and learn resilience-building techniques. The new information was so well received that the department

developed a discrete four-hour interactive training program called *Building Resilience: Surviving Secondary Trauma.* This training is offered twice a month, at no cost, to all first responders. Participants have noted that the training helped them understand that the very thing that makes them good at their jobs – their desire to help – can make them vulnerable to secondary traumatic stress. To date, 200 people have taken the course. Afterwards, it is common for trainees to make comments like: "Why didn't we know this before?" and "We want more of this."

The Kansas City Trauma Sensitive Schools (TSS) initiative began in 2013 with a meeting with area Principals, a presentation to the Board of Education, training for school counselors and nurses, and identification of schools to participate in a pilot project. In its first two years, TSS trained more than 80 educators and worked with more than 1300 students. Teachers report that the training has had a positive effect on both their personal and professional lives. They are implementing trauma sensitive practices in the classroom, and using "professional self-care plans" has helped create a more rewarding teaching experience. Students also report using new resilience tools and skills. Nine additional schools and school districts have requested or received consultation. As they begin their third year, the TSS team has identified several critical factors in implementing change in a large school system, including internal resilience champions, support from school leadership, focus on staff self-care, building staff capacity, and allowing sufficient time to build trusting relationships and time for self-study and coaching.

Spotlight on Implementation

LEADERSHIP. TMKC is neither a traditional organization nor an issue-based coalition with fixed membership. They are working for widespread change, and their goal is to have as many people and groups as possible involved. They chose as their model a new form of organization called a "movement network." Movement networks reflect the complexity of social problems, balancing the needs of individual members with collective action, maintaining fluid structures, and distributing leadership. Following this model, Marsha Morgan, the first Chair of the group, soon turned the reins over to co-chairs from Kansas and Missouri. Together they have made leadership development an ongoing activity. Monthly meetings are open, decision-making is by consensus, and a guest speaker – either a trauma survivor or a local agency representative – is featured each month. Afterwards, one of the more established members stays on to make sure new participants are oriented to the group and know that their contributions are welcome.

TMKC members with original logo.

CROSS SECTOR COLLABORATION. One of the most striking aspects of TMKC is the breadth of community involvement. At any monthly meeting you might find a landscape architect whose designs promote resilience, a judge who runs a trauma-informed court, an author or journalist who wants to learn more, a sports coach concerned about the young people on his team, or a community planner considering implications for urban development. The business community also plays an important role. In 2015, the KC Chamber of Commerce, in partnership with KC Blue Cross and Blue Shield, issued a plan for Healthy KC that includes a specific recommendation that their members become trauma-informed.

1. **GOVERNANCE AND LEADERSHIP** communicate and support the vision of a trauma-informed community.

2. Policy is reshaped to be trauma-informed.

3. Physical environment promotes safety and resilience.

4. Engagement and Involvement of all citizens and organizations is encouraged; no group is excluded.

5. **CROSS SECTOR COLLABORATION** is the norm.

6. Screening, assessment, and treatment are in place for identifying and responding to trauma.

7. Training and workforce development are available for organizations and for the general public.

8. Monitoring and quality assurance processes are used uniformly to inform and improve services.

9. Financing mechanisms make trauma-informed programs and trauma specific services sustainable.

10. Evaluation data are collected from a variety of perspectives.

Kansas City Highlights

- Crittenden Children's Center has developed a trauma-informed Head Start program called Head Start-Trauma Smart that is now nationally known as a best practice.

- The TMKC public awareness committee has partnered with a local violence prevention project, Aim4Peace, to help participants understand the impact of trauma and promote resilience.

- Local foundations, including the REACH Foundation, the Healthcare Foundation of Greater KC, and the Jackson County Mental Health Fund, have recognized the importance of the effort by providing financial support.

- In the spring of 2014, the first citywide "Resilience Day" was held. A weekly e-newsletter, the Resilience Register, currently goes directly to almost 600 recipients.

- Several behavioral health agencies have been certified or recognized for excellence in trauma services, including Cornerstones of Care (certified in the Sanctuary Model) and KVC Health Systems (recognized as Center of Excellence in Trauma Systems Therapy.)

MOST SIGNIFICANT CHANGE: People in Kansas City are now involved in addressing toxic stress, trauma, and resilience.

COMMUNITY TO COMMUNITY SHARING. TMKC drew inspiration from a number of sources, including Peace4Tarpon in Florida; the state of Wisconsin's Shift Your Perspective initiative; Canada's Handbook on Sensitive Practices for Health Care Professionals; and the Anna Institute. Kansas City played a key role in the development of a statewide developmental model for implementing trauma-informed approaches. Following the SAMHSA community trauma meeting in May 2015, several communities from across the country have contacted TMKC for assistance in developing police trauma training initiatives.

FOR FURTHER INFORMATION:

Trauma Matters KC
http://www.marc2.org/traumamatterskc/

The Missouri Model: A Developmental Framework for Trauma-Informed"
http://dmh.mo.gov/trauma/

Trauma Matters KC logo, designed to convey a spirit of growth, resilience and compassion.

Aligning the Workforce to Create a Trauma-Informed System

GETTING STARTED. The San Francisco Department of Public Health (SFDPH)'s "Trauma-Informed Systems" (TIS) initiative began in 2012 with a workgroup commissioned by the Department's Director, Barbara Garcia, and chaired by Dr. Ken Epstein, Director of Children, Youth and Families. SFDPH recognized trauma and toxic stress as a critical health concerns, with detrimental effects on agencies, people served, and across generations.

The Department has over 9,000 employees working in public health, hospitals, and ambulatory care services. They serve a city that has many assets, including a diverse population and a number of nationally recognized trauma experts. San Francisco also has challenges, including a large gap between rich and poor and significant racial disparities.

The workgroup recognized that using a trauma-informed framework could help improve services as well as address trauma in the workforce. Using a participatory leadership model and principles of implementation science, they convened a series of conversations with workers throughout the system to discuss implementing a trauma-informed framework. The resulting plan had two overarching goals – to create a common language and set of principles and to create ongoing, sustainable organizational change. Currently they are training all 9,000+ employees, implementing trauma-informed practices, and leading a coalition working towards a regional trauma-informed change.

POPULATION: 800,000

FOUNDED: originally a Spanish (later Mexican) mission; became part of the U.S in 1846

Built on 43 hills; has the world's largest landlocked harbor

Showed great resilience after 1906 earthquake and fires; 139 cisterns now located across the city

Not one SF bank failed during 1929 stock market crash

Has over 300 coffeehouses

Despite relatively small size, ranked 4th in the world in number of billionaires

Cable cars are the world's only moving National Historic Monument; almost 10 million people ride annually

The *Substance Abuse and Mental Health Services Administration* (SAMHSA) has a long-standing commitment to addressing the impact of trauma on individuals and communities. The *SAMHSA Spotlight Series* highlights different approaches to building trauma-informed, resilient communities. A setting is trauma-informed if the people in that setting *realize* the widespread prevalence of trauma, *recognize* the signs and symptoms, *respond* in an understanding and supportive manner, and *resist* doing further harm.

The goals of the *Spotlight* series are to:
1. Highlight innovative approaches to trauma-informed community change.
2. Provide information to other communities interested in becoming trauma-informed.

Substance Abuse and Mental Health Services Administration

SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

The Change Process

FOCUS ON THE WORKFORCE AND ORGANIZATIONAL CHANGE

The TIS initiative recognizes that in order to promote a shared culture, there must be common language, understanding, and commitment to change at all levels of the organization and system. Six core principles were developed to guide change efforts: trauma understanding, compassion and dependability, safety and stability, empowerment and collaboration, cultural humility and responsiveness, and resilience and recovery. These principles, along with suggested competencies for each, form the basis for a foundational training curriculum.

The TIS change process includes the following components:

- Mandatory, foundational training for all 9000+ public health employees.

- A trauma champions learning community designed to support, apply and sustain trauma sensitive practices.

- A train-the-trainers program to embed and harness expertise throughout the system.

- Intentional efforts to align TIS with all workforce and policy initiatives to increase organizational coherence, unity, and outcomes.

- Leadership engagement and outreach.

- Working towards establishing San Francisco as a trauma-informed city.

Foundational training, titled Transforming Stress and Trauma, is a one-time, interactive training delivered in a live format at various locations throughout the city. The curriculum focuses on the impact of trauma on the workforce, people served, and the system as whole. The trauma champions learning community forms the basis for an ongoing network of social change agents.

The foundational workforce training is a unique blend of classroom instruction, vignettes about trauma-informed practice, and a chance to share personal experiences.

The SF Trauma-Informed Systems initiative recognizes that in order to promote a shared culture, there must be common language, understanding, and commitment to change at all levels of the organization and system.

Alignment of organizational efforts is a key component of the change process. Within the Department of Public Health, TIS works closely with the Black and African American Health Initiative to ensure that institutional disparities are addressed. TIS integrates its work with ongoing cultural humility training to deepen understanding of the impact of racism on delivery systems and with staff development activities to build safe and respectful relationships. TIS is also working with the Training and Workforce Development department on a workforce satisfaction survey.

Spotlight on Implementation

CROSS-SECTOR COLLABORATION. The TIS initiative is actively working with other city departments and with agencies throughout the Bay Area. City departments involved to date include Juvenile Probation; San Francisco Unified School District (the eighth largest school district in California, educating over 53,000 students); First 5 (dedicated to the healthy development of children ages 0 to 5); Department of Children, Youth and Families; Human Services Agency of San Francisco, and the San Francisco Police Department. The TIS initiative has also produced early innovator trainings for the Child Abuse Prevention Center, the Family Violence Council, and Child Welfare, among others.

A dedicated Master training team provides live, interactive trainings two times a month for a cross-section of public health employees.

EVALUATION. SFDPH has a strong commitment to evaluation and data-based decision-making. TIS routinely gathers data on all aspects of the change process. A training evaluation is used to collect input on content (including immediate impressions, professional relevancy, and delivery), support for the initiative, and suggestions for improvement. A *Commitment to Change* project is also conducted after every training event. This project asks participants to commit to a specific action integrating TIS principles into their daily work. The trainee retains a copy of the form, and the TIS team follows up a few weeks later with a reminder. One month after the training, a subset of trainees are contacted to assess progress. This process is designed to send the message that implementation is taken seriously and that employee change is a major part of sustainability. TIS is also planning to measure the impact of the change process for workers and for people served. Proposed measures include a recently developed Trauma-Informed Principles Strengths and Needs Assessment; individual and systemic commitment to change; organization-wide workforce satisfaction; and multiple sources of client and patient satisfaction.

SAMHSA'S IMPLEMENTATION DOMAINS

SAMHSA has identified 10 domains that are essential to the implementation of trauma-informed approaches in both organizations and communities. Domains highlighted in this document are indicated by arrows. For further information, see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

1. Governance and leadership communicate and support the vision of a trauma-informed community.

2. Policy is reshaped to be trauma-informed.

3. Physical environment promotes safety and resilience.

4. Engagement and Involvement of all citizens and organizations is encouraged; no group is excluded.

5. **CROSS SECTOR COLLABORATION** is the norm.

6. Screening, assessment, and treatment are in place for identifying and responding to trauma.

7. **TRAINING AND WORKFORCE** development are available for organizations and for the general public.

8. Monitoring and quality assurance processes are used uniformly to inform and improve services.

9. Financing mechanisms make trauma-informed programs and trauma specific services sustainable.

10. **EVALUATION** data are collected from a variety of perspectives.

A Community Journey Towards Resilience

GETTING STARTED. In spring 2010, Robin Saenger, then Vice Mayor of Tarpon Springs, first encountered the Adverse Childhood Experience study. It was immediately clear to her that many of the social problems elected officials deal with daily have roots in violence and trauma. She reasoned that if multiple problems have a common cause, they may have common solutions — and the initiative to make Tarpon Springs a trauma-informed city was born.

As Vice Mayor, Saenger understood that citizen participation was key to community change. From the beginning, Tarpon residents joined city officials and committed professionals in shaping the new initiative. A small group started meeting regularly to learn more about trauma and resilience and to develop a strategy for change. By fall 2010, the library announced the purchase of new collections on trauma for adults and children and a community education day had been planned.

Over 250 people came to the first event. Soon afterwards, the initiative was named Peace4Tarpon (P4T), a website and Facebook page were developed, a local TV station featured a series of interviews about the project, and the City Council signed a Memorandum of Understanding to engage with the effort. Since then, trauma-informed practices have taken hold in a variety of organizations. Monthly Steering Committee meetings are open to anyone who wants to participate, and new people and organizations are constantly getting involved.

The *Substance Abuse and Mental Health Services Administration* (SAMHSA) has a long-standing commitment to addressing the impact of trauma on individuals and communities. The *SAMHSA Spotlight Series* highlights different approaches to building trauma-informed, resilient communities. A setting is trauma-informed if the people in that setting *realize* the widespread prevalence of trauma, *recognize* the signs and symptoms, *respond* in an understanding and supportive manner, and *resist* doing further harm.

The goals of the *Spotlight* series are to:
1. Highlight innovative approaches to trauma-informed community change.
2. Provide information to other communities interested in becoming trauma-informed.

Photo credit: Sue Thomas

POPULATION: 23,000

FOUNDED: in the early 1870's by settlers, including adventurers, farmers, artists and fishermen

Oldest city in Pinellas County

Known as the Sponge Capital of the World, the industry was well established by 1890. In the next two decades, over 500 Greek sponge divers arrived

Highest percentage of Greek Americans in any U.S. city; known for Greek culture and religious events

Vibrant arts community and home to world-class Leepa Rattner Museum of Art located at St. Petersburg College

Natural resources include beaches, parks, barrier islands, bayous, and the Anclote River

Substance Abuse and Ment l lth Services Administration
SAMHSA

The Change Process

FOCUS ON OPPORTUNITIES IN THE COMMUNITY AND IN LOCAL AGENCIES

P4T describes their planning process as "organic." That translates, in part, to capitalizing on inspiration and opportunities wherever they arise. In early 2013, the minister at the Unitarian Universalist Church was inspired by the prayer flags at a Buddhist festival. She proposed organizing a "peace flags" event to promote P4T. Three months later, 4,000 peace flags were strung together between palm trees, fluttering in the warm breeze, and thousands of people were learning about trauma-informed communities.

Volunteers are encouraged to "Bring whatever piece/peace they can."

Hundreds of Tarpon Springs residents had played a role. An art therapist helped the minister organize the event. A local hotel donated sheets to be cut into flag-sized pieces. Interns from St. Leo's College did outreach, taking materials to the Farmer's Market, the library, local businesses, churches and schools and collecting completed flags. The Mayor issued a proclamation in support of the event. The City Manager overcame a local ordinance prohibiting hanging materials in public spaces by deeming the project a public art installation. A Unitarian church quilting circle sewed flags together, and volunteers and city employees spent a day stringing them up. The project was timed to coincide with an annual Arts Festival which attracts thousands to the area. As pedestrians and motorists stopped to observe, P4T was there explaining why it is so important to address trauma and demonstrating the power of community involvement.

Volunteers at Peace Flag Event

The Pinellas Ex-Offender Reentry Coalition's (PERC) journey to becoming trauma-informed also started with one person. Denise Hughes Conlon, PERC's clinical director, was inspired by what she heard at the P4T Steering Committee in 2010. When she added the ACE assessment into PERC evaluations, the results were startling. Out of a possible high score of 10, the sex offenders in her program had an average ACE score of 9; women, 7; individuals with substance use issues, 6; and batterers 5. Clearly this was a direction worth pursuing. By 2013, she had incorporated the Seeking Safety curriculum into the substance abuse program, begun addressing trauma among sex offenders, made broad changes to the policy and procedures manual, trained the entire staff, and developed a tool to assess their progress. Plans for the future include the development of a peer support group and the adaptation of a SAMHSA anger management curriculum to include trauma-informed principles and practices.

Spotlight on Implementation

ENGAGEMENT AND INVOLVEMENT.
P4T was founded on the premise
that *every* citizen has a gift to offer to
the community. This "asset-based"
approach permeates all activities.
One of P4T's first steps was to
develop social marketing materials.
Posters were hung throughout the
city, and window stickers reading
"*Peace4Tarpon – Good for Business*"
(or "*Good for Children*" or "*Good for
Families*") started appearing. It wasn't
long before there was a "buzz" in the
community, and people started offering
to help. People contribute professional skills or share personal passions.
For example, a member of the local fire department became the pro bono
videographer. In another example, P4T supports the efforts of a retired
media specialist who organizes volunteers to read to children in the park.
Ripples expand outwards as individuals take the message to their own
networks. In the past 6 months, 2 additional community organizations
have requested assistance in becoming trauma-informed, the Unitarian
Universalist Church and the Probation Office.

CROSS SECTOR COLLABORATION. Members of P4T do not just
collaborate, they share resources. If one person or agency expresses
a need, chances are good that someone else will meet it. When
Suncoast mental health center wanted to place therapists in a high-risk
neighborhood, the Housing Authority offered two apartments, rent-free.
When a social worker described a family about to be evicted with no way
to move their belongings, a P4T member with a truck offered to help.
This spontaneous sharing reflects the belief that community problems are
everyone's responsibility.

FINANCING. P4T has no paid staff and no ongoing funding. They
believe that too much money too soon can create competition instead of
interdependence, and that resources will be found when needed. For P4T,
the most important question is not "Where can we find funds?" but "How
can we use existing resources differently?" So far the strategy has worked.
For example, the first Community Day was supported through a small grant
from the Rotary Club, pro bono speakers, and food from local restaurants.
In another example, over 1,000 community members have participated in a
free 4-hour workshop on Critical Incidents in Trauma Resolution offered by
a local psychologist.

**SAMHSA'S
IMPLEMENTATION DOMAINS**

SAMHSA has identified 10 domains
that are essential to the implementation
of trauma-informed approaches in
both organizations and communities.
Domains highlighted in this document
are indicated by arrows. For further
information, see SAMHSA's Concept
of Trauma and Guidance for a
Trauma-Informed Approach.

1. **GOVERNANCE AND
   LEADERSHIP** communicate and
   support the vision of a trauma-
   informed community.

2. Policy is reshaped to be
   trauma-informed.

3. Physical environment promotes
   safety and resilience.

4. **ENGAGEMENT AND
   INVOLVEMENT** of all citizens
   and organizations is encouraged;
   no group is excluded.

5. **CROSS SECTOR
   COLLABORATION**
   is the norm.

6. Screening, assessment, and
   treatment are in place for
   identifying and responding to
   trauma.

7. Training and workforce development
   are available for organizations and
   for the general public.

8. Monitoring and quality assurance
   processes are used uniformly to
   inform and improve services.

9. **FINANCING** mechanisms
   make trauma-informed programs
   and trauma specific services
   sustainable.

10. Evaluation data are collected
    from a variety of perspectives.

Tarpon Springs Highlights

- In 2014 Tarpon Elementary School raised its performance rating from F to C+. P4T contributed to this progress by providing mentors, tutors, a uniform bank, and home visits.

- P4T publishes a bi-annual resource guide for families, including everything from food banks to recreational opportunities. The guide is published in Spanish and English and is also available online.

- A professor and graduate students at the University of Florida are conducting an evaluation of P4T at no cost to the project.

- St. Petersburg College in Tarpon Springs is currently developing a certificate program in trauma-informed approaches as a first step towards a possible degree program.

- A breakfast held in 2015 for all Tarpon Springs school principals was the first step towards district-wide systems change. Afterwards, one middle school made a commitment to becoming trauma-informed and several others are exploring the possibility.

MOST SIGNIFICANT CHANGE: The number of individuals and organizations donating time and resources to P4T has exploded. A partial list of community partners includes 4 churches, 4 restaurants, 4 small businesses, 5 government agencies, 3 colleges, 1 civic group, and 25 key individuals who donate an estimated $177,000 annually in volunteer hours. Hundreds of others also contribute to specific projects.

COMMUNITY TO COMMUNITY SHARING: Inspiration for P4T came from the ACE study, trauma survivors sharing their personal stories, and the *Trauma Resolution Center* in Miami. New information and ideas were shared by visitors to Tarpon Springs from communities doing similar work, including Greenfield, MA; Ann Arbor, MI; and Sitka, AK. P4T has been the direct inspiration for several other communities, including Kansas City; Warwick, RI; Meadville/Crawford County, PA; and Gainesville, FL.
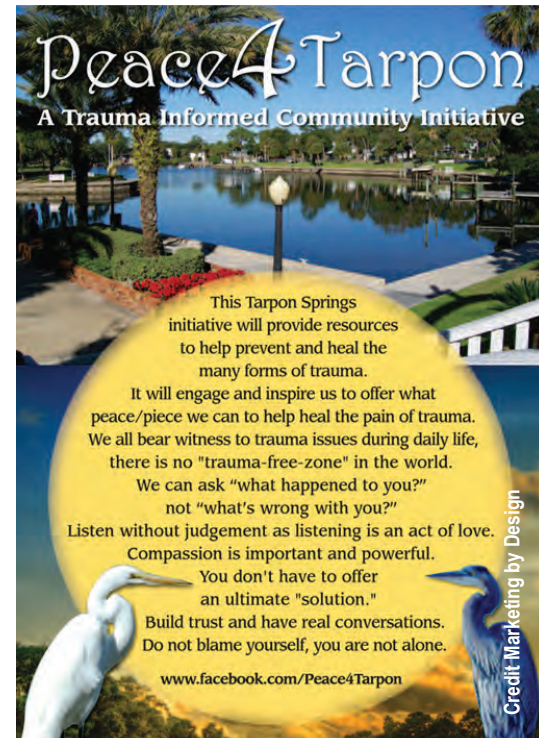
FOR FURTHER INFORMATION:

Peace4Tarpon
http://www.peace4tarpon.org/

Peace4Gainesville
http://www.peace4gainesville.org/

Trauma Resolution Center
http://www.traumaresolutioncenter.net/

Asset Based Community Development
http://www.abcdinstitute.org/

Social marketing poster designed by community members.

Mobilizing a Community for Resilience

GETTING STARTED. In February, 2010, when Teri Barila launched the first team meeting of the Children's Resilience Initiative (CRI) with colleague Dr. Mark Brown, she was building on over 12 years of prior community development efforts. As the Walla Walla Community Network Coordinator (part of the statewide Family Policy Council), Teri had worked with residents to develop an array of responses to community needs and challenges. Through this process, neighborhoods had mobilized and agencies had learned the power of collective action. These existing resources created a "scaffolding" to support the new emphasis on adverse childhood experiences (ACEs).

CRI has two goals – to educate the community about ACEs and the science of brain development, and to build resilience within the community. Walla Walla has amazing resources, but it also has problems: One out of four children lives in poverty, 65% of residents have no more than a high school degree, and gangs and drugs are common. CRI is an intensive, structured collaboration with over 30 partners, including schools, city government, health and social services, law enforcement, justice, the media, business leaders, and parents. The coalition works collectively to increase public awareness, and members work individually to reshape their own agencies and services. Priorities for the future include policy change, sustainability, continued measurement of progress, and increased outreach to the business and faith-based communities.

The *Substance Abuse and Mental Health Services Administration* (SAMHSA) has a long-standing commitment to addressing the impact of trauma on individuals and communities. The **SAMHSA Spotlight Series** highlights different approaches to building trauma-informed, resilient communities. A setting is trauma-informed if the people in that setting *realize* the widespread prevalence of trauma, *recognize* the signs and symptoms, *respond* in an understanding and supportive manner, and *resist* doing further harm.

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2. Provide information to other communities interested in becoming trauma-informed.

CITY POPULATION: 32,000

COUNTY POPULATION: 60,000

Native American name meaning "Place of Many Waters"

In southeast region of Washington, 4+ hours by car to Seattle or Portland

Settled by fur traders, missionaries, soldiers, gold prospectors and pioneers

Has received many civic awards, including Great American Main Street award (2001), Greatest Small City in the U.S. (2011) and Great Places in America: Neighborhood (2012)

Known for agriculture, particularly sweet onions

The Change Process

FOCUS ON LINCOLN HIGH SCHOOL AND THE HEALTH CENTER

The transformation of Lincoln High School is probably the best-known success story in Walla Walla. When Principal Jim Sporleder learned about the ACE study, the school had high levels of violence, serious disciplinary problems, and poor overall student performance. The story of how Sporleder turned the school around has been told in articles, video clips, and in a feature length documentary. An evaluation of changes in the school's performance concluded that after trauma-sensitive practices were implemented, students' resilience increased overall. Students who attained higher levels of resilience also had more positive experiences at school and performed better on grades and standardized tests.

The coalition works collectively to increase public awareness, and members work individually to reshape their own agencies and services.

Several aspects of this transformation are noteworthy. Changes in school policies and in how teachers and students interacted were profound. Disciplinary procedures shifted from an emphasis on consequences to helping students identify and control their own emotions. Teachers began to focus less on stopping challenging behaviors and more on underlying causes. Equally important was the co-location of a health center alongside the school. The Health Center at Lincoln (THC) was developed in response to the recognition that many students were not getting routine health, dental or mental health care. An adaptation of the School Based Health Center model, THC provides essential health services and helps students build resilience by creating social connections, providing concrete support, and teaching social/emotional competencies.

The success of Lincoln High has been an inspiration to other schools. THC has now opened a clinic at Blue Ridge Elementary, which has one of the city's most at-risk student populations. Blue Ridge is also home to one of three local Head Start programs adopting the Head Start/Trauma Smart model.

The Health Center at Lincoln High School

Spotlight on Implementation

PHYSICAL ENVIRONMENT. In a trauma-informed community, neighborhoods are safe, foster strong relationships, and support resilience. Establishing school-based health services is one example of building resilience through changes in the physical environment. To further strengthen neighborhoods, CRI has partnered with a grassroots organization called Commitment to Community (C2C). C2C works to build relationships, trust and ownership among residents and provides a "point of entry" for other service providers. Activities include neighborhood revitalization; social events and celebrations; development of community gardens, parks and recreational opportunities; and provision of basic supports.

BEFORE   **AFTER**

The photos show C2C and neighbors reinventing a local park to increase safety and rekindle community connections.

EVALUATION. Before launching CRI, Barila and Brown spent nine months gathering information on ACEs-related community needs and resources and assessing potential partners' interest in the new project. CRI continues to use data to monitor progress, set new goals, assess impact, and engage in shared learning, such as a recent series of focus groups held with major partners. Because so much of the work is done in partnership, CRI uses the collective impact model whenever possible. In this model, separate agencies use common measurement techniques to evaluate change involving multiple parties. CRI is also participating in an external evaluation of five counties implementing trauma-informed change efforts. This study, which is a project of the ACEs Public-Private Partnership Initiative (APPI), is measuring capacity development, community and agency change, and changes in ACEs-related social indicators.

SAMHSA'S IMPLEMENTATION DOMAINS

SAMHSA has identified 10 domains that are essential to the implementation of trauma-informed approaches in both organizations and communities. Domains highlighted in this document are indicated by arrows. For further information, see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

1. **GOVERNANCE AND LEADERSHIP** communicate and support the vision of a trauma-informed community.

2. Policy is reshaped to be trauma-informed.

3. **PHYSICAL ENVIRONMENT** promotes safety and resilience.

4. Engagement and Involvement of all citizens and organizations is encouraged; no group is excluded.

5. Cross-sector collaboration is the norm.

6. Screening, assessment, and treatment are in place for identifying and responding to trauma.

7. Training and workforce development are available for organizations and for the general public.

8. Monitoring and quality assurance processes are used uniformly to inform and improve services.

9. Financing mechanisms make trauma-informed programs and trauma specific services sustainable.

10. **EVALUATION** data are collected from a variety of perspectives.

Walla Walla Highlights

- Since 2012, the Resilience Trumps ACES website has had almost 21,000 users, over 29,000 sessions and 96,000 page views from 9 countries. Number of requests for the toolkit has doubled.

- The CRI Memorandum of Understanding has led to significant change in policy and practice in many community agencies, including the Children's Home Society and the Court Appointed Special Advocate program.

- Starting in 2013, the City Council designates each October as Children's Resilience Month. A community festival brings the message to a broad sector of citizens.

- A workshop for the business community, using an interactive computer learning lab, helped local businesses determine the cost of unaddressed ACEs to their bottom line.

- Ten agencies are training teams of trainers to help ensure sustainability. Using the *collective impact process*, participating agencies have agreed to a common agenda, goals, and tools to measure impact.

MOST SIGNIFICANT CHANGE: A 2014 health department survey conducted at 5 major community events found that 40% of the general population has a basic understanding of the terms "adverse childhood experiences" and "resilience."

COMMUNITY TO COMMUNITY SHARING. The CRI approach was grounded in the statewide Family Policy Council's community capacity development model, which emphasizes grassroots activism and community empowerment. Their commitment to evaluation was inspired by the University of Washington Communities that Care model. The project also drew from the Attachment, Self-Regulation and Competency model. Many other communities have been inspired by CRI and the Walla Walla experience. Media attention, staff presentations and community-to-community consultation have been important factors in spreading the word.

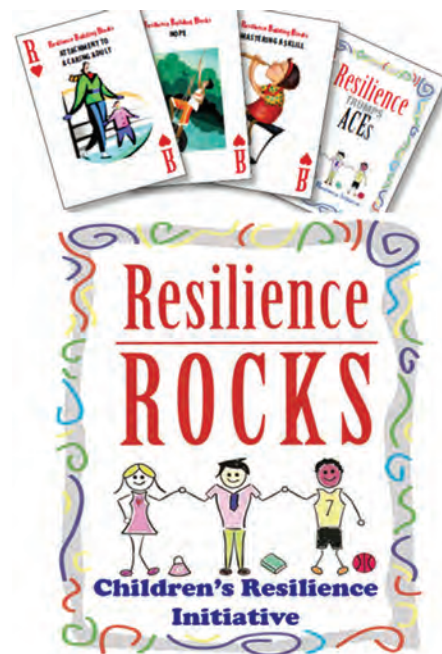**FOR FURTHER INFORMATION:**

Children's Resilience Initiative
http://resiliencetrumpsaces.org/

Commitment to Community
https://www.bmacww.org/services/commitment-to-community/about-c2c

Health Center at Lincoln
www.thehealthcenterww.org

Early LearningCoalition
http://earlylearningwallawalla.org/

Children's Resilience Initiative logo, designed to show that resilience can buffer adversity.

Healing Community by Sharing Lived Experiences

GETTING STARTED. The Central Massachusetts Recovery Learning Community (CMRLC) was formed by individuals who have lived experience with mental health diagnoses, trauma or extreme emotional distress. CMRLC was founded in 2007, with funding from the State Department of Mental Health, to educate the community about the fundamental value of peer-to-peer support in healing, and to ensure that people – whether diagnosed or not – can access peer support.

CMRLC is based on the premise that interpersonal connections can spark innate resilience, and that the experience of wellbeing can arise out of suffering. Sharing personal experiences with trauma does not necessarily lead to emotional or physical crisis. In fact, it can create bonds of deep caring and resourcefulness. While the norm within the general public is more often to quietly deny traumatic experiences, doing so may discourages real wellness and make it difficult to build authentic relationships.

CMRLC leaders are working to build connections with police, health and mental health providers, social services, schools, the justice system, government agencies, civic organizations and the community. Basic to these conversations is the freedom to speak openly about past events. Understanding pathways to supporting each other and to healing from trauma is ultimately humanizing. CMRLC demonstrates to the community that no one needs to stand powerless in the face of pain or crisis.

The *Substance Abuse and Mental Health Services Administration* (SAMHSA) has a long-standing commitment to addressing the impact of trauma on individuals and communities. The **SAMHSA Spotlight Series** highlights different approaches to building trauma-informed, resilient communities. A setting is trauma-informed if the people in that setting *realize* the widespread prevalence of trauma, *recognize* the signs and symptoms, *respond* in an understanding and supportive manner, and *resist* doing further harm.

The goals of the **Spotlight** series are to:
1. Highlight innovative approaches to trauma-informed community change.
2. Provide information to other communities interested in becoming trauma-informed.

COUNTY POPULATION: 815,000

METROPOLITAN AREA: 750,000

CITY POPULATION: 175,000

FOUNDED: by the English in 1673, incorporated in 1722

After Boston, largest city in Massachusetts

Has 15 colleges and universities

Referred to as the "Heart of the Commonwealth"

Home to the oldest musical festival in the country and the largest art festival in the state

First national convention for women's suffrage held in 1850

Home to the first U.S. public park

One of only a few cities to win the National Civic League's "All-America City Award" five times

The Change Process

FOCUS ON COMMUNITY EDUCATION

CMRLC has been working to improve community understanding of mental health, trauma and peer support for almost a decade. One of the first lessons learned was that people have tremendous capacity to connect and support each other in suffering and healing. However, using solely the diagnostic language of mental health often distances people. Rather than building bridges, it creates a chasm between "us" and "them." In contrast, the language and concepts of trauma, adversity and healing can help to connect people.

> **"Human suffering is part of everyday life — not an illness. When outsiders diagnose what is going on, they close off the choices we work so hard to open up."**

Vivian Nunez,
Latinos en Acción

In 2013, CMRLC partnered with the award-winning film company Digital Eyes Film to produce a documentary titled "What Happened to You?" The film includes an interview with Dr. Rob Anda from the ACE study, and examines the impact of childhood trauma through the eyes of CMRLC members. It encourages free discussion about trauma, and aims to open the door for healing. In the past two years, CMRLC has shown the film and led discussions at large community events, in primary health care settings, and in many other forums. These events create an open dialogue about trauma and mental health, and highlight the importance of personal narratives in healing relationships.

CMRLC has also partnered with a number of ethnic and cultural communities. The trauma lens can be particularly powerful in building bridges with people who don't relate to the concept of "mental disorders." Connecting with these communities has been a critical growth experience. CMRLC has learned how complex communities are, with many subcultures within one geographical area. They have seen how important it is to be multi-cultural and multi-lingual and to address historical trauma. And they have learned how people who are reacting to the micro-aggressions of racism can help reshape the mental health system.

Participants in leadership training

Spotlight on Implementation

LEADERSHIP. Every community member is a potential leader at CMRLC. Leadership development activities help people to identify and build on their own strengths, develop and practice skills, and take an active role in addressing internal and external community issues. People learn to talk about their experiences with trauma and mental health without overwhelming the listener with graphic detail and in a way that emphasizes self-empowerment. They learn skills of public speaking, advocacy, facilitation and peer support. And they get involved. CMRLC members join neighborhood councils, participate in community development activities, and get to know their legislators.

CMRLC leaders meet with Mayor Joseph Petty, a consistent CMRLC supporter.

PHYSICAL ENVIRONMENT. CMRLC seeks to create environments that are safe and facilitate recovery. They started by asking the basic question: "What does safety look like?" After numerous conversations, they designed a space that conveys openness and transparency while offering choice. There are both "open" spaces in which everyone can see and be seen and "closed" spaces for privacy. The specific layout is decided by those using a particular space at a given time, based on the needs of the moment. There are no "staff-only" spaces. People ask permission to enter once an activity has started, and bells on the doors alert people to the fact that someone has entered. Efforts are made to avoid loud noises, strong odors, harsh lighting, or other sensory stimuli that might be traumatic reminders. Signs are welcoming rather than controlling, and communication needs and access are part of day to day connection rather than a "special accommodation."

TRAINING AND WORKFORCE DEVELOPMENT. CMRLC emphasizes training and supporting "allies" –those who walk in solidarity with people who have experienced discrimination. The foundation of ally training is understanding personal and cultural identities and forming trusting and safe relationships. Training includes how to be a supportive ally, speaking up in everyday interactions to combat discrimination, and resolving conflicts through distinguishing between intent and impact.

SAMHSA'S IMPLEMENTATION DOMAINS

SAMHSA has identified 10 domains that are essential to the implementation of trauma-informed approaches in both organizations and communities. Domains highlighted in this document are indicated by arrows. For further information, see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

▶ 1. **GOVERNANCE AND LEADERSHIP** communicate and support the vision of a trauma-informed community.

2. Policy is reshaped to be trauma-informed.

▶ 3. **PHYSICAL ENVIRONMENT** promotes safety and resilience.

4. Engagement and Involvement of all citizens and organizations is encouraged; no group is excluded.

5. Cross sector collaboration is the norm.

6. Screening, assessment, and treatment are in place for identifying and responding to trauma.

▶ 7. **TRAINING AND WORKFORCE DEVELOPMENT** are available for organizations and for the general public.

8. Monitoring and quality assurance processes are used uniformly to inform and improve services.

9. Financing mechanisms make trauma-informed programs and trauma specific services sustainable.

10. Evaluation data are collected from a variety of perspectives.

SPOTLIGHT on Worcester, Massachusetts
BUILDING RESILIENT AND TRAUMA-INFORMED COMMUNITIES.

4

Worcester Highlights

- CMRLC works with police to ensure that interactions with the community are trauma sensitive and that peer support resources are routinely made available.

- *Latinos en Acción* is a statewide network designed by and for Latino community members working for mental health recovery and unity. CMRLC works with *Latinos en Acción* to build cultural awareness and to support the development of leadership and ally skills.

- CMRLC's *Parenting Journey* is a place for people who are addressing their trauma histories to reflect on how they were parented, re-write their own stories, reconnect with family members, and ensure that intergenerational trauma will not be repeated.

- CMRLC includes active outreach to young adults. Activities include a support group, a training program called *Finding the Leader in You*, and events on local college campuses.

- CMRLC leaders respond when people are being marginalized and are at high risk for additional layers of trauma, which often happens when seeking help. They work to humanize the connection between people who must use public services to survive and those who are paid to provide them.

MOST SIGNIFICANT CHANGE: Community members and mental health providers in Worcester County now recognize that mental health "symptoms" and behaviors are often responses to trauma. Personal narratives have become valued as an essential part of treatment.

COMMUNITY TO COMMUNITY SHARING. CMRLC was inspired by the ACE study, the affinity group and ally work of Dorrington and Saunders, and the Parenting Journey curriculum from the Family Center of Somerville. Groups inspired by them include the Worcester Police Department, group homes, hospitals, shelters, local legislators and the court.

FOR FURTHER INFORMATION:

CMRLC
http://www.centralmassrlc.org/about.htm

Transformation Center
http://transformation-center.org/

WRAP model
http://mentalhealthrecovery.com/

The Parenting Journey
https://parentingjourney.org/facilitators/impact/

What Happened to You?
https://www.youtube.com/watch?v=EQhqkZSvKs8
https://youtu.be/dYlbAAQgP28

http://www.madinamerica.com/2014/10/call-crazy/

The Kiva Center is CMRLC's physical location in Worcester. The logo is designed to represent wellness, self-determination and reciprocity. The Transformation Center is a Massachusetts network and technical assistance center.

CDC Surveillance And Data Collection For Child, Youth, And Adult Trauma

DATA COLLECTION.—The Director of the Centers for Disease Control and Prevention (referred to in this section as the "Director") may, in cooperation with the States, collect and report data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, and other relevant public health surveys or questionnaires. TIMING. —The collection of data under subsection (a) may occur biennially.
DATA FROM RURAL AREAS. —The Director shall encourage each State that participates in collecting and reporting data under subsection (a) to collect and report data from rural areas within such State, in order to generate a statistically reliable representation of such areas. DATA FROM TRIBAL AREAS.— The Director may, in cooperation with Indian Tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) and pursuant to a written request from an Indian Tribe, provide technical assistance to such Indian Tribe to collect and report data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, or another relevant public health survey or questionnaire. AUTHORIZATION OF APPROPRIATIONS. —To carry out this section, there is authorized to be appropriated $2,000,000 for each of fiscal years 2019 through 2023.

SEC. 7132. TASK FORCE TO DEVELOP BEST PRACTICES FOR TRAUMA-INFORMED IDENTIFICATION, REFERRAL, AND SUPPORT.

ESTABLISHMENT. —There is established a task force, to be known as the Interagency Task Force on Trauma-Informed Care (in this section referred to as the "task force") that shall identify, evaluate, and make recommendations regarding— best practices with respect to children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma; and ways in which Federal agencies can better coordinate to improve the Federal response to families impacted by substance use disorders and other forms of trauma.
(b) MEMBERSHIP. — COMPOSITION. —The task force shall be composed of the heads of the following Federal departments and agencies, or their designees:
The Centers for Medicare & Medicaid Services
The Substance Abuse and Mental Health Services Administration
The Agency for Healthcare Research and Quality
The Centers for Disease Control and Prevention
The Indian Health Service
The Department of Veterans Affairs
The National Institutes of Health
The Food and Drug Administration
The Health Resources and Services Administration
The Department of Defense
The Office of Minority Health of the Department of Health and Human Services
The Administration for Children and Families
The Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services
The Office for Civil Rights of the Department of Health and Human Services.
The Office of Juvenile Justice and Delinquency Prevention of the Department of Justice
The Office of Community Oriented Policing Services of the Department of Justice
The Office on Violence Against Women of the Department of Justice.

The National Center for Education Evaluation and Regional Assistance of the Department of Education

The National Center for Special Education Research of the Institute of Education Science

The Office of Elementary and Secondary Education of the Department of Education

The Office for Civil Rights of the Department of Education.

The Office of Special Education and Rehabilitative Services of the Department of Education

The Bureau of Indian Affairs of the Department of the Interior

The Veterans Health Administration of the Department of Veterans Affairs.

 The Office of Special Needs Assistance Programs of the Department of Housing and Urban Development

The Office of Head Start of the Administration for Children and Families

The Children's Bureau of the Administration for Children and Families

The Bureau of Indian Education of the Department of the Interior

Such other Federal agencies as the Secretaries determine to be appropriate.

(2)   DATE OF APPOINTMENTS. —The heads of Federal departments and agencies shall appoint the corresponding members of the task force not later than 60 days after the date of enactment of this Act.

(3)   CHAIRPERSON. —The task force shall be chaired by the Assistant Secretary for Mental Health and Substance Use, or the Assistant Secretary's designee.

(c)   TASK FORCE DUTIES. —The task force shall—

(1) solicit input from stakeholders, including frontline service providers, educators, mental health professionals, researchers, experts in infant, child, and youth trauma, child welfare professionals, and the public, in order to inform the activities under paragraph (2); and

(2) identify, evaluate, make recommendations, and update such recommendations not less than annually, to the general public, the Secretary of Education, the Secretary of Health and Human Services, the Secretary of Labor, the Secretary of the Interior, the Attorney General, and other relevant cabinet Secretaries, and Congress regarding—

(A) a set of evidence-based, evidence-informed, and promising best practices with respect to—

(i) prevention strategies for individuals at risk of experiencing or being exposed to trauma, including trauma as a result of exposure to substance use;

(ii) the identification of infants, children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma;

(iii) the expeditious referral to and implementation of trauma-informed practices and supports that prevent and mitigate the effects of trauma, which may include whole-family and multi-generational approaches; and

(iv) community based or multi-generational practices that support children and their families;

(B) a national strategy on how the task force and member agencies will collaborate, prioritize options for, and implement a coordinated approach, which may include—

(i) data sharing;

(ii) providing support to infants, children, and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma;

(iii) identifying options for coordinating existing grants that support infants, children, and youth, and their families as appropriate, who have experienced, or are at risk of experiencing, exposure to substance use or other trauma, including trauma related to substance use; and

(iv) other ways to improve coordination, planning, and communication within and across Federal agencies, offices, and programs, to better serve children and families impacted by substance use disorders; and

(C) existing Federal authorities at the Department of Education, Department of Health and Human Services, Department of Justice, Department of Labor, Department of the Interior, and other relevant agencies, and specific Federal grant programs to disseminate best practices on, provide training in, or deliver services through,

trauma-informed practices, and disseminate such information—

(i) in writing to relevant program offices at such agencies to encourage grant applicants in writing to use such funds, where appropriate, for trauma-informed practices; and

(ii) to the general public through the internet website of the task force.

(d) BEST PRACTICES. —In identifying, evaluating, and recommending the set of best practices under subsection (c), the task force shall—

(1) include guidelines for providing professional development and education for front-line services providers, including school personnel, early childhood education program providers, providers from child- or youth-serving organizations, housing and homeless providers, primary and behavioral health care providers, child welfare and social services providers, juvenile and family court personnel, health care providers, individuals who are mandatory reporters of child abuse or neglect, trained nonclinical providers (including peer mentors and clergy), and first responders, in—

(A) understanding and identifying early signs and risk factors of trauma in infants, children, and youth, and their families as appropriate, including through screening processes and services;

(B) providing practices to prevent and mitigate the impact of trauma, including by fostering safe and stable environments and relationships; and

(C) developing and implementing policies, procedures, or systems that—

(i) are designed to quickly refer infants, children, youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma to the appropriate trauma-informed screening and support and age-appropriate treatment, and to ensure such infants, children, youth, and family members receive such support;

(ii) utilize and develop partnerships with early childhood education programs, local social services organizations, such as organizations serving youth, and clinical mental health or other health care providers with expertise in providing support services and age-appropriate trauma- informed and evidence-based treatment aimed at preventing or mitigating the effects of trauma;

(iii) educate children and youth to—

(I) understand and identify the signs, effects, or symptoms of trauma; and

(II) build the resilience and coping skills to mitigate the effects of experiencing trauma;

(iv) promote and support multi-generational practices that assist parents, foster parents, and kinship and other caregivers in accessing resources related to, and developing environments conducive to, the prevention and mitigation of trauma; and

(v) collect and utilize data from screenings, referrals, or the provision of services and supports to evaluate outcomes and improve processes for trauma-informed services and supports that are culturally sensitive, linguistically appropriate, and specific to age ranges and sex, as applicable;

(2) recommend best practices that are designed to avoid unwarranted custody loss or criminal penalties for parents or guardians in connection with infants, children, and youth who have experienced or are at risk of experiencing trauma; and

(3) recommend opportunities for local- and State-level partnerships that—

(A) are designed to quickly identify and refer children and families, as appropriate, who have experienced or are at risk of experiencing exposure to trauma, including related to substance use;

(B) utilize and develop partnerships with early childhood education programs, local social services organizations, and health care services aimed at preventing or mitigating the effects of exposure to trauma, including related to substance use;

(C) offer community-based prevention activities, including educating families and children on the effects of exposure to trauma, such as trauma related to substance use, and how to build resilience and coping skills to mitigate those effects;

(D) in accordance with Federal

privacy protections, utilize non-personally-identifiable data from screenings, referrals, or the provision of services and supports to evaluate and improve processes addressing exposure to trauma, including related to substance use; and

(E) are designed to prevent separation and support reunification of families if in the best interest of the child.

(e) OPERATING PLAN. —Not later than 120 days after the date of enactment of this Act, the task force shall hold the first meeting. Not later than 2 years after such date of enactment, the task force shall submit to the Secretary of Education, Secretary of Health and Human Services, Secretary of Labor, Secretary of the Interior, the Attorney General, and Congress an operating plan for carrying out the activities of the task force described in subsection (c)(2). Such operating plan shall include—

(1) a list of specific activities that the task force plans to carry out for purposes of carrying out duties described in subsection (c)(2), which may include public engagement;

(2) a plan for carrying out the activities under subsection (c)(2);

(3) a list of members of the task force and other individuals who are not members of the task force that may be consulted to carry out such activities;

(4) an explanation of Federal agency involvement and coordination needed to carry out such activities, including any statutory or regulatory barriers to such coordination;

(5) a budget for carrying out such activities;

(6) a proposed timeline for implementing recommendations and efforts identified under subsection (c); and

(7) other information that the task force determines appropriate as related to its duties.

(f) FINAL REPORT.—Not later than 3 years after the date of the first meeting of the task force, the task force shall submit to the general public, Secretary of Education, Secretary of Health and Human Services, Secretary of Labor, Secretary of the Interior, the Attorney General, other relevant cabinet Secretaries, the Committee on Energy and Commerce and the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, and Congress, a final report containing all of the findings and recommendations required under this section, and shall make such report available online in an accessible format.

(g) ADDITIONAL REPORTS. —In addition to the final report under subsection (f). the task force shall submit—

(1) a report to Congress identifying any recommendations identified under subsection (c) that require additional legislative authority to implement; and

(2) a report to the Governors describing the opportunities for local- and State-level partnerships, professional development, or best practices recommended under subsection (d)(3).

(h) DEFINITIONS. —In this section—

(1) the term "early childhood education program" has the meaning given such term in section 103 of the Higher Education Act of 1965 (20 U.S.C. 1003);

(2) The term "Governor" means the chief executive officer of a State; and

(3) the term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(i) SUNSET. —The task force shall sunset on the date that is 60 days after the submission of the final report under subsection (f), but not later than September 30, 2023.

SEC. 7133. NATIONAL CHILD TRAUMATIC STRESS INITIATIVE.

Section 582(j) of the Public Health Service Act (42 U.S.C. 290hh–1(j)) (relating to grants to address the problems of persons who experience violence-related stress) is amended by striking "$46,887,000 for each of fiscal years 2018 through 2022" and inserting "$63,887,000 for each of fiscal years 2019 through 2023".

SEC. 7134. GRANTS TO IMPROVE TRAUMA SUPPORT SERVICES AND MENTAL HEALTH CARE FOR CHILDREN AND YOUTH IN EDUCATIONAL SETTINGS.

(a) GRANTS, CONTRACTS, AND COOPERA TIVE AGREEMENTS AUTHORIZED.—The Secretary, in coordination with the Assistant Secretary for Mental Health and Substance Use, is authorized to award grants to, or enter into contracts or cooperative agreements with, State educational agencies, local educational agencies, Indian Tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) or their tribal educational agencies, a school operated by the Bureau of Indian Education, a Regional Corporation, or a Native Hawaiian educational organization, for the purpose of increasing student access to evidence- based trauma support services and mental health care by developing innovative initiatives, activities, or programs to link local school systems with local trauma-informed support and mental health systems, including those under the Indian Health Service.

(b) D U R A T I O N .—With respect to a grant, contract, or cooperative agreement awarded or entered into under this section, the period during which payments under such grant, contract or agreement are made to the recipient may not exceed 4 years.

(c) USE OF FUNDS. —An entity that receives a grant, contract, or cooperative agreement under this section shall use amounts made available through such grant, contract, or cooperative agreement for evidence-based activities, which shall include any of the following:

(1) Collaborative efforts between school-based service systems and trauma-informed support and mental health service systems to provide, develop, or improve prevention, screening, referral, and treatment and support services to students, such as providing trauma screenings to identify students in need of specialized support.

(2) To implement schoolwide positive behavioral interventions and supports, or other trauma-informed models of support.

(3) To provide professional development to teachers, teacher assistants, school leaders, specialized instructional support personnel, and mental health professionals that—

(A) fosters safe and stable learning environments that prevent and mitigate the effects of trauma, including through social and emotional learning;

(B) improves school capacity to identify, refer, and provide services to students in need of trauma support or behavioral health services; or

(C) reflects the best practices for trauma-informed identification, referral, and support developed by the Task Force under section 7132.

(4) Services at a full-service community school that focuses on trauma-informed supports, which may include a full-time site coordinator, or other activities consistent with section 4625 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7275).

(5) Engaging families and communities in efforts to increase awareness of child and youth trauma, which may include sharing best practices with law enforcement regarding trauma-informed care and working with mental health professionals to provide interventions, as well as longer term coordinated care within the community for children and youth who have experienced trauma and their families.

(6) To provide technical assistance to school systems and mental health agencies.

(7) To evaluate the effectiveness of the program carried out under this section in increasing student access to evidence-based trauma support services and mental health care.

(8) To establish partnerships with or provide subgrants to Head Start agencies (including Early Head Start agencies), public and private preschool programs, child care programs (including home-based providers), or other entities described in subsection (a), to include such entities described in this paragraph in the evidence-based trauma initiatives, activities, support services, and mental health systems established under

this section in order to provide, develop, or improve prevention, screening, referral, and treatment and support services to young children and their families.

(d) APPLICATIONS. —To be eligible to receive a grant, contract, or cooperative agreement under this section, an entity described in subsection (a) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, which shall include the following:

(1) A description of the innovative initiatives, activities, or programs to be funded under the grant, contract, or cooperative agreement, including how such program will increase access to evidence-based trauma support services and mental health care for students, and, as applicable, the families of such students.

(2) A description of how the program will provide linguistically appropriate and culturally competent services.

(3) A description of how the program will support students and the school in improving the school climate in order to support an environment conducive to learning.

(4) An assurance that—

(A) persons providing services under the grant, contract, or cooperative agreement are adequately trained to provide such services; and

(B) teachers, school leaders, administrators, specialized instructional support personnel, representatives of local Indian Tribes or tribal organizations as appropriate, other school personnel, and parents or guardians of students participating in services under this section will be engaged and involved in the design and implementation of the services.

(5) A description of how the applicant will support and integrate existing school-based services with the program in order to provide mental health services for students, as appropriate.

(6) A description of the entities in the community with which the applicant will partner or to which the applicant will provide subgrants in accordance with subsection (c)(8).

(e) INTERAGENCY AGREEMENTS. —

(1) LOCAL INTERAGENCY AGREEMENTS.—To ensure the provision of the services described in subsection (c), a recipient of a grant, contract, or cooperative agreement under this section, or their designee, shall establish a local interagency agreement among local educational agencies, agencies responsible for early childhood education programs, Head Start agencies (including Early Head Start agencies), juvenile justice authorities, mental health agencies, child welfare agencies, and other relevant agencies, authorities, or entities in the community that will be involved in the provision of such services.

(2) CONTENTS. —In ensuring the provision of the services described in subsection (c), the local interagency agreement shall specify with respect to each agency, authority, or entity that is a party to such agreement—

(A) the financial responsibility for the services;

(B) the conditions and terms of responsibility for the services, including quality, accountability, and coordination of the services; and

(C) the conditions and terms of reimbursement among such agencies, authorities, or entities, including procedures for dispute resolution.

(f) E V A L U A T I O N.—The Secretary shall reserve not more than 3 percent of the funds made available under subsection (l) for each fiscal year to—

and (1) conduct a rigorous, independent evaluation of the activities funded under this section;

(2) disseminate and promote the utilization of evidence-based practices regarding trauma support services and mental health care.

(g) DISTRIBUTION OF AWARDS. —The Secretary shall ensure that grants, contracts, and cooperative agreements awarded or entered into under this section are equitably distributed among the geographical regions of the United States and among tribal, urban, suburban, and rural populations.

(h) RULE OF CONSTRUCTION.

—Nothing in this section shall be construed—

(1) to prohibit an entity involved with a program carried out under this section from reporting a crime that is committed by a student to appropriate authorities; or

(2) to prevent Federal, State, and tribal law enforcement and judicial authorities from exercising their responsibilities with regard to the application of Federal, tribal, and State law to crimes committed by a student.

(i) SUPPLEMENT, NOT SUPPLANT. —Any services provided through programs carried out under this section shall supplement, and not supplant, existing mental health services, including any special education and related services provided under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.).

(j) CONSULTATION WITH INDIAN TRIBES. —In carrying out subsection (a), the Secretary shall, in a timely manner, meaningfully consult with Indian Tribes and their representatives to ensure notice of eligibility.

(k) DEFINITIONS. —In this section:

(1) ELEMENTARY SCHOOL. —The term "elementary school" has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) EVIDENCE-BASED. —The term "evidence-based" has the meaning given such term in section 8101(21) (A)(i) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801(21)(A)(i)).

(3) NATIVE HAWAIIAN EDUCATIONAL ORGANIZATION. —The term "Native Hawaiian educational organization" has the meaning given such term in section 6207 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7517).

(4) LOCAL EDUCATIONAL AGENCY. —The term "local educational agency" has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(5) REGIONAL CORPORATION. —The term "Regional Corporation" has the meaning given the term in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1602)).

(6) SCHOOL. —The term "school" means a public elementary school or public secondary school.

(7) SCHOOL LEADER. —The term "school leader" has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(8) SECONDARY SCHOOL. —The term "secondary school" has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(9) SECRETARY. —The term "Secretary" means the Secretary of Education.

(10) SPECIALIZED INSTRUCTIONAL SUPPORT PERSONNEL. —The term "specialized instructional support personnel" has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(11) STATE EDUCATIONAL AGENCY. —The term "State educational agency" has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(l) AUTHORIZA TION OF APPROPRIATIONS. —There is authorized to be appropriated to carry out this section, $50,000,000 for each of fiscal years 2019 through 2023.

SEC. 7135. RECOGNIZING EARLY CHILDHOOD TRAUMA RELATED TO SUBSTANCE ABUSE.

(a) DISSEMINATION OF INFORMATION. —The Secretary of Health and Human Services shall disseminate information, resources, and, if requested, technical assistance to early childhood care and education providers and professionals working with young children on—

(1) ways to properly recognize children who may be impacted by trauma, including trauma related to substance use by a family member or other adult; and

(2) how to respond appropriately in order to provide for the safety

and well-being of young children and their families.

(b) GOALS. —The information, resources, and technical assistance provided under subsection (a) shall—

(1) educate early childhood care and education providers and professionals working with young children on understanding and identifying the early signs and risk factors of children who might be impacted by trauma, including trauma due to exposure to substance use;

(2) suggest age-appropriate communication tools, procedures, and practices for trauma-informed care, including ways to prevent or mitigate the effects of trauma;

(3) provide options for responding to children impacted by trauma, including due to exposure to substance use, that consider the needs of the child and family, including recommending resources and referrals for evidence-based services to support such family; and

(4) promote whole-family and multi-generational approaches to keep families safely together when it is in the best interest of the child.

(c) C O O R D I N A T I O N .—The Secretary of Health and Human Services shall coordinate with the task force to develop best practices for trauma-informed identification, referral, and support authorized under section 7132 in disseminating the information, resources, and technical assistance described under subsection (b).

(d) RULE OF CONSTRUCTION.— Such information, resources, and if applicable, technical assistance, shall not be construed to amend the requirements under—

(1) the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.); (2) the Head Start Act (42 U.S.C. 9831 et seq.); or

(3) the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.).

Task Force Biographies

DR. DENESE SHERVINGTON
Founder & CEO, Institute of Women and Ethnic Studies
Professor, Department of Psychiatry, Tulane University School of Medicine
Task Force Role: Chair and Subject Matter Expert

Dr. Denese Shervington has an intersectional career in public health and academic psychiatry. She is the President of The Institute of Women and Ethnic Studies (IWES), a community-based translational public health institute in New Orleans. She is also the Chair of Psychiatry at Charles R. Drew University. Dr. Shervington has held Clinical Professorships in the Departments of Psychiatry at Columbia University and Tulane University. A graduate of New York University School of Medicine, she also received a Masters of Public Health in Population Studies and Family Planning from Tulane University School of Public Health. She completed her residency in Psychiatry at the University of California San Francisco and is certified by the American Board of Psychiatry and Neurology. A Fellow of the American Psychiatry Association, in 2018 she received the Award for Excellence in Service and Advocacy; prior to which she received the Jeanne Spurlock Minority award. Dr. Shervington is also a member of the American College of Psychiatrists. In July 2019, Dr. Shervington testified before the Congress of the United States House of Representatives' Committee on Oversight and Reform on Childhood Trauma. She also co-chairs the New Orleans City Council (R-18-344) Children Youth Planning Board Taskforce on Childhood Trauma. She has authored several papers in peer-reviewed journals addressing health disparities, the social determinants of health and resilience in underserved communities. She is the proud parent of two amazing children, Kaleb and Iman, and grandchildren Ayelet and Haddassah.

DR. TORIN SANDERS
Pastor/SUNO/ New Orleans Children and Youth Planning Board
Task Force Role: Chair and Subject Matter Expert
Dr. Torin T. Sanders is a licensed clinical social worker, an ordained minister, an experienced family therapist, parent educator, mediator, and a mentor trainer. For over 21 years, Dr. Sanders has served as pastor of The Sixth Baptist Church, organized in 1858. Dr. Sanders earned his bachelor's degree from Howard University in Washington, D.C. He graduated magna cum laude and was admitted to Phi Beta Kappa. He earned both his master's degree and Ph.D. in social work from Tulane University. He currently serves as an Assistant Professor of Social Work at Southern University at New Orleans.

Prior to becoming a pastor, Dr. Sanders was a family preservation therapist, the supervisor of the parent-child center at Kingsley House, the coordinator of the Louis Armstrong Manhood Development Program at Milne Boys Home, Director of the Loss and Survival Team at Children's Bureau, and Vice-President of Programs for Volunteers of America-Greater New Orleans. Dr. Sanders has also served as a consultant to two community health clinics in New Orleans post-Katrina as well as a program to help young adults enter the construction industry.

A frequent guest speaker and presenter, Dr. Sanders is the recipient of numerous awards from organizations including the Federal Bureau of Investigation, Victims & Citizens against Crime, Alpha Phi Alpha Fraternity, and Rainbow PUSH. In 2004, Dr. Sanders was elected as a reform candidate to the Orleans Parish School Board where he twice served as President. He also serves on the boards of The St. Thomas Health Clinic, The New Orleans Council on Aging, Gulf Coast Social Services, and the Children & Youth Planning Board where he serves currently as Chairman. He is the chair of The New Orleans Council on Aging.

KAREN EVANS
Executive Director at New Orleans Children and Youth Planning Board
Task Force Role: Facilitator and Subject Matter Expert
Karen Evans is the Executive Director of the New Orleans Children & Youth Planning Board (CYPB), the organizations inaugural director, hired in October 2016. CYPB exists to advance system reforms that will improve positive outcomes for children and youth of Orleans Parish. Prior to this role, Evans spent eight years in executive leadership with Five Acres, a children's mental health/child welfare nonprofit agency with a $33 million annual budget located in Altadena, California, serving vulnerable children/youth and their families across Los Angeles County. While there her roles included Director of Program Development, Chief Strategy Officer and finally Chief Operating Officer.

Evans successfully served on a number of child/youth-serving boards and commissions while living in Pasadena, California and maintained active involvement in steering committees, policy and affinity groups at the national level through memberships with national professional associations. A recent New Orleans transplant, Evans continues to extend her reach beyond her role to support efforts that seek to advance the lives and opportunities for children, youth and families. Evans has served on the Central City Renaissance Alliance board, a neighborhood-based capacity building effort; is an Elder with ReThink, a youth development/advocacy building organization; and is a member of the steering committee with New Orleans Campaign for Grade-Level Reading.

Evans earned her Master's Degree in Public Administration from California State University at Northridge and her certificate in Nonprofit Executive Leadership from the University of Michigan, Ann Arbor.

DR. HEAD-DUNHAM, MHSD
MHSD Executive & Medical Director
Task Force Role: Subject Matter Expert
Dr. Rochelle Head-Dunham is a New Orleans native and currently serves as the Executive and Medical Director for Metropolitan Human Services District (MHSD), the Local Governance Entity tasked with service delivery for persons suffering from Mental Illness, Addictive Disorders and Intellectual/Developmental Disabilities for Orleans, St. Bernard and Plaquemines Parishes.

Dr. Dunham's academic appointments include Clinical Assistant Professorships at both Tulane and LSU Schools of Medicine. Her immediate past appointments were Assistant Secretary and Medical Director for the Office of Behavioral Health within the Louisiana Department of Health.

Dr. Head-Dunham's academic and clinical leadership has fostered statewide advances in the field of behavioral health, where she has lectured, trained, and taught both locally and nationally. Her pioneering efforts have advanced knowledge, skills and application of the standard of care for co-occurring mental and addictive disorders.

Dr. Dunham is also a trailblazer in her own right. A few of her accomplishments include:
FIRST psychiatrist to finish an Addictions Fellowship at Tulane Medical Center.
FIRST black to serve in a dual role as Assistant Secretary and Medical Director for the State of Office of Behavioral Health in Louisiana.

FIRST physician representative for the National Association of Substance Abuse and Drug Addiction Directors, receiving the Service Award in 2015 for outstanding service & commitment to the field of substance abuse treatment.

Dr. Dunham's mission and vision is to develop MHSD as the "Center of Excellence" for all behavioral, addiction, and intellectual/developmental disability needs, through expanding partnerships and service expansion, thereby becoming the known "go to" agency, "where we change lives!"

PAULETTE CARTER
Children's Bureau
Task Force Role: Subject Matter Expert
Paulette Carter is a Licensed Clinical Social Worker and serves as President/CEO of the Children's Bureau of New Orleans. Ms. Carter has worked at Children's Bureau for the past 16 years, starting as an entry-level social worker, serving as the director of the agency's grief and trauma program, and is now in her eight year serving as President/CEO.

Ms. Carter has been a mainstay in the mental health community in metro New Orleans over the past decade, working tirelessly to improve the delivery of mental health services to underserved children. She serves on several Boards and workgroups among which are the New Orleans Children and Youth Planning Board, the New Orleans Family Justice Center's Board of Directors, Youthshift, the New Orleans Health Department's Trauma Informed Care Workgroup, New Orleans Kids Partnership, the Council of United Way Agencies, and the Louisiana Adverse Childhood Experiences Initiative.

TAP BUI
United Way
Task Force Role: Subject Matter Expert
Vice President of Community Impact, Health, & Fund Distribution at United Way of Southeast Louisiana
Tap T. Bui is the Vice President of Community Impact, Health and Fund Distribution at United Way of Southeast Louisiana (UWSELA). In this role, she is responsible for directing efforts and strategies in the Health impact area for all seven UWSELA parishes, inclusive of research, grant-writing, program investments, collaborations, partnerships and related projects as they evolve. Ms. Bui also executes the fund distribution process including: designing and implementing the grant application and evaluation tools, hosting agency and volunteer trainings, and grants management and evaluation.
In addition, she serves as a member of the Institute of Mental Hygiene Board of Directors and the William

Winter Institute for Racial Reconciliation. She is a graduate of the New Orleans Regional Leadership Institute (NORLI) and is currently in the 2019 Charter Board Leadership Academy of the Louisiana Association of Public Charter Schools. Ms. Bui holds a Master's in Public Health from the LSUHSC School of Public Health and is a New Orleans native. She is a certified medical interpreter and fluent in Vietnamese.

RON MCCLAIN
IMH
Incoming Executive Director of Institute of Mental Hygiene
Task Force Role: Subject Matter Expert
A long-term resident of New Orleans, Mr. McClain has over 30 years experience in social service administration and university teaching in the social work field. Most recently, Mr. McClain has received recognition for his strategic re-building of the citywide program of Family Service of Greater New Orleans following Hurricane Katrina. His successes were featured in a social policy textbook by Dr. Bruce Jansson of the University of Southern California, Becoming an Effective Policy Advocate, From Policy Practice to Social Justice. In addition to a Master of Social Work from Southern University at New Orleans, Mr. McClain holds a Juris Doctor in Civil Law from Loyola University School of Law in New Orleans.

As President & CEO of Family Service of Greater New Orleans (10 years) and Children's Bureau of New Orleans (8 years), Mr. McClain led both agencies in achieving accreditation from the Council on Accreditation, an international accrediting organization for human service agencies. Mr. McClain also has a long history of civic engagement. Most recently, he was a member of the Loving Cup Selection Committee. He has served on the board of Agenda for Children, the Lindy Boggs National Center for Community Literacy, and Young Artists -Young Aspirations (YA-YA). He is also a member of the NOLA.com-Times Picayune Roundtable of Community Leaders and the New Orleans Civil Service Commission.

DR. LAUREN TEVERBAUGH
Tulane MD, FAAP Assistant Professor of Psychiatry and Clinical Assistant Professor of Pediatrics
Task Force Role: Subject Matter Expert
Dr. Lauren Teverbaugh has been at Tulane since 2017 and is also a Pediatrician and Child and Adolescent Psychiatrist
Triple Board Residency: Tulane University School of Medicine
Medical School: University of Illinois at Chicago
Bachelor of Arts: University of Michigan
Dr. Teverbaugh has diverse background in research and work centered around social and community activism including the behavioral effects of lead poisoning on children in Kingston, Jamaica, children with perinatally-acquired HIV and their families, health care disparities among the medially underserved, global health, sickle cell anemia, trauma-affected youth, and public health and policy. Her focus is on medically complex children and children with chronic medical illnesses and psychosocial dysfunction, sexual education and trauma, integrated interdisciplinary care, and school based delivery of care. She utilizes an interdisciplinary treatment model that is culturally sensitive and uniquely tailored address the health needs of communities of color.

As the Director of Pediatric Psychiatry at Tulane Lakeside Hospital Dr. Teverbaugh co-runs the consultation-liaison service. She provides supervision and teaching to the medical students, residents and fellows on the pediatric consultation-liaison service as well as in the school based clinics. Additionally, she provides direct pediatric and psychiatric care to children at JeffCare, a community-based health clinic.

JACK WAGUESPACK – Editor In Chief at Driftwood/Youth/826
Task Force Role: Providing Lived Experience

ALI LEE – Youth/Employ
Task Force Role: Providing Lived Experience

AMERICA LENOX – Youth/Employ
Task Force Role: Providing Lived Experience

STEFANIE MOORE, Grandparent/Caregiver
Task Force Role: Providing Lived Experience

LLOYD DENNIS – Silverback Society/Mentoring
Task Force Role: Providing Lived Experience

DONALD BERRYHILL, Pastor/NOPD
Task Force Role: Providing Lived Experience

KELLI JORDAN, OPSB
OPSB Director of Citywide Education Initiatives
Task Force Role: Systems Leader
Dr. Kelli Jordan hails from Atlanta, Georgia and is a graduate of Hampton University and the University of Tennessee. Her primary research interest is the underrepresentation of African Americans in gifted programs. Dr. Jordan moved to New Orleans as part of the Louisiana School Psychology Internship Consortium (LASPIC) to work for St. Bernard Parish Public Schools where she served as a certified school psychologist from 2009-2013. She helped reopen schools post-Katrina, while providing psychological services to students and conducting compliant evaluations for gifted and special education services.

Throughout her career, Dr. Jordan has completed various leadership fellowships including the Urban Leaders for Equity and Diversity Leadership Program (ULEAD) and New Leaders Council- Louisiana, where she currently serves as the Co-Selections Chairperson. She sits on the board of Children's Bureau, the oldest mental health agency for children in the New Orleans area, is an advisory board for the Special Education Leader Fellowship (SELF) and is a member of the Kingsley House Health Services Advisory Committee. She sits on the New Orleans Children and Youth Planning Board Trauma Task force and the New Orleans Behavioral Health Council, working to ensure a school voice is being heard in spaces that focus on improving services for traditionally underserved populations.

Dr. Jordan is also an active member of the community and gives back through various organizations in the New Orleans area. She is a member of Alpha Kappa Alpha Sorority, Inc., The Orchid Society and a National Association of School Psychologists. She is currently serving as a Director of School Support and Improvement for New Orleans Public Schools where she is leading initiatives around behavioral health and citywide supports for students with disabilities. Dr. Jordan is published in peer-reviewed journals and has presented on a variety of topics related to special education and mental health at national conferences and local leadership training programs.

EMILY WOLFE, City/OYF
Director for the Mayor's Office of Youth & Families, New Orleans
Task Force Role: Systems Leader
Emily Wolfe served as the Executive Director of the Broadmoor Improvement Association—a non-profit in New Orleans that has gained regional and national attention for its effort to revitalize the Broadmoor neighborhood. As Executive Director she provided overall strategic and operational leadership for the BIA's staff, programs, expansion, and the execution of its mission.

In 2012, she began working on a plan to develop a community Arts & Wellness Center in New Orleans. After several years carrying out a capital campaign that raised $2 million, developing a business plan and securing program partners, the Arts & Wellness Center opened its doors and now serves over 1,200 children and adults each month. Emily Wolfe earned her Masters in Public Affairs degree from UC Berkeley and my Bachelors degree from Bard College.

RANORD DARENSBURG
Judicial Administrator, Orleans Parish Juvenile Court
Task Force Role: Systems Leader
Upon completing his law degree and master of social work degree, Mr. Darensburg launched his career by combining a passion for the law and social service by co-founding and serving as Executive Director of Community Volunteers Association, a local non-profit serving at-risk youth in the community. This provided him with experience in developing and reforming systems that promote successful collaborations and social capital though networking.

Mr. Darensburg is a committed advocate for justice and community engagement. He has served as a public defender, hearing officer, Judge Pro Tempore, Clerk of Court, and Judicial Administrator. During his legal career, he volunteered for the Court Appointed Special Advocate program (CASA) serving as an advocate for children in court, served on the Judicial Reform Task Force, New Orleans Arts Council, Family Service of Greater New Orleans and the New Orleans Pro-Bono Project. He has been appointed to the Louisiana Governor's Advisory Council on Safe and Drug-Free Schools and Communities and worked for many other worthy causes.

Born and raised in New Orleans, he has kept one foot in the Crescent City while maintaining a global vision. He has been a fellow of the British American Project, a professional organization designed to foster ties between the United Kingdom and the United States, and a fellow to the Transportation Foundation International Transit Studies Program in Greece and Italy. As a college student he studied French, international policy, and art history in Toulon, France.

ROLAND BULLARD
Vice President of Student Success, Dillard University
Task Force Role: Systems Leader
Dr. Roland N. Bullard, Jr. is a higher education advocate who is committed to student success. Roland has worked or supervised areas such as Adult Education Programs, Advising, Campus Ministries, Community Service and Outreach, Counseling Services, First Year Experience, Greek Life, Health Center, Leadership Programs, Residence Life, Student Conduct, Student Activities, Title IX, Trio Programs, and the Women's Center. Bullard earned his Ph.D. in Higher Education from Indiana University-Bloomington, a M.Ed. from the USC- Columbia in Student Personnel Services and B.A. in Communication from FAU. Additionally, Bullard earned graduate-level certifications in non-profit management and fundraising from Indiana University and Boston University, respectively.

In 2007, Dr. Bullard was appointed a Harvard University Fellow. In this role he managed special projects for several key offices while serving in residence at the HU - John F. Kennedy School of Government in Cambridge, MA. He has also served as a higher education consultant as which he is contracted to create leadership development workshops for college students, provide assistance in policy formulation and analysis, and offer critiques of leadership/professional development curriculum.

Dr. Bullard also travels nationally as a Lead Facilitator for the LeaderShape® Institute. Roland is also considered a student development and non-profit management expert, as he has instructed numerous graduate and undergraduate courses in student affairs, higher education, and management. An active member of several professional organizations, Bullard is a Past President for SACSA and currently serves on the NASPA Region III Board.

VALLARIE BURRISS
Department Children and Family Services
Task Force Role: Systems Leader
Vallarie Burriss currently serves as Area Director for Orleans Region Department of Children and Family services, Child Welfare Division. She has worked for the agency since 1983, the majority of her social service career. Ms. Burriss is a licensed social worker (LMSW) working towards her LCSW. She has served in her current position since 2011 and has filled many capacities within the agency throughout her tenure with the agency. She has traveled throughout the state while serving as the Regional Director for Thibodaux Region, the Assistant Director of Field Services and the Area Director for Economic Stability, Child Welfare and Child Support. She has served on the board for the Desaix Neighborhood Association since 2013 and was once a member of the St. Thomas Consortium.

Ms. Burriss presented at Families Are Worth It National Conference in 2007 as a workshop speaker. She represented Kingsley House and presented with the now CEO of that agency. She presented material on how

to create and sustain collaboratives between the private sector and state government.

Ms. Burriss's job includes working to ensure the safety and well-being of children and families through staff intervention, community partnerships, public education and community awareness. As an Area Director she has been able to contribute best in providing data collection, current policy/program initiatives, agency trends and collaboration with community partners who share a common goal to improve the lives of children in Louisiana.

KRISTIE BARDELL
Director of Family Health, Louisiana Public Health Institute
Task Force Role: Systems Leader

Kristie Bardell serves as the Director of the Family Health Portfolio at the Louisiana Public Health Institute. She works to improve sustainability of school-based health centers, build capacity of schools to improve the overall health of students, and implement adolescent risk reduction initiatives. She works with schools, community-based organizations and faith-based entities to assess and build capacity around programming, clinical services and policy change to develop strategies to address health at a systems level.

Ms. Bardell has over fifteen years of experience in community health developing and implementing health improvement initiatives. She is a graduate of Tulane School of Public Health and Tropical Medicine receiving a Masters of Public Health. As a native of Louisiana and passionate strategist she continues to carve a pathway to health for all.