

# ISSUE BRIEF



January 2014

## BUILDING TRAUMA-INFORMED SYSTEMS OF CARE FOR CHILDREN IN OHIO

### The Problem: Trauma Exposure Harms Children and Contributes to Unhealthy, Violent Communities in Ohio

It is not unusual for Ray, a ten-year-old boy, to hear gun shots outside his bedroom window. He lives in a Cleveland neighborhood where violence is routine. Although he is afraid to walk the streets, he dutifully walks his younger brother and sister home from school while his mother is at work. Ray makes sure to feed and look after them until she returns.

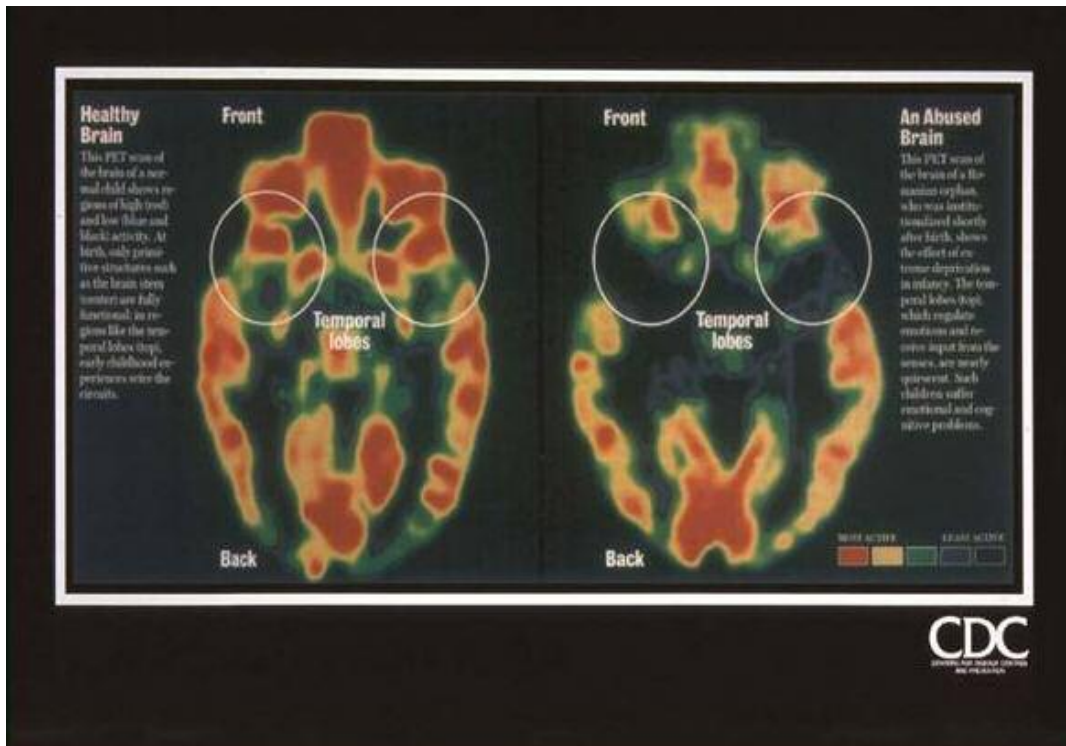
One night, his mother does not come home. Ray hears a knock on the door and sees a police officer standing there. The police officer informs him that his mother has been shot and killed. With his brother and sister still in bed, Ray starts to cry hysterically and falls to his knees. The police report reveals that there are no suspects; it was just another senseless act of gun violence.

Ray shows up to school the next couple of days agitated, irritable, and angry. Unable to pay attention in class, he starts acting out and getting into fights. His teachers do not want his bad behavior to disrupt their classrooms, so he is suspended from school. Out of school, Ray starts to hang around with a gang and soon has a never-ending supply of guns at his disposal. His group starts fights with other boys whenever they feel they are being disrespected. One night, the police show up during an altercation and arrest Ray for carrying a gun.



Ray enters a juvenile detention facility, agitated and angry. The public defender representing him thinks that with the symptoms Ray has been exhibiting, he must have Attention Deficit Hyperactivity Disorder (ADHD) and requests an assessment. The specialist that conducts the assessment never received training in trauma-informed care; she fails to ask Ray any questions about his home environment. Ultimately, she determines that Ray has ADHD. She prescribes him Ritalin and increases his doses whenever he acts more and more hypervigilant.

Ray's story only gets worse. He does not graduate from high school and reoffends as an adult. Once a victim of the violence that mars his community, he now contributes to it.<sup>1</sup>



**This is a healthy child's brain**

**This is a child's brain on trauma.**

Too many young Ohioans like Ray are exposed to trauma. Trauma is a response to an upsetting event or troubling circumstance in a child's life,<sup>2</sup> such as community and domestic violence, abuse, neglect, natural disasters, accidents, painful medical procedures, or the loss of a parent or caregiver.<sup>3</sup> Without proper intervention and treatment, children who experience and witness trauma face life-long physical, mental, behavioral, and emotional health problems, which in turn affect their school work, social lives, families, and communities. They suffer from disrupted neurodevelopment and social, emotional, and cognitive impairment. As they get older, they face disease and disability, such as major depression, post-traumatic stress disorder (PTSD), and heart disease. They are also more likely to suffer social problems, including intergenerational abuse and violence, homelessness, criminal behavior, prostitution, and unemployment—all potential contributors to violent, unhealthy communities, and early death.<sup>4</sup>

Children like Ray need early intervention and proper treatment so that they may live healthy, productive lives, and be part of healthy, nonviolent communities.

Trauma-informed practices provide the best opportunity for early intervention and treatment. They are designed to educate service providers on the prevalence of trauma, how to acknowledge the impact of trauma on children now and later in life, and how to provide the services and skills necessary to meet the needs of traumatized children. While many child-serving institutions and communities in Ohio provide or are beginning to provide trauma-informed intervention and care, there are still many more that do not. Schools, daycare centers, juvenile detention centers, pediatric care providers, behavioral and mental health service providers, child welfare systems, and all other child-serving institutions in Ohio must address trauma and prevent its negative effects. The physical, behavioral, social, and even economic health of our communities depends on it.

This issue brief will provide an overview of trauma-informed care and examples of screening/identification, assessment, and evidence-based treatment—three key elements that have been found to mitigate and prevent trauma symptoms. Next, it will highlight examples of

some of the many promising trauma-informed initiatives taking place in Ohio and gives recommendations for how communities and child-serving institutions can work together to build trauma-informed systems of care throughout the state. Ultimately, this brief advocates for the implementation of trauma-informed systems of care across Ohio, and particularly in schools and across every part of the juvenile justice system.

## Many Children Are Exposed to Trauma and the Negative Impacts are Devastating and Long-Lasting

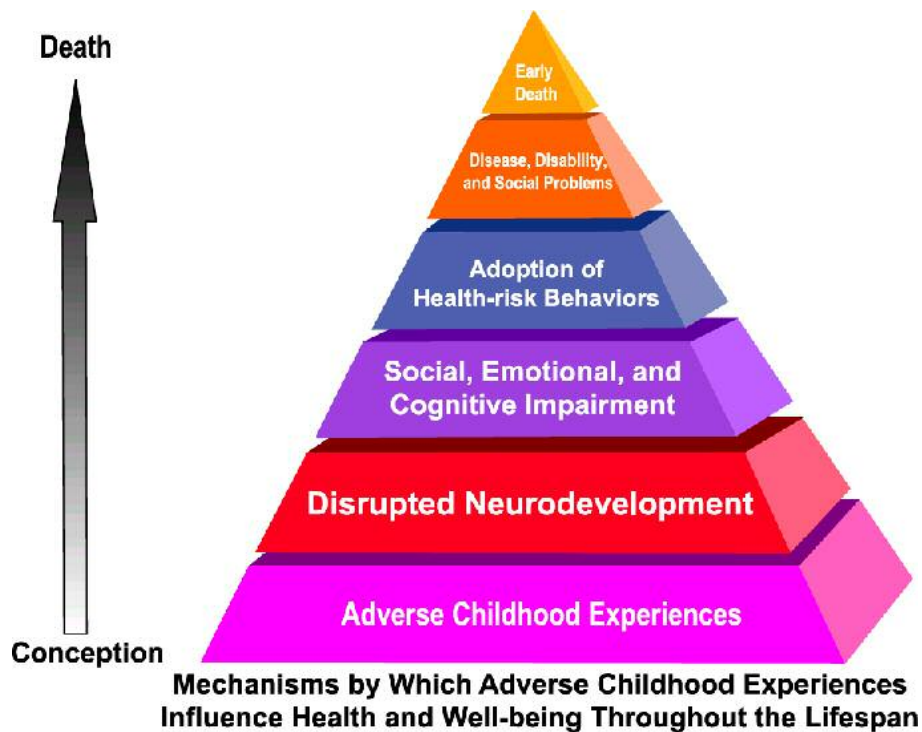
### Prevalence of Childhood Trauma

Most children, regardless of background, class, race, or gender, have been exposed to at least one or more traumatic events. According to the groundbreaking Adverse Childhood Experiences (ACEs) Study, conducted by the Kaiser Permanente Institute in collaboration with the Centers for Disease Control and Prevention (CDC), nearly two-thirds of American adults reported that they endured at least one adverse childhood experience.<sup>5</sup>

12.5 percent reported having endured four or more adverse childhood experiences.<sup>6</sup> In the National Survey of Children’s Exposure to Violence, more than 60 percent of children and adolescents surveyed reported that they were exposed to violence, either directly or indirectly, in the past year.<sup>7</sup> More than one-third (38.7 percent) reported that they experienced two or more direct victimizations.<sup>8</sup> Although we do not have a comprehensive set of data showing how many Ohioans have had adverse childhood experiences,<sup>9</sup> we do know that at least 60 percent of children in the Ohio child welfare system have endured at least one traumatic event, and in the Ohio juvenile justice system, it is as much as 90 percent.<sup>10</sup>

### Impact of Trauma on Children’s Well-Being

Numerous studies show that trauma harms children’s physical, mental, behavioral, and emotional well-being. The neurobiological effects of trauma combined with the adoption of health-risk behaviors (i.e., alcohol and drug abuse) create disease, disability, and social problems that may lead to an early death. The short-term and long-term negative effects of trauma may differ



Graphic source: [acestudy.org](http://acestudy.org)

based on individual characteristics and environment, the type of trauma endured, as well as the frequency, severity, and timing of the trauma.

Physical and sexual abuse and emotional neglect injures children and scars them for life in many ways. Children who have endured physical and sexual abuse tend to have PTSD and other mental health disorders,<sup>11</sup> suicidal behavior, eating disorders, risky sexual behavior,<sup>12</sup> and substance abuse.<sup>13</sup> Moreover, children who suffer physical abuse are likely to adopt either highly aggressive or regressive behavior in reaction to perceived physical intimidation, conflict, or threat from peers or adults.<sup>14</sup> Sexually abused children are more likely to fear future sexual activity or any kind of intimacy, or conversely, “promiscuously seek” sexual activity or intimacy.<sup>15</sup> Compared to physically and sexually abused children, neglected children generally “have more severe cognitive and academic deficits, social withdrawal and limited peer interactions, and internalizing (as opposed to externalizing) problems.”<sup>16</sup> Additionally, neglect impairs babies’ language development because if babies do not receive face-to-face talk and hear “countless repetitions of sounds,” they will fail to “build the brain circuitry” that enables them to make sounds and eventually say words.<sup>17</sup>

Exposure to violence, which is more prevalent in both urban and rural low-income communities, also significantly impairs children’s development. Nearly half of all children living in poverty witness violence, or are indirect victims of violence.<sup>18</sup> In a national study on victimization of children and youth, assault with a weapon, attempted assault, multiple peer assault, completed or attempted rape, and emotional abuse were significantly more common among households with incomes less than \$20,000.<sup>19</sup> For many children living in big cities, frequent and repetitive threats of violence create a state of heightened fear and chronic anxiety. Additionally, constant exposure to violence causes children and young people to adopt an ever-present attitude of hypervigilance, never feeling safe and preparing themselves for the next outbreak of violence. Like Ray, they trust nobody and believe it is

only a matter of time before violence takes another loved one or family member. Studies have shown that children who live in violent communities have more behavioral problems, greater occurrences of PTSD, and increased physical symptoms such as headaches and stomachaches, as well as lower capacity for empathy and diminished self-esteem.<sup>20</sup>

**Children and adolescents from minority backgrounds are at an increased risk for trauma exposure and are at an increased risk for mental health disorders such as depression and anxiety. Research indicates that minority children are over-represented in reported cases of child maltreatment and are more likely to be exposed to violence, either as direct or indirect victims.<sup>21</sup>**

### **Brain Research Shows Trauma Has Debilitating Effects on Children’s Brains**

Brain research has revealed one of the most significant reasons for the link between childhood trauma and long-term negative impacts: trauma damages the structure and function of children’s brains. Toxic stress changes the anatomy of the brain and with it, complex functions including memory, attention, perceptual awareness, thinking, language, and consciousness.<sup>22</sup> Consequently, children who have endured traumatic events or adverse childhood experiences from a young age encounter a range of cognitive issues such as poor memory and skill development, and they have lower IQ scores and grade-point averages and poor reading ability.<sup>23</sup> Students struggling with depression or anxiety also have a much more difficult time concentrating in school and completing

their work.<sup>24</sup> They may lack ability to regulate their behaviors and emotions which can cause them to act out, leading to delinquency, suspension, expulsion, and encounters with the juvenile justice system. Alternatively, on the opposite end of the spectrum, they may act withdrawn and isolated, creating a façade to peers and authority figures that they lack “character and positive motivation.”<sup>25</sup> Children who have suffered from multiple adverse childhood experiences or victimizations are at the highest risk for “losing fundamental capacities they need to develop normally and to become successful learners and productive adults.”<sup>26</sup>

### **The Relationship of Adverse Childhood Experiences to Adult Health and Disease**

When trauma is left unaddressed and untreated, it affects adult health. Children exposed to trauma are at high risk for adopting health risk behaviors, such as engaging in violence, delinquency, and alcohol and drug abuse as adults—creating social and relationship problems. Studies have shown that abused children and children exposed to community violence are at a greater risk of committing violence early in life and reoffending as adults. Boys who experience or witness violence are 1,000 times more likely to commit violence than those who do not.<sup>27</sup> Like Ray, they may join gangs or turn to criminal activities due to their sense of powerlessness, “perpetuating a cycle of violence by inflicting violence on others and becoming targets for further violence or incarceration.”<sup>28</sup> Physically and sexually abused children are at high risk for serious and often chronic problems with substance abuse.<sup>29</sup> When they become parents, they often have difficulty caring for or protecting their own children.<sup>30</sup> These functional impairments in parenting pass on again to the next generation, and again to the next generation, creating an intergenerational cycle of trauma.

In the ACEs study, researchers found that trauma exposure during childhood results in these health risk behaviors, which contribute to chronic disease and disability, such as ischemic heart disease, cancer, chronic lung disease, and liver disease in adulthood.<sup>31</sup> Further, adults who

have endured multiple adverse childhood experiences are likely to have more than one of these health problems later in life.<sup>32</sup>

### **The Economic Costs of Trauma**

All of the lasting, negative consequences of trauma come with significant costs to society. It is estimated that abuse and neglect cost Americans \$80 billion in the direct costs of hospitalization, law enforcement, and child welfare and the indirect costs of special education, juvenile and adult criminal justice, adult homelessness, and lost work productivity.<sup>33</sup> One study has predicted that the cost of violence and abuse on the healthcare system ranges between \$333 billion and \$750 billion annually, or up to 37.5 percent of the total health care dollar.<sup>34</sup>

#### **The community pays for the costs of all the long-term consequences of trauma:**

“In all communities, kids are the future—a costly future or a beneficial future. They grow up to live out their lives in healthy or unhealthy ways, in ways that contribute to the growth and health of their community or to the economic and emotional afflictions. And how they live their childhood determines their future. If a large number have high ACE scores, then the community ends up spending more money for cops, courts, prisons, welfare, social services, medical and mental health than for schools, playgrounds, community pools, and libraries. People working in education, prisons, child welfare agencies, and juvenile justice have known this intuitively for a long time. Now the research proves it.”<sup>35</sup>

## Trauma-Informed Care Mitigates Children’s Trauma Symptoms and Prevents them from Reoccurring

Trauma-informed practices help child-service providers identify the root causes of children’s challenging behavior and help families and communities adequately cope with the trauma they witness and experience. Without trauma-informed care and services, negative behaviors and symptoms that occur as a result of trauma exposure will persist and become further exacerbated by misdiagnoses and ineffective treatment models.<sup>36</sup>

The negative behaviors children exhibit when they are exposed to trauma can be characterized as symptoms, or coping mechanisms that they develop in order to deal with the trauma they endure. The trauma-exposed brain that was never able to fully develop and properly build resiliency inadequately prepares children for their next encounter with danger and pain. As a result, traumatized children’s brains are “stuck in a perpetual state of readiness to react without thinking,” even in response to the smallest threats.<sup>37</sup> Unable to turn off the survival strategies that their brain has been conditioned to use, they tend to act out in response to the slightest reminders or triggers of the trauma they endure.<sup>38</sup> Eventually, as described above, they also develop health risk behaviors, which contribute to social problems and disease.

Unfortunately, many professionals who work with children do not make the connection between children’s behaviors or symptoms and their exposure to trauma. They try to treat the symptoms without considering the root cause of the challenging behavior. For instance, when a child acts out in school because certain words or actions remind him of the abuse and violence he experiences or sees at home, he will likely be suspended for being a “bad kid” or he may even be misdiagnosed by a specialist as having attention deficit hyperactivity disorder (ADHD) or another disability, as was the case with Ray. Reactive, punitive discipline measures such as out-of-school suspension and expulsion or restraint and seclusion do not address the challenging behavior, they re-traumatize children,<sup>39</sup> sending them on a “tried and true road to

prison or dropping out of school, and a life damaged for no good reason.”<sup>40</sup> Likewise, misdiagnoses do not change or fix the challenging behavior.

Children who have been traumatized need trauma-informed intervention and care to prevent a lifetime of health, learning, and behavioral issues. Trauma-informed services are most effective when they:

1. Identify/Screen
2. Assess
3. Treat.<sup>41</sup>

### 1. Awareness, detection and identification of trauma exposure

Identifying children who have experienced or witnessed trauma is the first step toward putting them on the road to recovery. Identification may occur at the first point of contact with the child either through an informal process (i.e., trauma awareness training, where staff members are trained to recognize signs and symptoms of trauma exposure) or through a more thorough, formal, systematic method (i.e., screening tools).

Trauma-informed practices in schools: During the 2009–2010 school year, Jim Sporleder, principal at Lincoln Alternative School in Walla Walla, Washington, “didn’t know if he was going to make it.”<sup>42</sup> He was faced with 798 suspensions (days students were out of school), 50 expulsions and 600 written referrals for just 50 students—“kids who’d been kicked out of other schools” and came to Lincoln for their “last chance.”<sup>43</sup> After meeting with Teri Barila, co-founder of the Children’s Resilience Initiative in Walla Walla, and Natalie Turner, from Washington State University’s Area Health Education Center, Sporleder began to realize that trauma was likely the reason behind a lot of the students’ challenging behaviors.<sup>44</sup> He had to figure out a way to reach the kids that were going through adverse childhood experiences (ACEs) instead of punishing them.

The Lincoln High staff changed the school’s punitive discipline policies and became “trauma-informed,” learning how to spot students suffering from trauma.

Instead of automatically suspending or expelling “bad” students for their disruptive behavior, the educators and administrators now see students through a trauma-informed lens and associate challenging behavior with trauma-like symptoms. When a student erupts in class, the teacher will pull him out of the classroom and ask, “What’s going on? Because that was really intense.”<sup>45</sup> Another common response is: “You seem really upset, would you like to speak to someone in the health center?”<sup>46</sup> Once identified as a possible victim of trauma, teachers and school administrators can refer students to the health center next to the school so that they may be properly assessed by a trauma expert.<sup>47</sup> Since instituting this approach, the school’s suspension rate has dropped by a jaw-dropping 85 percent.<sup>48</sup>

Systematic screening for mental health behaviors related to trauma: Many juvenile detention facilities have started to administer screening tools such as the MAYSI-2 during intake, to identify youth with special mental health needs who may have experienced one or more serious traumas. The MAYSI-2 screens for alcohol and drug use, depression and anxiety, somatic complaints, suicide ideation, thought disturbance, and traumatic experiences. It is a self-report inventory of 52 questions that identify youth ages 12 to 17 who report symptoms of distress that are characteristics of “manifest feelings or behaviors that could require immediate attention.”<sup>49</sup> The questions are administered within the first 48 hours of being admitted to a detention facility and take approximately 10-15 minutes to complete.<sup>50</sup> This screening process gives the facility a sense of whether the children need to be further assessed by a professional for mental health issues attributed to trauma exposure.

### **2. Assessment and evaluation conducted by trained clinicians**

Once the child is identified as a possible trauma victim, professionals or clinicians who have been appropriately trained on the impact of trauma should conduct a mental and behavioral health assessment to determine whether the child is in fact suffering from traumatic

symptoms. This assessment will then drive linkage to care or treatment.

Example of trauma assessment: The following is a dependency case scenario from the Office of Juvenile Justice and Delinquency Prevention’s (OJJDP) Safe Start Center Series on Children Exposed to Violence: an attorney Guardian Ad Litem (GAL) represents a 10-year-old client, Shayla, who was allegedly physically abused and neglected by her mother. Shayla’s foster parents say she spends most of her time sleeping or watching television, and they often have difficulty getting her to wake up for school or join them for dinner. Shortly after Shayla had a phone conversation with her mother, she purposely cut herself. The GAL asks the caseworker to arrange a professional mental health assessment and learns that Shayla suffers from depression and has other symptoms of traumatic stress.<sup>51</sup>

### **3. Trauma-focused treatment**

Evidence-based treatment plans or programs are designed to meet the needs of individual children and to reduce negative effects of trauma. Common factors that play a role in determining which evidence-based treatment program is best suited for children’s needs include: (1) the profile of the child or group of children (i.e., age group, culture, background); (2) the type of trauma exposure (i.e., maltreatment at home, violence in communities); (3) the symptoms (i.e., depression, PTSD, anxiety); and (4) intended outcomes of the program (i.e., to increase coping skills, decrease symptoms, create more secure relationships, improve health-related functioning).<sup>52</sup> The National Child Traumatic Stress Network (NCTSN), funded by the Substance Abuse and Mental Health Service Administration (SAMHSA) and with more than 130 centers nationally, provides expertise on specific types of traumatic events, population groups, and youth-serving service systems, and supports the adaptation of effective evidence-based treatment models for communities across the country.<sup>53</sup>

According to the U.S. Department of Justice’s Office of Justice Programs, the following evidence-based treatment

programs are “effective” based on multiple studies showing “strong evidence to indicate they achieve their intended outcomes with fidelity.”<sup>54</sup> Each of the following examples of effective evidence-based treatment programs has been implemented by NCTSN centers. This is by no means an exhaustive list; these examples do, however, demonstrate how effective evidence-based treatment programs can be customized for different age groups, settings, and types of traumas experienced or witnessed.

- *Cognitive Behavioral Intervention for Trauma in Schools* is a school-based cognitive and behavioral therapy group intervention treatment program, “designed for children ages 10 to 15 who have had substantial exposure to violence or other traumatic events and who have symptoms of PTSD in the clinical range.”<sup>55</sup> The program reduces traumatic symptoms and helps children build resiliency skills to improve their abilities to handle toxic stress, thereby preventing future symptoms. Cognitive Behavioral Intervention for Trauma in Schools accomplishes these goals by using cognitive-behavioral theory (CBT) techniques such as relaxation training, exposing students to trauma triggers, and processing the traumatic experience to reduce anxiety and grief.<sup>56</sup> The program “has been implemented in elementary and middle schools across the country, with bilingual (Spanish, Russian, Armenian, and Korean) and multicultural urban and rural populations, as well as Native American groups.”<sup>57</sup> Multiple studies have found that Cognitive Behavioral Intervention for Trauma in Schools significantly reduces symptoms of PTSD and depression.<sup>58</sup>
- *Trauma-Focused Cognitive-Behavior Therapy* is a treatment intervention program designed to help families from all socioeconomic backgrounds and ethnic groups overcome the negative effects and emotional distress of traumatic events such as child sexual or physical abuse.<sup>59</sup> Trauma-focused CBT can be performed in a variety of settings. It minimizes serious emotional disorders such as post-traumatic stress, fear, anxiety, and depression by providing

children and parents with knowledge and “skills related to processing the trauma; managing distressing thoughts, feelings and behaviors; and enhancing safety, parenting skills, and family communication.”

<sup>60</sup> More than 60,000 mental health professionals have received training on trauma-focused CBT.<sup>61</sup> Multiple studies have found that trauma-focused CBT reduces PTSD symptoms and depression among child and parent participants, and increases use of effective parenting skills.<sup>62</sup> Follow-up evaluations have also revealed that these improvements were maintained for years afterwards.<sup>63</sup>

- *Trauma Affect Regulation: Guide for Education and Therapy (TARGET)* is a trauma-focused, emotion regulation psychotherapy treatment plan designed to serve adolescents and adults suffering from PTSD and substance use disorders.<sup>64</sup> It may be used in a variety of settings but it has been frequently adapted for use in juvenile detention facilities. TARGET introduces a step sequence of skills,<sup>65</sup> to help individuals “process and manage trauma-related reactions to stressful current situations” while maintaining sobriety.<sup>66</sup> In a randomized clinical trial in Connecticut where TARGET was delivered, delinquent girls ages 13 to 17 who met criteria for full or partial PTSD were found to have reduced PTSD and anxiety symptoms.<sup>67</sup> In another study of three juvenile detention facilities, recidivism rates declined significantly after implementation of TARGET.<sup>68</sup>

### Trauma-Informed Care Initiatives in Ohio

The following chart highlights some examples of the promising trauma-informed initiatives occurring in Ohio juvenile justice systems and schools. These initiatives illustrate what is being done to reduce the impact of trauma and increase children’s overall mental, physical and emotional well-being. In addition to the below examples, other trauma-informed care initiatives<sup>69</sup> in Ohio are focused on the child welfare system, the mental health system, hospitals, and domestic violence shelters.



| Type of Initiative  | Individual/Organization   | Description  |
|---|---|--|
| <p><b>Trauma Screening in Juvenile Justice Facilities</b></p> | <p>Ohio Department of Youth Services (DYS)</p>  | <p>ODYS received a grant from the Ohio Attorney General (AG) to identify and promote the use of a trauma screening tool to be used in all ODYS detention facilities across Ohio. The AG’s grant will also provide detention staff training in the MacArthur Foundation-sponsored <i>Mental Health Training Curriculum for Juvenile Justice</i>, an eight-hour training focused on adolescent development, mental health disorders and treatment, the important role of families, and effective treatment and practices.</p>  |
| <p><b>School-Based Trauma Programs and Centers</b></p>        | <p>Cleveland Metropolitan School District (CMSD)</p> <p>Cincinnati Public Schools (CPS)</p> | <p>CMSD’s Humanware program seeks to promote student safety and support by implementing social and emotional learning, a learning process that helps children develop essential skills of resilience and responsibility,<sup>70</sup> skills often lost to traumatic experiences.</p> <p>In 2001, the Cincinnati Board of Education launched the CPS Community Learning Center (CLC) Initiative, a plan to re-design schools as community “hubs,” with outside agencies offering counseling, after-school programs, nutrition classes, parent and family engagement programs, and health services, where trauma-informed care may be provided. An on-site Research Coordinator manages and aligns all of these partnerships. There are currently 39 elementary and secondary CLC sites within the district.<sup>71</sup></p> |

## Recommendations

Ohio has undoubtedly made progress in establishing trauma-informed systems of care. Nevertheless, trauma-informed practices and services must be offered in all of Ohio's child-serving organizations, including early care and education programs, schools, child welfare systems, juvenile justice facilities, and pediatric care providers, in order to serve and treat as many traumatized youth as possible. Many institutions still need to intervene and work together to break the negative chain reaction of trauma in children's lives and end the cycle of trauma that continues for generations.

Below are some recommendations for what communities and child-serving organizations can do in order to help implement effective trauma-informed care, thereby meeting the needs of traumatized children and building healthier, nonviolent communities.

### 1. Promote awareness of trauma and its devastating impact on children through outreach and education.

Outreach and education should be a coordinated effort among families, professionals, and child-serving organizations and should be focused on linking resources available regionally to as many children as possible.

### 2. Assess and improve services offered in the community

Communities can start to build the capacity to treat trauma once they have evaluated services already provided in the community—identifying whether there are trauma-informed services already in existence, whether there are any gaps in services, and if these services are lacking in any way. For instance, ask what systems have not yet instituted trauma-informed care? Do the organizations that have begun to institute trauma-informed care lack any of the three key elements of effective trauma-informed care: (1) identification/screening (2) assessment and (3) evidence-based treatment? Have these services been evaluated and have they proven to be effective?

### 3. Implement effective trauma-informed care with the three key elements.

Schools, juvenile detention centers, community correctional facilities, and others who come into contact with children on a regular basis must begin to put systems in place to identify, assess, and treat children who have been exposed to trauma.

**Identify/Screen**—All staff should either become “trauma-informed,” meaning they must be educated on the prevalence of childhood trauma, understand how trauma affects children and their environments, and be trained to recognize signs and symptoms of trauma exposure, or they must be trained to administer screening tools that identify children exposed to trauma. This will enable staff at different entry points to identify children who may be exhibiting trauma symptoms and intervene immediately to stop the negative chain reaction of trauma.

**Assess**—Once identified, these children must be referred to a professional clinician who has expertise on the impact of trauma. This professional will take into account their environment and determine whether they do in fact have mental health issues related to trauma in their lives. This important step reduces the risk of misdiagnosis.

**Treat**—Existing treatment providers must coordinate with child-serving organizations to develop intervention plans and/or institute appropriate and effective evidence-based treatment programs.

### 4. Work together with other child-serving organizations in a coordinated manner to expand and enhance a trauma-informed system of care.

Many organizations are not able to provide all three key elements of trauma-informed care due to various constraints. For this reason, child-serving systems should coordinate with outside agencies to provide appropriate services to meet children's needs. By working together internally and externally, child-serving organizations may ensure that trauma-informed services provide a “coordinated continuum of care for children and families.”<sup>72</sup>

For instance, children who enter the juvenile justice system may be screened at intake but they will need to be referred out to established clinicians and providers for proper assessment and trauma-focused treatment.

Schools, in particular, must coordinate efforts to implement comprehensive trauma-informed care. Schools are in a unique position to identify children who may be suffering from symptoms of trauma, and can provide an array of mental health and support services for children exposed to trauma. Educators and school administrators see and interact with their students on a daily basis and thus, may be the first ones to notice any troubling changes in behavior. Depending on their resources, schools can finance their own support services or work with community mental health centers to develop district-wide, on-site mental health units.<sup>73</sup> The Cincinnati Public Schools' Community Learning Centers are an excellent example of child-serving organizations working together to identify, assess, and treat children suffering from trauma. Many Ohio schools strapped for funding may emulate this kind of system, where important outside services, such as trauma-informed care, may be provided on site at minimal cost.

### **5. Work with partner organizations to institute trauma-informed interventions across the lifespan.**

Ohio must take an intergenerational approach to trauma break the cycle of trauma. For instance, if a child enters the child welfare system because of neglect as a result of severe substance abuse by a parent, the parent may also need to be screened and assessed for treatment and treated for any trauma. It is never too early or too late to intervene. The only way for the child to have any chance of returning to a stable home environment will be for his mother or father to receive the necessary trauma-informed intervention and care.

### **6. Eliminate punitive disciplinary practices that re-traumatize children.**

The elimination of punitive disciplinary practices is an especially important recommendation for schools and juvenile justice facilities. Punitive disciplinary practices

and policies, such as suspension, expulsion, seclusion, and restraint, must be replaced with trauma-sensitive discipline policies and environments that avoid inflicting secondary trauma. For example, the Dignity in Schools Campaign Model Code calls for “trauma sensitive schools,” which seek to identify the root causes of students’ behavior, including trauma, and dedicate resources to improving students’ behavioral health. In order to achieve this end, schools must develop “trauma-sensitive discipline policies,” balancing accountability with understanding of traumatic behavior; using positive disciplinary approaches, including counseling, restorative practices, guidance interventions and other non-exclusionary practices, as a primary response to student misbehavior; and minimizing disruption to education that results from disciplinary responses.<sup>74</sup>

Social and emotional learning leaders at Cleveland Metropolitan School District have worked toward eliminating punitive disciplinary practices in the district through the Humanware program. Cleveland schools have replaced in-school suspension with instructional planning centers, where educators work with children who are either referred to the centers or visit them voluntarily, helping students cool down during difficult times and consider positive responses to problems.<sup>75</sup> Teachers and students also use software programs that simulate possible trauma triggers and present outcomes of positive and negative responses.<sup>76</sup> Over Humanware’s six-year period, the number of out-of-school suspensions has dropped district-wide by 58.8 percent.<sup>77</sup>

### **7. Conduct ongoing evaluation.**

Ongoing evaluation must be conducted in order to determine whether trauma-focused individualized interventions plans and evidence-based treatment programs are working and data should be collected and provided publically, especially indicating successful trauma-focused treatments and services available to communities.



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## Conclusion

Too many Ohio children are punished, pushed out of school, and incarcerated due to behavior that has been imprinted into their brains by childhoods filled with trauma and toxic stress. Children suffering from trauma who are not appropriately identified and treated while they are young become troubled adults later, and this is both harmful to children and families and costly for the State of Ohio. Thus, when more Ohio child-serving organizations, particularly schools and juvenile detention centers, implement and integrate trauma-informed care throughout their programming, more Ohio children have a chance at successfully overcoming their adverse childhood experiences and achieving success.

The implementation of trauma-informed care must also be paired with the elimination of harsh, punitive disciplinary policies and practices to avoid inflicting secondary trauma on children.

While we applaud the Ohio child-serving organizations that have already implemented trauma-informed care and have taken steps to revise their disciplinary policies, we recognize that there are many more that may have never heard of trauma-informed care or have no idea what it entails. We hope that this issue brief helps disseminate information and examples of effective trauma-informed care to a wider audience; there is still much more work to be done to protect and support *all* Ohio children.

## Endnotes

- <sup>1</sup> This example reflects fact scenarios of cases handled by Cornerstone of Hope, a center for grieving children, teens, and adults in Cleveland, OH.
- <sup>2</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), Trauma Definition (2012), available at <http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx> (defining trauma as resulting 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.”). Therefore, trauma is the “sum of the event, the experience, and the effect.” *Id.*
- <sup>3</sup> National Child Traumatic Stress Network, Types of Traumatic Stress, available at <http://www.nctsn.org/trauma-types>.
- <sup>4</sup> See Centers for Disease Control and Prevention, *Adverse Childhood Experiences Reported by Adults—Five States, 2009*, 59 MMWR 1609, 1609 (2010), available at <http://www.cdc.gov/mmwr/pdf/wk/mm5949.pdf> (“ACEs have been linked to a range of adverse health outcomes in adulthood, including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality.”); John A. Fairbank, *The Epidemiology of Trauma and Trauma Related Disorders in Children and Youth*, 19 PTSD RES. Q. 1, 3 (2008), available at <http://www.ptsd.va.gov/professional/newsletters/research-quarterly/V19N1.pdf> (“The cumulative epidemiological evidence is that the adverse effects of traumatic stress experienced from infancy through adolescence may extend well into adulthood, increasing risk for lifelong problems such as depression, PTSD, substance abuse, low occupational attainment, and poor medical health.”).
- <sup>5</sup> Centers for Disease Control and Prevention, Adverse Childhood Experiences (ACEs) Study: Data and Statistics, Prevalence of Individual Adverse Childhood Experiences (last accessed Dec. 6, 2013), available at <http://www.cdc.gov/ace/prevalence.htm> (In this study of more than 17,000 adults, researchers found that 63.9% had faced some form of adverse childhood experience in any of ten categories, including neglect, sexual abuse, drug use in the household, presence of a mentally ill person in the household, and divorce or separation of parents.). ACEs may include verbal, physical, or sexual abuse, as well as family dysfunction. Jane Stevens, *Lincoln High School in Walla Walla, WA Tries New Approach to School Discipline—Suspensions Drop 85%*, ACEs TOO HIGH, Apr. 23, 2012, available at <http://ACESTOOHIGH.COM/2012/04/23/lincoln-high-school-in-walla-walla-wa-tries-new-approach-to-school-discipline-expulsions-drop-85/> (describing ACEs as “the bad things going on in [children’s] lives”).
- <sup>6</sup> Jane Stevens, *supra* note 5.
- <sup>7</sup> David Finkelhor et al., *Children’s Exposure to Violence: A Comprehensive, National Survey*, OJJDP JUV. JUST. BULL. 1, 1 (2009), available at <https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf>.
- <sup>8</sup> *Id.* at 2 (Types of victimization included: conventional crime, child maltreatment, victimization by peers and siblings, sexual victimization, witnessing and indirect victimization (including exposure to community violence and family violence), school violence and threats, and Internet violence and victimization.).
- <sup>9</sup> See Jane Stevens, *The Growing Interest in Aces and Trauma-Informed Practices*, ACEs TOO HIGH, June 21, 2013, available at [ACESTOOHIGH.COM/2013/06/21/the-growing-interest-in-aces-and-trauma-informed-practices/](http://ACESTOOHIGH.COM/2013/06/21/the-growing-interest-in-aces-and-trauma-informed-practices/).
- <sup>10</sup> Mary Kuhlman, *Ohio Agencies Target Childhood Trauma*, PUB. NEWS SERVICE, Oct. 8, 2012, available at <http://www.publicnewsservice.org/index.php?content/article/28773-1>.
- <sup>11</sup> See J.G. Hovens et al., *Impact of Childhood Life Events and Trauma on the Course of Depressive and Anxiety Disorders*, 126 ACTA PSYCHIATRICA SCANDINAVICA 198, 198–207 (2012).
- <sup>12</sup> See Brian Draper et al., *Long-Term Effects of Childhood Abuse on the Quality of Life and Health of Older People: Results from the Depression and Early Prevention of Suicide in General Practice Project*, 56 J. AM. GERIATRICS SOC’Y 262, 262–71 (2008).
- <sup>13</sup> See S.H. Shin et al., *Exposure to Childhood Neglect and Physical Abuse and Developmental Trajectories of Heavy Episodic Drinking from Early Adolescence into Young Adulthood*, 127 DRUG AND ALCOHOL DEPENDENCE 31, 31–38 (2013).
- <sup>14</sup> See Sjoukje deBoer et al., *Childhood Characteristics of Adolescent Inpatients with Early-Onset and Adolescent-Onset Disruptive Behavior*, 34 J. PSYCHOPATHOL BEHAV ASSESS 415, 415–22 (2012).
- <sup>15</sup> See Terri L. Messman-Moore et al., *Emotion Dysregulation and Risky Sexual Behavior in Revictimization*, 34 CHILD ABUSE & NEGLECT 967, 967–76 (2010).
- <sup>16</sup> See Kathryn L. Hildyard & David A. Wolfe, *Child Neglect: Development Issues and Outcomes*, 26 CHILD ABUSE & NEGLECT 679, 679 (2002).
- <sup>17</sup> Child Welfare Information Gateway, *Understanding the Effects of Maltreatment on Brain Development*, available at [https://www.child-welfare.gov/pubs/issue\\_briefs/brain\\_development/effects.cfm](https://www.child-welfare.gov/pubs/issue_briefs/brain_development/effects.cfm).

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- <sup>18</sup> National Scientific Council on the Developing Child, *Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: Harvard Working Paper #9*, at 1 (2010), available at [http://developingchild.harvard.edu/index.php/resources/reports\\_and\\_working\\_papers/working\\_papers/wp9/](http://developingchild.harvard.edu/index.php/resources/reports_and_working_papers/working_papers/wp9/).
- <sup>19</sup> David Finkelhor et al., *The Victimization of Children and Youth: A Comprehensive, National Survey*, 10 CHILD MALTREATMENT 1, 14 (2005) (The study examined a large spectrum of violence, crime, and victimization experiences in a nationally representative sample of children and youth ages 2 to 17 years).
- <sup>20</sup> Nat'l Scientific Council on the Developing Child, *supra* note 18, at 9.
- <sup>21</sup> U.S. Dept. of Health and Human Services, Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, 1, 39, 89 (2001), available at <http://www.ncbi.nlm.nih.gov/books/NBK44243/pdf/TOC.pdf>.
- <sup>22</sup> Nat'l Scientific Council on the Developing Child, *supra* note 18, at 5–6.
- <sup>23</sup> See Brigid Schulte, *New Report Find that Effects of Child Abuse and Neglect, if Untreated, Can Last a Lifetime*, WASH POST, Sept. 12, 2013, available at [http://articles.washingtonpost.com/2013-09-12/local/41994553\\_1\\_child-abuse-neglect-child-victims](http://articles.washingtonpost.com/2013-09-12/local/41994553_1_child-abuse-neglect-child-victims).
- <sup>24</sup> See *id.* at 22.
- <sup>25</sup> U.S. Dept. of Justice, Report of the Attorney General's National Task Force on Children Exposed to Violence, 1, 39 (2012), available at <http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf>.
- <sup>26</sup> *Id.* at 34.
- <sup>27</sup> Disability Rights Ohio, Trauma Informed Treatment in Behavioral Health Settings (last accessed Dec. 6, 2013), available at <http://www.disabilityrightsohio.org/trauma-informed-treatment>.
- <sup>28</sup> U.S. Dept. of Justice, Report, *supra* note 25, at 33.
- <sup>29</sup> *Id.* at 31–32; see B. Asgeirsdottir et al., *Associations Between Sexual Abuse and Family Conflict/Violence, Self-Injurious Behavior, and Substance Use: The Mediating Role of Depressed Mood and Anger*, 35 CHILD ABUSE AND NEGLECT 210–19 (2001); R. Maniglo, *The Role of Child Sexual Abuse in the Etiology of Substance-Related Disorders*, 30 J ADDICTIVE DISORDERS 216–28 (2011).
- <sup>30</sup> See Elizabeth Cannon et al., *The Intergenerational Transmission of Witnessing Intimate Partner Violence* Arch 163 PEDIATR ADOLESC MED 706, 706–08 (2009); Nat'l Scientific Council on the Developing Child, *supra* note 18, at 1 (Studies have shown that child maltreatment occurs most often in families that “face excessive levels of stress, such as that associated with community violence, parental drug abuse, or significant social isolation.”).
- <sup>31</sup> Centers for Disease Control and Prevention, Adverse Childhood Experiences (ACEs) Study: Major Findings (last accessed Dec. 6, 2013), available at <http://www.cdc.gov/ace/findings.htm>.
- <sup>32</sup> *Id.*
- <sup>33</sup> Brigid Schulte, *supra* note 23.
- <sup>34</sup> Academy on Violence & Abuse, Hidden Costs in Health Care: The Economic Impact of Violence and Abuse, 1, 8 (2009), available at <http://ccasa.org/wp-content/themes/skeleton/documents/Economic-Cost-of-VAW.PDF>.
- <sup>35</sup> Jane Stevens, *supra* note 5.
- <sup>36</sup> U.S. Dept. of Justice, Report, *supra* note 25, at 83.
- <sup>37</sup> *Id.* at 30.
- <sup>38</sup> Pia V. Escuerdo et al., The Safe Start Center Series on Children Exposed to Violence: Schools 1, 3 (2010), available at [http://www.safestartcenter.org/sites/default/files/documents/publications/PDF\\_IssueBrief3.pdf](http://www.safestartcenter.org/sites/default/files/documents/publications/PDF_IssueBrief3.pdf).
- <sup>39</sup> Jane Stevens, *supra* note 5.
- <sup>40</sup> Jane Stevens, *There's No Such Thing as a Bad Kid in These Spokane, WA, Trauma-Informed Elementary Schools*, ACEs TOO HIGH, Aug. 20, 2013, available at <http://acestoohigh.com/2013/08/20/spokaneschools/>.
- <sup>41</sup> See e.g., Elena Cohen et al., The Safe Start Center Series on Children Exposed to Violence: Understanding Children's Exposure to Violence (2009), available at <http://www.safestartcenter.org/sites/default/files/documents/publications/issuebrief1.pdf>.
- <sup>42</sup> Jane Stevens, *supra* note 5.
- <sup>43</sup> *Id.*
- <sup>44</sup> *Id.*
- <sup>45</sup> *Id.*
- <sup>46</sup> *Id.*
- <sup>47</sup> *Id.*
- <sup>48</sup> Jane Stevens, *supra* note 5.
- <sup>49</sup> Children's Defense Fund-Ohio, Mental Health Screening in Juvenile Detention Facilities: Issue Brief 1, 2 (2012), available at <http://www.cdfohio.org/assets/pdf-files/mental-health-juvenile.pdf>.
- <sup>50</sup> *Id.*

- <sup>51</sup> Lisa Pilnik et al., *The Safe Start Center Series on Children Exposed to Violence: Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates 1, 2* (2012), available at [http://www.safestartcenter.org/sites/default/files/documents/publications/PDF\\_IssueBrief7.pdf](http://www.safestartcenter.org/sites/default/files/documents/publications/PDF_IssueBrief7.pdf).
- <sup>52</sup> See *id.*, at 11.
- <sup>53</sup> The National Child Traumatic Stress Network (NCTSN), *The History of the NCTSN* (last accessed Dec. 6, 2013), available at <http://nctsn.org/about-us/history-of-the-nctsn>.
- <sup>54</sup> National Institute of Justice Office of Justice Programs, *About CrimeSolutions.gov* (last accessed Dec. 6, 2012), available at <http://www.crimesolutions.gov/about.aspx#3>. For ratings on all of the programs, please visit <http://www.crimesolutions.gov/Programs.aspx>.
- <sup>55</sup> National Institute of Justice: Office of Justice Programs, *Program Profile: Cognitive Behavioral Intervention for Trauma in Schools (CBITS)* (last accessed Dec. 6, 2013), available at <http://www.crimesolutions.gov/ProgramDetails.aspx?ID=139>.
- <sup>56</sup> *Id.*
- <sup>57</sup> Pia V. Escuerdo, *supra* note 38, at 7.
- <sup>58</sup> See e.g., Bradley D. Stein et al., *A Mental Health Intervention for Schoolchildren Exposed to Violence: A Randomized Controlled Trial*, 290 JAMA 603, 603–10, available at <http://jama.ama-assn.org/content/290/5/603.full.pdf+html>.
- <sup>59</sup> National Institute of Justice: Office of Justice Programs, *Program Profile: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)* (last accessed Dec. 6, 2013), available at <http://www.crimesolutions.gov/ProgramDetails.aspx?ID=195>.
- <sup>60</sup> The National Child Traumatic Stress Network, *Learning Collaboratives: Detailed Information* (last accessed Dec. 6, 2013), available at <http://www.nctsn.org/resources/training-and-education/learning-collaboratives-detail>.
- <sup>61</sup> Lisa Pilnik, *supra* note 51, at 11.
- <sup>62</sup> Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), *supra* note 59.
- <sup>63</sup> *Id.*
- <sup>64</sup> National Institute of Justice: Office of Justice Programs, *Program Profile: Trauma Affect Regulation: Guide for Education and Therapy (TARGET)* (last accessed Dec. 6, 2013), available at <http://www.crimesolutions.gov/ProgramDetails.aspx?ID=145>.
- <sup>65</sup> FREEDOM stands for: Focus, Recognize, Emotions, Evaluate, Define, Options, Make a contribution. *Id.*
- <sup>66</sup> *Id.*
- <sup>67</sup> Julian D. Ford et al., *Randomized Trial Comparison of Emotion Regulation and Relational Psychotherapies for PTSD with Girls Involved in Delinquency*, 41 J. CLIN CHILD ADOLESC PSYCHOL 27, 27 (2012), available at <http://www.tandfonline.com/doi/pdf/10.1080/15374416.2012.632343>.
- <sup>68</sup> Julian D. Ford & Josephine Hawke, *Trauma Affect Regulation Psychoeducation Group and Milieu Intervention Outcomes in Juvenile Detention Facilities*, J. AGGRESSION, 21 MALTREATMENT & TRAUMA 365, 365 (2012).
- <sup>69</sup> See Addendum: Trauma-Informed Care Initiatives Chart.
- <sup>70</sup> Cleveland Metropolitan School District, *Humanware* (last accessed Dec. 6, 2013), available at <http://www.clevelandmetroschools.org/Page/398>; John Bridgeland & Mary Bruce, *The Missing Piece – How Social and Emotional Learning Can Empower Children and Transform Schools*, HUFF POST IMPACT, May 16, 2013, available at [http://www.huffingtonpost.com/john-bridgeland/social-and-emotional-learning\\_b\\_3274283.html](http://www.huffingtonpost.com/john-bridgeland/social-and-emotional-learning_b_3274283.html).
- <sup>71</sup> Cincinnati Public Schools, *CLC Sites* (last accessed Dec. 6, 2013), available at <http://www.cincinnati-clc.org/clcsites>.
- <sup>72</sup> Elena Cohen, *supra* note 41, at 6.
- <sup>73</sup> Pia V. Escuerdo, *supra* note 38, at 2.
- <sup>74</sup> The Dignity in School Campaign, *A Model Code on Education and Dignity: Presenting a Human Rights Framework for Schools 1, 23* (2013), available at [http://www.dignityinschools.org/files/Model\\_Code\\_2013.pdf](http://www.dignityinschools.org/files/Model_Code_2013.pdf).
- <sup>75</sup> Collaborative for Academic, Social, and Emotional Learning (CASEL), *Cleveland Metropolitan School District* (last accessed Dec. 6, 2013), available at <http://www.casel.org/collaborating-districts/cleveland-metropolitan-school-district/>.
- <sup>76</sup> *Id.*
- <sup>77</sup> John Bridgeland & Mary E. Bruce, *supra* note 70.



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## CDF Mission Statement

The Children’s Defense Fund Leave No Child Behind® mission is to ensure every child a *Healthy Start, a Head Start, a Fair Start, a Safe Start* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities.

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