COALITION ADDRESSING
TRAUMA

CONGRESSIONAL ISSUE BRIEFING

Addressing the Mental Health Impact of Violence and Trauma on Children

October 11, 2011

Briefing Agenda

8:00 am	Speaker Arrival/Breakfast
8: 30 am	Opening Remarks **Helga Luest**, President & CEO, Witness Justice; Representative from the Coalition Addressing Trauma
8:40 am	A Survivor's Perspective **David Washington**
8:50 am	**Commissioner Samuels,** Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services
9:05 am	Science and Data **Elizabeth Hudson**, Trauma-Informed Care Consultant, University of Wisconsin-Madison, School of Medicine and Public Health; Consultant to Wisconsin Department of Health Services
9:15 am	**A. Kathryn Power**, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
9:30 am	Survivor Perspectives: A Video Presentation (tentative)
9:35 am	Q&A
10:00 am	Conclusion

Hosted by the Coalition Addressing Trauma, with Witness Justice
In cooperation with the **Congressional Victim's Rights Caucus** and the **Congressional Addiction Treatment & Recovery Caucus**

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American Group Psychotherapy Association
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On Our Own of Saint Mary's Wellness and Recovery Center
Stop the Silence: Stop Child Sexual Abuse, Inc.
Witness Justice

Congressional Issue Briefing:
Addressing the Mental Health Impact of Violence and Trauma on Children

SPEAKER BIOS

Elizabeth Hudson, LCSW
Elizabeth Hudson is employed by the University of Wisconsin-Madison's School of Medicine and Public Health and partners with the Wisconsin's Department of Health Services to integrate trauma-informed care into mental health and substance abuse systems, child welfare, school settings, homelessness services, and correctional settings. In 2009, Hudson and her supervisor, Marie Danforth, accepted the Wisconsin's Association of Family and Children's Agency's *John R. Grace Outstanding Leadership Award* for the Department of Health Services' work in promoting trauma-informed care and the reduction of seclusion and restraint. Hudson has worked in the field of trauma prevention and treatment for 20 years as an advocate, clinician, supervisor, and administrator. Hudson received the National Association of Social Workers' Award for Distinguished Service while working as a child and family therapist specializing in trauma work with children under the age of eight. She is a founding member of the national organization, Coalition Addressing Trauma, and regularly participates in national discussions regarding the integration of trauma-informed care across multiple human service systems.

Helga Luest, MIM
Helga Luest is a recognized expert in the field of trauma, including post-traumatic stress disorder, trauma-informed care, behavioral health responses to trauma, vicarious trauma and compassion fatigue, the healing process, navigating the criminal justice process for victims, victim rights, and the needs of friends and families of survivors. She is a national keynote presenter and trainer. Luest survived an attempted murder in 1993 and, more recently, domestic violence. As the founder and President/Chief Executive Officer of Witness Justice, Luest leads advocacy, program development, and contract initiatives, including subcontracts to provide communication and outreach activities for numerous federal agencies. She spearheaded the creation of the Coalition Addressing Trauma, an advocacy group aimed at bringing survivors of abuse, neglect, violence, disaster, terrorism, and war together with organizations and advocates to collectively address trauma as a public health crisis. Luest lead a statewide campaign in Wisconsin to promote trauma-informed care and is currently working on a national trauma campaign aimed at families for the Center for Mental Health Services, SAMHSA/DHHS. Witness Justice created the first e-learning facility for the Office on Violence Against Women, DOJ, called TrainingForums.org, where Luest developed curriculum on topics relevant to providers of domestic violence and other human services. Luest works with Artist Nick Kline on the GlassBook Project, an art-based initiative to address mental health stigma and discrimination, which was named one of the top five mental health innovations in the country by *Mental Health Weekly*. In 2011, Luest received the distinguished U.S. Congressional Eva Murillo Unsung Hero Award for her innovation, efficacy and advocacy, and was also ranked sixth in the top ten "most interesting people" by *DC Spotlight Newspaper*. Luest holds a BS in Marketing from American University and an MIM in International Management from the University of Maryland University College. She also has certification in private investigation and women's self defense.

A. Kathryn Power
A. Kathryn Power, M.Ed. is the Director of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of the US Department of Health and Human Services (DHHS). CMHS provides national leadership in mental health promotion, mental illness prevention, and the development and dissemination of effective mental health services. Director Power leads a staff of professionals in facilitating the transformation of our nation's mental health care system into one that is recovery-oriented and consumer-centered.

Bryan Samuels

Bryan Samuels is the Commissioner of the Administration on Children, Youth and Families (ACYF). Samuels has spent his career formulating service delivery innovations and streamlining operations in large government organizations on behalf of children, youth, and families. As Chief of Staff for Chicago Public Schools (CPS), Samuels played a leadership role in managing the day-to-day operations of the third largest school system in the nation with 420,000 students, 623 schools, 44,000 employees, and a $5 billion budget. Prior to this role, from 2003 to 2007, Samuels served as the Director of the Illinois Department of Children and Family Services (DCFS). While Director, he moved aggressively to implement comprehensive assessments of all children entering care, redesigned transitional and independent living programs to prepare youth for transitioning to adulthood, created a child location unit to track all runaway youth, and introduced evidence-based services to address the impact of trauma and exposure to violence on children in state care. As a result of his efforts, DCFS established the lowest caseload ratios for case managers in the nation; reduced the number of youth "on run" by 40 percent and number of days "on run" by 50 percent; decreased the use of residential treatment or group homes by 20 percent; and eliminated the number of past due child protection investigations by 60 percent. Prior to 2003, Samuels taught at the University of Chicago's School of Social Service Administration. Samuels holds a Master's Degree from the University of Chicago, Harris School of Public Policy Studies and a Bachelor's of Arts Degree from the University of Notre Dame.

David A Washington, LGSW, LCADC, AD/PC Sup

David A. Washington MSW, AD-PC Supervisor, is the Program Coordinator for a facility where he oversees a Jail Substance Abuse Program, Pharaoh Program, Rewriting Inner Script (RISE) Retreats, and the TAMAR Program (Trauma, Addictions, Mental Health, And, Recovery). He has been in the field of substance abuse since 1989, working for such agencies as The Johns Hopkins Hospital Program for Alcoholism and Other Drug Dependences. In 2000 he was hired as a Trauma Specialist in Maryland. Since that time, Washington has worked to advance the field of trauma services in the criminal justice system. He has presented on trauma informed services at numerous conferences and trainings. Most notable presentations: The Gains Conference; The Police and Correctional Training Commissions and Specialized Training; Illinois Department of Human Services; Office of Forensic Services; Ohio Department of Mental Health; and regional trainings throughout California (2009) and Florida (2010). Washington completed a 90-hour post-graduate trauma studies certificate program with Bessel van der Kolk PhD in May 2011. While Washington conducts group therapy for both men and women, he has specialized in working with men in the criminal justice systems that have a history of adverse childhood trauma. He is currently excited to be amidst one of the first treatment providers in Maryland to be implementing the curriculum "Sexual Health in Drug and Alcohol Treatment." David is a survivor of childhood rape and sexual abuse and has been in the process of recovery for 20 years. Washington sees his healing from trauma as a process. He still works through trauma triggers 30 years after the violence and abuse.

ISSUE BRIEF

Addressing the Mental Health Impact of Violence and Trauma on Children

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COALITION ADDRESSING TRAUMA

Author: Helga Luest, Presient & CEO, Witness Justice

In a letter to the President in 2006, the Congressional Addiction, Treatment and Recovery Caucus noted psychological trauma, caused by violence, abuse, neglect, disaster, terrorism and war, as a "public health crisis." While strides have been made to raise public awareness of the nature and impact of trauma and to provide trauma-informed care in adult services, child trauma remains a serious concern requiring much more than technical assistance and education to service providers. Because children "belong" to their families and do not have the same rights as adults, their welfare, safety and long-term health rest in the hands of their caregivers. All too often, we see that kids are left in situations of prolonged, interpersonal and repeated abuse and neglect, impacting their worldview, neurobiology, developmental momentum, mental and behavioral health, and subsequently, their ability to engage in healthy relationships.

What Is Happening to Our Children

Studies show that reports to social and child protective services come primarily from teachers, law enforcement and other social service or medical professionals, where most of the reports are of new concerns. The majority of abuse cases indicate parental harm; however where abuse or neglect is indicated, the abusive parent's access typically remains in tact. There remains a disparity in how and if states will actually pursue these cases in the criminal justice system. If the same level of violence or neglect were perpetrated by a stranger or someone outside the family, there would be a criminal investigation and process. But when a parent is accused, Social Services investigates under a different standard than what would be used by law enforcement. Studies have shown the long-term effects of violence and abuse on children's mental and physical health, and yet it is evident that social and child protective services rarely step in – and when they do, there is a disproportionate gender focus on and response to mothers. "Mothers are, if anything, losing custody more often to fathers, particularly when the men abuse them or their children, and abusive men now win child custody more than do men who are non-violent."[i]

In addition to abuse and neglect, children also face a host of other adverse conditions that can impact their health and development. The witnessing of violence (in the home, community, school, etc.), substance abuse in the home, mental illness in the home, parental separation and divorce, having an incarcerated parent or family member, and having a parent deployed to a war zone all contribute to trauma exposure for a child. Additionally, these adverse situations create toxic stress for the child, often forcing them to be responsible for themselves or even play the role of caregiver for others in the home. These adversities essentially rob the young person of their childhood and often force adaptations that can lead to health risk behaviors.

Children's capacity for language varies based on their developmental stage. When trauma and abuse disrupt normal language acquisition, behavior becomes their only

form of communication. These expressions typically come out when and where a child feels safe – often in school. Instead of asking "What is this child trying to communicate?" and "What is happening with this child?", we rush to try to find an answer to "What is wrong with this child?", missing the important role of behavior as communication. In addition to communicating distress, some of the most troubling behavior is a natural consequence to what we now understand as a "mental injury." Many of the primary complaints we hear from teachers (aggression, poor attention span, lack of problem-solving skills, spacing out, impulsivity) are the result of a nervous system that is out of balance. When we miss these cues, the child is labeled – typically as "bad," "troubled," "ill" or "disabled" – when the reality may be that behavioral problems are a cry for help. More and more, the response to children whose behavior has become problematic is to medicate, which can impact the child's health across the lifespan, and healthcare costs are significantly increased as a result. When we "listen" to the child's behavior, we have the opportunity to provide supportive interventions that can prevent a downward spiral that often leads to additional layers of trauma.

When we teach our children to tell a trusted adult if they are being harmed, if they are afraid or if they have been hurt, the child's expectation is that there will be some help and relief. Sometimes the child may not even realize what is happening to them as harmful, as "safe touch" is not uniformly taught to and understood by children. When a child experiences fear and harm, sometimes it is impossible for them to reach out for help because of threats and other coercive actions by the abuser. And when a child does break out of that place of fear to reveal what may be happening, it takes significant strength and courage. But what so many children are learning, as a direct result of our broken systems, is that even when they disclose and ask for help, nothing positive happens. The impact that this has on their esteem and worldview is profound – especially if it happens repeatedly.

For the small number of children that are given access to a mental health therapist, trauma screening is often absent from evaluation. When a child's abuse history is missed by mental and medical health professionals, not only does the trauma remain unaddressed, but the child may be labeled with a stigmatizing mental health diagnosis. Treatment strategies for complex trauma issues are hard to address within the current mental health system, which is ill equipped to provide cross-environment education and supportive strategies to caregivers and schools. Because some children grow up in communities where shootings and violence is prevalent and there is no "safe haven," their ability to stabilize their nervous systems becomes impossible, making it even more essential for trauma awareness and a coordinated care response to be in place.

The current laws that guide child protective services also require serious review and revision. If there is a level of abuse, violence or neglect – a threshold – that has to be reached for the child welfare agency to take action in the best interest of the child, then this needs to be clearly outlined. Many reports lead to superficial investigations. If we do not re-examine how these cases are processed and evaluated, we are just wasting tax-payer dollars with meaningless investigations, not to mention the time and stress for those who report and are involved in the investigation. We require social service staff to

report suspected abuse or neglect, and we strongly encourage the public to do so; but reporting is only successful in providing some safety for the child if the responsible agency actually does something. Unfortunately, many concerns are brushed off as "poor parenting" or "parenting style," or part of a bitter custody dispute rather than real risk to the child.

To illustrate some of what our children are experiencing...

Trauma, Violence and Neglect

Domestic Violence

- Approximately three to ten million children are exposed to violence in their homes each year.[ii]
- A child is abused or neglected every 42 seconds.[iii]
- Children who witness violence at home display emotional and behavioral disturbances as diverse as withdrawal, low self-esteem, nightmares, and aggression against peers, family members and property.[iv]

Traumatic Event Exposure

- In the United States alone, from 1996 to 1998, there were more than 5 million children exposed to some form of severe traumatic event such as physical abuse, domestic and community violence, motor vehicle accidents, chronic painful medical procedures and natural disasters.[v]
- A national survey of 12- to 17-year-old youth showed that 8 percent reported a lifetime prevalence of sexual assault, 17 percent reported physical assault and 39 percent reported witnessing violence.[vi]

Youth and Crime

- Most children who have turned to sex trade and trafficking ran away from home or were abandoned. The majority of those kids both use and sell illegal drugs. The risk of a child 10-17 being sex trafficked is higher than the risk that he or she will die in an accident or be raped or sexually assaulted.[vii]
- Law enforcement agencies arrested approximately 2.8 million juveniles in 1997. Of that number, 2,500 were arrested for murder and 121,000 for other violent crimes. Juveniles accounted for 19 percent of all arrests, 14 percent of murder arrests, and 17 percent of all violent crime arrests.[viii]
- Most of the children prosecuted in adult court are charged with non-violent offenses. About 10,000 children are held in adult jails and prisons on any given night, with very little, if any, educational services available during incarceration. Approximately 40-73 percent of the girls in the juvenile justice system have been abused, and 75 percent of them are regular users of alcohol and drugs.[ix]

Lesbian, Gay, Bisexual and Transgender (LGBT) Youth

- Young people who are lesbian, gay, bisexual or transgender are at least seven times more likely to be crime victims than heterosexual people. At least 75 percent of crimes against LGBT youth are not reported to anyone.[x]

- LGBT youth live, work and attempt to learn in constant fear of physical harm at school. 27 perecent have been physically hurt by another student.[xi]
- In a typical class of 30 students, 8 students (27 percent of the class) will be directly affected by homosexuality of self, one or more siblings, or one or both parents.[xii]
- Over half (56.4 percent) of transgender students reported verbal harassment based on all three personal characteristics—gender expression, gender and sexual orientation. Over half (55.2 percent) of these students also reported some incident of physical harassment with over a quarter reporting this type of harassment because of all three characteristics.[xiii]
- According to this study, gay and lesbian youth are two to three times more likely to complete suicide than other youths and 30 percent of all completed youth suicides are related to the issue of sexual identity.[xiv]

Children in Military Families

- Maltreatment of children in families of enlisted soldiers was 42 percent higher if a parent was deployed and away from home than when they were home.[xv]
- A report commissioned by the Army determined that during deployment, rates jump, outstripping civilian abuse rates: neglect (increases four-fold), maltreatment (increases three-fold), and physical abuse (increases two-fold).[xvi]
- Children aged 3 years or older with a deployed parent exhibit increased behavioral symptoms compared with peers without a deployed parent, after controlling for caregiver's stress and depressive symptoms.[xvii]

Media and Violence

- The National Television Violence Study found that nearly 2 out of 3 TV programs contained some violence, averaging about 6 violent acts per hour.[xviii]
- Young children (ages two through seven) are less exposed to media violence than older children, but data collected in 1999 show that they still spend more than three hours each day watching television and videos.[xix]

Bullying

- More than 50 percent of children between the ages of 8 and 11 reported that bullying is a "big problem" at school.[xx]
- 86 percent of children between the ages of 12 and 15 reported that they get teased or bullied at school, more prevalent than smoking, alcohol, drugs, or sex among this age group.[xxi]

Mental Health Impact

- In children, trauma may be incorrectly diagnosed as depression, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, generalized anxiety disorder, separation anxiety disorder, and reactive attachment disorder.[xxii] [xxiii]
- According to the U.S. Department of Health and Human Services, mental health problems affect one in every five young people. Two-thirds are not getting the

help they need. Between 7.7 and 12.8 million children have a diagnosable mental disorder.

- Rates of PTSD identified in childhood range from 2 percent after a natural disaster (tornado), 28 percent after an episode of terrorism (mass shooting), and 29 percent after a plane crash.[xxiv]
- In a community sample of older adolescents, 14.5 percent of those who had experienced a serious trauma developed PTSD.[xxv]
- The U.S. has the highest rates of childhood homicide, suicide, and firearm-related death among industrialized countries.[xxvi]

There is no question that our children are exposed to abuse, violence, neglect and other overwhelming adversity that is traumatic and has a long-term impact on cognitive, social, emotional and physical development. Our children need a different response from our systems, communities and families. They should have the right to be healthy, happy and safe.

What is Trauma?

The American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV) defines a "traumatic event" as one in which a person experiences, witnesses or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others. A person's response to trauma often includes intense fear, helplessness or sheer horror.[xxvii] Trauma can result from experiences that are "private" (e.g. sexual assault, domestic violence, child abuse/neglect, witnessing interpersonal violence) or more "public" (e.g. war, terrorism, natural disasters).

Medical researchers, sociologists and healthcare professionals increasingly recognize trauma as a significant factor in a wide range of health, behavioral health and social problems.[xxviii] [xxix] Trauma resulting from prolonged or repeated exposures to violent events can be the most severe.[xxx]

Clearly, different individuals react to trauma in their own way, depending on many mediating and exacerbating factors. Some of these factors include aspects of the individual (e.g., age, past experiences, strengths), the environment (e.g., supportive responses and access to safety and resources) and the nature of and circumstances surrounding their traumatic experiences (e.g., severity, frequency, intrusiveness, stigma, intentionality). For example, trauma associated with repeated childhood physical or sexual abuse, especially at the hand of a trusted adult, can become a central defining characteristic to a survivor's identity, impacting nearly every aspect of his or her life. Regardless of its cause, trauma is a central mental health concern and a "common denominator" for abuse, neglect, violence, disaster, terrorism and war victims.

The Human Cost

Trauma can have severe negative impacts on a person's physical and emotional state. The most common experiences include flashbacks, emotional numbness and

withdrawal, nightmares and insomnia, mood swings, grief, guilt, distrust and a lack of physical or sexual intimacy. Trauma has been linked to hallucinations and delusions, depression, suicidal tendencies, chronic anxiety and fatigue, hostility, hypersensitivity, eating disorders such as anorexia or obesity and other obsessive behaviors.[xxxi] Victims are at a much higher risk for co-occurring mental health disorders and substance abuse, violence victimization and perpetration, self-injury and a host of other coping mechanisms which themselves have devastating human, social and economic costs. Trauma has been linked to social, emotional, and cognitive impairments, disease, disability, serious social problems and premature death.[xxxii]

In fact, between 51 percent and 98 percent of public mental health clients diagnosed with severe mental illness report having trauma histories,[xxxiii] and prevalence rates within substance abuse treatment programs and other social services are similar.[xxxiv] In children, trauma may be diagnosed incorrectly as depression, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, generalized anxiety disorder, separation anxiety disorder and reactive attachment disorder.[xxxv] [xxxvi] Adults also encounter similar misdiagnosis and obstacles in having their trauma experiences understood and addressed.

The Adverse Childhood Experiences (ACE) Study, which examined the health and social effects of traumatic childhood experiences over the lifespan of 18,000 participants, demonstrated that trauma is far more prevalent than previously recognized, that the impacts of trauma are cumulative, and that unaddressed trauma underlies a wide range of problems. Chronic medical conditions such as heart disease, cancer, lung and liver disease, skeletal fractures and HIV-AIDS plague many trauma survivors. Also, a host of social ills from homelessness, prostitution, delinquency and criminal behavior, to the failure to finish school or an inability to hold a job, stem from the effects of a traumatic event. [xxxvii] [xxxviii] [xxxix] Fractured relationships and support systems also greatly impact the survivor and their ability to heal.

The Public Cost of Unaddressed Trauma

When unrecognized and untreated trauma manifests itself as civic problems, we all foot the bill. Trauma can significantly increase the use of healthcare and behavioral health services, as well as boost incarceration rates and increase the need for victim compensation and services. For instance, we know that more than 40 percent of women on welfare were sexually abused as children.[xl] So taxpayers then pick up the tab for the greater reliance on public resources such as Medicare, Medicaid, Welfare and other programs, plus the strain on the law enforcement, court, victim service and prison systems. Meanwhile trauma costs business and the American economy in decreased productivity and unemployment payments.

The financial burden of trauma to society is staggering. The economic expenditures of untreated trauma-related alcohol and drug abuse alone were estimated at $160.7 billion in 2000.[xli] The estimated cost to society of child abuse and neglect is $94 billion per year, or $258 million per day.[xlii] For child abuse survivors, long-term psychiatric and

medical health care costs are estimated at $100 billion per year.[xiii] Lost productivity from violence accounted for $64.4 billion annually, with another $5.6 billion spent in medical care.[xiv]

Next Steps

The Congressional issue briefing "Addressing the Mental Health Impact of Violence and Trauma on Children" that took place on October 11, 2011 marks an important first step in considering how our policymakers, Administration and government, communities and families can be more responsive to the needs of children. Given the state of the economy in the United States, where publicly funded program budgets are being greatly reduced, we need to find creative and collaborative approaches to meet the needs of our children. Prevention should be the primary focus, but building an understanding of how trauma impacts children and how to promote healing and resilience is paramount for their long-term wellbeing.

This issue brief will be updated with discussion points and recommendations following the Congressional briefing.

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RELEVANT RESEARCH

FAMILY • POLICY • COUNCIL

ADVERSE CHILDHOOD EXPERIENCES

The Most Powerful Determinate of the Public's Health

Abuse and Neglect

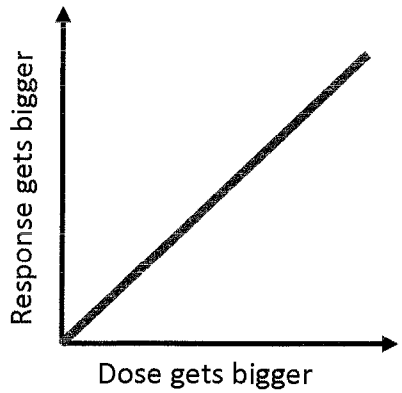
1. Child physical abuse
2. Child sexual abuse
3. Child emotional abuse
4. Neglect
5. Witnessing domestic violence against the mother

Indicators of Family Dysfunction

6. Mentally ill, depressed or suicidal person in the home
7. Drug addicted or alcoholic family member
8. Parental discord – indicated by divorce, separation, abandonment
9. Incarceration of any family member

EPIDEMIOLOGIC STUDY
OVER 17,000 PEOPLE IN ORIGINAL STUDY
WA FIRST IN NATION

A CLASSIC CAUSAL RELATIONSHIP
MORE ACEs = MORE HEALTH PROBLEMS



Dose-response is a direct measure of cause & effect. In this case:

The "response"—

The occurrence of the health condition

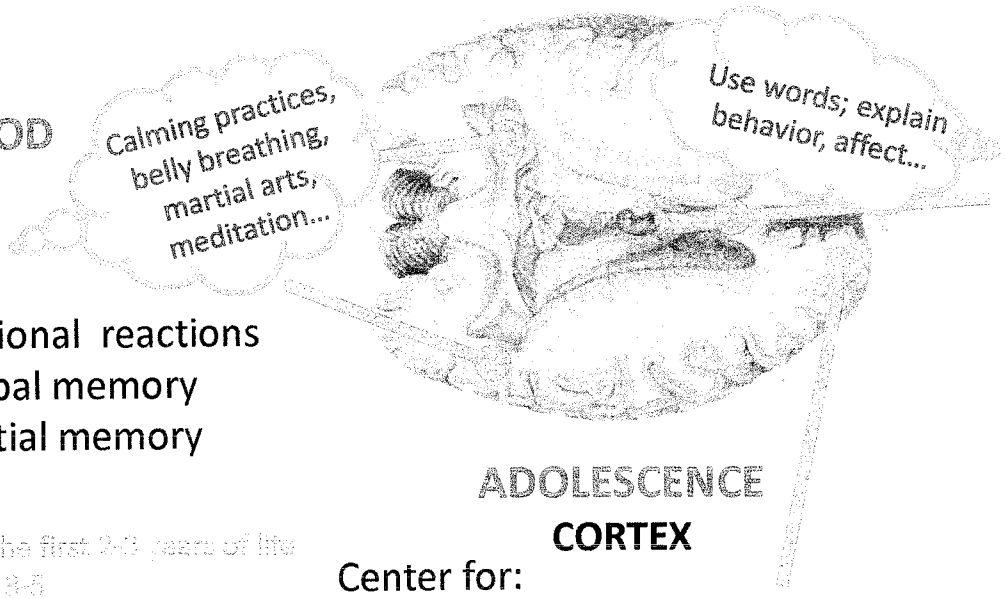
is caused directly by the size of

The "dose"—

The number of ACEs.

ACE Score: the number of <u>categories</u> of adverse childhood experience to which a person was exposed.

TRAUMA IS HARD-WIRED INTO BIOLOGY



EARLY CHILDHOOD

HIPPOCAMPUS

The center for:

- Controlling emotional reactions
- Constructing verbal memory
- Constructing spatial memory

VULNERABILITY
All maltreatment in the first 3-5 years of life
Sexual abuse at ages 4-5

Adaptation:

- Emotionally reactive—brain's braking mechanism fails
- Poor regulation of behavior
- Difficulty with verbal & spatial memory

Net loss in volume becomes evident in the 20s.

ADOLESCENCE

CORTEX

Center for:

- Thinking & judgment
- Executive function
- Long term memory
- Vision

VULNERABILITY
Witnessing DV
Sexual Abuse; 15-16

Adaptation:

- Poor executive function
- Impulsiveness
- Diminished abstract reasoning
- No hope for the future
- Limiting field of vision

MIDDLE CHILDHOOD

CORPUS CALLOSUM

Integrates hemispheres & facilitates:

- Language development
- Proficiency in math
- Processing of social cues, such as facial expression

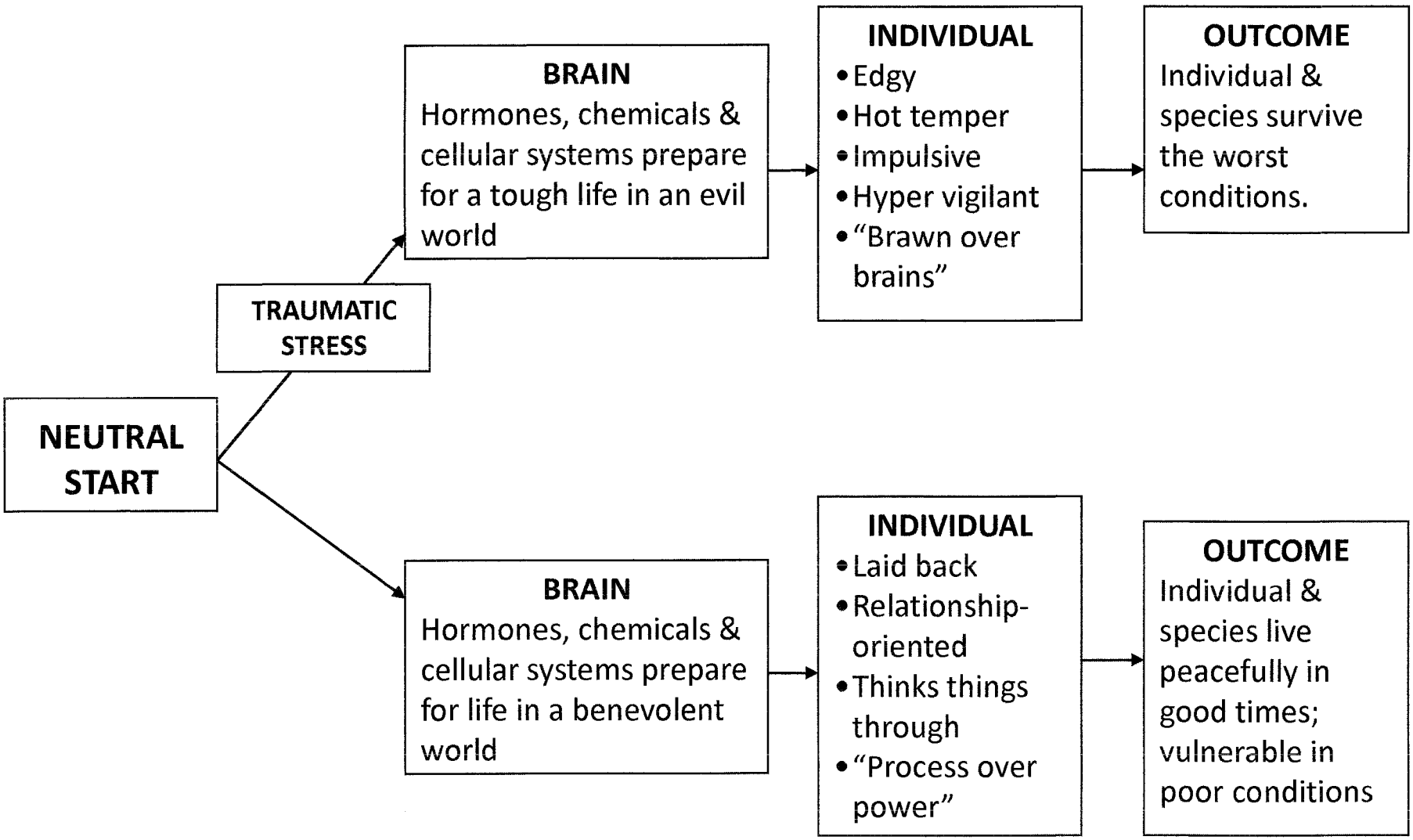
VULNERABILITY
Neglect in infancy
Sexual abuse at ages 9 and 10

Adaptation:

- Language delay
- Diminished math capacity
- Diminished integration & coordination
- Difficulty with social cues

From the work of: Dr. Martin Teicher, Harvard University & McLain Hospital

ADAPTATION TO ANTICIPATED WORLD

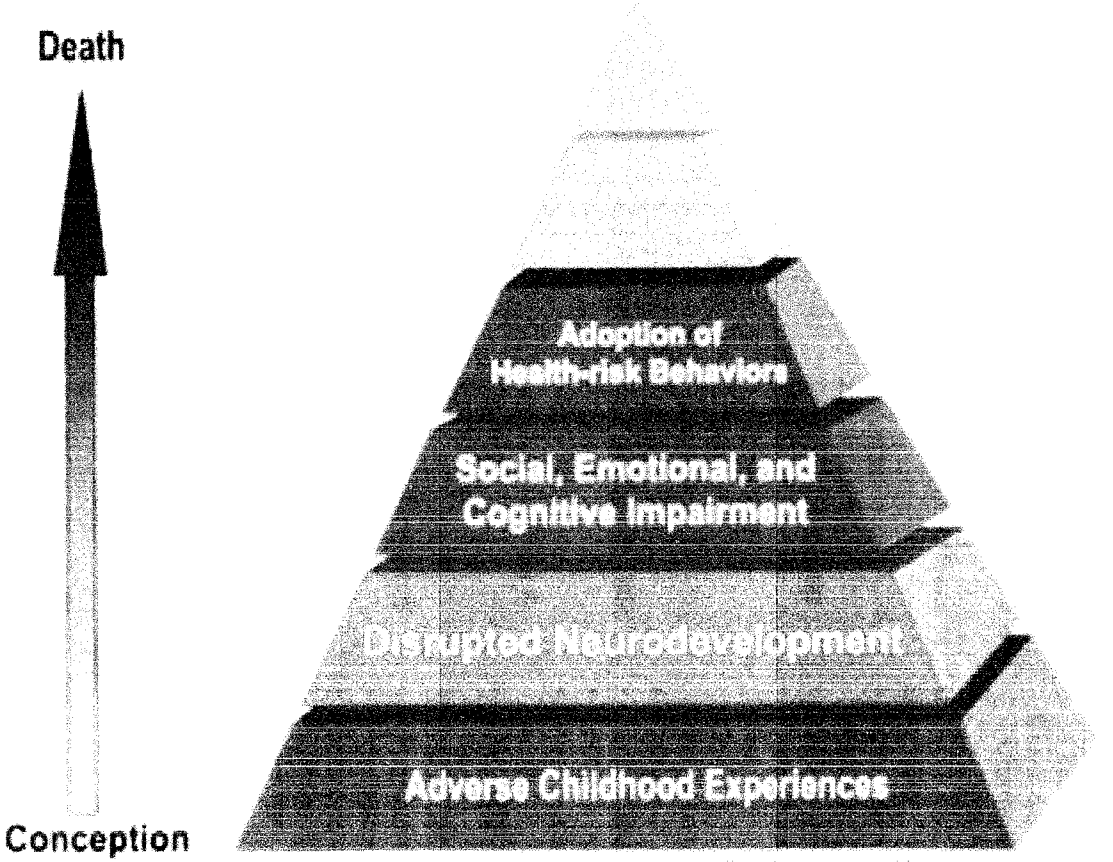


Impact of Trauma Over the Life Span

Effects of childhood adverse experiences:

- neurological
- biological
- psychological
- social

(Felitti et al., 1998)



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Adverse Childhood Experiences and Health & Well-Being over the Lifespan

Adverse Childhood Experiences	Impacts on Behavior, Learning, Relationships and Cognitive Skills	Impact of Trauma & Adoption of Health Risk Behaviors to Ease Pain of Trauma	Long-Term Consequences of Unaddressed Trauma
Abuse of Child • Psychological abuse • Physical Abuse • Sexual Abuse ***Trauma in Child's Household Environment*** • Substance abuse • Parental separation and/or divorce • Mentally ill or suicidal household member • Violence to mother • Imprisoned household member ***Neglect of Child*** • Abandonment • Child's basic physical &/or emotional needs unmet	***Effects on Interpersonal Skills*** • Ability to meaningfully distinguish between non/threatening situations • Ability to form trusting relationships with adults • Ability to modulate emotions • Easily over-stimulated • Overdeveloped fear response • Aggression due to misunderstanding • Defiance based on fear • Withdrawal as expression of vulnerability • Delayed social skills ***Language and Communication Skills*** • Learning/retrieving new verbal information effected • Language focused on tasks not a medium of social/affective exchanges • Language to build walls not bridges with others • Limited exposure to verbal problem solving ***Cognitive Skills*** • Sequential memory • Cause & effect relationships • Taking another's perspective • Distinguishing between un/important information • Identifying & regulating emotions • Executive functions • Self-direction in learning	***Neuro-biologic Effects of Trauma*** • Disrupted neuro-development • Difficulty controlling anger • Hallucinations Depression • Panic reactions • Anxiety • Multiple (6+) somatic problems • Sleep problems • Impaired memory & attention • Flashbacks ***Health Risk Behaviors*** • Smoking • Severe obesity • Physical inactivity • Suicide attempts • Alcoholism • Drug abuse • 50+ sexual partners • Sexually transmitted disease • Repetition of original trauma • Self-injury • Eating disorders • Dissociation • Perpetrate domestic violence	***Disease and Disability*** • Ischemic heart disease • Cancer • Chronic lung disease • Chronic unemployment • Asthma • Liver disease • Skeletal fractures • Poor self rated health • HIV/AIDS ***Social Problems*** • Homelessness • Prostitution • Delinquency, violence & criminal behavior • Inability to sustain employment—welfare recipient • Re-victimization: rape, domestic violence • Inability to parent • Inter-generational transmission of abuse • Long-term use of health, behavioral health, correctional & social services

Content drawn from *ACEs: Health and Wellbeing over the Lifespan* by Gary Wheeler and from Helping Traumatized Children Learn. Of note: Adverse childhood experiences have variable effects on individuals based on mediating and exacerbating factors; this chart represents results from epidemiological studies.

A Better Start

Child Maltreatment Prevention as a Public Health Priority

FRANCIE ZIMMERMAN
The Doris Duke Charitable Foundation

JAMES A. MERCY
Centers for Disease Control and Prevention

Imagine a community where all of the adults who interact with children—parents, family members, child care providers, teachers, doctors, nurses, clergy, and neighbors—actively engage in preventing child maltreatment *before* an incident of abuse or neglect occurs. Imagine a community where there is a wide continuum of prevention activities that extends well beyond providing direct services to individual families; a continuum that includes public education efforts to change social norms and behavior, neighborhood activities that engage parents, and public policies and institutions that support families. This type of broad-based, communitywide approach is often the purview of public health systems, because public health strategies, by definition, strive to promote the health and well-being of populations as a whole.

A public health approach to child maltreatment would address the range of conditions that place children at risk for abuse or neglect, not just at the individual and family levels but also at the community and societal levels. To use an analogy from the environmental field, a public health approach expands the focus from individual "endangered animals" to encompass the broader "habitat and environmental factors" that place species at risk. Historically, most child abuse prevention programs focused on individual and family dynamics, not communitywide or population-based strategies. That is changing. A growing number of practitioners and policymakers are implementing prevention efforts outside of the child welfare system in community settings that see large numbers of families with young children.

Although state and local departments of health do utilize comprehensive public health strategies, they typically do *not* address the specific problem of child maltreatment. This is a critical missed opportunity because, in addition to the immediate harm to children, there is a growing body of evidence that early traumatic experiences are associated with health problems throughout the lifespan (Shonkoff, Boyce, & McEwen, 2009). In fact, research shows an association between child maltreatment and a broad range of problems including substance abuse, intimate partner violence, teenage pregnancy, anxiety, depression, suicide, diabetes, ischemic heart disease, sexually transmitted diseases, smoking, and obesity (Fellitti et al., 1998; Mercy & Saul, 2009; Repetti, Taylor, & Seeman, 2002). Some of our nation's most serious health concerns can be linked to trauma from abuse and neglect early in life. Preventing maltreatment can be a powerful lever to move the population toward greater health and well-being.

Magnitude of Abuse and Neglect

CHILD MALTREATMENT—WHICH includes physical, sexual, and emotional abuse and neglect—is a problem of significant scope. In 2007, public child protective services agencies received reports of alleged maltreatment involving 5.8 million children. That is more than six times the number of children enrolled in all Head Start programs for the same year. Sixty-two percent of reports to child protective services, involving 3.5 million children, were screened for further investigation or assessment (a rate of 47 children reported per 1,000 children in the general population); 794,000 were determined to be victims of abuse or neglect. In 86% of these cases, parents or other relatives were responsible for the maltreatment. Neglect was the problem in 60% of the cases. Young children, under 7 years old, constitute the majority of child abuse/neglect cases (55.7%) and suffer the greatest harm. Infants less than 1 year old have the highest

Abstract

Child abuse prevention programs have historically focused on individual and family dynamics rather than community-based or societal strategies to prevent child maltreatment. Recently, there has been a growing recognition of the importance of communitywide efforts to prevent child maltreatment before abuse or neglect occurs by offering a continuum of services that promote the health of the population as a whole. The authors describe how a public health approach to child maltreatment addresses the range of conditions that place children at risk for abuse or neglect and include strategies at the individual, family, community, and societal levels to promote health and well-being.

rates of child victimization at 22 victims per 1,000 children (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, 2009).

The number of children officially reported to child protection systems substantially undercounts the total population of children who experience abuse or neglect. Conducted in 2008, the National Survey of Children's Exposure to Violence (NatSCEV) was the first national study to examine children's exposure to violence in homes, schools, and communities across all age groups (Finkelhor, Turner, Ormrod, & Hamby, 2009). In terms of maltreatment, NatSCEV found that more than 1 in 10 children surveyed (10.2%) suffered some form of maltreatment during the past year and nearly 1 in 5 (18.6%) did so during their lifetimes (Finkelhor et al., 2009). In contrast to the reports to public child welfare agencies noted earlier, rates of exposure to maltreatment from NatSCEV rose as children grew older. This is perhaps due to greater underreporting of maltreatment perpetrated against older children to public welfare agencies.

Consequences of Abuse and Neglect

FOR DECADES, THE negative impact of abuse and neglect on children has been documented to include injuries, disabilities, and other physical health issues; low academic achievement; and emotional problems. In recent years, newer brain imaging techniques have enabled scientists to document the effects of abuse and neglect on the developing brain and, hence, a broader range of health and social consequences of abuse and neglect. These images show that maltreatment early in life actually damages the brain's physical structure by impairing cell growth, interfering with the formation of health circuitry, and altering the neural structure and function of the brain itself (McEwen, 2007).

Jack Shonkoff, director of Harvard University's Center on the Developing Child, explains that, "There is extensive evidence that adversity can get 'under the skin' and undermine health and development. Persistent stress produces excessive elevation in heart rate, blood pressure, and stress hormones which can impair brain architecture, immune status, metabolic systems, and cardiovascular function."

Thus, early life experiences are built into our bodies. Abuse, neglect, and other traumatic events can take a serious toll, contributing to health problems over a lifetime. The Adverse Childhood Experiences Study (ACEs) provides powerful evidence of this. The ACEs is an ongoing study of over 17,000 primarily middle-class adults who are enrolled in the Kaiser Permanente health care system and who provided retrospective information about their childhoods (Fellitti et al., 1998). This study found that individuals who experienced five or more adversities (e.g., abuse, neglect, family dysfunction) were at fivefold greater risk for depression. Perhaps, the impact of early adversity on emotional well-being is not surprising, but the ACEs also found that an individual who had seven adverse experiences has a 10-fold greater likelihood of having heart disease (Fellitti et al., 1998). Recent findings from the ongoing ACEs indicate that early trauma is associated with shorter life expectancy. The researchers found that people with six or more adverse childhood experiences died nearly 20 years earlier on average than those without such experiences. Those who suffered substantial childhood trauma have double the risk for early death, compared with adults who had not endured adverse childhood experiences (Brown et al., 2009).

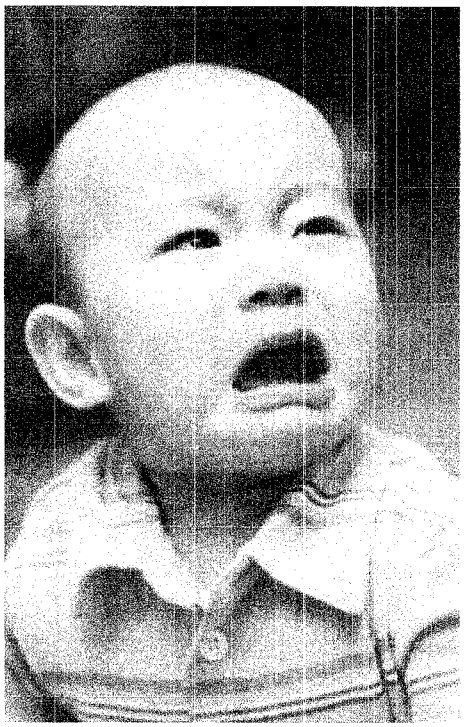


PHOTO: ©ISTOCKPHOTO.COM/PING HAN

Early traumatic experiences are associated with health problems throughout the lifespan.

Contribution to Health Disparities

EXPOSURE TO CHILD maltreatment is not randomly distributed within populations. The likelihood of a child experiencing maltreatment is associated with her or his social and economic environment (Braveman & Egerter, 2008). Children from households with lower income and parental education and who live in communities with greater concentrations of disadvantage, housing stress, low social capital, and lack of social support are more likely to be exposed to child maltreatment (Kotch, Browne, Ringwalt, Dufort, & Ruina, 1997; Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002; Sidebotham & Heron, 2006). These exposures exacerbate and sustain socioeconomic, racial, and ethnic health disparities across generations by compromising a child's health, cognitive abilities, and social skills over the course of his or her life (Braveman & Egerter, 2008). Therefore, although not currently recognized as such, the prevention of maltreatment may be critically important to reducing social and economic disparities in health.

PREVENT CHILD MALTREATMENT

There are a number of convincing reasons why public health agencies and practitioners should make concerted efforts to prevent child maltreatment.

- There is now a compelling scientific research base that makes the case for preventing maltreatment as a strategy to promote health and prevent disease across the lifespan.
- The child protection system sees only a fraction of the total number of children who experience abuse or neglect, and its involvement is after the fact.
- It is not practical, financially feasible, or even appropriate to provide individualized social services to all families.
- Public health efforts have successfully addressed other health concerns by using a mix of education, communication, and policy changes: Consider the use of bike helmets or "back-to-sleep" campaigns.
- Public health is experienced at addressing complex health issues (e.g., smoking, substance abuse) that require sustained, multiprong strategies that have been adapted to changes over time.
- Public health campaigns are often multidisciplinary, cutting across several service systems and engaging a variety of professionals as well as "regular" people.
- Public health agencies already have access to young children through immunization programs, as well as WIC (*W*omen, *I*nfants and *C*hildren), home visiting, and other maternal/child health initiatives.

A Role for Public Health

PUBLIC HEALTH INFRASTRUCTURE exists in every state, with an average of about 2,000 state employees in the workforce and state and federal funding of approximately $2.89 billion combined per state (Beitsch, Brooks, Menachemi, & Libbey,

Table 1. Reactive Versus Proactive Approach to Prevention of Child Maltreatment

Question	Reactive Approach to Child Maltreatment Prevention	Proactive Approach to Child Maltreatment Prevention
What is the problem?	Poor parenting	Lack of formal/informal societal support of parents and access to new information
What created it?	Upbringing, substance abuse, parental choice	Society with short-term vision, outdated theories on raising children, declining communities
Who solves it?	Police, CPS, foster parents, parents fixing themselves	Community leaders with vision, friends and neighbors, health care system, faith groups, doctors, schools, etc.
What created it?	Rescue children, punish parents, children heal themselves (baby bootstrap)	New info about development, more social interaction and parent support, reinforcement of positive behaviors

2006). However, championing a public health approach does not mean transferring responsibility from one public agency to another. Rather, a successful public health strategy would weave together programs, policies, and people. Such an approach would entail engaging a host of partners from other service systems (e.g., early education, schools, police, health care, parent education, and family support), as well as community-based resources (e.g., faith-based organizations, neighborhood leaders, libraries, recreation centers). Such a strategy would also entail educating the public through media and other outreach efforts. Cumulatively, public health strategies would influence individual behavior and build public will to support policy changes that promote healthy child development.

Think of the shift that has occurred, for example, with cigarette smoking. Antismoking efforts have moved well beyond educational programs urging individuals to quit, to policies that limit exposure to secondhand smoke and increase taxes on cigarettes—all aimed at reducing health problems caused by smoking. In combination, these elements have changed how society views cigarettes and have reduced U.S. smoking rates over time.

Child abuse and neglect prevention efforts have already moved significantly into public health terrain. Over the past decade, many prevention efforts have evolved from a narrow focus on individual victims involved in the child welfare system to a wider repertoire of prevention strategies that reach more families and are based in normal, nonstigmatizing places. There is strong momentum; new partnerships and programs show great promise for reducing risk and enhancing protective factors for children. Child abuse prevention is moving from a reactive to a proactive stance (see Table 1). Ultimately, through coordination between our child protective service and public health systems, an optimal balance can be achieved between these reactive and proactive elements of child maltreatment prevention reflected in Table 1. For examples of proactive initiatives, see sidebars:

Strengthening Families is the umbrella name for an array of strategies—including staff training, program enhancements, quality improvement efforts and policy changes—that integrate prevention into early education and child care programs. Dozens of states and localities are engaged in some type of Strengthening Families activity which is spearheaded by the Center for the Study of Social Policy and promoted by other national organizations such as ZERO TO THREE, Children's Trust and Prevention Funds, and the United Way. There is evidence that enriched early education programs can achieve prevention goals. The Chicago Longitudinal Study found that children who participated in the Child Parent Centers (which provided early education and family support services) had a 52% lower rate of substantiated maltreatment by age 17 than children in the comparison group who attended regular kindergarten (Reynolds & Robertson, 2003).

Communications

FURTHER BOLSTERING THE case for a public health approach is analysis conducted by communications experts that recommends moving away from a focus on child victims and the damage caused by abuse and neglect. Research commissioned by Prevent Child Abuse America and conducted by the FrameWorks Institute indicates that the public is well aware of the problem of abuse and neglect. However, people tend to default to familiar "frames" (widely and deeply held assumptions) when a familiar topic is raised. For maltreatment, default frames center on the most horrendous cases of abuse and the failings of public agencies to respond. These pervasive narratives leave little room for the more hopeful messages of promotion and prevention (Bales, 2004). FrameWorks recommends that communication about prevention be linked to information about child development, especially the critical early years of brain development and the impact of toxic stress. They also recommend emphasizing the theme of interaction, the "serve-and-return" exchange between young children and the adults in their environment, as well as the community resources that are needed to support families (Bales, 2009). Many child

THE NURSE FAMILY PARTNERSHIP (NFP) AND HOME VISITING

Begun as a research study in 1977 in Elmira, NY, the NFP has grown into a well-recognized and widely replicated direct service model that currently reaches more than 20,000 families per year in 25 states. The NFP uses specially trained, registered nurses to make home visits to young, first-time, low-income mothers and their babies over the first 2 years of the babies' life. The NFP has been assessed through three randomized controlled trials conducted over the past 30 years. These studies have documented a number of long-term positive outcomes for mothers and children, including improved prenatal health, fewer childhood injuries, fewer subsequent pregnancies, and increased maternal employment. (NFP, 2009). In the 15-year follow-up of the first trial, the NFP documented a 48% reduction in child abuse and neglect among families who received the home visit intervention (Olds et al., 1997).

The NFP and other home-visiting programs have been widely promoted as a strategy to prevent maltreatment. Enthusiasm for home visiting is based, in part, on the NFP's encouraging results and, also in part, on the commonsense appeal of reaching out to new parents who are generally responsive to support and information about their newborn baby. Subsequent evaluations of home-visiting programs have not had similar results to the NFP's first evaluation in terms of reducing abuse and neglect reports. In some instances, there were significant challenges with research methodology (i.e., collecting and analyzing child protection data over time), and in other instances, programs may not have been of sufficient quality to be effective. However, several other home-visiting programs have documented positive results in reducing harsh parenting practices, decreasing stress, improving the home environment, and/or improving child development. With growing interest and support from private, state, and federal sources, the NFP and other evidence-based home-visiting programs are poised for significantly greater expansion.

ABOUT THE COALITION ADDRESSING TRAUMA

COALITION ADDRESSING TRAUMA

ABOUT THE COALITION

Mission Statement:

To use the collective strength of consumers/survivors, organizations, agencies, corporations, coalitions, others to advance meaningful systemic changes for trauma survivors on a national scale.

Statement of Purpose:

1. To bring together a broad range of constituent groups, where trauma is a primary concern or focus, into a collaborative and unified advocacy coalition where collectively we address policy, system, social and community concerns for trauma survivors.

2. To share trauma-related research, evidence-based practices, news, findings and other information with legislative, executive and judicial branches of federal, state and local government, federal and state agencies and the news media in an effort to ensure a trauma-informed perspective.

3. To consider where the needs of trauma survivors are not currently being met and collectively consider how best to address those needs.

About the Coalition Addressing Trauma:

Why Does the Coalition Exist?
Because trauma is prevalent. Because support is needed in the aftermath. Because our human service systems lack trauma-informed approaches and sometimes do more harm than good. Because healing happens when understanding takes place.

How Will the Coalition Achieve its Mission?
By unifying constituent groups under one autonomous advocacy coalition to create a powerful, collective presence.

What does the Coalition Hope to Achieve?
To facilitate positive policy, system, social and community change, on a national scale, for survivors of trauma.

Information about the launch of the Coalition Addressing Trauma and the Planning Group: http://archive.constantcontact.com/fs064/1101376885042/archive/1105685234470.html

Individuals who would like to participate in the Coalition Addressing Trauma can sign up to our Yahoo group at: http://health.groups.yahoo.com/group/CoalitionAddressingTrauma/

Please take a moment to "like" the Coalition on **Facebook** at: https://www.facebook.com/pages/Coalition-Addressing-Trauma/203568336350899

Organizations interested in joining the Coalition Addressing Trauma should contact Helga Luest at hluest@witnessjustice.org or 202-550-5678.

COALITION ADDRESSING TRAUMA

Organizational Membership

A Special Space (Harpers Ferry, WV)
Advocates for Victims of Abuse (Winnemucca, NV)
American Association for Psychosocial Rehabilitation (national)
American Group Psychotherapy Association (national)
The Anna Institute, Inc. (national)
Arauz Inspirational Enterprises (national)
Arundel Lodge (Maryland state)
ASTOP Sexual Abuse Center (WI state)
Assistant Sibley County Attorney Donald E. Lannoye (Winthrop, MN)
Bennett Blum MD, Inc., Forensic and Geriatric Psychiatry (Tucson, AZ)
Community Alliance for the Ethical Treatment of Youth (national)
Center for Religious Tolerance (international)
Changing How Adults Nurture Children's Egos (CHANCE) (national)
Citizens 4 Kids (NJ state)
Community Alliance for the Ethical Treatment of Youth (national)
Grassroots Empowerment Project Inc. (WI state)
Institute for Health and Recovery (MA state)
Klingberg Family Centers (CT state)
Lutheran Family Services (NE state)
Meaningful Minds of Louisiana (LA state)
Mental Health America (national)
Mental Health America of Wisconsin (WI state)
NAMI Greater Milwaukee, Inc. (Milwaukee, WI)
National Association of State Alcohol and Drug Abuse Directors (national)
National Center on Domestic and Sexual Violence (national)
National Coalition for Mental Health Recovery (national)
National Council for Community Behavioral Healthcare (national)
National Sexual Violence Resource Center (national)
Oconomowoc Developmental Training Center (ODTC) (Oconomowoc, WI)
On Our Own of Anne Arundel County (MD state)
On Our Own of St. Mary's, Inc. (MD state)
Ozark Center (MO state)
Region 3 Behavioral Health Services (NE state)
SafePlace (Austin, TX)
Santa Maria Hostel, Inc. (TX state)
School Social Work Association of America (national)
Seminole Behavioral Healthcare (Seminole County, FL)
St. Aemilian Lakeside (Milwaukee, WI)
Stop the Silence: Stop Child Sexual Abuse, Inc. (national)
Truman Medical Centers (Kansas City, MO)
Veterans Empowerment Team (national)
Vietnamese American Psychological Association (national)
Veterans Health Council (Washington, DC)
Vietnam Veterans of America (national)
Wisconsin Alliance for Infant Mental Health (WI state)
Wisconsin Coalition Against Sexual Assault (WI state)
Wisconsin Family Ties (WI state)
Witness Justice (national)