Moving Toward A Caring Community:
A Local Look at Youth Trauma

Youth Trauma Analyst Team

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Introduction

Imagine walking through a jungle and coming face-to-face with a tiger. The hair on the back of your neck rises, you start breathing quickly, and a shot of adrenaline spreads through your bloodstream. This reaction pathway is the handiwork of millions of years of evolution designed to help you survive in circumstances of extreme stress. It is a brilliant system, but designed for brief durations of activity. What if you had to spend your every waking hour on alert for that tiger? How long do you think you would last?

Children who experience trauma often have their own tigers in their life. This could take the form of an abusive family member, insecure housing, or having to escape a war-torn country. These kids carry their tigers with them, trapped in a state of hypersensitivity that causes difficulty in distinguishing threatening stimuli from innocuous ones. A teacher may find it strange when a student jumps if they touch them on the shoulder, but that child may have been sexually abused and is thus sensitive to unexpected contact. Their tiger has taken up their focus, making it hard to discern the real tigers from the paper ones.

Paper tigers come from an old Chinese idiom, which describes something that seems menacing but in reality is harmless. They are often used as a metaphor to help explain the complex nature of trauma. Youth trauma results when a child experiences lasting adverse effects on their physical, emotional, and psychological well-being due to stressful stimuli. As such, it is not the event itself, but rather how the child perceives the event that dictates whether or not trauma develops. The number of such potentially harmful events a child has been exposed to is measured by Adverse Childhood Experiences (ACEs). The rates of ACEs among youth in America are startling. 26 percent of children in the U.S. will experience an ACE by the age of 4, the brain's most critical period of development.[1] As explained by Dr. Robert Block, the former President of the American Academy of Pediatrics, "Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today."[2]

However, broad scientific consensus states that trauma is treatable, and that outcomes are best when caretakers intervene early and use trauma-informed practices. These practices work with the child in a holistic manner, understanding the impact of environmental factors in their psychological well-being. While the science is clear, much of the data on trauma is relatively recent. Because research is still forthcoming and not yet widely understood, many policies and programs that aim to serve at-risk youth do not always follow the best treatment models. In fact, many traditional interventions actually run the risk of retraumatizing children. However, Charlottesville and Albemarle are making great strides to apply trauma-informed practices across their care systems. With these changes, there is good reason to be hopeful for

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[1] National Center for Mental Health Promotion and Youth Violence Prevention, "Childhood Trauma and Its Effect on Healthy Development," July 2012 (http://sshs.promoteprevent.org/sites/default/files/trauma_brief_in_final.pdf)

[2] Levins, Hoag. "The Cost-Saving Potential of Trauma-Informed Care." University of Pennsylvania Leonard Davis Institute of Health Economics. Accessed on 03.09.17 from: http://ldi.upenn.edu/news/cost-saving-potential-trauma-informed-primary-care

the future of care at the local level. By reducing the impact ACEs have on a child's life, communities of care will be able to break the cycle of trauma and prevent future abusive, neglectful, or otherwise unsafe conditions for children. To achieve this future, it is crucial all actors have a better understanding of the problems around trauma and corresponding solutions. This report aims to explore the landscape of trauma, tracing the history of our understanding; federal, state, and local policies, as well as current efforts being made on a local level to change the nature of how we address trauma.

What is Youth Trauma?

Defining Trauma

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as a condition resulting:

> "from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[3]

This definition highlights a key aspect of trauma in that it is not uniform. Rather, trauma focuses less on the damaging event and more on how it is experienced by the individual. As such, a diagnosis for trauma cannot come with a checklist but must account for a host of factors such as the individual's temperament, past experiences, and current environment. Thus, any exploration of trauma cannot be examined in isolation, instead requiring a holistic and nuanced approach. Much like other mental health issues, trauma's less visible nature has made it more difficult to recognize and treat than most physical ailments. This subtle nature has led to a relative lack of understanding of what trauma is and the implications trauma early in life can have on an individual's life. Only with the recent rise in understanding of the impact mental health can have on one's well-being have we been able to make major advancements in the understanding of trauma. As a result, there has been a rapid proliferation of research and services addressing trauma, but much of our understanding is relatively nascent and requires refinement.

However, certain key features have been made clear. The earlier a stressing event occurs, and the more extreme it is, the greater the likelihood that it will lead to trauma. Trauma can manifest itself in a myriad of ways, meaning treatment is most effective when tailored to the individual, often frustrating large-scale, more uniform solutions. Perhaps most importantly, while trauma can be treated, early intervention is unequivocally most effective.[4]

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[3] "Trauma." *SAMHSA Center for Integrated Health Solutions*. SAMHSA, n.d. Web. http://www.integration.samhsa.gov/clinical-practice/trauma.

[4] "Five Numbers to Remember about Early Childhood Development." *Center on the Developing Child*. Harvard University, n.d. Web. http://developingchild.harvard.edu/resources/five-numbers-to-remember-about-early-childhood-development/.

Physiological Impact

It is important not to conflate stress with trauma. In secure environments, stress can actually be a tool that leads to growth and increased resilience to future stressors, much like how a muscle is strengthened by repeated exertion. But what if that muscle is never allowed to rest and becomes overworked or has a tear that cannot heal? This is what leads to a toxic stress response (Figure 1). A toxic stress response occurs when a child experiences "strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support."[5] With prolonged activation of stress response systems, development is put on hold, potentially disrupting the developing brain and organ systems.

Figure 1. Graphic illustrating the three types of stress one can experience. Efforts should focus on cultivating environments that keep stress in the positive or tolerable range to prevent the development of trauma.[6]

Barking Dogs

The human brain develops from the bottom up, starting with more emotional (limbic) and impulsive decision making centers. The body's threat-response system is largely governed by these more basal hindbrain regions. In an emergency, the fight-or-flight system is prepared to act quickly, before the slow but rational cerebrum can process stimuli. When consistent thoughts of violence or other traumatic events flood a child's mind day by day, the primal portion of the brain stays activated, flooding the body with cortisol and forestalling brain development.[7]

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[5] "Toxic Stress." *Center on the Developing Child*. Harvard University, n.d. Web. http://developingchild.harvard.edu/science/key-concepts/toxic-stress/.

[6] Ibid.

[7] "Toxic Stress." *Center on the Developing Child*. Harvard University, n.d. Web. http://developingchild.harvard.edu/science/key-concepts/toxic-stress/.

As a result, the child may fail to develop sufficient neural connections in crucial forebrain regions, like the prefrontal cortex, which regulates long term planning and higher order judgment and decision making faculties.[8] This can lead youth to develop misanthropic attitudes and approach the world from a more limbic perspective, hindering opportunities and increasing the likelihood of engagement in risky behavior.

Figure 2. These hand motions are used to illustrate the "barking dog" method of understanding how trauma affects a child's brain. Multiple trauma-informed care training models use this hand motion to educate caretakers.

Imagine a child's brain is a closed fist with the thumb tucked inside (Figure 2). The outer layer of four fingers represents the prefrontal cortex in the brain, the decision-making epicenter. When a traumatic event occurs, this layer is not utilized, leaving the primal brain behind. This occurrence is represented by lifting the four fingers, leaving an exposed thumb to represent the small portion of the brain that stays alert during an emergency. Experts call this leftover primal center the "barking dog." When the prefrontal cortex is continually circumvented, children's brains erode to leave only the barking dog, forestalling the proper development of many of the child's executive functions.[9]

Measuring Trauma

Early advocates addressing adverse childhood experiences had difficulty quantifying trauma and establishing consensus on how to measure it. This difficulty in identifying the scope of the problem frustrated attempts to build coalitions and policies that properly addressed trauma and its causes. However, a landmark study by Felitti et al found particular childhood experiences had profound predictive ability on adult risk behaviors.[10] Felitti et al surveyed 8,056 patients about childhood experiences across seven categories: whether they had lived with

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[8] Perry, Bruce. "Impact of Abuse on Brain." Oklahoma University, n.d. Web. http://www.ou.edu/cwtraining/assets/pdf/handouts/2010/Impact percent20of percent20Abuse percent20on percent20Brain.pdf.

[9] Interview with Stephanie Carter.

[10] *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.* US National Library of Medicine National Institutes of Health, n.d. Web. https://www.ncbi.nlm.nih.gov/pubmed/9635069.

substance abusers, mentally ill, or suicidal household members, had witnessed violence against their mother, or had any imprisoned relatives. They then explored whether these experiences were predictive of the top ten leading risk factors for poor health later in life. These risk factors include: smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, any type of drug abuse, parenteral drug abuse (i.e. non-oral consumption), a high lifetime number of sexual partners (greater than 50), and a history of having a sexually transmitted disease.

Felitti et al gave individuals an Adverse Childhood Experience (ACE) score based on the number of categories of experiences they had faced. They found that the score was statistically significant with all measured adult risk factors and had a dose-dependent response; the higher an individual's ACE score, the higher the odds ratio for each risk factor. While effect sizes varied, all were statistically significant. These odds ratios can be found in Figure 3.

Table 4. Number of categories of adverse childhood exposure and the adjusted odds of risk factors including current smoking, severe obesity, physical inactivity, depressed mood, and suicide attempt

Health problem	Number of categories	Sample size (N)[a]	Prevalence (%)[b]	Adjusted odds ratio[c]	95% confidence interval
Current smoker[d]	0	3,836	6.8	1.0	Referent
	1	2,005	7.9	1.1	(0.9–1.4)
	2	1,046	10.3	1.5	(1.1–1.8)
	3	587	13.9	2.0	(1.5–2.6)
	4 or more	544	16.5	2.2	(1.7–2.9)
	Total	8,018	8.6	—	—
Severe obesity[d] (BMI ≥ 35)	0	3,850	5.4	1.0	Referent
	1	2,004	7.0	1.1	(0.9–1.4)
	2	1,041	9.5	1.4	(1.1–1.9)
	3	590	10.3	1.4	(1.0–1.9)
	4 or more	543	12.0	1.6	(1.2–2.1)
	Total	8,028	7.1	—	—
No leisure-time physical activity	0	3,634	18.4	1.0	Referent
	1	1,917	22.8	1.2	(1.1–1.4)
	2	1,006	22.0	1.2	(1.0–1.4)
	3	550	26.6	1.4	(1.1–1.7)
	4 or more	523	26.6	1.3	(1.1–1.6)
	Total	7,639	21.0	—	—
Two or more weeks of depressed mood in the past year	0	3,799	14.2	1.0	Referent
	1	1,984	21.4	1.5	(1.3–1.7)
	2	1,036	31.5	2.4	(2.0–2.8)
	3	584	36.2	2.6	(2.1–3.2)
	4 or more	542	50.7	4.6	(3.8–5.6)
	Total	7,945	22.0	—	—
Ever attempted suicide	0	3,852	1.2	1.0	Referent
	1	1,997	2.4	1.8	(1.2–2.6)
	2	1,048	4.3	3.0	(2.0–4.6)
	3	587	9.5	6.6	(4.5–9.8)
	4 or more	544	18.3	12.2	(8.5–17.5)
	Total	8,028	3.5	—	—

[a]Sample sizes will vary due to incomplete or missing information about health problems.
[b]Prevalence estimates are adjusted for age.
[c]Odds ratios adjusted for age, gender, race, and educational attainment.
[d]Indicates information recorded in the patient's chart before the study questionnaire was mailed.

Figure 3. Odds ratio for risk factors by number of ACEs.

Felitti et al sparked a new, more holistic approach to addressing childhood trauma. Their findings showed a clear linkage between early childhood experiences and poor health and risky behavior later in life. Ultimately, this seminal work showed how events in early childhood have profound effects, some as extreme as early death. These findings led to unprecedented levels of national interest in trauma research, such as the previously described Barking Dog study and Dr. Burke Harris' clinical work, which resulted in a flurry of research that has helped demonstrate the impact of trauma on life outcomes.

Many of these studies have also gone on to expand the definition of what is considered an ACE, such as socioeconomic hardship or the divorce of a parent.[11] While many will argue that these additional risk factors are less extreme than those studied by Felitti et al, it is important to analyze them without placing subjective weight on their impact, as trauma is experienced differently by each individual. Further, many of these studies have shown that not all individuals are equally likely to have ACEs. A survey by the U.S. Department of Health and Human Services called the National Survey of Child and Adolescent Well-Being (NSCAW) explored the increased risk felt by those who had interacted with children welfare services.[12] More than half of children in their population reported four or more adverse childhood experiences, compared with only 13 percent of the general population studied by Felitti et al. Almost four out of 10 of the youngest children in the NSCAW study had already experienced four or more adverse experiences. In the oldest age group (11 to 17 years old), more than two thirds (68 percent) of youth had four or more adverse childhood experiences. As a point of comparison, in the Felitti et al study, only about one in 10 people reported four or more experiences. These discrepancies in risk between the NSCAW study and the general population can be viewed in greater detail in Appendix A.

Felitti et al themselves found there were significantly fewer categories of exposure among whites, Asians, and college graduates ($P<0.001$). Other studies have gone on to find that socioeconomic status has strong predictive power on the number of ACEs a child will experience, which is of particular importance considering these same children are those least likely to have access to adequate treatment services (Figure 4).[13] For example, Dr. Nadine Burke Harris found that poor urban youth have rates of ACEs well above the national average. In her study, 67.2 percent of all patients in her data set exhibited at least one ACE, 15 percent higher than the general population.[14]

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[11] Stevens, Jane-Ellen. "Nearly 35 million U.S. children have experienced one or more types of childhood trauma." *ACES Too High*. N.p., n.d. Web. https://acestoohigh.com/2013/05/13/nearly-35-million-u-s-children-have-experienced-one-or-more-types-of-childhood-trauma/.

[12] "No. 20: Adverse Childhood Experiences in NSCAW ." *National Survey of Child and Adolesct Well-Being*. NSCAW, n.d. Web. https://www.acf.hhs.gov/sites/default/files/opre/aces_brief_final_7_23_13_2.pdf.

[13] Ibid.

[14] Burke, N. J., et al. The impact of adverse childhood experiences on an urban pediatric population. Child Abuse & Neglect (2011), doi:10.1016/j.chiabu.2011.02.006

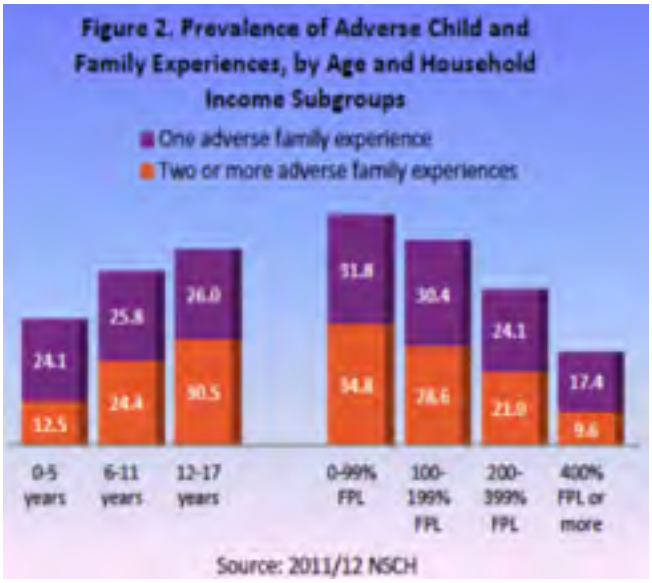

Figure 4. Results from the National Survey of Children's Health indicate the strong relationship between socioeconomic status and ACE incidence.

Felitti et al and successors like Dr. Burke Harris have allowed us to better map and understand the scope of trauma. However, the scientific community still have not been able to elucidate in full detail how to measure the progression of trauma once it begins to impact the individual, as seen in Figure 5.[15] This is a primary focus of current research.

Figure 5: The relationship between adverse childhood experiences and long-term life outcomes. There remain many gaps in our understanding of the progression of trauma experiences into observable impact.

[15] "Adverse Childhood Experiences." SAMHSA, n.d. Web. https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences.

Trauma-Informed Care

The importance of early, effective intervention is three-fold. First, development of a trauma-defined response is typically a gradual process. Early intervention helps to address the trauma experienced before it becomes cemented as a critical feature in the child's perspective.

Second, development is delayed when a child experiences trauma, and proper interventions can help limit the duration and severity of this delay, giving the child a better opportunity to grow and develop normally. Finally, there is an accumulative nature to ACEs, where those who have one ACE are statistically more likely to have multiple.[16] By helping mitigate the effect of a child's ACE, they are better protected and more resilient to future challenges.[17]

Value of Trauma-Informed Care

For an intervention to be effective in reducing an ACE's impact, it must take place in an environment conducive to healing and development.[18] When a surgeon excises a tumor outside of a clean operating room, his good intentions run the risk of doing more harm than good due to subsequent infection. Treating childhood trauma is no different; if solutions are implemented in poor contexts, their value is grossly undermined. This concept is the key feature that distinguishes trauma-informed care from other types of interventions. SAMHSA defines a trauma-informed approach as one that (1) realizes the widespread impact of trauma and understands potential paths for recovery, (2) recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system, (3) responds by fully integrating knowledge about trauma into policies, procedures, and practices, and (4) seeks to actively resist re-traumatization.[19]

This final criterion of SAMHSA's definition in particular has guided this report's efforts. Organizations working to reduce childhood trauma have realized that their efforts are hamstrung by retraumatization when youth exit their care or are living in environments that are not conducive to their growth. As such, emphasis has been placed on creating trauma-informed networks that pool resources and strategies to make not just trauma-informed workers, NGOs, parents, or schools, but entire trauma-informed communities. As explained by the National

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[16] "Overcoming Adverse Childhood Experiences: CREATING HOPE FOR A HEALTHIER ARIZONA." *Child Health Data*. Child Health Data, n.d. Web. http://childhealthdata.org/docs/drc/arizona-aces-efinal.pdf?Status=Master.

[17] "Building Resiliency Preventing Adverse Childhood Experiences [ACEs]." *Oregon Health Authority*. N.p., n.d. Web. 26 Mar. 2017. https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/Documents/OregonACEsReport.pdf.

[18] Burrell, Sue. "Trauma and the Environment of Care in Juvenile Institutions." *National Child Traumatic Stress Network*. NCTSN, n.d. Web. http://www.nctsn.org/sites/default/files/assets/pdfs/jj_trauma_brief_environofcare_burrell_final.pdf.

[19] "Trauma-Informed Approach and Trauma-Specific Interventions." *SAMHSA*. SAMHSA, n.d. Web. https://www.samhsa.gov/nctic/trauma-interventions.

Council for Behavioral Health, “trauma-informed care is now the expectation, not the exception, in behavioral health systems.”[20]

Examples of Interventions

What does trauma-informed care really look like? Take the story of Max, a hypothetical child whose story is based in real-life events as told to the authors during interviews. Max's life looks very different when he receives a non-trauma-informed intervention as compared to a trauma-informed one.

Max is eight years old and lives at home with a single mother. Max's mom has violent episodes on occasion that make Max afraid to come home. Without a strong support system in his family, Max develops low self-worth, which leads to a buildup of anger and anxiety. His pent-up angst starts to manifest itself in Max's behavior, leading Max to have his own violent outbursts on the playground and in the classroom. When Max's teacher thinks there might be something more serious going on at home, she and the principal call Child Protective Services, who remove Max from his abusive mom’s house and place him in a group home. The group home, a residential service run through the foster system, houses six to ten kids at a time, though they tend to come and go. He doesn’t connect well with the other kids because he doesn’t know if his next roommate will stay or leave, so his friendships are unstable.

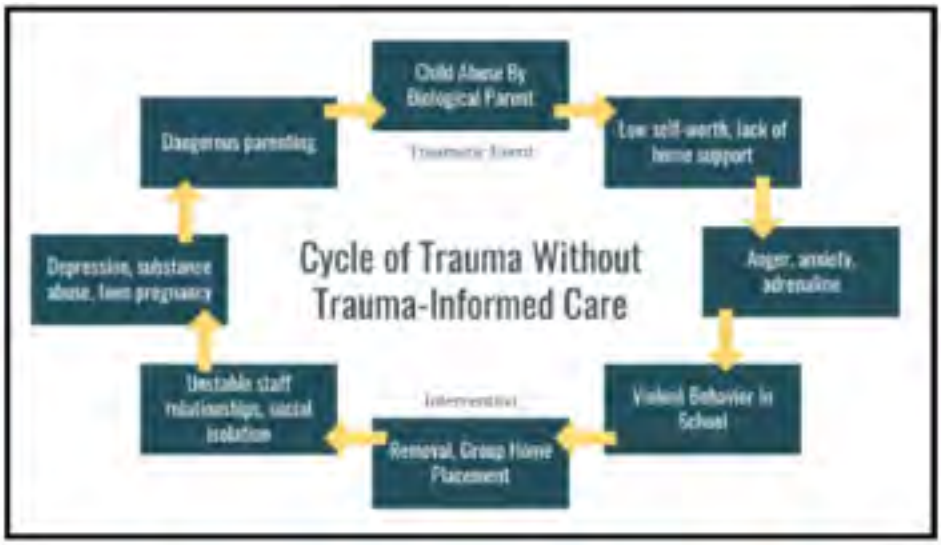

Figure 6. Max's story shows how the cycle of trauma hurts both himself and future generations.

Max doesn’t connect with any of the staff who work there since their shifts change from time to time, so he keeps to himself. Max develops even lower self-worth in isolation and starts making bad choices outside of school and the group home. Depression compounds with substance abuse, which compounds with teen pregnancy, which make it increasingly harder for Max to get back on track. When he’s a father himself, he is very likely to make the same parenting

[20] "Trauma-Informed Care." *National Council for Behavioral Health*. N.p., n.d. Web. https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/.

mistakes that his own mother made when he was eight years old, setting the stage for the experience of trauma across generations.

What if Max's teacher made a trauma-informed decision, and the Department of Social Services never put Max in the group home? What if Max's teacher asked not what was "wrong with him," but what happened to him? When Max's teacher noticed aggressive behaviors in class, she could have pulled him aside and asked what was going on outside of school, offered to have him go speak to the guidance counselor, and worked with him to develop strategies for how to handle his anger and excess energy when he feels a violent outburst coming on, like raising his hand and asking to take a moment in the hall. If the teacher came across the bigger problem going on at home, she could work with Child Protective Services and give them more information about Max's personality and needs as she knows them as his teacher. CPS could work to place Max in a "kinship home," a temporary residential situation in which Max would live with a non-offending family member, friend, doctor, teacher, or other more familiar figure to make Max's transition out of his mom's house smoother. Max could then benefit from a supportive home environment and trauma-informed social workers that help Max through the move. Having nurturing, reliable adults in his life makes Max feel like he can relax for once, and normal development can resume.

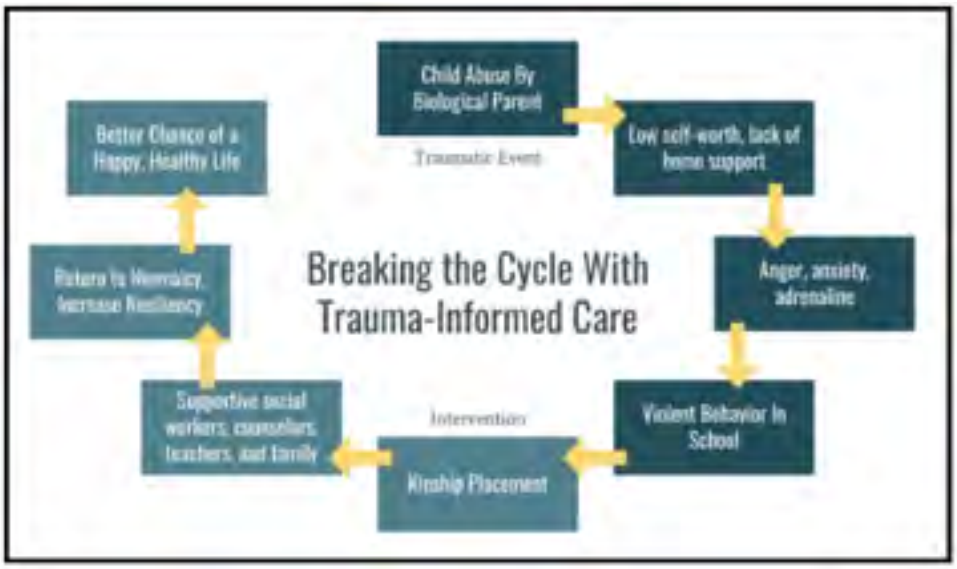

Figure 7. Max's story changes when trauma-informed interventions enter his life.

Through his hardships, Max can even become more resilient with the guidance from his support system because he now knows who he can trust and reach out to for future support. This resiliency sets Max up to have a better chance for a successful future and to be better able to handle stressors that may come his way, providing for the opportunity for a happier, healthier life.

Return on Investment[21]

In addition to the personal benefits that patients acquire when organizations and communities make the transition to a trauma-informed system, multiple studies have shown the economic value of trauma-informed care. According to researchers at Georgetown University in a report compiling results from several other studies, children receiving mental health services comprise less than 10 percent of the overall child population under Medicaid, but account for about 38 percent of all Medicaid child expenditures. The authors of this study state that this relationship shows the clear value that investing in preventative measures can have on reducing Medicaid expenditures. Additionally, a national study performed by ICF International found that improved systems of care resulted in a 42 percent drop in the average cost per child served for inpatient services among member providers of the Child Mental Health Initiative.[22] Over an eight-year period, the study estimated more than $37 million in savings were derived from improved outcomes for all children touched by this initiative's centers of care across the country. State and local implementations of systems of care saw dramatic positive results as well.

Finally, local level studies showed similarly remarkable savings due to the implementation of trauma-informed care. In Monroe County, NY, savings to the county averaged approximately $38,000 per youth, with overall savings around $500,000, in just the first year of implementing a trauma-informed system of care. In the second year of the program, savings per child increased to about $45,700, or nearly $1 million total. This study helps to outline the financial benefits of trauma-informed care to both the patient and the taxpayer.

Yet these figures fail to capture human costs and the untold preventable suffering that occurs as a result of ACEs. As mental health and trauma come into focus both in academic circles and the public eye, these concerns are becoming a greater priority in terms of research and new policy interventions to address trauma's negative consequences.

Challenges to Wide-Scale Implementation

Why has it taken so long for such an effective treatment model to come to prominence? Despite child trauma's urgency, a few critical factors have stalled the rollout of national trauma-informed care initiatives.

First, research on ACEs and their effects is still a young field of study. Though Feletti et al published their landmark study on ACEs nearly 20 years ago,[23] research on models of trauma-informed care did not become widely published until ten years ago, and only within the

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21 Stroul, Beth. "Return on Investment in Systems of Care for Children With Behavioral Health Challenges." National Technical Assistance Center for Children's Mental Health, Apr. 2014. Web. https://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf.

22 ICF International. (2013). Avoided costs of system of care-related outcomes: 2005–2010 communities funded by the federal Children's Mental Health Initiative. Atlanta, GA.

23 Hodas, G.R. *Responding to childhood trauma: The promise and practice of trauma-informed care.* Pennsylvania Office of Mental Health and Substance Abuse Services, 2006.

last five to seven years have calculations on trauma-informed care's return on investment been widely explored. The good news is that curiosity about trauma-informed care is growing. As more current, supportive data becomes available, many policymakers have begun to enter the fray. However, scarce top-down instruction and funding, coupled with the high upfront costs of training, has made implementation of trauma-informed care models difficult and costly for small communities. Until more comprehensive trauma-related legislation becomes law and administrative agencies increase funding, local actors will continue to be the driving force of the conversation about trauma-informed care implementation.

In addition, long-time professionals are at times resistant to changing old ways of trauma treatment. One educator this group interviewed, who requested to remain anonymous, discussed the complications of adding trauma-related care responsibilities onto a teacher's plate. On top of combatting language barriers, struggling to meet state academic standards, and following district and school policies, being a counselor to a child can seem above a teacher's pay grade. Other caretakers share this sentiment, sometimes seeing trauma-informed care as another box to check on their already long lists of tasks to complete. Some institutions are already content with the training they offer their staff and are hesitant to change something they think works. Additionally it is very easy for administrators of various systems to relegate trauma-informed care training to one sect of an institution, leaving all child trauma caretaking to a specific group of people.

A final aspect of trauma-informed care that prevents organizations from immediately joining the movement is the time and energy it takes to administer a trauma-informed response. Organizations and agencies on limited budgets have finite space in their offices and hours in their days to treat clients. Trauma-informed care requires careful attention to detail from caregivers, ensuring that everything, from the lighting in an office to the questions they ask a child, is trauma-sensitive and in-tune with a child's emotional and mental state. For counselors, doctors, social workers, and other professionals, this attitude toward care puts much more work on their part as they must adapt to the child, rather than the child to them. Hunter Smith, a program coordinator in the Charlottesville foster care system, described the difficulty that comes with bending a caretaker's mindset toward humble listening and intentional relationships, as opposed to transactional client-caretaker relationships and checking off boxes for behavioral and mental health. Smith ensures that his staff can keep up with a kid and continue to listen to a child even in their darkest hours. He asks, "Can you hang with them while they're cussing you out, crying to a staff member, or threatening to hurt themselves or others?"[24] Moreover, he challenges his employees to give this level of compassion to every kid who walks through their doors. Simply showing up, listening, and checking in can be powerful acts in a child's life if done consistently and from an early age.

Trauma-informed care invites caretakers to go the extra mile for a child because that presence of a sound relationship might be the best part of a child's day, week, or month. Though budget and time constraints are real challenges for organizations that want to implement trauma-informed care, the goal is for more groups to adopt trauma-informed practices so

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[24] Interview with Hunter Smith.

systems of care can divide the work more evenly across organizations and serve the greatest good for the greatest number. No one organization can do everything, but if everyone does something, then individual cases become much easier to manage. Despite these barriers to trauma-informed care, consensus among experts that it is best practice has influenced the crafting of policies that are beginning to help local organizations better adapt to trauma-informed care models.

Policies Addressing Trauma at the National Level

The large number of trauma-affected youths across the country calls for national attention. Legislation regarding child trauma from the last two decades has made substantial progress to addressing child trauma, creating the foundations for state and local action. Through various improvements of existing programs and the establishment of new initiatives, the federal government has played an integral role in helping put mental and behavioral health policy on the agenda, from Washington to the local level.

Victims of Crime Act (1984)[25]

The Victims of Crime Act (VOCA) establishes the Office for Victims of Crime within the Department of Justice. This office oversees the Crime Victims Fund that is financed primarily by fines paid by convicted federal offenders as well as donations from private citizens. As of September 2013, the fund balance had reached almost $9 billion. This fund provides grants that are devolved to state and local agencies and organizations to implement services for those affected by criminal activity. As such, these grants are often used to help court-involved youth. While many VOCA funded efforts have helped children such as court-involved youth, VOCA fails to address youth trauma in its many forms.

Children's Health Act (2000)[26]

The Children's Health Act was the first major piece of federal legislation that specifically addressed the issues of child trauma. This act authorized SAMHSA to form the National Child Traumatic Stress Initiative (NCTSI) that coordinates efforts among those organizations and agencies involved in addressing trauma. One of the most significant outcomes of this initiative is the National Traumatic Child Stress Network (NCTSN), designed to advance "state of the art, empirically supported strategies to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States." Members of the network include leaders in systems of care, such as education, law enforcement, child

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25 Rodino, Peter. "H.R.6403 - Victims of Crime Act of 1984." *Congress.gov*. Congress.gov, n.d. Web. https://www.congress.gov/bill/98th-congress/house-bill/6403.

26 "H.R.4365 - Children's Health Act of 2000." *Congress.gov*. Congress.gov, n.d. Web. 13 Mar. 2017. https://www.congress.gov/bill/106th-congress/house-bill/4365/text/pl.

welfare, juvenile justice, military family service, and physical and mental health programs.[27] The network is the primary vehicle through which best practices and strategies are disseminated to state and local actors. Through raising the standard of care and improving access to services for traumatized children, the NCTSN aims to raise professional and public awareness of child trauma and its negative effects on families, communities, and society.

Child Abuse Prevention and Treatment Act (2010)[28]

The Child Abuse Prevention and Treatment Act (CAPTA) was reauthorized in 2010 (originally enacted in 1974) and provides grant funding with the ultimate goal of strengthening and supporting families with children by protecting children from abuse, neglect, and maltreatment; improving the services for victims of and children exposed to domestic violence, and improving adoption assistance.

CAPTA is relevant to the dynamic legislative approach to alleviating the effects of child trauma because child abuse and neglect are forms of trauma that over 794,000 children in the U.S. face. Similarly, this bill addresses the negative impact that domestic violence has on children, reporting that child abuse occurs in approximately 30-60 percent of the houses in which there is domestic violence, often leaving children at a greater risk of "psychiatric disorders, developmental problems, school failure, violence against others, and low self-esteem." CAPTA helps establish the necessary funding for services that may alleviate some of the long-term effects of trauma.

One unique amendment in this reauthorized legislation is that CAPTA requires states to prepare and submit a state plan to remain in effect for the duration of their participation in the grant program. The state plan must be prepared and submitted annually to describe how funds appropriated from CAPTA were used to achieve the objectives of the grant program. It also requires states "to have a law mandating reporting by specified individuals of known and suspected instances of child abuse and neglect." This holds states accountable in supporting the necessary programs with federally allocated funding.

21st Century Cures Act (2016)[29]

The 21st Century Cures Act updates the Children's Health Act of 2000, establishing long-term funding for the NCTSI, which appropriates funding towards evidence-based and trauma-informed services for children who have experienced trauma. The act expands the focus of trauma prevention to include the mental, behavioral, and biological aspects of psychological

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[27] "The National Child Traumatic Stress Initiative: Helping Kids Recover and Thrive ." *The National Child Traumatic Stress Initiative:* . SAMHSA, n.d. Web. 18 Mar. 2017. https://www.samhsa.gov/sites/default/files/programs_campaigns/nctsi/nctsi-trifold-brochure.pdf.

[28] U.S. Department of Health and Human Services. "The Child Abuse Prevention and Treatment Act." *The CAPTA Reauthorization Act of 2010*. N.p., n.d. Web. 18 Mar. 2017. https://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf.

[29] "H.R.34 - 21st Century Cures Act." *Congress.gov*. Congress.gov, n.d. Web. 13 Mar. 2017. https://www.congress.gov/bill/114th-congress/house-bill/34/text#toc-H646806A0231C41E98274D433291C5E42

trauma response. The act's focus on the positive long-term effects of mental health resources and services on child trauma helps broaden the approach that community-based services consider in the treatment of a child. By focusing on the mental, behavioral, and physiological components of trauma that had previously not been present in federal legislation, the 21st Century Cures Act increases resources for pediatric mental health services.

Within the act, Title X provides pediatric health care grants to strengthen mental and substance use disorder care for children and adolescents. Title X also outlines the expansion of statewide and regional programs for access to pediatric mental health care. Most notably, pediatric mental health care programs can only receive Title X funding if their services support the "early identification, diagnosis, treatment, and referral of children with behavioral health conditions."

Virginia Youth Trauma at the State and Local Level

21st Century Context for Mental and Behavioral Health Policy in Virginia Trauma

The state of Virginia is familiar with the unfortunate realities of untreated mental health issues. In 2007, 25 students and five faculty members were fatally shot at Virginia Polytechnic Institute by Seung Hui Cho. Cho was a socially withdrawn student who had a history of mental illness and showed many signs of cognitive disturbance in his school work and public YouTube videos. One of the deadliest shootings in U.S. history, the Virginia Tech massacre sparked a new wave of government action in mental health affair that affects the way both the national and state governments treat trauma today.[30]

Soon after, another violent event in Virginia brought mental health back into the policy spotlight. State Senator Creigh Deeds was stabbed by his son, who then took his own life, in their Millboro home in November of 2013. Despite a long-time experience with mental illness, mental health workers were unable to find a hospital psychiatric bed for Deeds' son, leading to his dangerous release from state custody and the subsequent attack. After Senator Deeds' recovery, he became a major advocate of changing the way Virginia cares for its citizens with mental illness. He was key to the establishment of the Joint Subcommittee to Study Mental Health Services in the 21st Century. The four-year committee has since done extensive research on the treatment of mental health patients in the medical sphere, justice system, and other care administrations across Virginia.[31]

These major events in Virginia's history provide the context within which state policymakers have taken recent action related to mental health and trauma. The following

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[30] "Massacre at Virginia Tech leaves 32 dead." *This Day in History*. History.com, n.d. Web. http://www.history.com/this-day-in-history/massacre-at-virginia-tech-leaves-32-dead.

[31] Martz, Michael. "Virginia mental health panel begins work today." *Richmond Times Dispatch*. N.p., 20 July 2014. Web. 26 Mar. 2017. http://www.richmond.com/news/virginia/government-politics/virginia-mental-health-panel-begins-work-today/article_60dfea02-fe73-5304-8cd2-de11dd11d312.html.

selection of relevant policies have been mentioned by local actors in interviews to have direct influence on the way they operate.

State Policy

Virginia's legislative and executive branches have made strides over the last decade to improve the health and life outcomes of their constituents upon whom trauma has the greatest impact. Some of the most important policies are outlined below.

Virginia Department of Social Services

In 2003, the Virginia Department of Social Services (VDSS) implemented a Differential Response System, giving local departments of social services (LDSS) the flexibility to respond to reports of child abuse and neglect with either an investigation (the traditional protocol) or a family assessment.[32] Under this system, when a LDSS receives a report of abuse or neglect, the staff determines the urgency and validity of the report and then determines whether a family assessment or traditional investigation is most appropriate.

Family assessments are used in low to moderate risk cases that have no immediate safety concerns. These assessments involve the "collection of information necessary to determine the immediate safety needs of the child, the protective and rehabilitative services needs of the child and family that will deter abuse or neglect, risk of future harm to the child, and alternative plans for the child's safety if the family is unable or unwilling to participate in services."[33] Family assessments are intended to engage families, reduce the tension that accompanies a traditional investigation, and utilize community resources and the family's natural support network.[34] This change in protocol to include family assessments in these types of situations recognizes the potential damage of investigations as well as the nuance of child abuse or neglect cases.

2008 Mental Health Reform

Following the Virginia Tech massacre, Virginia began a massive overhaul of its mental health infrastructure. Within a year of the massacre, the Virginia legislature "improved the emergency evaluation process, modified the criteria for voluntary commitment, tightened procedures for mandatory outpatient treatment, and increased state funding for community mental health services."[35] $42 million was added to the state's community health care budget to

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[32] Voices for Virginia's Children. *A Portrait of Virginia's Child Welfare System*. Issue brief. N.p., May 2011. Web. http://vakids.org/wp-content/uploads/2015/12/A-Portrait-of-Virginia-Child-Welfare-System.pdf.

[33] Ibid.

[34] Voices for Virginia's Children. *A Portrait of Virginia's Child Welfare System*. Issue brief. N.p., May 2011. Web. http://vakids.org/wp-content/uploads/2015/12/A-Portrait-of-Virginia-Child-Welfare-System.pdf.

[35] Bonnie, RJ, JS Reinhard, P. Hamilton, and EL McGarvey. "Mental Health System Transformation after the Virginia Tech Tragedy." National Center for Biotechnology Information 28.3 (2009): 793-804. Web. <https://www.ncbi.nlm.nih.gov/pubmed/19414889>.

add caseworkers and psychiatrists. This reform was also seen by many as a down payment. Unfortunately, the impact of the recession decreased focus on these issues, and Virginia began again to lag behind. However, the incident with Senator Deeds' son reignited focus on the issue. This led to the creation of the Joint Subcommittee Studying Mental Health Services and has also been credited with the creation of the Children's Cabinet.

The Children's Cabinet

In 2014, Governor Terry McAuliffe created the Children's Cabinet to develop and implement a comprehensive policy agenda related to the education, health, safety, and well-being of youth throughout the Commonwealth.[36] The Children's Cabinet is tasked with evaluating and recommending strategies to optimize and align local, state, and federal public resources, along with public-private partnerships, to enhance programs and services for Virginia's children and their families. One of its biggest projects has been the "Classrooms not Courtrooms Initiative," an interagency effort to curb the number of students referred to law enforcement and subjected to exclusionary school discipline. Beyond the Classrooms Not Courtrooms initiative, the Children's Cabinet's Annual Report identifies two other priorities: leading the Challenged Schools Initiative, and advancing policy related to enhancing educational outcomes and workforce readiness in targeted communities.[37] As the Children's Cabinet becomes more established, it is likely to play a continually increasing role in shaping the field of youth trauma.

Vision 21: Linking Systems of Care for Victimized Children and Youth Demonstration Initiative

The Vision 21 initiative is the first comprehensive assessment of victim services in 15 years,[38] promoting a "systematic approach to permanently alter how the needs of victims are met."[39] In 2014, $12.5 million was allocated in the Congressional Consolidated Appropriations Act to the initiative, allowing the Office for Victims of Crime (OVC) at the U.S. Department of Justice to provide competitive funding opportunities for state Victims of Crime Act (VOCA) administering agencies.[40]

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[36] McAuliffe, Terence R. "CHAMPIONS FOR VIRGINIA'S CHILDREN: VIRGINIA CHILDREN'S CABINET ." *Executive Order NUMBER TWENTY ONE (2014)* . Commonwealth of Virginia Office of the Governor , n.d. Web. 26 Mar. 2017. https://governor.virginia.gov/media/3326/eo-21ada.pdf.

[37] "Governor McAuliffe's Children's Cabinet." *Virginia.gov*. Virginia.gov, n.d. Web. 26 Mar. 2017. https://hhr.virginia.gov/childrens-cabinet/.

[38] Commonwealth of Virginia Department of Social Services, Division of Family Services. *Virginia's Five Year State Plan for Child and Family Services, 2015-2019*. Rep. N.p., June 2014. Web. https://www.dss.virginia.gov/family/cfs_plan.pdf.

[39] *"Linking Systems of Care for Children and Youth." Vision 21: Transforming Victim Services Initiative. Vision 21, n.d. Web. 26 Mar. 2017. https://ovc.ncjrs.gov/vision21/pdfs/Vision-21-linking-systems-of-care-for-children-and-youth.pdf.*

[40] "About Vision 21." *Vision 21: Transforming Victim Services Initiative*. Office of Justice Programs, n.d. Web. 26 Mar. 2017. https://ovc.ncjrs.gov/vision21/.

In June 2015, Virginia was one of two states to receive a grant from OVC to implement and operate the Vision 21 initiative.[41] The VDSS received an initial award of $398,000, which will be followed by two additional awards to support the five-year implementation of the program. The VDSS' goal is to use this program to ensure that "every child entering any of Virginia's child-serving systems is assessed for victimization and provided comprehensive and coordinated services to fully address their needs."[42] Although the VDSS is the lead agency for this initiative, it has also partnered with several agencies to ensure collaboration, so that "no matter where a child or youth victim enters the system, they are identified and directed to appropriate and trauma-informed services."[43] This collaboration will better allow agencies to assess and remove barriers such as governmental jurisdiction and the lack of cross-systems knowledge, ensuring no child falls through the cracks.

Scale of the Problem

Though Virginia is clearly taking an active role in addressing mental health and youth trauma, most of these policies are relatively recent and their full effect has not yet been felt. While the number of Virginians with an ACE score of 1 or more mirrors the national average, Virginia is close to the bottom in terms of care.[44] In a ranking of all fifty states, Mental Health America placed Virginia at 38th for overall rates of accessibility of care, and 49th in the number of children with major depressive episodes that did not receive mental health services.[45] This translated into only one out of four youth with major depression receiving the treatment they needed. Thus, while Virginia may not exhibit an abnormal rate of mental illness by national standards, the state lags behind in care for its mentally ill population.

An additional challenge Virginia faces in treating mental illness is the large population of children living below the poverty line, 15.24 percent of all children. As previously explained, income level strongly correlates with a child's likelihood of having a non-zero ACE score. Families exposed to poverty face the effects of trauma at significantly increased rates as compared to their more affluent counterparts. Difficulty providing basic needs such as food, shelter, and clothing, puts families in poor homes at a remarkable risk of experiencing multiple ACEs in their lifetimes.[46] According to U.S. Census data, there are 3,464 minors in the greater

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41 Planter, Jaron. "VDSS Awarded Grant to Link Systems of Care for Victimized Children and Youth." Virginia Department of Social Services, 19 June 2015. Web. 26 Mar. 2017. https://www.dss.virginia.gov/files/division/pa/news_releases/2015/Vision21_revised2014.pdf.

42 Ibid.

43 Ibid.

44 2011/2012 National Survey of Children's Health. (n = 95,677) Tables compiled by Data Resource Center for Child and Adolescent Health.

45 Kleiner, Sarah. "Virginia is No. 38 in Mental Health America ranking." *Richmond Times Dispatch*. Richmond Times Dispatch, 25 Oct. 2016. Web. 26 Mar. 2017. http://www.richmond.com/news/virginia/article_66a80cf3-4f7f-5c66-9f14-d945fee28478.html.

46"Understanding the Impact of Trauma." *NCTSNET.org*. National Child Traumatic Stress Network, n.d. Web. http://www.nctsnet.org/sites/default/files/assets/pdfs/understanding_the_impact_of_trauma.pdf.

Charlottesville region living below the poverty line, 9.6 percent of children in Albemarle County and 20.73 percent of children in the City of Charlottesville.[47]

Local experts in child trauma frequently point to four cross-sections of Virginia's low-income youth population that are most vulnerable to ACEs and the unique challenges they face. They include English language learners, children involved with the foster care system, court-involved youth, and homeless children.

English Language Learners (ELLs)

Roughly one in ten public school students in the U.S. identifies as an English Language Learner, about 4.5 million students.[48] The vast majority of ELLs speak Spanish as their mother tongue (76.5 percent). All other languages are spoken with much lower frequency; the next most common primary languages spoken are Arabic, Chinese, Vietnamese, each making up only about 2 percent of ELLs. In Virginia, ELLs make up about 8 percent of total public school enrollment, but that figure rises to 10 percent in Charlottesville and Albemarle public schools.[49] This region also has higher levels of non-Spanish speaking ELLs due to the International Rescue Committee, which brings refugees from all over the world to the greater Charlottesville region each year. As a result, Charlottesville City School's ELLs speak 46 different languages, and Albemarle County Public School's ELLs speak over 70 languages, complicating efforts to provide services.[50]

Compared to non-ELL children, a greater proportion of these children have experienced major stressors such as refugee status, home removal, and community and school violence. These students already exhaust themselves juggling two languages and cultures during the school day, leading to extensive ego depletion that can allow otherwise innocuous events to have traumatic impact, especially if their home lives lack stability. While the neurological damage resulting from trauma can lead to devastating emotional and behavioral breakdowns in any child, this damage is particularly problematic for youths whose ability to learn English as a second language and adapt to another culture is impaired by stress-induced developmental lags.

Foster Children

Child abuse and neglect are the two most commonly cited parenting failures that lead to referrals to Child Protective Services (CPS). In 2011, U.S. Child Protective Services received

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[47] "Social Explorer." *University of Virginia Library*. University of Virginia, n.d. Web. http://www.socialexplorer.com/1c4cf9992b/edit.

[48] "English Language Learners." *Institute of Education Sciences*. National Center for Education Statistics, n.d. Web. https://nces.ed.gov/fastfacts/display.asp?id=96.

[49] "Fast Facts." *Charlottesville City Schools*. Charlottesville City Schools, n.d. Web. http://charlottesvilleschools.org/home/about-ccs/fast-facts/.

[50] "International & ESOL Program: Albemarle County's Linguistic Diversity." *Albemarle County Public Schools*. Albemarle County Public Schools, n.d. Web. https://www2.k12albemarle.org/dept/instruction/esol/Pages/Student-Demographics.aspx.

3.4 million referrals, representing 6.2 million children. Of those cases referred, about 19 percent were substantiated.[51] According to Prevent Child Abuse America, the American public spent approximately $80 billion on the effects of child abuse in 2012.[52] In substantiated cases of child abuse or neglect, children shift into state custody, moving into a foster home, group home, or psychiatric care facility. The local foster system cares for about 300 children in Charlottesville and Albemarle annually, spending about $33,000 per child each year.[53] These figures demonstrate how child abuse does not simply affect those who are abused, but the community at large.

Like other subsets of traumatized children, those in foster homes are more likely to be subjects of physical and sexual abuse, as well as mental, emotional, and financial manipulation, exposed to substance abuse, and collect other adverse childhood experiences. After spending extended periods of time in foreign households and group homes, children may also face re-traumatization when they return home if the initial situation that caused them to be removed has not improved dramatically if their parental attachment has weakened.

Court-Involved Youth

"Court-involved youth" as a population includes both children whose parents or guardians have committed crimes, and those who have committed crimes themselves. In Charlottesville alone, approximately 150 juveniles have been arrested since 2010 (Figure 8).

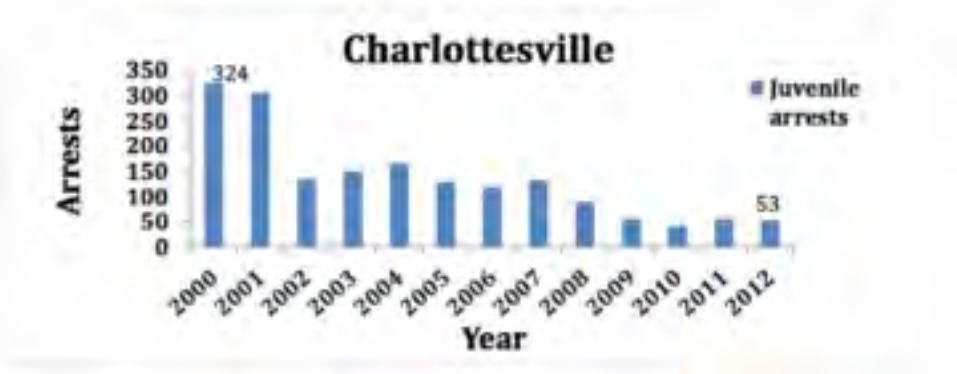

Figure 8. Juvenile arrests at the local level have decreased dramatically since 2000.[54]

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[51] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011*. http://www.acf.hhs.gov

[52]Prevent Child Abuse America, n.d. Web. http://preventchildabuse.org/.

[53] Class Lecture, Kaki Dimock.

[54] Warner, Todd. "Charlottesville Task Force Report on Disproportionate Minority Contact in the Juvenile Justice System ." CHARLOTTESVILLE DMC REPORT. University of Virginia Community Psychology Department, 2014. Web.

Virginia's rates of juvenile intake for property and violent crimes is well below the national average.[55] While juvenile arrests have decreased approximately 70% since 2001 in Charlottesville, children whose parents are going through the justice system are similarly exposed to trauma. 76 percent of children surveyed in the juvenile justice system have experienced some sort of trauma in their lifetime, and over half of all juvenile delinquents have two or more ACEs.[56]

On top of the traumatizing events court-involved youth experience that lead them to the court, involvement with the legal system can be re-traumatizing. Retelling stories, culturally insensitive questions, language barriers, and unwelcoming government and law offices can all have negative effects on a youth's mental health. Additionally, children involved with the juvenile justice system often overlap with the foster child population since the actions their parents or they have committed often are what lead to their unsafe home lives, and subsequent home removal. This complex population consists of the most traumatized, yet often most alienated children in the community.

Homeless Children

Virginia ranks 16th in child homeless populations with over 24,500 homeless children across the state. Furthermore, according to a 2010 study by the National Center on Family Homelessness, Virginia ranked 46th on policy planning for its homeless population.[57] However, according to a 2016 HUD report, homelessness has decreased by 35.7 percent from 2007-2016, demonstrating Virginia's improvements to homeless policy in recent years. Within the Charlottesville area, approximately seven percent of homeless people are children, a uniquely at-risk population for trauma.[58]

Children without stable housing experience ACEs on an astoundingly frequent basis. Homeless children go hungry twice as often as children who are not homeless. Half of all school-aged homeless children experience serious mental health disorders, compared to 18 percent of children who are not homeless. Their exposure to violence, substance abuse, and unstable family lives put them at major risk for trauma-related negative health and behavioral outcomes.[59] Compounded with shelter insecurity, these children have many types of trauma to deal with, though with little support to help them cope.

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55 "Measuring Juvenile Intakes." Virginia.gov. N.p., n.d. Web. <http://vaperforms.virginia.gov/indicators/publicsafety/juvenileIntakes.php>.

56 "Positive Behavior Interventions and Supports for Youth At-Risk and Involved in Juvenile Corrections." Positive Behavioral Interventions & Supports. PBIS, n.d. Web. https://www.pbis.org/community/juvenile-justice.

57 "Number of homeless children in Virginia, Maryland rising." WJLA. WJLA, 13 Dec. 2011. Web. <http://wjla.com/news/local/number-of-homeless-children-in-virginia-maryland-rising-70248>.

58 "Infographic: Homelessness in Our Community." NBC 29. NBC 29, 21 Nov. 2012. Web. <http://www.nbc29.com/story/20157101/infographic-homelessness-in-our-community >.

59 "Facts on Trauma and Homeless Children." *NCTSNET.org*. National Child Traumatic Stress Network, n.d. Web. http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/Facts_on_Trauma_and_Homeless_Children.pdf.

From English language learners, to homeless children, to impoverished kids across the state, Virginia's population contains a number of groups and individuals at a high-risk of trauma. As policymakers begin to acknowledge the scientific realities of trauma, both state and local governments have started to make major strides toward supportive systems of care for their constituents. However, local actors remain the primary force for providing auxiliary services.

Local Actors

The local region's care system for traumatized youth is comprised of three main bodies: government actors, school actors, and nonprofit organizations. All three branches of Charlottesville and Albemarle County's care systems actively seek to gain more trauma-informed care training and make positive change for disenfranchised groups of children in the local region.

Trauma-informed care has evolved into a larger conversation in the greater Charlottesville area as a result of government, school, and nonprofit collaboration in pursuing a trauma-informed community. To narrow the search for pioneers in this pursuit, this report has identified five key qualities that institutional leaders with the greatest potential for advancing best practices in the community present: (1) accessibility for low-income families, both in cost and location, (2) attitude of cultural humility, (3) child friendly space, (4) proven program effectiveness at producing positive outcomes for the traumatized population, and (5) prior implementation of trauma-informed care. Due to their excellence in meeting these criteria, the authors of this report find the following actors to be particularly exceptional candidates for high-impact philanthropy dollars.

Government Actors

Community leaders have begun to show more outright support for trauma-informed care initiatives in the last few years. Charlottesville Mayor Mike Signer has spoken more frequently about the importance of addressing child abuse and its causes and consequences.[60] While no members of the Albemarle County Board of Supervisors have put forward concrete plans to combat this issue, representatives from both Charlottesville and Albemarle's Departments of Social Services are active in the local child trauma prevention scene.

Community Attention Partners

[60] "ReadyKids Plants Pinwheel Garden in Support of Child Abuse Prevention." *Newsplex.com*. Newsplex.com, n.d. Web. http://www.newsplex.com/home/headlines/ReadyKids-plants-pinwheel-garden-in-support-of-child-abuse-prevention-374615171.html.

One major leader in implementing trauma-informed care training in local government systems is Charlottesville's Community Attention Partners. Community Attention includes three models of support: foster care, group housing, and community engagement programs.

Community Attention Foster Families (CAFF) works with CPS to place children removed from their families into supportive, welcoming homes that best meet their needs. CAFF strives to place children in "kinship" homes, rather than "resource" homes. In other words, a child would ideally live with a non-offending relative, a close family friend, a teacher, doctor, or other familiar individual to provide the smoothest transition possible between the biological family and new home. The screening and training processes for "resource" families (families outside a child's familiar network who volunteer through CAFF to temporarily foster children) rigorously examine a family's stability and willingness to adapt to various child backgrounds and behaviors. Foster families receive trauma-informed care training before they receive clearance for a child's placement in their home.

The Community Attention Home, or A-Home for short, is a group home that serves up to 12 kids at one time. The A-Home works with primarily short-term stays, with a 90-day intended maximum, aiming to help children and families in emergency situations. All staff members receive trauma-informed care training. Hunter Smith, the A-Home's program coordinator, detailed the measures their staff takes to ensure kids have as normal of an upbringing as possible while living in the home. From securing prom dresses to adjusting pick-up vehicles to blend in more with other family cars, staff at the A-Home understand how much the little things go a long way in these traumatized kids' lives. Their focus on relationships with their residents echoes the key advice of trauma-informed service models.

The Community-Based Services branch of Community Attention offers "diversion services," designed to keep kids involved in the juvenile justice system from recidivating or participating in other risky behaviors. Their programs range from life skills groups that promote confidence in child ex-offenders, to internship and service programs. The Community Attention Youth Internship Program (CAYIP) and Teens Give offer extracurricular experiences for low-income kids and teenagers who may otherwise, without these time commitments, become involved in risky behaviors. While Teens Give provides invaluable life experiences for children to better understand and meaningfully give back to their communities, CAYIP is a particularly unique opportunity for low-income kids because all internships are paid. This payment can help kids become more self-sufficient, allows kids to contribute to household payments, and facilitates financial learning and responsibility. Community-Based Services also offers additional accessibility for low-income families by providing transportation passes to children in their internship programs.

All three parts of Community Attention's service model embody the five key qualities for leadership in trauma-informed care. Residential services are free of charge to families, as are educational services for children and families. Through their family training and child intake process, they avidly seek families with adaptive abilities for children from other backgrounds and cultures to feel safe in their homes. As a result of their efforts, Community Attention has seen great success. In 2015, 66 percent of children discharged from the foster care system

achieved permanency, living with a stable, welcoming, long-term family.[61] Most importantly, Community Attention's three branches meet quarterly to check in on how previously implemented trauma-related programs are going, discuss new findings in trauma-informed care, and chart a course for improving the way their trauma-informed programs serve their clients.

School Actors

Schools have slowly begun to look into trauma-informed care, both nationally and locally. For example, the Lincoln Alternative High School in Walla Walla, WA implemented trauma-informed care in 2010 and saw tremendous results. After the switch to a trauma-informed model, Lincoln saw 75 percent fewer fights, a 55 percent increase in math assessment scores, and a threefold increase in seniors bound for college. Tailoring teacher practices to help students cope with trauma in a safe environment and provide unconditional love and support, while still upholding high expectations for learning, has set the standard for trauma-informed schools across the country.[62]

Local schools need interventions like the one seen at Lincoln High School. Charlottesville City Schools (CCS) and Albemarle County Public Schools (ACPS) educate a racially and socioeconomically diverse population of students. 46 percent of CCS students are black or Hispanic, though only 23 percent share that racial makeup in county schools.[6364] Two CCS elementary schools offer free breakfast and lunch for their whole student body, and nearly 30 percent of all ACPS students receive free or reduced-price lunch, a common metric for low-income student populations.[65] With the variety of backgrounds and stories to embrace throughout the school system, it is essential that local districts begin to more seriously implement trauma-informed care to help individual students with their unique traumas.

CCS and ACPS currently only mandate trauma-informed care training for teachers of English for Speakers of Other Languages (ESOL) classrooms. Since ESOL teachers touch some of the most challenged populations in the school system, this program seems effective on the surface. However, trauma training for ESOL teachers is limited, often given in under a few hours during a one-time workshop, limiting the quality of trauma-informed care teachers can give. Additionally, English Language Learners (ELLs) take classes and interact with administrators and faculty outside of their ESOL classrooms. Without a comprehensive trauma-informed care system, ELL children may still face re-traumatization in schools when they step outside the trauma-informed "bubble" of their ESOL classrooms. Finally, increasing the number of staff and faculty members who receive trauma-informed training, instead of just ESOL

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[61] Community Attention Foster Families Discharge Report 2014-2015. Retrieved from Garrett Jones

[62] *Paper Tigers*. N.p., 2015. Film. http://kpjrfilms.co/paper-tigers/.

[63] "Fact Sheet - Albemarle County Public Schools." *Albemarle County Public Schools*. N.p., n.d. Web. 26 Mar. 2017. https://www2.k12albemarle.org/acps/division/Pages/default.aspx.

[64] "Fast Facts." *Charlottesville City Schools*. Charlottesville City Schools, n.d. Web. http://charlottesvilleschools.org/home/about-ccs/fast-facts/.

[65] "Nutrition Services." *Charlottesville City Schools*. N.p., n.d. Web. 26 Mar. 2017. http://www.schoolnutritionandfitness.com/index.php?page=lunchapps&sid=1464118095830.

teachers, improves a school's capacity for care for all, not just a targeted subset of the population. As much as ESOL teachers can track the traumatization of refugees and immigrants, it may take an extra set of eyes to catch abnormal behaviors from foster kids, homeless children, and victims of neglect, which are less visible populations.[66] Thus, this report finds the lack of school-wide training to be a major gap in current policy. However, some schools in Charlottesville have already begun to take additional steps towards being fully trauma-informed.

Lugo-McGinness Academy

The Lugo-McGinness Academy (LMA), an alternative public high school in Charlottesville, is a great leader in the local movement toward a trauma-informed community. The school's mission aims to achieve students' personal and academic growth in a therapeutic and trauma-informed environment. Their principal, Stephanie Carter, has spoken on panels across Virginia about the social and academic success of her students, attributing much of their growth to the nurturing environment the school promotes, including small class sizes, ample time for recreation, and personal relationships with faculty and staff members.

LMA at all times receives at least 10 percent of its students from group homes and an additional 10 percent from foster care. At one point, 100 percent of all students at LMA were involved with the juvenile justice department. Prior to 2014, behavioral and academic performances from LMA's students were less than desirable. Before relocating to their current location in the 10th and Page neighborhood, students had no space to let loose and engage in stress-free play. Charlottesville Tomorrow quoted Cindy Nelson, LMA's English instructor when she said: "The old building looked like a warehouse and sent the subliminal message to students they were being warehoused… Lugo-McGinness is a positive place. Being sent here is not a punishment. It is an opportunity to change the course."[67] It is important not to undervalue the subtle messages we can send to youth in the way we arrange services.

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[66] Interview with Community Educator (asked to remain Anonymous)

[67] Paine, Grace. "Lugo-McGinness Academy ends first year on optimistic note." *Charlottesville Tommorow*. N.p., 13 Aug. 2015. Web. http://www.cvilletomorrow.org/news/article/21731-optimism-at-lugo-mcginness-academy/.

In the same year as the relocation, trauma-informed care became the standard of practice for the school. With Carter as the new principal, all staff and faculty received trauma-sensitive training that initiated a culture change among faculty, staff, and students alike. Since then, LMA has seen significant reductions in the number of kids suspended per month, as well as the length of suspensions when they occur, a 78 percent decline in the number of students who drop out, and dramatic decreases in the number of courses failed. Last year, every child at LMA passed at least one class. Figures 9 provides further context for changes in number of suspensions.[68]

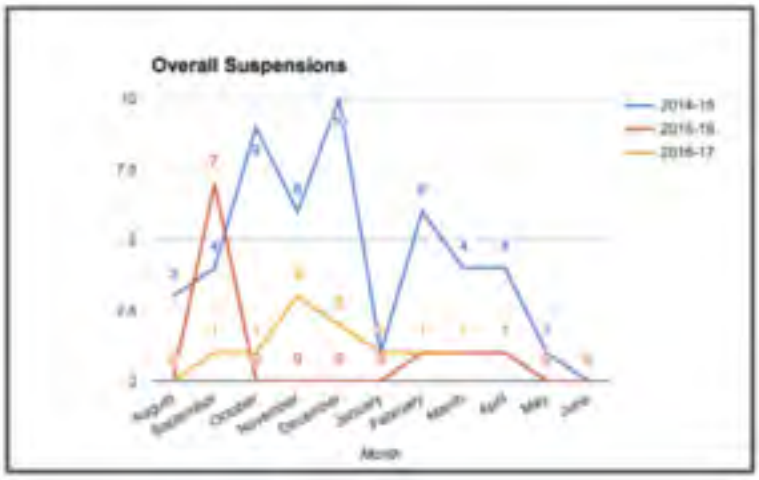

Figure 9: This graph shows the number of students suspended at LMA per month over the course of three years. From the first year of trauma-informed care implementation to today, LMA has seen dramatic decreases in the number of suspensions distributed.

As a free public school with a culturally aware staff, newly opened play space, and trauma-informed practices, the Lugo-McGinness Academy serves as a testament to the change trauma-informed care can make in Charlottesville and Albemarle County schools. While the authors of this report realize making such wide infrastructural change across the school system is difficult and may raise challenges not faced by LMA due to its small size and special population, there are still many translatable elements of their success that can be brought to benefit the broader student population.

Nonprofit Actors

Nonprofit organizations in Charlottesville and Albemarle County work closely to ensure the security, health, and self-sufficiency of community members across the local region. The three most prominent trauma-informed organizations for child welfare in the local region include Foothills Child Advocacy Center, ReadyKids, and Piedmont CASA.

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[68] Interview with Stephanie Carter.

Foothills Child Advocacy Center

The Foothills Child Advocacy Center is a trauma-informed, coordinated response and intervention system for alleged child victims of trauma. Their main function is to assess the behaviors of children who have undergone trauma, per Child Protective Services (CPS) referrals, and also to provide supportive services and educational resources for caretakers of traumatized children. Law enforcement and CPS use the Foothills office space to conduct forensic interviews with children in lieu of taking them to a police station or another more intimidating, potentially re-traumatizing environment. After a child undergoes assessment, Foothills often refers children and families to counseling resources, like ReadyKids. Foothills also organizes the Charlottesville and Albemarle Multidisciplinary Team, comprised of 14 local agencies, that serves to increase cross-agency collaboration and communication, and decrease duplication of child welfare services.[69]

Foothills meets all five key qualifications of leadership in trauma-informed care. The Foothills office is centrally located in the Charlottesville community with ample parking and close proximity to three bus route stops. Assessments, counseling referrals, and educational materials are free of charge to families. The organization exhibits cultural humility both in their interpersonal actions and organizational structure. Educational resources from Foothills come in low-literacy and Spanish formats to accommodate parents of different linguistic abilities and backgrounds. In 2011, Foothills became a member of the National Children's Alliance, a network of 795 child advocacy organizations that works to combat the effects of child abuse. The National Children's Alliance emphasizes cultural competency and diversity as two of their standards for membership. Additionally, Foothills' mission is to advocate and care for children and families in the local community in a safe and welcoming space. With light blue and light yellow walls, a quiet office environment, and cozy furniture, Foothills has created a warm and comfortable environment for children and families, eliminating negative distractions from the outside world as services are administered.[70]

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[69] "About Us." *Foothills Child Advocacy Center*. N.p., n.d. Web. 19 Mar. 2017. http://www.foothillscac.org/about-us.html.

[70] Foothills Child Advocacy Center. A Guide for Parents. (n.d.). *Foothills Child Advocacy Center*, 1-20.

Lastly, Foothills' ten years of operation in the community have proven to be effective for families as shown by the local and national recognition it has received. After serving more than 2,000 victims of child abuse, Foothills earned national re-accreditation for its services in February 2017. Accreditation requires compliance with high standards of efficient, effective, and consistent services for children and families. Foothills' renown is derived from its outstanding care, produced as a result of their trauma-informed values.[71]

Ready Kids

ReadyKids provides counseling services for children coping with adverse childhood experiences such as abuse, neglect, and refugee trauma. Referrals come primarily from the Department of Social Services as well as the Foothills Child Advocacy Center. The average age of a ReadyKids client is 10 years old, though they have recently initiated new programs specifically tailored for children under five, a crucial addition for trauma-informed practices.[72]

As such, ReadyKids also meets the five key qualifications of leadership in trauma-informed care. 73 percent of ReadyKids clients identify as low-income. Low-income families have access to ReadyKids' services due to their free counseling and its proximity to stops for three bus routes. Although the wait list for services can stall family treatment up to six weeks, ReadyKids is well-connected in the community and can often refer families who can afford counseling to other services for faster clinical help. For every child who comes through their doors, ReadyKids adopts a posture of cultural humility in service to their clients. ReadyKids employs two bilingual counselors to help treat Spanish- and French-speaking clients and offers direct outreach programs to the Southwood neighborhood in Charlottesville, where a large refugee population lives. They also operate in a child-friendly space. ReadyKids provides a flexible outpatient model for children under the age of five that allows the child to receive services in their home or in school, instead of an office environment. Counseling also takes place in their clean and welcoming headquarters just off of the Charlottesville Downtown Mall.

Finally, ReadyKids has seen success in its counseling efforts due to their model of care that keeps children in counseling until counselors, caretakers, and kids all agree that they have met the goals of treatment. Staff do not have a maximum number of visits a child can make for services. As such, while their average duration of treatment is 9 months, they have followed

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71 "Foothills Child Advocacy Center Earns National Re-Accreditation." *Newsplex.com*. CBS19, 3 Feb. 2017. Web. http://www.newsplex.com/content/news/Foothills-Child-Advocacy-Center-earns-national-re-accreditation-412694953.html.

72 Interview with Shannon Noe.

individual cases for as long as three years.[73] ReadyKids has trained staff members in trauma-informed, evidence-based treatments such as Eye Movement Desensitization and Reprocessing, Theraplay, and Art Therapy.[74] In 2021, ReadyKids will celebrate 100 years as an organization leading child welfare work in the Charlottesville and Albemarle area. Any resources directed towards ReadyKids should be done so with the purpose of reducing the average wait time for services.

Piedmont Court-Appointed Special Advocates (CASA)

Court-appointed special advocates are trained volunteers whom a judge appoints to advocate for the best interests of a child in court. Children aided by Piedmont CASA, the local chapter of the volunteer organization, include victims of abuse and neglect whose custodial and home placement decisions are processing at the juvenile court. CASA does not require volunteers to have a legal background, though they do undergo an intensive screening and a 32-hour training program upon consideration for partnership with the organization. While some case workers interact with a child for a short period of their court involvement, CASA volunteers work with kids throughout the entirety of the process, sometimes across many years, providing consistency in a child's otherwise hectic life.

Although primarily an advocacy organization, CASA has recently ventured into providing direct service. Recognizing a lack of resources for older foster care youths (those ages 14-18+) who are close to aging out of the system, last year CASA created the Bridges to Success program using funds obtained through a VOCA grant.[75] This program trains coaches to engage kids in the life-planning process, working with them to develop a "comprehensive, holistic and measurable plan and to guide and support youth in their transition to self-sufficiency and living an independent, interdependent life."[76] The goals of the program are to improve academic performance, develop soft and hard skills to maintain employment, and increase youth engagement. The ultimate goal of the program is to produce self-sufficient, resilient problem-solvers who are built for success after their involvement with the court system is over. Despite

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[73] Ibid.

[74] Ibid.

[75] Greater Charlottesville Trauma-Informed Care Network Steering Committee meeting.

[76] "Piedmont CASA Bridges to Success Coach/Mentor Job Description." *Piedmont CASA*. N.p., n.d. Web. http://www.pcasa.org/Job percent20Description percent20Piedmont percent20CASA percent20-percent20Coach-Mentor.pdf.

being a such a young program, this endeavor demonstrates how CASA is evolving to fill the gaps and provide important services to children who have experienced trauma.

Since opening its doors in 1995, CASA has been a key player in the local area's movement toward a trauma-informed community and demonstrates all five leadership qualities for trauma-related service organizations. CASA volunteers work with court-involved youth free of charge. They visit kids in court, at home, in school, or wherever else is a safe and supportive environment for their clients to learn about their case's progress. In this way, CASA's services are both accessible and child-friendly because meetings are personal and built on trusting relationships, rather than a strict advocate-client basis. CASA's mission promotes the need to include all children in its efforts towards a safer community for all families. Volunteers practice cultural humility by embracing the range of ages, races, and socioeconomic and cultural backgrounds of their clients, knowing that "each one deserves a safe and permanent home."[77]

CASA's work with trauma-informed care in the local legal system falls into a larger trend of successful child advocacy across the U.S. Studies have shown that trauma-informed judges, lawyers, and other court-involved specialists work more collaboratively than non-trauma informed groups towards effective home placements, shorter jail sentences, and family engagement in the legal process.[78] CASA's commitment to trauma-informed care is best displayed by their co-founding of the Greater Charlottesville Trauma-Informed Care Network alongside ReadyKids.

The Greater Charlottesville Trauma-Informed Care Network

While they have their own initiatives, community leaders, schools, and nonprofits come together in the Greater Charlottesville Trauma-Informed Care Network (TICN) to pursue community awareness of trauma. The overall network model and many of their resources come from the Greater Richmond Trauma-Informed Care Network, the first and best-established trauma-informed care network in Virginia.

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[77] "CASA Kids - Who Are Our Children?" *Court Appointed Special Advocates*. Piedmont CASA, n.d. Web. http://www.pcasa.org/kids.php.

[78] "High Quality Legal Representation for All Parties in Child Welfare Proceedings." *Administration for Children and Families*. U.S. Department of Health and Human Services, n.d. Web. https://www.acf.hhs.gov/sites/default/files/cb/im1702.pdf.

The Greater Richmond TICN functions as a subset of SCAN (Stop Child Abuse Now), a nonprofit dedicated to the prevention and treatment of child abuse and neglect in the Greater Richmond area.[79] While SCAN was founded in 1991, its trauma-informed community network was initiated in fall 2012. Seven professionals representing three different agencies established the network to raise awareness of and enhance the knowledge base for local professionals to learn about implementing trauma-informed child-welfare practices.[80] The network grew rapidly, and it now leads and convenes 113 members from 61 different nonprofit, for-profit, and government agencies on a regular basis.[81] One of its main services is providing free trainings to local organizations on a host of trauma-informed care subjects, including how to implement trauma-informed care in schools, trauma and resilience basics, how to build individual and community resilience, and how to prevent vicarious and secondary trauma.[82]

Local actors saw the success of the Greater Richmond Trauma-Informed Community Network. Recognizing the growing local interest in trauma-informed care, but lack of training and top-down information-sharing, two key actors—ReadyKids and CASA—came together in 2016 to form the Greater Charlottesville TICN. The network strives to create a shared language and procedure for administering trauma-informed care trainings to school, government, and nonprofit staff. Though new, the organization has attracted more than 70 individuals representing 24 organizations in the area to attend network meetings and is growing. For a list of current members, see Appendix B. The network seeks to continue expanding and hopes for the capacity to educate and train anyone who interacts with a child. With this training, they believe the Greater Charlottesville area will be a community in which children in high-risk environments have the support system they need in place to help them cope with potentially traumatic events.[83]

The Greater Charlottesville TICN has committed to the following goals in 2017:[84]

1. Implement organizational and community assessment.
2. Develop network membership and structure.
3. Develop communication strategies.
4. Provide community training and education.

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[79] *Trauma-Informed Community Network*. Greater Richmond SCAN, n.d. Web. http://grscan.com/trauma-informed-community-network/.

[80] "Trauma Informed Care." *Virginia.gov*. Virginia Department of Behavioral Health & Developmental Services, Web. http://www.dbhds.virginia.gov/individuals-and-families/children-and-families/trauma-informed-care.

[81] *Trauma-Informed Community Network*. Greater Richmond SCAN, n.d. Web. http://grscan.com/trauma-informed-community-network/.

[82] “Greater Richmond Trauma-Informed Community Network (TICN) Training Information." Greater Richmond TICN Training Committee & Trauma-Informed Schools Committee, n.d. Web. http://grscan.com/wp-content/uploads/2016/08/TICN-Training-Info-flyer1.pdf.

[83] Interview with Alicia Lenahan.

[84] Greater Charlottesville Trauma-Informed Community Network. *Steering Committee Strategic Plan*. 27 February 2017.

5. Advocate for improved trauma-informed care across the Charlottesville area community.

These goals demonstrate that although the network is still establishing itself, it has identified the key first steps for creating a supportive and trauma-informed community in Charlottesville and Albemarle. Nearly every local expert the authors interviewed were aware of the Greater Charlottesville TICN, proving its widespread influence and recognition among professionals across many agencies in child welfare.

However, getting trauma-informed care on the agendas of busy public servants, educators, and social workers has certainly not come easily. As is the case with challenges on the national scale, research on the subject is not yet widely known, causing the TICN to have to spend resources educating their peers on the value of trauma-informed care. Additionally, trauma-informed care requires upfront effort to readapt operations that run up against financial and time constraints overstretched organizations may face.

Because federal initiatives have been slow to roll out wide-reaching programs, smaller cities like Charlottesville often mirror programs from larger nearby metropolitan areas like Richmond and Washington D.C., in addition to conducting their own research on trauma. While the diversity of such information and practices leads to incredibly helpful cross-agency information sharing and discussion, it also leads to a lack of uniformity across agencies and organizations in regards to trauma-informed care training and application. The Greater Charlottesville TICN aims to eliminate this lack of uniformity while supporting individual groups' endeavors.

Community Attention Partners, the Lugo-McGinness Academy, Foothills, ReadyKids, and CASA all stand out as leaders in the local trauma-informed care movement, not only because of their excellence in meeting this report's standards for care, but also because of their connectedness in the community. As members of the Greater Charlottesville TICN, each of these organizations has great potential for lateral information sharing, both within Charlottesville and Albemarle, and beyond. The authors of this report see these groups as the most deserving candidates for high-impact philanthropic investment. The authors also believe that due to its wide-reaching membership and commitment to implementing trauma-informed care among all professionals, the Greater Charlottesville TICN itself could make further profound, positive change in the community with expanded financial resources.

Addressing Challenges of Care in Charlottesville and Albemarle County

While the organizations detailed above bring great positive impact to the community, Charlottesville and Albemarle's care systems continue to face significant challenges in addressing youth trauma. Local experts frequently cite roadblocks such as resource shortages and the prospect of inadvertently re-traumatizing those whom their services seek to help. Rather than viewing these challenges with discouragement, they can be viewed as opportunities for the

integration of trauma-informed care to alleviate some of the greatest pressures in a manageable way.

Shortage of Affordable Services

Although the Charlottesville and Albemarle region may have more resources available for child welfare and trauma-related services compared to some other Virginia localities, there still exists a significant shortage of services for those who need them.[85] Key examples were highlighted in interviews with local nonprofit leaders. These shortages included the shortage of youth Victims of Child Abuse (VOCA) counselors, the inability of the DSS in both the city and county to provide certain services due to caseload strain, and a lack of multilingual counselors in schools. While the implementation of trauma-informed care in these highlighted services may not completely eradicate their addressed shortages, it has the potential to spread strengths and resources throughout all members of the community. Instead of everyone who needs services looking to the one local organization that provides trauma-informed care, community members could have their choice of service provider because all caretakers would offer the same trauma-sensitive quality of care.

Shortage of Affordable Counselors

Shannon Noe, the Youth Counseling Program Manager of ReadyKids, described that she never has enough counselors in her program to fill the demand for ReadyKids' services. As a result, there is always a lengthy wait list of children who have experienced trauma and need assistance. Currently, ReadyKids has a wait list of 32 children; these children will have to wait for several weeks before they can meet with a counselor. In cases where the family has insurance, ReadyKids will refer children to private practice counselors. However, even if you do have insurance, co-pays can cause financial strain for low-income families, and private counselors often have wait lists as well, although generally shorter than that of ReadyKids.

In either case, there is often great spans of time between the traumatic incident and the start of treatment, and some may choose to forego receiving treatment due to frustration and the potential financial strain of the private practice option. This is problematic because when dealing with trauma, this report has shown that interventions are most effective when delivered as early as possible in order to prevent negative physiological, developmental, and mental health consequences. In cases of acute trauma, in the time between a traumatic incident occurring and reaching counseling, a child can develop negative thinking patterns and may come to believe that what happened to him or her was his or her fault.[86] However, when a child receives early intervention, along with appropriate social support, most will recover almost completely from their fear and anxiety caused by a traumatic experience within a few weeks.[87]

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[85] Interview Dina Blythe

[86] Interview with Shannon Noe

[87] Hodas, Gordon R. "Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care ." *Pennsylvania Department of Human Services* . N.p., Feb. 2006. Web. http://www.dhs.pa.gov/cs/groups/public/documents/manual/s_001585.pdf.

Shortage of Multilingual Counselors

As previously detailed, the population in Charlottesville and Albemarle is culturally and linguistically diverse. With over 40 languages spoken in Charlottesville schools and over 70 languages spoken in Albemarle County schools, even if a school has a counselor who speaks Spanish, which is not common, their qualifications do not meet the unique needs of Charlottesville and Albemarle's child population. Counseling services outside of schools struggle with meeting this need as well. While ReadyKids offers Spanish and French counseling for those who need it, those services do not account for the linguistic diversity of the refugee population in Charlottesville and Albemarle. This problem could be addressed by implementing of trauma-informed care to combat this communication challenge with cultural humility, understanding that verbal expressions of mental and emotional health may not work, but play and art therapy can be great stress relievers for kids with language barriers.

Consequences of Caseload Strain

Alicia Lenahan of Piedmont CASA identified a different type of shortage. She highlighted how, when faced with an overwhelming caseload and stretched very thin, DSS caseworkers operate within a reactive environment in which they have to prioritize which emergency to deal with first.[88] In these cases, services that are important, but not deemed crucial, fall by the wayside. One example of such a service is VDSS Section 13, which seeks to improve outcomes for older youth in foster care by preparing them for success in adulthood by finding families, establishing lifelong connections with significant role models, and providing services and supports in areas such as education, employment, finances, health, housing, and home management.[89] In the context of other more urgent VDSS services, such as removing a child from a violent home, allocating resources to these life-planning conversations does not seem as important. However, this is problematic because research shows that youth who age out of the foster care system without secure family relationships or or a significant role model are more likely to experience poverty, homelessness, incarceration, and mental health and medical problems.[90,91] Failing to provide this service means that these challenges will persist, resulting in significant economic, emotional, and social costs for the youth and society.[92] Trauma-informed care may not directly address the current oversubscription to child welfare services, but statistics show how implementing trauma-informed care can reduce dependency on social,

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88 Interview with Alicia Lenahan

89 "ACHIEVING PERMANENCY FOR OLDER YOUTH." *Virginia Department of Social Services*. Virginia Department of Social Services, n.d. Web. https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2015/Section_13_Achieving_Permanency_for_Older_Youth.pdf.

90 "National Survey of Child and Adolescent Well-Being." *NSCAW Study*. N.p., n.d. Web. https://www.acf.hhs.gov/sites/default/files/opre/aces_brief_final_7_23_13_2.pdf .

91 Courtney, Mark. "Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26." *Chapin Hall*. University of Chicago, n.d. Web. https://www.chapinhall.org/sites/default/files/Midwest percent20Evaluation_Report_4_10_12.pdf .

92 Ibid.

medical, and juvenile justice services in the future.[93] CASA is working to alleviate these concerns through its new Bridges to Success program (see page 44).

Re-traumatization

Although well-intentioned, the public institutions and service systems that are intended to provide services and supports to children who have experienced trauma are often themselves trauma-inducing.[94] Examples of practices that may cause re-traumatization can be found in the full array of trauma-related services. In the medical system, the use of invasive procedures during a screening for complications from abuse may lead to feelings of violation; in the school system, harsh disciplinary practices, such as repeated detentions or public shaming, may trigger painful memories and lead to reactive outbursts; in the child welfare system, abruptly removing a child from an abusive family may further damage their attachment pattern.[95] Thus, services' organizational practices may trigger painful memories and re-traumatize clients with trauma histories, inadvertently creating stressful or toxic environments that interfere with and undermine their desired goals and outcomes.

In Charlottesville and Albemarle, many of the local actors recognize the importance of reducing the potential for re-traumatization. However, this recognition needs to extend into ongoing assessment and training in order for them to be able to truly recognize and then work to mitigate re-traumatizing practices.

Costs of Trauma Informed Care Training

Trauma-informed care is well-supported in Charlottesville and Albemarle, and several local actors have highlighted the need for more training on trauma-informed care.[96] However, one of the main barriers to implementation in the community is the cost of training. SAMHSA offers free on-site training, but the organizations receiving training are expected to cover the visiting trainers' travel expenses. While this may not seem like an overwhelming cost, once the travel, lodging, and food expenses are totaled, it poses a significant financial burden to trauma-related services and nonprofits, as these often operate on strict budgets. For example, assuming the Greater Charlottesville TICN wanted to host a SAMHSA trainer for three days, these costs would total to over $800 (See Appendix C for calculations). This is a challenge that the Greater Charlottesville TICN has started to investigate due to its focus on supporting the ongoing training and education of community actors. This report sees this as an opportunity for those seeking to make high impact in improving trauma-related services.

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93 Stroul, Beth. "Return on Investment in Systems of Care for Children With Behavioral Health Challenges." National Technical Assistance Center for Children's Mental Health, Apr. 2014. Web. https://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf.

94 "Concept of Trauma and Guidance for a Trauma-Informed Approach." *SAMHSA*. Trauma and Justice Strategic Initiative, July 2014. Web. http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf .

95 Ibid.

96 Interview with Shannon Noe.

Although the challenges of care described above may seem daunting, these challenges are not insurmountable. Creating a fully trauma-informed community has the potential to alleviate many of these pressures. The first obstacle to overcome is the cost of trauma-informed training. Although it presents high upfront costs, this report has already demonstrated the long-term savings of trauma-informed care. Furthermore, once the initial training expenses are covered, the Greater Charlottesville TICN could implement a "train the trainer" model, with representatives from different organizations receiving training and then training their peers. This model would greatly reduce the cost of training and would go a long way toward creating the collaborative, trauma-informed community that has the potential to abate the aforementioned challenges to care this group has seen in Charlottesville and Albemarle.

Looking Forward

Considering the great amounts of interest in trauma and helping communities develop trauma-informed responses, there is good reason to believe that there are large changes in the landscape of trauma that will come in the next few years. Some of the primary factors that will dictate the climate around trauma in the near future are listed below.

Research

As addressed in this report, critical analysis into trauma and its impact on the developing child is a relatively nascent field of study. There is still much we do not know, but our understanding is growing at an exponential pace. The 2011-2012 iteration of the Department of Health and Human Services' National Survey of Children's Health was the first version to include questions regarding childhood trauma. The data from this study has been key in helping states understand the risk factors their populations are particularly vulnerable to and guide wise, trauma-informed policies. The 2016 iteration of this study, with data expected to be published this year, explored questions regarding trauma to an even greater degree. Additionally, the Department of Health and Human Services has recently launched its study on Environmental Influences on Child Health Outcomes, a massive seven-year longitudinal research endeavor that includes over 50,000 children. This program will give out $157 million in research grants throughout its duration. The large amount of resources devoted to this study highlights the emphasis the NIH is placing on studying issues related to childhood development, such as trauma.[97] These two studies will likely be primary data points guiding future understanding of trauma.

Policy Pipeline

Looking ahead, it is likely that most political action taken in the near future will need to take place on the state or local level. The new presidential administration's proposed budget pushes for broad cuts to the Department of Health and Human Services (18 percent),

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[97] "DCRI to coordinate national study of childhood health." *Duke Department of Pediatrics*. Duke University, 21 Sept. 2016. Web. https://pediatrics.duke.edu/news/dcri-coordinate-national-study-childhood-health.

Department of Housing and Urban Development (13 percent), and Department of Justice (4 percent), the three key agencies whose dollars go toward actors involved in childhood trauma.[98] Several bills that would advance conditions for these populations have languished in committee, such as the Trauma Informed Care for Children and Families Act, which would provide for dramatically increased funding for trauma informed care initiatives and establish a task force designed to research, recommend, and update best practices.[99] While some bills have made progress, such as the Mental Health First Aid Act (passed by the House), which would provide funding for teacher, school, and police trainings, political capital to encourage its passage in the Senate seems limited.[100] Under current political conditions, it is unlikely there will be much advancement of resources aside from that coming from the implementation of the 21st Century Cures Act over the coming years.

However, there is great reason to hope for support from the Virginia General Assembly. On December 1st, 2017 the four-year Joint Subcommittee to Study Mental Health Services in the 21st Century will submit its final report before dissolving. These findings are expected to bring great debate on how to improve Virginia's mental health infrastructure to the 2018 legislative session. The Assembly has already expressed clear interest in a strengthened system to help prevent future tragedies like those at Virginia Tech and the one that befell the Deeds family. Additionally, the Assembly has already expressed great interest in trauma-informed care and the value of networks. In January, it passed a resolution commending the efforts and successes of trauma informed care networks throughout Virginia.[101] As such, advocates serving children facing trauma stand to gain great victories from state level legislation in the coming years.

At the local level, the services most likely to interact with children who have experienced trauma—government services, school systems, and nonprofits—have already felt the impact of the presidential election, particularly related to the uncertainties raised by President Trump's strong stance on immigration. For example, a local school official who wished to remain anonymous explained how the fear and uncertainty of Immigration and Customs Enforcement (ICE) raids can take an emotional, psychological, and physical toll on developing children, leading to chronic fear, anxiety, and stress.[102] Schools have already noticed families dropping

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98 DeBonis, Mike. "GOP health-care bill: House Republican leaders abruptly pull their rewrite of the nation's health-care law." *The Washington Post*. The Washington Post, 24 Mar. 2017. Web. https://www.washingtonpost.com/powerpost/house-leaders-prepare-to-vote-friday-on-health-care-reform/2017/03/24/736f1cd6-1081-11e7-9d5a-a83e627dc120_story.html?utm_term=.19d9ab9d6d26.

99 "S.3519 - Trauma-Informed Care for Children and Families Act of 2016." *Congress.gov*. Congress.gov, n.d. Web. https://www.congress.gov/bill/114th-congress/senate-bill/3519.

100 Jenkins, Lynn. "H.R.1877 - Mental Health First Aid Act of 2016." *Congress.gov*. Congress.gov, Sept. 2016. Web. https://www.congress.gov/bill/114th-congress/house-bill/1877.

101 "House Joint Resolution No. 653: Commending Trauma-Informed Community Networks." *Virginia's Legislative Information System*. N.p., Jan. 2017. Web. http://lis.virginia.gov/cgi-bin/legp604.exe?171 ful HJ653ER.

102 *Immigrant and Refugee Children: A Guide for Educators and School Support Staff*. Guide compiled by United We Dream's Dream Educational Empowerment Program, the National Immigration Law Center, First Focus, First Focus and AFT.

out of Free & Reduced Lunch, likely because they are undocumented and do not want to be on the government's radar. The potential for such raids also complicates addressing the most vulnerable populations because any congregation of this specific group, even if intended to provide important services, can pose a threat for a raid.

To address this, actors such as the Greater Charlottesville TICN have discussed holding events to provide resources for a wide range of the community, so as to not single out this specific group but still provide them with important resources.[103] More broadly, Charlottesville Mayor Mike Signer declared Charlottesville a "capital of resistance" during the Trump presidency, with an explicit focus on protecting immigrants and refugees in the community.[104]During a rally in January, Signer announced that he is working with Senators Mark Warner and Tim Kaine to provide specific case assistance for immigrants who need visa help, along with other policy goals related to protecting these groups.[105]

Even with this announcement and intention to pursue a policy of resistance, the national political scene still presents a constant stressor to these families. In many ways, the current political climate has re-emphasized to the Greater Charlottesville TICN the importance of their commitment to children and creating a trauma-informed community.

Conclusion

This report has explored the complex nature of trauma and illustrated the myriad negative consequences a child can face when exposed to adverse childhood experiences, some as extreme as suicide and early death. However, this report has also found that adverse childhood experiences do not necessarily have to dictate one's life outcomes. With proper early intervention and stable, unconditional support from an adult figure in the child's life, the impact of these ACEs can be mitigated, or perhaps even erased.

This fact is illustrated beautifully by the story of J.D. Vance, author of Hillbilly Elegy. J.D. has an ACE score of six, which by all accounts would predict a troubled life for him with limited opportunity. Yet, J.D.'s life defies such expectations. J.D. is a proud alumni of Yale Law school and lives in a happy home with a wife, children, and pet dogs. What makes J.D. unique? Why was he able to overcome the impact of his ACEs? J.D. offers his own thoughts, describing his life after leaving his mother's home and moving in with his grandmother (a kinship placement, the very kind advocated for in a trauma-informed practice).

> "I'm sure that a sociologist and a psychologist, sitting in a room together, could explain why I lost interest in drugs, why my grades improved, why I aced the SAT, and why I found a couple of teachers who inspired me to

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103 Greater Charlottesville Trauma-Informed Care Steering Committee Meeting.

104 Neus, Nora. "Charlottesville Mayor Holds Rally to Declare City Capital of Resistance." *NBC29.com*. NBC29, 31 Jan. 2017. Web. http://www.nbc29.com/story/34389763/charlottesville-mayor-holds-rally-to-declare-city-capital-of-resistance .

105 Ibid.

> love learning. But what I remember most of all is that I was happy – I no longer feared the school bell at the end of the day, I knew where I'd be living the next month, and no one's romantic decisions affected my life. And out of that happiness came so many of the opportunities I've had [since]."

J.D. had someone who believed in him, someone he felt was rooting for him. That feeling of security provided him the foundation from which he could reach higher. However, it is important to note that not everything has been easy for him. J.D. reflects throughout his book on how ghosts of his childhood continue to haunt him. He gets irrationally angry at people during minor traffic incidents and still struggles with self-confidence issues at times. He realizes the trauma of his childhood is something he will always carry with him, but he knows he does not have to share this burden alone. He cites his grandmother (Mamaw), his wife, teachers, and professors as being key figures that have kept him on course.

This is the goal of trauma-informed care: to reach the child who has seen the worst, and help them see themselves as more than the sum of their experiences. Trauma-informed care, whether administered by a foster family, school, counselor, lawyer, or other caretaker, seeks to provide services in a supportive environment for kids. J.D.'s story may be unusual for those of his background, but it doesn't have to be. Communities are beginning to amass the tools and knowledge needed to help kids build resiliency amidst challenging circumstances, as this group has seen in parts of Charlottesville and Albemarle County that are doing incredible work. However, it is clear trauma cannot be treated alone. J.D.'s story cites at least a dozen individuals whose love and guidance led him to the person he has become today. If not for these people, he would have been without hope.

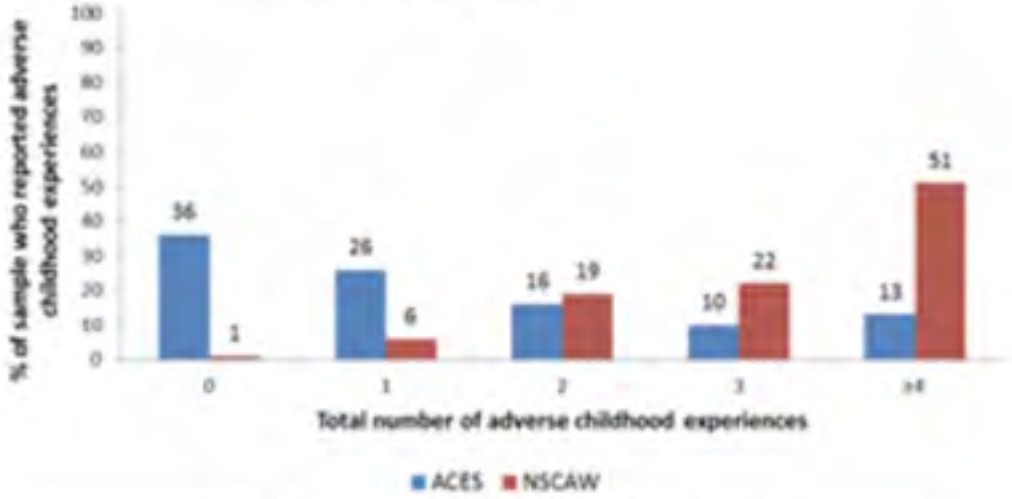
Thus, Charlottesville and Albemarle are best served by spreading trauma-informed care practices to as many people as possible, whether or not they are directly involved in the care of at-risk youth. There is no force as powerful as the dissemination of knowledge, and this is the domain in which the authors will explore ways to best invest limited funds.

Appendix

APPENDIX A

Individuals studied in the NSCAW population of children who had interacted with child welfare services were found to be significantly more likely to have 4 or more adverse childhood experiences than the general population in the ACES study.

Figure 1. Adverse childhood experiences in NSCAW vs. ACES[a,b]



[a] To account for item nonresponse (less than 10% for all ACE variables), multiple imputation was performed using MPlus 7.[30] Variables entered into the imputation model included child age, child race/ethnicity, caseworker-assessed harm, caseworker-assessed risk, current placement setting, and all 10 ACE variables. The imputation results increase confidence that results are not biased by missing data.

[b] NSCAW respondents reporting no adverse childhood experiences excluded those who entered CWS due to "other" types of maltreatment that did not map onto the ACES, including abandonment and exploitation. Brief descriptive analyses showed that these children were typically young, living in foster, and had low caregiver-assessed levels of harm and risk.

APPENDIX B

Members of the greater Charlottesville Trauma Informed Care Network:

Piedmont CASA
Partner for Mental Health
Offender Aid Restoration (OAR)
Departments of Social Services - Albemarle, Charlottesville
Region Ten
Schools - Charlottesville, Albemarle
Blue Ridge Bigs
ReadyKids
Jefferson Area Children's Health Improvement Program
People Places
Habitat for Humanity
Women's Initiative
Blue Ridge Detention Center
Elk Hill
The University of Virginia Curry School of Education
The Haven
City of Promise
Sexual Assault Resource Agency

Eastern Mennonite University
Department of Criminal Justice Services
Foothills Child Advocacy Center
Shelter for Help in Emergency

APPENDIX C

Estimating Cost of Bringing Trauma-Informed Care Training to Charlottesville and Albemarle.

Assuming the Greater Charlottesville TICN would like to host a SAMHSA trainer for a three day training conference, they would have to cover the following travel, lodging, and food costs. This estimate assumes the following: the trainer would be traveling from Rockville, MD, where SAMHSA is based, and the conference would include 3 full days from Monday-Wednesday, with the trainer arriving in Charlottesville on Sunday and departing on Thursday.

- Amtrak estimation of round-trip train ticket from Rockville, MD: $70 ($35 each way)
- Four night accommodation in Charlottesville hotel: $600 ($150/night)
- Four day food budget: $160 ($20 for lunch and dinner/day)
- Workshop materials budget: $20

This brings the total cost of bringing a trainer for just three days to $850.