

# ADVANCING PREVENTION PROJECT

## Building Trauma-Informed, Trauma-Sensitive and Resilient Communities To Support the NYS Prevention Agenda Webinar Q&A

### **Q: Can you tell more about late talking being a sign or symptom of abuse?**

Late talkers are at higher risk of abuse because they tend to be isolated and are also unable to express themselves, thereby making them less apt to ask for assistance or report abuse. Late talking may also be a result of emotional abuse against a caregiver who is in a highly controlled relationship (i.e., domestic violence).

### **Q: Where should local practitioners look for funding to do a community pilot project?**

At a community level, agencies can have conversations with local foundations to stress that it's something they want dollars to be invested in and pursued; and trying to partner and leverage dollars by pooling resources through grants across sectors. Agencies may have professional development dollars that can be pooled for a community-wide effort. Through SAMHSA there are opportunities for larger grants that become available so it can be helpful to periodically check their grant listings on their website. (For more information, see [link](#)).

Showing every year that there is a goal can help with momentum and keeping it going. Breaking it down into manageable bites can be helpful, too.

There are also varying types of technical assistance available through this project, the Advancing Prevention Project, for counties that would like to target trauma for their Prevention Agenda goals. For more information you can contact Michele Calvo at [mcalvo@nyam.org](mailto:mcalvo@nyam.org) or 212-822-7245.

### **Q: How or where are ACEs instruments available?**

<http://www.cdc.gov/violenceprevention/cestudy/questionnaires.html>.

### **Q: What is being done to engage, mobilize and empower the community - leverage the community asset - to transform and by extension change the environment that contributes greatly to ACEs?**

First, we must address all aspects of the community to make sure they are engaged in the process. The principles of "trauma-informed" include collaboration and restoring power, so we must be sure to plan with the community and not for the community. Taking advantage of the initiatives that are going on can be effective. In Monroe County, there is a cross-section of community members including people who are not formally engaged with an organization but just representing their neighborhood or community. Making sure their voice is at the table is a critical piece. Whether you're working in a school setting or in an organization, parent and student voices should be involved in the planning process. Strategies around that include making sure people are educated, that all people involved have the same

information. In Monroe, we used training on trauma and trauma-informed communities and ACES in the community; for example, training in the library which is open to all community members.

**Q: How long does it take for a school to learn about this and evolve into a trauma informed school?**

School districts should make at least a three year commitment. The first year is really geared toward onboarding everyone; conducting the training, in what their role is, understanding strategies. In year two, you're moving towards strengthening your internal capacity in those new strategies. Year three is focusing on sustaining that. In the end, that external support can leave and the school is going to sustain those changes. We cannot expect a one-time training to change behavior and the environment, so the last year is critical to create an ongoing commitment.

**Q: Have there been efforts to incorporate non-cognitive skills and techniques into building trauma-informed schools and communities?**

Incorporating mindfulness (mindfulness techniques, teaching breathing) in schools is a budding area of research that is finding positive effects. Dr. Meeker has worked with several schools in incorporating these techniques that have seen very positive results. As an example, in one elementary school classroom, the teacher incorporated about five minutes of breathing and mindfulness exercises after children returned back to the classroom from lunch, which could be a difficult time for students who may feel energized and have difficulty focusing. She found that investing those five minutes had a huge payoff, both academically and in the students' ability to generalize that information to other situations where they might normally become dysregulated, especially for students with particular challenges. Having interventions that are less cognitively based and more focused on the mind and body can be crucial, especially for many students that cannot verbalize their feelings. Allowing students to move in the classroom can also be very helpful for students who are feeling dysregulated, or on the verge of dysregulation. Non-cognitive approaches are an essential part of the package of interventions that a school might implement.

There are some schools, particularly in New York City, that are starting to adopt some yoga, breathing and relaxation practices in their physical education classes and that has been proven to be very effective, not just in trauma but also in treating ADHD, autistic children, and regardless of any diagnosis it can help improve executive functioning. The idea here is really the mind-body connection. With yoga and classes in martial arts and dancing, there's a connection between what you're thinking and moving your body, and this connection has been proven to be very effective in helping children cope with trauma and stress, to be able to channel some of what they're feeling into something more positive.

Mind Up is a curriculum developed out of the Goldie Hawn Foundation and you can look at that for schools to adopt. (For more information on Mind Up see [link](#)).

**Screening, interventions, models**

**Q: What type of interventions can be offered to children with trauma history? What does this look like in the school system?**

There are several interventions and models designed specifically for school districts. Below are some examples:

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based, group and individual intervention. It is designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. CBITS has been used with students from 5th grade through 12th grade who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters. CBITS uses cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure). (See [link](#)).

The sanctuary model (a national model) is a framework in which an entire school adopts a practice, similar to PBIS (Positive Behavioral Interventions and Support). What it says is everyone from the bus driver to the principle to the kitchen staff, to teachers in all subject areas, are trauma informed through a training that everyone receives. The children also receive it within their school. One example of that would be the SELF model (Safety, Emotions, Loss, Future). Every child goes through an understanding of those four areas and identifies triggers for themselves, in the school, that they know would be where they need to ask for a break from the teacher. And a teacher also has a SELF card, where they know their emotional triggers and what makes them feel safe, as well as their goals (“Future”). (For more information on SELF, see [link](#)). That’s a very general description of one intervention within a whole model called Sanctuary, developed by Dr. Sandra Bloom. The model has been implemented internationally. In schools it is usually targeted toward children who have social emotional issues, but can also be used in the child welfare system, and in the general population of schools, to incorporate into a PBIS model, which is a pyramid model. (For more information on PBIS, see [link](#).) (For more information on the Sanctuary model, see [link](#)).

The RWJF model of wellness is a good example of a universal intervention that can be applied in a school setting, which can help you begin by identifying what resources you have, and then promoting those resources; promotion is a crucial component of prevention. (For more information, see [link](#).)

Two other resources for trauma sensitive school approaches include Helping Traumatized Children Learn (see [link](#)) and The Heart of Teaching and Learning (see [link](#)).

**Q: there was a lot of discussion about implementing in school districts. What about earlier at child care centers? Are there any models for that?**

The trauma-informed principles can be applied within that setting by providing the same type of education and training provided in schools for staff in that setting, and for parents as well. There has been some trauma-informed work with head start programs, called “Head Start Trauma Smart”, which could serve as a model. Head Start Trauma Smart is similar to the Sanctuary Model in that everyone gets trained in it. It helps everyone in the school realize that each of us has an ACE score, and that it’s something to pay attention to for your health, and it doesn’t necessarily mean for a mental health disorder. (For more information on Head Start Trauma Smart, see [link](#)). The younger a child, the more critical it is to engage the parents. The parent’s stress, distress, and ACES plays an even larger role in their ability to be present for their child, where they may get some triggering in parenting. The more support we can give parents, the better.

If you have a child who is showing some signs of development or intellectual disabilities that may be secondary to trauma, you can always refer them to your local early intervention program, which is a free

program in every county. You can address many issues connected to developmental, intellectual or learning disabilities, as well as find family resources, counseling and training, before the child goes to school. (See [link](#) for a listing of county contacts for early intervention programs).

**Q: Can you recommend Evidence Based Practice models for use with children & youth who have been exposed to trauma?**

There continues to be growing evidence around different trauma-informed treatment options. One example is trauma-informed CBT (cognitive behavioral therapy), often provided in a clinical setting. You can also often provide training in CBT techniques like relaxation to non-CBT staff such as nurses.

Healthy Steps is a national evidence-based model that focuses on the integration of early childhood mental health within pediatric primary care. Montefiore Medical Center in the Bronx introduced the model about 10 years ago and they now have it in every pediatric practice (21 serving over 300,000 families), in which there are universal screenings (everyone gets screened), and the parents' ACE score is done. This is used as an opportunity to provide education and resources to the family, including home visits and more parent support based on those scores. The model also includes numerous other screenings including maternal depression and screening for children from ages 0-5. It can be implemented in any practice and one advantage of the model is that the training is not limited to medical professionals; you can actually train any member of your clinic staff, and make adjustments for your practice as needed. (For more information on Healthy Steps, see [link](#)).

**Q: Any thoughts about using psychophysiological measures such as RSA (respiratory sinus arrhythmia) or HRV (heart rate variability), as a more refined indicator of trauma?**

HRV is used more as a tool for monitoring self-regulation than an indicator of trauma. It has not yet reached the level of sophistication needed to be considered an indicator of trauma in and of itself. It needs to be associated with history and other findings, but once seen, can be used to monitor response to therapy (but, not by itself).

**Q: Are there any screenings you would recommend?**

There are a number of screening tools that are available including the UCLA PTSD Index Trauma Screen, the Trauma Symptoms Checklist, the Child PTSD Symptoms Scale and the Child Stress Disorders Checklist. Some measures only assess exposure to trauma or symptoms of trauma while other assess for both. It is important that if a screen is implemented that a process is in place for timely review and then appropriate triage ranging from referral from more comprehensive assessment and treatment to making a child protective report.

**Q: How would you broach the subject of abuse or neglect with a caregiver?**

It is important to preserve the therapeutic relationship with the caregiver while emphasizing the provider's/physician's responsibility for the child's well-being. I usually approach this subject very carefully and sensitively:

1. Give assurance that your foremost concern is for the child's safety and well-being and that you value your relationship with the caregiver
2. Carefully review your findings in the history and physical exam

3. Carefully review your differential diagnoses, starting with the non-abuse/neglect related possibilities
4. When mentioning the possibility of abuse or neglect, start with asking the caregiver if s/he ever had any concerns of anyone maltreating the child
5. State the reasons why abuse/neglect is a consideration given the history, signs and symptoms.
6. Make sure to frequently ask if the caregiver has any questions.
7. Remind the caregiver that as a health care provider, you are mandated to report any suspected cases of abuse or neglect.
8. Reassure the caregiver that you will make every effort to see to it that the child is healthy and safe
9. Close the conversation by making yourself available to the caregiver for additional questions and concerns

Given the implications of any suspected abuse or neglect, any health care provider should be prepared to deal with the possibility of anger, aggression, retaliation, and other emotionally charged reactions from the caregiver. It may be necessary to have one other clinical staff person to be present. The key is honesty and sensitivity.

**Q: Is there any data on the use of social media and the effects it may have on developmental psychology?**

In regard to screen time, in the youth risk behavior survey, there are questions about total screen time for kids who are using five or more hours of technology on an average school day.

In a trauma-sensitive and trauma-informed lens, the focus should not be on what parents or young people shouldn't be doing, but what they can do. Instead of focusing on limiting exposure to social media, focus instead on increasing one-on-one and relationship time, which would hopefully decrease screen time, emphasizing the importance of relationships and trusting adults. In the early childhood world, we know that it's important to not use screen time as a way of managing or watching children, especially given that we know so much about the neuroscience and the importance of connection and relationship in intellectual and emotional development.