

Please stand by for realtime captions. >> We will be getting started in just a few minutes. >> Good morning. Welcome to the OUR Children safety call. A monthly meeting. People are calling in right now. Can you please mute your telephone? We will probably mute the line as well for everyone. As our guest speaker comes on to speak today. We are excited you are here. We will get started in a minute. If you joined the call and would like to introduce yourself, let us know you are here. >> Good morning. Thank you for joining us. We will wait just a minute or so. Harold and Libby, are you back?

This is Sarah. >> This is Janet. Harold, are you back this is Janet. We will get started in a moment. You for joining today. We can hear a lot of people have joined the meeting today. We are excited to have everyone here.

This is Harold. I am back.

Libby, are you back? >> This is Leslie in Marist -- in Minnesota.

Libby is back.

Good morning. This is Janet. We are pleased you could join us today. I am going to mute your lines except for our leaders. I will introduce everyone in a moment. >> Can you hear me?

Can you hear me?

Yes. Sarah?

This is Sarah.

Welcome everyone. We are so pleased to have you with us on our monthly call. OUR Children project from hands invoices has been happening for many years. We have three goals around the project which includes increasing awareness and belief of child safety and skills in that area. To increase collaboration and commitments from relevant organizations. And increasing support that we have to keep our kids safe. Our levels of work include awareness and understanding of child abuse and neglect. Observing, reporting and responding. Prevention and systems change. We have a strategic plan we have been working on for the last couple of years. We just want to thank all of you who are here today and thank you for your commitment and dedication as chapters to send representatives from hands invoices. -- Hands and voices. Harold who is our committee meeting -- leader who will introduce our guest speaker. >> Hello. This is Harold. Thank you for joining. We have had a number of remarkable individuals share with us over the last few years to help us increase our understanding and awareness and ability to protect our children. One topic we really have not discussed anywhere near the extent we need to, the response. How do we go about responding to children in our lives that have experienced trauma? Not just neglect or abuse, but having a parent or a friend being shot at school. Today we are pleased to have our guest speaker to talk about responding to childhood trauma. She is the founding Director of the Charleston, South Carolina Child advocacy Center. She is currently a clinical faculty member at the Department of psychiatry and behavioral science. She was a previous member of the Board of Directors for the national children's alliance in partnership with the national child traumatic stress network. I actually became aware of her because she was getting a webinar about how to incorporate trauma-informed practices into the educational planning of children. Since then through dialogue and reading the information she shared with me, I have come to understand and value her knowledge base. Not only in terms of trauma-informed practice but the system that has been designed to respond to kids that have experienced trauma. Be at the child advocacy centers that do the initial reviews and documentation to the larger professional network and children services. She is a remarkable wealth of information. I would like to turnover the presentation to Dr. Ralston. Why do I need to be trauma-informed? Thank you for sharing your talent with us today.

Thank you. My name is Libby and I am so excited and pleased to be able to share with a group of like-minded individuals who are concerned about children. Just a tiny bit of history, we have known that bad things happen to people. Bad things happen to children. Like abuse, bullying. Exposure to violence. Natural disasters. Death of a loved one. There are all kinds of things that children experience that can create trauma. We have always known these experiences also impact individuals differently. There is a normal response to these events, feeling overwhelmed, depressed, sad. Impacting our sleep and appetite. As time passes some people can't integrate these experiences and move forward. However, others are not. From a mental health perspective, which is my background, we did not really know how to respond to those who were not able to move forward. We have no evidence of what worked. We knew that sometimes they have long lifetime effects. We were not sure what the effects were. We did the best we could. We listened and reflected and often support. But we had no research or clinical practices that have been researched for their efficacy. We approach these individuals whether they were children or adults and provided them to get -- the best guidance. We do not have knowledge about effective interventions.

All of that has really changed. It has changed based on research. Some of that research was around returning veterans from war who had post traumatic stress disorder. And perhaps one of the most impactful research that has impacted our approach to these children and has provided us the research that we needed, is the ACE study. Why do we as individuals who have children or individuals who are professionals, why do we need to be trauma-informed?

I think there are two primary reasons. Because of the prevalence of the essentially dramatic events experienced by our kids and the children we work with, and the second, many professionals who work with our children and those parents don't know how to respond to the experience of potentially traumatic events. What is a potentially traumatic event? On the call last month there was a lot of information about ACE. A study by the Kaiser Permanente. It was a large sample and they were asked about adverse childhood experiences. I think there were over 18,000 subjects and they found the higher the number of ACE the higher the risk for later problems. Including social problems, health problems, academic problems, emotional problems, psychological problems, vocational problems. Including leading to early death.

You heard about these questions last month but many had to do with the things we have already talked about. They had to do with exposure to emotional abuse. Special to bullying within the family. These were mainly family-based events. Exposure to physical abuse, sexual abuse, emotional neglect, physical neglect, losing a parent to divorce or abandonment or death. Exposure to domestic violence within the family. Exposure to substance abuse in the family and mental illness and a parent being in prison. There are also a lot of other potentially traumatic events. Harold mentioned car accidents. Research suggests that is the most common potentially traumatic event that children experience.

We also know that significant illness, hospitalizations, exposure to hurricanes, fire, tornado, all of those kind of natural disasters can impact. Those ACEs, the impact of those may be that they disrupt brain development which leads to many problems including delay. It can impact social, emotional, cognitive development. It can lead to high-risk behaviors which leads to disease, disability and social problems. And could lead to early death. I think the statistic I read is that if you experience up to six ACEs, it has the potential of reducing your lifespan by up to 20 years.

If we know this, why do we need to be trauma-informed? We need to be trauma-informed to know what to do. What we as parents can do, what we as professionals can do. Research has informed and expanded our knowledge. We grew from looking at children, looking at adults and asking, what is wrong with you? And beginning to ask, what have you experienced? This is the definition of the trauma lens. One of the goals of the national traumatic stress network is to have people be trauma-informed. When they experience a child who was having difficulties, when they experience adult who is having difficulties, to begin not looking at the difficulties but

looking at the etiology are what may be the cause of those difficulties and to begin asking, what has this child or this person experienced that might have contributed to how they are acting now?

Trauma-informed is good. Engaging in trauma practice is more important. What would trauma practice look like? What should we do when we see a child or adult who is having social, emotional, psychological, academic, vocational or physical problems? One of the first things we can do is screen for potentially traumatic events. And what that means is, looking at a child who is presenting with a problem, asking what they have experienced and moving from that broad question that we may ask to specific questions that would be asked of the child or family. An example of this might be, a child who has been defined in school as hyperactive. Or having attention deficit disorder. What we know is the impact of trauma can lead to behaviors that would be consistent with a diagnosis of hyperactivity or attention deficit disorder. In that case, by screening the child, we would want to rule out that the issues for this child -- we want to rule out they are related to posttraumatic stress.

In post traumatic stress, those symptoms involve the child or individual being hypervigilant, that means being on alert at all times. Out of fear that what they experienced that was traumatic may happen again. Or they may be thinking about it and reexperiencing a traumatic event. Which means they look as though they are not paying attention in class. Or they may be avoiding something in the classroom by not paying attention. Because it reminds them of the abuse that they experienced.

It is really important that we use standardized questionnaires to ask the children and families about potentially traumatic events that they may have experienced.

As parents, that is not necessarily something you would do. And as parents we often think we know everything our child has experienced. But we don't necessarily. The reason it is important for us parents to know about screening for potentially traumatic events, is if our child comes in contact with other professionals who are working with them, teachers, mental health professionals, physicians, that we want them to understand the potential impact of trauma. And to do research to screen the child to find out if the child has experienced potentially traumatic events.

One of the barriers to that when a parent is working with a professional in the community, sometimes people just don't want to talk about these things. Especially if it relates to abuse. Especially if it relates to sexual abuse. As parents, to advocate for our children in terms of the best services possible, you need trauma-informed -- and if the professionals we are working with are not trauma-informed, we need to share this with them. To be sure they do the screening and that the screening is positive. If we find in fact that the child has experienced potentially traumatic events, the next step is to ensure that the professional does a standardized trauma assessment to learn what the impact of the trauma has been on the child.

As a mental health professional who has been in practice for years and years, we did not really know how to respond to kids. I worked much of my professional life with abuse victims, I knew that abuse was bad for kids and knew it impacted kids but did not really know specifically from research what to do. We now have that information and knowledge. Many professionals are not aware of the research, have not been trained in trauma practices. We as parents, need to ensure that the professionals we are working with, the professionals that are working with our child, that professional is using trauma practice.

Being trauma-informed is very important. But how do you act on that knowledge? As parents we act on that knowledge by ensuring that the professionals who are working with our child are trauma-informed and are using evidence-based practice.

Research has shown us the impact, the potential impact of trauma on our kids. Research has now provided us with many evidence-based trauma focused, mental health interventions, to help the child or the individual heal from the trauma that they have experience. And those evidence-based practices, as parents who have children who may have experienced trauma, as professionals who work with children and may have experienced trauma, we have the responsibility to advocate for those children in the best possible way. And to use evidence-based treatment. Let me give you an example. In the medical profession for years and years and years, their practice has been based on evidence of the efficacy of the treatments that they use. That is not been the case in mental health. We are a long ways in the mental health field from systematically using evidence-based practices. It is the responsibility of those who are trauma-informed to try to spread that and to require that the treatment that our kids get is evidence-based.

For example, if your child had a broken leg and you took that child to a physician and the physician told you what treatment they were going to use and that treatment -- you may ask what is the evidence of the effectiveness of the treatment? If a physician said, there are more effective treatments but they are costly and I have not purchased the equipment or have not gotten the training to provide that treatment. But this treatment seems to work well. Or I have had use this treatment for years and have not been any complaints. Would you have that physician treat your child? I don't think so.

But that is what has happened for years in the mental health field. As parents and professionals who are trauma-informed, you really have a responsibility to ask those questions of the provider. I have worked with many mental health providers over the years and since the availability of evidence-based treatment they would say, I have been to the kids sexually abuse for years and I have never had any complaints. People really like me. That is not good enough. We now have trauma assessments that tell us the impact that the trauma has had on the child, identifies the symptoms. And that guides the treatment would provide. So the treatment is informed by the trauma assessment and the treatment needs to be evidence-based.

Let me give you a few examples of characteristics of evidence-based treatment. For trauma involved it is skill building, competency building. It is not just listening. It is teaching individuals how to manage, how to cope, how to be able to move forward, how to integrate this experience not have this experience defined them for the rest of their lives. Evidence-based treatments usually have components and they are delivered in a systematic kind of way. Time-limited. They are based on assessing success, defining success and evaluating success through the years of the trauma specific assessment. And they also involve treatment for the child as well as the caregiver. Those are some of the characteristics of evidence-based treatment. Those are important for parents and other professionals to know. I encourage any professionals who have not been specifically trained in evidence-based treatment to go out and get that training so you deliver that treatment that is effective to the clients you are serving. I encourage any of you who are parents who are kneading this kind of treatment for your child or concern about your child, that you seek out mental health professionals who have the training and use evidence-based treatment and you are able to track the progress of your child. And able to clearly define for you when the child has successfully completed treatment.

Time is running. Do we need to take questions?

Libby , this is Harold . We have more time to share information before questions. The more examples you can give of what is trauma-informed practice both at school and in the home, we will open for questions and about another five or 10 minutes.

Okay. The evidence-based treatments I am aware of -- I encourage you to look at the child welfare clearinghouse to get a more complete listing of evidence-based treatments for children who have been physically abused within a family who are younger than six, parent-child interaction therapy that involves focusing on teaching the parents how to ignore inappropriate

behaviors and how to respond to appropriate behaviors. And teaching behavior management that is not abusive. Very often when very young children are physically abused, it is because a parent does not have knowledge and skills and behavior management. And they lash out out of frustration and harm the child. This teaches parents and it involves working specifically in skill building with the parents and with her child. For older children, around physical abuse, there is an intervention called alternatives for families. Alternatives for families cognitive behavior therapy. It is for families with children five years old and up. It involves the child and the parents. And it is a lengthier treatment. But the evidence of its effectiveness is very strong. For children who have experienced sexual abuse, there is a treatment called trauma focused behavior therapy. It is probably the gold standard in the trauma treatment in that it has the most research behind it in terms of efficacy. It is probably the evidence-based treatment that has provided the most training across the country. Certainly child advocacy centers utilize that and have training. It is a 12-20 week treatment that involves the child and caregiver. It is skill building and competency building also. There is a trauma-informed evidence-based treatment that is a group treatment that many schools have implemented. Once they found a child has had potentially traumatic experience and is showing symptoms, this group format has been shown to be very effective within the school setting. We certainly know that some schools have mental health professionals from their local mental health centers stationed at the schools. We also know that many have social workers assigned to the schools. It is really critical that these individuals have specific training in evidence based treatment.

We know a lot of kids who have IEP's or 504 may have symptoms of trauma. When that is the case it is really critical that the IEP or 504 is trauma-informed. As that is being developed that a child be screened for trauma and have a promised specific assessment so that the interventions are individualized, that child can get to the basis of the problems that are being presented. I cannot overstate how impactful and how common trauma symptoms are in the children that we see you are having problems in school or having social problems in school and in the lives. You are having emotional problems you have been diagnosed with other kinds of symptoms. If you just think about a child who has been diagnosed as hyperactive or one of those behavioral diagnoses, we know the most common treatment for those is medication. If what you are dealing with is really a child not with hyperactivity or with ADHD, but a child with trauma, you are making those symptoms worse. You are giving them medication that will exacerbate, make their problems with their presentation much worse. It is really critical that we do assessment so that we know what it is we are treating. When we develop the treatment plan, whether a mental health treatment plan for an intervention plan within the school, that that plan based on the assessment and it is delivered with an evidence-based intervention or treatment.

Thank you very much. Janet, would you unmute the microphones. >> We have talked about kids with special needs and we talked about the child advocacy scenarios in the national area. We agreed we are aware of the kids with disabilities as being needful of social services. Generally speaking it is difficult to find professionals in the CAC, any -- in the trauma professions that are well-versed in working with kids with disabilities. Can you talk briefly about that?

I can respond to that from a personal, professional perspective. I am well-informed about trauma and about interventions for trauma. And other mental health issues. I am not experienced in dealing with children with disabilities. I say that and I know that sometimes children with disabilities, the disabilities may be related to trauma or exacerbated by trauma. I also know just from common sense that children with disabilities are more at risk for potentially traumatic events. And maybe less prepared in terms of resiliency to deal with those. That is something we did not really talk about. Trauma impacts individuals differently and those people who have high resiliency are often more able to manage. Some children with disabilities may be very resilient. They have had to be. What I have become aware of thanks to Harold, the world I spent the last 25 professional years being involved in are not at all prepared to deal with children with disabilities. A child who has hearing difficulties or hard of hearing were to come in because there was an allegation that the child had been the victim of some type of abuse, we were not skilled in interviewing the child. We were well trained in how to interview children but

not in how to interview children with disabilities. In speaking with Harold, it has become really clear to me that we have to do crosstraining. We talk a lot about getting out of our silos and crosstraining. That is something that has not happened to my knowledge either through the national Child traumatic stress network or through the national children's alliance. I think it is critical that we do that. That we reach out to people like you all to help train us and our staff across the country. There are over 800 child IBC centers across the country. I have no doubt some have some expertise in this area. I know there are not policies at the national level. There are not standards at the national level regarding working with children with disabilities. I think that is radical.

Before I open the call for questions, I have been working in the field of education since 1971. And from 1980 as a professor training people to become teachers of the deaf. I do not recall any workshop or conference that I attended from 1971 until 2000 trauma-informed processes were talked about. But understanding the cause for the behaviors and using trauma-informed practice was never the case. I will tell you that the Council for children, that is one of the challenges we are putting forth to include that in their effort to understand the treatment of our kids. As a general rule, with very few exceptions for special ed, trauma-informed practice is helpful in working with kids. We have some people on the telephone. Would anyone care to ask Dr. Ralston a question?

This is Kristin from Illinois. I do have a question. Thank you for your presentation. I wondered as a parent of a child who is deaf and hard of hearing and also a professional who works with families, I wondered if you had any resources, whether a website or maybe a book or audio materials that you would recommend that we could use with our families and provide to families that we work with so we can make them aware of this.

I am aware of a number of resources. I think that we provided the website for the national Child traumatic stress network. I will tell you that they have an unbelievable number of resources for multiple issues related to child trauma. And they are excellent resources. I would encourage that you look at that. I am also going to share -- I will send it to Harold and maybe you can be shared. I think one of the things we did not talk about today in terms of parents, what our role and responsibility is in terms of advocating for the safety of our children from various types of abuse. That is probably another topic to cover. I can send it to Harold and that can be shared. There are also wonderful resources through the child welfare clearinghouse. And resources available to the national Child -- children's alliance. If you live in a community that has a child advocacy center, reaching out to them and finding out what they are doing regarding trauma. That is one of the required standards for accreditation. That children advocacy centers provide trauma screening, trauma assessment and evidence-based trauma focused treatment.

Thank you. I appreciate that.

I will send a text that Dr. Ralston sent earlier. It is designed for educators but I found it to be particularly helpful. It is available online for free as another resource. Any other questions?

This is Candace from Minnesota. Thank you for your presentation. Most of us probably on this call our parents who are parent practitioners. We provide support to families who are just finding out about their child's hearing loss. I wonder if there are tips you may offer to practitioners like ourselves may experience families who have had trauma, the parents had trauma or realize the child has been experiencing trauma. Other tips you can pass on about establishing trust, providing support that we as practitioners should know.

I think one of the things that is helpful is as you are working to engage a family or a child, to share the fact that you are trauma-informed and to share potential information. As you do that with families to help them through your verbal sharing of information about the potential impact of trauma, to help them identify what they are expressing with their own child or what they experienced in their own life. And to encourage the trauma specific assessment and treatment.

Do I know of people who are able to do a trauma assessment with a deaf or hard of hearing client? No. I don't. That is one of the issues that we need to consider. How do you deliver this treatment to families who experience deafness or hard of hearing? These are issues that we will have to address. In the meantime I think engaging the family by helping them know you are trauma-informed, helping them be trauma-informed, I think that when you share this information and they begin to think what is happening with my child is the result of this experience and to know there is treatment and intervention, it helps to normalize that for the child or the family. And helps them engage with you in looking for interventions to help with the healing.

Dr. Ralston, a question came through. She is the leader for a project that is a group of people that are trying to find children's literacy and books that parents can read to her with their children to help them become informed and safe and self actualize. Do you know of any children literature books dealing with this topic of trauma that parents could be reading with their kids? It would not scare the kids but help give them a sense of not feeling alone or ways to express feelings.

I know there are such books. I have look at them. I don't have the titles right now. I would be more than happy to send you that information that you could disseminate.

That would be very helpful. The group has reviewed one book on this topic it is called Alex and the scary things by Melissa Moses. It is a great text. I found it in Edinburgh when I was there. It is about a kid who experience something but it does not say what it was. It gives very specific trauma-informed practices that work for this kid -- this child. Alex and the scary things by Melissa Moses. It is one I would recommend.

We have time for one or two more questions.

This is Janet from Boulder Colorado. Thank you. This was so interesting. I don't think I ever heard it more clearly described what evidence-based treatment is when you described it as structured, time-limited, has a definition of success. Thinking about evidence-based practices for supporting families, I notice you sent us the NTSB or whatever. Under the parent caregiver section there is trauma treatment and it has a list the kind of describes what parents should look for in a mental health provider. Like experience working with kids. Do you have any other suggestions for us in terms of if we are supporting a family or we as parents need mental health providers in this area? What would your advice be in terms of what kind of questions to ask to make sure we get the right kind of provider who is using evidence-based practices?

My experience would be or my recommendation would be to ask them. What is your experience in dealing with trauma? How do you screen? What assessment tool do you use? And what is your training in evidence-based treatments? And actually I would ask about the length of training. I will tell you in most evidence-based treatments, training programs last about one year. They involve learning sessions. Usually two learning sessions and then consultation calls. I would want to know if the mental health practitioner has had that specific kind of training. I would want to know what kind of supervision they receive. I would want to know how they measure success. I would want to know how they monitor progress. The answers to those kinds of questions -- or how they determine what treatment the child needs. You want to hear that they use trauma specific assessment tools. To identify treatment needs. And you want to hear they use the same tools to measure progress. On the assessment tools they identify symptoms and halfway through treatment you want to know that the symptoms are reducing. And success is at the end of treatment. That those symptoms are significantly reduced. I would want to ask those specific kinds of questions of mental health practitioners. I will tell you that if you -- if they are offended by you doing that, look for someone else.

Thank you so much.

One must question, if not, we may do a summary and talk about next week as time permits.

This is Sarah. I missed the name of the assessment tool that you recommended might be used in school situations. Could you show that again?

The assessment tool I would use any standardized assessment tool. There is a long list of assessment tools. If you look up trauma specific assessment, you can find lists. What I was talking about was an intervention called [Indiscernible]. You can on about that. It is a group treatment modeled that is used in schools. Become on about that if you go to the national child dramatic stress network and look it up.

Thank you. >>
Janet, do you want to do a summary?

Thank you Dr. Ralston that was so interesting. For those of you that have not had a chance to look at the resources sent ahead of time, look at those. They are absolutely fantastic. Thank you, Dr. Ralston .

I had asked Harold to share a conference he was at this past weekend. Our Michigan chapter of Hands & Voices put on a conference . We are actually hoping it can be used as a model or an idea for others. I will turn it over to Harold to share with the group.

It is good to be able to share additional good news. It was a Michigan chapter of Hands & Voices . It was a conference called family matters 2018. They had a huge range of activities for kids as well as for parents. They had day-to-day safety in case of fire up to stranger danger. And parents were given information about OUR Children's Project project and helping parents be effective with each other and children and risk factors. And focusing upon success. What other strategies to help our kids be successful? I would suggest any of you considering a conference or a daylong event for your chapter to contact Jamal Frost at the Michigan Hands & Voices and talk with her about this remarkable conference she had about safety both the children as well as for adults. It was well organized, well attended and is one I think is a model for the rest of the chapters to consider emulating.

Today, I have a quote that I would like to share. It is from Danielle burdock. She is the author of a book called emerging with wings. Trauma is personal. It does not disappear if it is not validated. When it is ignored or individuals are invalidated the silent screams continues internally only to be heard by the one held captive. When someone enters the pain and here's the scream, healing can begin. I think that today in terms of our presentation on trauma-informed practice , it means listening to the children. Understanding that they have a problematic behavior but there probably was a worse experience that may be causing that behavior. Giving them the opportunity to share with us what were the trauma experiences is one of the first steps in them healing. If we ignore it and don't give them an opportunity to share the experience, the adverse child experiences, the experience will haunt them and possibly hurt them throughout their entire life. Janet, that is a brief description of the Michigan Hands & Voices conference this past week . And my quote. I can turn it back to you for closing.

Thank you. Thank you all of you who have joined today. We have two more meetings in April and May before we take our summer break. We are working on our final agendas for those meetings. We hope you will join us. We believe in the power of spreading the word around this. As you are representing your chapter on this call today, we ask you take the information you have learned and share it with your other chapter leaders and families. I often think about our very first starting point in this project many years ago. To just have the conversation. To begin to talk to others about our children's safety and success. I loved what Dr. Ralston said when we asked what we can do as parents , be open to talking to others and say we are trauma-informed. We have resources that can help. To remember that at the very baseline, having conversations with others have a lot of power. Thank you for joining us today. We look forward to seeing you again. Always on the second Tuesday morning of the month at 12:00 eastern

time. You will receive more information as we get closer to our next agenda. Thank you for joining and we hope you have a wonderful day. Thank you.

Thank you Dr. Ralston.

Thank you. >>

Goodbye. >>

[Event concluded]