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A QUARTERLY PUBLICATION OF THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

## Oklahoma: SHAREing the Journey Toward a Trauma-Informed State

A series of record-breaking tornadoes and storms struck Oklahoma in May, 2013, in the middle of the first year of the “Be-Me” initiative at the Oklahoma Department of Mental Health and Substance Abuse Services, Oklahoma City. As a result, the department’s plan for establishing statewide trauma-informed and trauma-specific services didn’t unfold exactly as Gwendolyn Downing had envisioned. Downing, the department’s Manager of Hope and Resilience, was dispatched as part of a team to provide services for the disaster areas – most notably, the city of Moore, OK, where there were 24 fatalities including 7 children at an elementary school. Downing was dealing simultaneously with the DSM-5-related changes to service contracts. She called her grant project officer, Cicely Burrows-McElwain, and said, “My quarterly goals may need a bit of tweaking!”

Despite the necessary diversion to disaster response, the Department accomplished all of its projected goals in the first year of the grant, Downing reported. According to members now involved in the Be-Me initiative, that success can be attributed to the years of collaborative work that took place before the grant was awarded. (Be-Me is not an acronym but rather an echo from the Seabiscuit racehorse story, often used in department trainings to analogize children’s resilience and ability to “be me.”)



**L to R: Katie Bottoms, Coordinator of Child Trauma and Resilience, Gwendolyn Downing, Manager of Hope and Resilience, and Pamela Toohey, Coordinator of Child Trauma and Resilience, all of the Oklahoma Department of Mental Health and Substance Abuse Services.**

### Built Layer by Layer

The NCTSN Category III grant for Oklahoma’s Be-Me initiative outlines an ambitious agenda to establish sustainable trauma-informed behavioral health services throughout the state. The goals include training staff members at all 14 Community Mental Health Centers to

understand the impact of trauma, not just on children and families served by the system but on providers working in the system; and to implement statewide trauma screening and assessment and trauma-specific treatment for children and families.

Since the 2003 NCTSN funding cycle, when Downing first encountered trauma-informed mental health services, the building blocks have been put in place to spread services throughout Oklahoma. At that time, Downing worked for a state children’s hospital, which, along with Family & Children’s Services in Tulsa (a Category III grantee then and now) and a domestic violence shelter, had the privilege, she said, of participating in one of the first Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) Learning Collaboratives.

In 2006, the Oklahoma State Legislature appropriated funds for piloting child-trauma training at selected community mental health agencies and domestic violence

>>> *cont’d on pg. 3*

## Former Foster Youth Makes Her Voice Count

While in foster placement as a teen, Chaney Stokes encountered many obstacles as she struggled to come into her own – and she didn’t mince words when it came to expressing her frustrations to the people around her. “I wanted to feel like I had control over my own life,” Stokes recalled.

These days, Stokes facilitates NCTSN’s *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents* (also known as the Resource Parent Curriculum) and conducts outreach at the Center for Child and Family Health (CCFH) in Durham, NC. Last year she became the Family-Partner Coordinator at the center, after having worked there as a part-time co-facilitator since 2011. Now 27 years old, and a wife and mother, Stokes credits her personal growth and self-discovery to a combination of her faith, support from key adult mentors, and involvement with a nonprofit foster youth advocacy organization.



**Chaney Stokes supervises a youth group as part of her duties as a mentor with Strong Able Youth Speaking Out (SaySo).**

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*This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.*

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## Making Her Voice Count *cont'd from pg. 1*

Kelly Sullivan, PhD, is the Mental Health Services Director for CCFH, which is an NCTSN Category III site. She said she values the insightful connections Stokes has made about the experiences of her past and how they relate to her now. “All of those connections are exactly what we want parents to be able to understand,” Sullivan said. “It’s as if [parents in the workshops] are getting to talk to a more reasonable and mature version of the child they have at home, that other person that they hope one day their child will be.”



**Chaney Stokes, Family-Partner Coordinator, Center for Child and Family Health in Durham, NC.**

### **Journey to Acceptance**

Stokes’s journey to her current professional life has been productive though fraught with difficulty. As a 15-year-old in foster care, she reflected, “I felt guilt and shame and could not understand why I was the only one of my siblings permanently removed from my home.” Although her foster parents did not mistreat her, there was a mismatch between their expectations and her

choices, Stokes said. “They were a little older and expected their foster children to respond and react the way their biological children had.”

Stokes often voiced her frustrations to her social worker, who told her about a foster youth advocacy organization in North Carolina known as SaySo, short for Strong Able Youth Speaking Out. Stokes attended an event hosted by SaySo and immediately connected with its mission of involving youth living in substitute care in advocacy and policy development issues. Nancy A. Carter, ACSW, MSW, Executive Director, Independent Living Resources, Inc., in Durham, and founding director of SaySo, recalled meeting “a very outspoken” Stokes, who was struggling with common issues faced by teenagers in foster care. “They want independence, but it’s hard to get that in foster care,” Carter noted. The goal of SaySo was and is to help youth channel those feelings and to energize them to create solutions, and not just complain about their situations. That was the message that Stokes “latched onto,” Carter said.

Stokes also found acceptance from the organization and its members. “I was never judged for my mistakes,” she said, “even though I was making decisions that were not always the brightest.” (She became pregnant at age 17). “SaySo was like a family to me – they provided me with structure and I felt like I belonged to someone.” Involvement with SaySo, she said, “formed the foundation of where I am today.”

Soon after joining SaySo, Stokes was elected to the Youth Board of Directors, comprised solely of youth members and the only administrative voting body in the organization. She also helped organize a local chapter of SaySo in Onslow, her home county in North Carolina. She served on the Board until

2004. By then the mother of an infant son, Stokes took time to focus on being a parent and finishing high school.

### **More Doors Open**

In 2008, Stokes returned for SaySo’s 10-year reunion and celebration, and she reconnected with Carter and other members. She ran for the Board of Directors again; and subsequently became one of the first alumni youth to be hired as a SaySo Regional Assistant. The position offered compensation and the opportunity to expand her job skills. The only drawback, she later realized, was that as a SaySo staff member, she would have to resign her Board position. Carter recalled that it was the first time Stokes could not vote, “and it drove her nuts because she wanted her voice to count. That’s the epitome of Chaney.”

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***“I had opportunities to share my story, and I now feel confident enough to know that I am more than just my story.”***

*CHANEY STOKES, Family-Partner Coordinator,  
Center for Child and Family Health in Durham, NC*

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But Stokes soon had another opportunity to make her voice count: Carter recommended her to CCFH as a member of its team for the Breakthrough Series Collaborative on using trauma-informed child welfare practice to improve the stability of foster-care placements. Carter noted that Stokes had gone through the Helping Youth Reach Self-Sufficiency training to become a mentor, and that the CCFH opportunity fit nicely with that effort. Stokes was willing, but she was also feeling the pressure of working with a team of clinicians. “I felt like I had to put my ‘A game’ on,” she said, “because I was there representing so many young people who weren’t able to express their voice the way they wanted to.”

### **Reciprocal Growth**

Today, Stokes revels in her career direction and being a parent and (since 2009) a wife. She credits the NCTSN and CCFH for helping her find her voice. “I had the support of professionals who were willing to listen and hear my experience even if I wasn’t all put together in the beginning,” she said. “I had opportunities to share my story, and I now feel confident enough to know that I am more than just my story. I can be, on many different levels, an asset to the partnership.”

Hiring Stokes as Family-Partner Coordinator is a new venture for CCFH, Sullivan said. The arrangement is a testament to Stokes’s personal and professional growth, but also represents a new direction for CCFH, toward including families and youth as collaborators and partners rather than simply listening to their stories. “This is new for us, to work with people with lived experience,” Sullivan said. “Chaney has helped us pave this new path.” ■

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## Oklahoma: SHAREing the Journey *cont'd from pg. 1*

programs contracted with the Department of Mental Health and Substance Abuse Services. The department partnered with the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center, recalled Susan R. Schmidt, PhD, Associate Professor, to provide training and consultation on trauma assessment and TF-CBT to mental health providers at selected agencies. Downing, who had by then transferred to the department's central office, supervised the pilot projects. In Schmidt's view, Oklahoma's trauma training initiative has "grown from seedlings, which has helped us be attentive from the very beginning to growing in a way that is manageable and sustainable."

### Facilitating the Shift

When it secured its NCTSN grant in 2012, the department was already in the process of making trauma-specific services mandatory at its Community Mental Health Centers. However, not all of the community agencies had the same level of resources. A majority of Oklahoma's 77 counties are rural; often, that meant that the ability to provide trauma-specific services was restricted to the existing workforce. This fact, along with turnover and limited funding for initial training and ongoing sustainability, highlighted the vital importance of trauma-informed training for all staff members. The goal, Downing said, was to introduce trauma-informed services into the workplace "without making it harder on people."

To better meet the need for basic trauma-informed training at all levels, in multiple centers and systems, the department has been working on a new Web site called SHARE: Strengthening Hope and Resilience Everyday (<http://www.ok.gov/odmhsas/SHARE.html>). The site went live on October 1, 2014, and will provide resources and a place to register for a free three-hour training on trauma-informed core principles. Trainings are open not just to the behavioral health system but to partner child-serving systems like child welfare, juvenile justice, children's courts, and advocates. Free CEUs will be provided as needed.

The University of Oklahoma trainers have also improved accessibility by using teleconferencing and other remote check-ins with their training sites. Beverly W. Funderburk, PhD, Associate Professor of Research in the Department of Developmental/Behavioral Pediatrics, and a trainer in Parent-Child Interaction Therapy, noted that her department has also had a contract for years with the Oklahoma Department of Mental Health and Substance Abuse Services. "We have worked for stability of our model," Funderburk said, "by training Level 1 trainers who can then serve as onsite trainers and supervisors when there is turnover, thus avoiding the need for the staff member to travel offsite for their training." The university has also developed a Web site ([www.oklahomatfcbt.org](http://www.oklahomatfcbt.org)) where families, providers, and professionals can find out more about TF-CBT services and upcoming trainings in the state.

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***"I think we are still climbing in terms of trauma-informed services in our state, which is wonderful."***

*CHRISTINE MARSH, LCSW, Program Manager and Director of Child Abuse and Trauma Services, Family & Children's Services, Tulsa*

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### Bringing in Network Talent

In the second year of the Be-Me initiative, Downing and Katie Bottoms, Coordinator of Child Trauma and Resilience, were joined by Pamela Toohey, whom Network members will recognize as a noted speaker and who has worked as a consultant with the Chadwick Center for Children and Families in San Diego, CA. Two other leaders – Christine Marsh, LCSW, Program Manager and Director of Child Abuse and Trauma Services, Family & Children's Services in Tulsa, and Roy Van Tassel, MS, LPC, who is currently Director of Trauma and Evidence-Based Intervention at Cenpatico, in Austin, TX – have been key collaborators since the initial 2003 grant cycle. Van Tassel continues to train and consult in Oklahoma. Marsh, having been involved in trauma care for more than 10 years, said, "I constantly wonder whether we have hit a plateau [in our roll-out of trauma-informed services], but I think we are still climbing in terms of trauma-informed services in our state, which is wonderful."



### Future Needs

By the fourth year of the Be-Me initiative, Oklahoma's goal is to have in place the necessary structure for sustainable trauma-informed and trauma-specific services. Downing said she also wants to address the realities of resource-challenged public and rural mental health centers. She is pushing to include training of paraprofessionals in the mix. If Downing's enthusiasm and drive are any indication, that goal should be well within reach. "Her center is really the glue that is keeping this momentum going," remarked Christine Siegfried, MS, NCTSN staff liaison. ■

## NCTSN Affiliates: On Sustaining the Network Mission

In 2013, the Network's 112 Affiliate members, comprised of 45 organizations and 67 individuals, served 92,000 children who had experienced trauma. That service demonstrates the commitment of the Affiliates to the NCTSN mission, because they deliver these services without current NCTSN funding. The Affiliate members "truly believe in the mission and the vision of the Network," said Kimberly L. Blackshear, BS, who is Program Coordinator, Site Integration and Collaboration, and the Affiliate Program Contact at the National Center for Child Traumatic Stress at Duke University in Durham, NC.

"The Affiliate program is the most unique aspect of our Network," Blackshear said. The program has steadily grown since its inception in 2005 (see timeline pg. 5). Affiliates can avail themselves of various supports to facilitate their Network involvement, from inclusion and leadership roles in NCTSN Collaborative Groups, to free printing services for mission-related work, to liaison support in navigating the Network.

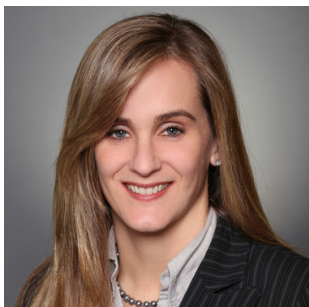
Below we feature snapshots of three Affiliate organizations that have found creative ways to support active programs and services initiated during former funding cycles, and to thus sustain the momentum of the trauma-informed agenda.

### **Jewish Board of Family and Children's Services (JBFCs), Center for Trauma Program Innovation, New York, NY**

The Jewish Board of Family and Children's Services has more than a century of experience and currently serves more than 30,000 individuals each year – adults, children, and families from low-income and racially diverse neighborhoods who have



**Paula G. Panzer, MD, Chief of  
Clinical and Medical Services at  
JBFCs.**



**Christina Grosso, LCAT, Director  
of Trauma Services and Training,  
JBFCs.**

been exposed to interpersonal and community violence. In 1998, the agency established the Center for Trauma Program Innovation to support the dissemination of trauma-informed care and trauma-specific services; in 2009 this center was integrated into the Martha K. Selig Educational Institute, the decades-old training program at JBFCs. Paula G. Panzer, MD, Chief of Clinical and Medical Services at JBFCs, noted that the center builds capacity to provide best practices in treating trauma and field-testing trauma services. An example of the latter occurred during the second of the center's two NCTSN funding periods (2002-2005; 2005-2009). Christina Grosso, LCAT, Director of Trauma Services and Training, worked closely with Judith Cohen, MD, to implement one of the first TF-CBT residential treatment models using primary

caregivers. JBFCs staff also collaborated with Sandra Bloom, MD, and other co-creators of the Sanctuary® Model at the Andrus Children's Center in Yonkers, to adapt the model for adolescents in residential treatment settings.

"Sustainability has been challenging for us in this fiscal climate," Grosso said, "and we have relied on the expertise gained through our involvement with the NCTSN in implementing and sustaining practice in community settings. We have been able to expand the Sanctuary model to five more programs and increase our evidence-based practice to include interventions such as Life Skills/Life Story, TF-CBT, SPARCS [Structured Psychotherapy for Adolescents Responding to Chronic Stress], and Psychological First Aid in 16 programs system wide, with over 450 clinicians trained."

Panzer observed that in the six years since funding ended for the Center for Trauma Program Innovation, "We've done a lot of crisis and post-disaster work, serving over 35 community programs and reaching more than 15,000 individuals. We're trying to ensure sustainability, so we have spent a lot of time trying to figure out what sticks and what is realistic in a public practice setting."

Panzer and Grosso agreed that Network involvement still yields valuable collaborations. "As a large community-based behavioral health organization with a training institute," Panzer said, "we do not have the same capacity to carry out research that academic centers do. However, the Category II sites benefit from our ability to implement and field-test programs." For example, in 2012, Grosso contributed a chapter on TF-CBT for youth with developmental disabilities to Cohen's latest book on TF-CBT adaptations in community settings; the chapter was based on Grosso's trauma work with children in residential and day treatment services at JBFCs. In Network roles, Grosso and her team are active with Affiliate program conference calls and in Collaborative Groups on child welfare, child sexual abuse, and grief in schools. "We try to sustain both the camaraderie and the networking that we have so loved with the NCTSN," she said.

### **Chaddock Trauma Initiative of West Central Illinois, Quincy, IL**

Located near the Iowa-Illinois-Missouri border, Chaddock daily serves 90 students from the tri-state area who attend the therapeutic day program. The 32-acre campus also houses a residential facility and a specialized Developmental Trauma and Attachment Program, which serves children from ages 8 to 16. Many of these children are adoptees from the foster care system or overseas orphanages who experienced extreme abuse, neglect, or other trauma in their early years.

Founded in 1853, Chaddock maintains an expansive national as well as international reach, said Angel Knoverek, PhD, LCPC, ACS, Director of Clinical Services at Chaddock. Children and families from 27 different states, one tribal nation, and 17 countries have benefitted from Chaddock's services. During its NCTSN funding period (2008-2012), Chaddock's

**>>> cont'd on pg. 5**

## Affiliates Sustain Network Mission *cont'd from pg. 4*



**Front row, L to R: Kelly Green, Clinical Support Manager; Jerry Douglas, Director of Education; Debbie Reed, President/CEO; Molly Bainter, Associate Director-Clinical Services; ♦ Back row, L to R: Tony Vincent, Associate Director-Admissions; Kathy Nelson, Associate Director-Clinical Services; Michelle Robison, Associate Director-Clinical Services; Ryan Brown, Associate Director-Residential Services; Angel Knoverek PhD, Director of Clinical Services.**

Trauma Initiative project focused not only on treating child traumatic stress but providing training for parents, foster parents, educators, and other professionals through The Knowledge Center at Chadlock. Knoverek is an endorsed trainer for SPARCS, and the NCTSN funding enabled the center to disseminate this model in school settings, collaborating with school counselors, social workers, and psychologists. Although the NCTSN funding is “fabulous,” Knoverek said, she pointed out that even more valuable are “the connections and relationships that support the mission of the Network.” As a result of these relationships, Knoverek serves as a co-faculty member for a SPARCS Learning Collaborative in North Carolina; organized an Illinois statewide SPARCS Learning Community forum; and recently conducted a Psychological First Aid training for the Lake County (IL) Health Department, a current Category III site.

Regarding Chadlock’s Affiliate membership, Knoverek said, “Continuing involvement takes leadership buy-in, and I am very fortunate to be at an agency that, despite no NCTSN funding, is still prioritizing our ability to retain involvement in the Network as much as we possibly can.”

### **Aurora Mental Health Center, Aurora, CO**

By the time Kathie Snell, MA, LPC, Deputy Director Child and Family Services, joined Aurora Mental Health Center, the agency was already involved with the Network’s Affiliate program. In fact, Aurora was one of the initial cohort of agencies in the Network’s first funding cycle (2001-2005), and became a charter member of the Affiliate program at its inception.

Attending her first All Network Conference in 2007, Snell was not sure what to expect. She said she quickly found that other Network members were generous in sharing their expertise and experiences, whether or not an agency was currently funded. “We get all of the new materials that are created and we can then start dispersing them in our agencies on a regular

basis,” Snell remarked. “I think it is unusual to find a national group of people who support one another that way.” Snell has been an integral participant, with two colleagues from the Arapahoe County Department of Human Services, in the NCTSN Child Welfare Breakthrough Series Collaborative (see IMPACT Spring 2014). She and colleagues at Aurora Mental Health also joined a Parent-Child Interaction Therapy Learning Collaborative, led by the University of California at Davis and funded by SAMHSA, which featured telemedicine training of key staff members. The center’s Early Childhood Program manager participates with the Network’s Early Childhood Committee; and their manager for the Intercept



**Kathie Snell, MA, LPC, Deputy Director Child and Family Services, Aurora Mental Health Center.**

program (which serves children with developmental disabilities and mental illness) is now working on the initiative to develop the *Intellectual and Developmental Disabilities Trauma Toolkit*. “Our team has been able to adapt some of the evidence-based trauma interventions for this group and to share some of that work,” Snell said.

Blackshear said she visited the Aurora site last August and noted that the center is currently implementing six evidence-based practices, and has been able to support and retain staff members over the long term. Snell said that Aurora’s Executive Director and CEO Randy Stith, PhD, “supports our teams and staff members, providing time and resources, so that we can continue to offer excellent trauma-informed services and programs and be successful in our community partnerships.” Continuing involvement with the Network is more of a time issue than a funding issue, she added. “The bottom line is that we feel there is so much to gain that it’s worth the investment of time.” ■

### **Timeline of the NCTSN Affiliate Program**

- 2005** Initial discussions around “Alumni program” begin after first funding cohort ends
- 2006** First roster of affiliate organizations formed; first affiliate meetings take place
- 2007** Alumni program renamed Affiliate program; individual Affiliates invited to join program; official Affiliate Charter formulated; NCTSN Steering Committee creates two slots for Affiliate members
- 2009** Affiliate Advisory Group forms; two additional Steering Committee slots created for Affiliates
- 2011** First SAMHSA-funded Affiliate-only national meeting convenes in Baltimore, MD

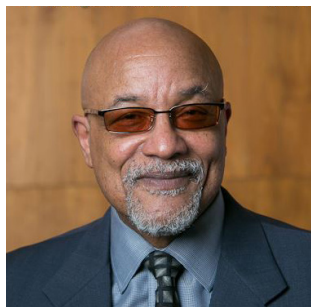
## Racial Disparities in Juvenile Justice Call for Holistic Approach

In 2011, according to data collected by the Office of Juvenile Justice and Delinquency Prevention, black youth in America were 4.6 times more likely than white youth to be detained or confined to facilities for the same offenses. Latino youth were 1.8 times more likely to be detained. These statistics have prompted juvenile justice experts and organizations, such as the Oakland, CA-based Burns Institute, to conclude, “We do not have a [youth] crime problem in this country; we have an incarceration problem.”

### Multi-System Approach

Many factors drive the disproportionate detention of minority youth, said The Honorable Judge J. Wesley Saint Clair, who presides over the King County Juvenile Court in Seattle, WA.

“There are so many moving pieces, from the child welfare system, to our school system, to the formal juvenile justice system.” In addition, Saint Clair said, behavioral and physical health agencies tend to operate in a “siloe” fashion, which means “that we’re not taking a very holistic examination of the process.”



**Judge J. Wesley Saint Clair** presides over the King County Juvenile Court in Seattle, WA.

For the past 20 years, several initiatives at the federal, state, and local levels have been aimed at lowering juvenile detention rates and addressing disproportionate minority representation. In 2008, updates to the Juvenile Justice and Delinquency Prevention Act of 1974 began requiring states to reduce racial and ethnic disparities and to focus more

on prevention. The Juvenile Detention Alternatives Initiative, a project of the Annie E. Casey Foundation since 1992, has sponsored initiatives in 200 jurisdictions in 39 states. These and other initiatives emphasize a multi-system, collaborative, and data-driven approach to change and prevention.

### The Trauma Component

Disproportionate rates of minority youth detention have been attributed to the War on Drugs, which mandated stiffer sentences for nonviolent crimes of drug possession; zero tolerance policies initiated in schools; poverty; and family trauma. Even when all involved agencies are “at the table,” the trauma component of these experiences can often be missed, said Clinton Lacey, Deputy Commissioner of Adult Operations for the New York City Department of Probation.

Lacey recalled a recent department-wide case conference concerning a 19-year-old African American youth who had missed appointments with his probation officer. He had also stopped attending his drug treatment diversion program, and was continuing to smoke marijuana. During the discussion, department members learned that the young man had no



**Clinton Lacey, Deputy Commissioner of Adult Operations for the New York City Department of Probation.**

father at home, an older brother in prison, and a troubled relationship with his mother. Lacey asked, “Has a mental health screening been done?” He suspected that the young man had been impacted by trauma, that he was possibly depressed, and that his continuing drug use was an attempt to self-medicate his depression. “The probation officers were not trying to be punitive,” Lacey explained, “but they were clearly frustrated.

They had not been properly equipped to understand trauma. Without a trauma lens, I think that the systems are missing a key part of what’s driving the problems. Understanding of trauma should point us in the direction of what should become healing therapeutic interventions, spaces, and opportunities.” He added that mental health and child-serving professionals, especially those with expertise in assessing and treating trauma, can be valuable contributors to the cross-system collaborations necessary to effect change. “Without that lens, we must ask ourselves, how may we at probation be contributing to the racial disparity we now see in our criminal and juvenile justice systems?”

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**“We do not have a [youth] crime problem in this country; we have an incarceration problem.”**

*Burns Institute, Oakland, CA*

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Saint Clair concurred, saying, “We have to fix the fundamental premises that we operate under.” To that end, Saint Clair, who started a book club, has handed out copies of *The New Jim Crow* (by Michelle Alexander) to 80 of his colleagues on the bench in order to increase their awareness of the historical trauma still affecting today’s African American families. The book club meets monthly and has now drafted an action plan to address what Saint Clair calls the “hyper-incarceration of black youth.”

### Avoid the Blame Game

Lacey collaborates with various agencies in New York City to help minority youth avoid the detention spiral. He and Saint Clair advise against assigning blame for minority-disproportionate detention rates. One way to do this is to engage stakeholders in looking at the data and the decision points (that is, the junctures at which youth come into contact

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## Racial Disparities in Juvenile Justice *cont'd from pg. 6*

with law enforcement or the justice system: arrest, referral to court, diversion, secure detention, delinquency findings, probation, and confinement in secure correctional facilities). “We know at specific decision points that kids of color and their white counterparts are getting different treatment with different outcomes,” Lacey said. “And that’s the definition of disparity.” Tracking the data can lead to a different conversation and specific problem-solving around the issue.

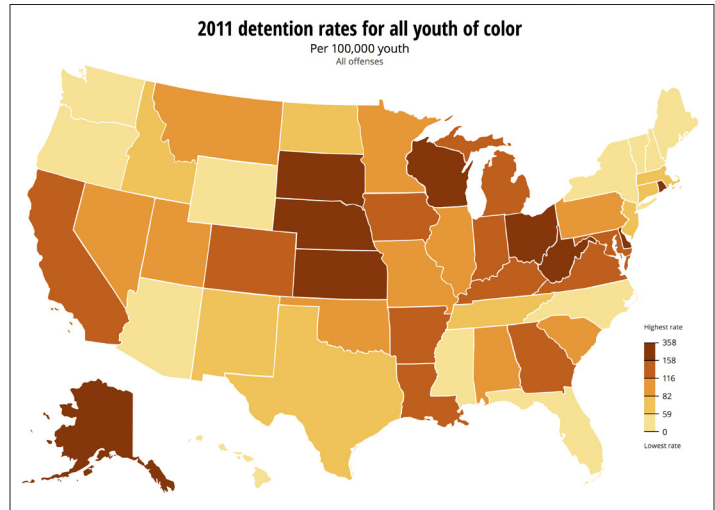
Other major decision points occur outside the justice system. Saint Clair noted that the zero tolerance movement has also been inequitably applied to youth of color, and that changing that equation can be tricky. In the Seattle-King County area, with 2.2 million people, there are 19 school districts run by independently-elected school boards that set their own priorities. When it comes to the disparate impact of zero tolerance on black males, “You have to pick and choose who you’re going to have that discussion with,” Saint Clair said. “And again, you don’t want to get them into the defensive mode because then they’re not listening to what’s being said.”

“We need to look for collaborative models where we bring stakeholders together,” he continued. “Instead of pointing fingers [at the schools, parents, the court, etc.], we need to focus on our commonalities. When we have built relationships on trust and respect, then we can use that as a foundation for reaching solutions.”

### Where to Intercede?

In 2003, Seattle-King County was one of 10 communities funded by the Robert Wood Johnson Foundation Reclaiming Futures initiative. *Reclaiming Futures: Communities Helping Teens Overcome Drugs, Alcohol and Crime* was designed to build community solutions to substance abuse and delinquency by developing the infrastructure necessary to deliver comprehensive care within the juvenile justice system. The purpose of the project was to design and implement an effective continuum of assessment, treatment, and supports for substance-abusing youth coming through the court system; and to provide supports beyond the court and treatment systems for substance-abusing youth and youth with co-occurring disorders.

Among other accomplishments, the Seattle initiative produced a resource that annotates guidelines from different agencies (social work, juvenile probation, schools, dependency courts, etc.) relevant to the releases necessary for sharing information among agencies. A new juvenile detention center, which will house social services offices as well as detention facilities, is set to break ground in Seattle in early 2015. Another document, *A Vision for King County 2024*, is the outgrowth of meetings held with 200 members of the Seattle community. It will provide the foundation for concrete steps to effect change, Saint Clair said. “The community speaks to issues of restorative justice,” he noted, “and so now we’re looking at those restorative justice principles and seeing how we can implement them within our various institutions – with,



Source: Burns Institute, Oakland, CA. For more data and interactive map, see: [data.burnsinstitute.org](http://data.burnsinstitute.org)

you know, lots of struggle with that, because that’s not how we usually do business.”

Lacey and Saint Clair admitted these efforts can be frustrating at times, especially when leaders struggle with budgetary challenges and insufficient social services. It is important, they emphasized, to attend to secondary trauma training to sustain their own momentum for change. ■

*The NCCTS extends a special thank you to Vivian H. Jackson, PhD, Georgetown University, and the NCTSN Culture Consortium for their conceptualization of the Spotlight on Culture series.*

### A Trauma-Informed Response to Children Crossing to the US

This past summer the Network’s Culture Consortium, Terrorism and Disaster Program, and Policy Taskforce partnered to respond to the needs of unaccompanied immigrant minors crossing the border into the US. Network-wide survey results were collected and used to inform the first-ever virtual Town Hall meeting addressing this topic from a trauma-informed perspective. To access the meeting, click on the Events Calendar link below; select September; click Apply; and then scroll to “Understanding Unaccompanied Minors. . .”

[http://www.nctsn.org/about-us/events-calendar?date\\_filter%5Bvalue%5D%5Byear%5D=2014&date\\_filter%5Bvalue%5D%5Bmonth%5D=9](http://www.nctsn.org/about-us/events-calendar?date_filter%5Bvalue%5D%5Byear%5D=2014&date_filter%5Bvalue%5D%5Bmonth%5D=9)

Stay tuned for future *Spotlight on Culture* articles addressing the needs of these children, and their families and communities.

## Have You Heard?

Chicago-based **La Rabida Children's Hospital** recently earned its second recognition from the National Committee for Quality Assurance (NCQA) for its medical home programs, which offer primary care to children with special healthcare needs. The NCQA recognized the hospital's Patient-Centered Medical Home for its work with the medical home model, which has been shown to promote higher quality and lower costs of care while improving patient outcomes. In 2011, the hospital was the first independent pediatric facility in Illinois to receive NCQA recognition. The medical home model aligns with standards of the American Academy of Pediatrics, which defines the model as delivering "continuous, comprehensive, accessible, family-centered, coordinated, compassionate, and culturally effective medical care to every child and adolescent." The medical home programs at La Rabida are in the areas of prematurity, failure to thrive, developmental delays, adolescent care, and chronic diseases including lung conditions.

**Risk Reduction through Family Therapy**, developed by **Carla Kmett Danielson, PhD**, is a multi-component, family-focused treatment that addresses symptoms experienced by trauma-exposed adolescents. This population is highly vulnerable to the development of PTSD, substance abuse, and revictimization. The risk reduction treatment is novel in its integration of psychopathology and risk behaviors as targets of therapy; standard care for trauma-exposed youth usually entails separate treatment of these components. The risk reduction model is appropriate for all forms of trauma including but not limited to sexual abuse and assault, physical abuse and assault, exposure to domestic or community violence, and traumatic grief. Risk Reduction Through Family Therapy is individualized to the needs, strengths, developmental factors, and cultural background of each adolescent and family.

The **Adelphi University School of Social Work** has long been a valuable resource for educating students and professionals in the treatment of adults who have experienced trauma. A program focused on adolescent trauma was a natural extension for the school. The school's **Institute for Adolescent Trauma Treatment and Training** has now partnered with **MercyFirst**, one of the largest residential programs for youth in New York, to train more than 1,000 social work students and mental health professionals on Long Island and parts of New York City in evidence-based trauma interventions. This skilled workforce will then deliver treatment to 4,000 or more adolescents. **Mandy Habib, PsyD**, and **Victor Labruna, PhD**, are serving as directors of the institute.

## Did You Know?

In Boston, the **Early Trauma Treatment Network** is building the capacity of the **Massachusetts Early Intervention** program to identify and support young children who have experienced trauma. The treatment network is collaborating with the Massachusetts program on three sets of activities. The first activity is the development and delivery of a Child-Parent Psychotherapy Learning Collaborative with a focus on supporting children with developmental disabilities and trauma, and their caregivers. The program team is also developing "at a glance" tip sheets for early intervention providers, as well as a brochure for caregivers (in English and Spanish), for purposes of increasing awareness and identification of trauma in young children, supporting caregivers in their efforts to talk about trauma in developmentally appropriate ways, and providing referral information. Finally, the collaborators are developing a new training module for the early intervention program – mapped onto core competencies in early intervention and the expressed needs of providers – that will translate elements of Child-Parent Psychotherapy for services including trauma screening and reflective supervision.

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## About IMPACT

IMPACT is a publication of the National Child Traumatic Stress Network (NCTSN). It is produced quarterly by the National Center for Child Traumatic Stress (NCCTS), co-located at UCLA and Duke University. The NCCTS serves as the coordinating body for NCTSN member sites, providing ongoing technical assistance and support.

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*Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.*



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