U.S. Secretaries Innovation Group

Optimizing Service Responsiveness for Youth with Multiple Adverse Experiences

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“Elevator” or “Grocery Store” Points

- 1) Improving child protection and reducing poverty are critical for reducing violence and continued cycles of trauma,
- 2) We can do a lot more than we are doing for traumatized children and youth if we;
  - Understand what it takes to heal trauma,
  - Focus on multi-faceted services of sufficient duration and stability,
  - Train practitioners.
- 3) Better partnerships between many sectors, including service and research, can improve the impact of expenditures we already make for traumatized youth, and states can incentivize those partnerships.

What is trauma?

- Events that induce a state of terror and helplessness in the victim:
  - Natural or person-made (war) disasters
  - Violence against persons
  - Serious, life-threatening illness (asthma, heart attack)
  - Poverty that threatens survival
- When perpetrated by humans, trauma is characterized by a victim, a perpetrator, and often a bystander (citizenry who do not help are complicit in trauma)

Types of trauma

- **Single type and time limited**, over as services are offered. Ex: brief sexual abuse of child with solid community resources
- **Complex:** multiple types of trauma occurring over long duration in development. Ex: child in poverty grows up physically abused, exposed to community violence and poor education with deprived community resources
- **Type 3 trauma**: complex trauma with serious illness, homelessness, lack of protection by child welfare authorities or police, repeatedly exposed to criminal acts such as forced drug trafficking by father
- **Concurrent:** trauma ongoing during course of service requires modifications in trauma treatment models - ex. Homeless youth
- **Accumulation of risk model**: more types of trauma over longer time yields more psychological risk

Effects of trauma (1)

- Single type
  - trigger percepts lead to flashbacks with fight or flight response,
  - avoidance of triggering contexts (such as schools),
  - agitation, hyper vigilance,
  - difficulty with emotional self-regulation
  - frequent use of drugs for self-soothing,
  - self-blame and reduced self-esteem,
  - sleep disturbances,
  - impaired memory for events

Effects of trauma (2)

- Complex trauma adds:
  - disorganized attachment to caregivers,
  - learning difficulties due to impaired memory,
  - demoralization,
  - psychosomatic symptoms,
  - impaired relationships (distorted interpretations of communications and difficulties managing interpersonal conflict)
- Type 3 trauma adds:
  - severely impaired reality-testing,
  - impaired immune system and other health functions,
  - developmental disabilities,
  - bouts of homicidal/suicidal rage (see Zagar's model for predicting homicide risk),
  - serious illegal activities

How many children/youth are victimized by trauma?

- Nationwide telephone survey of youth and caregivers reported by Finkelhor et al., 2013 (consider that youth will under-report when caregivers are in the room during phone interviews):
  - 80% experienced at least one form of victimization in their lifetimes;
  - Two-fifths (41.2%) of children and youth experienced a physical assault in the last year;
  - 1 in 10 (10.1%) experienced an assault-related injury;
  - Two percent experienced sexual assault or sexual abuse in the last year, but 10.7% for girls aged 14 to 17 years;
  - 13.7% experienced maltreatment by a caregiver, including 3.7% who experienced physical abuse.

Complex Trauma (van der Kolk)

- Prevalence: In a study of “normal” HMO US population:
  - 11.0% reported having been emotionally abused as a child,
  - 30.1% reported physical abuse,
  - 19.9% sexual abuse;
  - 23.5% reported being exposed to family alcohol abuse,
  - 18.8% to mental illness,
  - 12.5% witnessed their mothers being battered and
  - 4.9% reported family drug abuse.

Polyvictimization

- Finkelhor et al., national sample of 4053 youth in telephone interviews, 2008, found exposure to multiple forms of victimization was common.
- Almost 66% of the sample was exposed to more than one type of victimization,
- 30% experienced five or more types, and
- 10% experienced 11 or more different forms of victimization in their lifetimes.
- 40% of polyvictims are children under 13 years old.
- “Polyvictimization is more highly related to trauma symptoms than experiencing repeated victimizations of a single type and explains a large part of the associations between individual forms of victimization and symptom levels.”

Trauma exposure and mental health needs of poor youth

- 21% of poor youth have mental health problems (Stagman et al., 2010)
- 75-80% of poor youth who need mental health care never receive it (National Center for Children in Poverty)
- African-American, Latino, and First Nations youth are substantially more at risk for mental health problems (2-3x), yet also substantially less likely to receive mental health care

Trauma exposure for Chicago African-American youth in high-poverty, high-violence communities

Youth participating in our programs are motivated to improve their lives, not committed gang members, and attending school (e.g. not the most traumatized in their communities)

- All have witnessed the death of someone from serious community violence
- 20 percent don't have money for personal hygiene supplies such as soap, deodorant, shampoo, sanitary protection, laundry soap
- 15 percent chronically or periodically homeless
- 15 percent pregnant or parenting
- 30 percent do not have funds for bus fare to school or after school program
- 30 percent suicidal with our program being the only available mental health care
- 20 percent experience unprotected (by child welfare authorities, despite mandated reporting) type 3 trauma
- 15% report caregivers have guns at home and regularly expose them to gun violence (witnessing shooting of pets, use of guns to intimidate family members and neighbors, etc.)

More Factors in Trauma Exposure

- Intact and caring families with minimal strife reduce risk even in war zones (Garbarino et al.), yet in high poverty U.S. urban neighborhoods two-parent families typically are less than 15% of all families
- In impoverished U.S. communities burden of child competence and resilience falls almost entirely on families because of greatly reduced educational and other social supports. Rates of entry into foster care are 22x higher for this population.
- Impoverished youth dominate in jails, most for nonviolent offenses, held in jail because they cannot post bond. They lose jobs, custody of children, and are traumatized while awaiting trial (Subramanian, 2015).
- Racial disparities in arrest rates and sentencing compound the risk for people of color (*The New Jim Crow).*

Children's disabilities and trauma

- 4% of U.S. children have a disability;
- Disabled children are 3x more likely to be victimized by their families and others than non-disabled children (*Risk and Prevention of Maltreatment of Children with Disabilities,* Child Welfare Information Gateway);
- Wisconsin Longitudinal Study of life course of U.S. citizens parenting a child with a disability found that
  - parents of a child with a developmental disability had lower rates of employment, social participation, and larger families;
  - parents of children with severe mental health disabilities had higher rates of physical symptoms, alcoholism, and psychological distress than other parents.

Improving protection services: A view from the trenches

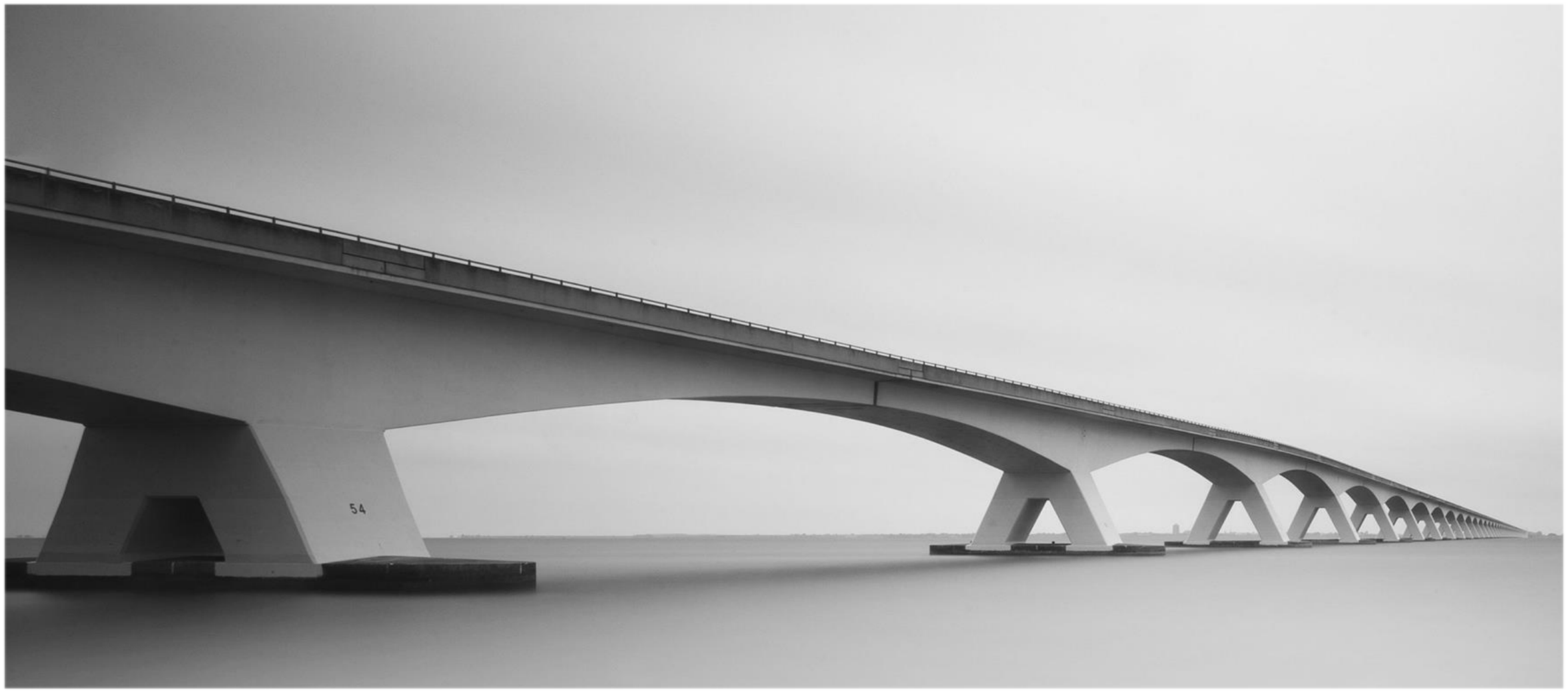
- Improved child protection can reduce community violence: most violence caused by the minority of youth experiencing complex or type 3 trauma
- Observation: 15 percent of youth we served victimized by serious abuse (rape by caregiver; threats with guns, severe physical abuse leaving cigarette burns, wounds) yet multiple reports by our program and school staff did not result in bringing caregivers to court or protection of children
- Adequate investigation of child abuse reports requires well-trained investigators sensitive to childrens' difficulties in reporting and terror when victimized; most investigators lack adequate training
- Local child welfare workers and mandated reporters in gang-ridden communities or situations need to be protected, as they are intimidated by angry caregivers with guns
- Police may be overwhelmed and unresponsive, although some are heroic

On the ground obstacles: Lack of mental health care

- Caregivers responsible for child abuse or neglect generally were traumatized and need mental health care but in impoverished communities accessible, culturally relevant mental health care is rare
- Highly traumatized youth need long-term mental health care (several years) as well as protection but most do not receive it
- Mental health facilities won't take decompensated violent state wards so foster families and residential care staff are dealing with kids who need facilities with more intensive and trained staffing

On the ground obstacles: Inadequate educational resources

- Trauma yields specific educational challenges schools are often unequipped to meet - Schools need models suitable for great need. People who can't learn because of trauma are likely to remain poor.
  - Emotional and even sometimes physical abuse happens in schools in poverty areas and with disabled children, which re-traumatizes children
- In poverty schools staff who report child abuse can be intimidated by angry parents with guns; school security generally is not sufficiently protective
- Schools in poor, violence-prone communities can be victimized by drive-by shootings and in-school violence, requiring schools be closed or pre-occupied with helping students with traumatic reactions



Towards a better future

Recommendations

Trauma Treatment Models Work

- With documented effectiveness, for general mental health care:
  - Play therapy (Bratton et al., Iliana Gil, Gary Landreth)
- For neglect and severe trauma:
  - Neurodevelomental therapeutics (Bruce Perry)
- For complex trauma:
  - the Attachment, self-regulation and competence model, (Kinniburgh et al., 2005),
  - the integrative psychotherapy model (Lanktree & Briere 2013),
  - child-parent psychotherapy (Lieberman 2005; Lieberman & van Horn 2011).

Considerations for Service Planning (1)

- Effective trauma treatment requires:
  - A context in which recurrent trauma is not concurrent with services (e.g. residential care that does not abuse and re-traumatize),
  - Educated therapists (Masters' degree or better) with several years' experience or sound clinical supervision,
  - At least a year outpatient treatment, at least 1x weekly for single-type, with several years for complex trauma,
  - Type 3 trauma necessitates residential care with duration at least 5 years in a stable setting with stable therapeutic relationships,
- In impoverished communities, only very rarely are the above conditions met.

Considerations for Service Planning (2)

- Given a context in which trauma is concurrent with treatment (unprotected child abuse, exposure to community violence and other stressors of poverty), important gains can be accomplished as long as
  - The programs are long-term (until college admission), accessible, multi-faceted (individual and group counseling, sex ed, academic and vocational preparation),
  - Staff are well-trained (Masters or above with many years experience or good clinical supervision),
  - Include educational supports so youth experience success in school, with learning disabilities assistance,
  - Include inpatient admissions during symptom exacerbations resulting in violence against self and/or others,
  - Include residential care for those most-traumatized youth unable to manage in the community.

More Person Power through Partnerships

- Competitive, problem-focused **University** partnerships (Bloomberg model)
  - To better prepare child welfare workers
  - For service-based research expertise that includes youth and practitioners as co-researchers (EU model)
    - Expected long-term commitment so University personnel don't have to be re-oriented to service challenges
- **School** partnerships to improve resources for involved families and state wards
- **Public transportation**: provide free bus fare for all poor youth who attend school and after school enrichment programs
- State-sponsored **"Service Hub"** meetings in disadvantaged communities
  - to jointly problem-solve, coordinate services, prevent overlap and gaps,
  - With reps of child welfare, mental health, police, schools, medical and social services, and community residents including foster parents and youth.

Service-based Participatory Research

- Researcher engages with those involved with a problem to carry out research process (EU model, Bucharest early intervention project), including problem formulation, data collection, analysis, and reporting findings
  - Develop best practices models by including service recipients as research partners about the services they receive
  - Employ state wards as co-researchers so they get employment skills experiences such as data gathering and analysis, critical thinking skills, presentation and writing skills and credits on resume.

Consumer Evaluations Improve Services

- More feedback from mandated reporters such as school social workers and pediatricians needed to improve child protection services
- Involve state wards in developing best practices service models
- Ask parents who were successful in overcoming trauma, abuse and neglect to:
  - work with social service professionals,
  - guide parent support groups and
  - Write and blog about how they prevailed... To reach others in their communities

Multi-function Local Services

- After school programs have documented effectiveness
  - Include counseling components, sexual and romantic health and academic and vocational preparation
  - Cross-age mentoring to build positive social networks among older and younger community youth as alternatives to intimidating gang networks
- Local school-based family support services
  - Facilitate culturally-relevant service provision
  - Eliminate transportation obstacles and stigma of going to mental health clinic,
  - Minimize expenditures of paying for clinical facilities as funds can be used to upgrade school facilities to make space for family support

More Resources

- National Child Traumatic Stress Network: http://www.nctsn.org
- Crimes against Children Research Center: http://www.unh.edu/ccrc/
- Columbia Univ. National Center for Children in Poverty: http://www.nccp.org (includes state demographic wizard)
- Longitudinal Study of Attachment in Families at risk: http://www.cehd.umn.edu/icd/research/parent-child/publications/attachment.html

- Garbarino, James. (2015). *Listening to Killers.* Oakland, CA: University of California Press.
- Courtois, C. and J. E. Ford (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. New York, Guilford Press.
- Boyle, Greg. (2010). *Tattoos on the Heart: The Power of Boundless Compassion.* NY: Free Press. About Homeboy Industries, highly effective employment rehabilitation program for gang members : http://www.homeboyindustries.org.
- Ram Subramanian et al. (2015) *Incarceration's Front Door: The Misuse of Jails in America.* New York, NY: Vera Institute of Justice.