UTAH DEPARTMENT OF OCCUPATIONAL AND PUBLIC LICENSING TRAUMA CONTINUING EDUCATION REQUIREMENT PROPOSAL

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Proposed Bill

Require mental health and related medical professionals in the State of Utah to complete two hours of professional development on trauma, trauma-informed care, or a trauma-specific modality during their licensure cycle.

Proposed Training Content

Core Trauma-Informed Care competencies

- Becoming trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
- Evaluating and initiating use of appropriate trauma-related screening and assessment tools.
- Approaching interventions from a collaborative, strengths-based approach, which acknowledges the resilience of trauma survivors.
- Learning the core principles and practices that reflect trauma-informed care (TIC).
- Anticipating the need for specific trauma-informed treatment-planning strategies, which support the individual's recovery.

- Decreasing the inadvertent re-traumatization that can occur from using standard organizational policies, procedures, and interventions with individuals, including clients and staff members, who have experienced trauma or are exposed to secondary trauma.
- Building a trauma-informed organization by incorporating specific strategies across each level of the organization, including universal screening and assessment procedures for trauma; interagency and intra-agency collaboration to secure trauma-specific services as appropriate; referral agreements and networks to match clients' needs; mission and value statements endorsing the importance of trauma recognition; consumer- and community-supported committees and trauma-response teams; and program policies and procedures, which ensure trauma recognition as well as secure trauma-informed practices, trauma-specific services, and prevention of re-traumatization.
- Building a trauma-informed workforce, which includes in-depth training to enhance understanding of the impact of trauma on individuals and among providers (i.e., secondary traumatization); screening, assessment, and referral processes; and other trauma-specific counselor competencies and ethics.

  (This section modified from Substance Abuse and Mental Health Administration (SAMHSA) Treatment Improvement Protocol (TIP) 57)

Organizational trauma-informed principles

1. **Safety:** Throughout the organization, staff and the people they serve feel physically and psychologically safe.

2. **Trustworthiness and transparency**: Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.
3. **Peer support and mutual self-help**: Peer support and mutual self-help are integral to the organizational and service-delivery approach, and are understood to be a key vehicle for establishing safety, building trust, and empowering all involved.
4. **Collaboration and mutuality**: There is true partnering and leveling of power differences between staff and clients, as well as among organizational staff—from direct-care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.
5. **Empowerment, voice, and choice**: Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated, and new skills developed as necessary. The organization aims to strengthen the staff members', clients', and family members' experiences of choice and recognizes that every person's experience is unique and requires an individualized approach. This recognition includes a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. This belief in resilience builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.
6. **Cultural, historical, and gender issues**: The organization actively strives to move past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age,

geography), offers gender-responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma

(This section modified from SAMHSA Guiding Principles of Trauma-Informed Care)

Adverse Childhood Experiences (ACE) Study scientific principles

- The 1995-1997 Centers for Disease Control and Prevention (CDC) and Kaiser Permanente (KP) ACE Study and subsequent research show that most individuals in the U.S. have by age 18 experienced adversity in at least one category of ACEs—an "ACE Score" of one out of a maximum of 10. The adverse childhood experiences studied by the CDC and KP are divided into 10 categories and include:
    - childhood emotional abuse
    - childhood physical abuse
    - childhood sexual abuse
    - childhood emotional neglect
    - childhood physical neglect
    - separation or divorce of parents
    - witnessing the violent treatment of one's mother or stepmother
    - a household member who misused or abused alcohol and/or drugs
    - a household member who was depressed, mentally ill, and/or attempted suicide
    - a household member who was incarcerated.
- Those who experienced adversities in four or more of the 10 categories face as adults dramatically increased risks (as compared to peers with an ACE Score below four) of adult-onset chronic-health problems, including those associated with early death, e.g.

heart disease, cancer, diabetes, liver disease, and sexually transmitted infection, including HIV.

- Science on ACEs includes an understanding of the neurobiology of toxic stress—how toxic stress caused by ACEs damages the function and structure of children's developing brains. Adverse childhood experiences may be seen as toxic stressors, as a toxic stressor can be defined as an experience which interrupts the normal developmental trajectory of a child, leading the child down a path of poor health and well-being across the lifespan. (See Attachment: *The Lifelong Effects of Early Childhood Adversity and Toxic Stress* [Shonkoff et al., 2011])
- Also important is recognizing the health consequences of ACEs—how toxic stress caused by ACEs affects short- and long-term health, and can impact every part of the body, leading to autoimmune diseases, such as arthritis, as well as heart and lung disease, breast cancer, lung cancer, etc.
- Science on ACEs also includes an understanding of historical and generational trauma (epigenetic consequences of toxic stress)—how toxic stress caused by ACEs can alter how our DNA functions, and how those alterations are potentially passed on from generation to generation.
- Also important is resilience research—understanding neuroplasticity and the body's natural healing mechanisms and tendencies towards healing. Resilience research ranges from looking at how the brain of a teenager with a high ACE Score can be healed with cognitive behavioral therapy, to how schools can integrate trauma-informed and resilience-building practices, which result in an increase in students' scores, test grades, and high-school graduation rates.

(This section modified from ACEs Too High website with additional references added)

For more information, view these informational videos on ACEs published by the Academy on Violence and Abuse (AVA):

3-Minute Video

8-Minute Video

Current Licensing and Graduate-training Program Requirements for Trauma Training

The Utah Division of Occupational and Public Licensing (DOPL) requirements for clinical mental health counselors (CMHCs), licensed clinical social workers (LCSWs), and marriage and family therapists (MFTs) do not currently specify required training in trauma or trauma-informed care. Most graduate programs in the state of Utah do not provide or require specific training in trauma or trauma-informed care. For example, the CMHC program at the University of Utah (U of U) does not specifically mention trauma in its curriculum. Trauma education is neither specifically required in the Brigham Young University (BYU) MFT coursework, nor in BYU or U of U Ph.D. programs. The University of Utah College of Social Work recently began requiring courses studying ACEs and trauma (SW 6301, 6302, 6303). The University of Utah School of Medicine offers sparse, optional lectures occurring primarily in the second year of medical training, but otherwise very little training or exposure to trauma-informed care principles or the science associated with ACEs.

Importance and Rationale for Trauma Training

Trauma-informed care principles are preventative. Unaddressed trauma may be one of the United States' most expensive societal issues. The societal and economic impact of trauma is

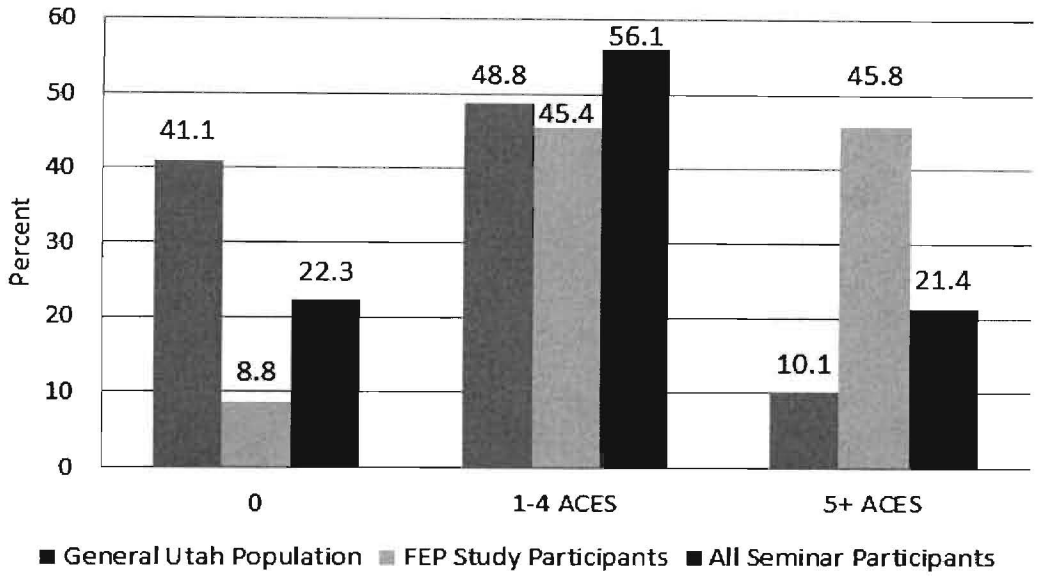
evidenced at various levels of our communities. Incorporating trauma-informed care in our community has the potential to greatly reduce suffering and reduce symptoms of trauma, which impact both emotional and physical health functioning. Further, the impact of trauma on a social level has the capacity to be negotiated more effectively if it is addressed sufficiently. If trauma is addressed on a social level, community and state programs will be able to reduce operational costs and provide more effective, sustainable treatments to those they serve. These agencies are also at risk for the development of secondary trauma in their workforce. The impact of secondary trauma can contribute to higher employee turnover rates, reduction in productivity, higher rates of absenteeism, and the negative effects of trauma discussed in other research.

- The long-term negative health consequences of childhood trauma are "increasingly being recognized as major health concerns and the true cost to the health care system may reach hundreds of billions of dollars a year." (Dolezal et al., 2009)
- The financial costs for victims and society are substantial. A recent CDC study, The Economic Burden of Child Maltreatment in the United States and Implications for Prevention, found the total lifetime estimated financial costs associated with just one year of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse, and neglect) is approximately $124 billion. The lifetime cost for each child-maltreatment victim who lived was $210,012, which is comparable to other costly health conditions such as stroke, with a lifetime cost per person estimated at $159,846 or type 2 diabetes, which is estimated between $181,000 and $253,000.

Prevalence of ACEs in Utah Public Assistance Recipients

The graph below illustrates data collected in 2010 by the Utah Department of Health for the percentage of ACEs reported in the general Utah population (left column). The middle column illustrates the percentage of ACEs in recipients of public cash-assistance programs administered by the Department of Workforce Services. This data was collected by the University of Utah's Social Research Institute in 2014. The right column illustrates the percentage of reported ACEs in those working in helping professions that attended a statewide training offered in partnership with the University of Utah and the Department of Workforce Services, collected in 2016/2017. The 1762 total attendees were composed of (those who self-identified) representatives/employees of DWS (730, 37.4%) and other agencies (1032, 52.8%). Agencies and community partners represented were Utah Department of Human Services, educators of early childhood through higher education, mental health providers from various agencies, Utah Department of Health employees, judiciary and law enforcement, housing authorities, and childcare providers.

This graph identifies the trauma present in those working in various helping professions across our state. Personal trauma history is one of the leading risk factors for the development of secondary trauma. This data suggests that this risk factor needs to be addressed in our program employees.



Secondary Trauma to Helping Professionals

Research demonstrates that those working in the helping professionals are often negatively impacted through secondary trauma. Trauma awareness, education, and training can significantly reduce the impact of secondary trauma.

- Between 40% and 85% of "helping professionals" develop vicarious trauma, compassion fatigue and/or high rates of traumatic symptoms, according to compassion fatigue expert Francoise Mathieu (2012).
- Social workers (Master of Social Work): 70% exhibited at least one symptom of secondary-traumatic stress (Bride, 2007).
- Social workers: 42% said they suffered from secondary traumatic stress (Adams et al., 2006).
- Therapists specializing in sexual assault: 70% experienced vicarious trauma (Lobel, 1997).
- Hospice nurses: 79% moderate-to-high rates of compassion fatigue; 83% reported not having a debriefing support after a patient's death (Abendroth & Flannery, 2006).

- Child welfare workers: 50% traumatic-stress symptoms in designated as "severe" (Conrad & Kellar-Guenther, 2006).
- Child welfare workers: 34% met the criteria for a diagnosis of posttraumatic stress syndrome (PTSD), due to secondary traumatic stress (Bride, 2007).
- Child protection service workers: 37% reported clinical levels of emotional distress associated with secondary traumatic stress. (Cornille and Meyers,1999).
- Child protection workers: 50% reported suffering from "high" to "very high" levels of compassion fatigue (Conrad & Kellar-Guenther, 2006).

Potential positive impact if this legislation is passed

The positive potential impact of required trauma-informed care training is immeasurable. Following are examples, both anecdotal and evidence based:

- Increased understanding of trauma and and trauma-informed care principles among mental health and related medical providers.
- Trauma-informed mental health and medical providers are better equipped to make effective treatment and referral decisions to appropriately trained-trauma professionals when needed.
- Reduction in secondary trauma and improved resiliency in helping professional
- More timely, efficient, and effective identification and treatment of trauma-related symptoms.
- Lower rate of burnout in counselors who use evidence-based trauma therapies. (See *Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists*

- Prevention of transmission of future intergenerational trauma.
- Reduction in overall costs to society of mental, physical, and behavioral healthcare costs, as well as societal costs such as in the education and criminal systems, as previously mentioned.
- Lower rates of substance addiction, as unresolved trauma has been shown to be one of the highest predictors of substance addiction.

National Legislation in Trauma-Informed Care

A variety of public legislation, resolutions, policies, and community initiatives regarding trauma and trauma-informed care are being enacted around the country. (See Appendix A: State Trauma-Informed Care Initiatives and Trauma Informed Care Network Legislation)

Personal Testimonials: Professionals and Clients

This is not a comfortable diagnostic formulation; it points out that our attention is comfortably focused on tertiary consequences far downstream. The diagnosis shows that the primary issues are well protected by social convention and taboo and points out that we have limited ourselves to the smallest part of the problem: the part where we are comfortable as mere prescribers of medication. Which diagnostic choice shall we make? Who shall make it? And if not now, when? (Felitti, 2001)

It's hard to believe that when I worked in mental-health crisis centers we rarely inquired about trauma. Now we better understand the centrality of trauma in behavioral health conditions. We recognize the need for a workforce trained in trauma-specific interventions that can be

offered in settings that are grounded in a trauma-informed approach and guided by the voices of people with lived experiences of trauma. (Larke N. Huang, Ph.D., Director of SAMHSA's Office of Behavioral Health Equity and SAMHSA's lead for the Strategic Initiative on Trauma and Justice)

Kristan Warnick, M.S., CMHC, Founder of Healing Pathways Therapy Center and the Trauma Informed Care Network

As a therapist I have found my work to be much more optimistic, effective, and hopeful since I have become trauma trained. It is amazing to see more efficient and effective trauma techniques resulting in significant and lasting change in my clients. I have clients over and over ask me why in their years of therapy no one has ever educated them about and addressed their issues in this way. I currently have a client who for years was seen as mentally ill, depressed, anxious, and suicidal. She was hospitalized several times and easily pegged as "the sick one" in her marriage. Earlier this year she read *The Body Keeps the Score* by Bessel Van der Kolk and subsequently sought out my services as a trauma-trained therapist. Since then, the whole course of her treatment has changed—she no longer meets the criteria for previous diagnoses, she is now able to recognize years of unhealthy patterns in her marriage and establish boundaries to insist on health and improvement in her relationship. For years, the fact that she had been sexually abused by her grandfather remained unidentified and unaddressed in her treatment and great progress is being made as we are tackling that head-on. It is frustrating to have clients who've been through years of therapy before meeting a mental health professional who is aware of and able to treat trauma. I have respected colleagues who have received little to no education concerning trauma, such as one who said to me, "Often it might be six months into therapy

before I even think to ask a client about trauma." Another colleague has stated that "PTSD cannot be healed." We have also been increasing our efforts to collaborate with medical professionals in our community and this has great improved outcomes for our clients, increased appropriate referrals for trauma treatment, and improved understanding and awareness in medical professionals of factors impacting their patients' health and well-being.

Kara Patin, LCSW

I am a trauma-trained therapist and have worked with the University of Utah and various community and state agencies to provide trauma-related trainings. In my experience as a therapist I often hear from clients that they have worked with multiple therapists, and found therapy to be largely ineffective. They are referred to me or our clinic because they are still in need of help and someone who is familiar with our work has encouraged them to do so. Once clients start to become educated about how their trauma histories impact their lives and are able to receive evidence-based recovery treatments, they see and feel changes they once thought were impossible to achieve. Prior to receiving trauma trainings, as the result of personal interest I worked in the drug court system and other community mental health agencies. In retrospect, had I the training I do now, I believe the treatment I provided would have been much more effective. Further, I often worked on teams with other providers who collectively served hundreds of people at once. As a trainer I have delivered information to hundreds of people who are amazed to hear the impact and prevalence of trauma. On the level of the attendee, I have heard multiple times how their lives have been impacted personally and that they have developed a new level of understanding for themselves and loved ones. On the level of their work with others, many have reported an increased perspective and capacity for understanding and empathy. I believe this

education has the capacity to reduce turnover and secondary trauma in helping professions, make treatments in the community more effective, and reduce the various negative impacts of trauma on our community at large.

Ashley S. Weitz

By the age of six, I had an ACE Score of nine. As a child, I lacked context for my circumstances and for the consequences of the actions of others. Into early adulthood, I lacked understanding of why I so often felt very isolated and different from my peers. In a constant state of emotional crisis, I felt at all times like I was about to be hit by a train. I was very often sick and I felt exhausted from surviving—never thriving. In my early 20s, I reached a time when I was no longer able to "tread water." I was hospitalized multiple times for suicidal ideation and treated for multiple inaccurate psychiatric diagnoses. Without any understanding of *why* I seemingly suddenly "crashed," I attempted therapy with many clinicians. However, I was nearly six years into full-time, twice-weekly therapy before I was introduced to data on ACEs and the neurobiology of trauma. Suddenly, I realized I had spent over 25 years of my life attempting to make sense of something that was never mine to own. Finally, I saw objective data that supported and validated everything I experienced—both emotionally as well as physically. I began to understand that while my experiences were abnormal, I had every right to feel everything I'd tried so hard to avoid for fear I was "crazy." I now have so much more compassion for myself and for others. I no longer live in a constant state of confusion and fear—feeling trapped inside a world that felt so random, so chaotic, for so long. My physical health has improved dramatically, as have my own sense of well-being and quality of life. I am now aware that though my past may have been dictated by circumstances or choices of others, I am no

destined to live "in" those experiences. For the first time in my life, my future is entirely up to me.

Current Utah legislative support for Trauma-Informed Care initiatives

In March 2017 the Utah State Legislature passed House Concurrent Resolution 10: "Concurrent Resolution Encouraging Identification and Support of Traumatic Childhood Experiences Survivors," which: "*Encourages state officers, agencies, and employees to promote interventions and practices to identify and treat child and adult survivors of severe emotional trauma and other adverse childhood experiences using interventions proven to help and develop resiliency in these survivors.*"

Bill Sponsor: Edward H. Redd, MD

Floor Sponsor: Todd Weiler

Cosponsors: Patrice M. Arent, Joel K. Briscoe, Rebecca Chavez-Houck, Kay J. Christofferson, Brad M. Daw, Rebecca P. Edwards, Steve Eliason, Stephen G. Handy, Lynn N. Hemingway, Sandra Hollins, Ken Ivory, Brian S. King, Karen Kwan, Karianne Lisonbee, Carol Spackman Moss, Derrin R. Owens, Val K. Potter, Marie H. Poulson, Susan Pulsipher, Angela Romero, Raymond P. Ward, Elizabeth Weight, and Mark A. Wheatley

References

Abendroth, M., & Flannery, J. (2006). Predicting the Risk of Compassion Fatigue. *Journal of Hospice & Palliative Nursing,8*(6), 346-356. doi:10.1097/00129191-200611000-00007

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational Prevention of Vicarious Trauma. *Families in Society: The Journal of Contemporary Social Services,84*(4), 463-470. doi:10.1606/1044-3894.131

Bride, B. E. (2007). Prevalence of Secondary Traumatic Stress among Social Workers. *Social Work,52*(1), 63-70. doi:10.1093/sw/52.1.63

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect,30*(10), 1071-1080. doi:10.1016/j.chiabu.2006.03.009

Cornille, T. A., & Meyers, T. W. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity and predictive factors. *Traumatology,5*(1). doi:10.1177/153476569900500105

Curtis, L. (2010, May 29). Case backlog postponing deportations – Las Vegas Review ... Retrieved July 27, 2017, from https://www.reviewjournal.com/news/case-backlog-postponing-deportations/

Felitti, V. J. (2001). Reverse Alchemy in Childhood: Turning Gold into Lead. *Health Alert, a publication of the Family Violence Prevention Fund, 8*, 4.

Figley, C. R. (1995). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized.* New York, NY: Brunner/Mazel.

Hawkins, H. C. (2001). Police Officer Burnout: A Partial Replication of Maslachs Burnout Inventory. *Police Quarterly,4*(3), 343-360. doi:10.1177/109861101129197888

Lipsky, L. V., & Burk, C. (2009). *Trauma stewardship: an everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler .

Lobel, J. A. (1997, May). The vicarious effects of treating female rape survivors: the therapists perspective (Doctoral dissertation, University of Pennsylvania, 1996). *Dissertation Abstracts International,57*(11-B), 7230.

Mathieu, F. (2015). *The compassion fatigue workbook: creative tools for transforming compassion fatigue and vicarious traumatization.* New York, NY: Routledge.

Perez, L. M. (2010). Secondary Traumatic Stress and Burnout among Law Enforcement Investigators Exposed to Disturbing Media Images. *Journal of Police and Criminal Psychology,25*(2), 113-124. doi:https://doi.org/10.1007/s11896-010-9066-7

Perron, B. E., & Hiltz, B. S. (2006). Burnout and Secondary Trauma Among Forensic Interviewers of Abused Children. *Child and Adolescent Social Work Journal,23*(2), 216-234. doi:10.1007/s10560-005-0044-3

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., Garner, A. S., . . . Wood, D. L. (2011). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics,129*(1). doi:10.1542/peds.2011-2663

Thomas, J. (2013). Association of Personal Distress With Burnout, Compassion Fatigue, and Compassion Satisfaction Among Clinical Social Workers. *Journal of Social Service Research,39*(3), 365-379. doi:10.1080/01488376.2013.771596

Appendix A

State Trauma-informed Care Initiatives and Trauma Informed Care Network Legislation

SUMMARY

The following is a sample of public policy (including legislation, resolutions, and other policies) and community initiatives regarding trauma and trauma-informed care around the country. When available, links are provided to the original legislation or resolution.

PUBLIC POLICY: Legislation

I. Texas Senate Bill No. 1356 Sec. 161.088: Trauma-Informed Care Training

a. The department shall provide trauma-informed care training during the preservice training the department provides for juvenile probation officers and juvenile supervision officers.

b. Juvenile correctional training must provide knowledge, in line with best practices, of how to interact with juveniles who have experienced traumatic events.

II. Texas House Bill No. 2789 Sec. 161.088: Trauma-Informed Care Training

a. The department shall develop or adopt trauma-informed care training for employees who work directly with individuals with intellectual and developmental disabilities in state supported living centers and intermediate care facilities.

b. The executive commissioner by rule shall require new employees to complete the training before working with individuals with intellectual and developmental disabilities and shall require all employees to complete an annual refresher training course.

III. Minnesota State Legislature: HF 892 A House resolution to the Governor, recognizing the well-being of Minnesota children

a. This is a resolution relating to the use of current science on childhood brain development, adverse childhood experiences, and toxic stress to prevent child abuse and neglect before it starts and ensure the well-being of all Minnesota children. This resolution summarizes and cites several key research findings, as WHEREAS statements, resolving for them to be considered as important strategies. It also calls for a taskforce to be formed, focusing on the development of trauma-informed policy and practices, with the goal of addressing social determinants of health and well-being and eliminating racial and ethnic disparities in their state.

IV. Vermont: H.762 Legislation

a. Reimbursement for primary care provided to a Medicaid patient shall be contingent upon the provider's use of Adverse Childhood Experience questionnaire for the purpose of assessing the patient's health risks.

b. By 12/15/14 the Department of Health shall submit a report to the Senate Committee on Health and Welfare and to the house Committee on Health Care containing recommendations on the following: whether and how trauma-informed care could be more widely incorporated in the practice of medicine throughout Vermont and whether the use of adverse childhood experiences and other preventive medical services could be expanded.

V. Massachusetts: H. 3528 Legislation

a. Requires all schools to develop action plans for creating safe and supportive schools, creates a commission on statewide implementation, and provides technical assistance to help schools and districts achieve safe and supportive schools.

PUBLIC POLICY: Resolutions

I. Alaska Joint Resolution 21

a. A resolution urging the governor to join with the Alaska legislature to respond to the public and behavioral health epidemic of adverse childhood experiences by establishing a statewide policy and providing programs to address this epidemic.

II. California State Assembly and Senate Concurrent Resolution No. 155 Relative to Childhood Brain Development

a. This resolution framed Adverse Childhood Experiences in terms of childhood brain development and toxic stress. This measure urged the Governor to identify evidence-based solutions to reduce children's exposure to adverse childhood experiences, address the impacts of those experiences, and invest in preventive health care and mental health and wellness interventions. It also urged the Governor to consider the principles of brain development, the intimate connection between mental and physical health, the concepts of toxic stress, adverse childhood experiences, buffering relationships, and the roles of early intervention and investment in children as important strategies.

III. Pennsylvania House Resolution No. 191

a. Passed the House but not Senate

b. Declares support for a public health approach to violence and statewide trauma-informed education.

IV. Wisconsin: Senate Joint Resolution No. 59

a. Resolution on early childhood brain development. It resolves that policy decisions enacted by the Wisconsin state legislature will acknowledge and take into account the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships, and note the role of early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital. It also summarizes and cites several key research findings, including that it is more effective and less costly to positively influence the architecture of a young child's developing brain than to attempt to correct poor learning, health, and behaviors later in life.

PUBLIC POLICY: Other

I. States collecting adverse childhood experience information as part of the CDC Behavioral Risk Factor Surveillance System (2009–2014)

a. Alaska, Arkansas, Arizona, California, Connecticut, Florida, Hawaii, Iowa, Illinois, Kansas, Louisiana, Maine, Michigan, Minnesota, Montana, Nebraska, North Carolina, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Washington, Wisconsin (Total = 29)

II. Australia: Adults Surviving Child Abuse (ASCA) Guidelines

a. The national guidelines for trauma-informed care are currently being disseminated through state and federal governments and government agencies as well as federal and state-based mental health bodies, umbrella practitioner organizations, nongovernmental organizations and to consumers, workers and practitioners. Adults Surviving Child Abuse has also submitted a proposal to develop education and training workshops and online learning programs for primary care physicians and mental health practitioners from different disciplines. The guidelines are the five principles from Fallot and Harris.

COMMUNITY INITIATIVES

I. Chadwick Center for Children & Families: Trauma-Informed Care Systems Dissemination and Implementation Project

a. Chadwick Center for Children & Families is working strategically with five "supercommunities" across the country who will serve as communities of excellence and will lead the transformation of public child welfare agencies into trauma-informed systems within their respective jurisdictions. Ultimately, the Project will be working specifically with each supercommunity to identify and spread trauma-informed child welfare practices across their region.

b. Supercommunity locations: Custer County, Oklahoma; Orange County, California; State of Rhode Island; Southeastern Minnesota; Volusia County, Florida

II. San Francisco, California: Trauma Transformed Initiative (T2)

a. A regional effort funded by a four-year grant from Substance Abuse and Mental Health Services Administration. Youth, families, health directors and public health

leaders from the seven counties committed to partnering with communities to break the cycle of intergenerational trauma and poverty.

III. Philadelphia, Pennsylvania

a. In November 2014, a community coalition held a discussion to determine how to make a trauma-informed community. The goal of was to use trauma-informed principles to redesign the enrollment processes for six public assistance programs in Philadelphia.

IV. Florida: Peace4Tarpon Trauma-Informed Community Initiative

a. Tarpon Springs, FL is working to become the first trauma-informed community in the nation. Peace4Tarpon Trauma Informed Community Initiative is a grassroots effort designed to identify and address the root causes of the most challenging issues (such as domestic violence, bullying, unemployment, homelessness, and substance abuse) through community partnerships rather than addressing symptoms.

V. Mobilizing Action for Resilient Communities (MARC)

a. The MARC project, supported by the Robert Wood Johnson Foundation, supports 12 community partners to reduce adverse childhood experiences (ACEs) and promote resilience. The project supports communities building the movement to create a just, healthy and resilient world.

b. Each community will join a two-year learning collaborative where they will share best practices, try new approaches and become models for other communities in implementing effective solutions for combating ACEs. Communities: Alaska; Albany, NY (The HEARTS Initiative for ACE Response); Boston, MA; Buncombe

County, NC; The Dalles, OR; Illinois; Kansas City, MO; Montana; Philadelphia, PA; San Diego, CA; Sonoma County, CA; Tarpon Springs, FL; Washington; Wisconsin.

VI. Washington: ACEs Public-Private Initiative

a. Washington's ACEs Public-Private Initiative is a group of private, public and community organizations in Washington State working together to reduce children's exposure to trauma—or "adverse childhood experiences" (ACEs)—and the substantial social, emotional and physical tolls that may result.

VII. Tennessee: Adverse Childhood Experiences Awareness Foundation

a. The Adverse Childhood Experiences Awareness Foundation launched a statewide education initiative to educate leaders in private industry, health care, government agencies, and social-welfare organizations about the importance of investing in prevention efforts to save the tax-payer dollars, reduce the impact on the special education system, and the criminal justice and healthcare system so future generations of Tennesseans aren't having to deal with the residue of adverse experiences.

VIII. Arizona: Adverse Childhood Experiences Consortium

a. A panel of business and government elites was held at Phoenix Children's Hospital regarding how to handle adverse childhood experiences afflicting Arizona's youth.