



## **Webinar Transcript**

# **Breaking the Cycle of Intergenerational Teen Pregnancy Using a Trauma-Informed Approach**

Operator: Welcome and thank you for standing by. At this time, all participants are in a listen only mode. During our Q&A session, you may press star one on your touchtone phone if you would like to ask a question. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I'd now like to turn the meeting over to Ms. Sabrina Chapple. Ma'am, you may begin.

Sabrina Chapple: Thank you. Good morning, good afternoon, and welcome to today's webinar, *Breaking the Cycle of Intergenerational Teen Pregnancy Using a Trauma-Informed Approach*. The focus of today's webinar will be on practical strategies for using a trauma-informed approach to breaking the cycle of intergenerational teen pregnancy. At this time, I'll go ahead and hand it over to Deborah Chilcoat, Healthy Teen Network's Senior Training and Technical Assistance Provider. Deb?

Deborah Chilcoat: Thanks, Sabrina. On behalf of Child Trends and all the presenters, we would like to thank the Office of Adolescent Health for the opportunity to share this vital information about how to apply a trauma-informed care approach to break the cycle of intergenerational teen pregnancy. I'm very pleased to be facilitating today's webinar. Today we also have several very knowledgeable professionals who have generously given their time to prepare and present content for today's webinar. Let's meet them, shall we?

We're lucky to have with us today representatives from both the National Crittenton Foundation as well as from two of their family organizations. First

we have Jeanette Pai-Espinosa. Jeanette is the president of the National Crittenton Foundation. The National Crittenton Foundation is the unifying body of a collaboration of agencies that serve girls and young women. They use a unique mix of strategies to build the capacity of Crittenton agencies to engage in national strategy and to increase and build survivor leadership. Jeanette has over 40 years of experience in advocacy, education, public policy, strategic communication, program development, and direct service delivery.

She also serves as the chair of the National Foster Care Coalition as the co-director of the National Girl's Initiative of the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention. She also serves on the board of the directors of the Human Rights Project for Girls as well as the Women's Service Advisory Committee at the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Welcome Jeanette.

We also have Suzanne Banning. She's the president and CEO of Florence Crittenton Services of Colorado. Florence Crittenton Services is a nonprofit with a mission to educate, prepare, and empower teen mothers and their children to become productive members of the community. They pioneered a nationally recognized two-generation program model that helps families break the cycle of poverty through education, health and wellness, and economic and social asset building. Their trauma-informed service model more than doubles the national high school graduation rate of teen mothers in their community and ensures that their children are kindergarten ready.

Ms. Banning joined Florence Crittenton Services in 2004 and became CEO in 2014. As president and CEO, she successfully led the Building for Teens' Family Success capital campaign and the construction of the new and

expanded Florence Crittenton campus. In 2015, she helped to launch Colorado Teen Parent Collaborative in order to consolidate support and advocacy initiatives to benefit teen mothers and their families. She is a member of the Denver Women's Collaborative and served on Denver's Birth to Eight Roadmap Advisory Committee. Welcome, Suzanne.

We also have Barbara Burton. She's the executive director of Florence Crittenton Homes and Services, a 116-year-old organization in Helena, Montana which provides a two-generation trauma-informed approach to supporting young families through comprehensive services. She has over 18 years' experience working with marginalized young families in developing approaches to meet the unique challenges of a rural population with diverse needs. She currently serves on three state advisory committees for early childhood, TANF, and child welfare.

In addition to her involvement at the state level, she represents her organization nationally as a member of the National Crittenton Foundation family of agencies where she participates in national advocacy and research for girls and young women. Barbara has presented at the Mother Baby Convening in Washington, D.C. as well as authoring articles on young mothers in foster care, juvenile justice, and homelessness. She is the mother of two adult children and enjoys spending her free time in the mountains of Montana with her husband and dog. Barbara holds a Master's degree in Nonprofit Management and a background in finance, which she says comes in handy nearly every day.

We also have Melanie Prummer. She is the executive director and has been since 2012 with Battered Persons Advocacy, a victim support agency in Douglas County, Oregon. She relocated from Tacoma, Washington and has over a decade of experience working in Douglas County as the program

director at the Boys and Girls Club of the Umpqua Valley. Melanie has 16 years of experience in managing nonprofit organizations and brings expertise in partnering with local government agencies and community agencies in both Oregon and Washington.

Melanie served as the clinical supervisor with Catholic Community Services for three years, assisting in the development of the Pearce County Mental Health Crisis Team and wraparound services to children and their families. She volunteered for several nonprofits including NeighborWorks' community property management board and currently serves on the Umpqua Health Alliance advisory board. Melanie holds a Bachelor's of Arts from the University of Tasmania, Australia, and a Master's in Counseling from Northwest Christian University. Melanie has been working with community partners on the Safer Futures project since its inception in 2013. Welcome, Melanie.

Today's webinar is just one of the myriad of resources available to you, the grantees. The PAF Web site has been restructured to separate the PAF program from the PAF resource center. The new program section provides information on who PAF serves, organizations currently being funded, and successful grantee strategies in addition to important program guidance for PAF grantees. The streamlined PAF resource center has updated training and technical assistance resources and tools that are more easily accessible. We encourage you to use and share these pages to further build support for your work and the work with your young families. This is also where we will be archiving today's webinar slides, transcripts, and audio recording.

There are a few interactive features of the webinar platform that we are using today. During the webinar, we will use both the polling feature and the Q&A feature. At any time, you can send us a comment via the text box. So, if you

look on your screen, you should see the Q&A feature and the message box, the text box on the right hand side. So, how about if we test this app just to make sure everybody found the text box? I'd like for you to type the title of a book, movie or television show that you highly recommend. It can be anything, a book, a movie, television, your guilty pleasure. So, just take a moment and type your response in the text box.

Okay we've got some recommendations. The Third Chapter, the Glass Castle, the Outlander series, which I guess is on Starz now. Thank you. Life is Beautiful, The Explosive Child. Any more recommendations? No? Oh, let's see, the Immortal Life of Henrietta Lacks. Oh, yes. That was a fabulous book. Okay. Scandal, I know a lot of people are addicted to Scandal. Ghost from the Nursery, ooh ominous. Let's get one more. Oh, Willy Wonka's Chocolate Factory. Aw, okay, thank you. Yes, that one's a classic. I appreciate that. So, it looks like you all - well most of you found the text box. Feel free to keep sending those recommendations. We'll keep a tab on those.

Okay, thanks everybody. So, before we begin, I want to acknowledge the complexity of intergenerational teen pregnancy. There are lots of factors at different socioecological levels that contribute to the intergenerational nature of teen pregnancy. This webinar will focus specifically on adverse childhood experiences and how expecting and parenting teens' and their family members' adverse childhood experiences can increase the risk of a family's experience of teen pregnancy across generations.

This webinar will also focus on how practitioners can apply practical trauma informed approaches to support these young people in their quest to break the cycle of intergenerational teen pregnancy. At the conclusion of today's webinar, you'll be able to define three key terms, those being intergenerational teen pregnancy, adverse childhood experiences, which we're going to

abbreviate as ACEs, and trauma-informed approach. We think you can also be able to identify at least three correlates between adverse childhood experiences as reported on the ACEs study and intergenerational teen pregnancy. And then lastly, be able to list at least three strategies that effectively and positively influence teens' ability to break the cycle of teen pregnancy.

So at the end of the webinar, there will be a short feedback form. Please do not disconnect right away and we will put the link in the text box for you to see. All right, let's get started. We're going to open with a poll. Intergenerational teen pregnancy is when several generations of one family experience a pregnancy in their teens. I know that many of you have probably worked with families like this at your agencies, and I'd like to take a quick poll to learn about your experience. So, I'm going to read you the question and then the box to respond will pop up on your screen.

The first question is how often do you work with young people who have family members who also have experienced a teen pregnancy? Always, often, sometimes, never? And the poll is open. Give everybody a minute to respond, a few moments to respond. And we'll close the poll in ten, nine, eight, seven, six, five, four, three, two, one. Let's take a look at those results. It looks like about 27 percent of you said often and 20 percent said sometimes, nine percent said never, two percent said always. And there are a good number of you who didn't respond. So, if you would, for the next poll, be sure to give us a response. We want to make sure that everyone's voice is heard and you've had a moment to tell us a little bit about your work through these polls. All right, thank you everybody.

Those of you who didn't respond, you get another shot. So, typically what is the relationship between the young person you work with and the family

member who also experienced pregnancy during adolescence? Is it the mom? Is it the father of the teen who's currently pregnant or parenting? Is it the sister, brother, cousin, or other? So, we have opened the poll. We'll give you a few moments too. And I think you can choose multiple responses. If you're not able to, my apologies. So, select the one that most often is who has also experienced a teen pregnancy.

Okay we're going to close the poll in ten, nine, eight, seven, six, five, four, three, two, one. Let's take a look and see who you indicated also experienced a pregnancy during adolescence. Okay, by far it seems that the teen's mother experienced a teen pregnancy as well. Some of you indicated it was the sister and then some said other. So, if you're inclined, you can tell us in the text box who that other person might have been. Still a good number of you haven't responded. We'd really like for you to engage with these polls. We are very interested in hearing more about your work. Thank you to everyone and let's dive into what the literature tells us.

We know that daughters of teen mothers were 66 percent more likely to become teen mothers themselves and that younger siblings of teen parents are more likely to become pregnant as teens themselves. So, in general, younger siblings of teen parents are more likely to be sexually active during early adolescence than teens whose older siblings are not teen parents. There are many different factors that contribute to intergenerational nature of teen pregnancy. Some of which are overarching, and some of which vary from family to family.

One way to discuss these factors is by using the social-ecological model as a guide. The social-ecological model is a theory based framework for understanding, exploring and addressing the social determinants of health at many levels. So, we can be looking at the individual level where we'll talk

about those ACEs and their access to healthcare or their access to education, for example. The person with whom the individual has a relationship would be the next concentric circle out. This could be influenced by parenting styles or supervision and monitoring. Peers also have a great influence on these young people.

We can look at the community. What is the quality of the schools, the exposure to violence, potential access to employment? And then if you look at the broader context of society, what are the social and cultural norms? Is there access to comprehensive sexuality education? And then youth- and minority-friendly policies. These are all factors that would be influencing teen pregnancy.

But during today's webinar, we're primarily focusing on addressing determinants at the individual level, specifically ACEs and how they can perpetuate intergenerational teen pregnancy. As a quick disclaimer, I know many of you are working with young fathers. While our presenters today will mostly be speaking about their work with young women, it is important to keep in mind that the tenets of trauma-informed care hold for both women and men and that the information the presenters are sharing is valuable for anyone working to break the cycle of intergenerational teen pregnancy. So, for now, I'd like to turn it over to Jeanette who is going to tell us more about adverse childhood experiences or ACEs and how they impact intergenerational teen pregnancy. Jeanette?

Jeanette Pai-Espinosa: Great. Thank you, Deb. Well, I know that many of the PAF grantees already know a lot about the ACEs study. So, I'm only going to briefly review the study and then discuss our own ACE administration equipment that we conducted among our agencies a few years ago. For those not familiar with the ACE study, it was conducted by Kaiser Permanente and the Centers for

Disease Control and Prevention, the CDC, to investigate the effect of childhood abuse, neglect, and family dysfunction on later life - at later life, health, and wellbeing. The study was conducted from 1995 to 1997 with two waves of additional data collection.

Seventeen thousand confidential surveys were conducted with the health maintenance organization members from southern California regarding their childhood experiences and current health status and behaviors. The CDC continues ongoing surveillance of ACEs by assessing the medical status of the study participants via periodic updates and morbidity and mortality data. On the screen, you're going to see the conceptual model for the ACE study. As you can see, adverse childhood experiences disrupt the normal neurodevelopment of children which leads to social, emotional, and cognitive impairment. These impairments then lead to adoption of health risk behaviors and ultimately disease, disability, social problems, and even death. Next slide please.

The study breaks adverse childhood experiences into three categories: abuse, household dysfunction and neglect. Now they're further divided into subcategories. Abuse includes psychological abuse, physical abuse, and sexual abuse. Household dysfunction includes substance abuse, mental illness, intimate partner violence, criminal behavior, and divorce. Neglect includes both emotional and physical neglect. Your score can range from zero to ten. As the number of ACEs a child experiences increases, so does their risk for negative health outcomes.

There are many negative health outcomes associated with adverse childhood experiences. The outcomes highlighted in pink on the slide that you're looking at are among the top ten leading causes of death in the United States. You can also see on the left that adverse childhood experiences can lead to high-risk

sexual behaviors. These negative health outcomes also include risk for experiencing intimate partner violence, having multiple sexual partners, unintended pregnancy, early initiation of sexual activity, and adolescent pregnancy. As you can see, this study shows that adverse childhood experiences can have an enormous long-term impact on health.

In 2011 and 2013, the National Crittenton Foundation oversaw the administration of the ACEs survey at 18 Crittenton agencies in 16 states. We're only going to discuss some of the outcomes of this study today. To see the entire study and results, you can go to the National Crittenton Foundation website. We've included links to many of the resources at the end of this webinar. The chart on the screen shows different groups of young women who are supported by Crittenton agencies and how they score compared to the original women from the ACEs study.

As you can see, the women served by the Crittenton agencies scored much higher with many more adverse childhood experiences, 53 percent compared to 15 percent. You can also see that young mothers had higher scores than the general population served by Crittenton agencies, ranging from 61 percent to 70 to 74 percent for a juvenile justice involved young mom. These graphs show that a significant percentage of the National Crittenton Foundation females with teen pregnancies or children have high ACE scores. Next slide please.

Our study also showed that the children of the National Crittenton Foundation females have high ACE scores as well. We'll talk a little bit more about this in a minute. Our study showed that on average those children of TNCF females surveyed between the ages of zero to six scored around two on the ACE survey. Children between the ages of seven to ten scored significantly higher around a five and children 10 to 18 years old scored around a four.

This study made it clear to us that our ACEs can become our children's ACEs and that to heal the children we also need to support the parents to heal. Simultaneously supporting parents to heal from their own childhood adversities while ensuring that their children get the best start possible in life, is a most powerful two-generation strategy.

Deb Chilcoat: Thank you, Jeannette, for sharing the information from the ACE study that you all did at National Crittenton. Your work makes it so clear how closely ACEs are linked to intergenerational teen pregnancy. We also know that the literature tells us that an increased number of ACEs can lead to increased risk of pregnancy. So, that aligned. This is because many risk factors for teen pregnancy are also ACEs or closely related to them, including family disruption, household substance abuse, physical abuse, or general maltreatment.

Additionally, young people who are experiencing ACEs may not be experiencing those protective factors, which we know reduce unintended pregnancies such as high-quality family interactions, connectedness, and satisfaction with relationships, also greater parental supervision and monitoring and greater parent/child communication about sex, condoms, or contraception.

You know, researchers believe that a third of teen pregnancies could be prevented by eliminating exposure to ACEs. These facts tell us how ACEs are linked to teen pregnancy, but they don't tell us how ACEs are linked to the intergenerational nature of teen pregnancy. So, let's take a look at what research tells us about the link between intergenerational teen pregnancy and ACEs. We're going to walk through these using categories of adverse childhood experiences used in the study.

So, many of you already know that teens who are abused are more likely to experience pregnancy and that the experience of interpersonal violence is correlated with rapid repeat pregnancy among low income adolescents. You also know that household dysfunction plays a huge part and it could include substance abuse, mental illness, parental separation or divorce, or criminal household members. We all know that teen mothers have a higher incidence of post-partum depression but we also want to stress that there's a correlation in teen moms between increased stress from parenting and the risk of post-partum depression.

You know, 88 percent of teen mothers in 2010 were unmarried when their child was born. Now of those teen mothers who were not married when their child was born, only about one third went onto marry by the time their child reached aged five. More than one third of teens who were married when their child was born actually split up by the time their child reached age five. And about 42 percent who were cohabitating when their child was born split up too.

Neglect, as Jeanette said, includes emotional and physical neglect. Compared with women who had their first birth at age 20 to 21, teen mothers are more than twice as likely to have a child placed in foster care during the first five years after birth. The numbers: 3.12 percent versus 1.44 percent. They're also twice as likely to have a reported case of abuse or neglect. So, as you can see, all of these data also point to the children of teen parents having higher ACEs scores as Jeanette has seen in her study as well. This puts them at greater risk of pregnancy themselves later on. So, Jeanette, the National Crittenton Foundation has a model that synthesizes all this data quite nicely. Can you just share a little bit more about it?

Jeanette Pai-Espinosa: Sure. Absolutely. We developed a model we call the Vicious Cycle, which really helped us to better understand and visualize the interconnection between what is most often viewed as a separate cycle of generational childhood adversity including violence, poor outcomes, and poverty. The Vicious Cycle is a model we created during a process of internal soul searching about why the population of girls, young women, and women had not changed more since 1883, when we were founded. We wanted to identify how we might be part of the problem.

The Vicious Cycle helped us identify that we were stuck in poor outcomes only addressing symptoms. So, it's a framing model, more than a model of practice. It taught us that we have to be supporting folks at all points of the cycle if we ever hope to break it. It shows us that it's not four separate cycles but rather one that requires comprehensive approaches to break. Today our primary systems of care, such as child welfare and juvenile justice, are built around poor outcomes. In general as a society, our response to children acting out - whether that is truancy, defiant behavior, running away, early onset of sexual activity - is to focus on the behavior and the poor outcomes, not to address the root causes of it.

The status quo today is separate systems working in silos to respond to poor outcomes. But when viewed as components of the same Vicious Cycle, what becomes obvious is the need to address childhood adversity and the resulting trauma as a precursor to poor outcomes. Furthermore, the Vicious Cycle highlights the inability of public systems working in silos to effectively interrupt the cycle. Most people will say that they have experienced some form of childhood adversity as defined by their family, cultural and social contexts. Why then do two people who experience the same adversity react differently?

We're still learning about the answer to this question but what we do know is that some people have more resources available to them to buffer the impact of the adversity. For example, a child who lives in a stable family with the financial means to get the support needed to heal is at less risk of being stuck in poor outcomes and living life in poverty. In contrast, children and families impacted by intersectional oppression for generations are at high risk of experiencing multiple acute forms of childhood adversity, which in turn pushes them into systems addressing poor outcomes and poverty.

Because the vicious cycle most often plagues families generationally, the model does not propose a beginning or an end. Instead, it points to the critical need to address all points of the cycle through a continuum of services and opportunity that spans each phase of the cycle. The challenge is shifting the focus from addressing isolated poor outcomes to supporting individuals and families over time and changing the trajectory of their lives.

Deborah Chilcoat: This is such a great model, Jeanette, and I love how this echoes our earlier discussion of the social-ecological model. The model really helps to explain the intergenerational nature of not just teen pregnancy, but trauma in general too. We know that young people who experience trauma are more likely to have mental health issues, engage in alcohol and drug abuse, and exhibit violent behavior as an adult - meaning that children of teen parents who have ACEs are more likely to experience ACEs themselves. This is just reinforcing what we believe and now know. So, this model demonstrates how the intergenerational nature of these risk factors definitely contribute to the intergenerational nature of teen pregnancy.

So Jeanette, your study at the National Crittenton Foundation identifies specific ACEs or categories of trauma that were most experienced by the

young women you assessed. Can you tell us a little bit more about what you found? Oh Jeanette, are you on mute by chance?

Jeanette Pai-Espinosa: Sorry about that. Yes, I am.

Deborah Chilcoat: Oh, no worries. No worries. Thanks a lot.

Jeanette Pai-Espinosa: Yes if you look at the chart that you see up now, you can see a couple areas highlighted in yellow. We see psychological abuse, emotional neglect, alcoholism or drug use in the home. You also see very high loss of biological parent from the home, particularly for young mothers, and juvenile justice. So, we've done this study twice and these high percentages in these particular areas prove to be true across both of the studies. Next slide.

So our study also identified the ACEs that were most prevalent for children of the Crittenton mothers. You can see the similarities between the ACEs of the children and their mothers if you look back to the last chart. Without support, it's clear that the mothers' ACEs are becoming the children's, resulting in heightened risk for poor health outcomes, including early onset of sex and unintended pregnancy. The result, of course, is intergenerational teen pregnancy. And we do, however, know from our experiences that when we invest in two-generation approaches, the ACE scores for multiple children can fall relatively quickly.

For mothers receiving comprehensive support from Crittenton agencies, that took the ACE survey for multiple children, the score of each subsequent child is lower than the previous child. That is as parents receive support to heal and learn, this too is passed onto their children. Deb?

Deborah Chilcoat: Yes, that's fascinating. And it makes good sense that they're getting the services and the support that they need. Hopefully it gets better over time. Okay, so we want to do another poll. The question is, which category of ACEs do you address most with your clients? You can select more than one response and the responses are abuse, household dysfunction, and neglect. If you have other ACEs that you address and you're inclined to put those in the text box, you're welcome to do so. But we have opened the poll and we'd love to hear from all of you which ACEs you address most with your clients, the young people you work with.

Okay we're going to close the poll in ten, nine, eight, seven, six, five, four, three, two, one. Let's see the results. Okay, by far, household dysfunction, about 35 percent of respondents had said that that was a category you deal with most. And then next is abuse, at 14 percent of you, and then neglect at four percent. So, yes clearly you can see that ACEs are a critical part of our work. But the question then is what can we do to address these in the work that we do? These are their experiences but we need to know how to address them.

So the best way to address intergenerational teen pregnancy that is perpetuated by intergenerational trauma is by using a trauma-informed approach in all the work that you do with each generation of the family that you're working with. So, a trauma-informed approach is a program, organization, or a system that one, realizes the widespread impact of trauma and understands potential paths to recovery and healing. Second, it recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system. Third, it responds by fully integrating knowledge about trauma in policies, procedures, and practices. And then finally, it definitely seeks to actively resist re-traumatization. And you can learn more

specifically about those at SAMHSA and we'll have information at the end to share.

But I also want to give you a heads up. You know, OAH has been very committed to trauma-informed approaches and there are many helpful resources about trauma-informed approaches at the Office of Adolescent Health Teen Pregnancy Prevention resource center. So, pictured on the screen are two really helpful resources. The first is a checklist for integrating a trauma-informed approach in teen pregnancy prevention programs. And this is a document by the Substance Abuse and Mental Health Services Administration or SAMHSA on the right hand side of your screen. It provides more information on trauma-informed approaches and guidance on implementing them, so two really key resources that you should take a look at.

Again, we know that many of you probably already know about these and participated in possibly even an OAH webinar last year which was titled *Creating Safe Spaces: How to Integrate a Trauma-Informed Approach Into Your Teen Pregnancy Prevention Program*. But we just want to refresh your memory. So, let's take a quick review of the six principles of trauma-informed care. So, the first one is safety. The young person has to feel safe not only in their environment but also with you and the staff of the organization. So, you want to be sure that you are providing that space for them.

Trustworthiness and transparency, oftentimes people have suffered trauma, trouble with trust, and the best thing that you can do is build rapport, build that trust and don't hold back. Create transparency with this young person. Be aware of disclosure and where the balance is of your boundaries and theirs but really, genuineness goes a far way, a far distance.

Peer support, understanding that both the client as well as you will need peer support. And then collaboration and mutuality, this is not a top down dictated way of approaching the young person and what they need. You talk with them. You find out what exactly they need and then come to an agreement sharing with one another what exactly will be most beneficial, ultimately empowering them and giving them voice and giving them choice. And then taking into consideration the cultural, historical, and gender issues which may be influencing what has happened to them or may be specifically the root cause of some of the trauma.

So let's talk to the folks in the field who are applying trauma-informed approaches to break the intergenerational cycle of teen pregnancy and learn more about how to integrate trauma-informed approaches into our practice. We're going to go back to Jeanette with the National Crittenton Foundation. Jeanette, can you tell us more about how your work with the ACE study informed your approach?

Jeanette Pai-Espinosa: Sure. First I do want to note that the practice implications I'm going to make are based on inferences drawn from our results from respondents at the administration we did at the ACE study. As you mentioned earlier, further research is certainly needed in this area for more definitive findings and recommendations to be made. But if you look at the chart, we clearly have seen that there's a group of girls for whom ACEs are normative. The girls we see in Crittenton agencies tend to come in with scores of four or higher and we have noted recently that there's a cluster of girls who have scores that are eight, nines, and tens.

So there's no doubt for us that we really, if you look at the policy implication, have to focus on reducing overall exposure to ACEs and other forms of adversity. We're well aware that the ACE survey has its limitations and are

working on expanded versions for us to use the next time around. You'll also see under findings that girls' ACE scores are higher than boys and even perhaps more important is that there are differences in the prevalence of individual ACEs. For example, girls have much higher exposure to sexual abuse than boys do. Not better or worse, just something we have to understand as we look at, you know, what is driving girls and boys into the system - into our different systems of care. Policy implication: a gender lens really should be used in all systems to better understand appropriate services and support responses for girls. Next slide.

So two more findings, children of parents with high ACE scores experienced adversity at young ages. I think we saw that in the data earlier and I think the policy implication really is about two- or multi-generational approaches. And I think that's really consistent with all of the six principles, Deb, that you talked about earlier. We've just seen it to be very successful in reaching across and around families.

Another finding initial result suggests a connection between ACE scores and well-being. In our last administration of the ACE, we added well-being domain questions in the area of stress and coping and connectedness and found a significant connection between the ACE scores and how strong their connections were and how well they were able to cope and how stressed they reported being. So, the policy implication for us really is really, how do we do further work that increases connection for young people? Because that's where we saw the biggest correspondence with the actual ACE score. That's it.

Deborah Chilcoat: Jeanette, it sounds like the individual agencies also have used the ACE surveys to reinforce using a trauma-informed approach within the own organizations with their clients. Can you share a little bit more about this as well?

Jeanette Pai-Espinosa: Sure. You'll be able to hear specifics from Suzanne and Barbara in a minute but the main objective of doing this across our agencies really is to obtain an ACE score for each person or family member of the young person which can help agency personnel understand their trauma histories and to connect those scores to wellbeing domains and outcomes that can help change the trajectory of their lives. The second really is to aggregate the data within an across agencies to inform treatment interventions, system responses to the trauma, and public policies to address childhood trauma and to prevent it for future generations.

Agencies administering the ACE survey with their own clients can serve several purposes. And of course we understand that the ACE survey is not a clinical assessment. But the first purpose is to support screening assessment, treatment, and self-empowerment, and this really all comes from our agencies and the feedback that we've received from their use of it. The administration of the ACE survey provides a snapshot of the extent of adverse childhood experiences among clients of the family of agencies. For current clients, it can be used as a screening tool that informs intervention and provides a brief opportunity to have a conversation with young people about their trauma histories.

The second is to further refine the interventions for young people at the agency level. ACE survey results can be instructive to agency staff as they continue to refine and customize treatment and service interventions. And ACE findings complement other tools being used to understand what's working for different populations of the young people that they serve.

The third really is to educate the broader community. There's a critical need across communities to educate stakeholders, such as medical professionals,

law enforcement, schools, and other referring systems about the trauma experiences of individuals served by the agency and how they agency works to address that trauma. ACE findings allow the agency to better describe the populations they serve and their trauma histories and to promote trauma-informed treatment to build resiliency and mitigate the impact of ACEs.

Finally, it's used to inform public policy. By collecting ACE data across the family of agencies, the National Crittenton Foundation can more effectively advocate for public policies to ensure that girls and young women receive high-quality trauma-informed services as early as possible in the most appropriate setting to meet their needs.

Deborah Chilcoat: It sounds like this is a really useful tool for agencies within the Crittenton family of agencies. I want to just go back to the principles, the guiding principles, of trauma-informed care and just remind folks that if you do a simple Google search - I know I went through them fairly quickly, but if you - put in "SAMHSA and trauma-informed care" it lands on a page that has a much more thorough description of the guiding principles of trauma-informed care. So, please take a moment to look at that for a more comprehensive explanation.

But right now let's turn and hear from the two agencies that learned how to apply a trauma-informed care approach and a multi-generational approach in the work that they do and if and how they applied the ACE study. First we're going to hear from Suzanne Banning. And just a reminder, she's with the Florence Crittenton Services of Colorado. So, Suzanne?

Suzanne Banning: Thank you Deb. So, here in Colorado, the mission of our Florence Crittenton Services is to educate and prepare and empower teen moms and their children. We are using the two-generation approach by providing learning and

developmental opportunities for both pregnant and parenting young women, ages 14 to 21, their children. And we use a three integrated program approach. We have our student and family support program. We have our early childhood education center. And then we partner with our Denver public schools to run a high school.

Our main focus is on the teen mothers and their children. However, I do want you to know we help young fathers. As a support to the teen moms, we work to ensure that our campus is a safe and accepting place for the young fathers to come, receive guidance and support, accessing different community resources including help with our key partners in obtaining a GED, career guidance. We also help them apply for college or technical school, public assistance, and of course parenting education.

So to go over some of our demographics, on this slide you'll see that we're serving around 240 teen moms per year. That's a picture of a bunch of our young women at the beginning of the school year. But on campus at any point in time is usually about 120, 140 teen moms and 100 children. The children we serve are six weeks all the way through preschool. Now as statistics were talked about earlier, 73 percent of our moms have one or two parents who didn't graduate from high school and 55 percent are children of teen mothers. We have a large population of youth of color and 82 percent are Hispanic.

The majority of our moms are 18 or under and 30 percent are English language learners. So, that's something we work with as well. And this is interesting because at least 50 percent had irregular attendance or had dropped out of school before really becoming pregnant. The pregnancy was a wakeup call to say okay I need to do something and that's when they arrive on our campus.

So our program model as I mentioned is a two-generation focus and the graphic depicts that. It really is to help teen families to break the cycle of poverty through education, health and wellness, economic and social asset-building. The campus is a full-service family resource center. We serve as a single point of entry for the teen mothers, their children, and as well as working with the fathers and extended family members. We work to have them receive customized wraparound services connecting them with community resources that are going to help meet their needs.

Now the academics as I mentioned earlier are provided by our Denver public school partners. [Unintelligible] provides the ECE, early childhood education. We have up to 110 slots. We provide the social and emotional support, which I'll go into more detail in a moment, both for the mom and the child, so focusing on both, parenting education, after school tutoring. We do a lot of life skills training, financial literacy, and of course make - this all makes it possible for the mothers to succeed, not only academically but also as parents.

So as far as our social and emotional support model which really focuses a lot on working with the trauma informed care, each young woman when she comes to us is - has an intake process that allows her family advocate to have an understanding of both her needs and her child's needs. The intake itself identifies the traumatic experiences past and present that are affecting the teen mom's life.

Now this intake information also includes the use of Protective Factor Survey, an assessment of - the assessment gives a baseline indicator, but we include the attendance, the academic performance, and classroom behavior. This information is then combined to identify each teen mom's current status in the growth assessment framework you see on the screen so we're really working

in six skill areas and then gauging where the young woman is in all of those areas and they can move back and forth as you might imagine.

The Family Advocacy Services -- the family advocate in the programs -- are tailored then to each teen's mom's needs according to the intake and baseline assessment. So, this would include frequency of individual sessions, the home visits, the mental health counseling, medical treatment, basic needs, legal help and class - the classes that they are assigned. Now our onsite partnerships which are so important in this model include mental health care providers that are here every day of the week, and this really helps us with our ability to help the teen moms work through the trauma that they've experienced and then be able to succeed.

The family advocates work with the campus educators -- so the teachers -- High School teachers and the ECE teachers -- help them to understand how to communicate and negotiate what each teen mom based on her history in order to bring other strengths -- and this is very important -- avoid triggering her. The family advocates working with the ECE teachers also ensure the coordination of services and customization of the educational program based on the child's development needs as well as the prospective of the family's history -- so again, taking into account that intergenerational trauma.

If the mom is receiving trauma, obviously, the child is as well. So, what does this all do for us -- some of the successes I feel we have because of our approach in all these wraparound services that we provide? We have more than doubled the graduation rate for teen mom's [unintelligible], the developmental milestones of the young children, as you can see 98 percent, and the children that do not meet the milestones we obviously do remedial work and bring in partners to help with us to create some IEPs.

Keeping our children up on immunization, well-baby child checks are very important. Next slide please. Our teen moms, when they go on maternity leave they get six weeks. We stay connected with them both from the social and emotional-mental component as well as keeping them up on their academics. We are very excited that our teen moms consistently show increased knowledge of parenting and their parenting skills.

We have three different parenting classes that they must take. And then we just added a school based health center when we did our campus redevelopment so we are the only school in Colorado that has a school based health center both for pediatrics and OB/GYN and last year we just opened it and it is, I will tell you, an important ingredient now to our success. So, strategies in general, I think, as, you know, I think about what to apply in order to create this campus and model.

We really want to make sure all of our staff is trained to understand what the trauma-informed approach means. We need to make sure that they're aware of these triggers for teen moms or their child. Often, you know, really the teachers in both classes -- the ECE and the High School -- need to be consistent in language that we're using. We need to be aware of the internal biases and assumptions that we all carry to the campus and make sure that we reflect on that; we act compassionately and accept a lot of the things and issues that our young woman bring to us.

We want to model for our young moms how positive relationships look. What is it when the peers and the service providers; what does that look like and with your children especially? I think the other thing that we really added over the last few years is this mental health counseling onsite. What we have found is when our girls come to this campus we need to make sure everything they need is here.

If we prior we had said, “Okay, here’s a pass, you know, go offsite to see a mental health counselor,” it wasn’t happening so by bringing it onsite with the partnerships we’ve hired service providers who specialize also in infant and toddler mental health and child development, that’s been very important. And lastly I would say, training our staff to make sure they know what to do to take care of themselves. We understand that, you know, they have the secondary trauma which can be just as challenging so let’s make sure the self-care is there. And that’s it.

Deborah Chilcoat: Great. Thank you so much Suzanne. We’re going to turn our attention now to Barbara Burton and she is with Florence Crittenton in Montana. Barbara?

Barbara Burton: Thank you Deb. Great to be here. So, Florence Crittenton in Montana provide services to pregnant and parenting teen mothers and young woman in a residential treatment program up to the age of 21 and we also offer community-based services to young families basically of all ages with young children so the young parents in our residential program have generally been diagnosed with a mental health condition that precludes their independent success in the community, as well as being pregnant and parenting a child under the age of four.

They’re often involved in foster care, the juvenile justice system, or both, but at times may be referred by a parent or county health nurse, school counselor or other professional. They receive trauma-based mental health therapy, parenting skills, and life support skills. This includes many of the community-based services we provide as well. Our community services focus on parenting support.

Parenting classes such as Circle of Security Parenting, Love, and Logic are used to support parents' learning and skill-building as well as their understanding of child development and attunement, home visiting services including parents of teachers, and safe care provides families in the community with regular visits in their homes and are often by trained parenting educator who works with the family. These interventions are supported by community parent support groups as well, and by facilitators.

In addition, we have a child enrichment center that provides support assessments and childcare for infants and toddlers ages zero to two. We specialize in offering a teen prenatal group called, "Loving Your Babies from the Inside Out" that was developed by Florence Crittenton Home and Services in Montana specifically to address the unique needs of a pregnant teen mother who has experienced trauma. This group addresses body changes, labor, delivery and the tenth month of pregnancy from a trauma lens and focuses on attachment to baby.

This group normalizes the birth and supports teens through an experience that can be retraumatizing especially to those who have experienced sexual abuse. Finally, we have a young mothers support group called, "STRIVE" -- "Striving to Reach Independent Values and Education". This group covers everything from body image to bullying in a teen-friendly interesting way that prepares young mothers for social engagement and goal setting. Florence Crittenton does work with fathers in a residential program.

We have virtually every scenario of fatherhood involvement imaginable. If legally appropriate, we engage the fathers early in treatment and support their interaction with their child. They're invited into therapy which at times means a long-distance session or conducting sessions with incarcerated fathers. If

possible, they're encouraged to make regular visits along with spending time with both mother and child to learn the same parenting skills and techniques.

If the father can't be engaged, it's our job to support the mother through the process of determining what that means both psychologically and legally. In our community services, fathers are much more likely to be fully engaged. They participate in parenting classes, home visiting services, and are very likely to be the ones initiating the request for services. Single fathers are seeking out much more support these days as both the requirement for custody and voluntarily than they have in the past.

Next slide please. So, Florence Crittenton in Montana utilizes a two-generation trauma-informed approach that is relationship based to supporting young families. This includes building a continuum of services that focuses on working with the entire family. I carry this a step further to say it's a multi-generational approach as the majority of young parents we work with are teens and including the teens parents in treatment is a critical component of ensuring long-term success.

This often means working with families who are struggling with generations of conflict, trauma, and poverty, and many times, mental illness. Our outcomes may vary for families. The primary goal is a resolution of some of the long-term trauma and conflict that led to the current situation. As you can see from the diagram, the generational approach focuses on each member of the family and addresses their needs within the family system both separately and together.

A lack of any of these supports may result in trauma for the child. By potentially reducing stress in the environment, we may reduce the likelihood of childhood trauma. Using comprehensive services allows us to provide

intensive residential services with 24 hours' supervision and support and/or for families that require lesser support. We utilize weekly home visits for parenting classes or perhaps the first step is stable housing.

Our program focuses on finding the right solution for each family, but we can best resolve this stress. The theory of change is that we can potentially, in one generation, begin to see the reduction of intergenerational trauma by reducing chaos and stress in families. The initial step is to assess the parents' level of trauma. We've done this with a quick assessment through the ACE questionnaire. While it's not a full assessment tool, it does give us a picture of the level of childhood trauma and a starting point for treatment. Each youth in our program is given the assessment at intake and then again after three months.

The three-month timeframe allows us time for the youth to build trust in the treatment team and often results in a higher ACE score as the client feels more comfortable disclosing abuse and neglect. Each ACE assessment, along with the data of additional assessments is used to build an individual treatment plan. The plan is the building block for helping the client reach their goals.

The ACE assessment also informs the staff regarding how a particular client might feel and react in stressful situations. For example, we've noticed a high correlation of youth who struggle with labor, delivery, and ultimately breastfeeding or close contact with their baby after birth. It's no great surprise to anyone this on this webinar. But the reasons why are complicated.

ACE scores and trauma-informed therapy can help us find not only the reasons why, but also help us navigate some very default passages for pregnant and a parenting young mother. A girl who's been sexually abused may not only struggle with the idea of breastfeeding for obvious reasons, but

it triggers in her a fear that she'll somehow sexualize her child. She may not be able to disclose this abuse.

So as we, as her caregivers, need to be ever aware and make an outside ways, she may avoid the idea of OB checks, she may talk about needing to have drugs or a C-section, she will need help understanding where these feelings are originating and need an advocate to interface with the medical community who may not be trauma-informed and see her as defiant, a typical troubled teen, or just a problem patient. Without appropriate support, her trauma will be potentially passed onto her child in her actions and behaviors throughout her pregnancy, delivery, and first year. This is the most critical time for attachment and brain development for the baby.

In our program, the ACE results have shown us many things. The top four results of ACEs within our clients are as follows: 100 percent of our clients have experienced the loss of a biological parent, 84 percent have experienced living with a household member who was depressed, mentally ill, or attempted suicide, 74 percent experienced living with someone who abused drugs or alcohol, 68 percent had a household member who went to prison.

The average ACE score for our clients is a seven. It's not uncommon to have clients with a score of 10. This information is shared with our clients, but only with the support of their therapist and case manager to help them process what it means. In terms of how our ACE data informs our practice, we review aggregate data to see for our services need to be changed, increased, etc. For example, over the past four years, we've significantly changed the program focus of our services in our residential program.

Previously, we had a very strong independent living program teaching many life skills. After a thorough review of our data, we greatly reduced the focus

on life skills and amped up our therapeutic services. The life skills there are a great deal of importance. We have six to nine months to impact a life change. Finding a way to impact the next generation through attachment therapy, trauma treatment, and parenting education, was far more important.

Finally, Montana has fully embraced ACEs. Through the data gathered with the National Crittenton Foundation, the ACE data has allowed us to bring real numbers to advocate for the needs of young families. Demonstrating the level of trauma experienced by young parents greatly increased the empathy among skeptics who blamed the same young parents for the lack of appropriate parenting or simply becoming pregnant in the first place. Showing an average ACE score of seven or higher among our young mothers greatly improves the understanding of risk factors for their children, if no intervention is provided.

We're currently using ACE data with state and legislative officials to improve resources for young families throughout the [unintelligible] viewing support solely for children and child protective systems. Finally, implementing trauma informed care within your agency is critical if you work with human beings. Most people have what we call a "Default Internal Working Model".

We've been conditioned to react to the world in a certain way and look through a certain lens. You also never know who might be the one person who will make a difference in the life of another. Trading for everyone in your agency ensures consistent supports for your clients in a culture of caring. At Florence Crittenton and our staff has provided with training on ACEs as well as Circle of Security Parenting, which is based on attachment theory.

In addition, we're training our entire facility in art, attachment, self-regulation and competency this fall. Our ARC framework for intervention with youth and families who have experienced multiple or prolonged traumatic stress.

ARC identifies three core domains that are frequently impacted among traumatized youth in which are relevant to future resiliency. It's always important to remember trauma-informed care is not a program, but rather a way of having a relationship with other people.

It's how we choose to see them and their reaction and interactions with other people in their surroundings. We should question, "I wonder what happened to them that caused them to react that way," rather than think, "What a horrible way to act. They must be really mad, bad, angry," you can fill in the blank. We need to check our own emotions at the door. It's not always about us.

In other words, the way another person reacts to a situation may have nothing to do with us even when they're standing in front of us screaming. this could've been triggered by a memory creating a trauma consciously or subconsciously." Our job is to remain calm, impartial, and supportive. Ruby's case demonstrates a lot of what we discussed.

During the day she was a great mom, but staff reported that in the evening she often ignored her son's cries, refusing to feed him or comfort him, particularly just before bedtime. When questioned about this, she became increasingly defensive, even aggressive at times, lashing out at staff rather than discussing solutions. During therapy it finally came out that Ruby had been severely molested by her father, and, you guessed it, it was always in the evening or at bedtime.

After much processing, she was able to verbalize her fear of repeating with her child what had happened to her. Her solution was to avoid her child altogether than to risk hurting him. Staff was able to support her by bringing

her tea at bedtime, sit with her, read to her, change her point of view of nighttime rituals all while ensuring that her baby was fed and cared for.

It would've been very easy to assume she was tired at night or selfishly didn't care when the opposite was true. She just didn't have the tools to manage a healthy solution. We're all human and many of us have experienced our own trauma ensuring we have the supports in place for our staff to debrief, get help, and learn from experiences is critical. We dedicate part of our weekly staff meetings to debriefing and staff support.

Additionally, an open door policy for staff to come forward with stress or problems is critical. Understanding the way trauma affects our behavior, our mental status, our interactions with others and simply our way of viewing the world can greatly improve how we work with our clients.

Deborah Chilcoat: Barbara, that was very, very important information. We thank you so much so much for presenting today. We are now going to hear from Melanie, who works with Safer Futures in Oregon, and she is a PAF grantee. Melanie?

Melanie Prummer: Thank you Deb. So, the Safer Futures Project focuses on the intersection between health and intimate partner violence and so the mission of this project is to improve services for pregnant woman who are victims of domestic violence, sexual assault, or/and stalking. So, according to the CDC, more than one in three woman have experienced rape, physical violence or stalking by an intimate partner in her lifetime so we believe that identifying current or past violence can help prevent further abuse and lead to improved health status across the lifespan for both the mother and her child.

So we are also using the ecological model to integrate collocated domestic violence advocacy services within healthcare systems, and as you can see,

working with participants, providers, programs, and policy makers and key stakeholders. But through our partnerships that advocate connects with programs that target teens such as birth control clinics, school-based health clinics and qualified medical homes, and so within each of those programs our goals are to improve the safety and well-being of woman who are victims, enhance healthcare providers' confidence and knowledge about intimate partner violence issues, improve the screening and referral process with our partner agencies and engaging pregnant and parenting mothers in advocacy services.

We're providing services to women of any age who are pregnant at the time they become victims of intimate partner violence. We know there are many health risks and increased risks for complications during pregnancy. For example, low weight gain, infections, first and second trimester bleeding, and there are also higher rates of depression, suicide, and drug use. We also serve woman of any age who are pregnant during a one-year period before they become victims of intimate partner violence.

So some of the partners on our project include Public Health, Oregon Health Alliance -- which is our coordinated care organization for the Oregon health plan members, ADAPT -- which is our addictions treatment program -- Cal Creek Tribes and UCAN which is a non-profit organization coordinating the home-visiting nurse program. So, you can see in this service menu offered in the slides that we provide these services to patients accessing services through all those clinics.

So providers can consult with the advocate and conduct a screening. We also encourage universal education to all patients whether they're experiencing violence at the time of the appointment or not. You can also see that we offer emergency assistance such as shelter, peer counseling, support groups, and a

prenatal yoga group. And this year [unintelligible] doula trains to assist us in ensuring trauma-informed services by partnering this midwife or the physician and so we're also the point of contact for providing other referrals including legal aid housing or even food.

So at the individual level our participants we provide education to both parents and children about trauma and its effects on the brain and we also provide information about resiliency and talk to survivors about building upon their own strengths or even their children's. So, at the provider level, we provide trainings to advocates and healthcare community members to understand the effects of trauma and the implications across the lifespan.

We're also working with providers to develop a comprehensive intake so that we're looking at not just screening for intimate partner violence, but understanding a person's life from birth until now looking at how adversity may be impacting their behavior or their health. So, the intake also assists us in building upon strength and to begin collaborative problem-solving with the survivor or the patient.

So our goal is to integrate trauma-informed care across systems using the ACE as the unifying science to shift our community's culture and as a result, we've expanded our work to schools and the juvenile department by providing them trainings and tools. And as we talk about ACEs with clients and the impact of toxic stress on their health, we also believe it is just as vital to have these discussions with our staff -- our advocates -- providing trauma and supervision and addressing their self-care regularly.

So at the policy level we're working with leaders across sectors so for - not just in healthcare, but also education, government, some of our funders, and other social service organizations and we're working to align all of our

resources. So, a recent accomplishment has been to secure funding for our community to send a team of six members in leadership positions to the Sanctuary Institute in New York this October [unintelligible] and [unintelligible] asked, “Why the century model?” and our community has chosen this because it’s a trauma-responsive evidence-supported approach that has a clear and structured methodology for organizational culture shifts and changes and focusing on treatment by understanding the overwhelmingly stressful and traumatic experiences survivors have experienced especially during their own childhood.

So to build upon education about ACEs, we’re assisting providers including within our own program to have trauma-informed services and facilities. So this means that when we’re providing case management, for example, or supportive services to mothers, we apply the trauma-informed principles. So, for example, communicating with compassion, as mentioned earlier, our staff framed questions with, “What happened to you?” versus, “What’s wrong with you?”

We also promote safety -- so discussing with clients what concerns them most and talking about a safety plan rather than having a “cookie cutter” plan -- safety plan -- where everyone’s acknowledging everyone’s situation is different or their concern may vary. And we also pursue the person’s choice -- so allowing clients to decide what works for them and their child -- so building on their strengths again, providing education options so that clients can make an informed decision.

So this summer I’m going back to our community work. James Redford, the maker of “Paper Tigers,” has met with 75 stakeholders from our community and we discussed with James the impacts that we can have on using our own community. So, one of the things that came up was talking about how we can

all show compassion through appropriate touch and saying, “I care about you,” and so if we all use trauma-informed principles, we would hope that children and families would have supportive, trusting relationships with professionals in some different systems throughout our entire community.

And earlier this year during focus groups we were given feedback from young mothers, and their feedback was that they felt really retraumatized and unsupported by systems, and so we’re using this feedback to prioritize our work as we move forward.

So in summary, our hope is for all providers to implement meaningful comprehensive assessment from birth to now exploring adversity during childhood, training new physicians and staff, and making training a requirement doing like new employee orientations, and then also ongoing education and utilizing information shared on the ACE and resiliency questionnaires for both staff and patients.

So other things were born during this project implementation includes feedback that patient feels frustrated because there’s a lack of support and our goal is to elevate the voice of patients or survivors to influence policy and practice change. We have also learned that using ACEs as the unifying science opens doors to start conversations with providers that traditionally we have not reached and [unintelligible] also looked for opportunities to educate others or this is become obvious to us.

And an example of that was success when we used an expert witness to testify about ACEs, intimate partner violence, and the health consequences, especially the impact on a person’s mental health. And so, thank you again for allowing me to share a little bit about our project.

Deborah Chilcoat: Thank you for sharing so much. It was really great to hear from all of the agencies. Melanie, you were talking about collaboration, safety, choice, Barbara you touched on trustworthiness, and how it might result in higher ACEs scores it's because people are more willing to share what has happened and, of course, Suzanne, when you were talking about avoiding retraumatization, you know, you hit on most of the guiding principles of trauma informed care so it was really, truly great to hear from all of you and to hear how you're using trauma-informed care to reduce the likelihood of intergenerational teen pregnancy.

But I wanted to just continue to sympathize some of the recommendations that you all made and review a few actionable steps that organizations can take now. So, just keep in mind that research on trauma is constantly evolving and it's really important to have regular professional development events so that everyone in the organization, not just those who are doing direct service with clients, have all of the current information on trauma and are well informed.

So, number one, we really encourage you to do a needs assessment to understand what staff's current level of knowledge is, but then take a good look at where they [unintelligible] so that when you do your training it's relevant and it's meeting the need. One other thing to keep in mind is we want to make sure that staff can truly can recognize the signs and symptoms of trauma which could include fear, anxiety, depression, anger and hostility, aggressive behavior, sexually inappropriate behavior, self-destructive behavior, or feeling isolated or stigmatized.

A lot of these people have very poor self-esteem or have difficulty trusting others. As you heard, many of them start using substances and may have sexual difficulty or maladjustment. So, science had also included if you want to look outside of the individual that problems with peers and family

members. They could be acting out or have some problems in school in their performance in school is not so great.

Of course, depression, anxiety disorders, and externalizing disorders those things are things to keep an eye out for. If you think about the younger children -- children ages zero to two, signs of trauma could include poor verbal skills, memory problems, you know, they might have an excessive temper or be really aggressive, they may experience regressive behavior, excessive screaming or crying, they could be easily startled, they could be really, really fearful of being separated from their parent or their caregiver, and they could have appetite issues or poor appetite or sleep difficulties so it's really important that staff are fully trained in the signs and symptoms of trauma for adults, young parents, and children, really, of all ages.

I think it was Barbara who said we're human beings and so keep that in mind when thinking about trauma. Another thing to think about is with the staff. They may very well experience secondary trauma. And just to explain what that is, it's the emotional duress that results when an individual hears about firsthand trauma experienced by someone else.

The symptoms can mimic those of post-traumatic stress disorder and can trigger the person to re-experience the personal trauma that they had. Some staff comes to this work already having experienced trauma themselves and it makes them more vulnerable to the secondary trauma so please make sure you have some strategies for preventing and intervening in secondary trauma and as an organization have clinical and reflective supervision.

Find some balance to the number of trauma cases a particular staff member has. You know, be flexible with their schedule so they can have some flex time and also incorporate secondary trauma training and create external

partnerships with secondary trauma intervention providers. Train organizational leaders and nonclinical staff on secondary trauma and all the symptoms and signs that go along with it.

And, you know, it's also a great idea to provide ongoing assessment and understand what exactly the staff's risk and resiliency is to trauma. Of course, we always want to advocate for practicing good self-care, maintaining a healthy work/life balance, and developing a personal wellness plan. Continuing to train on risk reduction and self-care is really important and supervisors as well as employee assistance programs are available and counseling services are available, not only making people aware of it, but really encouraging them to use it so they need to.

So in order to take a multi-generational trauma-informed approach, it's important for us to understand how trauma impacts families. So, Number One, families dealing with high stress, limited resources, and multiple trauma exposures often find their coping resources depleted. Their efforts to plan or problem solve are not effective, they're not working, and it often results in ongoing crisis and discord.

Secondly, extended family relationships can offer sustaining resources in the form of family rituals and traditions, emotional support and caregiving. Some families who have experienced significant trauma across generations might experience current problems in functioning and they risk transmitting the effective trauma to the next generation which we've been talking about since the beginning of the webinar.

Parent/child relationships are essential in the parents and children's adjustment after trauma exposure so protective, nurturing, and effective parental responses are positively associated with reduced symptoms in

children. At the same time, parental stress, isolation and burden can make parents less emotionally available to their children and less able to help them recover from trauma. Results intimate relationships can be a source of strength and coping. However, many intimate partners struggle with communication which makes them less available to each other and increases the risk of separation, conflict, and interpersonal violence.

Siblings. Sibling relationships can offer buffer against the negative effects of trauma, but siblings who feel disconnected or unprotected can have high conflict. So, siblings not directly exposed to trauma can suffer secondary or vicarious traumatic stress which can mirror post-traumatic stress and interfere with functioning at home or school. So, also, you know, be sure to integrate your knowledge about trauma into all of the policies and procedures within your organization.

This means focusing on policies and procedures around clients' needs rather than simply focusing on organizational needs so that you can ensure that clients are not being unintentionally retraumatized. So, think about making policies that ensure providing timely screening and comprehensive assessment of trauma, maintaining the transparency of service planning and implementation; speaking feedback from clients about their experience, and insuring materials and communication are in a language that the client truly understands.

So here you can find the contact information of today's presenters. One thing I should say is there have been a few mentions of advocacy during today's presentation. Just a reminder, as PAF grantees, advocacy is not allow - an allowable activity; however, activities such as raising awareness, education and providing technical assistance are. Advocacy is also - we want make sure that we're steering away from lobbying.

So when thinking about the information that has shared and some of the activities, we just wanted to be clear that you keep those in mind. So, thank you again to the guest presenters. And now we want to turn our attention to our audience and we do have time -- just a little bit. If you have questions, we would appreciate it if you would put those in the question-and-answer box. And just to let everyone know in case you haven't seen it, I actually just put the link for *Six Guiding Principles of Trauma Informed Care* in the chat box so take a look at that while we wait for some questions to come in.

So one question is, "It seemed like when we look at the *Six Principles of Trauma Informed Care*, we touched on safety, trustworthiness, collaboration and choice," I'm going to ask the panelists if any of you are specifically working on cultural, historical, or gender issues? I guess it goes to any of the guest speakers today.

Melanie Prummer: So this is Melanie and we've actually specifically pulled out some of that principle and looking at that work even independently and looking at equity and inclusion and so currently we're looking at revising our mission statement We're looking at how we evaluate staff work around that and we're also looking at adopting a one percent change policy which in essence is looking at staff's professional development and setting goals for themselves where they devote one percent of their paid time which is about 20 hours a year to equity inclusion and understanding that work.

Deborah Chilcoat: Really? Interesting, Melanie. Thank you. Are any of the other panelists working specifically on cultural, historical, and gender issues? How about peer support? We really didn't hear much about that particular guiding principle. Anybody doing specific work around that?

Suzanne Banning: This is Suzanne in Colorado. We have set up a group format. We think the peer component is very important since all the girls on the campus are pregnant or parent teen some having been here for a few years creating various groups with themes for the girls to choose to be in and to work together with facilitators, but they're mainly run by the girls themselves -- the young woman -- with the facilitators so the peer components very important in our model.

Deborah Chilcoat: Okay, great. Thank you Suzanne. Okay, I'm going to go around and if each one of you could just tell us one specific strategy that you think that the audience needs to know about. I'm going to let you do one strategy that you think they should really investigate. Jeanette?

Jeanette Pai-Espinosa: I would say to not rule out those -- I'm kind of tagging onto what Suzanne said in terms of the peer to peer -- but also peer to near peer, so connecting young woman in their teens, young woman in their 20s that kind of walked in their footsteps. I think there's a lot of power there. I would certainly look to technology as a way to make that happen.

Deborah Chilcoat: Okay. Barbara?

Barbara Burton: Gosh, that's a big question. You know, I think peer is obviously one, but I think also, you know, never neglecting the fact that you're working with a family and not just an individual and I think we get caught up in that sometimes and looking at the dyad and ensuring that when you're looking at the work that you're doing even going sometimes beyond the dyad to the whole family component and seeing how all of that's interplaying on the work that you're doing.

Deborah Chilcoat: Excellent. Suzanne?

Suzanne Banning: You know, I think that safety - I know that our girls when we talk to them the number one reason they have chosen to come to the campus is because it's a safe place for their child and for them, and we really have high protocol around [unintelligible], the campus, you know, the girls really feel the fact that their child is safe and that I think that's very important.

Deborah Chilcoat: Okay. And Melanie? Melanie, are you mute by chance?

Melanie Prummer: Sorry, yes I was.

Deborah Chilcoat: Okay.

Melanie Prummer: So I think focusing on hope and exploring resiliency is really important and we have conversations here every day about retraining the brain.

Deborah Chilcoat: That's powerful. Okay. One question. "So protecting the privacy of these young families, how do you ensure their privacy is protected while still sharing enough information with the staff to be able to support these young people with a trauma-informed approach?" This is for everybody, so if you have an answer you just want just jump in, that'd be great.

Barbara Burton: Well, this is Barb. We, obviously, work off a "need to know" and we have a pretty extensive staff here that works with our families, but, you know, there's a certain amount I think that the staff in general need to understand that most of the clients that we work with are trauma affected so knowing that you're working with the trauma affected population, there's a certain ground level of information that you just use as your toolbox and beyond that the details really aren't so important, and clinically we don't need to know every detail of what's happening with every client so "need to know" becomes sort of the

caveat, you know, “Do you really need to know those details to be able to do what you need to do with this client?” and our clinical staff lead that charge.

Deborah Chilcoat: Okay. Others?

Suzanne Banning: Again, this is Suzanne in Colorado. I agree with what Barbara just said. I think that for us knowing that, you know, the girls on the campus all have this trauma that the training we have for the staff, you know, gives them the tools they need no matter what that trauma was. Does it really matter, you know, when they've all had it? Let's use some basic work and go forward with that.

Deborah Chilcoat: Anyone else? Okay. Oh, go ahead.

Melanie Prummer: I would just add that I - that's how we also practice, but sometimes we would even clarify with our clients what may be shared and what the purpose behind that would be in the staffing, and so we ask clients if there's anything that they would not want to be shared with another staff person.

Deborah Chilcoat: Excellent. Okay. Looks like we have come to the conclusion of our question-and-answer, but before we all hop off the webinar, we want to just remind you to stay in tune with upcoming events and don't forget that you can always request technical assistance. Now if you need support on this topic or another topic related to your work, you can definitely request TA. Just remember that this is free for all of your grantees. You just simply submit a TA request using the link that you see on your screen.

Just wanted to let you know though that if you request, if submitted now, will actually have to wait or will be honored at the beginning of the next contract year so at the end of September or early October we will be able to respond to that TA request. We will make sure that everyone here who requests TA, gets

a response. We don't want anyone to feel as though we're not being responsive, okay?

So go ahead and put your request in. We'll get to you as soon as the next contract year begins. Okay, so now in your chat box, you're actually going to see the link to the webinar feedback form -- and thank you all so much for staying on a just a wee bit longer than we expected. Please keep in mind that the evaluation will inform the future webinars that we do and we really value all of your input.

We are also going to be sharing a few [unintelligible] in addition to what some of those guest speakers had provided so you want to make sure that you take a look at the resources that we have compiled and, you know, some of this includes where the data that we shared originated so definitely dive into that, take it all in. You also have information here about how to get the National Crittenton ACE tool kit and I'm sure that the guest speakers would love to hear from you if you have questions.

So thank you again, and right now I'm going to turn it back over to Sabrina to close out today's webinar.

Sabrina Chapple: Hello. Thank you. That was a wonderful, wonderful webinar and I'm sure the participants got a lot of out of that and will take advantage of the technical assistance that will be available. Just want to let you know that our webinars will be made available on the OAH website. Typically takes a couple of weeks for it to be uploaded, but you may also prepare grantees to reach out to your project officer in a couple of weeks to get the actual presentation. We look forward to providing some additional webinars in the future and we, again, thank you for your participation and we wish everyone a great week. Thank you. And thank our presenters as well.

Operator: And thank you. This does conclude today's conference call. You may disconnect your lines and have a great day.

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