

# SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

*Prepared by*  
SAMHSA's Trauma and Justice Strategic Initiative  
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## Contents

Introduction .....	2
Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach.....	3
Background: Trauma — Where We Are and How We Got Here .....	5
SAMHSA’s Concept of Trauma .....	7
SAMHSA’s Trauma-Informed Approach: Key Assumptions and Principles.....	9
Guidance for Implementing a Trauma-Informed Approach .....	12
Next Steps: Trauma in the Context of Community .....	17
Conclusion.....	17
Endnotes .....	18

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## Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

***The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.***

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.<sup>1,2,3,4,5</sup> Research has also indicated that with appropriate

supports and intervention, people can overcome traumatic experiences.<sup>6,7,8,9</sup> However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.<sup>1,10,11</sup>

***With appropriate supports and intervention, people can overcome traumatic experiences.***

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.<sup>12,13</sup> Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.<sup>5,14</sup> Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.<sup>15,16,17</sup>

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing “business as usual.” In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma

experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their “business” under the framework of a trauma-informed approach.

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## Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

### PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual’s capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this

framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems “talk” to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

### APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

*The key questions addressed  
in this paper are:*

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

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## Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.<sup>18,19,20,21</sup> National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.<sup>22,23,24,25</sup> With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.<sup>3,25</sup>

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.<sup>26</sup> Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

*Trauma survivors have powerfully and systematically documented their paths to recovery.*

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.<sup>25,27</sup>

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.<sup>28,29,30,31</sup>

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

## **FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES**

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a

trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

***SAMHSA continues its support of grant programs that specifically address trauma.***

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in

primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

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## SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

***Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

## THE THREE “E’S” OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

**Events** and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA’s concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as “trauma and stressor-related disorders” to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual’s **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one’s country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of “why me?” The individual’s experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal,

shattering a person’s trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual’s cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).<sup>1</sup>

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual’s inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one’s neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.<sup>1,3</sup> Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

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## SAMHSA’s Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as “trauma-informed care” or “trauma-informed approach” this framework is regarded as essential to the context of care.<sup>22,32,33</sup> SAMHSA’s concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

*A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.*

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

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### THE FOUR “R’S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People’s experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional). There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer-run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.<sup>27</sup> Staff who work within a trauma-informed environment are taught to recognize how organizational practices may

trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

## SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

### SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:<sup>24,36</sup>

- 1. Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.
- 2. Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.
- 3. Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term “Peers” refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as “trauma survivors.”
- 4. Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating 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. As one expert stated: “one does not have to be a therapist to be therapeutic.”<sup>12</sup>
- 5. Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.<sup>34</sup> Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.
- 6. Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

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## Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiple levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Falot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.<sup>20</sup> While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a “checklist” or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.<sup>35,36,37,38</sup> What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

### *TEN IMPLEMENTATION DOMAINS*

- 1. Governance and Leadership**
- 2. Policy**
- 3. Physical Environment**
- 4. Engagement and Involvement**
- 5. Cross Sector Collaboration**
- 6. Screening, Assessment, Treatment Services**
- 7. Training and Workforce Development**
- 8. Progress Monitoring and Quality Assurance**
- 9. Financing**
- 10. Evaluation**

**GOVERNANCE AND LEADERSHIP:** The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

**POLICY:** There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be “hard-wired” into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

#### **PHYSICAL ENVIRONMENT OF THE ORGANIZATION:**

The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

#### **ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES:**

These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

**CROSS SECTOR COLLABORATION:** Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization’s mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

#### **SCREENING, ASSESSMENT, AND TREATMENT SERVICES:**

Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

#### **TRAINING AND WORKFORCE DEVELOPMENT:**

On-going training on trauma and peer-support are essential. The organization’s human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

#### **PROGRESS MONITORING AND QUALITY ASSURANCE:**

There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

**FINANCING:** Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

**EVALUATION:** Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six

key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Falloot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.<sup>39, 40, 41,42</sup>

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

**SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH**

KEY PRINCIPLES					
Safety	Trustworthiness and Transparency	Peer Support	Collaboration and Mutuality	Empowerment, Voice, and Choice	Cultural, Historical, and Gender Issues
10 IMPLEMENTATION DOMAINS					
<b>Governance and Leadership</b>	<ul style="list-style-type: none"> <li>• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach?</li> <li>• How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?</li> <li>• How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?</li> </ul>				
<b>Policy</b>	<ul style="list-style-type: none"> <li>• How do the agency’s written policies and procedures include a focus on trauma and issues of safety and confidentiality?</li> <li>• How do the agency’s written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery?</li> <li>• How do the agency’s staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training?</li> <li>• How do human resources policies attend to the impact of working with people who have experienced trauma?</li> <li>• What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?</li> </ul>				

## SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

(continued)

10 IMPLEMENTATION DOMAINS <i>continued</i>	
<b>Physical Environment</b>	<ul style="list-style-type: none"> <li>• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff?</li> <li>• In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this?</li> <li>• How has the agency provided space that both staff and people receiving services can use to practice self-care?</li> <li>• How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).</li> </ul>
<b>Engagement and Involvement</b>	<ul style="list-style-type: none"> <li>• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services?</li> <li>• How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information?</li> <li>• How is transparency and trust among staff and clients promoted?</li> <li>• What strategies are used to reduce the sense of power differentials among staff and clients?</li> <li>• How do staff members help people to identify strategies that contribute to feeling comforted and empowered?</li> </ul>
<b>Cross Sector Collaboration</b>	<ul style="list-style-type: none"> <li>• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions?</li> <li>• Are collaborative partners trauma-informed?</li> <li>• How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services?</li> <li>• What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?</li> </ul>
<b>Screening, Assessment, Treatment Services</b>	<ul style="list-style-type: none"> <li>• Is an individual's own definition of emotional safety included in treatment plans?</li> <li>• Is timely trauma-informed screening and assessment available and accessible to individuals receiving services?</li> <li>• Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services?</li> <li>• How are peer supports integrated into the service delivery approach?</li> <li>• How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women?</li> <li>• Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding?</li> <li>• How are these trauma-specific practices incorporated into the organization's ongoing operations?</li> </ul>

## SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

(continued)

10 IMPLEMENTATION DOMAINS <i>continued</i>	
<b>Training and Workforce Development</b>	<ul style="list-style-type: none"> <li>• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences?</li> <li>• How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions?</li> <li>• How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions?</li> <li>• How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety?</li> <li>• How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors.</li> <li>• What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work?</li> <li>• What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?</li> </ul>
<b>Progress Monitoring and Quality Assurance</b>	<ul style="list-style-type: none"> <li>• Is there a system in place that monitors the agency's progress in being trauma-informed?</li> <li>• Does the agency solicit feedback from both staff and individuals receiving services?</li> <li>• What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency?</li> <li>• How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes?</li> <li>• What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?</li> </ul>
<b>Financing</b>	<ul style="list-style-type: none"> <li>• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development?</li> <li>• What funding exists for cross-sector training on trauma and trauma-informed approaches?</li> <li>• What funding exists for peer specialists?</li> <li>• How does the budget support provision of a safe physical environment?</li> </ul>
<b>Evaluation</b>	<ul style="list-style-type: none"> <li>• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach?</li> <li>• How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey?</li> <li>• What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality?</li> <li>• What measures or indicators are used to assess the organizational progress in becoming trauma-informed?</li> </ul>

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## Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

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## Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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## CHICAGOLAND TRAUMA-INFORMED CONGREGATION NETWORK

### Who are we?

The Chicagoland Trauma-Informed Congregation Network is an interfaith table that brings together faith-rooted organizations and others who are interested in practically applying our collective wisdom to respond to the call to facilitate and deepen the role of faith communities in recognizing and creating “safe and brave spaces”<sup>1</sup> that support the healing of trauma experienced by individuals and communities. The Network is not a direct service provider, but a vehicle for education, learning, networking, connection to resources, and skill-building related to empathic listening, intersection of faith, trauma and restorative justice.

### Importance of our focus on communities of Faith

**Research and empirical data** reveal that communities of faith/religious communities have historically played a critical role in supporting individuals, families and communities who have been impacted by trauma. They often play an important role in “meaning making” after an individual or community experiences trauma. Katrina is a great example. Post-Katrina as people were seeking to make sense of why it happened, some faith leaders further traumatized the impacted community by attributing the traumatic event to God’s punishment of a wicked people. Following Hurricane Katrina, 92% of those who survived and evacuated to shelters in Houston said that their faith played an important role in helping them get through the impacts of trauma ([www.kff.org/newsmedia/7401.cfm](http://www.kff.org/newsmedia/7401.cfm)). The impacts may be physical, emotional, spiritual and/or moral.

While faith communities and leaders play an important role in the healing process, it is imperative to be cognizant of their limitations. When the faith leader has been educated as a mental health professional, he or she can substitute for a professional therapist short term. As trusted members of the community, they can play a critical role in identifying and referring people in need of professional support. This is a key step in initiating healing and leading to more

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<sup>1</sup> Safe space and brave space is used to describe an environment where an individual or community is able to face their pain, fears and insecurities as part of the process for healing.

steps and processes that may bring the person to wholeness in a healing community.

Lastly, it is important be for faith leaders and communities of faith to be aware their religious doctrine or practices can be a source of trauma, if intentions are not clear.

### **Vision Statement**

We envision loving Communities of Faith that are informed and skilled in identifying and “creating safe and brave spaces”<sup>2</sup> that facilitate and provide space for healing of individuals and communities who have experienced trauma.

### **Mission Statement**

We provide support to faith communities in their efforts to enhance their capacity to be places of healing through education, skills transfer and connection of the intersection of faith, trauma and restorative justice.

### **Guiding Principles**

- **Faith-rooted**

*We value the unique and transformational gifts of all religious traditions and their potential to healing trauma. Some of the common gifts include faith, hope, moral imagination and spirit power. Our work will incorporate these gifts in our collaborative work with faith communities to enhance the potencies of just gifts.*

- **Love-rooted (Agape, Shalom, ??????)**

*From our experience and faith we believe that when our actions are characterized by “Agape or love-rooted relationships” facilitate healing. Rev. Dr. Martin Luther King, Jr. described Agape, as “understanding, accepting, creative and redeeming good will toward all people facilitate true healing. It is restorative and concretized in justice. The giver seeks*

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<sup>2</sup> Space that is safe and brave is where individuals can be vulnerable and free to do their healing work. It is characterized by confidentiality, trust, openness. Brave space is an emerging competency in community psychology. It’s call is for the establishment of a relationship that attends to the ethics of social justice.

*nothing in exchange for agape". (Rev. Dr. Martin Luther King, Jr. Levels of Love, 1962 )The language for love-rooted may be different for various faith tradition, however, the concepts are similar.*

- **Community-driven & Community-focused**

*We value self-determination, the wisdom and gifts of faith communities, therefore our actions will intentionally seek to be supportive of community-rooted/grounded approaches to facilitating healing. We also recognize the importance of awareness of community norms, attitudes, practices and behaviors in the facilitation of healing. Such efforts support the entire population within a faith community.*

- **Systemic Action**

*We recognize the important role of organizational policies, laws and power structures in creating and sustaining efforts that focus on creating sustainable brave space that provide and facilitate healing. Such efforts may focus on addressing the environmental contexts that influence trauma. Changing or enhancing systems through organizational policy, laws and power structures help to sustain the effect of our efforts.*

- **Leading Causes of Life**

*We seek to facilitate life and hope in individuals and communities. Focusing on trauma alone ignores the life and strength that exist in every trauma situation. Rev. Dr. Gary Gunderson has identified five leading causes of life (blessings/intergenerativity, coherence, connection, agency and hope). We will focus on incorporating the leading causes of life in our trauma work as a means of facilitating hope and healing.*

- **Collaborative**

*We recognize the work of creating safe and brave spaces for healing in the diverse faith communities of Chicagoland is complex and multifaceted and will therefore require multi-sector involvement. Our potential for success is enhanced when we work collaboratively.*

- **Do Nothing for Someone without the Someone's Involvement**

*Science and experience has taught us that individual and community involvement and ownership are critical to wise sustained actions, therefore we will seek to facilitate healing actions by involving those who are impacted by trauma.*

DRAFT

## **Definition of Key Terms**

### **Trauma<sup>3</sup>**

The word 'trauma' originates from a Greek word meaning 'to tear' or 'to rupture'. In the case of psychological trauma, this understanding is reflected in the notion of psychological wounding and the penetration of unwanted thoughts, emotions and experiences into the psyche or being of the person (Kaminer & Eagle 2010:2). It is important to note that the field of trauma is an evolving area of study. One current critique is the approaches to defining trauma generally describe it as a solely a psycho-biological phenomena. This is the case with SAMSHA's definition below. Some researchers argue that this approach is too limiting, because it ignores the spiritual and moral injury impacts of trauma.<sup>4</sup> Searches for a definition that addressed these deficiencies were unsuccessful, so we offer a working definition for consideration.

Individual **trauma** results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (SAMSHA: <https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>)

### **Alternative Definition of Trauma**

**Trauma** results from an event, series of events, or set of circumstances experienced by an individual or community as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual or community's functioning and mental, physical, social, emotional, spiritual and/or moral well-being.

### **Resilience**

**Resilience** refers to an individual's ability to cope with adversity and adapt to challenges or change. ... Optimism and the ability to remain hopeful are essential to **resilience** and the process of recovery. ( Visit **SAMHSA's** Partners for Recovery Initiative's **Resilience** Annotated Bibliography – 2013 (PDF. |Oct 5, 2015)

### **Risk and Protective Factors**

**Risk factors** are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. (Visit

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<sup>3</sup> Note: I'm still gathering definitions and researching. The definitions for trauma, resilience, risk and protective factors are from the scientific community and do not reflect the languages of faith. If anyone has definitions that believe will be helpful to our work, please share them. Octavia, thank you for sharing CDPH's definitions. The Illinois ACES Response Collaborative is using SAMSHA definitions. We want to align our definitions and speak the language of faith.

<sup>4</sup> Manda, C., 2015, 'Re-authoring life narratives of trauma survivors: Spiritual perspective', *HTS Teologiese Studies/Theological Studies* 71(2), Art. #2621, 8 pages. <http://dx.doi.org/10.4102/hts.v71i2.2621>

### **Compassionate Listening**

Compassionate Listening is a quality of listening which creates a safe container for people to be free to express themselves and connect with what matters most in that given moment. It simply and profoundly means empathizing with the feelings and the underlying values, needs, dreams of people who have been affected by events and circumstances, sometimes of their own doing, and sometimes out of their control. It is about bringing all our attention and compassion to the state of another human being.<sup>5</sup>

### **Restorative Justice**

Restorative justice brings those harmed by crime or conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. This is part of a wider field called restorative practice.<sup>6</sup>

### **Safe and Brave Space**

### **Moral Imagination**

Our faith traditions hold powerful truths about what it means to be whole and healthy as individuals and communities. We have a vision of health that does not settle for just the absence of disease, but that embraces abundance, justice and the opportunity for everyone to live out their highest spiritual capacity. We claim this vision and raise it as an important contribution by people of faith to the work of health justice. (Source: )

### **Spirit Power**

Spirit power is the sense of calling and conviction that comes from faith that drives us toward and through work that seems beyond us. It is the belief that we are empowered by a source of love and healing to reach farther than we could on our own, to do things that are considered impossible. It is the power that is inherent in the gathering of people who share this calling and belief. (Paraphrase from statement by Rev. Jim Benn)

*Original 7/5/17*

*Revised 8/1/17*

*3<sup>rd</sup> Revision 8/21/17*

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<sup>5</sup> Hwoschinsky, C. (2001). Listening with the heart: A guide for compassionate listening. Indianola, WA: The Compassionate Listening Project.

<sup>6</sup> <https://restorativejustice.org.uk/what-restorative-justice>

*4<sup>th</sup> Revision 10/25/17*

DRAFT

## The Partnership for Resilience: Structures to Drive Change

### Resilience Teams

- Vision-keepers and drivers of change. Support broad awareness. Own annual action plan for the school district, and have ongoing in-district meetings to facilitate work and integrate it with other district initiatives.
- Usually 5-10 people including an administrator; teacher/union leader; and nurse, social worker, or other support staff; can be a larger group.
- Convene quarterly across districts for action planning, professional development, networking, accountability.

### District Liaisons

- Smaller group with passion to build a trauma-sensitive system and capacity to lead.
- Usually 2 people who can serve as a point of contact for problem-solving and as liaisons with the district's Resilience Team.
- Convene monthly across districts for continuous improvement, professional development, introductions to new resources.

### Administrative Team Sessions

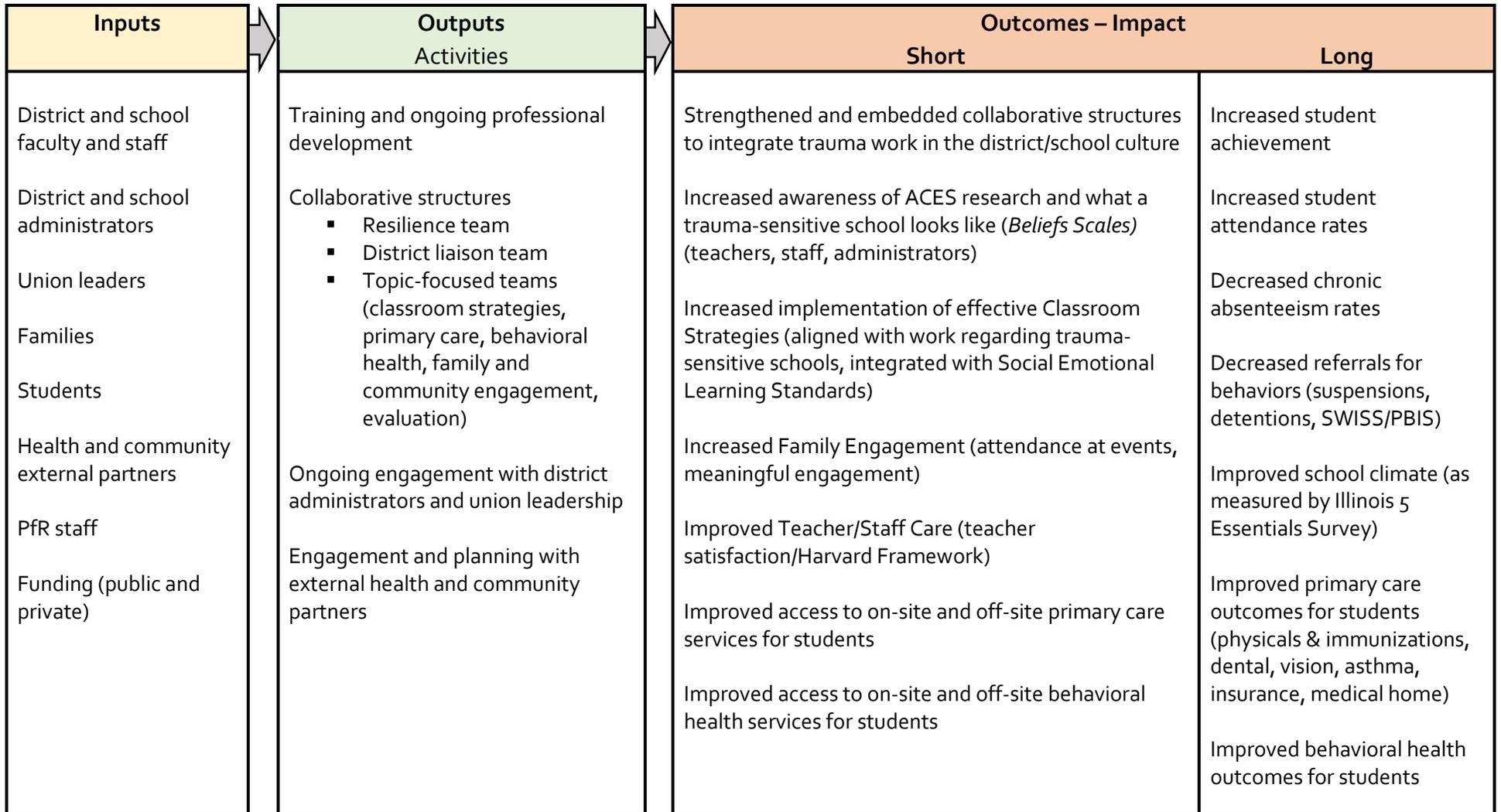
- Partnership staff and representatives from the district's Resilience Team join administrative team meetings within districts to frame the work, discuss the role of the administrator in building trauma-sensitive schools, review the action plan for the district.

### Cross-district Subcommittees

- Define, lead, reflect on, evaluate, and continuously improve action on the topic.
- Participation depends on the topic, for example family engagement, primary health care, behavioral health, classroom strategies, teacher care. Topical priorities emerge from Resilience Team goals.
- May meet within district (e.g., primary health care where local providers, who are part of the subcommittee, vary) or across districts (e.g., classroom strategies).

# Partnership for Resilience (PfR) Trauma Sensitive Schools Logic Model

**Situation:** Adversity, trauma, and poverty are impacting a growing number of students.



## Assumptions

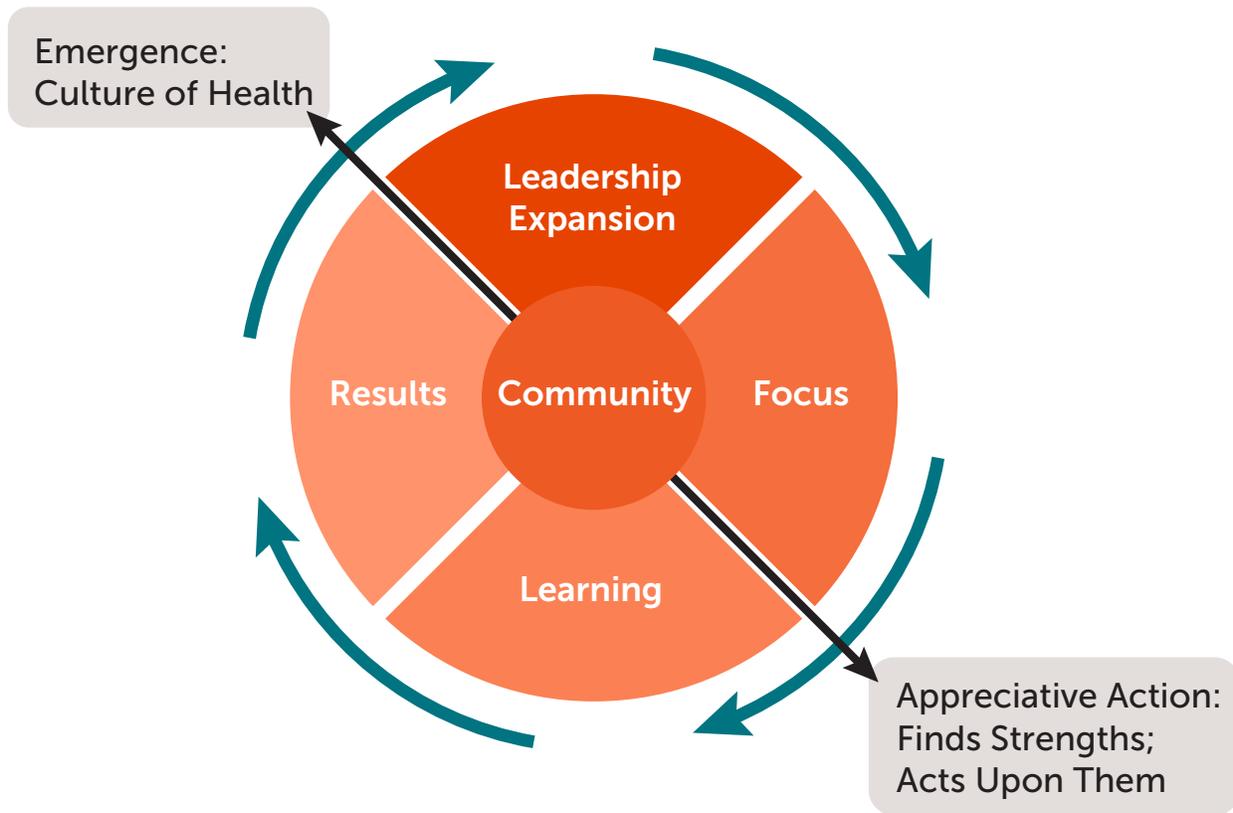
Each school district designs and implements programs specific to the needs of its population

## External Factors

The whole child approach aligns with resources available through the Every Student Succeeds Act (ESSA)

# Self-Healing Communities

A Transformational Process Model for Improving Intergenerational Health



Commissioned by the Robert Wood Johnson Foundation

Laura Porter  
Kimberly Martin, PhD  
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June 2016



## Self-Healing Communities

### A Transformational Process Model for Improving Intergenerational Health

In the 1980s, when the timber and fishing industries declined, and in 2003, when the aluminum reduction manufacturing plant went bankrupt, Cowlitz County residents lost more than jobs—they lost their ways of life. Compounding problems, the region was also devastated by the volcanic eruption of Mount St. Helens in 1980 and the second largest urban landslide in U.S. history in 1998. Through the 1980s and 1990s the county experienced chronic underemployment (over 15 percent), and many health and social problems—infant mortality, births to mothers ages 10 to 17, violence against self and others, chronic disease, youth hospitalizations for suicide attempts, and dropping out of school, for example—were occurring at rates in the worst quartile of county rates throughout the state. In less than two decades, though, this community has achieved stunning child safety and school completion results for a small investment (see Table 1).

The turning point occurred when their theory of change shifted from solely adding or enhancing direct service programs to incorporating layers of strategy that supported parents as agents of culture change. They began working to “improve parent skills so they can give sound advice and be good mentors to their children, and, in turn [parents] will gain skills and relationships to give sound advice to the community—and that advice will make a better system of help for them and for other families” (Cowlitz Network Report, 2007). They held education events to learn about the science of adversity, hosted networking cafés, organized neighborhood residents and linked service strengths across disciplines; for example, court-appointed special advocates were deployed in schools to ensure that children served by the child welfare system had appropriate education plans that supported their academic progress. The work was strategic, personal and trauma-informed.

Cowlitz County’s story demonstrates what is possible when a community turns from a culture of illness, conflict and despair to a culture of self-healing. When communities develop the capacity to shift typical cultural patterns, individuals within the community gain new knowledge and skills, and the community as a whole becomes a learning organization characterized by a rhythm of engagement that invites flourishing: continuous, steady, strong growing into well-being.

Creating this kind of change is the goal of the Self-Healing Communities Model (SHCM), a process model with demonstrated success in improving the rates of many interrelated and intergenerational health and social problems.

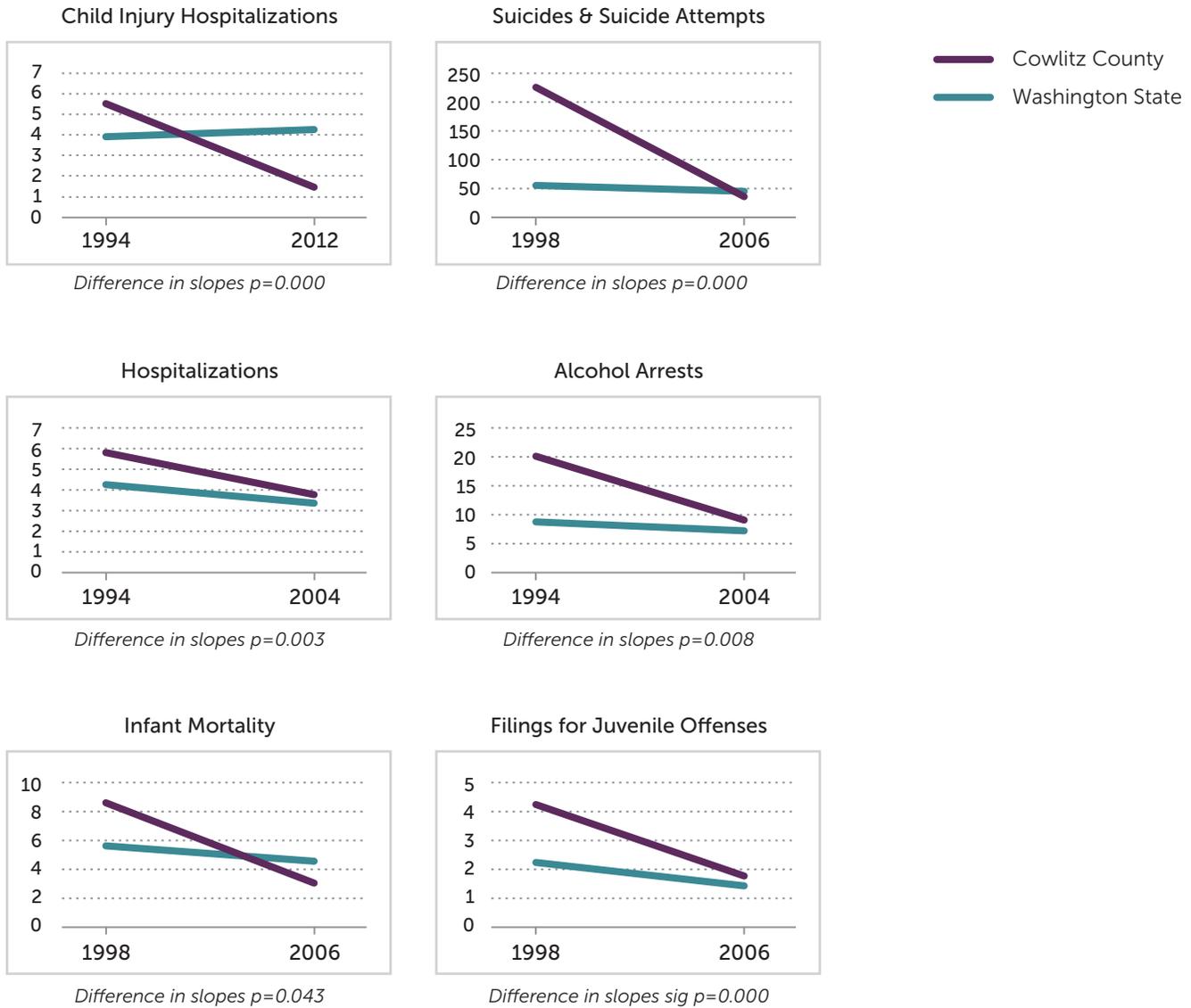
The SHCM builds the capacity of communities to define and solve problems most relevant to them and generates new cultural norms that mirror the values and aspirations that community members have for their children. It requires investment in the processes of healthy community and family life: engagement, learning, innovation and reflection. Uncommon partners across disciplines, systems and cultures must be invited to share resources, high expectations, respect, and a commitment to a new sense of shared identity—one of hope, optimism, efficacy, curiosity and welcoming.

## Self-Healing Communities

Table 1

### Change in Rates of Selected Youth & Family Problems Cowlitz County versus Washington State Rates

Note: Please refer to Appendix 1 on page 16 for the complete data labels for each graph.



Source: Washington State Department of Social and Health Services Research and Data Analysis Division, 2015

### SELF-HEALING AND SHARED LEADERSHIP

Cowlitz County is just one of dozens of communities that implemented SHCM strategies over 15 years to achieve profound change. A key strategy from the SHCM is the expansion of leadership: empowering community members to participate in decision-making and problem-solving. In 2005, Cowlitz County employed this approach in order to address problems in a neighborhood that was documented to have the highest emergency call rates. A project coordinator sat on the hood of her car in the neighborhood, day after day, even though residents came out of their houses to say that she should not be sitting there because the neighborhood wasn't safe. She knocked on doors and talked with individuals at the thresholds of their homes asking how she could help. Residents warned her that it was dangerous to hang out on the streets in their neighborhood, especially at night, because of a pack of feral dogs.

The coordinator knew the *prevailing view* about why it was so dark in that neighborhood at night—*people like the dark because it covers up criminal activity*. She questioned that assumption and asked the people who lived there: "Why is it so dark here at night?" When she heard the answer, she thought, "Shame on us that we didn't know: It's dark in this neighborhood because people can't afford lightbulbs."

There were three problems that affected the neighborhood: (1) darkness and danger; (2) people feeling powerless over their own safety; and (3) wrong assumptions that created a barrier to real improvements in the quality of people's lives. Seeing these dynamics inspired creative and powerful solutions.

Notes were delivered to all the houses letting people know that volunteers (recruited from civic clubs) would be coming to each house to count the number of outdoor light fixtures missing lightbulbs. The note invited every person to participate in a free barbecue and community lighting ceremony—with bulbs supplied by a hardware store owner who was invited to help. A date was set for a celebration that neighborhood residents called *Take Back the Light*. Lightbulbs were distributed to people who could install them, and they waited for the time when everyone would turn on the lights at the same moment. When the lights came on, the celebration began: free food, music, conversations among people who had feared one another, and hope.

People began to think about what else they could do to make their neighborhood even better. The *Take Back the Light* initiative provided a simple solution to a problem that residents cared deeply about and became a symbol of the kinds of small changes with big impact that could be accomplished when people take time to truly

understand one another. Because the action addressed a problem that was important to those living with it and the solution involved everyone in the area, success belonged to the neighborhood, and everyone had the satisfaction of being a part of the change. People who were not considered leaders in the past became leaders of the future, and the capacity of the community to solve problems flourished.

### NEW APPROACH PRODUCES PROFOUND RESULTS AND COST SAVINGS

In 1994, 10 elected and appointed state officials working as the Washington Family Policy Council oversaw formation of a statewide system of local coalitions called Community Public Health and Safety Networks (Networks). Networks were required by the state to prioritize and select three of seven<sup>1</sup> social problems for improvement and were provided small grants and technical assistance from the Council. At that time, the Council and Networks used a standard approach to prevention: monitoring risk and protective factors for each social problem, targeting factors for change, analyzing service gaps related to the factors, and selecting programs to fill those gaps. Assistance for communities was intended to help community coalition members to make decisions about prevention program selection in order to achieve desired participant outcomes.

Community decision-making was informed by cross-sectional data (e.g., monthly number of out-of-home placements of children; annual arrests for violent crime). These data document what is occurring, but do not illuminate why. Use of this type of data typically invites debate about which problems are worse than others, which, in turn, becomes a barrier to creating collaborative solutions.

In 1999, Council staff made an intentional change in the way they worked with communities. The Council brought together two scientific frameworks, each of which offered new paradigms of thought that were relevant to generating health and social improvements: living systems theory and Adverse Childhood Experience (ACE) Study concepts. At that time, living systems theory, incorporating relativity, chaos, quantum and network theories, had not been widely applied in the social sphere. The ACE Study findings revealed childhood adversity—such as abuse or neglect—to be the common origin for the social problems of concern to Washingtonians. Washington State was among the first of the states to apply these findings in order to reduce all

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1 Networks selected three of the following: child abuse and neglect; family violence; youth violence; youth substance abuse; dropping out of school; teen pregnancy; or youth suicide.

## Self-Healing Communities

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ACE-attributable problems concurrently. Taken together, systems theory and ACE concepts became a new unifying framework for improving the lives of children, families and communities.

As community residents and professionals became more familiar with using systems-thinking knowledge and tools, they also became more hopeful, engaged and motivated to co-create positive change in their communities. State staff compiled and distributed trend-over-time data for each community in order to support local dialogue and insight about drivers of social patterns. Conversation among Network and Council members shifted from a focus on answers, to examination of past assumptions and future possibilities.

Communities are complex, dynamic systems; concurrently, individuals affect community, and community affects the lives of individuals. Council staff understood that making improvements within complex, dynamic systems is not a deterministic process. There is no silver bullet. Therefore, the Council urged communities to continuously learn, manage and improve their strategies, focus on preventing the origins of health and social problems, and develop redundancies and habits of working that would enable rapid response and course correction when unintended consequences occurred.

Changes that Council staff made in orientation and activities included the following:

1. Learning directly from leading researchers in the fields of neuroscience, epigenetics, ACEs, and resilience (NEAR Science), as well as complexity theory. Social networks were used to disseminate scientific findings with fidelity via a train-the-trainer program. Quarterly education events were designed to develop a knowledge ecology that was welcoming, challenging and celebratory (Goldstine-Cole, 2009).
2. Organizing decision-making around two core values: fundamental respect for the wisdom in every human being and transformational change, and employing a few basic principles in their work, namely, inclusive leadership, NEAR-informed engagement, emergent capabilities, right-fit solutions, and hope and efficacy. These principles informed a coaching model for technical assistance.
3. Changing contracts to require course correction when outcomes were not favorable. The contracts controlled for learning and application of learning, thus turning away from traditional contracting forms that control for activities or outcomes. Both the state and local parties to the contract agreed to learn, manage and improve their own roles in the dynamics that were generating child and family outcomes.
4. Using findings from communities as a springboard to introduce new questions into state policy deliberation. For example, social problem rates were not randomly distributed among communities in Washington. Some communities had none of these problems occurring at high rates; other communities had all of these problems occurring at high rates. The Council asked: Does the state need to be a different kind of partner in places where many problems occur at high rates?
5. Reducing the frequency of required reporting in order to support deeper reflection and meaning-making at the local level.
6. Measuring the development of community capacity for solving interrelated social problems using an index developed for this purpose. At the same time, the Council monitored the correlation between community capacity index scores and changes in the rates of seven social problems in communities using the SHCM. Comparison counties were not using the model. Monitoring revealed profound results: Rates of multiple problems were reduced concurrently in communities using the SHCM consistently for eight or more years (see Tables 2 and 3).

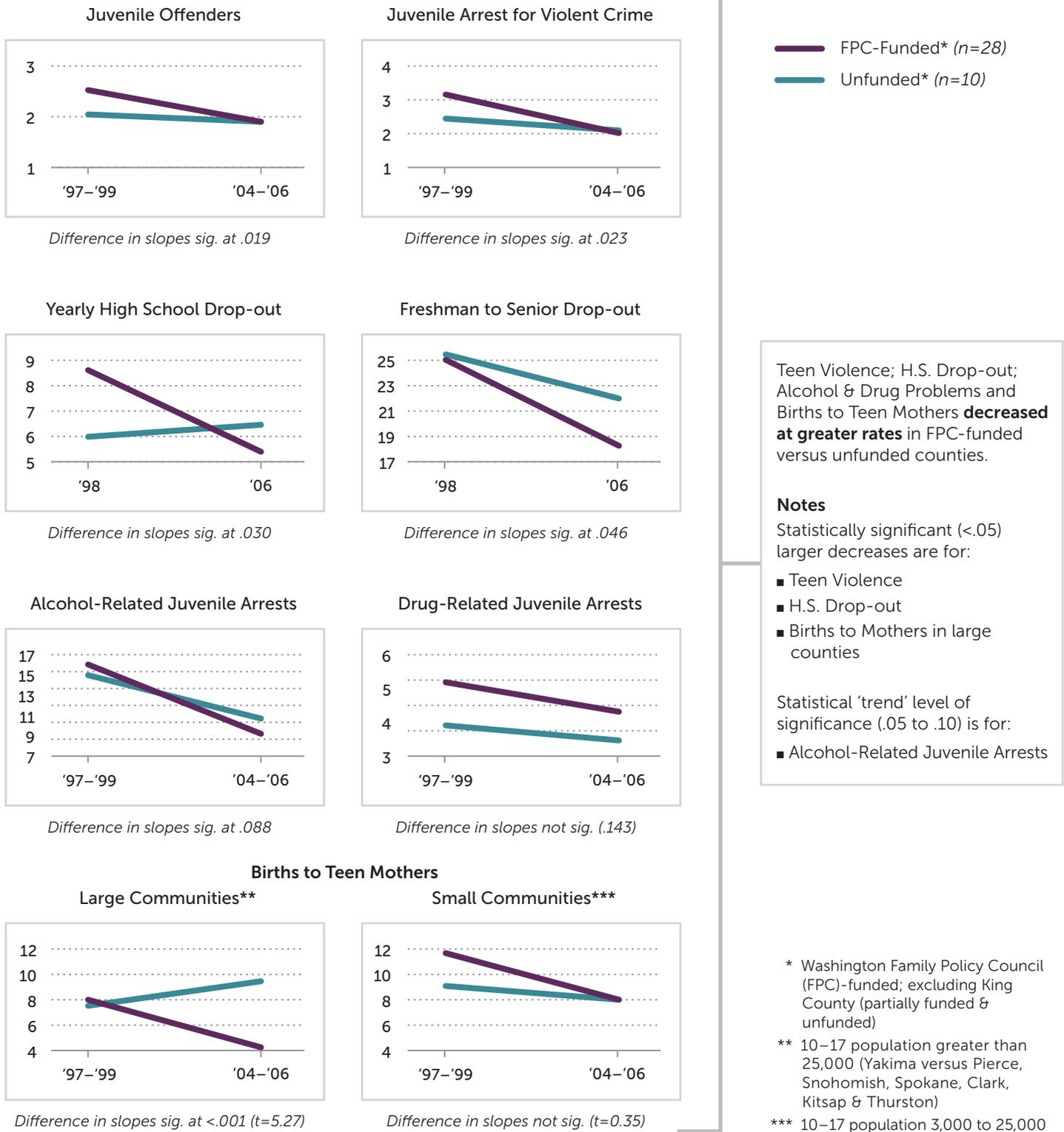
The SHCM mirrors how living systems retain identity and health under changing conditions. Yet this model is not simply about sustaining change. It is also about change that is focused on common origins of many high-cost health, social and productivity problems. It is about working with a whole new point of view regarding where problems come from.

The ACE Study concepts, including NEAR research findings, provide a framework for transformational change. Because ACEs are common across all socioeconomic and ethnic groups, diverse people relate personally to this science. When people learn about ACEs, many experience increased compassion for self and others and an 'aha' insight about how our efforts can fundamentally transform the health of future generations.

# Self-Healing Communities

Table 2  
**Change in Rates of Youth & Family Problems Among Teens**  
**FPC-Funded Counties versus Unfunded Counties**

Note: Please refer to Appendix 1 on page 16 for the complete data labels for each graph.

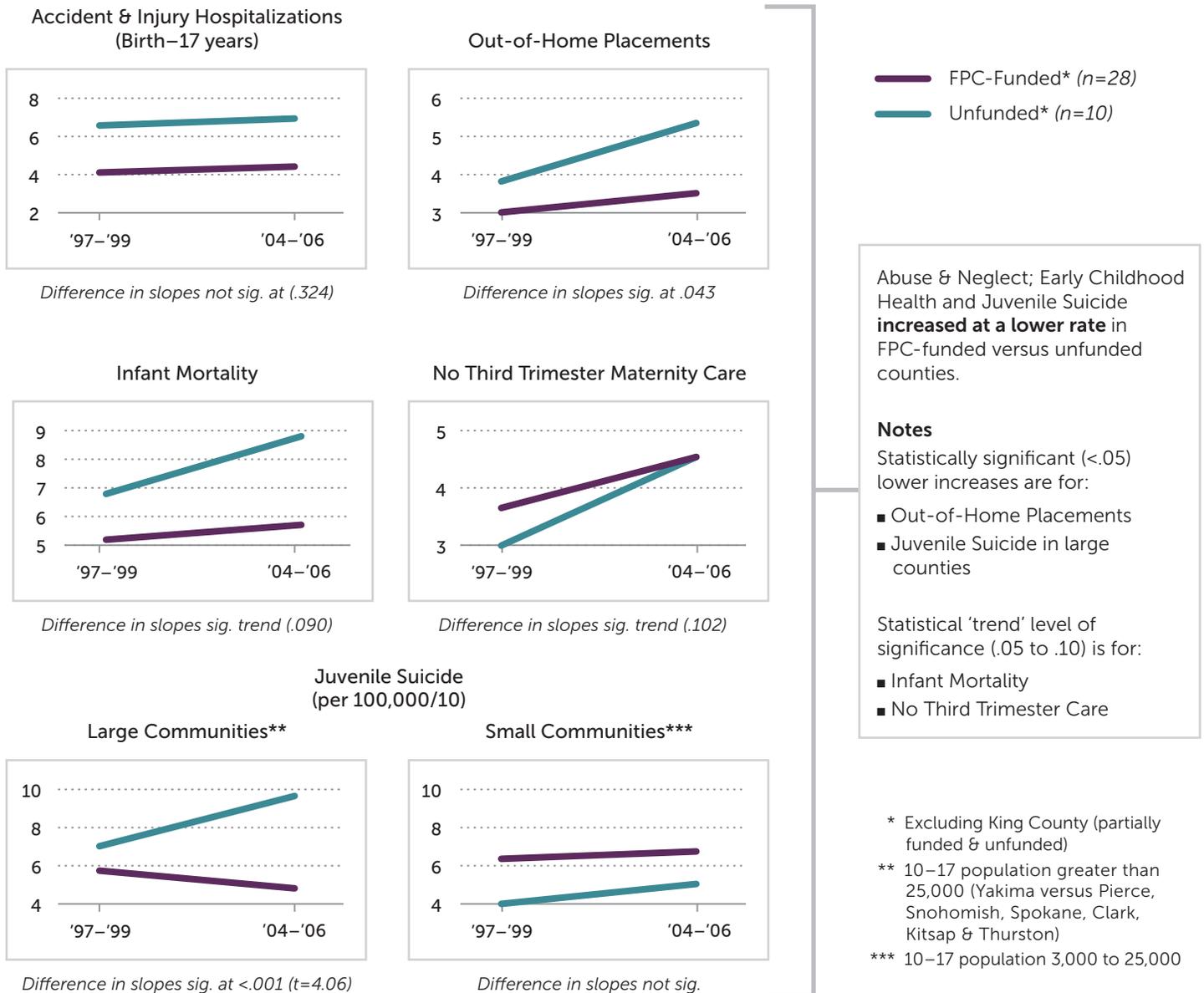


Source: Longhi et al., 2009

## Self-Healing Communities

Table 3  
**Change in Rates of Children & Family Health & Safety Issues**  
**FPC-Funded Counties versus Unfunded Counties**

Note: Please refer to Appendix 1 on page 16 for the complete data labels for each graph.



Source: Longhi et al., 2009

The Washington experience produced stunning results for a small investment. The budget for the Community Network partnership using the SHCM was, on average, \$3.4 million per year between 1994 and 2011. Per-year avoided caseload costs in child welfare, juvenile justice and public medical costs associated with births to teen mothers were calculated to be \$27.9 million, based on prevented cases between 2002 and 2006 (Scheuler et al., 2009). Because of the progressive nature of adversity and associated costs for public services throughout the life course, plus lost tax revenue from productivity loss, the taxpayer savings from Network-improved rates from 2002 to 2006 were conservatively estimated at an average of \$120 million per year (Scheuler et al., 2009). The cost/benefit ratio for this investment is impressive: for every dollar spent, 35 dollars were saved (Scheuler et al., 2009).

### UNDERSTANDING HEALTH AND SOCIAL PROBLEMS

Our understanding of the origins and dynamics of child, family and community problems changed rapidly during the period of time when the Council and Networks were developing methods and strategies for improving child and family life. Those changes were integrated into the work. In 1998, the first peer-reviewed publications from a landmark study [Adverse Childhood Experiences (ACEs)] revealed the most powerful determinant of the public's health. The study revealed that nearly 67 percent of adults had experienced one or more categories of significant abuse, neglect and/or dysfunctional family issues before age 18, and 27 percent had experienced three or more categories (Felitti et al., 1998). Later publications showed that ACEs are clustered (Dong et al., 2004), compounded by societal responses, and escalate over the life course and across generations (see Dube et al., 2003 and 2006). In addition, neuroscientists and epigeneticists established the biological and genetic mechanisms that explain why ACEs increase risk for disease, disability, early death (Anda et al., 2006), and intergenerational transmission of ACEs (see Table 4).

The accumulation of childhood adversity combined with ACE-attributable adult problems, such as incarceration, workplace injury or homelessness, has a profound effect on risk for lost daily functioning, a loss that affects families, communities and the U.S. economy. For example, among adults in Washington State with an ACE score of three or more who also experienced three or more adult adversities, 56 percent report not being able to do usual activities in half to all of a given 30-day period (Reeves et al., 2012).

Table 4  
**ACEs, ACE-Attributable Problems, Intergenerational Escalation**

<i>Adverse Childhood Experiences (ACEs)</i>	<i>Increased Risk: Problems, Co-Occurrence</i>	<i>Intergenerational</i>
<b>Abuse or Neglect:</b> 1. Physical abuse 2. Sexual abuse 3. Emotional abuse 4. Physical neglect 5. Emotional neglect	<ul style="list-style-type: none"> <li>• Dysregulation (emotion, memory, attention, learning, reactivity, sleep, immune function, pain, arousal, violence)</li> <li>• Alcohol, tobacco, drug dependence</li> <li>• Mental health or emotional problems that restrict activities</li> <li>• Serious and persistent mental illness</li> <li>• Adult incarceration</li> <li>• Divorce</li> <li>• Homelessness</li> <li>• Disability that impedes daily functioning</li> <li>• Education (low academics, school suspensions, no high school graduation, no secondary degree)</li> <li>• Unemployment</li> <li>• On-the-job injury or illness</li> <li>• Health risk or disease (obesity, cardiovascular disease, cancer, asthma, diabetes, autoimmune disease, chronic obstructive pulmonary disease, ischemic heart disease, liver disease)</li> <li>• Dissatisfaction (with life, neighborhood, sexuality, relationships, self)</li> </ul>	<b>ACEs for Next Generation:</b> <ul style="list-style-type: none"> <li>• Physical, sexual, or emotional abuse</li> <li>• Physical or emotional neglect</li> <li>• Any of five categories of household dysfunction</li> </ul>
<b>Household Dysfunction:</b> 6. Drug-addicted or alcoholic family member 7. Mentally ill, suicidal or depressed family member 8. Incarceration of household member 9. Parental discord—separation, divorce 10. Violence against a parent		<b>ACE Health Effects and Other Factors:</b> <ul style="list-style-type: none"> <li>• Poverty</li> <li>• Homelessness</li> <li>• Parent with chronic disease</li> <li>• Parent chronically dissatisfied</li> <li>• Social isolation</li> </ul>

Source: Foundation for Healthy Generations, 2014

**THE CONTEXT FOR SUSTAINABLE SOLUTIONS**

Health and social problems occur in the context of family, community and culture. In the past three decades, our understanding of the ways that we can or cannot work together to solve health and social problems has changed (Ostrom, 2002). We have learned about the power of networks to carry information, connect like-minded people and provide a flexible yet durable infrastructure for social movements. The scientific framework for solving problems in our world has been also transformed by chaos, quantum and relativity theories. When combined, these recent discoveries call for new modes of thinking and action that transcend traditional linear and categorical thinking about prevention of our nation’s most troublesome health and social problems.

Importantly, in this same time period we have experienced and describe herein a fast-paced journey that transitioned from knowledge acquisition and management by experts,

to distributed knowledge that is managed and shared by the population as a whole. Knowledge is changing so fast that detailed plans and programs can become obsolete before they can be implemented; therefore, system-innovation processes must be integrated into health-improvement strategies and policies. The SHCM promotes emergence of new ways of fostering a Culture of Health in communities that incorporate low-cost, locally promoted, sustainable solutions on a scale that can match the magnitude of health and social problems.

**FOCUS ON COMMUNITY TO ENHANCE PREVENTION, HEALING AND RESILIENCE**

Service-system silos of programming, mazes of eligibility and application processes, and limited availability in many of the communities most in need allow escalation of adversity across the life course and lead to an ever-increasing demand for services. The cost of these services prohibits their use as a primary strategy for

addressing common problems of adversity, trauma and their sequelae. Services are generally not designed to address four or five co-occurring major health and social problems concurrently, even though co-occurring problems are common among adults with high ACE scores. Although direct services are necessary and important, they are insufficient in the face of a chronic public health disaster.

Policies and programs that were intended to improve health and safety often fail among specific populations due in part to community variation in ACE prevalence and associated escalation of ACE-attributable problems over time. Diverse groups are situated differently relative to the institutions and resources of society, but funders often operate as if sameness equals fairness. This way of thinking has a down side: “Universal programs are very likely to exacerbate inequality rather than reduce it” (Powell et al., 2009).

In fact, many people do not seek healing or recovery through formal services. We prefer to turn to one another and/or to culture-specific home- and community-healing practices, such as movement, mindful/prayer practices, relationship and ritual. We rely on a circle of trustworthy people for help and support. The size, availability and effectiveness of that circle of support depends on the health, functionality and capacity of the community. New sources of support may be added by bridging cultural differences and through culture change, powerful strategies for improving recovery and resilience for individuals and families.

We now have new information about how social problems are linked together through childhood adversity. We know that ACEs are common in every socioeconomic group in our nation. We have evidence that these problems are so widespread that we cannot use direct services to address them. Investments in structural solutions will not solve these dynamic problems. Rather than restructuring decision-making groups, programs, service locations or evaluation dashboards, we need to engage the public, inspire innovation, support peer helping, and ease the daily stress burden of parents so they can better protect and nurture the next generation. This means that we have to change the way we think about social problems and solutions.

### Promoting Culture Change

SHCM strategies aim to increase the capacity of a community to reduce adversity. Community members learn to incorporate new customary ways of being with self and others that change how people experience and deal with the world: their culture. Understanding how this happens requires recognizing what culture is and how it can change.

Culture comprises the abstract, learned, shared rules/standards/patterns used to interpret experience and to shape behavior (Martin, 1997). It is a fluid phenomenon, co-created every day by the interactions of the individual members of the group for which it organizes the world. The fundamental role of culture as it functions in the everyday lives of individuals, regardless of nationality, ethnic background, geographical location or ancestry, is to help us to interpret the world around us and adapt to our environments.

Developmental (childhood) experience shapes biology, epigenetics and culture. Usually people cannot purposefully change their biological or genetic traits. But they can intentionally change their culture; and cultural changes can impact not only their own health and well-being, but also that of their children and others in their community. And we now know that changes in culture have the potential to shape biology, epigenetics and culture for future generations.

We acquire our cultures as we grow up, experiencing the world through interactions with and observations of others. The shared quality of culture is what makes the behaviors and beliefs of one individual intelligible to others in his or her group. When we recognize patterns of experience, behavior and interaction, we can relax and respond appropriately without having to think about every response. In this way, culture acts as a kind of autopilot: we unconsciously follow cultural norms, but we also have the ability to take ourselves off autopilot and consciously take control of our perceptions, thoughts and behaviors. Doing so can lead to profound and positive change.

Culture is an emergent property resulting from the interaction of individuals living in a group. Individuals experiment with new rules or patterns, and these innovations either spread because others find them useful and superior to the old ways, or they are rejected as disruptive to the system and soon die out. In this way, culture is fluid, as each individual in the group is constantly balancing conservation of patterns that have served well in the past with trials of innovative new strategies that may or may not work better in new circumstances. Culture change is not about incidents of change; it is an ongoing characteristic of shared rules/standards/patterns that can be harnessed to create self-healing communities.

Social problems frequently arise from cultural patterns that have developed in one group over time, often as adaptations to adverse circumstances over which these people had little control. These cultures (or subcultures) emerge literally as a response to adversity, and they may appear deviant to mainstream individuals. When our

autopilot leads us to judge others by our own standards rather than trying to understand why they do things differently, it creates huge barriers for cooperation across different cultures, whether they be national, religious, ethnic, socioeconomic, generational, community, neighborhood or trauma-impacted cultures. In order to overcome misunderstandings, we must be willing to bring our own culture into consciousness and to consider carefully how it relates to the cultures of others.

For example, in her 1974 book *All Our Kin: Strategies for Survival in a Black Community*, Carol Stack describes the culture of reciprocity, or “swapping,” that existed in a Black ghetto in a Midwestern city in the late 1960s. Government agencies and mainstream society condemned the family structures, employment patterns and ways of life of those living in “The Flats,” because they violated many mainstream cultural norms. Most notably, residents of “The Flats” made no attempt to save money to raise themselves out of poverty, but instead frequently gave away what they had.

Stack shows the efficiency of the system of swapping as the central economic strategy for this group of Blacks who experienced systematic discrimination in a community where there were very few low-level jobs, and the ones that did exist were generally temporary and very low paying. The culture that emerged reflects patterns of belief, meaning and behavior that were more effective under the circumstances with which they had to live.

Individuals and groups have the power to influence what others do by changing their own behavior and attitudes, that is, by changing their culture. But change requires hope, optimism and efficacy. In order to improve generational health and equity, we need to encourage communities to recognize their ability to make change, engender hope that what they do will make a difference, and encourage them to drill down into their autopilot cultures to challenge unexamined patterns that prevent realization of the community’s aspirations. The processes communities use to increase efficacy, examining patterns and making cultural changes, are general community capacity-building processes.

### Developing General Community Capacity

General community capacity (GCC) refers to the ability of a geographically based group of people to come together, build authentic relationships and reflect honestly about things that matter, share democratic leadership, and take collective actions that assure social and health equity for all residents (Morgan, 2015). Scholars distinguish this type of community capacity, which focuses on enhancing the infrastructure, skills, motivation and norms of a community, from the kind of

community capacity that is used to implement programs, which focuses on implementing proven model activities and evaluation protocols with fidelity (Flaspohler et al., 2008). High levels of GCC help communities to meet all kinds of challenges, from reducing interrelated and chronic problems (Hall, 2012) to recovery after a natural disaster (FEMA, 2011), without significant loss of the community’s common purposes and shared identity.

GCC depends on whether the culture of the community allows and supports its members to work together under pressure. Increasing the GCC of a community is a holistic, long-range culture-change strategy that includes connecting people so that they can provide support and assistance for each other and generate solutions for locally prioritized issues. Strategies and programs become better aligned with the hope-filled actions of residents and professionals. Better adapted, more resilient communities with high community capacity have extensive, community-wide networks of relationships through which reciprocity can flow and by which collaboration can occur. People in many, if not most neighborhoods and communities in the United States lack the kind of relationship networks that optimize community capacity and resilience.

Communities can improve the relational experience of everyday life by changing the patterns and purposes of social interaction among residents. At the heart of GCC is the connection between the number and kinds of relationships people develop and their ability to successfully address their problems. As neighborhoods are able to make changes, even small ones, there is an infusion of self- and collective-efficacy, optimism and excitement fueled by hope. As demonstrated in the Cowlitz County story, people begin to talk with one another, sharing their problems and ideas and forming relationships among themselves and, eventually, with individuals and organizations outside their neighborhoods. Individual relationships grow into networks of connection that allow each part of the community to know the needs of all the other parts and offer help and support to meet those needs.

As culture change and GCC development improve the context of community life, people’s social-emotional needs are better met and social bridging increases within and between social networks, neighborhoods and across communities. Population-based surveys demonstrate that adults who report having two or more people they can rely on for practical help when needed are 65 percent less likely to go hungry because they don’t have enough money for food; 53 percent less likely to have insulin-dependent diabetes; 94 percent less likely to report being depressed all or most of the past month; 62 percent less likely to experience symptoms of serious

and persistent mental illness as indicated by scores using the Kessler 6 Scale (Kessler et al., 2010); and 59 percent less likely to report poor health for more than half of a month (Foundation for Healthy Generations, 2014). The health of the entire community is improved, and adults are likely better able to protect the next generation from ACE accumulation.

### THE THREE PROPERTIES OF THE SELF-HEALING COMMUNITIES MODEL (SHCM)

The Self-Healing Communities Model is based on more than 15 years of experience with the successes that emerged from a new approach to solving health and wellness issues in communities across Washington State. From 1994 to 2012, Washington State supported use of the SHCM in 42 communities. They assessed community capacity to gauge effective use of the four-process phases of the SHCM: leadership, focus, learning and results. High GCC scores were associated with reduced rates of multiple interrelated social problems and lower ACE scores for youth aging into adulthood (Hall, 2012). Higher scoring communities improved five or more separate problem rates concurrently. In these communities, high GCC proved to be a significant contributor that positively improved youth academic, physical and mental health through increased reciprocity and social bridging and changes in peer and school social norms (Longhi et al., 2009).

Because reducing ACE scores offers the potential for decreasing the prevalence of many health, disability, education and employment problems, the SHCM's focus on culture change and increased GCC is likely to generate significant cost savings for government, private and public sectors (Kezelman et al., 2015; Sidmore, 2015). Communities don't have to achieve the highest GCC criteria to benefit, though. Less than a decade of work in low- and middle-scoring communities in Washington resulted in decreases in the rate of at least one social problem in each community (see Tables 2 and 3).

The SHCM has three properties, each of which is essential to the process by which change occurs: Partners; Principles; Process.

#### Partners

Funders, subject matter experts, and community members are partners who work in concert to support culture change. Partners each work in their own sphere of influence, and together their insights and abilities link and leverage efforts to galvanize connectivity and achieve unity of purpose and effort.

#### Meta-Leadership

Meta-leaders are described by the National Preparedness Leadership Institute as leaders who “think and perform differently. By taking a holistic view, they intentionally link and leverage the efforts of the whole community to galvanize a valuable connectivity that achieves unity of purpose and effort” (Marcus et al., 2013). Local leaders exercise courage, self-awareness and persistence in confronting the community's most challenging problems with honesty, humility and hope. They are willing and able to keep their own emotional reactivity in check and to work with others to reflect critically on strategies already in place and to identify high-leverage choice points and options for future strategy and activities.

Successful partners carry moral boldness into their work—and they are willing to ask anyone and everyone to give resources to the common good. They are effective because they have a genuine commitment to improving their community, a neutral and bird's-eye view of the systems and people who can generate improvements, and they enthusiastically chart a course of action, often with incomplete information, to which others want to contribute. Meta-leaders are able to “[stand] at the intersection of many constituencies [and] knit together social networks that complement hierarchical power structures. Rooted in a spirit of respect and inclusion, these complementary connections ensure that when disruption strikes, all parts of the social system are invested, linked, and can talk to one another” (Zolli et al., 2012).

#### Local Partners

Because lasting culture change requires the community to embrace new ways of thinking and behaving, change must be centered on the community. Diverse community members—those most affected by adversity; those committed to improving the lives of children and families; and those ready and willing to offer resources that will support small, iterative layers of change—must engage in hopeful, creative dialogue about how they want things to change, and then begin and sustain the process with small changes that will build into larger transformations.

A paid local coordinator and a core team of community members who develop a reputation for neutral facilitation are essential partners who shepherd the overall process and maintain the impetus for culture change. These people continuously watch for and act upon ideas and resources that might make a difference, keep community members engaged, and keep the shared vision and purpose of change in focus. The core team must be willing to provoke uncommon leaders to action and must be committed to the SHCM process. The core team works in partnership with the coordinator

## Self-Healing Communities

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to stay one or two steps ahead in the process and thinks through design and invitation for the next phase.

Vital to the core team's role is the ability to use data to illuminate the gap between what is and local aspirations for what could be. The proficiencies required to achieve community support involve meta-leadership and management skills; public accountability, civics and public health practice knowledge; and content expertise related to improving child and family systems of care. Over time, or through partnerships, additional skills are needed: data analysis; meaning-making from data; evaluation of process and outcomes designed to support learning; systems thinking; and management of flexible or pooled resources with accountability to multiple political or funder interests.

Service-providing organizations also have an important role in developing general community capacity. Direct services provide financial, transportation and other resources in times of crisis, and develop individuals' capabilities necessary for participation in community life. These same services can be delivered in ways that also build community and social networks that will remain in the lives of clients after formal services have ended.

### External Partners

External partners (e.g., funders, evaluators, educators from outside the community) who maintain a long-term relationship with the community have a unique perspective and view of the community as a whole, including its changes over time. These partners can be valuable participants with the local meta-leadership team when invited, and they can also contribute to leadership efforts by providing learning opportunities that can bring together people from many communities who are working with similar challenges or strategies.

Rather than providing programs for direct services, external partners provide right-fit assistance for the capacity-building processes of the community, which may include support for a paid local coordinator, seed money for culture change initiatives at the community level, and access to content experts who share knowledge about the causes and impact of adversity and evidence about the relative effectiveness of strategies for change. External partners also convene community leaders from different places with similar strengths and challenges so they can compare notes and learn from one another.

Funding partners should provide flexibility and educational supports while concurrently maintaining very high expectations. Funders can challenge communities to take on the most difficult issues, using innovation cycles, with full knowledge that success will not always follow. As true partners, the funders will invest

time and resources into adapting their own practices, including contracting, education and assistance, to align with the processes of the SHCM. Taken together, challenge and support can help communities to achieve stunning results.

### Principles

Six principles create the integrity of the Self-Healing Communities Model. The use of these principles requires a fundamental understanding of meta-leadership and a commitment to consider everyone who wants to help as a leader of culture change. In order to fully infuse these principles into community capacity-building work, community members participate in learning, skill-building, as well as design and implementation of new strategies for improving health. They participate in regular reflective dialogue about the degree to which all aspects of community strategy and activities are consistent with the principles.

1. *Inclusive Leadership With Downward Accountability:* Leaders are accountable to the communities they support, and they engage and improve the lives of people most affected by adversity. When people who are directly affected by policy reforms become decision-makers about the ways to innovate, adapt and coordinate efforts, those reforms are better able to address the problems for which they were created. The ability of leaders to build trust, listen, and acknowledge their own roles in the dynamics that produce status-quo outcomes are central to the SHCM.
2. *Learning Communities:* Self-Healing Communities create and participate in iterative cycles of change that move from learning, to innovative action, to evaluating, examining and frequently changing previous assumptions based on new information. This creates a new level of learning that initiates the cycle again. Recognizing that cultural assumptions must be changed and developing the ability to drill down into cultural autopilots to make those changes are some of the great accomplishments of communities using the SHCM.
3. *Emergent Capabilities:* New lines of communication, peer support systems, self-organizing networks, and communities of practice<sup>2</sup> augment the formal service-delivery system and generate an infrastructure for change.
4. *NEAR-Informed Engagement:* Self-Healing Communities practice inclusion, compassion and

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2 A community of practice is a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly.

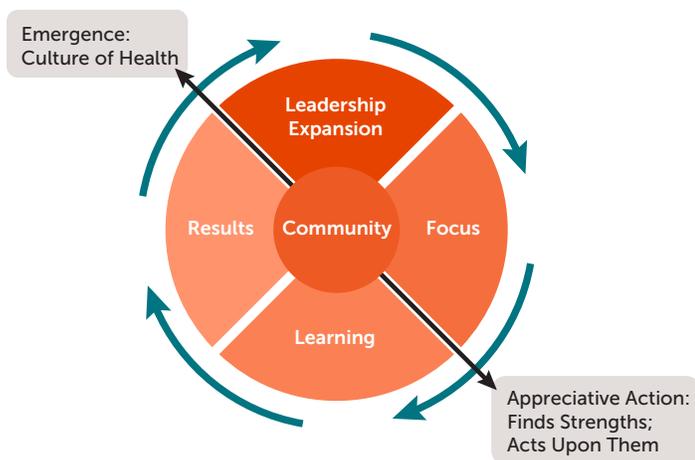
appreciation for the core gifts of every person while recognizing that offering those gifts can be more difficult for people most affected by ACEs or other adversities. Choice, safety and collaboration are intentionally designed as primary features of engagement.

5. *Right-Fit Solutions Given Available Resources:* Communities using the SHCM address complex, severe and multigenerational problems by building ingenious solutions around available resources. They employ a multipronged, layered and aligned set of strategies to produce significant impact.
6. *Hope and Efficacy:* Self-Healing Communities nurture hope and efficacy by noticing, supporting and celebrating hope-filled action that transforms community identity, inspires peer helping systems, and builds the capacity of a community to generate well-being.

### Process

The SHCM process consists of four phases of community engagement that provide increasing opportunity for community members to overcome or reduce stress and adversity and the life challenges they generate by developing and expanding healthy social and cultural networks and practices. The rhythm of the SHCM four-phase process allows time for reflection and emergence of new perspectives, leaders and opportunities, and also time for active inquiry and intentional changes to practice (see Figure 1). The phases of this process are powerful because success in each phase naturally invites success in the next, forming self-reinforcing cycles that mirror processes in healthy living systems.

Figure 1



1. *Leadership Expansion:* Communities that expand the circle of people who are actively engaged in leading community improvement efforts are more likely to succeed. Coordinators invite people of different sectors, classes, neighborhoods, political affiliations and disciplines, including people most affected by ACEs, to develop and manage activities and strategy. Leadership that is characterized by reciprocity, not only by sacrifice or expert standing, is especially powerful.

Examples of activities in this phase are:

- Generative conversations with a mix of residents, service providers, local officials and resource people. Conversations may be recorded to capture preferred language for describing problems or solutions, offers of expertise, and hints about what would build hope and confidence in the community's ability to solve problems.
- Product development to illustrate the tension between people's values and beliefs and the community's current results.
- Invitation, in the form of personalized requests, for people to contribute to community-improvement activities.

2. *Focus:* Community members generate shared understanding of the values, mental models (ways of thinking) and cultural patterns that interact to generate status-quo outcomes. Neuroscience, epigenetics, ACEs, and resilience research (NEAR Science) combined with systems-thinking skills provide a particularly useful framework for developing this shared understanding.

Examples of activities in this phase are:

- A community summit, think tank or gathering for learning about issues of mutual concern that results in a shared action agenda that invites everyone to contribute.
- Distribution of summit outcomes to establish common language, illuminate shared values and generate further learning and opportunity.
- Recruitment of a local meta-leadership team to keep communication moving.
- Celebration routines to appreciate all those involved.

3. *Iterative Cycles of Learning:* Interactive and reflective processes facilitate the learning of community members and continuously transform the community as a whole. In this phase, new information or perspectives are introduced. People are invited to reconsider assumptions, changing context and the constellation of factors that generate current outcomes. People and systems organize efforts so that the strategies used in different disciplines are

complementary and mutually reinforcing. Evaluation with a focus on learning is vital to success.

Examples of activities in this phase are:

- Knowledge- and skill-building activities that are informative (e.g., professional development); motivating (e.g., marketplace for people to offer help, policy dialogue); and entertaining (e.g., family engagement activities such as the Children's Resilience Treasure Hunt: <http://resiliencetrumpsaces.org>).
  - Celebration routines to appreciate all those involved.
  - Family or community cafés—with structured dialogue, free food, and childcare.
  - Peer-to-peer help: formal or informal systems for people to help and be helped by people outside of their immediate social circle.
  - Reflective practices that generate feedback to the system as a whole.
4. *Results*: Local participation in outcome research and reporting motivates communities to design iterative improvements to strategies and activities based on results (Schorr et al., 2011). Data is used to generate a powerful community journey story that explains success as it unfolds over time and invites deep commitment to culture change within a community.

A community that is focused on results does not get fixated on a small number of data sources as an agreed-upon metric for an initiative. Instead, they use data to build a sense of shared identity: *We are the ones who are creating a better future for our children*. That shared identity drives next-step improvements to the community's strategy. These communities use data to tell a story about local people and attract unusual resources, such as in-kind donations of labor, space, materials and expertise. They use data to generate questions that matter enough for people to try something new, to illuminate new effective strategies and to help everyone to recognize: *We are in this together*.

Researchers have long recognized that the evaluation of community-level interventions is complicated. Randomized procedures are difficult to apply to complex, multi-causal community interventions, including embedded variables of local culture, knowledge and involvement (Trickett et al., 2011). However, over time, participatory action research and learning produce both quantitative and qualitative variables and measures for developmental evaluations that assess local effectiveness and results in ways that are meaningful to local people (Patton, 2011). The SHCM uses a developmental evaluation approach.

Examples of activities in this phase are:

- Products that show process and outcome measures from activities or strategies.
- Conversations to determine the kinds of actions people thought were promising, and why.
- New ways to monitor the success of the system as a whole in moving toward goals.
- Publications or presentations of data that offer a new framework for thinking about community dynamics and results, and challenge people to co-lead next steps.
- Community Capacity Index scores that provide feedback to the community, with awards given for strengths and progress.

## IMPLICATIONS

The health and social problems we are facing in too many communities are highly complex. They are interrelated and intergenerational. To the extent that there are interventions that can address problems, they tend to focus on narrow sets of outcomes and are hard to adapt to real-world conditions. Interventions tend to be expensive, and yet we have very limited resources. If we have any chance of turning things around, we need solutions that address the complexity of problems and can be easily and effectively replicated in different community environments at a modest cost. Building the community capacity to create a Culture of Health for neighborhoods and families offers us the best hope for doing that in our time.

Think of a future in which adversity in childhood is rare, in which the healthy development of children is supported by parents with the capabilities and community supports so that each child reaches his or her full potential. Reciprocity and strong community capacity will provide the opportunity for children to develop strong cognitive and problem-solving skills, self-regulation, the ability to make good choices, and a sense of safety and efficacy. They will experience the security and connectedness that comes from having healthy relationships and being part of a strong community that reaches out to all of its members across cultural differences to care for each other, and they will have those experiences to pass on to their children. As median ACE scores are reduced across generations, we will create sustainability in our social, health, workforce-development, and other service systems that is born from reducing need. Reinvestment of avoided costs can drive iterative cycles of improvements, so communities will have the capabilities and cultural norms to continuously flourish.

**APPENDIX 1. COMPLETE LABELS FOR GRAPHS**

**Table 1. Change in Rates of Selected Youth & Family Problems**

Child Injury Hospitalizations	The child injury or accident hospitalizations as a percentage of all hospitalizations for children (age birth–17).
Suicides and Suicide Attempts	Number of people who committed suicide or were admitted to the hospital for suicide attempts per 100,000 population (all ages).
Hospitalizations	The child injury or accident hospitalizations as a percentage of all hospitalizations for children (age birth–17).
Alcohol Arrests	The arrests of younger adolescents (age 10-14) for alcohol and drug law violations, per 1,000 adolescents (age 10-14)
Infant Mortality	The deaths of infants under one year of age, per 100,000 population of infants under one year of age.
Filings for Juvenile Offenses	Number of juvenile offenses filed with the courts per 1,000 adolescents (age 10-17). <i>Note: Criminal and juvenile offender filings are categorized by the primary (i.e., most serious) original charge against the defendant in the following order: homicide, sex crimes, robbery, assault, theft/burglary, motor vehicle theft, controlled substances, other felony, and misdemeanors.</i>

**Table 2. Change in Rates of Youth & Family Problems Among Teens**

Juvenile Offenders	Number of adolescents convicted of a felony or misdemeanor crime per 1,000 adolescents (age 10-17).
Juvenile Arrest for Violent Crime	Number of arrests of adolescents (age 10-17) for violent crime per 1,000 adolescents (age 10-17). <i>Note: Violent crimes include all crimes involving criminal homicide, forcible rape, robbery, and aggravated assault.</i>
Yearly High School Drop-out	The proportion of students enrolled in grades 9-12 who drop out in a single year without completing high school, as a percentage of all students in grades 9 through 12 that year.
Freshman to Senior Drop-out	The percent of students dropping out prior to graduation.
Alcohol-Related Juvenile Arrests	The arrests of adolescents (age 10-17) for alcohol violations, per 1,000 adolescents (age 10-17).
Drug-Related Juvenile Arrests	The arrests of adolescents (age 10-17) for drug law violations, per 1,000 adolescents (age 10-17). <i>Note: Drug law violations include all crimes involving sale, manufacturing, and possession of drugs.</i>
Births to Teen Mothers	The live births to adolescents (age 10-17) per 1,000 females (age 10-17).

**Table 3. Change in Rates of Children & Family Health & Safety Issues**

Accident & Injury Hospitalizations (Birth to 17)	The child injury or accident hospitalizations as a percentage of all hospitalizations for children (age birth–17).
Out-of-Home Placements	Rate per 1,000 children (age birth–17)
Infant Mortality	The deaths, of infants under one year of age, per 100,000 population of infants under one year of age.
No Third Trimester Maternity Care	Percent of pregnant women not receiving maternity care in the 3rd trimester of pregnancy.
Juvenile Suicide	The adolescents (age 10-17) who committed suicide or were admitted to the hospital for suicide attempts, per 100,000 adolescents (age 10-17).

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# Self-Healing Communities

A Transformational Process Model for Improving Intergenerational Health

## Executive Summary



Commissioned by the Robert Wood Johnson Foundation

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June 2016



## Self-Healing Communities

### A Transformational Process Model for Improving Intergenerational Health

#### EXECUTIVE SUMMARY

This article presents a model with demonstrated success in improving rates of many interrelated and intergenerational health and social problems by investing in the people most at risk and reducing and preventing the root cause of these problems: Adverse Childhood Experiences (ACEs). The Self-Healing Communities Model (SHCM) builds the capacity of communities to intentionally generate new cultural norms and thereby improve health, safety and productivity for current and future generations.

The SHCM brings together recent scientific discoveries into a single framework. In less than three decades, scientific discoveries in epidemiology, neuroscience, epigenetics, and network and systems theory have changed our understanding of the origins and dynamics of social and health problems. The landmark Adverse Childhood Experiences Study established that accumulation of adversity during child development, including abuse, neglect and household dysfunction, is the most powerful determinant of the public's health. We have also learned about the power of networks to carry information, connect like-minded people, and provide a flexible yet durable infrastructure for social movements. The scientific framework for solving problems in our world has been also transformed by chaos, quantum and relativity theories. When combined together, these recent discoveries call for new modes of thinking and action that transcend traditional linear and categorical thinking about prevention of our nation's most troublesome health and social problems.

Importantly, in this same time period we have experienced and describe herein a fast-paced journey that transitioned from knowledge acquisition and management by experts, to distributed knowledge that is managed and shared by the population as a whole. Knowledge is changing so fast that detailed plans and programs can become obsolete before they can be implemented; therefore, system-innovation processes must be integrated into health improvement strategies and policies. The SHCM promotes emergence of new ways of fostering a Culture of Health in communities

that incorporates low-cost, locally promoted, sustainable solutions on a scale that can match the magnitude of health and social problems.

In this new paradigm, it is becoming increasingly clear that direct-service interventions are necessary but not sufficient to produce transformative health improvements, generate population-based change, or catalyze the social movement necessary to address the scope of the problems generated by ACEs. Direct services reach only a small portion of the people affected, and the cost of direct services prohibits their use as a primary strategy for preventing ACEs, their intergenerational transmission, and the wide array of serious health and social problems they cause. Moreover, these services are often limited in their effectiveness and generally not designed to address complex and comorbid health and social problems concurrently, even though co-occurring problems are common among children and adults with high ACE scores. And challenges associated with the maze of eligibility and application processes, silos of programming, and limited service availability in communities that are most in need do nothing to slow the escalation of adversity across the life course that leads to a vicious cycle of ever-increasing demand on service systems.

Investments in static or structural solutions will not solve dynamic problems. Rather than restructuring decision-making groups, programs, service locations or evaluation dashboards, we need to engage the public, inspire innovation, support peer helping, ease the daily stress burden of parents and promote change in all of the systems that serve them so that together communities can better protect and nurture the next generation. ACEs are common in every socioeconomic group in our nation. We have to change the way we think about social problems and solutions to generate change that is affordable, scalable, and designed to produce exponential improvements in population health.

The SHCM is based on 15 years of promoting community capacity and culture change in communities across Washington State, where health outcomes were dramatically improved as a result. In the SHCM, as communities develop the capacity to shift typical cultural patterns, individuals within the community gain new knowledge and skills, and the community as a whole becomes proficient at critically evaluating all of the underlying assumptions that shaped previous action. Residents and professionals co-create practice-improvement cycles that produce stunning results. Investments in culture change processes are vital for this success.

### CULTURE AND COMMUNITY CAPACITY

Strategies that increase the capacity of a community to reduce adversity can be incorporated as new and customary ways of being with self and others. These new ways change how people experience and deal with the world: their culture. Culture comprises the abstract, learned, shared rules/standards/patterns used to interpret experience and shape behavior (Martin, 1997). We are not consciously aware of most of our culture; instead, culture becomes our autopilot. We unconsciously follow cultural norms, but we also have the ability to consciously take control of our perceptions, thoughts and behaviors. In order to improve generational health and equity, we need to empower communities to recognize their own ability to make change, engender hope that what they do will make a difference, and challenge unexamined patterns that prevent realization of the community's aspirations. The processes communities use to improve hope and efficacy, examine patterns, and make cultural changes are general community capacity-building processes.

General community capacity (GCC) refers to the ability of a geographically based group of people to come together, build authentic relationships and reflect honestly about things that matter, share democratic leadership, and take collective actions that assure social and health equity for all residents (Morgan, 2015). Increasing the GCC of a community is a holistic, long-range culture-change strategy that includes connecting people so that they can provide support and assistance for each other and generate solutions for locally prioritized issues. Better adapted, more resilient communities with high community capacity have extensive, community-wide networks of relationships through which reciprocity can flow and foster collaboration.

The SHCM has the power to decrease ACE prevalence and intensity from one generation to the next, thereby concurrently reducing many mental, physical, behavioral and economic/productivity problems. Solutions are durable because they are born from culture change—change that becomes a part of the autopilot for people's ways of being with one another. Improvements are sustainable because they originate from solving problems, rather than treating symptoms, and they emerge from within the often-unexplored pool of creativity, resources and resilience in communities that change from their traditional "autopilot" to a culture that creates health.

### THE SELF-HEALING COMMUNITIES MODEL

From 1994 to 2012, Washington State supported use of the SHCM in 42 communities. Community capacity was assessed using an index containing indicators of effective use of the four process phases of the SHCM: leadership expansion, focus, learning and results. Communities using the SHCM for eight or more years reduced the rates of seven major social problems: child abuse and neglect, family violence, youth violence, youth substance abuse, dropping out of school, teen pregnancy and youth suicide. Communities with consistently high index scores improved five or more separate problem rates concurrently. Per-year avoided caseload costs in child welfare, juvenile justice and public medical costs associated with births to teen mothers were calculated to be over \$601 million, an average of \$120 million per year, for a public investment of \$3.4 million per year (Scheuler et al., 2009).

The SHCM has three properties, each of which is essential to the process by which change occurs.

#### I. Partners

Funders, subject matter experts, service providers and community members are partners who work in concert to support culture change. Partners each work in their own sphere of influence as meta-leaders, and together their insights and abilities link and leverage efforts, transcending the limitations of existing silos and services to generate connectivity and achieve unity of purpose. Direct services provide financial, transportation, and other resources in times of crisis, and they can develop individuals' capabilities necessary for participation in community life. In Self-Healing Communities, these same services are delivered in ways that also build community and social networks that will remain in the lives of clients after formal services have ended.

#### II. Principles

Six principles create the integrity of the SHCM: (1) inclusive leadership; (2) learning communities; (3) emergent capabilities; (4) engagement informed by neuroscience, epigenetics, adverse childhood experience and resilience research (NEAR); (5) right-fit solutions; and (6) hope and efficacy. The use of these principles requires a fundamental understanding of meta-leadership and a commitment to consider everyone who wants to help as a leader of culture change. In order to fully infuse these principles into community capacity-building work, community members participate in learning, skill-building, as well as design and implementation of new strategies for improving health. They participate in regular reflective dialogue about the degree to which all aspects of community strategy and activities are consistent with the principles.

### III. Process

The SHCM process consists of four phases of community engagement: leadership expansion, focus, learning and results. Use of the process provides increasing opportunity for community members to overcome or reduce stress and adversity and the life challenges they generate by developing and expanding healthy social and cultural networks and practices. The rhythm of the SHCM four-phase process allows time for reflection and emergence of new perspectives, leaders and opportunities, and for active inquiry and intentional changes to policies, formal services, and the day-to-day interactions of community members. The phases of this process are powerful because success in each phase naturally invites the next, forming what systems-thinking experts call a virtuous self-reinforcing cycle that mirrors the emerging understanding of healthy living systems.

### IMPLICATIONS

The health and social problems we are facing in many communities are highly complex. They are interrelated and intergenerational. To the extent that existing interventions can address problems, they tend to focus on narrow sets of outcomes and are hard to adapt to real-world conditions. Interventions tend to be expensive, and yet we have very limited fiscal resources. If we have any chance of turning things around, we need right-fit solutions that address the complexity of problems and will inspire emergent change in different community environments at a modest cost. Building the community capacity to create a Culture of Health for neighborhoods and families offers us the best hope for doing that in our time.

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### About the Authors

**Laura Porter** is co-founder of ACE Interface, LLC. Ms. Porter supports leaders in over 25 states, providing education, facilitation and empowerment strategies for building flourishing communities. Ms. Porter concurrently serves as the senior director of The Learning Institute at the Foundation for Healthy Generations, a Seattle-based nonprofit. She is an award-winning public servant who is best known for her work directing systemic improvements to the child and family serving system in Washington State. Working with elected and appointed state officials from the legislature and seven state agencies, and leaders of community-based collaborative organizations, Ms. Porter and colleagues developed a unique model for improving the capacity of communities to deliver stunning results for a small investment. Ms. Porter holds a BA degree from The Evergreen State College.

**Dr. Kimberly Martin** is a professor of anthropology at the University of La Verne and president of the Southwestern Anthropological Association. Dr. Martin's areas of specialization include cognitive and psychological anthropology, gender, sustainable culture, culture change, ethnic identity and group affiliation in the United States, Europe, Mesoamerica and the Pacific. Her current interests involve culture change theory as it applies to identity, affiliation, and sustainability in a globalizing world. Dr. Martin teaches a variety of anthropology and student research courses at the University of La Verne. She has also served as a multicultural consultant, leading workshops for educational, government and professional organizations. Dr. Martin earned a BA in Psychology from Stanford University, an MA in Anthropology from the University of Hawaii and a PhD in Anthropology from the University of California, Riverside.

**Dr. Robert Anda** is co-principal investigator of the Adverse Childhood Experience Study (ACE) and co-founder of ACE Interface, LLC. For more than a decade, Dr. Anda served as a senior scientist at the Centers for Disease Control and Prevention conducting research in disease surveillance, behavioral health, mental health and disease, cardiovascular disease, psychosocial origins of health-risk behaviors, and childhood determinants of health. Dr. Anda is the author of more than 200 publications, including numerous government publications and book chapters, and has received many awards and recognition for scientific achievements. The ACE Study is being replicated in numerous countries by the World Health Organization (WHO), and is in use to assess the childhood origins of health and social problems in more than 25 U.S. states. Dr. Anda provides education and consultation about the ACE Study and its application throughout the country,

and throughout the state of Washington. Dr. Anda holds an MD from Rush Medical College with board certification in internal medicine, and an MS degree in Epidemiology from the University of Wisconsin.

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## **Handout for Shared Learning in Trauma and ACEs from Norway and Illinois**

**Below is a sampling of other related projects being done by Suzette Fromm Reed, PhD**  
Associate Professor National Louis University

1. Publication on How to Increase Community-Wide Resilience to Decrease Inequalities due to Adverse Childhood Experiences (ACEs): A Case Study Journal of Prevention and Intervention in Community (in process).
2. Work on how ACEs apply in higher education.
3. Publication in process on Collaborating for Equity and Justice, a comparison of how to communities are using an ACEs frame.
4. How a University and community work together to create systemic change.

# BOUNCE BACK

## MANAGE YOUR PHYSICAL ENERGY

- Practice restorative sleeping habits.
- Discover spiritual habits useful for relaxation.
- Know how many days in a row you can work.
- Select exercise that you can most enjoy.
- When is the last time you had positive physical contact with someone?

## KEEP PERSPECTIVE

- Accept what you cannot change and focus on what you can change.
- Acknowledge what you do well and celebrate success.
- Remember you have limits and honor them.
- Find ways to laugh and enjoy life that helps you maintain a realistic optimism.

## FIND MEANING, PURPOSE, AND GROWTH

- How do you define or explain your sense of purpose?
- Are you living your values at home and in your work?
- Are you satisfied with how you are living your talents?
- Discover how spirituality fits into your life.

## BUILD CONNECTIONS

- Who can you turn to for support - what type of support does each person offer?
- In what ways can you support others?
- Is there someone you want to start being more genuine with?
- Who is a role model of who you want to be in your work and life? Who is a model of who you don't want to be?

## ENHANCE EMOTIONAL INTELLIGENCE AND SKILLS

- Can you be flexible with your mood and emotions when needed?
- In stressful situations create worse version and better version stories.
- Do you know the difference between your emotions and the emotions of those around you?

### Sources:

Resilience: The Science of Mastering Life's Greatest Challenges, Steven M. Southwick, M.D. and Dennis S. Charney, M.D., Cambridge University Press, 2012

Roffey Park Resilience Capability Index: <http://www.roffeypark.com/resilience-capability-index/>

Mission and Spiritual Care



Advocate  
Children's Hospital



Take a Bath Listen to Music Take a Nap Go to a body of water Watch the clouds Light a candle Learn something REST your legs up on a wall Let out a sigh Fly a Kite Watch the stars Write a Letter

NEW Listen to a guided relaxation Read a Book

# 50 Ways to Take a Break

Sit in NATURE 2x Move twice as slowly

MEDITATE Take Deep Belly Breaths

Call a Friend Buy some Flowers

Meander around Town Find a relaxing scent

WRITE in a journal Notice your Body Walk Outside

Go for a run Take a bike ride

Create your own coffee break View some ART

Silence Eat a meal in SILENCE Turn off all electronics

Go to a park Pet a furry creature

read or watch something FUNNY

Examine an everyday object with Fresh Eyes Drive somewhere NEW

Go to a Farmer's Market

Forgive Someone

COLOR with Crayons Make some MUSIC

Climb a Tree Let go of something

Engage in small acts of KINDNESS

Do some gentle stretches Paint on a surface other than paper

Write a quick poem Read poetry

Put on some music and DANCE Give Thanks



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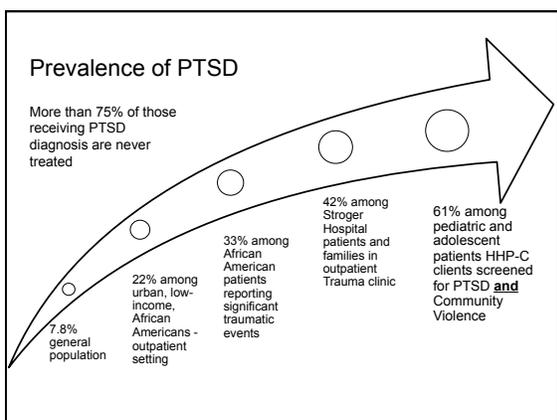
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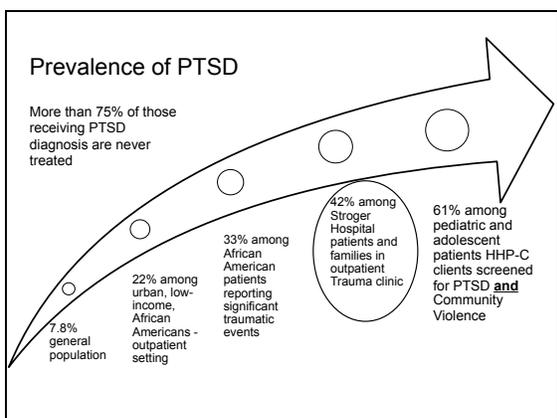
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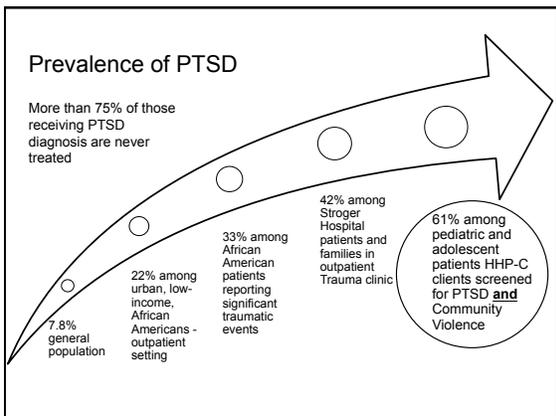
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### PTSD Screen

CHILD TRAUMA SCREEN QUESTIONNAIRE (CTSQ)

\_\_\_\_\_  
 Patient Identification Information

\_\_\_\_\_  
 Questions that you may have after an incident

This section is about your personal reactions to the incident that happened to you. Please indicate whether the following things have happened to you since the incident.

	CTSQ Date
1. Do you have lots of thoughts or memories about the incident that you don't want to have?	Yes No
2. Do you have bad dreams about the incident?	Yes No
3. Do you feel or act as if the incident is about to happen again?	Yes No
4. Do you have bodily reactions (such as a fast beating heart, stomach churning, sweating and feeling dizzy) when reminded of the incident?	Yes No
5. Do you have trouble falling or staying asleep?	Yes No
6. Do you feel grumpy or lose your temper?	Yes No
7. Do you feel upset by reminders of the incident?	Yes No
8. Do you have a hard time paying attention?	Yes No
9. Are you on the "look-out" for possible dangerous things that might happen to yourself and others?	Yes No
10. When things happen by surprise or all of a sudden, does it make you "jump"?	Yes No

Score (scores greater than or equal to 5 indicate a positive screen for trauma symptoms)

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### Community Violence Assessment

12 TYPES OF VIOLENT EXPOSURE and 2 SAFETY QUESTIONS

- Have you or someone you care about been hurt by violence?
- Have you seen anyone get shot or shot at?
- Have you been shot or shot at?
- Have you seen anyone jumped or badly beaten?
- Have you been jumped or badly beaten?
- Have you seen a stabbing?
- Have you been stabbed?
- Has a member of your family been killed?
- Has someone you go to school with been killed?
- Has a close friend been killed?
- Have you witnessed a homicide?
- Have you heard gunshots in your neighborhood?
- Is it safe in your neighborhood?
- Is it safe at school?

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### Violence Exposure

HHPC CLIENTS

The teens in this pilot study were exposed on average to:

- 7.7 types of community violence.

Among those with positive PTSD screens the average exposure was:

- 8.6 types of community violence

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### Link Between Violence and Positive PTSD Screen

The combination of violent injury and prior exposure to community violence increased the risk of a positive PTSD screen in the following ways:

■ Family member killed	68%
■ Been shot	75%
■ School mate killed	83%
■ Seen someone jumped	83%
■ Friend killed	88%
■ Witnessed homicide	100%

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### HHPC Clients and PTSD

PTSD Positive Kids	48%
Have a Bad Mood	89%
Looking out for Danger	86%
Upset by Reminder of Incident	73%

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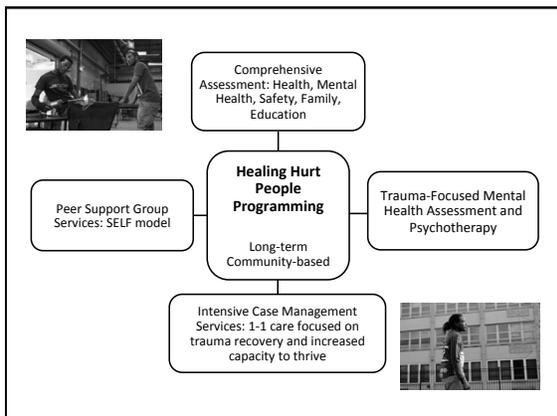
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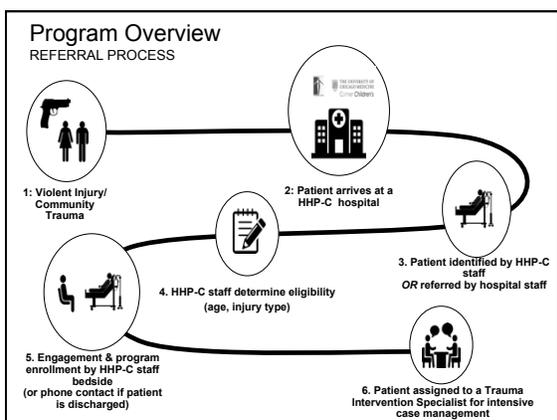
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**S**AFETY  
**E**MOTIONS  
**L**OSS  
**F**UTURE\*

\*Sanctuary Model, Sandra Bloom & Healing Hurt People Philadelphia at Drexel University

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### SAFETY

- Physical
- Psychological
- Social
- Moral/Ethical

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### Emotions

EMOTIONAL LITERACY:  
Know your feelings



EMOTIONAL SELF-REGULATION:  
Emotional states do not have to determine behavior

Coping with Complex Emotions

- Psychoeducation
- Mindfulness practices
- Exercise
- Counseling
- Yoga
- Community – friends and family
- Hobbies

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### Loss

- Grieving
- Saying goodbye
- Refraining from reenactment
- Moving on

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## FUTURE

Future is about managing the FREEDOM and the RESPONSIBILITIES that come with the power to make choices in one's life – choices that are not determined by the past.

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**HEALING HURT PEOPLE CHICAGO**  
Injury And Mental Health In The Acute Trauma Setting

The Rev. Carol Reese, LCSW  
Co-PI and Program Director, Healing Hurt People - Chicago  
Violence Prevention Coordinator  
Cook County Trauma Unit  
John H. Stroger, Jr. Hospital of Cook County

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## 2017-2018 Policy Agenda

Strengthening Chicago's Youth (SCY) supports public policies that will prevent violence and build resilience among our youth. These policies generally share the following principles:

- Developmental approach that recognizes how violence emerges over the life course and the impact of trauma on development.
- Ecological approach which notes that violence and its solutions occur at the individual, family, community, and societal levels.
- Knowledge that each child, family, and community is unique.
- Recognition that it is better to keep a child or family from being exposed to violence than to treat the effects of exposure.
- Strength-based approach that focuses more on development of assets and skills than on remedy of deficits.
- Acknowledgement that violence prevention requires involvement from many different disciplines.
- Emphasis on data including encouragement of strong surveillance, use of local data, evidence-based polices, and evaluation.
- Attention paid to enhancing existing infrastructures, sustainability, implementation, and funding.
- Participation of the people and organizations most affected by the policy in its development.
- Acceptance of the fact that violence cannot be addressed without addressing race, segregation, gender, sexual orientation, and poverty.
- Basis in social justice, ensuring that potential negative effects of policies should not be borne disproportionately by already oppressed populations.

For 2017-2018, SCY will focus on supporting the following policy recommendations. This list was prioritized by members of the SCY collaborative on the basis of timeliness, implementation and political feasibility, importance, and alignment with SCY's policy principles.

1. Raise public awareness of how positive parenting contributes to academic, economic and family success, and promote culturally competent parenting enrichment opportunities.
2. Develop strategies to build needed capacity for community-based organizations in high-need areas to deliver quality programs for youth and families.
3. Support gun violence prevention policies that have been shown to make a difference, including anti-trafficking laws and enforcement measures and evidence-based approaches to keep guns from dangerous people.
4. Decrease detention and incarceration and minimize arrests, and reinvest savings into community-based resources alternatives, prevention, and early intervention.
5. Implement sustainable funding mechanisms for school-based, community-based, and faith-based mental health and substance abuse services, including health promotion, standardized screening, connection to services, and outcome tracking.
6. Support justice policies in all settings that reflect evidence regarding brain development, including knowledge about the impact of trauma.
7. Build cultures of compassion at schools across all levels of the socioecological model.
8. Promote economic and community development, including strategies such as affordable housing and quality of life planning.
9. Reduce use of disciplinary practices that remove children from school in Chicago Public Schools and promote approaches that foster supportive school climates.
10. Redefine the concept, process and impact of "arrest" for youth.

# Strengthening Chicago's Youth

## Ann & Robert H. Lurie Children's Hospital of Chicago

**Strengthening Chicago's Youth (SCY)** is convened by Ann & Robert H. Lurie Children's Hospital of Chicago to address the issues of violence that impact the health and safety of Chicago youth. Every day children are exposed to violence in their communities, schools and homes, and the effects of exposure to violence can last throughout a lifetime. To help ensure a healthier future for every child, we must build communities' and families' capacity and skills to raise safe, resilient, emotionally healthy youth. SCY's focus is to build capacity among our violence prevention partners, 3600+ public and private stakeholders, to connect, collaborate and mobilize around a public health approach to violence prevention—encouraging partnerships that strengthen existing efforts and benefit the children of Chicago.

**SCY encourages everyone to take action to prevent violence – here's what you can do.**

*What can policymakers do?*

*What can individuals do?*

### Sustained investment in children and youth

Make a commitment to fund programs and implement laws that will enable our young people to reach their full potential.

Parents: Establish a regular time to check in with your kids.

Everyone: Consider becoming a tutor/mentor. Learn more about local opportunities through Tutor/Mentor Connection ([tutormentorconnection.org](http://tutormentorconnection.org)) or the Illinois Mentoring Partnership ([ilmentoring.org](http://ilmentoring.org))

### Equitable access to high quality mental health services

Ensure that resources are dedicated to allow every Illinois resident to get the mental health care they need.

Look out for our family, friends, and neighbors and encourage them to get help when you see signs of trouble.

Learn more about the signs and symptoms of mental illness or crisis and how to help by attending a Mental Health First Aid training ([mentalhealthfirstaid.org](http://mentalhealthfirstaid.org))

### Common sense approaches to gun violence prevention

Enact and enforce gun violence prevention policies that have been shown to make a difference, including anti-trafficking laws and enforcement measures and evidence-based approaches to keep guns from dangerous people.

If you must keep a gun in your home, store it unloaded and locked up with a trigger lock or in a gun safe, with the ammunition locked up separately.

Learn more or volunteer through the Illinois Council Against Handgun Violence ([ichv.org](http://ichv.org))

### Juvenile justice system that reflects what we know about adolescent development

Recognize that adolescents' brains are not fully developed and adopt policies that view a child's involvement with the justice system as an opportunity for intervention to prevent further delinquent behavior.

Parents: Model good behavior and teach children how to resolve conflict appropriately.

Everyone: Get involved in community organizing with Community Organizing and Family Issues ([cofonline.org](http://cofonline.org))

### Sustained investment in strong communities

Adopt community and economic development policies to rectify the fact that the toll of violence falls disproportionately on low-income, minority communities.

Get involved in your community—Join or start a block club, attend CAPS meetings, or volunteer at your local school.

Get more information about block clubs at CAPS at [home.chicagopolice.org](http://home.chicagopolice.org) and about schools at [cps.edu](http://cps.edu)



## A public health approach to tackling a growing issue



Preventative behavioral health can change the trajectory of a child's life. Research shows that preventive behavioral health improves positive behavior and reduces negative behavior in children and adolescents. Our approach is embedded within a broader philosophy that promoting mental wellness, health, and resilience has a positive impact on many areas of a young person's life, including academic learning, family and social relationships, and in later years, their professional success.

For adults who work with youth, understanding the importance of social-emotional wellness and resiliency building is imperative. We train school and clinical professionals and community agencies how to use innovative, evidence-based approaches when they work with children who have experienced trauma. We also work with community leaders and policymakers to ensure statewide systems and resources support best practices in behavioral health.

### A holistic approach

We are committed to addressing the issue of mental health reform holistically. Each element of our work reinforces our commitment to building more resilient children.



**School mental health** – We work with school staff, clinicians, administrators, and community organizations to build better access to mental health services for children and adolescents.

**Trauma training** – We share trauma-informed best practices with teaching professionals who work with children.

**Research** – We identify, evaluate, and disseminate intervention best practices.

**Pre-professional mental health training** – We train new generations of clinical professionals in our public health approach to mental health.

**Advocacy and policy** – We lead advocacy and policy initiatives to ensure statewide systems and resources support best practices in behavioral health.

Learn more at [www.childhoodresilience.org](http://www.childhoodresilience.org) or email us at [ccr@luriechildrens.org](mailto:ccr@luriechildrens.org).

# The Plan



## Overarching Outcome:

*To lead change through building level resilience teams in order to build capacity as a trauma-sensitive school*

### **PART 1: Resilience Team Plan Development**

1. What are the objectives of your building resilience team?
2. Describe the recommended membership and structure of the team and plan its operation.
3. Determine recommendations of baseline data to collect.
4. Develop a draft timeline for your anticipated work for the upcoming year for

### **PART 2: Implementation of staff training to raise the level of awareness**

1. What spheres of influence and portals of entry exist for you to raise the level of awareness about Trauma Informed Systems in your workplace?
2. Prioritize topics that you have determined that will be covered in your efforts to raise the level of awareness in your workplace. (select 2-3)

### **PART 2a: Implementation of staff training to raise the level of awareness**

1. Discuss ways to assess whether your efforts have been successful for each of the prioritized items.
2. Take one idea and develop a design and possible timeline as an example of possibilities for implementation.

### **PART 3: IMPLEMENTATION POSSIBILITIES**

What are topics and initiatives aligned with the Flexible Framework: An Action Plan for Schools ([traumasensitiveschools.org](http://traumasensitiveschools.org)) that resonate with your team as priorities for your school?

Framework components:

- Staff training – raising the level of awareness
- School-wide infrastructure and culture
- Linking with mental health professionals
- Academic instruction for traumatized children
- School policies, procedures, and protocol
- Nonacademic strategies

\*Prioritize 3-5 Items- (staff training- raising the level of awareness must be one of the priorities)

### **PART 3a: IMPLEMENTATION POSSIBILITIES**

1. Discuss data which could be collected for each of the prioritized items.
2. Determine ways you will bring these ideas to your colleagues for input to build consensus.
3. Take one idea and develop a design and possible timeline as an example of possibilities for implementation.

**Enhancing Police Responses**  
*to* **CHILDREN EXPOSED**  
*to* **VIOLENCE**



*A* **Toolkit**  
*for* **Law Enforcement**



**Yale Medicine**  
CHILD STUDY CENTER

**OJJDP** Office of Juvenile Justice  
and Delinquency Prevention  
Office of Justice Programs • U.S. Department of Justice

# Enhancing Police Responses to **CHILDREN EXPOSED** to **VIOLENCE**

This toolkit was prepared under cooperative agreement number 2012-CV-BX-K056 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice. OJJDP is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance; the Bureau of Justice Statistics; the Community Capacity Development Office; the National Institute of Justice; the Office for Victims of Crime; and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART). Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.

All materials contained in this toolkit are property of the International Association of Chiefs of Police (IACP), the Yale Child Study Center, and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the U.S. Department of Justice. Materials contained herein may not be published without explicit written permission from IACP, Yale and OJJDP. Law enforcement professionals may reproduce, distribute, transmit, and share these tools for the purpose of identifying and responding to children exposed to violence.

The article titled, “The Officer’s Role in Responding to Traumatized Children” was originally published in the Winter 2015 issue of *The Tactical Edge*, the official publication of the National Tactical Officer’s Association. [www.ntoa.org](http://www.ntoa.org).

The tool titled, “Teaching the Tactical Breathing Technique” was adapted for law enforcement from “How to Teach Your Child Calm Breathing” by the Anxiety Disorders Association of British Columbia (AnxietyBC) in 2014 and available at <https://www.anxietybc.com/parenting/how-teach-your-child-calm-breathing>, accessed February 1, 2017.

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Office of Justice Programs ♦ U.S. Department of Justice

## Acknowledgments

The core content of **Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement** is based on principles, practices and approaches developed at the Childhood Violent Trauma Center at the Yale Child Study Center (Yale) over 25 years, and through implementation of the Child Development-Community Policing (CD-CP) program in New Haven, CT and in Charlotte, NC. Building on the knowledge and expertise gained through the CD-CP program, the Yale Child Study Center and the International Association of Chiefs of Police (IACP), in partnership with the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs, U.S. Department of Justice, joined forces to create the **Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement (Toolkit)**. This **Toolkit** is designed to meet the unique needs of today's officers, who may or may not have the opportunity to work in close collaboration with trauma-informed mental health and child welfare professionals.

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Convening both law enforcement and mental health experts, the IACP-Yale team first developed the **Protecting and Serving: Enhancing Law Enforcement Response to Children Exposed to Violence (Protecting and Serving)**, a classroom training curriculum for frontline police officers which is a companion to this **Toolkit**. Following the development of the curriculum, the tools included in this **Toolkit** were developed. The following individuals made significant contributions to the content and development of the **Protecting and Serving** curriculum, as well as to the development of this **Toolkit**.

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In addition, the IACP, Yale and OJJDP created a multidisciplinary Advisory Working Group to provide advice and guidance to inform the development of the training, tools and resources. The IACP and Yale would like to express our gratitude for the vital contributions of the following Advisory Working Group Members who are listed below with affiliations at the time of participation.

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## **U.S. Department of Justice:**

The IACP and Yale Child Study Center would like to thank the professionals at the U.S. Department of Justice, including former U.S. Attorney General Eric Holder and Assistant Attorney General Karol Mason for their steadfast leadership to address the issue of childhood exposure to violence. In addition, we extend our appreciation for the leadership, assistance and support provided by OJJDP Administrator Bob Listenbee and staff members Carmen Santiago-Roberts, Kristie Brackens, Cynthia Pappas, Robin Delaney-Shabazz, Catherine Pierce and Scott Pestridge.

\*contributing author of Protecting and Serving training curriculum

\*\*co-author of National Tactical Officers Association article

## Purpose/Introduction

This Toolkit provides practical tools and resources to assist law enforcement agencies in building or enhancing effective operational responses to children exposed to violence (with or without a mental health partner). This toolkit contains tools targeted to police leaders and frontline officers.

Several tools were first developed for the ***Protecting and Serving: Enhancing Law Enforcement Response to Children Exposed to Violence*** training curriculum for frontline police officers, developed and launched by the IACP, Yale and OJJDP.

## Instructions

The tools within this toolkit are organized into three types:

### Overview:

- Chief's Briefing on Children Exposed to Violence
- The Officer's Role in Responding to Traumatized Children

### Operational Protocols:

- On-Scene Acute Protocol for Children Exposed to Violence
- Protocol for Responding to the Needs of Children at Scenes of Domestic Violence
- Principles and Practices of Death Notification to Children

### Assessment Tool:

- Organizational Self-Assessment Tool and Action Planning Tool

### Operational Tools:

- Reactions that Police May Observe From Children and Youth
- What Traumatic Stress Reactions May Look Like On-Scene
- Effective Police Responses to Traumatic Stress in Children of Different Ages
- Commonly Asked Questions from Children and Example Police Responses
- Common Issues with Caregivers and Police Responses
- What to Do When Your Child is Exposed to Violence – Brochure
- Teaching the Tactical Breathing Technique to Children and Parents

These tools are designed to be practical and useful to law enforcement professionals. There are a number of ways that the tools can be applied in the field. Ideally, an agency would seek to have the ***Protecting and Serving: Enhancing Law Enforcement Response to Children Exposed to Violence*** training curriculum for frontline police officers, then adopt the tools into practical use, including the protocols, and integrate the use of the materials agency-wide.

Another option is for an agency to integrate the protocols and materials into the agency's existing practices and approaches.

A third option is for interested individual officers to incorporate the knowledge and practices encompassed within the tools into their practice and approaches in the field, while keeping with their agency's existing protocols and policies.

# TOOLKIT CONTENTS

[A Law Enforcement Executive's Brief on Children Exposed to Violence](#)

[Organizational Self-Assessment Tool and Action Planning Tool](#)

[On-Scene Acute Protocol for Children Exposed to Violence](#)

[Protocol for Responding to the Needs of Children at Scenes of Domestic Violence](#)

[What Traumatic Stress Reactions May Look Like On-Scene](#)

[Reactions that Police May Observe from Children and Youth](#)

[Effective Police Responses to Traumatic Stress in Children of Different Ages](#)

[Teaching the Tactical Breathing Technique to Children and Parents](#)

[Commonly Asked Questions from Children and Example Police Responses](#)

[Common Issues for Caregivers and Police Who Respond to Children Exposed to Violence](#)

[What To Do When Your Child Is Exposed To Violence – Brochure](#)

[Principles and Practices of Death Notification to Children](#)

[The Officer's Role in Responding to Traumatized Children](#)



## International Association of Chiefs of Police

### *Serving the Leaders of Today, Developing the Leaders of Tomorrow*

The International Association of Chiefs of Police (IACP) is a professional association for law enforcement worldwide. For more than 120 years, the IACP has been launching internationally acclaimed programs, speaking on behalf of law enforcement, conducting groundbreaking research, and providing exemplary programs and services to members across the globe.

Today, the IACP continues to be recognized as a leader in these areas. By maximizing the collective efforts of the membership, IACP actively supports law enforcement through advocacy, outreach, education, and programs.

Through ongoing strategic partnerships across the public safety spectrum, the IACP provides members with resources and support in all aspects of law enforcement policy and operations. These tools help members perform their jobs effectively, efficiently, and safely while also educating the public on the role of law enforcement to help build sustainable community relations.

# Yale Medicine

## CHILD STUDY CENTER

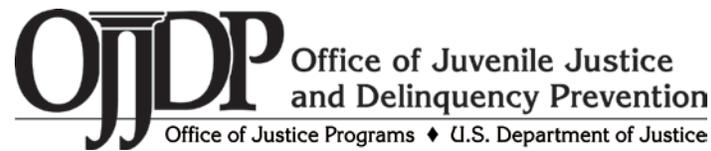
### Yale Child Study Center

The mission of the Yale Child Study Center is to improve the mental health of children and families, advance understanding of their psychological and developmental needs, and treat and prevent childhood mental illness through the integration of research, clinical practice, and professional training. For more than 100 years, researchers and practitioners at the Yale Child Study Center have worked to translate clinical observations and research findings into innovative, effective, and accessible models of clinical care, to train succeeding generations of clinicians and researchers and to disseminate knowledge to inform policies and encourage adoption of evidence based practices in the care of children and their families.

Responding to childhood trauma has been a critical aspect of these endeavors. Since 1991, the Childhood Violent Trauma Center (CVTC) at the Yale Child Study Center has been a leader in the field of law enforcement-mental health collaboration and early mental health treatment, developing innovative strategies and approaches to identify and intervene on behalf of children and families who are vulnerable following exposure to violence and trauma. In partnership with the New Haven Department of Police Service, the CVTC developed the Child Development-Community Policing Program (CD-CP) in order to capitalize on the significant role that law enforcement can play in responding to and aiding in the recovery of children and families exposed to violence.

The Childhood Violent Trauma Center has:

- Developed and implemented innovative multi-disciplinary collaborative program models such as the CD-CP program which provide immediate coordinated police, mental health, and social service interventions, in addition to follow-up services and mental health treatment to children and families exposed to violence and trauma;
- Partnered with Charlotte-Mecklenburg Police Department and Mecklenburg County Public Health in Charlotte, NC to train communities in CD-CP.
- Developed the Child and Family Traumatic Stress Intervention (CFTSI), an early brief mental health treatment that has demonstrated effectiveness in reducing children's trauma symptoms in the aftermath of traumatic experiences, and reducing or interrupting PTSD and related disorders in children.
- Provided training, technical assistance and consultation to law enforcement, first responders, and emergency management personnel nationwide;
- Provided nationwide consultation in times of crisis (school and community mass shootings including Sandy Hook, the terrorist attacks of 9/11, and natural disasters such as Hurricanes Katrina and Rita) to communities, law enforcement agencies, mental health providers, schools, media outlets, and local, state, and national government leaders;
- Supported public awareness and policy initiatives relating to childhood exposure to violence; and
- Provided extensive direct clinical services to children and families exposed to violence and other traumatic events.



## The Office of Juvenile Justice and Delinquency Prevention

The Office of Juvenile Justice and Delinquency Prevention (OJJDP), a component of the Office of Justice Programs, U.S. Department of Justice, provides national leadership, coordination, and resources to prevent and respond to juvenile delinquency and victimization. OJJDP supports states and communities in their efforts to develop and implement effective and coordinated prevention and intervention programs and to improve the juvenile justice system so that it protects public safety, holds offenders accountable, and provides treatment and rehabilitative services tailored to the needs of juveniles and their families. OJJDP sponsors research, program, and training initiatives; develops priorities and goals and sets policies to guide federal juvenile justice issues; disseminates information about juvenile justice issues; and awards funds to states to support local programming.

### **Vision Statement**

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) envisions a nation where our children are healthy, educated, and free from violence. If they come into contact with the juvenile justice system, the contact should be rare, fair, and beneficial to them.

# Enhancing Police Responses to **CHILDREN EXPOSED** to **VIOLENCE**

When police are equipped to provide trauma-informed, developmentally-appropriate responses to children exposed to violence:



They can create a safe environment to help children re-establish a sense of security and stability.

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They can play an important role in helping children and families begin to heal and thrive.

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Childrens' attitudes towards police can be shaped in the moment, or a seed can be planted to reshape attitudes towards police in the future.



# A Law Enforcement Executive's Brief on Children Exposed to Violence

## The Problem: A Public Health & Safety Crisis

Current levels of children's exposure to violence (CEV) in their homes, schools, and communities, and the traumatic disruption of successful development that so often follows, constitute a public health crisis.

**When children are not identified and supported in recovery following exposure to violence, they are at greater risk for:**

- School failure
- Mental health disorders such as anxiety, depression, post-traumatic stress disorder (PTSD), and personality disorders
- Substance abuse disorders
- Involvement with the juvenile and criminal justice systems
- Repeated victimization, and perpetration of, sexual and physical violence, and domestic violence
- Perpetration of community violence
- Higher rates of chronic physical illness
- Early death

## Why Police Should Be Concerned and Involved in Responding to CEV

When a trauma lens is applied to policing practices, children and families experience law enforcement professionals as strong and powerful partners, allies in their efforts to reclaim their own strength. When seen as allies in recovery from trauma, police agencies throughout the United States may be able to capitalize on powerful strategies that also contribute to the strengthening of relationships with the communities they serve.

## Key Messages

- Police are so much more than law enforcers in their community. Police bring order to chaos and can restore a sense of safety and security in the wake of violence.
- Police officers play a major role in the lives of vulnerable children and can be a key protective factor, along with family, schools and the community, all of which can be critical in changing the trajectory towards negative outcomes that are so often associated with trauma and violence.
- Because of their unique role in responding to emergent calls for service, law enforcement professionals are also uniquely positioned to recognize and identify children who may be traumatized by overwhelming events, and to utilize trauma informed practices—both immediately on-scene and beyond the emergency calls for service—that can help to initiate children's recovery.

## The Results

When police are equipped to provide trauma-informed, developmentally-appropriate responses to children exposed to violence:

- They can create a safe environment to help the child re-establish a sense of security and stability.
- They can play an important role in helping the child and family begin to heal and thrive.
- A child's attitude towards police can be shaped in the moment, or a seed can be planted to reshape a child's attitude towards police in the future.
- A foundation of trust between the police, youth, families, and the community is developed.
- Officers feel more effective and satisfied in their work.

## Steps for Leaders

Enhance your agency's response to children and families exposed to violence by:

- **Training** all frontline officers on how to recognize traumatic stress symptoms and how to effectively, interact and support children and their families in regaining stability in the midst of chaos.
- **Implementing** the tools and resources within *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*.
- **Knowing** the resources within your community that support children and families exposed to violence.
- **Partnering** with local mental health professionals specializing in childhood trauma.
- **Engaging** your community by raising awareness of the issue of children exposed to violence and the efforts your agency and community partners are taking to help children and families overcome the effects of childhood trauma. Utilize **Changing Minds** public awareness resources available at <https://changingmindsnow.org/>.

Building community trust happens one interaction at a time.

## Key Messages

- Officers trained on biological, neurological, and psychological responses to trauma will be better prepared to recognize and identify these symptoms in their everyday encounters with children and family members and to replace impersonal interactions with up-close, personal and meaningful policing responses to calls for service involving violence and other catastrophic events.
- When law enforcement agencies embrace their critical role in the healing process, they not only advance the recovery of individual children and families, but they strengthen relationships and advance healing between law enforcement professionals and the community itself.

This resource is part of the *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*. Visit: [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence)

This toolkit was prepared under cooperative agreement number 2012-CV-BX-K056 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice. OJJDP is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance; the Bureau of Justice Statistics; the Community Capacity Development Office; the National Institute of Justice; the Office for Victims of Crime; and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART). Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.



# AN ORGANIZATIONAL SELF-ASSESSMENT AND ACTION PLANNING TOOL

## for Law Enforcement Agencies to Enhance Capacity to Respond to Children Exposed to Violence

### Why Complete This Tool?

**C**ommunities should support a culture and practice of policing that reflects the values of protection and promotion of the dignity of all—especially the most vulnerable, such as children and youth most at risk for crime or violence.<sup>1</sup>

**Final Report**  
The President's Task Force  
for 21st Century Policing

Law enforcement officers are the most prominent first responders to violence that affects children's lives, and officers are uniquely positioned both to recognize and to intervene on behalf of children and families who are at their most vulnerable following exposure to violence. Police officers can play a central role in reestablishing order, increasing public safety, and aiding recovery in the wake of overwhelming violent and traumatic events that occur every day in neighborhoods, schools, and homes. Early identification, re-establishing order and safety, and increasing opportunities for recovery from violent trauma are interventions police officers can make, interventions which can meaningfully interrupt the repetition of violence, criminality and victimization to which children are too often exposed.

<sup>1</sup> President's Task Force on 21st Century Policing. 2015. Final Report of the President's Task Force on 21st Century Policing. Washington, DC: Office of Community Oriented Policing Services, U.S. Department of Justice.

Despite the essential role of law enforcement in the lives of children exposed to violence, for many law enforcement professionals, this has not yet become a central part of the mission to serve and protect. Every law enforcement agency can benefit from a closer look at its practices and policies for responding to children exposed to violence. This tool is designed to identify current strengths, as well as areas for improving your agency's response to children exposed to violence. Some agencies will discover opportunities to put new strategies into place, while other agencies will identify areas that can be fine-tuned.

### What is the Purpose of this Tool?

This tool is intended to be completed by law enforcement agencies interested in assessing and enhancing their agency's capacity (whether working in collaboration with mental health partners or not) to respond effectively to children exposed to violence. Part A is an assessment of current activities in your department related to children exposed to violence. Part B is an Action Planning Tool that will utilize responses from Part A to identify possible strategies and approaches to enhance your agency's response to children exposed to violence. Part C offers tools and resources, including those tools that comprise the **Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement ("Toolkit")** to support your agency in these efforts.

This tool is an opportunity to take a close look at what is currently in place and consider what more may be needed in order to best equip officers to respond to scenes where children and families are impacted by violence. This tool is intended to help agencies identify areas of current strength as well as challenges in addressing the needs of children and families exposed to violence, as well as those of officers responding to them. The assessment is followed by an Action Planning Tool that can be informed by your responses to the assessment questions. In Part C, there is also information on the tools and resources available in the **Toolkit** that will enable your agency to implement your Action Plan.

## What is Meant by “Children Exposed to Violence?”

**Law enforcement engages with children exposed to violence and potentially traumatic events every day, responding to calls for service where children are in danger or perceive that their safety or wellbeing is at risk. Here are some examples of children exposed to violence typically encountered by law enforcement:**

- *A child who was standing immediately adjacent to a person who was assaulted.*
- *A 16-year-old girl believed to be a sex trafficking victim.*
- *A child who lives in a home with chronic domestic violence—officers have been to calls at that address numerous times.*
- *A child who was watching TV when an assault took place in another room of the home.*
- *A teen who was robbed at knife point.*
- *A pre-teen who was out playing in the neighborhood and witnessed a gang shooting.*
- *Children at home when bullets were shot through windows.*
- *A 16-year-old gay male who reports being harassed and then beaten by neighborhood peers.*
- *Children involved in traumatic accidents.*
- *An 11-year-old boy alleges severe and chronic beatings by his father after serious bruising was reported by the school.*
- *A 14-year-old girl, picked up by police as a runaway, alleges that her mother’s boyfriend has been raping her over the course of the past year.*

**For over two decades, the leading figures in child mental health, policing, and violence intervention have worked closely with the United States Department of**

**Justice to increase our understanding of the scope and impact of childhood exposure to violence, with the aim of increasing the role of police in addressing what constitutes a major public health crisis facing the United States. We now know that the problem of childhood exposure to violence has reached epidemic proportions. The National Survey on Children’s Exposure to Violence (NatSCEV), the most comprehensive nationwide survey of the incidence and prevalence of children’s exposure to violence to date, tells us exactly what kind of a problem we are facing:<sup>2</sup>**

- More than 1/3 of children were physically assaulted within the previous year (37 percent) and approximately 7 in 10 youth (69.7 percent) had been assaulted during their lifetimes.
- Approximately 2 in 5 children and youth surveyed (41.2 percent) were victims of at least one assault in the past year, and approximately 1 in 10 (10.1 percent) were injured in an assault.
- 1 in 4 study participants witnessed a violent act in the past year (22.4 percent), and approximately 1 in 12 witnessed family violence in the past year (8.2 percent).
- In the past year, 15 percent suffered some form of maltreatment and 5 percent reported being sexually victimized (8 percent over their lifetime).

## What Does This Mean For Law Enforcement?

**W**e can stem this epidemic if we commit to a strong national response. The long-term negative outcomes of exposure to violence can be prevented, and children exposed to violence can be helped to recover. Children exposed to violence can heal if we identify them early and give them specialized services, evidence-based treatment, and proper care and support. We have the power to end the damage to children from violence and abuse in our country; it does not need to be inevitable.<sup>3</sup>

### Executive Summary

Report of the Attorney General’s National Task Force on Children Exposed to Violence

<sup>2</sup> Finkelhor, D., Turner, H., Shattuck, A., Hamby, S., & Kracke, K. (2015). Children’s Exposure to Violence, Crime, and Abuse: An Update. *Juvenile Justice Bulletin – NCJ 248547*. Washington, DC: U.S. Government Printing Office.

<sup>3</sup> Attorney General’s National Task Force on Children Exposed to Violence. 2012. Report of the Attorney General’s National Task Force on Children’s Exposure to Violence. Washington, D.C.: U.S. Department of Justice.

## Why be Concerned about Children Exposed to Violence?

**Because this exposure has the potential to cause trauma, and unrecognized, unaddressed trauma can have dramatic negative consequences in both the short and long-term. Children’s exposure to violence, whether as victims or witnesses, is often associated with long-term physical, psychological, and emotional harm. Children exposed to violence are also at a higher risk of engaging in criminal behavior and/or being victimized later in life, thus becoming part of an ongoing cycle of violence. This is something officers know very well from their own experience. There is increasing scientific evidence demonstrating that:**

- Children are more likely to be exposed to violence and crime than adults.<sup>4</sup>
- A child’s exposure to one type of violence increases the likelihood that the child will be exposed to other types of violence and be exposed multiple times.<sup>5</sup>
- Children exposed to violence are more likely to suffer from depression, anxiety, and post-traumatic disorders; fail or have difficulty in school; and become delinquent and engage in criminal behavior.<sup>6</sup>
- Children exposed to violence are more likely to engage in risky behaviors during childhood and adolescence including early initiation of smoking, sexual activity, and illicit drug use<sup>7</sup>

## Why Should My Agency Utilize This Tool?

Representatives of law enforcement agencies interested in taking a closer look at their agency’s capacity to respond effectively to children exposed to violence (with or without mental health partners) should utilize this tool. This is not a survey. It is a tool for you to assess your agency’s current policies and practices as well as an action planning tool to help your agency improve operations related to identifying and responding to children exposed to violence.

4 Finkelhor, D., Turner, H., Ormrod, R., Hamby, S., and Kracke, K. 2009. *Children’s Exposure to Violence: A Comprehensive National Survey*. Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

5 Ibid.

6 Ibid.

7 Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245-258.

## How Should My Agency Utilize This Tool?

To be most effective, this effort should be led by a member of Command Staff within the agency but incorporate three operational viewpoints. This “champion” is in a position to engage and set priorities for the department related to the issue of children exposure to violence. While this leader champions this process, the tool itself is best completed by operational staff (not policy, planning or evaluation personnel). This ensures the best view of the current state of practice from those officers policing within the community.

- 1. Identify a team of three (3) operational personnel:**
  - a. Leader (Command staff, captain or above)
  - b. Supervisor (1<sup>st</sup> line or mid-level, up to lieutenant)
  - c. Patrol officer
- 2. Provide the Assessment Tool and Action Planning Tool to each of the three team members and instruct them to answer the questions in Part A according to how things CURRENTLY OPERATE in your department (rather than how they think they should be) so that they can be prepared to meet and discuss together.**
- 3. Each team member completes the Assessment Tool (Part A) in advance and reviews the Action Planning Tool (Part B) to prepare to meet together to discuss.**
- 4. Team members meet together to discuss the Assessment Tool and complete the Action Planning Tool together.**

The completed tool is also meant to serve as an Action Plan that your agency can utilize to implement to enhance your agency’s capacity to identify and respond to children exposed to violence. You will note that several questions have a long list of choices. These long lists were created purposefully. No agency is expected to be able to check every option. These choices are an opportunity to consider areas of improvement and specific strategies that could be employed to move your agency ahead.

After the questions, you will find an Action Plan Tool on page 16 to fill out based on your responses to the questions. The answer choices are specific actions you may consider for your Action Plan.

# Part A: ASSESSMENT TOOL

## Enhancing Your Agency's Capacity to Respond to Children Exposed to Violence: An Assessment Tool

### Current Practice

For the following series of questions (Questions 1–5), indicate what actions would typically be taken by officers in your agency. For each question, check all that apply.

**Who answers this question?**

**1. Officers respond to a domestic violence (DV) situation and see a 10-year-old child standing next to a parent who has visible signs of injury.**

- Assess and take steps to enhance the child and parent's immediate physical and psychological sense of safety
- Note the presence of children in the report
- Contact a DV advocate for the victim (e.g. victim services officer in the department, court based DV advocate, DV advocate in the community, etc.)
- Contact a child trauma clinician
- Contact other mental health provider/partner
- Contact another family member or alternate caregiver for the child, depending on the severity of the parent's injury and whether medical attention is required
- Other: *specify* \_\_\_\_\_
- None of the above

*Command Supervisors  
Patrol Officers*

**2. Officers respond to a shooting call in the parking lot of a housing complex. A victim is located on the ground with a gunshot wound and several adults and children can be observed walking nearby.**

- Note the presence of children on scene in the report
- Conduct a community canvass to learn who else may have been impacted by the event
- Contact a child trauma clinician
- Contact other mental health provider/partner
- Other: *specify* \_\_\_\_\_
- None of the above

*Command Supervisors  
Patrol Officers*

	<b>Who answers this question?</b>
<p><b>3. A 15-year-old boy is the victim of an armed robbery.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Contact victim's parents/caregivers</li> <li><input type="checkbox"/> Contact victim advocate for family, with parent/caregiver permission</li> <li><input type="checkbox"/> Call child trauma clinician</li> <li><input type="checkbox"/> Contact other mental health provider/partner</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>4. A citizen goes to a friend's house and locates the two adult occupants inside suffering from apparent gunshot wounds; three children ages two, nine and 13 are located inside the house.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Note the presence of children in the report</li> <li><input type="checkbox"/> Attempt to locate parent or other caregiver</li> <li><input type="checkbox"/> Communicate directly with children about what is happening now and what will happen next</li> <li><input type="checkbox"/> Notify municipal child protection/child welfare agency</li> <li><input type="checkbox"/> Call child trauma clinician</li> <li><input type="checkbox"/> Contact other mental health provider/partner</li> <li><input type="checkbox"/> Contact child advocate (courts or other state entity)</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>5. While on scene at a call for service, officers in my agency routinely inquire whether:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The victim to whom you are responding has children</li> <li><input type="checkbox"/> Children were physically present as victims, witnesses or suspects</li> <li><input type="checkbox"/> Children live in the home where the incident occurred</li> <li><input type="checkbox"/> Children live with the victim, witness or suspect</li> <li><input type="checkbox"/> None of the above</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>

# Training

For the next series of questions (questions 6–10), indicate the training opportunities available to your agency. Check all that apply.

**Who answers this question?**

**6. Officers at my agency are trained to implement a standard operating procedure or general order specifically related to a child exposed to violence identified on scene.**

- Yes
- No

*Command  
Supervisors  
Patrol Officers*

**7. Training and professional development is made available to officers in my agency, related to the following topics:**

**Child development**

- None
- less than 1 hour
- 1–3 hours
- more than 3 hours

**Impact of trauma**

- None
- less than 1 hour
- 1–3 hours
- more than 3 hours

**Child abuse & neglect**

- None
- less than 1 hour
- 1–3 hours
- more than 3 hours

**Trauma-informed responses to children and families impacted by violence and other catastrophic events**

- None
- less than 1 hour
- 1–3 hours
- more than 3 hours

**Domestic violence training specifically focused on the impact and challenges of domestic violence faced by non-offending parents and their children**

- None
- less than 1 hour
- 1–3 hours
- more than 3 hours

*Command*

	Who answers this question?
<p><b>8. Patrol officers at my agency participated in the following types of training last year, and for the indicated length of time:</b></p> <p><b>Child development</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Impact of trauma</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Child abuse &amp; neglect</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Trauma-informed responses to children and families impacted by violence and other catastrophic events</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Domestic violence training specifically on the impact and challenges of domestic violence faced by non-offending parents and their children</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul>	<p><i>Patrol Officers</i></p>

	Who answers this question?
<p><b>9. Supervisors at my agency participated in the following types of training last year, and for the indicated length of time:</b></p> <p><b>Child development</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Impact of trauma</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Child abuse &amp; neglect</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Trauma-informed responses to children and families impacted by violence and other catastrophic events</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Domestic violence training specifically focused on the impact and challenges of domestic violence faced by non-offending parents and their children</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul>	<p><i>Supervisors</i></p>

	<b>Who answers this question?</b>
<p><b>10. Executives/Leaders at my agency participated in the following types of training last year, and for the indicated length of time:</b></p> <p><b>Child development</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Impact of trauma</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Child abuse &amp; neglect</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Trauma-informed responses to children and families impacted by violence and other catastrophic events</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul> <p><b>Domestic Violence training specifically focused on the impact and challenges of domestic violence faced by non-offending parents and their children</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> less than 1 hour</li> <li><input type="checkbox"/> 1–3 hours</li> <li><input type="checkbox"/> more than 3 hours</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>

# Policies and Procedures

For the next series of questions (Questions 11–19), indicate what policies and procedures are currently in place within your agency. For each question, check all that apply.

**Who answers this question?**

**11. My agency has policies and procedures in place that outline how to respond to children exposed to violence.**

- Yes
- No

*(if yes, check all that apply)*

- Responding to children exposed to violence is included in the strategic plan
- There are General Orders or SOPs relating to responding to children exposed to violence
- Children exposed to violence are indicated on incident report
- Responding to children exposed to violence is mentioned during roll call or daily briefing
- We have signed MOUs with agencies related to responding to children exposed to violence
- There are executive level meetings with partners focused on responding to children exposed to violence
- Children exposed to violence is brought up during CompStat, Executive Staff meetings/briefings
- Some policies exist e.g. Domestic Violence, Sexual Assault, Child Abuse, Response to Child Victims
- We have a pilot project related to children exposed to violence
- Other: *specify* \_\_\_\_\_

*Command  
Supervisors  
Patrol Officers*

	<b>Who answers this question?</b>
<p><b>12. Supervisors in my agency:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mention responding to children exposed to violence in roll call or daily briefings</li> <li><input type="checkbox"/> While on scene, ask officers whether children were exposed to violence and what actions were taken to respond to their needs</li> <li><input type="checkbox"/> Routinely review reports to ensure that children exposed to violence are identified</li> <li><input type="checkbox"/> Attend regularly scheduled meetings to review cases where children exposed to violence were identified</li> <li><input type="checkbox"/> Attend intermittently scheduled meetings to review cases where children exposed to violence were identified</li> <li><input type="checkbox"/> Attend training with professionals from other agencies, including mental health and municipal child protection/child welfare agency</li> <li><input type="checkbox"/> Lead seminars or teach other professionals about how officers in our agency respond to children exposed to violence</li> <li><input type="checkbox"/> Work on building partnerships to provide positive social support for children exposed to violence e.g. mentoring, athletics, etc. targeted to youth at-risk following exposure to violence</li> <li><input type="checkbox"/> Develop specific activities to enhance how our agency responds to children exposed to violence</li> <li><input type="checkbox"/> None of the above</li> </ul>	<i>Patrol Officers</i>
<p><b>13. Supervisors in my agency reinforce policies and procedures around responding to children exposed to violence among officers.</b></p> <p><i>Choose one:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Strongly agree</li> <li><input type="checkbox"/> Agree</li> <li><input type="checkbox"/> Neither agree nor disagree</li> <li><input type="checkbox"/> Disagree</li> <li><input type="checkbox"/> Strongly disagree</li> <li><input type="checkbox"/> We don't currently have specific policies and procedures in place</li> </ul>	<i>Patrol Officers</i>
<p><b>14. My agency offers an award or commendation specifically for excellence in the area of responding to children exposed to violence</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> I don't know</li> </ul>	<i>Command Supervisors Patrol Officers</i>

	<b>Who answers this question?</b>
<p><b>15. When dealing with children exposed to violence my agency responds—on scene—with the following mental health providers:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> City/County Mental Health</li> <li><input type="checkbox"/> Emergency Psychiatric Mobile Crisis Teams (could be contracted with County, a hospital, or a local non-profit)</li> <li><input type="checkbox"/> Non-profit mental health agency</li> <li><input type="checkbox"/> Private mental health provider</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul> <p><b>Officers have a mental health professional to contact and consult with about responding to children exposed to violence. <i>Select one:</i></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> On-scene, 24/7/365</li> <li><input type="checkbox"/> On-scene, in some cases; by phone at other times</li> <li><input type="checkbox"/> Monday–Friday during business hours</li> <li><input type="checkbox"/> My agency does not have a mental health partner to assist in responding to children exposed to violence</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>16. These activities are typical practice in my agency</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Officers attend regularly scheduled meetings to review cases where children exposed to violence were identified and plan responses to these cases</li> <li><input type="checkbox"/> Mental health providers are non-sworn members of the police department</li> <li><input type="checkbox"/> Mental health providers have ID cards / access cards</li> <li><input type="checkbox"/> Mental health providers have access to police reports</li> <li><input type="checkbox"/> Mental health providers have assigned workspace in station or substation</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>17. These activities are typical practice in my agency.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Officers notify mental health partners of children exposed to violence while on scene</li> <li><input type="checkbox"/> Officers refer children exposed to violence to the mental health partner as part of the on-scene response</li> <li><input type="checkbox"/> Officers and mental health partners plan together on how to follow up</li> <li><input type="checkbox"/> Officers and mental health partners conduct joint in-person case follow-up with active cases</li> <li><input type="checkbox"/> Officers and mental health partners conduct community canvassing after incidents of violence</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>

	<b>Who answers this question?</b>
<p><b>18. Expectations for how officers collaborate with mental health partners to respond to children exposed to violence are clearly communicated through:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Officers' job descriptions</li> <li><input type="checkbox"/> Other written documents</li> <li><input type="checkbox"/> Annual evaluations</li> <li><input type="checkbox"/> Departmental awards</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul> <p><b>The following activities take place in my agency:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cross-training with partners who also respond to children exposed to violence</li> <li><input type="checkbox"/> Roll-call training on approaches to responding to children exposed to violence</li> <li><input type="checkbox"/> Officers participate in follow up with mental health partners to families where children exposed to violence have been identified</li> <li><input type="checkbox"/> Multi-disciplinary team meetings</li> <li><input type="checkbox"/> Clinicians do ride-alongs</li> <li><input type="checkbox"/> Clinicians are familiarized with standard police practice e.g. hostage negotiations and graduated use of force</li> <li><input type="checkbox"/> Officers receive introductory training on child development, including the impact of trauma on children at different ages</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>19. Officers are evaluated on the basis of the following in their performance evaluations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Regular referrals of appropriate cases of children exposed to violence</li> <li><input type="checkbox"/> Collaborative follow-up</li> <li><input type="checkbox"/> Officer-initiated follow-up (where officers follow up on their own cases)</li> <li><input type="checkbox"/> Participation in case conferences</li> <li><input type="checkbox"/> Feedback from citizens/families about officer's activities</li> <li><input type="checkbox"/> Feedback from mental health partners about officer's activities</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>

# Collaboration

For the next series of questions (questions 20–26), indicate how your agency works with partners. Check all that apply.

**Who answers this question?**

## 20. Domestic Violence (DV) Services Provider

- Our agency does not work directly with a DV shelter or DV advocacy organization
- Officers provide families with referral information to a DV shelter or DV advocacy organization
- Officers make referrals to DV shelters or DV advocacy organization
- Officers meet with DV shelter staff or with DV advocates to discuss cases together
- Police conduct joint follow-up visit with DV Services Providers
- Other: *specify:* \_\_\_\_\_

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Supervisors  
Patrol Officers*

## 21. Local government child protection/child welfare agency

- Child welfare agency staff respond jointly with officers on scenes involving children exposed to violence
- Officers make referrals to child protection/child welfare agency
- Officers meet with child protection/child welfare agency to discuss cases together
- Police conduct joint follow-up visits with the child protection/child welfare agency
- Other: *specify:* \_\_\_\_\_

*Command  
Supervisors  
Patrol Officers*

## 22. Mental Health Provider

- Mental health providers respond jointly with officers on scenes involving children exposed to violence
- Officers provide families with referral information to a mental health provider
- Our department has an established relationship with a mental health agency and officers can alert the mental health agency when they are concerned about children exposed to violence
- Officers meet with mental health providers to discuss follow up with children exposed to violence
- Police conduct joint follow-up visits with a mental health provider
- Our agency has a mental health provider on staff to work with children and families exposed to violence
- Our agency does not work directly with a mental health provider to address the needs of children exposed to violence
- Other: *specify:* \_\_\_\_\_

*Command  
Supervisors  
Patrol Officers*

	<b>Who answers this question?</b>
<p><b>23. Victim Service Provider (intra-agency, external, governmental or non-profit)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Officers provide families with referral information to victim service provider or victim/witness advocate</li> <li><input type="checkbox"/> Police make the referral to victim service provider</li> <li><input type="checkbox"/> Police meet with victim service provider to discuss cases</li> <li><input type="checkbox"/> Police conduct joint follow-up with victim service provider</li> <li><input type="checkbox"/> Our agency does not work directly with a victim service provider</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>24. School Staff</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Police coordinate with school staff to support children exposed to violence</li> <li><input type="checkbox"/> Police meet with school staff to discuss how to support children exposed to violence</li> <li><input type="checkbox"/> Police conduct joint follow-up with the local school system to address the needs of children exposed to violence</li> <li><input type="checkbox"/> Our agency does not work directly with the local school staff to identify and address the needs of children exposed to violence</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>25. Faith Communities</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Police connect families with faith communities</li> <li><input type="checkbox"/> Police make the referral to faith communities</li> <li><input type="checkbox"/> Police meet with faith communities to discuss how to support children exposed to violence</li> <li><input type="checkbox"/> Police and faith communities conduct joint follow-up in the community</li> <li><input type="checkbox"/> Our agency does not work directly with faith communities to identify and address the needs of children exposed to violence</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>
<p><b>26. Officers at my agency have the opportunity to discuss cases of children exposed to violence with partners in order to facilitate follow-up and be advised of status:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Weekly</li> <li><input type="checkbox"/> On a regular basis, but less often than weekly (bi-weekly, monthly, etc.)</li> <li><input type="checkbox"/> As needed</li> <li><input type="checkbox"/> No formal case conference is held, but officers and partners discuss cases as needed</li> <li><input type="checkbox"/> My agency identifies and responds to children exposed to violence without a specific community partner</li> <li><input type="checkbox"/> My agency identifies and responds to children exposed to violence in partnership with mental health professionals on staff within the police agency</li> <li><input type="checkbox"/> Other: <i>specify</i> _____</li> <li><input type="checkbox"/> None of the above</li> </ul>	<p><i>Command Supervisors Patrol Officers</i></p>

# Part B:

# ACTION PLANNING TOOL

**A**fter completing the questions, if your agency is interested in moving forward in further developing your response to children exposed to violence (CEV), this Action Planning Tool can be used to help you lay out the steps to take to shape your agency's response to children exposed to violence.

As you completed Questions 1–26 above, you probably noticed that the answer choices were quite detailed. Those answer choices provide strategies and approaches that can be considered as possible actions your Department might take.

### Assessment Areas:

- Current Practice
- Training

- Collaboration
- Policies & Procedures

- Existing Mental Health Partnerships

#### Example:

Training & Mental Health Partnerships

### Current Practice

*What's working now?*

#### Example:

Have Crisis Intervention Team (CIT) but only working with mental health partners on CIT.

## Needed Changes

*What is not working? Which strategies listed in the Assessment Tool Responses would you wish to incorporate?*

### Examples:

Children Exposed to Violence are not being identified or responded to at all.  
Cross-training with partners who also respond to children exposed to violence.

## Tools & Actions

*What is needed to move forward (support, advice, resources, partners, training)?*

### Examples:

Get the Chief on board.  
Identify a mental health partner that provides child trauma treatment.

- Search NCTSN.org to search for a possible local National Childhood Traumatic Stress Network member

Request **Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement**

## Obstacles & Solutions

*What may stand in the way? And how might it be overcome?*

**Examples:**

Understaffed so it's difficult to take officers off the road – but could possibly stagger training across 3 months.

*By When?*

**Example:**

Six (6) months

*What will success look like?*

**Examples:**

# of officers trained

# of children referred for treatment to partner

# of officers with an increase in job satisfaction

# Part C:

# TOOLS AND RESOURCES

**T**he *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement* was developed by the International Association of Chiefs of Police and the Childhood Violent Trauma Center at Yale University School of Medicine's Child Study Center, in collaboration with the New Haven Department of Police Services, Charlotte-Mecklenburg Police Department and Mecklenburg County Health Department's Trauma and Justice Partnerships, and in partnership with the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, United States Department of Justice. Contents include:

1. *A Law Enforcement Executive's Brief on Children Exposed to Violence*
2. *Organizational Self-assessment Tool and Action Planning Tool*
3. *On-Scene Acute Protocol for Children Exposed to Violence*
4. *Protocol for Responding to the Needs of Children at Scenes of Domestic Violence*
5. *What Traumatic Stress Reactions May Look Like On-scene*
6. *Reactions that Police May Observe from Children and Youth*
7. *Effective Police Responses to Traumatic Stress in Children of Different Ages*
8. *Teaching the Tactical Breathing Technique to Children and Parents*
9. *Commonly Asked Questions from Children and Example Police Responses*
10. *Common Issues for Caregivers and Police Who Respond to Children Exposed to Violence*
11. *What To Do When Your Child Is Exposed To Violence – Brochure*
12. *Principles and Practices of Death Notification to Children*
13. *The Officer's Role in Responding to Traumatized Children*

## Would Your Agency Benefit From?

- Adopting policies and procedures designed to enhance response to children exposed to violence (CEV)?
- Training on protocols for all officers responding to scenes involving CEV?
- Implementing training and protocols developed to address the needs of CEV?
- Consulting with police colleagues about collaborative partnerships to address CEV in your community?

## Learn More about Law Enforcement/Mental Health Collaborative Response to Children Exposed to Violence:

- **Yale Child Study Center and New Haven Department of Police Services**  
[medicine.yale.edu/childstudycenter/cvtc/programs/lawenforcement.aspx](http://medicine.yale.edu/childstudycenter/cvtc/programs/lawenforcement.aspx)
- **Charlotte-Mecklenburg Police Department and Mecklenburg County Health Department's Trauma and Justice Partnerships**  
[charmeck.org/mecklenburg/county/HealthDepartment/CommunityHealthServices/TJP/Pages/CD-CP.aspx](http://charmeck.org/mecklenburg/county/HealthDepartment/CommunityHealthServices/TJP/Pages/CD-CP.aspx)
- **International Association of Chiefs of Police**  
<http://www.theiacp.org/children-exposed-to-violence>

## Consult with Domestic Violence Training and Technical Assistance Provider:

- **Futures Without Violence**  
[www.futureswithoutviolence.org/](http://www.futureswithoutviolence.org/)

## Find a Child Trauma Mental Health Specialist in Your Community:

- **National Childhood Traumatic Stress Network**  
[www.nctsn.org/about-us/network-members](http://www.nctsn.org/about-us/network-members)

## Obtain Public Awareness Tools and Resources:

- **Changing Minds Campaign**  
[changingmindsnow.org](http://changingmindsnow.org)

This resource is part of the *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*. Visit: [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence)

This toolkit was prepared under cooperative agreement number 2012-CV-BX-K056 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice. OJJDP is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance; the Bureau of Justice Statistics; the Community Capacity Development Office; the National Institute of Justice; the Office for Victims of Crime; and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART). Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.



# ON-SCENE/ACUTE PROTOCOL

## for Children Exposed to Violence

The following on-scene protocol is to be used in addition to carrying out your agency's standard response regarding how to secure a scene; identify those in need of emergency medical attention; and identify perpetrators, victims, and witnesses relevant to the investigation. To respond most meaningfully to children and families who have been exposed to violence and overwhelming events, officers should take the following trauma-focused steps:



### 1. Identify who has been exposed to violence and trauma based on proximity.

- Consider who may be at greatest risk because of exposure to violence as a victim or a witness.
- There are two types of proximity to the event that are critical for officers to consider:
  - Physical proximity: anyone who saw or heard the event or was exposed to the aftermath of the event. (For the purposes of identifying who may have been exposed to violence, the definition of "witness" is more broad than it typically would be in police investigation.)
  - Emotional proximity: anyone who's loved one may have been involved in the event (as victim, witness, or perpetrator).



### 2. Seek and locate a parent or adult caregiver who can assume responsibility for the immediate care of the children.

- If a parent or caregiver is not present, identify an appropriate caregiver who, optimally, is close to the family and close to the children.
- The parent, caregiver, or known adult will be the point of contact for the responding officer as they work together to assess and meet the needs of the children.



### 3. Determine if child protective services should be contacted, per your agency's policy.



### 4. Prepare for possible questions from children by learning as much as you can about the status of the incident prior to talking with children. For example:

- Confirm arrest/custodial status of perpetrators.
- Confirm medical status of, and medical plans for, victims and/or perpetrators.
- When information is not yet known, communicate that to children and caregivers. It is okay to say "We don't know that information yet."

**Prepare in advance for the likelihood that children will have concerns about very specific issues, and will turn to officers for answers. For example:**

- Why the police are there and what actions the police took while there.
- Whether anyone was arrested and where that person(s) was taken.
- The medical condition of victims (and perpetrator, if known to the child).
- What is happening next, for example:
  - Where the child is going to stay tonight.

- What is going to happen to the victim/perpetrator/witnesses.
- What is likely to happen after the police have left, including how further questions and concerns will be addressed.



## 5. Provide information to parents or caregivers and then children.

If the parent or caregiver has been identified, you should first communicate information to the parent or caregiver (if he or she does not already have the information) and then provide the information to the children together with the parent or caregiver, when possible.

When there is no parent or caregiver available, it is incumbent on the police officer to communicate directly with the children.

### When communicating with children:

- Be at the child's eye level.
- Introduce yourself by name.
- Ask the child's name.

### Following that:

- Explain in simple, direct terms why the police are there.
- Explain what is happening now.
- Explain what will happen next.
- Ask the child what questions or concerns she or he has.

Children are reassured when officers talk to them in a calm and comfortable manner. However, while demonstrating ease and concern is helpful, your job is not to “cheer up” a child who may have legitimate reasons to be upset.



## 6. Respond to questions in a straightforward and concise manner. Use simple and plain language.

### Questions such as the following can be expected from children:

- *Why are the police here?*
- *What's happening to my mommy/daddy/brother?*
- *Why did the ambulance come?*
- *Is my mommy/daddy/sister okay?*
- *Where are you taking my mommy/daddy/brother?*
- *Where are you taking the bad guy?*
- *Is my mommy/daddy/grandma coming back?*
- *Is the bad guy coming back?*
- *What's going to happen to me?*
- *Will this happen again?*

Anticipate that the information you provide may need to be repeated. For sample responses, see the accompanying tool, *Commonly Asked Questions from Children and Example Police Responses*.<sup>1</sup>



## 7. Assess for ongoing threats to safety.

**Identify any threats to the child and family. Consider completing the following steps and utilizing the following sources of information:**

- Criminal history check.
- Address history check.
- Existence of restraining and protective orders.

<sup>1</sup> This resource is part of the *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*. See [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence)

- Safety check of the immediate environment (e.g., the home, vehicle).
- Officer knowledge and experience of the child and family.
- Current information about criminal activity in the neighborhood (e.g., drug activity, gang activity, gun violence).

Think critically about other things that could contribute to the family's sense of safety.

Sometimes children ask police officers to take small steps to help make them feel safe. Children may express a wish to have you look under the bed or in the closet, which can easily be done and will contribute substantially to the child's sense of safety. This kind of request is also another opportunity to recognize that the event that has initiated the police response has made the child anxious. It is also an opportunity to communicate with the child about the realities of the current situation and steps that are being taken to ensure safety.

**The simple fact that the officer pays attention to the child is often the most powerful proof that the child has a new ally, a new protector, a new friend.**

In addition to ensuring physical safety, when officers recognize and address families' emotional responses, police play a critical role in establishing psychological safety for children following their exposure to violent or overwhelming events.

## 8. Take steps to increase the physical safety of the children in the home.

**In order to address the concerns that the police, families, or both have about repeated threats to safety (e.g., return of perpetrator, risk of retaliation, or generalized fearfulness that often follows traumatic events), the following steps can be taken:**

- Inquire about specific concerns family members may have about safety issues.
- Inform the family of immediate next steps to be taken by the police and offer to respond to follow up questions and concerns about safety, status of the investigation, arrest, and subsequent status of alleged offender.
- Inquire about temporary alternative lodging and provide information about local shelters, if necessary.
- Provide information regarding restraining/protective orders (what they are and how to obtain them), when appropriate.
- Connect the family to available resources for children and families in crisis (and when indicated, coordinate with child protective services—see Step 3 above).
- Determine if/when follow-up visits from officers would be helpful as a demonstration of continued attention to the family's well-being.

It is important for officers to remember and to communicate to caregivers that it is not uncommon for everyone to feel generalized fearfulness even after the reality or threat of danger is no longer present. Therefore, in addition to the steps listed above, it can be helpful to give a brief description of what children and adults may experience in the aftermath of violent or overwhelming events.

## 9. Offer to review with parents or caregivers the *What To Do When Your Child Sees Violence*<sup>2</sup> brochure that outlines common reactions caregivers may observe in their children following traumatic events, including, for example, changes in:

- Mood (e.g., fearfulness, irritability, sadness, excitability).
- Behavior (e.g., problems with sleep and eating, defiance, demanding or seeking attention).
- Concentration and focus (e.g., at home and at school).
- Social interaction (e.g., withdrawal, arguing and fighting, risk-taking).

Officers can help parents or caregivers understand potential connections between the event and behaviors they may observe in their children following the event, which may be traumatic stress reactions.

<sup>2</sup> This resource is another tool in the *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*. See [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence)

**Officers can also remind impacted parents or caregivers that:**

- Parents or caregivers, too, may be vulnerable to similar reactions.
- The more that parents or caregivers are aware of their own reactions, the better they will be able to address their own needs and those of their children.



**10. Develop a plan for follow-up.**

For many families, the continued attention of a uniformed law enforcement officer is essential in re-establishing a sense of safety and moving in the direction of recovery.

In addition to the importance of police presence in terms of re-establishing psychological safety while on-scene, when police officers follow up with families in the days and weeks following an event, it can make a significant difference to children and families. Even when brief, a follow-up by police officers to children and families impacted by violence and trauma sends a powerful message of concern and appreciation while confirming officers' role in the community as sources of protection, safety, and service.

**A follow-up visit by the police provides an opportunity:**

- For children to see police when there is not a crisis—no one is going to the hospital or to jail—and everyone may be calmer.
- To review the status of family concerns.
- To identify and recommend additional services that may support the family's recovery.
- To solidify a personal connection with a police officer who demonstrates continued commitment as an ally in the family's recovery.
- For children, families, and communities to develop and strengthen positive expectations of relationships with police.

**Follow-up steps by officers:**

- Visit the family, in the course of a shift, when possible.
  - Call to arrange a visit in advance, as appropriate.
  - Even very brief visits (five minutes) can be powerful components to children and families' efforts to regain a sense of security and well-being.
- Review the status of any existing restraining or protective orders.
- Discuss the usefulness of having a school resource officer reach out directly to affected children at school, where available.

**If your department has access to resources or partners that can offer support for children and families during their recovery from traumatic events, these can inform discussions with the caregiver about possible follow-up intervention strategies. Valuable resources could include:**

- Medical/behavioral health assistance.
- Housing assistance.
- Domestic violence advocacy.
- Food assistance.
- Legal assistance.
- Youth programming.

This resource is part of the *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*. Visit: [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence)

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# Protocol for Responding to the Needs of Children at Scenes of Domestic Violence

The following protocol builds on the information provided in the On-Scene Acute Protocol and offers strategies and approaches that officers can take to address the specific and additional burdens borne by children at scenes of domestic violence. This protocol is to be used in conjunction with your agency's standard response regarding securing a scene; identifying those in need of emergency medical attention; and identifying perpetrators, victims and witnesses relevant

to the investigation. In addition, this protocol is also to be used in conjunction with your agency's policy for responding to domestic violence.

Domestic violence scenes are by nature often chaotic and upsetting. Once the first policing goals of securing the scene and re-establishing order have been achieved, officers should take the following trauma-focused steps to respond most meaningfully to children who have been exposed to domestic violence.

## 1. Recognize and assess the needs of the parent who is a domestic violence victim.

Paying attention to the traumatic impact of domestic violence on the parent who is a victim is the first step in addressing the needs of children. This interaction begins with the officer directly recognizing and acknowledging the traumatic impact of events on the victim. In order to help victimized parents be attentive to their children's needs, the non-offending parent needs support to regain a sense of safety and control in the aftermath of the traumatic experience of the domestic violence.

Police officers can help to identify and address basic needs for immediate shelter, safety, advocacy and/or services for the victim and the children; officers can also help the victim to identify immediate family members and friends the victim wishes to contact for support.

## 2. Ask if there are children living in the home and whether or not they were present during the incident leading to police response (if it is not immediately apparent).

In addition to inquiring directly, check for signs that would indicate that children reside in the home (e.g., toys, children's clothing, etc.). If children reside in the home, but are not on scene when officers arrive, officers should inquire whether children were present and determine their specific whereabouts and safety in the home or elsewhere. Officers should not assume that children were not at the scene simply because they are not readily apparent when officers arrive. Moreover, even when children are not direct witnesses to the violence, it does not indicate their lack of awareness of the violence.

**3. Document the presence of children of all ages at scenes of domestic violence, whether children were direct witnesses to the event or were elsewhere in the home, and any observable reactions in the children present on scene.**

Officers should not assume that children were sleeping (even if it is nighttime) or unaware of domestic violence even if it is reported that they were not witnesses to the incident that occurred.

Children of all ages, including children under the age of three, can be terrified by harsh and threatening tones of voices, as well as other sounds that indicate perpetration of violence and victimization by violence, especially when the violence involves their parents or caregivers. Exposure to domestic violence is harmful to children and the traumatic impact of witnessing domestic violence can negatively influence children's development.

When officers pay attention to the presence of children on scene, they have an opportunity to:

- Ensure that children are not physically injured.
- Document evidence of crimes involving risk of injury to the victim and the children.
- Determine if children are witnesses to a crime.
- Determine if a child's immediate safety and welfare requires involvement of Child Protective Services, in accordance with agency protocols.
- Establish a basis for facilitating access to appropriate services for the victim and children.
- Talk with parents/caregivers about signs and symptoms that are often seen in children's behavior following exposure to domestic violence. This is a way to help parents anticipate a range of normal reactions that can also be indications of the need for additional services and support.

Identification of children can, in fact, lead to greater support for vulnerable victims and child witnesses, particularly when there are advocacy, treatment and other services to which victims and their children can be referred.

**4. Avoid interviewing a parent in front of a child, if possible.**

Children may have many conflicting feelings about parents who are either the victims or perpetrators of domestic violence. Similarly, children may have conflicting feelings about police officers, regardless of the necessity of officers' responding to the home.

Given the complicated experiences of children exposed to domestic violence, police can avoid adding to children's burdens by, whenever possible, avoiding conducting investigative interviews with parents in the presence of children. If this is not possible, and children are present during the interview of a parent or caregiver, the respect with which officers treat both victim and perpetrator can be extremely important in decreasing the level of distress the child may be experiencing.

**5. Avoid using children (including adolescents) as linguistic interpreters.**

Officers should refrain from asking children and adolescents to act as interpreters for parents for whom English is not their first language or for parents who are deaf. When a child or adolescent acts as an interpreter, there are some potential difficulties:

- Adults may not give a full/accurate account of what has occurred in order to protect the interpreting child from hearing the details.
- If the adult does give a full account, the children may be exposed to details they should not be.
- The child may have an increased sense of responsibility for the outcome of events.
- The family may blame the child for the outcome of the interpreted interview.
- A child and/or adolescent may not have an accurate vocabulary or understanding to convey the details of the event.

***This protocol builds on an excellent resource developed through the National Child Traumatic Stress Network entitled *Cops, Kids, and Domestic Violence*, available at <http://www.nctsn.org/products/cops-kids-and-domestic-violence-law-enforcement-training-dvd-2006>***

## 6. Avoid arresting the parent in front of the child, if possible.

Whenever practically and tactically possible, make the arrest, including handcuffing and questioning, in a location away from the children's sight and hearing.

- There are circumstances when an arrest involves verbal and physical struggles between responding officers and adult family members. When the subject of an arrest is combative, the speed and efficiency of arrest may not only minimize dangers to officers and the perpetrator but can also minimize the already high levels of distress experienced by children who are on scene.
- When an arrest in front of children cannot be avoided, the respect that officers are able to demonstrate towards the offending parent can have an enormous impact in decreasing the burden of complicated feelings the child may be having as a result of such an upsetting incident. This is particularly important in response to those families who may typically view the police with suspicion, or worse, fear and resentment.
- Treating adult subjects of arrest with respect can help to calm the behavior of the combatant(s), which in turn, can benefit children.

Complicated Experiences of Children May Include:

- Children may be angry that the police are arresting the offending parent, even if the behavior of that parent was upsetting or scary.
- Children may be saddened to see a parent arrested, even if that parent was behaving in an upsetting or frightening way.
- Children may be scared by the officers' assertion of power and control over the perpetrator, particularly if the perpetrator resists.

On the other hand, children may be comforted by an officer's presence, which brings with it a return to calm and an end to the out-of-control feeling that domestic violence creates.

For children who have repeatedly seen or heard about parents, friends, or family members being arrested and incarcerated, police action may trigger a host of negative memories and feelings.

***For more information, please see IACP's Model Policy on Safeguarding Children of Arrested Parents with accompanying tools and resources available at <http://www.theiacp.org/cap>.***

## When Children Need to Be Interviewed as Witnesses

In some cases, police will not need to conduct direct interviews with children, because physical evidence and adult statements will be sufficient for the criminal investigation.

If it is necessary to interview a child, keep the following in mind:

- *Children respond to being interviewed by police very differently depending on their age and stage of development.*
- *Young children communicate in a different way from adults and older children and require special interviewing techniques.*
- *Children may find the experience of being interviewed difficult and anxiety provoking, especially if they are being asked to give information about the behavior of parents whom they love, or if they feel they are being asked to choose sides.*
- *Children may be at risk for an offending parents' attempts to influence the child's interview with police (for example, the offending parent may try to justify the abuse to the child on the basis of the victim's bad behavior).*

These conflicts may be especially relevant for children who are aware that their parents do not trust the police and would like their children to have as little contact as possible with officers.

## 7. Keep children with known, non-offending parents or caregivers, whenever possible.

- Begin by addressing the emotional, behavioral, and/or physical reactions that parents or caregivers (who are victims) may be having. This can have an enormous impact on the ability of the parents or caregivers to better recognize and focus on the emotional needs and wellbeing of their children.
- If a non-offending parent is either seriously injured, or so emotionally distraught that he/she cannot look after the children at the scene, officers can help him/her to identify and find a relative or close friend whom the children know and trust who can come immediately to the scene and assume temporary responsibility. This is also an opportunity for officers to help connect victims to domestic violence advocates in communities where this resource is available.

When officers are attentive to the safety and psychological needs of domestic violence victims, they are not only protecting victims, but supporting parents' strength and ability to care for their children.

Typically, the most effective means of providing safety and security to a child is to support the child's non-offending parent in caring for the child. Officers should talk with the non-offending parent about what he/she thinks he/she needs in order to stay safe, and can direct her/him to available resources in the community.

In general, police officers will be more helpful to children if they see their role as assisting and supporting parents, rather than as providing safety and security to children independent of the parent. When possible, reminding offending parents of the impact their behavior has on their children can be helpful in re-grounding the offending parent in their responsibilities as well.

Whenever possible, officers should avoid separation of young children from non-offending parents. The experience of separation is often more distressing to a child than the event which brought police to the family home.

In many cases, police officers are involved with making decisions about child care. Even in instances where Child Protective Services is called, officers often make interim placement decisions until Child Protective Services arrives.

After initial investigation on scene, and in conjunction with a supervisor, if there is probable cause to arrest both parents, officers should attempt to leave the children with a family member or friend rather than with someone not known to them. In some jurisdictions, it may be possible to use a written summons rather than a custodial arrest for one caregiver and to leave that person home to care for the children. This decision must be determined by local laws and agency policy. Make sure to check with a supervisor.

### **Guidelines for determining the appropriate interim placement of a child. *These guidelines may not be applicable in all jurisdictions.***

- The child should be placed with the non-offending parent. If the officer has questions concerning the capability or competency of the non-offending parent, protocols for notifying Child Protective Services should be followed. A domestic violence advocate should also be contacted.
- If the primary parent or caregiver is not available due to arrest, the arrested caregiver should be given a reasonable opportunity to select and contact an alternate caregiver unless there is a compelling reason not to do so, or the arrest is for child abuse or neglect.
- When possible, a preliminary NCIC check and check of child protection case files should be conducted on the alternate caregiver chosen by the parent as soon as reasonably possible. In many states, any previous arrest for child abuse, sexual crimes, domestic violence, recent arrests for drug offenses, or other violent felonies shall disqualify the individual from taking custody of the child.
- If the parent is unable or unwilling to identify a caregiver, and other suitable arrangements cannot be secured within a reasonable period of time, typically that the child will be taken into the custody of a child protection agency or another authorized partner organization.

*Extracted from IACP's Model Policy on Safeguarding Children of Arrested Parents.*

## **8. Speak to parents about the well-being of the children.**

- Ask the parents or caregivers about the wellbeing of their child/children.
- Try not to talk negatively about either parent in front of children.
- Express the concern you share with the parents for well-being of the children.
- Provide parents with information about the potential impact of exposure to domestic violence on children.

Once the scene is secured and some degree of calm has been restored, officers should begin a conversation with parents by asking them about the wellbeing of the child/children. Frequently parents will remark that they believe children are fine and were not affected by the incident; at times parents will go so far as to say that the child was unaware of the event because s/he was in another room, asleep, or watching television. For many parents these statements do not reflect a failure of general concern about their children but rather express a wish that the horrors and helplessness of being victimized are not compounded by the additional sense that the experience has upset or damaged their children.

Officers should not be deterred from this protocol if the parent says the child has not been affected by the events which brought officers to the scene. Officers can express a shared concern for the well-being of the children: *“I know how overwhelming/upsetting this experience is for you and also how worried you must be about how your child is doing after what happened. I am too, and I want to make sure we do everything we can to be of help to you and your child.”*

The same strategy of expressing concern for children’s wellbeing can be useful as you work to conduct the conversation in a place where the child will not overhear: *“I know you will want to talk about this in a place where your child won’t overhear.”*

Officers should be prepared to provide caregivers with information regarding safety and legal issues such as protective orders and temporary custody, as well information about domestic violence advocacy and victim services and shelters. Similarly, this is an opportunity to start a conversation using the **When Your Child is Exposed to Violence**<sup>1</sup> brochure about signs, symptoms and responses to children exposed to violence.

## 9. Speak to children to explain what has happened and what will happen next

- Introduce yourself and describe your role in simple terms.
- Sit or squat so you are physically at the child’s level and able to make eye contact.
- Acknowledge that something upsetting has happened.
- Refrain from asking children about or focusing on details of the incident itself. Instead, officers can be most helpful by giving children factual

information as well as being available to address questions and concerns that children may have, while communicating directly to children that the officer realizes how upsetting the events and the circumstances might be.

- Explain to children why any use of force by the police may have been necessary.
- Describe in clear terms about what is going to happen next (e.g., what is going to happen to the parents, what is going to happen to the children, where the children will stay tonight, etc.)
- Be realistic. Do not say “Everything will be okay” or make promises you cannot keep.
- Discuss ways in which children can keep themselves safe.
- Leave a number that children can use to reach police.
- Before you leave, explain what is likely to happen next in terms of children staying safe.

For sample language, please see **Questions Commonly Asked by Children When Police Are On Scene and Examples of Police Responses**, another tool in IACP’s **Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement** available at <http://www.theiacp.org/children-exposed-to-violence>.

## Helping Children to Make a Safety Plan

Officers can state that the occurrence of the violence is not the child’s responsibility, nor is it the child’s responsibility to stop the violence. However, it may help to review basic plans about what the child can do if another incident of domestic violence occurs.

For example, officers can ask children who are age 5 and older if they know how to use the phone and if they know what number to call if the violence re-occurs. Officers can ask children if they know how to find someone safe in the building or neighborhood in which they live.

Remind children that the police are there to help. Children should know that if there is violence in the future, they can call the police. When a police officer reiterates this to a child it sends the child the message that the police officer “has the child’s back” and helps increase the child’s overall sense of psychological safety.

<sup>1</sup> This brochure is part of the **Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement**. See [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence).

## 10. Know your resources

It is beneficial to police officers to become familiar with the resources and key stakeholders in their community. Relationships with other professionals can make the officer's job easier and more effective.

- Domestic violence advocates and shelters
- Victim advocacy and victim assistance organizations
- Domestic violence hotlines and crisis lines
- Family Justice Centers
- Child Protective Services
- County or city social services
- Child welfare and child advocacy groups
- Mental health professionals
- Emergency medical services/medical professionals
- State victim compensation programs

## 11. Follow-up with the child and family, if possible

- Visit the family, in the course of a shift, when possible.
  - Arrange a visit in advance, if possible
  - Even very brief visits (five minutes) can be powerful ways to support children and families' efforts to regain a sense of security and well-being.
- Review the status of any existing restraining or protective orders.
- Discuss the usefulness of having a School Resource Officer reach out directly to affected children at school, where available.

For many families, the continued attention of a uniformed law enforcement officer is essential in re-establishing a sense of safety and moving in the direction of recovery.

In addition to the importance of police presence in re-establishing psychological safety while on scene, when police officers follow up with families in the days and weeks following domestic violence, it can make a significant difference to children and victims. Even when brief, a follow-up by police officers communicates a powerful message of concern for children and families while confirming the officers' role in the community as sources of protection, safety, and service.

### A follow-up visit by the police provides an opportunity:

- For children to see police when there is not a crisis—no one is going to the hospital or to jail—and everyone may be calmer.
- To review the status of the family's safety and other concerns.
- To identify and recommend additional services that may support the family's recovery.
- To solidify a personal connection with a police officer who demonstrates continued commitment as an ally in the family's recovery.
- For children, families, and communities to develop and strengthen positive expectations of relationships with police.

Follow-up contact with victims of domestic violence and their children has been demonstrated to decrease the repetitive nature of emergency calls for service and a potential reduction of levels of severity of violence when it does re-occur.

This resource is part of the *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*. Visit: [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence)

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# What Traumatic Stress Reactions May Look Like On-scene

## Physical

- Shaking
- Increased heart rate
- Physical complaints (headaches, body aches)
- Hives
- Diarrhea
- Inactivity or slow physical movement
- Physically stuck/slow/nonresponsive (or immobilized)
- Nausea and vomiting

## Cognitive

- Confused
- Difficulty making decisions
- Loss of train of thought
- Incoherent thoughts
  - Talking about things that seem random or not connected to what is being asked
- Getting “stuck,”
  - Preoccupation with elements of the event
  - Thoughts dominated by fixed focus on particular elements of the event
  - Pressured demands for more information, regardless of attempts at redirection
  - Repeats concerns or questions in spite of information that has been made available or the fact that more information is not available
- Failure of memory or inconsistent memory about events
- Poor sense of time
- Inability to recall place and identifying information regarding suspects and others involved in the event

## Emotional

- Inconsistent emotions that may seem “all over the map,”
  - Wailing, sobbing
  - Volatile, angry
  - Verbally attacking others
- An apparent absence of feelings
  - “The thousand-yard stare”
- Inappropriate emotions
  - Sudden fits of laughter
  - Giggling

## Behavioral

- Agitated
  - Pacing
  - Moving hands and arms in a nervous fashion
  - Foot tapping
  - Finger drumming
  - Swiveling head
  - Darting eyes
- Immobilized
  - Inactivity or slow movement
  - Seeming stunned and slow to respond to external cues and stimuli such as questions, attempts to make eye contact, etc.
- Irritable
- Angry
  - Verbal outbursts/yelling
- Withdrawn/isolated
- Fatigued
- Young children may be
  - Clingy
  - Fussy
  - Running around

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# REACTIONS THAT POLICE MAY OBSERVE

## From Children and Youth

Police may observe the following reactions from children and youth they encounter on the job. These are examples of some common reactions that children and youth have to police; these are not meant to be exhaustive lists of all the different reactions that police officers might encounter. While the reactions officers can expect may be broadly defined by a child’s developmental stage, a given child may exhibit one or more of the following reactions, no matter what his or her age.

Young Children (0–5 years old)	School Age Children (6–12 years old)	Teenagers (13+ years old)
<ul style="list-style-type: none"> <li>■ <i>Appear a little standoffish</i></li> <li>■ <i>Appear shy</i></li> <li>■ <i>Appear scared</i></li> <li>■ <i>Need reassurance from parents/caregivers when around police</i></li> <li>■ <i>Depend on their parents or caregivers for safety and security, even around the police</i></li> </ul>	<ul style="list-style-type: none"> <li>■ <i>Appear a little standoffish</i></li> <li>■ <i>Act very curious</i></li> <li>■ <i>Have notions of police as good and/or bad</i></li> <li>■ <i>Are often proud to know an officer</i></li> <li>■ <i>Have lots of questions about officers’ tools (the gun, the car, the siren)</i></li> <li>■ <i>Want to know how many “bad guys” an officer has arrested or shot</i></li> </ul>	<ul style="list-style-type: none"> <li>■ <i>Are very affected by peers’ attitudes of police</i></li> <li>■ <i>Want to appear brave or standoffish, especially when in a group of peers</i></li> <li>■ <i>Have trouble dealing with authority</i></li> <li>■ <i>Conflicted about relationships with authority figures</i></li> <li>■ <i>May be confrontational or rude</i></li> <li>■ <i>Capable of being cooperative and friendly</i></li> </ul>

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# EFFECTIVE POLICE RESPONSES to Traumatic Stress in Children of Different Ages

## No matter what the child's age police can:

- Ascertain the presence of children on-scene.
- Communicate in an authoritative and respectful way that can help to calm both caregivers and children.
- Support parents or caregivers in recognizing and reducing immediate symptoms of distress in their children.
- Consider phase of development and symptoms of distress when interacting directly with a child.

## Infants (0–12 months)

### Typical Development

#### Keep in mind, infants:

- Rely completely on their parents or caregivers
- Center their sense of security on their parents or caregivers
  - The sooner that parents or caregivers are calm and in control, the more that they are able to be responsive to the infant's needs
- Need to be nurtured and cared for in a reliable way that ensures that basic physical and emotional needs are met
  - Separation from a parent or caregiver can be terrifying
  - A child's sense of safety and security can be shattered by witnessing violence

### Common Responses to Exposure to Violence

#### Watch for these symptoms of distress in infants:

- Inconsolable crying
- Flailing
- Extreme body tension or physical rigidity
- Demanding of physical closeness, but not being soothed by it
- Whimpering

#### More worrisome responses to watch for:

- Calm, quiet, docile, lethargic, glassy-eyed
- Asleep in the midst of chaos

### What Police Officers Can Do

#### What you can do for infants on-scene:

- Recognize that scenes to which police are called are frequently chaotic and that infants are exposed to tremendous stimuli
- Ensure that the infant is in the least chaotic part of the scene to which you have responded
- Show concern for children's safety with your words and actions
- Remind parents or caregivers of how important it is to get as calm as possible in order to support their young children
- Help parents or caregivers decrease their own distress in order to be able to attend to their children
- When parents or caregivers are not able to respond to your attempts to help them calm down and attend to their children, identify alternate caregivers to monitor and attend to infants
- Ensure parents or caregivers have a support system such as family, friends, neighbors, or community services prior to leaving the scene

## Toddlers (12–36 months)

### Typical Development

#### Keep in mind, toddlers:

- May be crawling by 8–12 months and walking by 12–18 months
- Speak some words around 12 months and two-word sentences by 24 months
- Have clearly defined relationships with their primary caregiver and heightened vulnerability to separation fears
- Assert their independence – “Terrible Twos”
- Have heightened concerns about physical safety

### Common Responses to Exposure to Violence

#### Watch for these symptoms of distress in toddlers:

- Screaming, crying, clinging, acting “babyish”
- Loud demands for attention
- Whining
- Toileting accidents
- Increased displays of characteristic features of this phase (e.g., separation fears—loud and vocal demands for attention, more and louder demands for uninterrupted physical contact)
- Withdrawn and too quiet

#### *More worrisome responses to watch for:*

- Calm, quiet, docile, lethargic
- Asleep in the midst of chaos
- Overly familiar and friendly with unknown adults (including the officer)
- Repeating what they saw and heard and can’t be stopped

### What Police Officers Can Do

#### What you can do for toddlers on-scene:

- Ensure that toddlers are physically safe and are being sufficiently monitored
- Help parents or caregivers find a place to sit and address them in a calm and respectful but authoritative manner
- Assist parents or caregivers in decreasing their own distress while reminding them that staying calm is the best way to safeguard the children from distress
- Seek out an alternate caregiver, if necessary

## Preschoolers (3–5 years)

### Typical Development

#### Keep in mind, preschoolers:

- Use play to express ideas and feelings
- Have increased cognitive, language, and physical capacities
- Have increased ability to differentiate reality from fantasy, but still often believe in the magical power of their thoughts and feelings
- May believe that they caused a bad thing—an accident, fire, fight, or arrest— to happen
- May also believe that their behavior or wishes are responsible for a parent’s or caregiver’s arrest or removal
- May see police officers as larger than life, or imagine police officers as action figures who can help, hurt, or take them away

## Common Responses to Exposure to Violence

### Watch for these symptoms of distress in preschoolers:

- Increased difficulty separating from caregivers
- Increased worries about their bodies
- Difficulty eating, sleeping, toileting
- Increased tantrums, clinginess, baby talk
- Fearful avoidance and phobic reactions
- Withdrawal
- Inattention and inability to follow directions
- Provocative or demanding behavior

## What Police Officers Can Do

### What you can do for preschoolers on-scene:

- Help caregivers become calm and in control
  - The most important people in young children's worlds are the parents or caregivers and the extent of the parents' or caregivers' distress and anxiety will play a central role in determining the level of both immediate and longer-term impact of events on children
- Seek out an alternate caregiver, if necessary
- Get down on the children's level by kneeling or sitting
- Find out if the children have any questions and what those questions are
- Help children to re-engage the thinking part of the brain through fine-motor activity. Drawing is one activity that enhances children's ability to become more focused and organized in both thoughts and emotions.

## School Age Children (6–12 years)

### Typical Development

#### Keep in mind, school-age children:

- Develop intellectual, sensory-motor and social skills
- Develop self-awareness and self-esteem
- Channel impulses into school, sports, friends, etc.
- Demonstrate an increased ability to form relationships outside the home and family with peers and other adults and may be susceptible to their influence
- Can turn to other figures, in addition to parents or caregivers, who can offer reassuring/calming/authoritative presences (e.g., relatives, family friends, teachers, clergy, and police officers)
- Are especially concerned with issues of right and wrong, fairness and justice

## Common Responses to Exposure to Violence

### Watch for these symptoms of distress in school-age children:

- Frightened
- Challenging authority
- Hyperarousal
- Jittery
- False bravado
- Clinginess
- Apparent excitement about violence and traumatic events or apparent indifference
- Social and emotional withdrawal
- Crying, hyperventilating

## What Police Officers Can Do

### What you can do for school-age children on-scene:

- Attempt to limit the child's further exposure to out-of-control behavior once you arrive on-scene
- Find out what questions children have and talk to the children about what happened in direct and plain language
- If children are so distressed that they are unable to put their thoughts and questions into words:
  - Teach the Tactical Breathing Technique
  - Help children to re-engage the thinking part of the brain through fine-motor activity. Drawing is one activity that enhances children's ability to become more focused and organized in both thoughts and emotions.
- Emphasize the current plan to keep them safe
- Support caregivers in meeting the children's needs
- Seek out an alternate caregiver, if necessary

## Adolescents (13–18)

### Typical Development

#### Keep in mind, adolescents

- Experience physical changes that have an impact on psychological development
- Develop a sense of themselves as individuals who are distinct and independent
- Attempt to distinguish themselves from their parents
- Test limits to secure evidence that they are still connected and protected
- Teenagers' relationships with authority figures provide opportunities to test limits and independence, and teenagers are very good at drawing police into their struggles about authority
- Focus on appearance, competence, sexual exploration and intimacy
- Experience a greater ability to think abstractly
- Feel that a sense of belonging is incredibly important

### Common Responses to Exposure to Violence

#### Watch for these symptoms of distress in adolescents:

- Rage and anger
- Crying
- Physical dysregulation (e.g., rapid breathing/hyperventilation, agitation, restlessness, etc.)
- Expressed disinterest (don't know/don't care)
- Anxiety
- Excitement
- Disorganized language/thinking
- Talking obsessively about what happened

## What Police Officers Can Do

### What you can do for adolescents on-scene:

- Take behaviors of concern or verbalized unsafe thoughts seriously
- Know that adolescents are especially vulnerable to humiliation and help teenagers "save face"
- Offer support and guidance
- Set clear expectations and firm limits
- Be aware that when officers respond to adolescents with respect and genuine engagement, teens can be surprisingly eager and receptive to the calming authority that officers can offer in the aftermath of overwhelming events

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# TEACHING THE TACTICAL BREATHING TECHNIQUE

**A**s an officer, you often encounter adults and children in distress following their exposure to violence and overwhelming events. One simple way to help a child or an adult regain focus and a sense of control is to teach them how to take calming and focused breaths, using the **Tactical Breathing Technique**. Tactical breathing is a tool that is widely deployable and useful in many situations. Mental health professionals often teach

this skill, but it is a skill that police officers can easily learn to teach as well.

It is helpful to teach the tactical breathing technique to the parents or caregivers and children together, if possible, so that the parents or caregivers can support children in using the skill once you leave the scene. Parents or caregivers can also benefit from using the skill themselves.

## Why is Tactical Breathing Important?

When children experience or witness violence or traumatic events, they may feel anxious, confused, or overwhelmed. When people have these feelings, they often tend to take short, quick, shallow breaths or even hyperventilate.

- Shallow breaths can actually make the feeling of anxiety worse.
- Tactical breathing can help to lower children's (or adults') anxiety and help them regain a sense of control.
- Tactical breathing increases the supply of oxygen to the brain and helps to counteract immediate traumatic arousal that leads to increased heart rate, respiration, muscle tension, etc.
- Tactical breathing stimulates the parasympathetic nervous system (the part of the involuntary nervous system that serves to slow the heart rate, increase intestinal and glandular activity, and relax the sphincter muscles), thus reducing the immediate intensity of traumatic arousal.

- Tactical breathing can also help to interrupt the distressing and repetitive thoughts and images that often follow traumatic events and that contribute to physical and psychological arousal.
- Tactical breathing is easy to teach children and parents or caregivers, and can be a useful tool for them both immediately, and after you have left the scene.

## Teaching the Tactical Breathing Technique

### Step 1: Explain tactical breathing to child, together with the parent or caregiver.

When teaching this technique it is helpful for officers to try it with the child and parent or caregiver.

*“I think it might be helpful for me to teach you a technique for calm, focused breathing. This will be something you can use right now, and can also use if you are having trouble sleeping, feeling worried, or thinking about what happened and need to re-focus. When you use calm, focused breathing, you take a special kind of slow breaths, and I'm going to show you how to do it.”*

## Step 2: Teach the tactical breathing technique.

- Ask the child to put one hand on his or her chest and the other hand on his or her stomach.
- Ask the child to take a slow breath in through the nose. (*Ask him or her to think of a favorite smell. Sharing a favorite smell of your own can break the ice as you are trying to teach a child this skill.*)
- Let the child know, that as she or he breathes, his or her hand should rise with their stomach, while the other hand (the hand on the chest) should move very little.
- Instruct the child to hold his or her breath for 1 or 2 seconds.
- Instruct the child to exhale as slowly as possible through the mouth. (*You can tell the child to imagine he or she is slowly blowing out several candles on a birthday cake.*) The child can be told that as he or she lets the breath out, the hand on the stomach should go down, while the hand on the chest should move very little.

Encourage the child after he or she has tried it for the first time:

*“Good job! Now let’s try that again. Take a slow, deep breath in, hold it for a second, and then slowly blow out all the air.”*

- Repeat for at least 3 to 5 breaths.

### Note:

This tool was adapted for law enforcement from “How to Teach Your Child Calm Breathing.” by the Anxiety Disorders Association of British Columbia (AnxietyBC) and available at <https://www.anxietybc.com/parenting/how-teach-your-child-calm-breathing>.

### Helpful Hint:

When using tactical breathing, check to see if the child’s upper body area (shoulders and chest) is fairly relaxed and still. Only the belly should be moving.

Tactical breathing is a useful technique, but it is not the only technique that can be employed to help people become calm and feel more in control following violence and overwhelming events. Infants and toddlers will be best served by other more developmentally appropriate techniques for re-regulation, for example, being held, hearing soft reassuring speech, or playing a game of peek-a-boo. These are techniques that caregivers can be encouraged to employ with their own children. Occasionally the officer or other team member will employ these or other techniques with infants and younger child if there is not a caregiver present. Decisions about which technique to employ should be made by officers in consultation with their supervisors on scene.

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# QUESTIONS COMMONLY ASKED by Children When Police Are On-Scene and Examples of Police Responses

Children often have many questions for officers who are responding to calls for service. Officers may feel uncertain about how directly they should answer children's questions or might be concerned that any information they offer may be too much for children to handle.

***The reality is that when children are dealing with chaotic and upsetting events, police officers can be the most reliable and critical sources of order, information and adult support available on-scene.*** The simple acts of listening and responding to questions can be reassuring

demonstrations to children that they have not been forgotten and that their concerns matter. Moreover, this kind of police interaction helps to re-establish the very basic sense of predictability, order, and safety that is often lost in the aftermath of violent events and is so essential in initiating a process of recovery. The following questions come up frequently when police officers respond to scenes where there are school-age children. The answers suggested here are not meant to be definitive, but rather to offer some language that officers can adopt and adapt for themselves.

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## Child: Why are the police here?

**Officer:** *Because mom/dad/adults got out of control and the police are here to help everyone get back in control. It is not okay for people to hurt each other and that's why we are here. Sometimes even grown-ups need help from us (the police) to stop hurting each other and get things safe again.*

## Child: What's happening to my mom/dad?

**Officer:** *Mom/dad needs help getting back under control. We need to take mom/dad down to the police station.*

## Child: Why did the ambulance come?

**Officer:** *The ambulance needs to take mom/dad to the hospital so that they can be checked out and helped by the doctor. As soon as the doctors know more about how your mom/dad is doing, we will tell you about that.*

**Child: Is my mom/dad okay?**

**Officer:** *I know this may feel scary because of what happened to mom/dad. S/he is at the hospital and the doctors are going to be taking care of him/her. We will know more about how your mom/dad is doing when the doctors are finished checking her/him out and seeing what s/he needs. Then we will be able to know more about when s/he is going to come home, and we will tell you when we know.*

**Child: Where are you taking my mom/dad?  
Why are you taking my mom/dad?**

**Officer:** *When grown-ups get out of control, they are breaking the law. We need to take mom/dad to the police station because that's where s/he needs to be right now to make sure everyone is safe and because they were breaking the law. We are taking mom/dad to jail/down to the police station. They may need to stay at least overnight. They can get calm, and we can make sure there is a plan for everyone*

*to stay safe. It is our job as police officers to make sure that we help people follow the law, including being able to stop hurting each other.*

**Officers responding to an incident of domestic violence can add:** *We will talk with mom/dad to make sure s/he feels safe and can keep you safe.*

**Child: Is my mom/dad coming back?**

**Officer:**  
**If disposition is unknown:** *Your mom/dad was taken to the police station. I don't know what the plan is right now, but I will let you know when I know. We do know that your mom/dad will be safe.*

**If disposition is known:** *Mom/dad will not be coming back tonight. In the morning they will need to see the judge. The judge will decide when your mom/dad will be released from jail/allowed to come home. Either way, we will make sure that you know what is happening with mom/dad as soon as we know.*

**Child: Does that mean my mom/dad will be in jail?**

**Officer:** *Yes, your mom/dad will be in jail tonight. We will have a better idea tomorrow about when they will be coming home.*

**Child: What's going to happen to me?**

**Officer:** *We will make sure you have a safe place to be tonight. You will be with [specify adult who will be responsible for children, e.g. grandma, aunt]. We will make sure that adult has a telephone number/information about how to find out what is happening with your mom/dad. (Officers should identify an appropriate telephone number for caregivers to find out information on loved ones who are injured or arrested such as for the hospital emergency department or the front desk at the police department.)*

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# COMMON ISSUES

## for Caregivers and Police Who Respond to Children Exposed to Violence

Parents and caregivers are the most important sources of support for children who have been exposed to violence and overwhelming events. However, in the chaos that frequently follows calls for service, parents and caregivers may be reeling from the same events that impact their children. In those moments, parents and caregivers can benefit from an officer's assistance to help them gain perspective

and become refocused on ways in which they can best support their affected children.

The following issues come up frequently when police officers respond to scenes where children have been exposed to violence or overwhelming events. Police officers can play a key role in preparing and assisting parents and caregivers to best support their children in these situations.

### MINIMIZING

Frequently, and understandably, caregivers seek to minimize the impact that events may have on their children. However, officers should not be deterred from taking steps to respond to children exposed to violence even if the caregiver says that a child has not been affected.

Officers do not need to create a confrontation with caregivers; instead, they can work to find and highlight shared interests and common goals. For example, it often works well to express a concern for children as a concern that is shared with caregivers. For example, the officer might say: ***"I know that you must be worried about how your child is doing after what happened. I'm worried, too, and I want to make sure we do everything we can."***

### REDUCING FURTHER EXPOSURE

As part of the process of protecting and serving the interests of the child, officers will want to limit children's ongoing exposure to overwhelming and upsetting circumstances. Officers should take steps to remove children from scenes where out-of-control behavior is occurring. To the extent possible on-scene, officers should limit adult conversations from being held in children's hearing. Again, the strategy of working with the parent or caregiver for the best interest of the child can be employed, and officers might say: ***"I know you will want to talk about this in a place where your child won't overhear."***

In general, children are more likely to see police officers as helpful if their parents are treated with respect. Officers should try to be neutral in front of children and in front of parents or caregivers, even if those parents or caregivers have broken the law and may be perpetrators.

## ADDRESSING SAFETY CONCERNS

Officers should be prepared to provide parents and caregivers with information about safety and legal concerns such as protective orders and temporary custody. Even if the family has been through the process of obtaining a protective order before, it can be helpful for police to take a few moments to explain the process again because it can be difficult for people to process information in the immediate aftermath of frightening or overwhelming events. Explaining the protective order procedure helps the family to predict what will happen next—this is part of the process of regaining control following the loss of control that trauma causes.

If the offender fled the scene or there are other reasons why a protective order cannot immediately be put into place, the children

and parents or caregivers might be afraid. It can be helpful to review with the parents or caregivers available options for increasing their immediate sense of safety. For example, the officer can raise questions about alternative places to stay (with family, friends, etc.) as well as offer information about domestic violence service providers and emergency shelters. The officer can also ensure that a contact is made with a domestic violence advocate or victims services personnel from the police department or community agency. Similarly, the officer should tell the parents or caregivers what the next steps are to secure the arrest of the suspect, with an agreement to inform the family as soon as the suspect has been apprehended. Should the family decide to stay in the home, offering to walk through the home to evaluate security measures (windows, locks, etc.) can be extremely reassuring to family members. Lastly, officers should encourage family members to contact the police immediately should they have any contact (visual, social media, telephone, etc.) with the alleged perpetrator.

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# HOW YOU CAN HELP YOUR CHILD

For some children, going over the events with the adults they trust can help them feel less alone. Giving kids time to talk about their questions and concerns can be very helpful.

For other children, talking about what happened may be very hard. They may show their distress in other ways, such as upsetting behaviors.

Recognizing your child's reactions can be an important first step towards helping your child recover.



## In case of emergency, **DIAL 9-1-1**

To reach a police officer who works in your neighborhood when it is not an emergency please contact:

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To reach a child trauma specialist, please contact:

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**Yale Medicine**  
CHILD STUDY CENTER

**OJJDP** Office of Juvenile Justice and Delinquency Prevention  
Office of Justice Programs • U.S. Department of Justice

# What To Do WHEN YOUR CHILD IS EXPOSED TO VIOLENCE



**Important Information  
and Resources for  
Parents and Caregivers**



## What Happens When Your Child Is Exposed to Violence?

When children see and hear too much that is frightening, their world feels unsafe and insecure. Experiencing violence and other traumatic events can overwhelm children and teenagers, and lead to problems in their daily lives, including:

- Sadness and nervousness
- Behavior problems
- Trouble concentrating and learning
- Trouble getting along with family, friends, and teachers

## What Caregivers Should Watch For

In the days and weeks following an incident of violence, you may notice one or more of these reactions in your child. Some reactions are common for anyone, and some are more likely for children of specific ages.

### YOUNG CHILDREN

- Clinginess to mother or caregiver
- Irritability, fussiness, difficulty being soothed
- Bedwetting or problems with toileting
- Frequent nightmares or waking in the night

### OLDER CHILDREN

- Problems paying attention at school
- Fighting with siblings, peers or adults

### ALL AGES

- Being easily startled, jumpy, or uneasy
- Repeating events over and over in play or in conversation
- Being quiet, upset and withdrawn
- Being tearful or sad
- Talking about scary feelings or ideas
- Daydreaming or being easily distracted

**Getting help early for your children can start to make things better now, and may prevent long-lasting difficulties.**



**Too many children in our community are affected by violence. We can work together to make our children feel safe again.**

Attach Business Card Here

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# Principles and Practices of Death Notification to Children

**N**otifying the next of kin that a family member has died is one of the most challenging tasks for law enforcement officers. There are additional challenges that police officers face when children must be notified of the death of a family member or loved one.

In recognition of the difficulties associated with making death notifications and with the goal of conducting them in the best manner possible, the National Law Enforcement Policy Center of the International Association of Chiefs of Police (IACP) drafted a model policy that serves as the foundation for the following notification procedures for death notification to children. This protocol sets out specific procedures for officers to follow as they provide surviving family members with useful information and support in a manner consistent with professionally-accepted crisis intervention techniques. The current protocol builds on the earlier work of the IACP and draws on 25 years of experience in joint police-mental health death notification approaches that have been implemented by the Child Development-Community Policing program at the Yale

Childhood Violent Trauma Center. This protocol integrates principles and practices that will support the specific needs of children facing the death of a loved one or family member.

It is optimal in death notification that information about death of a family member be delivered first to the adult next of kin before notification is made to children. Officers can play a critical role in supporting parents or caregivers in delivering the news of a death to their child; occasionally officers are called upon to deliver the news directly to children themselves. This protocol offers supportive information for each scenario.

*The following protocol is to be used in addition to carrying out any relevant agency protocols regarding securing a scene; identifying those in need of emergency medical attention; and identifying perpetrators, victims and witnesses relevant to the investigation. To respond most meaningfully to children and families who have been exposed to violence and overwhelming events, officers should take the following trauma-focused steps:*

## 1. Plan Ahead

Prior to making the notification collect essential information:

- Gather details concerning the deceased, to include full name, age, race and home address, as well as details of the death, location of the body and personal effects, and other pertinent information. While it may not be appropriate or necessary to share all known details with surviving family members, being aware of the details may help inform your interaction with surviving family members.
- Confirm the relationship of the person(s) you will be notifying to the deceased.
  - When it is known that children will need to be notified of a death, particular effort should be made to locate the closest relatives, beginning with the parents or caregivers, followed by grandparents, aunts or uncles, then siblings.
- Determine in advance who will be present at the notification, if possible.
  - There is often no way to be certain who will be present upon your arrival; if the death has occurred in a public place large groups may have gathered at the scene. Locating family members and those directly impacted by the death is an important first step in the notification process.

- Officers should also determine if translation services will be required to communicate with family members and should arrange for a translator, if necessary.

At times officers are called upon to make death notifications to individuals whose primary language is not English. It is recommended that wherever possible, the child not be used as a translator.

## 2. Go in pairs to make the notification

- Work with a partner to make the death notification, whenever possible.
  - Identify who will partner with you to make the notification. This may include police colleagues, clergy or mental health professionals.
  - Working in pairs supports both the officer and the family receiving the notification. In some communities, there is a mental health professional or a clergy partner with whom police can collaborate to make death notifications.
- Create a plan with your partner, to include:
  - Who will actually give the initial information.
  - What information will be provided.
  - Where the notification will take place.

Having a clear understanding of each partner's role and responsibility in advance is helpful in ensuring that the notification goes smoothly and that neither too much nor too little information is given.

Having a plan may help each partner feel more comfortable with the difficult task.

## 3. Make the notification in person

- Ask permission to enter the residence or workplace.
- Move those who are to be notified to a space that offers the greatest privacy possible.

If the person to be notified is at work, try to find a private space away from colleagues and passersby to ensure privacy. When conducting the notification in the family home, it is optimal for family members to hear the news in private away from others who may have gathered.

At times, the need to restore order may arise while making a death notification. By providing structure and ensuring order, officers can support family members in

their acute grieving process. Families often know best how to support one another, but officers can be helpful managing and facilitating the scene so that families can grieve together.

- Request to speak with immediate survivor(s).
- Identify yourself and your partner(s).
- Verify the relationship of the survivor to the deceased.

## 4. Make the notification in a timely manner

Avoid delays in notifying the next of kin. Timely notification of death is critical, especially in the era of social media.

Wherever reasonably possible, avoid using the name of the deceased over the radio prior to notification of immediate surviving relatives.

## 5. Make the notification first to parents or caregivers

It is optimal for the death notification to be made to the adult next of kin before officers have any direct contact with children or deliver notification of a death to children.

When adults receive the death notification in advance of their children, they have the opportunity to react to the news and to ask questions of the officers providing the notification. Officers can answer questions and help adults plan for how they will deliver the news to their children.

In some circumstances, family members may have dramatic physical reactions (such as hyperventilating, fainting, or respiratory distress) upon receiving news of a traumatic death and may require medical attention. For this reason, personal effects of the deceased should not be delivered to survivors at the time of death notification as this could further burden or overwhelm the survivor. Should officers and their partners feel concerned about any acute medical distress, call EMS for assistance.

## 6. Deliver the notification in plain language

- Be straightforward.
- Avoid euphemisms, graphic detail and police jargon.
- Refer to the deceased by first name or by the relationship to the family member(s) receiving the notification.

What is said in every situation needs to be unique. **The simple and straightforward delivery of the facts about a death is the most important and often the most difficult aspect of the notification process.** It is important to remember that the overwhelming nature of the news may make it difficult for the individual to actually take in what they are hearing. Sometimes one may need to repeat the information while stating an appreciation for how hard it is to believe such horrible news. Officers should be aware

that family members may experience a delay in fully understanding the news and that demonstrations of being overwhelmed (e.g., screaming, sobbing, repeated denial or refusal to accept the information, etc.) are common.

In this period of acute upset, it is often difficult for the officer to resist the inclination to say something to try to decrease the family member's pain. **However, the quiet, sympathetic presence of the officer, may be the most reliable and steadfast source of stability available to those hearing tragic news.** This same patient and stable presence also sets the stage for the officer to then address specific questions about the circumstances of the death.

At times, the need to restore order may arise while making a death notification. By providing structure and ensuring order, officers can support family members in the acute grieving process. Families often know best how to support one another, but officers can be helpful managing and facilitating the scene so that families can grieve together.

## 7. Support the parent to notify the children of the death

It is preferable for a parent or caregiver to make the notification to his/her own child, whenever possible. Officers can play an important role in preparing and supporting caregivers to take on this task.

- **Encourage the family to think about what words they want to use.**
- **Talk with the caregiver in advance about messages that might *not* be helpful, for example, telling the child that the parent is away on a trip or at work in order to avoid telling the child that there has been a death.**

The officer should talk with the caregiver about the fact that children need to hear the news simply and directly. The statement of fact about death of a loved one can be prefaced with a statement such as "I have some very sad news," but should then be delivered in a candid manner.

- **Offer support to the caregiver if they would like it while they are providing the news, for example, by sitting nearby.**

## Overarching Principles of Death Notification:

- Plan Ahead and Prepare
- In Pairs, In Person, In Time, In Plain Language
- With Compassion

- **Ensure the parent or caregiver has a firm understanding of what the plan will be for the children going forward, i.e. where children will stay, with whom, who will take care of funeral arrangements, etc.**

Parents and caregivers often feel an additional burden on top of their own shock and acute grief reactions; that is, they may understandably wish to find a way of minimizing the emotional weight that the news will have on their children. Parents can be reminded that:

- Children are supported when parents can show them that they are listening and paying attention to children's attempts to navigate receiving the terrible news.
- Having support from other family members not only helps parents themselves, but can support parents in their efforts to support their children.
- When children's worlds have been disrupted by the death of a loved one, they may be especially vulnerable and made more anxious by displays of emotional distress in parents and other family members. Parents can be reminded that rather than hiding their feelings from their children, it is far more useful to children when affected adults can put into words how upsetting the news is, and that even though they are very upset, they will be available to continue to look after the child. The person delivering the news may feel a wish to diminish the full impact of the news, but it is important to remember that this is both unrealistic and an unrealistic burden, that only adds to the difficult task of being the messenger of such unwanted information.
- The death of a loved one often raises concerns for children about their own well-being: Who will look after them? Who will take care of their needs? Will they be able to continue doing the things that they are accustomed to doing? It is important to keep this in mind and be able to address these questions and concerns as they arise.

Officers can help parents or caregivers remember that children may have a range of responses to news of death and that children's responses may be different than those of adults. Adult caregivers should be prepared for a range of possible reactions from children:

- Not seeming to hear or understand the message that has been conveyed
  - When this occurs, it can be helpful to repeat the information and add that the news is upsetting and unbelievable and that it is not surprising that it is hard to take in.
- Little overt emotional response
  - Children may respond with blank expressions, confusion, or withdrawal of their attention.

- Fidgety and overactive
- Briskly acknowledge the information and then go off to play or watch television, as if there has been no emotional impact.

Adult caregivers may be distressed by this seeming lack of concern or lack of demonstration of remorse about the loss. Remind adult caregivers that, quite to the contrary, these reactions demonstrate the extent to which the child is overwhelmed and having automatic reactions that reflect an inability to fully digest the enormity of the information right away. This is an important time to remind parents or caregivers not only of the normalcy of this behavior, but also that children will be able to ask questions and express their feelings a little bit at a time.

## 8. Help parents and caregivers to make the notification to children, if assistance is needed

- Offer to support parents or caregivers in making the notification.
- Make the notification directly to children, if parents or caregivers are unable and/or request assistance.
- If officers make the notification directly to children, provide basic facts and then offer an opportunity for children to ask questions.

There are times when parents and caregivers will be overcome by their own emotional reactions and will request that the officer and partner communicate the information about the death of a loved one to children directly.

The officer should employ the same principles described for the parent or caregiver in delivering the notification. Provide the most basic information about the fact of the death and basic details of what has occurred, then pause to allow children to ask what questions they have. This will allow you to provide information that is most responsive to the child's current concerns. Remember, digesting such disturbing news is an ongoing process. Your role in delivering the news begins but does not complete that process. It is not your job, nor is it possible to protect the child from the pain and upset that the news will bring. Speak directly to children about the fact that this is a lot of information and that there will be time to talk about it in the future, including time to talk about the wish that none of this was real or happening at all.

Where there is an ongoing investigation, those providing the notification can communicate to children and caregivers that they will be in touch to provide additional information if it becomes available. **The person providing the notification can also ask children if they have questions. The adult making the notification should**

**seek to answer the questions that they can (directly and simply) and remind children that all the answers may not be known at present but that adults will communicate additional information as it is known.**

For older children, questions about details of injuries or the length of time that the deceased was alive before dying may emerge. Avoid police jargon, but do not use euphemisms or give misinformation. For example, you might say "your father was shot" or "your father was in a car accident" without going into details unless you are specifically asked. Questions that emerge about details are a way to confirm the unbelievable and may often be a way to confirm the extent of the deceased's suffering. When the information is accurate, being able to state something such as "your father died very quickly," is something to keep in mind.

Many children under the age of 12 do not have a basic understanding of what death means. **Asking children what they understand about death can be an important starting point for describing in simple terms that death refers to the body stopping.**

## 9. Deliver the notification with compassion

- Utilize clear, simple language to make the notification.
- Demonstrate compassion and empathy through direct and honest communication. Family members receiving the notification often experience great confusion and overwhelming emotion. While as a police officer you cannot change the reality of the situation, your compassion and empathy can be a significant source of support at this difficult time. Direct and honest communication will be clear demonstrations of your compassion and empathy.
- Avoid euphemisms which may inadvertently create confusion. Euphemisms for death (e.g.,

“passed away” or “gone to heaven”), may be easier to deliver at times, but can be harder to understand and should be avoided by officers in their direct delivery of the death notification. Trauma can interfere with a person’s ability to think clearly. In addition, the language and culture of the family may affect how any euphemisms are understood or interpreted. Choose words to communicate as clearly and simply as possible, so as not to make the situation more difficult for the family to comprehend.

## 10. Be Prepared

- **Be prepared for a range of heightened emotional responses and recognize that individuals may need time to formulate questions before proceeding.**
- **Bring a list of community referral agencies** that may be helpful to provide to the survivors such as family crisis services.
- Before leaving, **help the child and caregiver access appropriate support.** It may be helpful to suggest that they call a friend or family member who can lend support.

If needed, and if possible in your jurisdiction, arrange to bring the family to an identified source or support.

- **Be aware of confusion on the part of survivors.** Officers should speak slowly and deliberately, and any pertinent information that the survivor may need should be written down. This includes the following:
  - disposition of the body
  - location of personal effects
  - identification requirement/procedures and
  - notifying officers’ names, agency and telephone numbers
- **Leave your card and remind them that they can reach you any time.** If feasible, also plan to follow up with the family within a few days. When you do follow up, keep in mind that grief and trauma can cloud memory. Do not be surprised if family members do not remember you. Re-explain how you can be helpful and if the family is not interested, suggest that you might follow up after the funeral.

## In the Case of Suicide

No matter what the cause of death, the most painful and challenging elements of acute grief reactions are about the loss itself and the sudden, unanticipated nature of the loss.

When a loved one dies by suicide, the challenges for those providing the notification may feel especially difficult. Loved ones receiving the news of a suicide frequently have multiple questions about the specifics of the death itself. These questions reflect the attempt to digest what feels like unbelievable and shocking news. The need for answers about the “hows and whys” of a death by suicide is, in part, an attempt on the part of grief-stricken loved ones to comprehend the news of the loss.

When those providing the notification are aware of this, they are better prepared to respond factually to specific questions about what is, and is not, known (such as the motivation of the suicide victim) while recognizing and verbalizing how painful and overwhelming the loss is. Often little is immediately known about the specifics regarding the circumstances or motivation. It is precisely this fact that can be conveyed in introducing the news or in responding to family members who are already aware of the cause of death.

The person providing the notification can verbalize how painful and troubling the news is, but also that it will take time to better understand why the suicide has taken place.

**The most important source of support for a child receiving news of a death are that child’s parents or caregivers.** In circumstances involving suicide, the same

principles for notification apply. Ideally the parent will be notified of the death first and will then be supported in telling the child the news of the death.

When police officers are asked by caregivers to give the news of a death directly to a child, the officer should discuss with the caregiver precisely how she or he will deliver the news to the child. For example, the officer can discuss with the parent that they will be telling the child that the loved one died. If the child asks, “How did my father die?” the officer will tell the child that “your father died by killing himself/ taking his own life.”

Whether it is the caregiver or the officer delivering the news to the child, the person delivering the news should be prepared to be direct about the facts, and acknowledge how shocking the information is.

### Once the news of a death by suicide has been delivered to a child:

1. **Wait to hear what questions the child has and answer those questions simply and directly.**
2. **Answer only questions that you are asked - remember to take cues from the child regarding the level of detail to provide.**
3. **Remember that giving children false information can create more difficulties as it will be difficult to shield children from what others are talking about.**
4. **Acknowledge that it will take time to understand why this happened.**

# Quick Reference Sheet: Death Notification to Children

## 1. Plan ahead

- Gather essential information concerning the deceased, including full name, age, race and home address, as well as details of the death, location of the body and personal effects, and other pertinent information.
- Confirm the relationship of the person(s) you will be notifying to the deceased.
- As best you can, determine who will be present at the notification.

## 2. Go in pairs to make the notification

- Work with a partner (may include police colleagues, clergy or mental health professional) to make the death notification whenever possible.
- Create a plan, with your partner(s), which includes:
  - Who will actually give the initial information.
  - What information will be provided.
  - Where the information will be provided.

## 3. Make the notification in person

- Ask permission to enter residence or workplace.
- Request to speak with immediate survivor(s).
- Identify yourself and your partner(s).
- Move those who are to be notified to a space that offers the greatest privacy possible.
- Verify the relationship of the survivor to the deceased.

## 4. Make the notification in a timely manner

- Avoid delays in notifying the next of kin. Timely notification of death is critical, especially in the era of social media.
- Wherever reasonably possible, avoid using the name of the deceased over the radio prior to notification of immediate surviving relatives.

## 5. Make the notification first to parents or caregivers

## 6. Deliver the notification in plain language

- Be straightforward.
- Avoid euphemisms, graphic detail and police jargon.
- Refer to deceased by first name or by the relationship to the family member(s) receiving the notification.

## 7. Support the parent to notify the children of the death

- Prior to beginning the death notification, it is preferable to confirm what the plan will be for children going forward i.e., where children will stay, with whom they will stay, who will take care of funeral arrangements.

- Encourage the parent to think about what words they want to use to deliver the news.
- Talk with the parent in advance about messages that might not be helpful, for example, telling the child that the person who has died is away on a trip or at work in order to avoid telling the child that there has been a death.
- Offer support to the caregiver if they would like it while they are providing the news, for example, by sitting nearby.

## 8. Help parents and caregivers to make the notification to children, if assistance is needed

- Offer to support parents or caregivers in making the notification.
- If parents or caregivers are unable to make the notification and/or request assistance, officers can make the notification.
- If officers make the notification directly to children, provide basic facts and then offer an opportunity for children to ask questions.

## 9. Deliver the notification with compassion

- Utilize clear, simple language to make the notification.
- Demonstrate compassion and empathy through direct and honest communication.
- Avoid euphemisms for death (e.g., “passed away” or “gone to heaven”) which may inadvertently create confusion.

## 10. Be prepared

- Be prepared for a range of responses and allow ample time for recovery before proceeding.
- Bring a list of community referral agencies that may be helpful to provide to the survivors such as family crisis services.
- Before leaving be sure the child and caregiver have appropriate support. If needed, arrange to bring the family to an identified source or support.
- Be aware of confusion on the part of survivors. Your speech should be slow and deliberate. Any information the survivor needs should be written down, as well as stated. This includes the following:
  - disposition of the body.
  - location of personal effects.
  - identification requirement and procedures.
  - notifying officers’ names, agency and telephone numbers.
- Leave your card and remind them that they can reach you any time.
- If feasible, also plan to follow up with the family within a few days.

This resource is part of the *Enhancing Police Responses to Children Exposed to Violence: A Toolkit for Law Enforcement*. Visit: [www.theIACP.org/Children-Exposed-to-Violence](http://www.theIACP.org/Children-Exposed-to-Violence)

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WINTER 2015



## SPECIAL FEATURE

**12** The officer's role in responding to traumatized children



# THE OFFICER'S ROLE IN RESPONDING TO TRAUMATIZED CHILDREN

**After you get who you came for,  
don't forget who you leave behind**

By Ryan Butler and Sarah M. Greene

Photos courtesy of  
Stacey Butler



**E**mpirical and anecdotal evidence continue to demonstrate the powerful impact law enforcement officers have when interacting with children during the course of their work. This is clearly demonstrated through the implementation over the past 20 years of various forms of community policing, neighborhood-based officers, school resource officers and police-sponsored outreach programs. But where does the role of the tactical officer fit within this current push to connect law enforcement officers and children?

Tactical officers fill a variety of roles based on their agency structure and mission, ranging from multi-agency SWAT teams, narcotics or high-risk warrant service squads and street crime interdiction units. With the variety of formats and responsibilities of these units, what should the individual officer or his supervisors expect of tactical operators when responding to situations involving children? The basis of understanding for any officer in regards to responding to children lies in some level of initial training related to the normal development of children from birth through at least adolescence. It is important for officers and deputies to understand healthy developmental progression at various ages so that they are then able to recognize situations in which a child is exhibiting symptoms of current or previous trauma.

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Tactical units, by their very nature, engage in dynamic activities that are detailed, thoroughly pre-planned and involve extensive training prior to their execution. Just as a pre-raid briefing will review the expected layout of the target location, suspects and weapons intelligence indicates may be present, it will also review other household members likely present, including children. The knowledge of children present is not just a tactical consideration from a safety standpoint, but provides a very serious issue for the case officer or

tactical officers involved in the operation to consider. Is the child's presence at this location an ongoing safety issue? How will children be addressed while the target location and suspects are being secured and searched?

Just as a tactical team ensures it has the appropriate breaching equipment, they also must plan for after the scene is secured and how they will address children they encounter. The age of the children present certainly plays a factor in how an officer may tailor his response; however, of greater importance during the operational planning is the officer's cognizance of the fact that a dynamic entry of a child's home, the arrest of a parent or family member or the mere presence of several armed law enforcement officers can be a lot for a child to process mentally and physically due to the potential release of stress hormones.

## **INTERACTING WITH CHILDREN ON SCENE**

After the location has been cleared and secured, consider moving the child away from adults being questioned, perhaps to a play area or the child's bedroom where they may feel more comfortable. Removing obscuring garments such as a balaclava or ballistic helmet can humanize the interaction between the child and the officer, of course always deferring to the individual policies and SOPs of your agency. With older children, being able to make a simple statement about why the police need to be there, such as "in order to interrupt illegal activity," can be important. Officers might comment on the fact that there were loud noises and now they are over.

Ask the child generic questions about toys present or items he or she appears interested in, such as sports

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teams, video games or other apparent hobbies. This not only refocuses the child from the stress he or she may be feeling from the recent incident, but also aids in restabilizing, both psychologically and physiologically, from an acute stress response. Infants, toddlers and preschoolers require special attention due to their inability to protect themselves or meet their own basic needs.

Children under the age of five often need immediate attention to physical needs, like diaper changes, food or protection from an unsafe environment. School age or adolescent children may be resistant to attempts at communication or rapport-building because of a need to act older or not seem “child-like.”

If operational security allows, you may choose to utilize a primary caregiver or family member who is present to provide care for these younger children. If a primary caregiver is not present, or due to security limitations cannot be allowed to provide care, one of the officers should be designated to ensure the child’s needs are met.

Afford older children or teenagers an opportunity to speak to you or ask questions. Be frank with them to establish mutual respect while using age-appropriate language during your interaction. If your agency’s SOP precludes a tactical officer fulfilling this role, you may need to request assistance from patrol or a youth detective.

Many officers, particularly those without children, feel uncomfortable or marginalized when tasked with “babysitting” a child on scene. This task should not be viewed in a pejorative sense, but rather as an extension of the law enforcement mission of public safety and ensuring that the child sees that the purpose of the officers’ presence is to ensure a safe and stable environment.

Officers can work within their own comfort level around children on scene, whether that involves playing with trucks on the floor or simply asking the children about a picture they drew or

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**Law enforcement officers have a tendency over their careers to become desensitized to the effect that their professional presence can have on people they interact with, particularly children.**

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their favorite football team. Law enforcement officers have a tendency over their careers to become desensitized to the effect that their professional presence can have on people they interact with, particularly children. For many children and adolescents, though the latter may not admit it to their peers, a law enforcement officer still evokes an image of a real-life superhero. This image can be used to the officer’s benefit while trying to calm a child during or following a tactical operation.

Officers can conduct a safety check of the child’s room, closet and under the bed. An officer can take a few moments to reassure the child that he is there to keep the child safe and will return if something scary happens again.

If the child has a school resource officer, contact that officer and explain the recent incident in which you encountered the child. This provides continued reassurance to the child and demonstrates that law enforcement has an overall concern for the child’s welfare. School provides a stabilizing environment for a child and utilizing the school resource officer as a regular partner in your agency’s response to children exposed to violence is a force multiplier.

Tactical response situations also provide an excellent opportunity for

an officer to identify children who are exhibiting signs of current traumatic distress or perhaps behavior that suggests an extensive trauma history. In both situations, children who do not appear to react or acknowledge the presence of law enforcement during the initial phase of a tactical action are providing a very strong cue to the officer that they are in fact having traumatic reactions. A lack of crying, screaming, visually expressed fear or apprehension does not mean the child is unaffected, but rather has been so affected that the baseline for emotional response has been severely altered by overexposure to negative stimuli.

### **RESOURCES**

While the role of officers in identification and initial response to these children is critical, addressing their behaviors or clinical, emotional and mental health needs is beyond the capacity of a law enforcement officer’s training. This is, however, the opportunity for the officer to utilize additional resources to assist with the resolution for the incident scene that includes the best interest of the affected children.

Just as an officer may request a crime scene unit for evidence processing, or

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**A lack of crying, screaming, visually expressed fear or apprehension does not mean the child is unaffected, but rather has been so affected that the baseline for emotional response has been severely altered by overexposure to negative stimuli.**

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K9 or aviation units for search and tracking support, there is a need for an officer to have support to deal with children exposed to violence that they encounter while on duty. Depending on your local municipality, state or tribe, there may be previously identified resources such as child protective services, social service agencies or non-profit groups who provide clinical support to children. Identifying these resources prior to the officer needing them while on a scene is critical to law enforcement personnel being able to effectively address the child's needs.

The efficacy of these programs and professional relationships can be enhanced through cross-training of the involved personnel and encouraging ride-alongs by the clinical providers so they are afforded an opportunity to establish a greater understanding of the situations in which officers and deputies are encountering children in their work. Taking the time to identify and develop a professional partner (optimally one who specializes in providing trauma-informed mental health responses) can have immediate on-scene benefits to the officers as well as the children.

If the intelligence briefing for your tactical operation indicates the presence of children, consider contacting one of these providers and have them staged nearby with a patrol officer or at a team office or substation so they are not too far removed from the incident location as to impede a prompt response. A professional provider may be better able to determine if the information being provided by the child is more likely to lack veracity because of the child's developmental stage, which could be of use to the investigation.

At a minimum, the presence of the professional partner allows additional officers to be available for assignment to other on-scene tasks. Having one

## Responding to Children Exposed to Violence

The International Association of Chiefs of Police (IACP), in partnership with the Yale Child Study Center (YCSC), supported by the U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, has a new toolkit for law enforcement on how to identify and respond to Children Exposed to Violence (CEV). The impact that law enforcement officers can have when interacting with children during the course of their work has been most powerfully demonstrated by the Child Development-Community Policing (CD-CP) program begun in New Haven between the YCSC and the New Haven Department of Police Services and replicated in Charlotte-Mecklenburg, North Carolina, and numerous communities across the country. The toolkit grows out of more than two decades of innovative law enforcement-mental health collaboration with the CD-CP program at the core, and benefits from IACP's deep experience in creating tools needed by the field. Tools include:

- Agency Self-Assessment and Action Planning Tool
- Classroom Training Program for Frontline Officers
- Factsheets and Tipsheets
- Model Protocols for Acute On-Scene Response and Domestic Violence Incidents
- Cross-Platform Mobile App (Pocket Guide)
- Online Training Series
- Model Policy on Safeguarding Children of Arrested Parents
- Library of CEV resources for law enforcement at [IACPYouth.org](http://IACPYouth.org)
- Roll Call Training Video

These resources were also developed in collaboration with the New Haven (CT) Department of Police Service, Charlotte-Mecklenburg (NC) Police Department and Mecklenburg County (NC) Trauma & Justice Partnerships.

To obtain resources or for more information, contact [CEV@theiacp.org](mailto:CEV@theiacp.org)

of the officers present to initiate the clinical response for the children on scene at a traumatic event enhances the safety of the scene and establishes a connection between the child and the officer. This not only provides an immediate psychological and physio-

logical benefit to the child, but does truly establish a greater understanding of law enforcement and the officer's overall mission in that house, apartment complex or community.

## TRAINING

As with any program or strategy, the key to successful and consistent implementation is the demonstrated support of the command or executive staff of the individual law enforcement agency. Commanders must ensure that all of their officers are exposed to training which focuses on their response to children encountered during their tour, as well as establishes a set of expectations for the officers. We all place emphasis on and devote resources to the things that are most requested of us and that our command places in priority.

Leadership must continue to encourage officers to take an active role in identifying and addressing children present during traumatic events. Contact your local community college, social service provider, professional law enforcement association or even the hospital. They may be able to provide direct training to your officers or refer your agency to curriculum which can be delivered by your agency's training staff.

Seek a resource in your community who may be able to present basic information regarding childhood development which can aid an officer in identifying when a child is in need of additional clinical or medical resources. (See insets.)

Officers should not be expected to be clinical service providers, but they are a very powerful part of addressing something in need of stability, support and safety: the life of a child. ■

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**Commanders must ensure that all of their officers are exposed to training which focuses on their response to children encountered during their tour, as well as establishes a set of expectations for the officers.**

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## Top 5 Considerations for Tactical Officers When Responding to Children Exposed to Violence

1. Check for signs of children's presence when planning operations.
2. Avoid making an arrest in a child's presence, if at all possible.
3. Consider moving the child away from adults being questioned.
4. Acknowledge that something upsetting happened when talking to children and avoid saying, "Everything is going to be OK."
5. Reassure the children that you are there to keep them safe and can return if something scary happens.

Source: IACP/Yale/DOJ Children Exposed to Violence Initiative

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# A Practical Guide for Creating Safe and Supportive Environments in Teen Pregnancy Prevention Programs



## Overview

Ensuring that adolescents feel safe and supported is key to creating a teen pregnancy prevention (TPP) program culture that enhances self-esteem, self-confidence, and autonomy in order to equip youth with the skills and knowledge they need to make healthy decisions. This practical guide provides research-based tips to help TPP programs create safe and supportive environments for the youth they serve.

As you work to ensure that your TPP program is successfully creating a safe and supportive environment for all youth, keep the following points in mind:



1. Youth often feel uncomfortable talking about relationships and sexual health. Safe and supportive environments help build the **trust, self-confidence, and self-esteem** that all youth, especially those that have experienced trauma, need to discuss sensitive topics.
2. Ensuring **physical and emotional safety** creates a safe and supportive environment for all participants.
3. It is estimated that sixty-four percent of individuals in the U.S. have experienced at least one *adverse childhood experience* (ACE).<sup>1</sup> Because youth don't always talk about difficult or traumatic experiences, it is critical for TPP program staff to **foster a safe and supportive environment for ALL youth**.
4. Several **resources are available** to help organizations create safe and supportive environments, particularly for those at highest risk for poor sexual health outcomes.

## Definitions

- **Physical safety:** an experience in which one is free from physical harm or threat.
- **Emotional safety:** an experience in which one is free from bullying, harassment and humiliation and is able to express emotions, feel confident to take risks, and supported in trying something new.

Adapted from: Osher, D., Sprague, J., Weissberg, R. P., Axelrod, J., Keenan, S., Kendziora, K., & Zins, J. E. (2008). A comprehensive approach to promoting social, emotional, and academic growth in contemporary schools. *Best practices in school psychology*, 4, 1263-1278.; The National Center for Safe and Supportive Learning Environments. <http://safesupportivelearning.ed.gov/topic-research/safety/emotional-safety>

## Safety is Essential

Creating and maintaining physical and emotional safety is a primary factor for optimal adolescent development and a best practice for all youth-serving programs.<sup>2</sup> Physical and emotional safety are critical factors in violence prevention and trauma recovery<sup>3</sup> as well as teen pregnancy prevention<sup>4</sup>. A positive climate that is based on norms, values, and expectations that help students feel emotionally and physically safe increases young peoples' motivation to learn, reduces aggression, lowers substance use, and improves mental health.<sup>5</sup>

Ensuring a safe and supportive environment for all youth is essential when working to increase knowledge and skills needed to prevent teen pregnancy and make healthy decisions. In fact, because TPP programs often address sensitive topics, emotional and physical safety are particularly critical. Additionally, for youth who have experienced trauma, safety and support are vital in minimizing the negative effects of trauma and maximizing protective factors and resilience.<sup>6</sup>

## Guiding Principles for Safe and Supportive Environments

Creating and maintaining a safe and supportive environment is a process with several interrelated components:

- Organizational policies and practices
- Staff practices
- Youth and community partners

While all three components are important, organizational policies and practices are the foundation that support staff practices and facilitate vital partnerships with youth and community partners.

*More than anything else, being able to feel safe with other people defines mental health: safe connections are fundamental to meaningful and satisfying lives.*

*-Bessel van der Kolk*

### Organizational Policies and Practices

To ensure that TPP programs adhere to guiding principles for safe and supportive environments, it is important to have clear policies that are consistently monitored and enforced. While individual staff attitudes and skills are important, organizational policies and practices are the foundation for supporting those skills and promoting safe and supportive environments throughout all programming for youth. It is essential to educate staff and youth about policies and explain how they are implemented. Below is a list of policies and organizational practices to consider. You will find a list of resources at the end of this guide to help develop or strengthen your organization in each of these areas.

- **Anti-discrimination:** Anti-discrimination policies protect program participants and staff from discrimination based on age, disability, sex, race, color, national origin, religion, sexual orientation or gender identity. Organizations should periodically update their anti-discrimination policy and ensure that all staff and program participants are aware of the policy.
- **Anti-bullying and harassment:** Anti-bullying and harassment policies explicitly address the emotional and physical safety of program participants and staff. Staff and participants should be aware of the procedures for filing a complaint. Links to state regulations and a sample policy are included in the Resources section.

- **Physical safety:** It is important to ensure that youth are free from physical harm or threat. Assessing physical safety includes youth interactions with staff and peers in your program as well as how safe youth feel getting to your program space. School climate surveys and community mapping techniques can be adapted to help organizations establish a periodic assessment protocol to set priorities and track progress.
- **Professional development & training:** Professional development policies should include requirements for periodic training on trauma, implicit bias, working with at-risk youth (e.g., LGBTQ, homeless, foster care, juvenile justice, etc.), positive youth development, and self-care to optimize staff wellness, job performance, and role modeling. Policies should also address supervision and accountability to ensure staff receive ongoing support and feedback.
- **Program self-assessment:** Program self-assessments are an important part of monitoring policies and procedures in order to identify areas for improvement and document compliance.
- **Supportive partnerships:** Policies for developing partnerships should include protocols for assessing whether potential partner organizations provide safe and supportive environments for all youth. Consider asking youth who have been referred to partner organizations about their experiences as a part of your protocols. Make sure your policy is flexible enough to include a variety of potential partners who can help meet the physical and emotional safety needs of youth, such as: juvenile justice, education, health, and mental health organizations.

### **Staff Practices**

Creating safe and supportive environments basically comes down to how TPP program staff interact with youth. Consider the following guiding principles for all interactions with youth: **care, nurture and respect**. On the next two pages there are questions intended to help TPP staff internalize these principles and provide concrete examples of how to most effectively work with youth. The principles are adapted from core components of Positive Youth Development<sup>7</sup> and Trauma-Informed Care<sup>8</sup>. They reflect several key elements of youth-focused, evidence-based programs, including being goal-directed, providing a structured approach, using techniques that involve repetitive practice with feedback, and problem solving.<sup>9</sup>



## **CARE: Show genuine concern for all youth.**

- **Instill hope and expectation for a positive future:** Do I explicitly express belief in all youth's abilities to effect positive change in their lives? *Look for opportunities to acknowledge when youth make a positive change, no matter how small the change.*
- **Non-judgmental interaction:** Are my interactions with all youth warm, empathic, and genuine? *Be aware of the tone of your voice and body language. When engaged in conversations, use active listening skills so youth feel both heard and valued.*<sup>10</sup>
- **Confidentiality:** Do I explain and reinforce the limits of confidentiality using clear and simple language, stressing my role in keeping all youth safe? *Explain the legal requirements for reporting risk of harm to self or others at the beginning of the program. If youth ask for assurance that you won't tell anyone before disclosing something, reassure them that you will listen and support them while also reminding them about the limits of confidentiality.*
- **Acknowledge limitations:** Am I always clear and honest about my limits in providing physical and emotional safety? *Just like confidentiality, it is important to explain limitations in creating and maintaining safe environments. Don't make promises you can't keep, like saying that bullying won't happen. Focus on what you can promise, such as consistently enforcing respectful behavior.*

## **NURTURE: Create opportunities for all youth to learn new skills and gain confidence.**

- **Affect regulation:** Do I teach, model, and reinforce healthy ways for youth to manage stress and express emotions without causing harm to self or others? *Explicitly encourage their efforts when you notice youth using healthy coping strategies to manage stress and express emotions.*
- **Positive youth development:** Do I elicit the strengths and resources of all youth in my program? *Create frequent opportunities to get to know the strengths and interests of youth through one-on-one conversations and group activities.*
- **Develop competency:** Do I provide all youth with opportunities to try out new skills and challenge themselves in a supportive environment? *Facilitate activities that give youth opportunities to discover new skills and increase knowledge such as practicing social skills and effective sexual communication.*<sup>11</sup>
- **Encouragement:** Do I encourage youth to accept mistakes as a learning experience and react with flexibility to support them? *Explicitly inform youth that you view mistakes as a normal part of learning and respond with flexibility that allows them to correct any mistakes.*<sup>12</sup>

## **RESPECT: Recognize the dignity and worth of all youth.**

- **Respectful communication:** Do I clearly acknowledge each youth's right to make his or her own choices? *Let youth know in advance when you will be discussing potentially sensitive topics and clearly let them know that they do not have to participate in discussions that make them uncomfortable.*
- **Advertise acceptance:** Are there visible signs that this program is a place where diversity is respected and valued? *Display images that reflect the diversity of youth impacted by teen pregnancy.*
- **Respect Identity:** Do I always use words that respect diverse racial, ethnic, gender, and sexual orientation identities? *Use diverse examples so all youth feel represented. Learn and use youth's chosen names and preferred pronouns with regards to gender identity.*
- **First do no harm:** Do I avoid words or behavior that could traumatize or stigmatize anyone? *When youth are being disruptive, avoid confronting or embarrassing them as such behavior could escalate a situation and re-traumatize a youth who has experienced trauma.*

### **Youth and Community Partners**

When working to create a safe and supportive environment for youth, it is critical to engage with youth as well as community partners. Not only can these stakeholders provide valuable information that can be used to assess how well you are doing, but they can also serve as invaluable partners as you identify opportunities for improvement. Make sure to engage with youth and community partners on an on-going basis.

- **Youth engagement:** Programs should consider creating formal and informal opportunities – such as focus groups and surveys – for youth to provide input. Youth Leadership Councils can serve as valuable partners in assessing, planning, and implementing efforts to foster a safe and supportive environment for all youth. Links to several school climate surveys that can be adapted for TPP programs as well as guidance on how to actively engage youth are located in the Resources section.
- **Community partners and stakeholders:** Community Advisory Groups can also serve as valuable partners in assessing, planning, and implementing efforts to foster a safe and supportive environment for all youth. Community partners can play a critical role in identifying potential strategies to promote safe and supportive environments for youth and the local resources to support those strategies. Community stakeholders can be particularly helpful if community concerns, such as violence, have been identified as a physical safety concern for youth in your program.



### **Summary**

Physical and emotional safety are the foundation for effective programs for teen pregnancy prevention. Creating a safe and supportive environment within TPP programs can help youth learn they can take risks, speak truthfully about difficult experiences, and learn skills that will empower them to achieve their goals and make healthy choices related to their sexual and reproductive health.

## Resources

**Disclaimer:** This is a list of some, but not all, of the relevant resources available to support organizations in providing safe and supportive environments for ALL youth. OAH does not endorse any of the resources listed other than those developed by OAH.

### Anti-discrimination, Anti-bullying, and Anti-harassment

- **Website:** Multiple resources on anti-bullying (OAH). <http://www.hhs.gov/ash/oah/resources-and-publications/publications/healthy-relationships.html#Bullying and School Climate>
- **Website:** Laws, regulations, guidance, & MOUs related to discrimination and harassment in the workplace (U.S. Equal Employment Opportunity Commission). <http://www.eeoc.gov/laws/types/index.cfm>
- **Policy brief:** *Providing a Safe, Nondiscriminatory School Environment for Transgender and Gender-Nonconforming Students* (California School Boards Association). [https://www.csba.org/GovernanceAndPolicyResources/DistrictPolicyServices/~media/CSBA/Files/GovernanceResources/PolicyNews\\_Briefs/Transgender/201402\\_PBNonDiscriminationGender.ashx](https://www.csba.org/GovernanceAndPolicyResources/DistrictPolicyServices/~media/CSBA/Files/GovernanceResources/PolicyNews_Briefs/Transgender/201402_PBNonDiscriminationGender.ashx)
- **Database:** HHS Resource Center on Bullying with links to state anti-bullying laws and regulations (Stopbullying.gov). <http://www.stopbullying.gov/laws/index.html>
- **Sample policy:** *Sample Anti-Bullying Policy* (American Bar Association). [http://www.americanbar.org/content/dam/aba/events/labor\\_law/2012/03/national\\_conference\\_on\\_equal\\_employment\\_opportunity\\_law/mw2012eeo\\_eisenberg2.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/events/labor_law/2012/03/national_conference_on_equal_employment_opportunity_law/mw2012eeo_eisenberg2.authcheckdam.pdf)

### Professional Development

- **Tip sheet:** *Five Things to Know About Staffing Teen Pregnancy Prevention Programs* (OAH). [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/Assests/staffretention-tipsheet.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/Assests/staffretention-tipsheet.pdf)
- **On-line course:** *Creating a Safe Space for LGBTQ Teens* (Family and Youth Services Bureau). <http://ncfy-learn.jbsinternational.com/course/index.php?categoryid=12>
- **Toolkit:** *Creating Safe Spaces for GLBT Youth* (Gay, Lesbian, & Straight Education Network). <http://www.glsen.org/safespace>
- **Guide:** *Linking the Roads: Working with Youth Who Experience Homelessness & Sexual Violence* (National Sexual Violence Resource Center). [http://www.nsvrc.org/sites/default/files/publications\\_nsvrc-publications-guides-linking-roads-working-youth-who-experience-homelessness.pdf](http://www.nsvrc.org/sites/default/files/publications_nsvrc-publications-guides-linking-roads-working-youth-who-experience-homelessness.pdf)

### Physical Safety

- **Assessments:** *A compendium of valid and reliable measures of school climate* (National Center on Safe Supportive Learning Environments). <http://safesupportivelearning.ed.gov/topic-research/school-climate-measurement/school-climate-survey-compendium>
- **Website:** *Multiple resources and training to prevent youth violence* (Centers for Disease Control and Prevention). <http://vetoviolence.cdc.gov/apps/stryve/home.html>
- **Website:** *Multiple resources on youth safety including digital and internet safety* (National Organizations for Youth Safety). <https://noys.org/>

## Resources (continued)

### Program Self-assessment

- **Checklist:** *A Checklist for Putting Positive Youth Development Characteristics into Action in Teen Pregnancy Prevention Programs* (OAH). [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/Assests/pyd-tpp-checklist.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/Assests/pyd-tpp-checklist.pdf)
- **Checklist:** *A Checklist for Integrating a Trauma-Informed Approach into Teen Pregnancy Prevention Programs* (OAH). [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/Assests/traumainformed-checklist.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/Assests/traumainformed-checklist.pdf)
- **Assessment:** *Trauma-Informed Agency Assessment* (Thrive Initiative). <http://thriveinitiative.org/trauma-informed/trauma-informed-agency-assessment/>
- **Toolkit:** *Creating Safe Space for GLBTQ Youth: A Toolkit* (Advocates for Youth) <http://www.advocatesforyouth.org/storage/advfy/documents/safespace.pdf>

### Youth and Community Engagement

- **Tip sheet:** *Referrals and Linkages to Youth-Friendly Health Care Services* (OAH). [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/Assests/referrals\\_and\\_linkages\\_to\\_youth\\_friendly\\_health\\_care.pdf](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/Assests/referrals_and_linkages_to_youth_friendly_health_care.pdf)
- **Website:** *Multiple resources on engaging youth* (OAH). [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/engagement.html#EngagingYouth](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/engagement.html#EngagingYouth)
- **Website:** *Multiple resources on engaging with partner organizations* (OAH). [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/building-collaborations.html#community](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/building-collaborations.html#community)
- **Toolkit:** *Guidance on how to implement photovoice – a strategy for assessing community safety* (Community Tool Box). <http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/photovoice/main>

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# A Checklist for Integrating a Trauma-Informed Approach into Teen Pregnancy Prevention Programs



## What is a Trauma-Informed Approach?

Trauma refers to experiences that cause intense physical and psychological stress reactions. It can refer to “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.”<sup>1</sup>

SAMSHA defines “a program, organization, or system that is trauma-informed as one that: 1) *Realizes* the widespread impact of trauma and understands potential paths for recovery; 2) *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3) *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and 4) *Seeks* to actively resist *re-traumatization*.”<sup>2</sup>

For resources on incorporating Trauma-Informed Approaches into your program, please visit: [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/cultural-competence.html#Trauma-Informed-Care](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/cultural-competence.html#Trauma-Informed-Care)

References:

1. <http://media.samhsa.gov/traumajustice/traumadefinition/definition.aspx>
2. <http://www.samhsa.gov/nctic/trauma-interventions>

## Introduction to a Trauma-Informed Approach

While a teen pregnancy prevention (TPP) program generally focuses on providing sexual health education, ensuring access to youth-friendly health care services, and engaging youth, families, and communities, a trauma-informed approach (TIA) is a way of addressing vital information about sexuality and well-being that takes into consideration adverse life experiences and their potential influence on sexual decision making. A trauma-informed approach to sexual health is critical to promoting lifelong sexual health and well-being for anyone who has had adverse childhood and/or adult experiences. Principles of a trauma-informed approach can be integrated into any TPP program.

Before conducting this checklist, review the two-part series on Trauma-Informed Care: Tips for Teen Pregnancy Prevention Programs [Part 1](#) and [Part 2](#). Part 1 provides the rationale for TPP programs to build their capacity to address youth's exposure to violence and Part 2 recommends seven strategies to make programs trauma-informed.

This checklist can help you identify where your TPP program is already utilizing a trauma-informed approach as well as determine additional opportunities for integrating a trauma-informed approach into your program.

## How to use this checklist

Use this checklist to find out where your TPP program is already integrating principles of a trauma-informed approach and where you can improve your use of a trauma-informed approach.

For each of the three levels of integration there are several items, each of which can be answered with “Describes us well,” “Almost there,” “We’re just getting started,” or “Does not describe us.”

It is helpful to have several program staff members review the checklist individually, compare and discuss the results, and brainstorm strategies for improvement. If you notice that most of your areas for improvement are centered in one of the three levels, check out the resources we have for those specific areas. If your areas for improvement are spread across the checklist, consider reviewing some of the general materials on trauma-informed approaches to support your plan for making these important changes. If items on the checklist are beyond the scope of your program, consider referring teens to community partners for those services (for example: mental health referrals), as needed.

Please note that some of the checklist items are similar to the key principles of the [Positive Youth Development checklist](#), as integrating a Trauma-Informed Approach requires many of the same underlying components to making all youth feel comfortable and valued.

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# 1

## Integrating a TIA at the organizational level

These items assess the degree to which your organization provides empirically-based health promoting policies and practices that promote self-regulation and enhance physical and emotional safety for everyone involved in the TPP program.

TIA characteristics	Describes us well	Almost there	Just getting started	Does not describe us
Our organization has a steering committee (or leverages existing advisory groups) with representation from administration, program facilitators, and youth to assess needs and develop an action plan and a timeline for implementing an integrated TIA to TPP.				
Our organization has a process in place for making referrals and maintains a referral directory of trauma-informed agencies, providers, and services and updates them on an annual basis. This includes local, licensed mental health service providers who have documented specialized training in a TIA.				
Our organization has partnerships with community agencies that adhere to SAMHSA’s six key principles of a Trauma-Informed Approach: 1) Safety; 2) Trustworthiness and Transparency; 3) Peer support; 4) Collaboration and mutuality; 5) Empowerment, voice and choice and; 6) Cultural, Historical, and Gender Issues. <a href="http://www.samhsa.gov/nctic/trauma-interventions">http://www.samhsa.gov/nctic/trauma-interventions</a> . (You may want to use this checklist when thinking about your partners or share it with other agencies.)				
Our organization operates and makes decisions with transparency by documenting the values and rationale behind each decision.				
Our organization sets clear policies and informs adolescents of the program’s legal requirements such as limits of confidentiality.				
Our organization reviews all policies and procedures, such as program emergencies, crisis situations, and reporting child abuse and neglect on an annual basis, and shares policies and procedures with all staff.				

TIA characteristics	Describes us well	Almost there	Just getting started	Does not describe us
Our organization has a plan to best build internal capacity to provide a TIA to TPP which includes training and technical assistance as part of staff professional development.				
Our organization ensures evidence-based and empirically-informed resources regarding the role and impact of trauma, such as developmentally congruent education materials, workbooks, and therapy models, are easily accessible for both staff and program participants.				

Notes:

# 2

## Integrating a TIA at the program level

These items assess the degree to which the TPP program utilizes trauma-informed practices and materials to enhance understanding, learning, memory retention, and well-being throughout all program activities. Such practices promote skill building, competency development, and behavior change.

*Please note that any adaptation to evidence-based teen pregnancy prevention (TPP) programs should be discussed and reviewed with OAH as it may require OAH approval.*

TIA characteristics	Describes us well	Almost there	Just getting started	Does not describe us
Staff members recognize that adverse childhood experiences influence a youth’s participation in program activities.				
All TPP programs are facilitated in an environment that is comfortable, accommodating, and considerate for everyone involved – youth, families, and staff.				
Staff members continuously attempt to engage and stay in touch with participants and their families.				
Staff members provide warm, non-judgmental, empathic, and genuine interactions at all times with participants and their families. (This component is also a key for staff training.)				
Staff members provide explanations for all rules and requests.				
During the introduction to our program, our TPP facilitators read a short statement that reflects a trauma-sensitive approach. For example: “Sex and sexuality can be very sensitive topics, and can sometimes be tough to talk about. Not everyone has had positive sexual experiences, and some young people have a difficult time, especially when you have experienced bad things in the past. The purpose of this program is to learn how to take good care of yourself sexually. If at any time you are feeling uncomfortable or having trouble participating, please let us know.”				

TIA characteristics	Describes us well	Almost there	Just getting started	Does not describe us
In our TPP program, adolescents help create “group agreements” that provide the foundation of physical and emotional safety for all program activities.				
As part of an introductory packet, all TPP program participants are given information on trauma-informed community resources as well as our organization’s policy on confidentiality and mandatory reporting.				
Staff are trained and able to adapt trauma-informed information into curricula so that fidelity to the model is not compromised. Fidelity is assessed at regular intervals.				
Program implementation is monitored for continuous quality improvement in terms of applying the TIA principles.				

Notes:

# 3

## Integrating a TIA at the staff level

These items assess the staff's capacity to fully engage with program participants who have had adverse childhood experiences.

TIA characteristics	Describes us well	Almost there	Just getting started	Does not describe us
Staff are initially trained on a trauma-informed approach and how to apply trauma-informed principles in every interaction with youth. Additionally, all staff participate in professional development or continuing education specifically related to using a TIA on an annual basis.				
Staff members carry out trauma-sensitive interactions that take trauma-related histories, symptoms, and behavior into consideration.				
Participants report that our TPP staff members are trustworthy and reliable in all interactions with participants.				
Staff model positive, non-shaming communication that supports healing for those in need and promotes health and well-being for everyone.				
Staff support healing for those in need through referrals to designated licensed mental health professionals and verified by our organization to be trauma-informed.				
Staff members continuously model and promote healthy relationships.				
Staff promote assertive communication and negotiation with sexual partners to establish and maintain healthy relationships.				
Staff listen patiently without interruption, provide information and answers in a pleasant manner, and ensure all participants have opportunities to speak and be heard.				

TIA characteristics	Describes us well	Almost there	Just getting started	Does not describe us
Staff provide an introductory statement defining and explaining trauma cues and the potential for curricula topics to bring up adverse childhood experiences.				
Staff are trained and able to provide warm, non-judgmental, empathic, and genuine interactions at all times, including ongoing training on connecting with youth while maintaining healthy professional boundaries.				
Supervision addresses quality and maintenance of trauma-informed practice, respectfully addresses all staff questions and trauma-related concerns, and provides ongoing staff support.				

Notes:

*Disclaimer: This is a list of some, but not all, of the relevant resources available to support organizations in integrating a trauma-informed approach (TIA). OAH does not endorse any of the resources listed other than those developed by OAH.*

## General resources on a trauma-informed approach

- Trauma-informed care section of the OAH TPP Resource Center. *Presentations, tool kits, podcasts, fact sheets, and webinars.* OAH. [http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/training/cultural-competence.html#Trauma-Informed\\_Care](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/cultural-competence.html#Trauma-Informed_Care)
- Trauma and Violence. *Webpage.* SAMHSA. <http://www.samhsa.gov/trauma-violence>
- Website dedicated to raising the standard of care and improving access to services for traumatized children, their families and communities throughout the United States. *Resource center.* National Child Traumatic Stress Network (NCTSN). <http://nctsn.org/>
  - Child Trauma Toolkit for Educators. *Toolkit.* National Child Traumatic Stress Network (NCTSN). [http://www.nctsn.org/nctsn\\_assets/pdfs/Child\\_Trauma\\_Toolkit\\_Final.pdf](http://www.nctsn.org/nctsn_assets/pdfs/Child_Trauma_Toolkit_Final.pdf)
  - Child Welfare Trauma Training Toolkit: Supplemental Handouts. Questions for Mental Health Providers. *Toolkit.* National Child Traumatic Stress Network (NCTSN). <http://www.dcjs.virginia.gov/trainingevents/juvenile/casa/QuestionstoAskMHProviders.pdf>
  - Training Resources. *Website.* National Child Traumatic Stress Network (NCTSN). <http://learn.nctsn.org/>
- Trauma-Informed Care. *Website.* National Clearing House on Families and Youth. <http://ncfy.acf.hhs.gov/topics/trauma-informed-care>
- Trauma-Informed Care Tips for Pregnancy Prevention Programs. *Tip sheet.* The Office of Juvenile Justice and Delinquency Prevention (OJJDP). [http://ojjdp.gov/programs/safestart/TipSheetFor\\_Pregnancy.pdf](http://ojjdp.gov/programs/safestart/TipSheetFor_Pregnancy.pdf)
- A Trauma-Informed Approach for Adolescent Sexual Health. *Guidebook.* Resources for Resolving Violence. <http://resourcesforresolvingviolence.com/>
- Trauma-informed care practice guide to promote systems that recognizes, understands, and appropriately responds to trauma and its effects on children and their families. *Guide.* State of Connecticut. [http://www.ct.gov/dcf/lib/dcf/trauma-informed\\_care/pdf/trauma-informed\\_care\\_-\\_practice\\_guide\\_september\\_2012.pdf](http://www.ct.gov/dcf/lib/dcf/trauma-informed_care/pdf/trauma-informed_care_-_practice_guide_september_2012.pdf)
- Handling Disclosures of Trauma: Guidelines for Evidence-Based Intervention (EBI) Facilitators. *Tip sheet.* John Snow, Inc. <http://rhey.jisi.com/files/2013/11/Trauma-Disclosure-Guide-Sheet.pdf>
- Youth Services Policy Development Tool. *Toolkit.* Break the Cycle. [http://www.breakthecycle.org/sites/default/files/youth\\_services\\_policy\\_development\\_tool\\_2.pdf](http://www.breakthecycle.org/sites/default/files/youth_services_policy_development_tool_2.pdf)
- Responding to Community Violence and Trauma. *Toolkit.* County of San Diego. <http://sandiego.camhsa.org/files/Impact-Trauma-Toolkit-4.12.pdf>

## Resources related to working with specific youth populations

- Video to help professionals learn about the impact of trauma on LGBTQ youth. *Video. National Child Traumatic Stress Network (NCTSN).* <http://www.nctsn.org/products/nctsn-safe-places-video>
- Trauma-Informed Organizational Toolkit for Homeless Services. *Toolkit. National Center on Family Homelessness.* <http://www.familyhomelessness.org/media/90.pdf>
- Integrating Trauma Informed Approaches in Runaway and Homeless Youth Program. *Tip sheet and Resources. FYSB.* <http://www.acf.hhs.gov/sites/default/files/fysb/trauma20120829.pdf>
- Trauma-informed services for pregnant and parenting survivors. *Toolkit. Pregnant Survivors* <http://pregnantsurvivors.org/>

## Resources related to interpersonal/domestic violence and sexual assault

- Three-Part Series on Trauma-Informed Domestic Violence Services. *Special collections report. FYSB.* <http://www.acf.hhs.gov/programs/fysb/news/trauma-informed-dv-services-20140807>
- Guidelines for assessing and responding to domestic violence in child health settings. *Guide. Futures without Violence.* <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/pediatric.pdf>
- Tipsheet series on creating trauma-informed services at domestic violence programs. *Tip sheets. National Center on Domestic Violence, Trauma & Mental Health.* <http://www.nationalcenterdvtraumamh.org/publications-products/creating-trauma-informed-services-tipsheet-series-for-advocates/>
- A Guide for Sexual Assault Programs and Their System Partners. *Guide. Washington Coalition of Sexual Assault Programs.* [http://www.wcsap.org/sites/wcsap.huang.radicaldesigns.org/files/uploads/resources\\_publications/special\\_editions/Trauma-Informed-Advocacy.pdf](http://www.wcsap.org/sites/wcsap.huang.radicaldesigns.org/files/uploads/resources_publications/special_editions/Trauma-Informed-Advocacy.pdf)

## Adverse childhood experiences

- The Adverse Childhood Experiences (ACE) Study.
  - *Centers for Disease Control and Prevention.* <http://www.cdc.gov/violenceprevention/acestudy/>
  - *SAMHSA.* <http://captus.samhsa.gov/prevention-practice/targeted-prevention/adverse-childhood-experiences/1>
- The Truth about ACEs. *Infographic. The Robert Wood Johnson Foundation.* [http://www.rwjf.org/en/library/infographics/the-truth-about-aces.html?cid=xsh\\_rwjf\\_pt](http://www.rwjf.org/en/library/infographics/the-truth-about-aces.html?cid=xsh_rwjf_pt)

# TRAUMA CONCEPTS AND RESTORATIVE PRACTICES



**ACEs (Adverse Childhood Experiences) Or Traumatic Event**– An ACE describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.

**ACEs Score** - The ACE score is a measure of cumulative exposure to adverse childhood experiences. Exposure to any single ACE is counted as one point. As the number of ACEs increases, so does the potential for adverse outcomes.

The Centers for Disease Control and Prevention's landmark 1998 study that demonstrated that traumatic childhood experiences are the root cause of many social, emotional and cognitive impairments that lead to an increase in health risk factors, and increased risk of violence or re-victimization, disease, disability and premature mortality.

### Examples of ACEs

<ul style="list-style-type: none"> <li>• Car accident; other accident</li> <li>• Natural disaster</li> <li>• Serious illness lasting for an extended period</li> <li>• Violence in the neighborhood, e.g. witnessing a shooting or harmful experience to another person</li> <li>• Death of someone close</li> <li>• Being bullied at school or in the neighborhood</li> <li>• Serious injury, harm or death you caused to someone else</li> <li>• Sudden, violent death of someone close</li> </ul>	<ul style="list-style-type: none"> <li>• Painful or traumatic medical experience or procedure</li> <li>• Recurrent physical abuse</li> <li>• Recurrent emotional abuse; Any attempt or uncomfortable touching of the body or sexual contact or abuse or witnessing any of these</li> <li>• Any alcohol and/or drug use or abuse by someone in the household that caused a significant problem</li> <li>• Divorce, separation, custody, visitation situation that was difficult</li> </ul>	<ul style="list-style-type: none"> <li>• Any household member who spent time in jail or prison</li> <li>• Someone in the household who was chronically depressed, mentally ill, institutionalized or attempted to commit suicide</li> <li>• Mother treated violently</li> <li>• Victim of racism, severe social deprivation (poverty, hunger, homelessness), homophobia;</li> <li>• Experience as a refugee;</li> <li>• Emotional or physical neglect</li> </ul>
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**Restorative Practices** help to provide safe spaces for storytelling that may identify the presence and source of ACEs.

### Adverse Outcome – Health and social consequences of ACEs.

#### ACEs have been linked to:

<ul style="list-style-type: none"> <li>• Altered brain development and physiology</li> <li>• Impaired academic efforts</li> <li>• Low life potential</li> </ul>	<ul style="list-style-type: none"> <li>• High-risk behaviors (addictions, etc.)</li> <li>• Social challenges and behavioral problems</li> </ul>	<ul style="list-style-type: none"> <li>• Chronic health conditions</li> <li>• Early death</li> </ul>
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# TRAUMA CONCEPTS AND RESTORATIVE PRACTICES



**Protective Factors** - *Biological, developmental, family, community, and system characteristics that mitigate the negative impacts of ACEs for a particular person.*

**Examples**

<ul style="list-style-type: none"> <li>• Close relationships with competent caregivers or other caring adults</li> <li>• Exposure to parental resilience</li> <li>• Caregiver knowledge and application of positive parenting skills</li> <li>• Social connections</li> </ul>	<ul style="list-style-type: none"> <li>• Identifying and cultivating a sense of purpose (faith, culture, identity)</li> <li>• Cultivating Individual developmental competencies (problem solving skills, self-regulation, agency)</li> <li>• Children's social and emotional health</li> </ul>	<ul style="list-style-type: none"> <li>• Socioeconomic advantages and concrete support for parents and families</li> <li>• Communities and social systems that support health and development, and nurture human capital</li> </ul>
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**Relationship to Restorative Practices**

<ul style="list-style-type: none"> <li>• Helps to provide a safe space for storytelling that uncovers ACES, social challenges, behavioral problems and risky behavior</li> <li>• Helps to establish or repair healthy relationships, social connections and emotional health</li> </ul>	<ul style="list-style-type: none"> <li>• Can help to cultivate a sense of purpose</li> <li>• Can help to identify parent and self-resilience</li> <li>• Restorative conversations, can help to develop problem solving skills, self-regulation and agency</li> </ul>	<ul style="list-style-type: none"> <li>• Restorative conversations, affirmations and mindfulness activities can help to develop social and emotional health</li> </ul>

**Resilience** - *is the result of interactions between a person's adverse experiences and his or her protective factors. Resilience is the "bounce back."*

For example: A child who is raised in a verbally abusive and alcoholic home receives positive feedback and support through regular contact with a mentor, and learns to express themselves through circle conversations.

Restorative Practices provide safe spaces for relationship building and social connection, which fosters resilience.

Information on Trauma Adapted from the Centers for Disease Control and Prevention, the Illinois ACEs Response Collaborative and Audrey Stillerman, MD, MPH, Associate Director of Medical Affairs, Medical Director, School Health Centers, Office of Community Engagement and Neighborhood Health Partnerships, Assistant Professor of Clinical Family Medicine, University of Illinois Health Sciences System

# EQUITY CONCEPTS AND THE RESTORATIVE MINDSET



	Definition	Harm Created	Relationship to Restorative Mindset
ASSIMILATION	A process by which outsiders (persons who are considered "others" by virtue of race, cultural heritage, gender, age, religious background, sexual orientation, etc.) are brought into, or made to take on and then live out of, as much as possible, the existing identity of the dominant group.	<ul style="list-style-type: none"> <li>• Persons are devalued</li> <li>• Persons are marginalized</li> <li>• Persons are traumatized by denial of their cultural attributes and identity.</li> </ul>	A restorative mindset recognizes the dynamics of power, which affect persons in the community.
DISCRIMINATION	The denial of justice and fair treatment by individuals and/or institutions including employment, education, housing, banking, healthcare and political rights. Discrimination is an action that can follow prejudiced thinking.	<ul style="list-style-type: none"> <li>• Persons are devalued.</li> <li>• Persons are marginalized</li> <li>• Persons are traumatized by denial of rights</li> <li>• Persons and entire generations set up for failure</li> </ul>	<p>A restorative mindset recognizes the dynamics of power, which affect persons in the community.</p> <p>Restorative practices provide safe space to identify and address issues of inequity.</p>
DIVERSITY	Means different or varied. The population of the United States is made up of people of diverse races, ethnicities, nationalities and cultures.	Persons can be made to feel less than or unwanted by those who do not see the value of diversity	<p>A restorative mindset seeks to identify and address aspects of implicit bias.</p> <p>Restorative Practices provide safe space to identify and address aspects of implicit bias.</p>
DOMINANT CULTURE	Refers to the cultural group with the greatest political power in a given context, e.g. European American, Protestant, and/or male culture in traditional U.S. society.	<p>All who fall outside of this group are adversely affected.</p> <p>Weakens the vitality and strength of the whole society; Permanently deprives groups of their rights .</p>	A restorative mindset recognizes the dynamics of power, which affect persons in the community.
EQUAL VS. EQUITABLE	Providing the same opportunity to persons without the same resources to take advantage of those opportunities makes equal treatment or provision inequitable.	<p>Persons are adversely affected by equal opportunity that is blind to their resources.</p> <p>Example: Equal is every child having a desk. Equitable is every child having a desk that fits their size enough to allow them to sit and work.</p>	<p>A restorative mindset recognizes the dynamics of power, which affect persons in the community.</p> <p>Restorative practices provide safe space to identify and address issues of inequity.</p>

# EQUITY CONCEPTS AND THE RESTORATIVE MINDSET



<p style="writing-mode: vertical-rl; transform: rotate(180deg);">IMPLICIT BIAS</p>	<p>An unconscious or conscious inclination or preference either for or against an individual or group that interferes with impartial judgment.</p>	<p>Bringing or allowing biases to the situation blocks establishing healthy relationships.</p>	<p>A restorative mindset seeks to identify and address aspects of implicit bias.</p> <p>Restorative Practices provide safe space to identify and address aspects of implicit bias.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">INCLUSIVE</p>	<p>Having a posture (attitude or policy) of inclusion of diverse others.</p> <p><b>Caveat:</b> Inclusion, however, does not inherently imply diversity or pluralism and can even be seen to imply the opposite in some instances.</p>	<p><b>Example of Caveat:</b> A school may enroll a prescribed number of and minorities but then expects and requires these persons to take on the pre-existing dominant cultural or ethnic identity. This school may then refer to itself as "inclusive," but it is not pluralistic since a single dominating identity remains, which others are assimilated into. Or to put it another way, the newly "inclusive" school is seeking to be inclusive while ignoring or erasing diversity.</p>	<p>True diversity and multiple perspectives are embraced as valuable to the community.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">MINORITY</p>	<p>A group or subgroup, or a member of such, which has limited access to positions of power and, therefore, little influence upon the larger group, institution, or society.</p> <p>Since women (who are roughly 50 percent of the population) are often, but not always, referred to as a minority group (some use the phrase "minorities and women" to reference those outside the dominating "majority"), and African Americans and Hispanics retain their "minority" status even if they constitute over fifty percent of the population of an area, it is clear that "minority" is not determined numerically.</p>	<p>Designation promotes inequity; denies the humanness of groups; denies the notion that all groups are entitled to voice, participation and human rights.</p>	<p>A restorative mindset recognizes the dynamics of power, which affect persons in the community.</p>

# EQUITY CONCEPTS AND THE RESTORATIVE MINDSET



<p style="writing-mode: vertical-rl; transform: rotate(180deg);">RACISM</p>	<p>Racism is racial prejudice plus power. Racism is the intentional or unintentional use of power to isolate, separate and exploit others. This use of power is based on a belief in superior origin, identity of supposed racial characteristics.</p> <p>Racism confers certain privileges on and defends the dominant group, which in turn sustains and perpetuates racism. Both consciously and unconsciously, racism is enforced and maintained by the legal, cultural, religious, educational, economic, political, military and other institutions of societies.</p> <p>Racism is more than just a personal attitude; it is the institutionalized form of that attitude. It is both overt and covert. (It has Individual, Systemic and Institutionalized forms).</p>	<p>Promotes inequity; denies the humanness of groups; Denies the notion that all groups are entitled to voice, participation and human rights.</p>	<p>A restorative mindset recognizes the dynamics of power, which affect persons in the community.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">TOKENISM</p>	<p>Hiring or having a few women and/or racial or ethnic minority persons represented, so as to appear inclusive, while actually remaining mono-cultural.</p>	<p>Denies human rights and promotes the notion that certain groups are less than and unworthy of full participation.</p>	<p>A restorative mindset recognizes the dynamics of power, which affect persons in the community.</p> <p>True diversity and multiple perspectives are embraced as valuable to the community.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">POWER</p>	<p><b>Power</b> The ability to influence or control the behavior of people <b>Power Dynamics</b> The sociological or political concept which refers to how power works to influence interactions in a particular setting (such as a classroom, school, community)</p>		<p>A restorative mindset recognizes the dynamics of power, which affect persons in the community</p> <p>Restorative Practices provide safe space to identify and address power dynamics and minimize effects</p>

Information for Equity discussion and charts adapted from Intersection of Race, Trauma and Restorative Justice (Nehemiah Trinity Rising), A Framework for Understanding the Causes of Racial Inequalities in 21st Century America by Fulbright-Anderson and Associates, LLC and A Sacred Conversation on Race, United Church of Christ



**RESTORATIVE JUSTICE AND NEHEMIAH TRINITY RISING**

**HOW WE FULFILL OUR MISSION**

**Our Vision:** To create an ***Avalanche*** of ever-increasing numbers of people with knowledge and passion about the benefits of using restorative justice practices in resolving conflict in schools and communities.

**Our Mission:** To provide advocacy, education and opportunities that promote and utilize restorative practices.

<b><u>Education</u></b>	<b><u>Training (Skills Transfer)</u></b>	<b><u>Implementation</u></b>	<b><u>Advocacy</u></b>	<b><u>Collaborations</u></b>
<p><b>Building awareness of the philosophy and practices and their connection to faith and community.</b></p>	<p><b>Building capacity of people with the knowledge and skills to spread the word and prepare others.</b></p>	<p><b>Assisting organizations in infusing their environment. We take a holistic approach to implementation. We also provide just in time relationship reconciliation</b></p>	<p><b>What we learn through the building of relationships often uncovers systemic issues which need to be addressed. We accomplish this in coalitions</b></p>	<p><b>Because we can go farther together than alone, we accomplish our mission in collaboration with others who are doing related work.</b></p>
<ul style="list-style-type: none"> <li>-Seminars</li> <li>-Workshops</li> <li>-Experiential circles</li> <li>-Written Material</li> <li>-Reading Lists</li> <li>-Participation in organizations.</li> <li>-Intersections (Racism, Trauma, Post Traumatic Slavery</li> <li>- National:               <ul style="list-style-type: none"> <li>- NACRJ</li> <li>-</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>-Circle training</li> <li>-Asset Mapping</li> <li>-Asset Based Community Organizing</li> <li>-Restorative conversations</li> <li>-Trauma and Resilience Informed Environments and Programs</li> </ul>	<ul style="list-style-type: none"> <li>Schools               <ul style="list-style-type: none"> <li>- 17 CPS Schools</li> <li>- York H.S. (Cook County Jail)</li> </ul> </li> <li>-Churches</li> <li>-Jails/Prison</li> <li>-Organizations</li> <li>-Woodlawn</li> <li>-Alternatives to Incarceration (Roseland)</li> <li>-Washington Park</li> <li>- Family Reunification</li> <li>-Heartland Alliance READi program</li> </ul>	<ul style="list-style-type: none"> <li>-End Money Bail coalition</li> <li>-IDOC Health Care Coalition</li> <li>-Just Housing Initiative</li> <li>-Right on Justice</li> <li>-TRHT</li> </ul>	<ul style="list-style-type: none"> <li>-Next Movement</li> <li>-Illinois ACEs Collaborative</li> <li>-Embrace RJ In Schools</li> <li>-Reunification Rides</li> <li>-Trauma Informed Congregations and Communities</li> <li>-Advocate Healthcare</li> <li>-CGLA</li> <li>-Chicago Police</li> </ul>

*Then they said, "Let us start building!" So they committed themselves to the common good.* Nehemiah  
2:18 (b)