SANDY HOOK ADVISORY COMMISSION
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Afternoon Session
Legislative Office Building
Hartford, CT

SCOTT JACKSON, Committee Chair
KATHLEEN FLAHERTY
PATRICIA KEAVNEY-MARUCA
DENIS McCARTHY
DAVID SCHONFELD
CHRISTOPHER LYDDY
HAROLD SCHWARTZ
EZRA GRIFFITH
WAYNE SANDFORD
BERNARD SULLIVAN
ALICE FORRESTER

CONNECTICUT COURT REPORTERS ASSOCIATION
P.O. Box 914
Canton, CT 06109

AGENDA

III. Addressing Trauma
Julian Ford, Ph.D., Professor of Psychiatry, University of Connecticut Health Center

Robert Franks, Ph.D., Vice President/Director of Connecticut Center for Effective Practice, Child Health Development Institute

IV. Other Business
V. Discussion
VI. Adjournment

THE CHAIRMAN: Next up I believe we have Dr. Ford.

DR. FORD: Thank you and thank -- I want to thank all the members of the commission for the opportunity to speak with you. And, again, as Dr. Marans and Dr. Pynoos said, thank you very much for the work that you're doing on behalf of our state and our communities.

By the way, I'm also -- I'm an IRB chair, so I have these kinds of questions come before me all the time. That's an institutional review board. That's -- those are the research ethics boards that tell researchers what they may or may not do, guided by the federal regulations, of course. We don't really set the regulations.

And I think one of the great things that could come out of this commission would be a plan that actually lays the groundwork for the kind of proactive research that you're just talking about, Dr. Schonfeld, because it is too late when -- when the crisis has hit. It's always too late. But you do what you can.

And you can't also put the care and the well-being of those who are affected second to science, so having a foundation in place where there

are collaborative relationships between the research community, the clinical community, and the other service providers -- schools, family organizations -- that would be a major step forward. That's -- that's -- would be quite unique. I don't think that exists.

And one of my colleagues actually is starting to develop a line of research specifically looking at what -- what can we do to identify children before they're traumatized and then be able to follow them in large numbers. And he's working at the Connecticut Children's Medical Center to develop some projects specifically on that -- on that note, to not wait until the trauma strikes.

Okay. Well, let me -- I want to just broaden the focus for a few moments. I know that this has been -- that you've heard a lot. You've had a lot to digest, so I want to just stay with the two primary, major points.

Number one is that the kinds of crises and the violence that so tragically has struck Sandy Hook and our state and everyone involved, the schools and the providers as well as the other members and the first responders, is just one layer.

And if we can go on, Melissa. Thank you.

So, much of the time -- sorry. The slides have reformatted themselves. What you're seeing is -- and you can see it graphically here because there are layering -- that violence is really just one layer on top of many other layers in the lives of children and families.

And I think about the kinds of kids who we see -- the "poly" should follow up with "victimization" there, but -- the kids we see at a clinic that I direct, that works with kids who are referred from our juvenile justice system and our child welfare system specifically because they have trauma histories and because nobody else knows what to do to help them. So we are kind of the -- one of the last resorts.

And those kids come in saying things to us like -- and these, of course, are not their real names and their identities are disguised. Like Charles, who said, "I don't do goals. I know you want me to do goals, but I don't do goals. And anyone who messes with me or gets in my way, I'll make them pay, and that includes you."

So that was that five-year-old that Dr. Marans saw, ten years later. And he's still operating on a very basic survival mode.

Or Maria, who, a year younger but mother of a child, already, and sometimes more than one child, says, "My baby is my life. She's the only one who really loves of me, and she's a good girl, not like me."

Now, that's where you begin to see how violence affects children, because already, she's bonding with this child and trying to be a mother at the age of 14, and at the same time, she is clearly needing a mother. She's clearly needing that sense of safety, that sense of family and control that Dr. Marans was talking about, and she's looking to exactly the wrong person for that.

So it's not just the hypervigilance, the reactive aggression, the unwillingness to connect, or the apparent unwillingness, I should say, because these kids are really relationship-seeking, in my experience. They are hungry for relationships, but they have also been burned really badly, and not just once but repeatedly.

And Alex, who you can't quite see, but he said, "My brother got murdered and I miss him every day, and I don't want to die like he did."

So these -- this is the range of kids. That's a -- he's a nine-year-old, and we see younger

kids than that, too. But this is how violence affects kids. This is what Dr. Pynoos was saying. But these are the kids, okay.

So what are we going to do? Well, first I would suggest -- next slide, Melissa -- we've got to think about the fact that these are kids who are not just victims, they're poly-victims, so they have experienced multiple kinds of violence and victimization, not just multiple incidents but kinds.

They've experienced abuse in their own homes, neglect very commonly; interpersonal violence, witnessing that in their families; and then of course, as they grow older, the community. And sometimes, even when they're still very young, the communities -- not just urban communities, but rural and suburban as well -- can be hotbeds for violence in ways that we often overlook when we're thinking only about the catastrophic incidents.

So just as illustration of that, Dr. Finkelhor, who Dr. Marans cited in his survey, they found that not only is violence or victimization prevalent, 67 percent of all kids, by the age of 17, have experienced some form of victimization, but fully one in five of them have experienced at least four different types. And that means the types I

just told you about, not just abuse, but neglect, interpersonal violence, dating violence, bullying, community violence of other kinds. At another -- in that same sample, they found that 10 percent of those kids, by the age of three to six, had experienced nine types of violence, of victimization, by the age of three to six.

Margaret Briggs-Gowan, who's a colleague of mine at the UConn Department of Psychiatry, does research with Alice Carter with very little kids. And she's found that kids -- 20 to 25 percent of kids, especially in high-risk groups, where there's poverty, where there is economic disadvantage as well layered on top -- that a substantial subgroup of those kids, by the time that they get to preschool, they have experienced multiple forms of interpersonal violence, okay.

So I don't want to -- I don't want to ruin your day, but frankly, this is a truly epidemic problem. That's why the task force was commissioned by the attorney general. But it's not just violence; it is layers and layers of violence.

We found in a -- we looked at -- I'm sorry this is off the -- I don't know what happened to the formatting on this computer.

But we found, in a reexamination of the data from this national survey conducted by Dean Kilpatrick and his colleagues, of adolescents, that there was a subgroup of kids, 8 to 17 percent of them -- and depending on how you define it, it's sometimes as many as 30 percent, almost one in three -- who had experienced this kind of poly-victimization, multiple forms of traumatic violence in their lives by the time that they had reached the age of 17, sometimes much younger than that.

And that poly-victim group, if we could go to the next one on those, you can see them, because -- I won't -- I won't try to explain all of this complicated graph, but if you look toward the right-hand side of this graph, you see that those categories, which you can't read on this, of course, those are the interpersonal violence types. And you can see that there's several of these -- of these lines of groups that spike on those. And where they spike on one, they tend to spike on two or three or four. Those are the poly-victims.

And there are three different subgroups, one of whom have experienced profound sexual abuse, Dr. Putnam's area of work; one of whom has

experienced that but often physical abuse as well; and then another that have experienced also profound community violence. And those are the kids toward the right here, where you see just spike after spike after spike. Those are kids who haven't just experienced a little bit of violence or one type, but multiple types.

And who do you suppose are the kids, these adolescents, who are most likely to develop PTSD? Even compared to other kids who have experienced substantial trauma exposure, these kids have odds ratios, going back to Dr. Marans' presentation or Dr. Pynoos's presentation, that are two to three times higher than other traumatized kids.

So this is the subgroup of kids, 10 to 25 percent of kids, even in just the community, just in all of our communities. And they're also more likely to develop depression, so it's not just PTSD. And they're also more likely to associate with peers who are involved in delinquency. So they're on a -- they're on a risky course, a very serious risky course.

If we could go on, Melissa.

Half of the children in the juvenile justice and child welfare systems, when we look at some of

the results from studies -- we did one -- Dr. Connor and Dr. Hawke and I did a study where we looked at a sample of kids who were in long-term psychiatric care and also child welfare care, and 52 percent of them had histories of abuse and impaired caregivers and multiple out-of-home placements.

So these are kids who have experienced trauma in just repeated ways, very complex and often losing their families in the midst of this, which is, as Dr. Marans said, an ultimate catastrophe for them, even if their families are not safe to be in.

There's also a group, going down to the third bullet, that -- actually, I should have corrected this.

When we looked at the -- a survey of over almost 2000 kids in our -- in Connecticut's juvenile detention centers -- we've been doing trauma screening in those detention centers, by the way, for eight or nine years now and providing follow-on services for the kids who are traumatized. And of those, 1959 kids, 5 percent of them had these complex histories. And actually, it's more than just abuse, out-of-home placements, and the parent caregivers; it's also exposure to domestic violence; it's also exposure to community violence.

And those kids, even that 5 percent, even as much risk and difficulty as they're in in the juvenile detention centers -- so they're already in fairly significant trouble in their lives -- they had substantially higher rates of PTSD, substance abuse problems, suicidality, problems with anger and aggression than their piers right there, who are also in deep trouble.

So this is a group, wherever you turn -- whether it's juvenile justice, child welfare, mental health, or just the community, just our schools and pediatric practices -- who are experiencing a level of problem and difficulty that is an enormous challenge for -- not just for them, but for all of us. How do we help these kids? Let's go on.

And they show up in those two subgroups that you can see with all the spikes.

Okay. Next, Melissa. Thank you.

So what does this do? Well, it basically -- in a nutshell, this leaves kids -- children, adolescents -- in basically coping and survival mode. They are essentially functioning as if their survival was always imperiled, even though they often don't even know it themselves. They may be the last to know it because they've become so used to it.

And this affects how their bodies function, as Mr. Marans said, and that's the core of it. They no longer have control of their bodily reactions. They see red and they find themselves doing things that they would never do if they could just stop and think. And these are not kids who are fundamentally impaired. These are bright kids. These are kids who are resilient. These are not kids who need to be fixed. These are kids who need to be brought out of a chronic state of living as if their survival was threatened every moment of their lives. And, again, they're often the last to know it.

And it affects everything -- their emotions; their thinking; their behavior; their ability to make safe choices and use self-control; and their ability to relate, as well as -- off the slide -- who they view themselves as, because so many of these young people, children and adolescents, essentially what they say to us is, "I'm damaged goods. There's something really wrong with me, or none of this would be happening to me. Something about me is making this happen or not making it work out better. It's got to be me."

And why are they doing that? Because they're adolescents or they're children growing in

adolescence. They are fundamentally egocentric, and it's got to be about them. But in this case it's a terrible thing, because it's a burden, not an opportunity.

Okay. Next slide.

So they can't stop and think, in many cases, even though they can be the -- they can test off the charts on IQ tests. They can do fantastic in school, at times, when they're not feeling emotionally disregulated, when they're not feeling triggered by some potential threat, which, typically, by the way, I might tell you, is not an actual danger; it is a reminder. It is not trauma. It is a reminder of what happened to them and how they had to react instantly without thinking, in order to survive, because otherwise, there would be no food for them for days on end, or otherwise somebody would get killed.

So these are not kids who are reacting to trauma all the time. These are kids who are reacting to ordinary events in their lives that other kids just move right through, and they think there's something wrong with them. And we've got to be very careful, because teachers, caregivers, police officers, judges, courts, child welfare workers,

pediatricians, all of us can think that there's something wrong with them. There's something wrong, but it is not something wrong with them. They are trying to survive. So they can't stick with goals because they have a more important goal, and that is dealing with the moment.

The young man who said he doesn't do goals, he does goals all the time, but his main goal is just to get through this moment.

Okay. Next slide.

And that will end it. Well, okay. While we are trying to see if we can clean up the computer, let me tell you what I think I was going to tell you on the slides, okay.

And I was going to show you a -- now that I've given you all the bad news, to just echo and build on what Dr. Pynoos and Dr. Marans have told you, so what do we do about this?

Well, we've got to do something, and we can't necessarily provide all these kids with evidence-based treatment instantly, even though the capacity to do that in the state is growing rapidly, and Dr. Franks will talk about more that.

But we've also got to -- we've got to spread some information, I think, and help people, ordinary

people like ourselves; our sons, if they're principals; our families; our pediatricians. Without doing formal programs, necessarily, we've got to spread the word that something has changed for children and families when they experience layer after layer of violence.

So what is that? Well, in brief -- and maybe I'll be able to show you, but if not, I'll just talk you through it. What we can show them is that, actually, what's changed is that their brains have changed in a very straightforward, clear way.

Now, it's actually very complex, to be -- to be quite honest with you, and neuroscientists are just beginning to unravel all of this. And I can't begin to tell you all the details, because I'm not a neuroscientist, but I'm a consumer and I work with them.

And essentially, what it boils down to is this: that we've all got an alarm in our brains. And we all know that alarm, because that's the alarm that goes off when you realize you've got to wake up; when you've been daydreaming, when you've been a little bored by the speaker, but then, whoops, you've got to pay attention.

But it's also the same alarm that goes off

if there's somebody shooting in your school and people are getting killed and people are screaming and there is a horrible, scary, awful event. It is the same area of the brain. It's an area deep in the middle of the brain -- oh (indicating) -- and it has to do with -- and it leads to all these problems. But let's just jump ahead, okay. Let's go all the way to the brain. I'll come back to this in a moment.

Okay. There we go.

So, very simply -- and I will not try to give you an academic course -- this alarm is essentially set to do whatever it takes to keep us alive, and it operates at about the level of a two-year-old, maybe, okay. It's that little kid who wants right now what he wants or she wants. And what this alarm wants is only for us to be safe but doesn't have any judgment.

So there's also two other areas of the brain that are instrumental and that actually make this all work very nicely. Of course it's much more complicated than that, but there's a filing center that retrieves memories, kind of like the librarian of the brain.

And when the alarm goes off -- you'll notice

that the filing system is right next to the alarm center. When the alarm goes off, as -- the first thing that we do, any of us, is we try to figure out, what is it that I know that I can use to help me understand this situation? What's going on?

So without even realizing it, before we even have a conscious thought, we have the immediate retrieval of memories.

Now, if you have a kid -- if we could just go on one slide. Thank you, Melissa. Two -- one more.

If you have a kid who's experienced profound threats to their survival, when that alarm goes off, the first thing that's going to come up on -- in their filing center, in their memory retrieval area, is going to be retrieval of memories that have to do with threat, with loss, with distrust, with being unprotected, with being abandoned, with doing bad things, with not being able to prevent bad things from happening but being helpless, hopeless.

So what you see there is a picture of an alarm system where the information that then gets up to the very far right-hand side, the thinking center or the prefrontal cortex, right in front of our -- our back of our foreheads, the information that gets

to our conscious awareness is disaster, catastrophe, helplessness, all kinds of -- and don't just -- don't think; just react.

So what we have here, then, is a stress or alarm system in the brain that's now become set to go instantly into crisis mode, even when what may have triggered that alarm may be a very minor thing. It may even be a very happy thing. It might be a birthday. It might be a reunion with a parent after you've not been with them for a long time. It might be returning to school after something terrible has happened, like at Sandy Hook. And it might be seeing the very people who you trust the most and who you know you can count on.

And so what happens, then, is that kids don't realize that at the same time that they're experiencing the conscious sense of safety, support, security, help, protection, on a deeper level, they may be experiencing this sense of profound alarm.

And that, I would suggest to you, is what posttraumatic stress disorder essentially is: It's being in an alarm state, that is not conscious and that you don't even understand, where your body or a part of your body has essentially highjacked your brain and your body in the same -- for the sake of

protecting you.

Now, why is this important? Because if we find ways to make this kind of information, just this simple information, available to kids, families, teachers, pediatricians, then they don't have a black box when they look at this child who seems to be having these apparent reactions and can't seem to recover because there's something wrong with them because they can't get over the violence.

No. It's very clear. There's nothing wrong with this child. And what we have to do, then, is help this child and their family and their caregivers and their community reset. And you could think of the alarm systems in the brains of people at, you know, all walks of life in Newtown, Sandy Hook. They're not all going off like this, but for many they are. And there's nothing wrong with them, but they don't know what's happening or they don't know why they're reacting the way they're reacting.

And that, I would submit to you, is a major part of the problem, simply a lack of some basic, fundamental public health information that we need to provide to people on a much more systematic basis.

I'll give you a quick example, and then I'll turn it over to Dr. Franks or be glad to answer any

questions, because I've just skimmed through a lot more than I intended to.

I have had the opportunity to meet with a group of individuals who usually don't get attended to at all, but, fortunately, through the youth and family services organization, were remembered. And that is not the teachers or the school personnel, but their spouses and significant others. And I had the privilege of meeting with a group of those individuals about a month ago, and we're going to meet again soon, and we may continue to meet.

And what they told me was that, in essence, they've seen exactly this (indicating). And they're seeing it day in and day out, in their spouse or their fiancé or their partner. And they had no idea, you know, what is going on. When is this ever going to be over? When is she or he going to be back to normal again? Why are they so completely obsessed with bringing the teachers from Columbine here and doing everything else and they -- but they cannot spend five minutes with their own family?

So that's the kind of absence of information that, with a little bit of correction, once we talked about it -- I didn't even show them the slides, because we were just talking. I didn't want to show

them slides. But once we talked about it and they realized, oh, of course, you know, this is a reaction that makes total sense, and it's going to take a while because it -- it's not something that my spouse, my fiancé, my partner can just reset. But if I understand that, now I'm not feeling like I'm in the dark and I just have to wait helplessly until she gets back to normal again.

And that's the same for the parents who are wondering about that with their children, for anyone who's affected and has also the secondary effects of caring for those who were directly affected.

So that's -- that's my message to you. I would like you to consider that in the midst of dealing with the -- the immediacy of this kind of a horrific crisis and the needs of the community, the families, the schools, that you also consider the much broader picture of children who are being exposed and families being exposed to violence, as Dr. Marans said, all over, all the time, and for whom we need -- they need as much of a foundation as those who have been through the crisis. And they'll be a part of the solution in the future, and they'll then be better prepared should it ever tragically happen to them.

But to do that, we need to get this kind of information out so that people, regular people, don't just think that it's a bunch of mental health stuff and a bunch of things that are wrong with them or their children or their families. Thank you.

MR. CHAIRMAN: Thank you. Questions, comments for Dr. Ford?

A SPEAKER: Excellent.

MR. CHAIRMAN: Thank you for your presentation.

Dr. Franks.

(Discussion off the record.)

DR. FRANKS: I'm going to go ahead and get started while we're working on pulling the slides up.

There's a -- there's a lot of information that was covered today, and some of it was also contained in my presentation as well. But what I want to focus on, which I think is very important for the commission to hear, is that we heard a lot today about national statistics, about the impact of trauma on children, about some national models for intervention. And it's important to know that we actually have a lot of resource and assets here in Connecticut that have been in place for some time. And I want to tell you a little about what those

resource and assets are.

Let me get through that, because we already talked about it.

In Connecticut, we actually do have some information about the exposure of trauma to children in various systems, so we actually are aware that in our outpatient child guidance clinics, according to all the data that is collected systematically across the state, 53 percent of children on intake report that they have been exposed to trauma.

We actually know more specifically, in 22 agencies that we've trained in trauma-specific interventions, that that range is between 60 to 80 percent. And to support Dr. Ford's presentation earlier, we actually know that the average numbers of traumas that children experience are eight.

So, for children seeking outpatient treatments in our clinics across the state, on average, those children have experienced eight different forms of trauma, so, important to remember.

We also know that in our juvenile justice system, as Dr. Ford mentioned earlier, about 80 percent in our detention system report a history of trauma and about 50 percent or so are symptomatic, with either partial or full PTSD.

We also know -- and I actually don't have this on the slide -- that through our emergency mobile psychiatric service system, which sees about 11,000 children per year, about 53 percent of those children also report that they have experienced trauma.

So just in those systems alone and also if you -- if you -- it's over 20,000 children in Connecticut. If we add in the EMPS numbers that -- that grows to about 25,000 at least. So we're talking about a tremendous number of children in our state that have been exposed to trauma.

As Dr. Marans and others have established, it doesn't mean that all those children are going to be symptomatic, but we do know that in clinical samples, clinical populations, the likelihood of experiencing some symptoms as a result of exposure is higher than usual. And conservatively, we can say that at least 25 percent of those kids are probably experiencing some type of trauma.

We already talked about the fact that these traumas could be wide-ranging. There's a variety of different forms of trauma that children experience and do experience. When you look into the types of trauma that children experience, when we look at the

data that we've collected in those eight different forms of trauma, it's a range of different experiences. It's community violence; it's experiencing domestic violence; it's being the victims of violence themselves, so this layering effect that Dr. Ford described.

I'm not going to go through the reactions to trauma, because I think that was well-covered.

I do want to point out that there is a risk for misdiagnosis, and we're going to talk a little more about training pediatricians.

And oftentimes when I train pediatricians in recognizing the signs and symptoms of trauma, one of the sort of bells that goes off with them is that they may be missing kids in their practice or seeing them as suffering from other disorders, when, in fact, it may have actually been related to a trauma history or child traumatic stress symptoms.

So there's a range of different disorders, and we begin to look at the way these disorders are diagnosed. Many of the symptoms overlap with child traumatic stress. So if you see a child that's having difficulty regulating their behavior or they're having difficulty maintaining their behavior, their composure in a classroom, it would be very

easily [sic] to identify that child as perhaps having an attentional deficit disorder or a conduct disorder, yet that child may be suffering, in fact, from a child traumatic stress-related condition.

This was actually also mentioned earlier today, and I guess it's good that many of my former mentors actually have trained me well. But the adverse childhood experience study that was conducted really showed the relationship between these early childhood negative experiences and lifelong health and mental health problems.

So I want to emphasize -- and this was said earlier -- that if left untreated, many of these conditions and disorders could lead to lifelong problems that -- that can cause both disease and disability.

It also was established -- and I just want to also remind folks -- that there's a linkage between being a victim and later going on to offend. And you could look at some of these statistics in more detail, but in many cases your risks for being involved in a juvenile justice system or being an offender more than double if you're been exposed to trauma, if you've been a victim, or if you've also encountered maltreatment. So it's a very

well-established relationship between being a victim or being maltreated and then later going on to offend.

One study actually showed even more dire consequences. Linda Teplin, who does a lot of research with juvenile justice populations, recently released some data that she's analyzed that shows that, in the longitudinal sample she's been following, about 10 percent of the kids that she's identified as having traumatic stress issues have died within about a ten-year period, incredibly dramatic results. And these are kids that she saw first in childhood, in the teenage years. Ten years later they're dead.

It's been argued by Vincent Felitti and others that trauma could really be seen as this public health issue, and it could also be seen as -- as a preventible issue if we identify and intervene early. And it could actually -- we could actually prevent some of the most significant social ills as a result.

A cost analysis study that was done in 2007 estimated that the annual cost to the United States for child maltreatment resulted in direct and indirect costs totaling $104 billion. So when we're

talking about budget saving and how we could actually save money in our federal budgets, this is a place we should be looking.

The former president of the American Psychiatric Association made the metaphor that really, you know, trauma is to mental health as smoking is to cancer. We really have to think of it in that public health way, but -- in much the way that Dr. Pynoos mentioned earlier today.

It's very important to know, though, that there is help available. You talked -- you asked about evidence-based practices, models that work.

We actually have introduced and disseminated evidence-based models across Connecticut. And not only have we disseminated them, but we've evaluated their effectiveness. We have -- we haven't just relied on the research that says, hey, these models work. We've looked at their efficacy and we've seen some excellent results in our samples in Connecticut.

We actually, probably about ten years ago, in Connecticut, began looking at the issue of mental health. I direct a center for effective practice at the Child Health and Development Institute. And that center was originally created looking at this issue of: How do we improve the standard of mental health

care in our state? How do we work with state agencies, our partners at Yale and UConn, other major institutions, to advance our knowledge about our best practices? How do we increase and improve the level of care being delivered by our providers? And how do we work with our state agencies to ensure a quality of care? And we've actually made a lot of progress in the past decade in that area.

Three things I want to highlight today -- and this is very important for the commission to know -- is that we've actually been involved in really trying to create a statewide trauma-informed system of care through a variety of activities. And this actually precedes any of the horrific events, of course, that we have experienced in Newtown.

We actually have been working to implement systematic screening and identification of children who have experienced trauma. And we actually have done that through a variety of ways. We have trained, as I said, to date -- and we're planning on training more -- 22 outpatient child guidance clinics across the state. All of those child guidance clinics universally screen all of their children coming in for intake, for trauma.

We also screen trauma -- thanks to Dr. Ford

and others -- children in detention for trauma and other mental health issues, so we actually have very good data on children in our juvenile justice system who experience trauma.

We are right now in the middle of a federal grant and are working with the Department of Children and Families to implement universal trauma screening in DCF, in the child welfare system, and I'll tell you more about that in a second.

I have been working across the state through our EPIC program, which I'll discuss in a little more detail, to implement a training for pediatricians, school nurses, school social workers, and other health care providers in screening for trauma, and then also the training of law enforcement in identifying trauma, spearheaded by the work in New Haven through Dr. Marans.

We've also implemented a range of evidence-based practices in this state. The one that we have implemented most widely is the trauma-focused cognitive behavioral therapy, which I will talk about a little bit more in a second. But this particular model, we are actually -- in the United States, we're one of the few states that has a statewide dissemination of that model. So it's important for

you to know that.

We live in a state that actually has made significant efforts to training its provider community in an evidence-based trauma-focused practice, as well as Dr. Ford's target model, dialectical behavioral therapy. We are going to be training agencies in Dr. Marans' CFTSI through the federal grant, as well as a therapeutic drama model.

We also have thera- -- trauma-informed approaches in our harmony care settings. We've actually trained -- which is formed by Riverview, so went north and south, in TF-CBT, as well our training school staff in TF-CBT. We have also implemented the risking connection and restorative approach in those agencies. So there's been a lot of effort to try and build our system of care across the state.

Two years ago we are -- we were one of the five states in the nation awarded an Administration for Children and Families -- which is the division of the federal Health and Human Services Department -- a $3.2 million grant to implement a trauma-informed child welfare system.

So we've been working with Dr. Marans and other experts from around the country in TF-CBT, as well as our local folks here at DCF, to focus on

three main areas: workforce development, training our child welfare staff on how to be more trauma-sensitive, understand the impact of trauma on children. We have been implementing -- and it will go live in 2014 -- a universal trauma screening.

And we've been working with folks from the Child Study Center and others to develop that screening protocol. And we've also been disseminating, as I said, trauma-focused cognitive behavioral therapy to additional agencies, linking those agencies to their child welfare provide -- counterparts, as well as we're going to be doing the same over the next two years with CFTSI, which is the Yale model that Dr. Marans described earlier.

The EPIC program, which I referenced earlier, is a program that was developed at the Child Health and Development Institute and with the local chapter of the American Academy of Pediatrics. And it's a model that uses academic detail.

So you know the sort of classic pharmaceutical salesman who comes into a pediatric practice and works with the staff to deliver information about their product. We have a similar methodology to meet with staff -- usually it's over lunchtime -- of a pediatric practice. We provide

them with training on a variety of topics, everything from developmental assessment to screening for autism. And now, most recently, we designed and implemented a trauma model.

In that trauma model, we educate pediatrics providers about the impact of trauma on children, recognizing signs of symptoms of trauma in child traumatic stress. And then we also introduce using a standardized tool that they could actually use to screen children in their practice.

We then also bring with us a local community-based provider who provides trauma-focused services. And it's very -- that's a very important part of the work, because that provider is their link to making -- once they identify the children, to make ref- -- making referrals in their community.

So we've just begun delivering this module, and ironically, the module went live about a month before the Newtown shootings. And it was -- we actually had trained the Danbury Hospital staff several weeks before this event took place. And luckily, Dr. Marans and his team were actually able to provide some follow-up and provide with some individual consultation.

We have trained 21 pediatric practices to

date in that model. That includes 392 physicians, nurses, and staff. And what's most notable is, in our partnership with the state Department of Education, following Newtown, there was a tremendous outcry -- and you can let your son, the principal, know this, that -- for training in recognizing kids who are experiencing trauma and how to link them to community-based services.

So since the Newtown incident, we have had a tremendous outcry from school districts across the state. We've trained ten school districts, which include 728 school nurses, psychologists, and social workers, using the EPIC module to train in screening or identifying children that are at risk.

That entire endeavor was funded by CHCI's parent foundation, The Children's Fund, which wasn't anticipating, obviously, the need or interests in this particular module.

The state Department of Education has expressed interest in wanting to eventually train all schools across the state in using this module. And clearly, 21 pediatric practices is just scratching the surface. But we have, to date -- this is just in the past, you know, four or five months -- trained over a thousand professionals in this module.

Also, as I mentioned, through the concept grant, we will be introducing universal screening of child welfare staff, so that when child welfare staff are working with children and families, they will be identifying whether or not there is a trauma history and linking those children and families to community-based providers. It's anticipated that once that is up and running, we should be screening about 14,000 children per year.

As I mentioned earlier, we will be disseminating the CFTSI module, which Dr. Marans already briefed you on. And we are continuing to disseminate trauma-focused cognitive behavioral therapy, which DCF had actually funded the original dissemination of in 2007.

This particular model has over eight randomized controlled studies that show its effectiveness. We also know, through the National Child Traumatic Stress Network, that it's shown to be effective in multiple real-world settings all across the country.

We actually -- actually coming from the National Child Traumatic Stress Network before I came back to Connecticut, I really felt this was an important intervention we need to introduce. And the

Department of Children and Families, we worked really collaboratively with them to disseminate this module, over a three-year period, to 16 agencies.

We train agencies using a learning collaborative approach, so we just don't do a one-shot training. We actually bring a -- multiple groups of agencies together to learn over the course of a year. We have four or five in-person learning sessions. They practice the skills in between. We collect data all the way through, and we ensure that the practice is imbedded at the agency with fidelity. And we've shown some very good outcomes as a result of using that methodology.

We actually have, to date, as I said, trained 22 agencies. Right now any family in Connecticut should be within about an hour's drive of receiving treatment. There are many centers in our urban areas, Clifford Beers being one of them, treatment at the Child Study Center in New Haven, here at The Village in Hartford, and in many other centers across the state.

One of the challenges is there is -- despite having so many agencies trained, there is limited access. It -- we really are only beginning to scratch the surface of some of the need. And we also

hear from providers that it's challenging for them to deliver this evidence-based practice, because the typical Medicaid reimbursement or private insurance reimbursement they might receive doesn't really cover their costs of delivering the service. So this is a real challenge that we face as a state.

We have a -- an evidence-based model that works. We have a trained workforce. But they're finding it's challenging to deliver that, in some cases, for financial barriers.

We also are seeing that there are a low number -- we're not anywhere near the capacity we would like to reach in terms of the capacity of the agencies we have trained. So we're trying to put more effort into quality assurance and ongoing training, due to issues such as staff turnover, to make sure that we have trained clinicians.

Just to give you a little snapshot, as of September 2012, we've seen over 2000 children with TF-CBT in Connecticut. These are some statistics about their background: The one thing I just want to note is that the most common traumatic events they cite are sexual abuse, physical abuse injury, death of a loved one, and separation from a caregiver.

So these are the kinds of issues that

children who are experiencing trauma are experiencing. And as I mentioned before, they're averaging about eight different trauma types per child.

This is just a snapshot of a sample evaluation that we conducted of some of our outcomes. And we're actually seeing significant decreases, in children who complete treatment, in both their depression symptoms and their PTSD symptoms. We're very proud that, actually, these results in our community-based settings are comparable to the treatment developers in terms of their effect.

And we're actually seeing -- if you go back and you look through the criteria in which these children were diagnosed for PTSD, in about 82 percent of the children served, they would actually have a remission of that diagnosis. They would no longer qualify for the diagnosis following treatment.

We are -- we've also seen some other benefits of disseminating this model, including reduced no-show rates of families receiving treatment in the clinics, increased staff morale. We're hearing from clinicians, "Wow, I really feel like I'm being effective, that I have a model that works. You know, I've been seeing some of these families for

years, and I haven't been able to be effective with them. Now I'm actually making a difference in their lives."

We're seeing shorter lengths of stay in treatment. On average, the TF-CBT treatment takes about five to six months, and we're seeing symptom reduction in that time. And it's likely that we're going to be seeing significant future cost savings, because these are families that are actually being discharged and they're being restored to functioning. Not to say that some of these kids don't come back into treatment in the future, but we're seeing it as a very highly effective treatment to get them back on track.

Here is a map of where our providers are across the state. And you could see that we've done a fairly decent job disseminating the model. There are the usual pockets.

We have one more dissemination. We're going to be training approximately six more providers in TF-CBT next year; hope to target the areas that are underserved. And we will also be disseminating CFTSI in the following two years.

So just, in summary, I think it's -- as was well-established today, in Connecticut, childhood

exposure to trauma is a significant public health issue. We can't ignore it. It's important that we identify these kids and identify them early. If we don't identify them early, if we don't screen and link them to appropriate services, they are likely to have a life -- they could have potential lifelong difficulties. And they could also result in tremendous cost burden for the families as well as for our state if we don't identify and treat these issues early.

We -- it's important for all of you to know that we have a range of services in place. The services may not be fully implemented. They may not -- we may not be reaching all the affected children and families. But we don't -- we're not starting from scratch here. We actually have had some very significant efforts made in the state, and by bolstering and supporting the work that has already been ongoing, we could definitely move in the right direction.

It is important to know that there are issues of capacity and access to services that work, and that I really want to bring the message today that we have to examine, as a state, for delivering effective models of care that in some cases require

additional time, supervision, attention to the delivery of services. We also have to recognize there may be a cost burden for the providers who are providing these services and ensure that they're reimbursed adequately.

Some of the challenges that we face, we definitely need to continue our training of professionals that have contact with children, especially in pediatrics.

In many cases, when we do train providers in communities, there are a lack of trained clinicians and providers that -- for those clinicians to refer to.

What I hear time and time again, when I work with schools or pediatricians, is, "If I see this problem, I want to know what I can do with it. I need to know someone to turn to. I need to have someone to call on the other end of the line. It's not enough for me just to know this is a problem. I need to be able to know what to do next."

I actually spoke with a friend of mine from college recently who called me because her son was involved in the Boston marathon bombing, and he was very close to the blast. And she said to me, "I called my pediatrician, and he didn't call me back."

She said, "So I called again, and when I spoke to him," he said, "I'm not really sure what to do."

And this is an example, chil- -- families often turn to their pediatricians in times of crisis. We have to ensure that our pediatricians are equipped to deal with these types of crises.

As I mentioned, there's a limited capacity of our existing providers. We do hear complaints that those with private insurance have difficulty accessing these services. And, you know, I often am challenged by friends and colleagues, who ask me for a referral, to identify clinicians who are trained, who could actually provide these types of services.

We also, in our state, have very limited services for young children ages zero to five. We do have the dissemination of Child First, but that's for only the most needy high-risk families. We need to look at other models of care and practice to intervene with children in their younger years.

We have very limited trauma-focused treatments in our schools and limited access in our schools. So one step is training schools to identify these issues. The next step is building the capacity of schools to respond, through our school-based health clinics, through linkages with community-based

services.

As I mentioned, it takes extra cost and time to utilize some of these services, and we do have to address the issue of staff turnover.

We also just can't train folks without paying attention to the service. One thing that I've learned in doing the work that I have at the state level, it's an ongoing process of ensuring quality of care. Our children and families and our state deserve quality of care. Irrespective of where they go for treatment in this state, they should be -- have access to a similar level of quality of care, and it requires ongoing quality assurance and training to make that happen.

So my recommendations are that we need to build and strengthen a trauma-informed system of care across our systems, including pediatrics, behavioral health, early childhood schools, child welfare, and juvenile justice.

We have to make sure that we have training in place for all of those sectors.

We have to ensure that there are adequate providers to provide trauma-focused treatments.

We have to build the capacity of existing programs to meet the need of children and families in

our state.

We have to ensure that -- just irrespective of insurance status, that children and families have access to these services.

As I mentioned, we need ongoing qual- -- training and quality assurance for these programs.

We have to ensure that there are increased access to trauma-focused service in juvenile justice settings, given the number of children that are exposed to trauma in those settings.

We need to increase services available, particularly for those early childhood, young children, and also for children in school-based settings.

We have to ensure that providers have appropriate incentives, whether it's reimbursement or other incentives, to deliver quality care.

And then we also need to collect outcome data to ensure that these programs are working.

MR. CHAIRMAN: Thank you, very much, Dr. Franks.

Questions/comments, Dr. Griffith?

DR. GRIFFITH: Thank you very much for the presentation. I had a couple of questions, because

as I look at your slides and listen attentively to what you are producing there, I mean, is there -- is there any family -- is there any family in Connecticut not experiencing trauma?

DR. FRANKS: That's a good point. And I -- you know, trauma is a factor of the human existence. I think that's a fundamental part of being human. We all experience -- most of us experience -- I think there's few that get off of this earth without experiencing some traumatic event. And I think it's very important to note that not all of the children who are exposed to trauma are going to go on to develop symptoms or have difficulties.

But I think what we are beginning to see and understand is that trauma, in many cases, is at the root of many of the social ills we see. And for that population of children that become symptomatic, for those -- that percentage of children that go on to develop chronic difficulties, we really need to be able to identify those children and families early, particularly -- and you -- it makes sense that the children who are in our state system, such as juvenile justice, those children and families are much more likely to have experienced the negative effects of trauma exposure, which have led to those

negative sequelae that lead them to having involvement in the juvenile justice system.

For many children and families that seek treatment in our outpatient clinics, in many cases they have intergenerational histories of trauma and family violence which have contributed to some of the difficulties they're experiencing.

So yes, I think many of us experience trauma. I can't tell you how many times -- when I do a training of school nurses or school staff, how many times people come up afterwards to tell me about themselves or their sibling or their brother, and I'm sure my colleagues have the same experience. But it is something that we cannot ignore.

So absolutely -- and I think as Dr. Pynoos mentioned earlier -- it is something we need to view as a public health issue.

DR. GRIFFITH: Well, just permit me another follow-up question, because I am trying to figure out how to deal with it in the context of the realities of what we've got to deal with in the United States. And my preoccupation for many years has been the minority populations.

The way you have described it and your colleagues have described it, it seem -- it seems to

me it would be hard to find -- I'm not -- trying to find even what the correct wording would be. It would be hard to find a family not subject to these experiences in some form or other, which then leads me to how you all think about it, because it seems to me, then, that we are in the process -- and, in fact, everyone knows this happens anyhow.

There are -- there are certain neighborhoods that are going to be considered traumatized neighborhoods and everybody in it is therefore not functioning, et cetera, et cetera. I mean, it's a -- it's a labeling system that I'm not sure I understand.

Now, do -- my -- it also leads to confusion on another level, because everybody knows that, for example, the traditional use of the PTSD classification resisted for many years, and I don't even know formally what they're going to do, because I haven't read it. But they -- clearly, they excluded, for example, discrimination experiences in reaching the classification of posttraumatic stress disorder.

So the funny thing is that many of these neighborhoods are having these experiences, and yet the mental health professionals have turned around

and said, "But they can't be considered PTSD people." It's a funny -- it's a funny thing; I'm trying to figure out how to get out of it.

And there's the suggestion also, then, that the capacity for resilience in these neighborhoods is substantially reduced in comparison to nonminority neighborhoods.

So I don't know if you want to say a last word to help me out on my -- my puzzlement, and it's not just your lectures.

DR. FRANKS: Yeah.

DR. GRIFFITH: It's the traditions, I think, that the mental health professionals and the researchers have pursued in using this terminology that's puzzling to me.

My last comment, I -- I'm wondering if there's any therapist, though, who considers themself a bona fide therapist, who is doing something other than trauma-informed care. I mean, can you -- can you do good care and still do non -- nontrauma informed? I mean -- some of this language -- some of this language I find baffling for the purposes of figuring out how you structure --

DR. FRANKS: Yeah.

DR. GRIFFITH: -- you know, teaching

mechanisms, for example.

DR. FRANKS: I'm going to let Dr. Marans respond, as I just have a couple quick comments, and I'll turn the response over to him.

I do think that one point I want to make is that although, yes, in urban neighborhoods, in certain areas, there are higher levels of community violence, when we look at rates of domestic violence, of interpersonal violence, of death and loss, no zip code is immune to those issues. So I think that's one -- one -- one point I do want to make.

I'm going to turn it over to Dr. Marans for the rest of these issues. But I do think that there are many -- I think that -- the answer to your question is yes, I think there are clinicians who don't necessarily view their work through a trauma-informed lens. It doesn't suggest that they should not, but I think there are many clinicians who aren't aware of the information that we've presented today.

DR. MARANS: Just to second that, I'm much more concerned, and we saw -- we see it especially in the aftermath of a mass casualty event. There are lots of good clinicians who have not learned more structured approaches that map onto the specific

phenomena associated with acute and longer-term traumatic difficulties.

But that takes us back to the language, the nosologies that were -- we would all be so lucky, right, if none of us had ever experienced traumatic events? Right? No. Exactly.

But I think there's a difference between experiencing trauma and experiencing some of the longer-term -- what we refer to as disorders, but the maladies associated with the failure of recovering from trauma.

And that also, I think, plays into your second issue, which is, what are the other elements that complicate that recovery process? So, for example, if one is living in a situation in which the demonstrations of being disenfranchised and undermined -- whether by discrimination, unemployment, lack of opportunity, failure of decent housing, et cetera, et cetera -- all of these things conspire to undermine the capacity, both in terms of support and in terms of internal resources, to master the experience of being overwhelmed.

So the first part is, I think it's very important we make a distinction between the idea of -- as Dr. Franks and others were saying, we don't

go through life without having traumatic events. The question isn't about whether we experience traumatic events and whether it's -- can be enormously disruptive. It's the extent to which it continues to disrupt our development in our longer-term functioning and adaptation.

DR. FORD: And if I may, we'll all be learning fairly soon, from another very large study, that the two things that are most detrimental to a recovery from exposure to trauma, Dr. Griffith, poverty and a prior traumatic exposure.

So if you hearken back to what I was talking about in terms of poly-victims, there are perhaps most of us who will experience a traumatic event in our lives, and most of us will have reactions, and most of us will fortunately recover.

But those children and families, individuals, who experience layer after layer of traumatic victimization, they are the ones who are in the greatest need. And we don't have to try to devote all our resources to everyone as if this is the -- this is something where we have to treat every individual, because we all are trauma survivors. That would not be realistic, of course.

But we can focus our interventions on those

who are at the greatest need, and we can identify them. We already know -- we know pretty much who they are. We just have to get out there in the ways that Dr. Franks was talking about and find them and link them to the services that can help.

DR. PYNOOS: I think my point earlier, to begin with, is that traumatic experiences need to be taken seriously. "Seriously" doesn't mean there's a diagnosis. It means even in an individual's life, they usually have a serious place in their life. It's not only their reactions, but you learn -- an eight-year-old is there when his mother is shot, knows they're ineffective. It's a very difficult experience. So that doesn't mean you have to give care, but it means to stratify as well.

So we worked at a high school -- I mean, I've worked in the inner cities across America different times and -- and around the world, in war zones. It is to take it seriously. So if you're in an inner city during the crack cocaine epidemic that Steve Marans mentioned, our country did nothing, in this country -- you're talking about discrimination -- to rehabilitate children in adolescence who had no gang affiliation, heard gunshots every night, had never slept through the

night, and we were asking them to learn during the day, and who were seeing dead bodies and shot, without any assistance at all.

I mean, I -- you know, Carl Bell and I used to be a voice in the eighties about that when the -- the height of the epidemic. It led to an antiintellectual ideology that wasn't there before the crack cocaine epidemic, because they couldn't learn. It became part of the actual hip-hop, I mean, everything from that.

But it means that you can go in a high school, like we did in San Fernando Valley. This is not more than 10 years ago, 15 years ago. They have thirty -- they had health groups. They had all kinds of groups on campus, but they had 35 students in that high school who had been shot. And nobody had never identified them.

When I said stratify trauma into how you are going to intervene, they had the worst posttraumatic stress symptoms, and none of them had ever been seen, even though they had the largest health care outreach clinic in LAUSD.

We found out because the messenger who was helping us on the research pulls up his trowser and says, "I've been" -- "I lost" -- you know,

"I" -- lost half his calf, and -- muscle, and he had a high PTSD.

So it's stratifying those approaches. The approaches aren't all-intensive treatment. They are to help -- if you were at a shooting in an inner city school, as we've done, and you're in the -- near the bus stop, they all had an exposure, but the good friend who tries to stop the bleeding and no one gives him help afterwards -- and we know that from first responders; don't think that isn't happening.

So we don't look at it always one and the same, but you take it all seriously and you try to understand what to do, and you try to understand how to respond to that. And it really changes citizenship.

I mean, there is no -- you know, we heard that juvenile justice. My last example, we worked in an inner city school -- I mean, you have to get a sense of this -- where five mothers had been murdered in that one school, one elementary school. And one of the boys who was in there when his mother was murdered, who felt totally ineffectual, was -- the fourth grade teacher looked on him -- was convinced -- really good fourth grade teacher, I mean, someone you'd want to -- that he was going to

grow up to be a murderer.

But just his -- he went into a treatment that was effective, a group treatment placed at school, and he went -- he became a leader in his classroom.

And she came up to us afterwards and said -- I mean, imagine the change in his care to have a teacher that now sees him not as growing up to be a murderer but growing up to be a leader, within a six-month period of time. That's not uncommon, is that an issue across the United States.

And if you talk about immigrants in the United States, there have been very successful programs. Immigrants come with civil war experiences, seeing their father murdered, again, in that, being in horrible disasters where there was great loss of life and they were trapped.

There have been successful programs helping immigrants, children, when they come to the United States to address those experiences, because they actually can't -- we did a children-in-war videotape. Early on in the network, that was -- the goal was to help school teachers understand how to integrate that child into their classroom and into their peers, because they actually couldn't speak of their

experience. Other students in the United States didn't believe them, and they had no way to talk about it, and yet it was very much a part of who they were.

So we think that this area -- again, it isn't all intensive treatment. There are a lot of strat- -- teaching -- we can go into schools and war zones and teach them how to handle reminders and change their behaviors and change how they do -- that's not -- that's a public skill to help provide, because my last example was just on Julian's. We work on juvenile justice.

Example I'll give you is a boy in juvenile -- residential juvenile justice. That's kind of, like, a last stage before just being in prison. And they're waking -- they put on the lights to wake him up at night and wake him up in the morning. They'd just turn on the light at 6 a.m., and he becomes -- needs restraints almost every morning, incorrigible. He goes into one of our treatments, a trauma -- a trauma/grief component treatment that we do for adolescents.

And it turns out that his best friend, a year earlier, had been killed in a car accident, hit. And he wasn't there. He didn't see it. But he got

there at the time that his friend's body was being put in the ambulance and taken away, never to be seen again, with no goodbyes, with the ambulance lights flashing.

And he suddenly understood that this is a reminder to him. But it wasn't just him knowing in treatment. Having trauma-informed -- we have a "think trauma," where we taught the frontline staff to think about how trauma is an influence. He could talk to the residential staff -- people he stays and sleeps and care for him -- about this.

And they figured out -- not just a treatment. They figured out to wake him up before the lights went on. They started waking him up before the lights went on. He was a totally different kid, seen in a totally different light.

So that's not an expensive intervention in some ways, but we do very little of that. And a lot more of that would actually benefit a lot more children and families in this country.

MR. CHAIRMAN: Dr. Schwartz.

DR. SCHWARTZ: I just briefly want to interject the word "resilience" into this discussion, which hasn't popped up, just to say that trauma is an important model. Resilience is an important model

also. There are many things we don't know about it. As you know, it may have genetic factors, epigenetic factors, psychosocial developments, you know, throughout life, which certainly differentiate and distinguish within these broad populations, you know, I think, and clearly suggest that attention to trauma is important but that we won't, in some sets of people, find that it's an overwhelming factor.

I'd like to know just a little bit about trauma-focused CBT in terms of broadening its reach throughout the state. What is involved, actually, in becoming trained in trauma-focused CBT? Can it be delivered in a group model, or is it an individual therapy only, et cetera?

DR. FRANKS: Sure. So a couple things. Just in response to your comment about resilience, I've -- I wholeheartedly agree and I actually think -- we didn't talk about this today -- there's so much you can talk about, obviously, on this topic.

But the resilience of children and their families helps mediate their response to trauma, obviously. And one of the things that some of these models do, such as trauma-focused cognitive behavioral therapy, is it instills the self-regulatory capacities in the child and,

importantly, in the caregiver. The caregiver and the child actually learn those -- those skills simultaneously.

And so, in a sense, you're actually promoting and building the resiliency of that family in the future and help them cope with potential future traumas or when they are confronted with traumatic reminders in the future.

TF-CBT is a phase treatment. It is -- right now the way in which we are training folks in Connecticut is through this learning collaborative structure, sponsored through the Department of Children and Families and funded right now through a federal grant. The state has funded that training in the past.

There also have been certain clinicians that have been identified in the Sandy Hook area, that have been trained through Dr. Marans and Carrie Epstein and others to -- to provide the treatment. And they're providing -- there's, I think -- you mentioned there's 40 clinicians right now that are -- that are providing that treatment.

If an individual practitioner wants to learn the model, there is an online training for TF-CBT that you can take as the first step to learning the

module, and that is actually -- the Medical University of South Carolina hosts that online training. And then the treatment developers can be contacted. And there are several opportunities around the country to attend an intensive two-day training.

In Connecticut, though, the way we're building capacity providers is through providers requesting training. They have to go through an RFQ process. The state actually gives them a small stipend to offset their administrative costs for participating in the training and then pays for all aspects of the training over the course of a year period.

Yes.

DR. FORD: Commissioners, my apologies, but I need to depart. I'm running late and about to miss a conveyance of longer term --

DR. PYNOOS: He's my ride back, so --

MR. CHAIRMAN: We -- we thank you for your time. We --

DR. PYNOOS: (Undiscernible) ... constructive action. Adolescents around the world, after being traumatized, need to do something that actually answers what happened to them in

constructive ways: after wars, helping the disabled; helping -- educating students that -- younger students. It's that activity that can be built into the social fabric that actually enhances a constructive response, which I think goes beyond sometimes the word "resilience." And we know a lot of ways to do that, certainly with youth.

MR. CHAIRMAN: Thank you. We have time for one more.

Ms. Flaherty.

MS. FLAHERTY: Just one very quick question. When you were making your recommendations, it had struck me first that increasing support for training -- I had first pictured that as training of all these different provider folks as training regarding screening and identification. But it looked like even that the current system had nowhere near the capacity that was needed to treat children who needed trauma-informed care. And I said that didn't seem to work for me.

But now with what members of the panel were saying, there's training that can be done to recognize things and do things for kids, that doesn't involve any kind of treatment. So I just wanted to make sure I had that clear.

DR. FRANKS: Yeah. I think that's right. And what we -- when we are training pediatricians or school nurses or other staff, one of the things that we're really trying to -- excuse me -- help them do is to really perhaps look at these children through a slightly different lens, to understand their behavior through a different lens, to understand there might be different explanations for what they're seeing in a pediatric office or a school nurse's office or in a classroom environment. It doesn't always mean that those kids are going to necessarily need an evidence-based practice. There could be a variety of responses that may be appropriate for that child and family.

But I think what we're trying to do is create a system where there's an increased level of awareness about these issues and the sequelae of -- from -- of traumatic exposure so that we could then build the appropriate response system if it's not there, and also to ensure that our provider community understands what the need is, so they could begin addressing that need.

I mean, you know, on your commission, I mean, you have an ex -- an expert in that, Dr. Forrester, who really -- you know, Clifford Beers

is a perfect example of a trauma-informed agency, that I think she could take a lot of credit for transforming it into such over the years.

Because of the awareness of the role of trauma in children's lives, it doesn't mean that every child at Clifford Beers receives TF-CBT, but it does mean that when they're working with those families and children, they're beginning to understand the role that trauma plays in their lives.

DR. FORD: And as a quick example there, every one of the community-based programs that the court support services division of the judicial branch runs -- they're called Youth Empowerment for Success and Family Support Center programs. Every one of those programs delivers educational groups for kids. And some of them -- one of them happens to use the TARGET model that I represent. Others involve work on anger management. There's a voices approach for girls.

So there -- there are a variety of ways of getting this information out to kids and families, that aren't treatment, but they still provide this kind of information about how trauma affects the brain, the body, relationships, and what kids and families can do about it before they necessarily have

to get into a more intensive treatment like TF-CBT.

MS. FLAHERTY: Thanks so much.

THE CHAIRMAN: Thank you, Doctors. We've kept you past your time, and we appreciate your patience with us. Your presentations were excellent, and thank you very much for joining us.

Members of the commission, we do have open discussion on the agenda. Again, we are late but would still like to take a couple of minutes to -- to talk about where we're going and to the extent that the commissioners would like some open discussion on what we've heard today.

Last week we talked a little bit about a draft statement on our focus here on mental health care. And so I'd like to distribute sort of a written version of what we discussed with -- that incorporate some of the comments that you made.

For the benefit of those watching or those in the audience, I will go through some of the focused areas:

No. 1, a deeper evaluation of youth and young adult service offerings and accessibility.

2, reviewing the confusing and disjointed delivery system.

3, reviewing the recommendations of prior

prominent reform efforts, specifically the report of the governor's Blue Ribbon Commission on Mental Health in 2000, written in response to Governor John Rowland's Executive Order 17A.

Item No. 4, establishing a credible threat assessment model.

Item 5, promoting the importance of mental health and resiliency, not just the treatment of mental illness.

6, promoting a sound approach to the recognition of and sensitivity to special circumstances, such as posttraumatic reactions or bereavement, in establishing mental health and behavioral support structures.

Now, what is the -- what is the goal of this document? The goal of this document is to help provide a prism in which we can review the voluminous information on mental health and mental illness that we have -- we have, over the last several weeks, been exposed to.

So what are the -- what are the outcomes, as I see them? And the way that I see them is not necessarily the -- what the group needs to do. But I did want to share with you my thoughts on that.

We have seen, in this building, in -- after

this tragedy, we have seen a lot of people point the finger at other people. We have seen a lot of people hold up a piece of paper and say, "This, I don't -- this wouldn't -- this wouldn't have stopped Sandy Hook," and tried to discount the value of that item because this single item would not have stopped Sandy Hook.

My thoughts on Sandy Hook are this: Everyone, every one of us, bears some culpability in Sandy Hook, every single one of us. And therefore it's up to every single one of us to do something about it. And it doesn't happen with a single effort. It doesn't happen with a single -- a change in policy. It doesn't happen with a -- a single change in law. It change -- there have to be multiple changes. We have to look at the whole system as it relates to a number of items, including some controversial items.

So what -- what I -- what I would propose is that the commission seek to fulfill its mission by creating a series of policy reports in a series of areas.

Now, mental health service with mental illness is complicated, and I, as a layperson, certainly do not have the capacity to determine each

and every area, but I will give you some of my back-of-the-envelope thoughts on what nine of these policy reports may be:

1, looking at the mechanics of treatment with special focus on children, that is, how to increase standards of care for everyone seeking service.

Item No. 2 -- and I will -- I will shoot this around by e-mail as well and seek your thoughts and comments on it.

2, access to mental health services and mental illness treatment, understanding the obstacles and the opportunities.

Item 3, delivery of support services and threat assessment models in schools and other areas of congregation for children.

Item 4, a discussion of the effectiveness and the fairness of Connecticut mental health laws.

Item No. 5, a review of recovery/resiliency efforts in the Newtown community, as a whole, as well as the individuals involved in the Sandy Hook tragedy.

Item 6, understanding the effective role of law enforcement in providing crisis intervention services.

Item 7, understanding the effects of media violence and entertainment and media coverage of tragedies, large and small.

Item 8, methods to encourage the use of mental health and treatment services, including data, statistics, and understanding proactive approaches to research.

Item 9, 21st century approaches to community supports for individuals with autism spectrum or dis- -- developmental disorders.

Now, we haven't even heard on some of those -- of those items, but those are items that emerged to me, in discussions as a group and with individuals, as areas in which we may -- or which we -- areas that -- that have a heightened profile, that we at least want to discuss at -- we at least want to touch upon, and, I think, at the end of the day, a series of policy reports in those areas. Maybe some will drop off the list if it's determined that the value to that is limited. And others may come on, and some of those may need to be broken apart, the mechanics of treatment.

And we've heard evidence-based practices. We've heard about this issue of trauma and how to fold it in. So maybe some of those will need to be

broken apart. But those are -- those are general areas that I see as having high value at this point, that we may need to want to think about creating policy reports on.

So I open the floor to thoughts, comments, and other discussion.

Dr. Forrester.

DR. FORRESTER: Thank you, Mayor. I think that one of the topics perhaps that's engulfed in one of these matters around the conversation around stigma, that I felt like we have had a lot of testimony on that and in understanding the role of avoiding, you know, talking about mental health or trauma in the work in regard to that.

THE CHAIRMAN: Absolutely. It -- in translation it dropped off my point 8, which is methods to encourage the use -- encourage the use of mental health and treatment services, but that is -- that is my stigma item right there.

Dr. Schwartz.

DR. SCHWARTZ: I think this is a great start. I'd like to go home and sort of just think about it and focus on it and -- and I think it's a great starting point for a discussion that we all can have.

Should we have this discussion by e-mail? Should we reserve a session to -- just devoted, you know, to this, or how would you like to proceed?

THE CHAIRMAN: What I'd like to do is -- is have a little bit of an iterative process, much like with this developing the focus, our areas of focus.

What I'll do is I will push it out to you by e-mail so that you can see the way that I've worded it.

But the -- but discussion of it outside of sort of individual questions should be done at a meeting to maintain the public integrity of the process.

Dr. Schonfeld.

DR. SCHONFELD: I agree. I think this is a great idea, to start trying to figure out what our priorities, areas, are.

And I wonder if people want to talk about the process by which we're going to determine what our priorities are, whether it's -- whether it's just based on voting among us or whether it relates to some of the guidelines about how we would select those priorities.

So as an example -- I'm just picking one, the last one, which was 21st century approaches to

individuals with ASD and developmental disorders. As a developmental behavioral pediatrician, I can tell you that this alone could take years to really do well. And also as a developmental behavioral pediatrician, I will tell you that I think it's very important.

So I -- I'm struggling a little with how I would even prioritize that. And so I don't know if we want to try and identify certain criteria about whether it has implications that could be handled through legislative changes or policy changes within the state or whether it relates to what we think is central to some particular issue that we define.

I just -- I'm afraid what we will do is just each be talking about the importance of all of them and then end up without really having made a lot of progress in prioritizing.

THE CHAIRMAN: We've operated on a consensus basis, so by sort of discussion, every once in a while we've raised our hands to say, "Yes, I think that has value," or, "I think that that should be left on the table."

But it will -- it will certainly be a work in progress. I think any one of these could create -- could create a tome of its own, and that's

certainly not, I don't think, what we were asked to do. I think we were asked to identify these items, make some specific policy recommendations as -- as we see fit.

And that policy recommendation may be the creation of another group of people to give study to an area that requires it. For example, this issue of stigma, we have a lot of professionals around the table. But what do we do to reduce stigma? It may not be within our skill set. That may be a marketing professional's job, to determine how to approach that issue.

So I don't -- I don't know that we need to have all of the answers. We need to be able to identify all of the right questions, though.

DR. SCHONFELD: As another way of looking at it, as another -- for example, you could take media violence in -- the role of media violence in entertainment and then say, "Well, what -- what would this group or what would the State of Connecticut be able to do to impact on that?"

And if it was determined that that was probably more of a national issue or might not be something that we would be able to change through anything within the state, in my opinion, that might

then fall to a lower priority of what this group would do, not that the issue is of less importance.

And so one approach that people might want to do is just take these as they're looking at it and at least think to themselves, what suggestions do they have of approaches that might make an impact on that issue? And then if they don't have any or can't think of any, they might wish to judge that as a lower priority for us to focus or efforts.

And that's what I meant by thinking through some guidance as to how does one prioritize. They are all very important. And so it may be that if we think we have some -- some way to impact it, then I would say that that might be one way that it should rise in priority.

And so I -- there may be other issues about whether it's -- there may be other guidance about whether or not it's, you know, germane specifically to Connecticut or whether it is approached best by a statewide approach.

So I'm just trying to think of some ways that I could try and figure out what would be the most appropriate priority rather than my just looking at these -- all these very important topics.

THE CHAIRMAN: Ms. Keavney.

MS. KEAVNEY-MARUCA: I have two comments in response. One is the time. I sense from your comments that you feel a time limitation to get a good number of things done and done well and thoroughly. And -- and so -- so if you put time constraints on it, then of course -- of course you've got to seriously prioritize.

But then I think back to the -- the state developed the permanent commission on the status of women, because that was a huge issue. That required a good deal of study, and things were constantly changing, a commission, or whatever we might want to recommend.

But there's no reason why we couldn't say we need, for this particular time -- whatever, how many years going forward -- a permanent commission on the status of safety or on the status of mental health treatment in Connecticut, because it appears, from all that we've heard for the past several months, there's a huge problem with that. There's a stigma problem. There's a treatment problem. There's a capacity problem. There is a lot of problems. We certainly can't solve them, but we could identify them.

And then in terms of the other issue you

raised, with the media, I think there are things that may come out of this commission as simple -- maybe that's not the right word, but as recommendations. So things that we might recommend, that all schools implement, for example, a unit on vi- -- the impact -- after we have a presentation perhaps and we have facts, a unit on how violent videos affect children and spread that information out, educate the public on that. That could be the capacity of what we are able to do, but at least we've addressed it, because we see it as something that contributes to safety in Connecticut.

THE CHAIRMAN: Thank you. And that actually -- that brings up something that I should have mentioned. In talking to some folks from around the country who have been paying attention, there are two things I think the commission should bear in mind, two words of caution that I was issued.

One is, this is a big issue. It's not a Connecticut issue. So don't get trapped in being limited to Connecticut.

And the other was, remember your audience. Your audience is not necessary -- not necessarily professionals. Don't get too wound up in the specifics of complicated matters. Keep in mind that

your audience is policymakers, who don't have -- who may not have a broad background in it. Your audience -- your audiences are the moms and dads and the PTAs. So as you discuss, as you write, as you propose, keep in mind that your audience is, in large measure, lay consumers.

Dr. Schwartz.

DR. SCHWARTZ: And I'd say I think our audience also is national, not just state. People are going to be looking -- waiting for this on a national basis. And I -- and I do think using media, again, you know, as an example, there may be areas -- you know, we may have some recommendations for mental health law in Connecticut, because we know the questions and we think we know the answers.

There may be other areas, like media, where perhaps as far as we'll go is, we'll lay out what we think are the really -- the relevant questions for the policy to be about the impact of violent media on kids. It may be beyond us to work out all the answers and make a substantial set of recommendations.

But I don't think, with each one of these nine goals, that this is what we stick with, we have to necessarily go into the same depth and have the

same process. But I sure, as -- I hope that we don't just decide to ignore some things because -- because they're too big.

THE CHAIRMAN: Any other discussion?

Well, thank you for staying here for a long day.

Dr. Schwartz, one more thing.

DR. SCHWARTZ: One more question. I'm sorry. So -- I apologize, but -- so do you think -- should we have a session on this, I mean, devote a whole session to it? And do we have any -- any sense of what's coming up after next week?

THE CHAIRMAN: Yes. The -- so we are scheduled for a full day next Friday and then for a half day on the following Friday.

And at that point I'd like to spend a little bit more time just in general dialogue, because we're going to take a break, and we all wanted -- I want everyone to take something away, that they can think about during the break, that they can start to -- to figure out how they want to -- they want to proceed. So I'd like to have a more in-depth conversation two Fridays from now.

Well, thank you, everyone. We will see you next Friday. (Hearing concluded.)

CERTIFICATE

I hereby certify that the foregoing 78 pages are a complete and accurate transcription, to the best of my ability, of the electronic sound recording of the April 26, 2013, Sandy Hook Advisory Commission hearing.

Jill E. Remillard Date
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