

KENTUCKY STRENGTHENING FAMILIES

The 6 PFs are research based in that when these 6 PFs are present, regardless of the number of risk factors present in the home, the likelihood of family dysfunction *reduces* and in exchange the rate of school readiness, children reaching optimal development and the strength of the family unit increases.



Six Core CYSCHN MCHB Outcomes

1. Family Partnership
2. Medical Home
3. Early and Continuous Screening
4. Adequate Insurance
5. Ease of use of community based services
6. Transitions

Protective Factors

- Parental Resilience
- Social Supports
- Knowledge of Child Development
- Concrete Supports in times of need
- Social-emotional Competence of the child

Protective Factors – the Medical Home

The positive effect of having a family-centered medical home remained after adjusting for confounding factors, like household income, race/ethnicity, or health status.

Children with two or more adverse childhood experiences were

- 1.9X as likely to have problems getting needed referrals
- 1.7 times more likely to experience problems getting needed care coordination

Children who had adverse childhood experience but had care in a family centered medical home

- Were more likely to exhibit resilience
- Were less likely to have a parent report they were always aggravated with their child

Protective Factors – Medical Home

Dr. Nadine Burke Harris
Center for Youth Wellness
www.centerforyouthwellness.org



- Screen – Counsel – Refer
 - ACE 0-3 with no symptoms – counsel
 - ACE 0-3 with symptoms, or ACE ≥ 4 , Refer for treatment
- Family -Centered Medical Home Model
 - Multidisciplinary team
 - Address social determinants
 - Specific counseling – exercise, mindfulness, other stress reduction
 - Treatment models to address trauma
- Improvements: school performance and attendance, diabetes control, asthma control

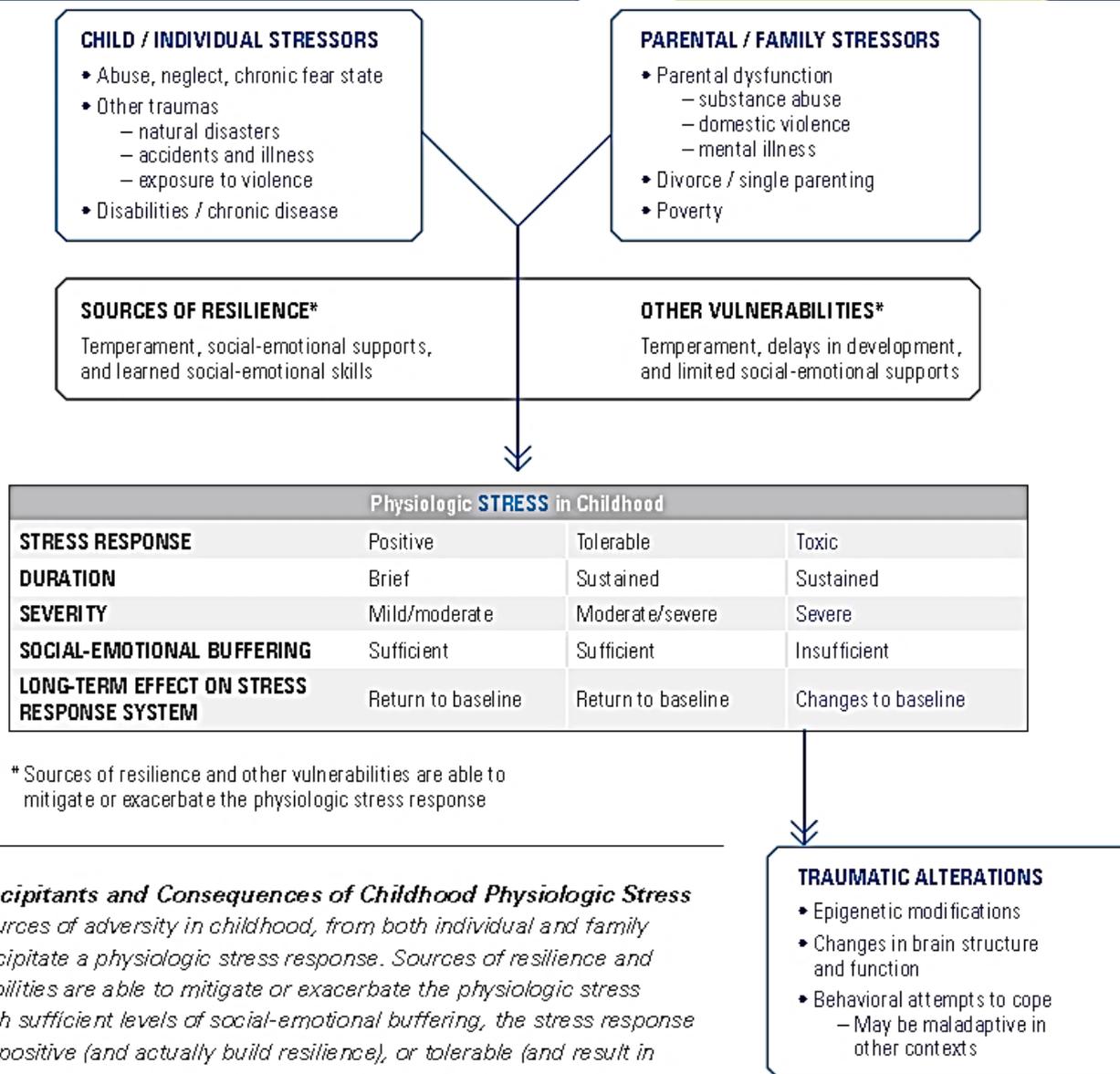


Figure 2. Precipitants and Consequences of Childhood Physiologic Stress
 Significant sources of adversity in childhood, from both individual and family stressors, precipitate a physiologic stress response. Sources of resilience and other vulnerabilities are able to mitigate or exacerbate the physiologic stress response. With sufficient levels of social-emotional buffering, the stress response can be either positive (and actually build resilience), or tolerable (and result in no sustained changes). With insufficient levels of social-emotional buffering, the physiologic stress response is sustained or severe and becomes toxic, resulting in potentially permanent alterations to the epigenome, brain structure, and behavior. These traumatic alterations may actually be adaptive in threatening or hostile environments, but they are often maladaptive in other, less threatening contexts.

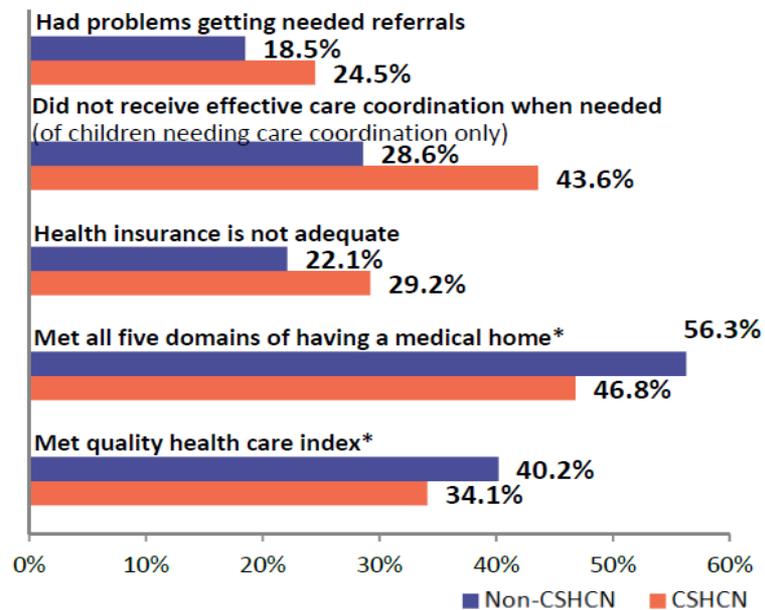
Trauma-Specific Anticipatory Guidance

WHAT YOU WILL SEE	WHY IT OCCURS	HOW FAMILY CAN RESPOND
<p>Traumatized children will respond more quickly and more forcefully than other children to anything they think is a threat.</p> <p>Traumatized children are more likely to misread facial and non-verbal cues and think there is a threat where none is intended.</p>	<p>Areas of the brain responsible for recognizing and responding to threats are turned on. This is called hypertrophied.</p> <p>Brain does not recognize that this new situation does not contain the same threats.</p>	<p>Do not take these behaviors personally.</p> <p>Helping the child understand your facial expression or the tone of your voice will help lessen the chance of the child's behavior escalating in situations that otherwise do not seem threatening.</p>
<p>Traumatized children need to be redirected or behavior may start to escalate.</p>	<p>Responding with aggression will trigger the child's brain back into threat mode.</p> <p>Logic centers shut down; fight, flight, or hide response takes over.</p>	<p>Avoid yelling and aggression.</p> <p>Lower the tone and intensity of your voice.</p> <p>Come down to the child's eye level, gently take hold of the child's hand, and use simple, direct words. Give directions without using strong emotions.</p>
<p>Children don't always know how to say what they are feeling. It can be hard for them to find words. Often they are not told that how they feel is okay.</p>	<p>Emotion and language centers are not well connected. Memory centers that hold words are blocked.</p>	<p>Tell the child it is okay to feel the way she feels and to show emotion.</p> <p>Give the child words to label her emotions.</p>

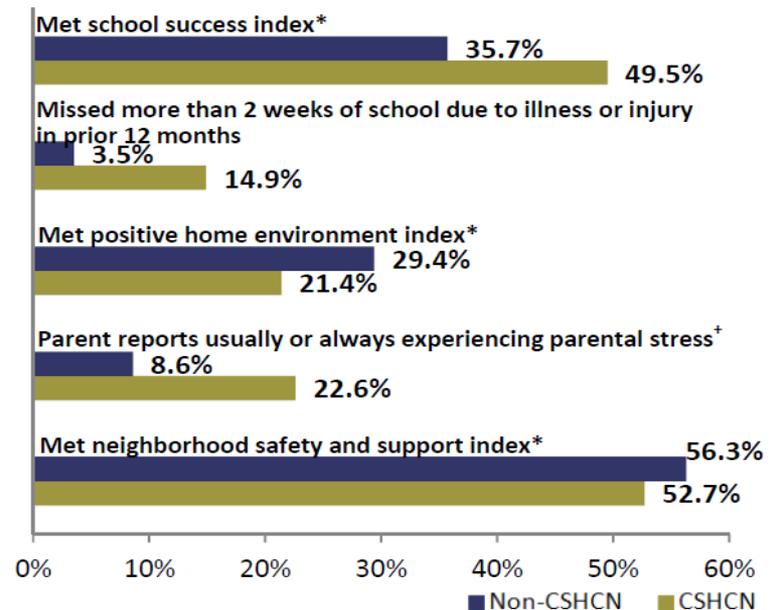
Trauma-Specific Anticipatory Guidance

WHAT YOU WILL SEE	WHY IT OCCURS	HOW FAMILY CAN RESPOND
<p>Traumatized children do not have the skills for self-regulation or for calming down once upset.</p>	<p>Children have had to constantly be watchful for danger. Parts of the brain that keep us alert stay turned on, but the parts of their brains used for self-regulation and calming have not grown with the child.</p>	<p>Develop breathing techniques, relaxation skills, or exercises that the child can do when getting upset. Praise the child for expressing feelings or calming down.</p> <p>Guide the child at first, then just remind the child to use his skills when you start to see the child getting upset.</p>
<p>Traumatized children will challenge the caretaker, often in ways that threaten placement.</p>	<p>Children come with negative beliefs and expectations about themselves (worthless, powerless) and about the caregiver (unreliable, rejecting).</p> <p>Children often reenact or recreate old relationships with new people. They do this to get the same reactions in caretakers that they experienced with other adults because these lead to familiar reactions.</p> <p>These patterns helped the child survive in the past, prove negative beliefs, help the child vent frustration, and give the child some sense of mastery.</p>	<p>Give messages that say the child is safe, wanted, capable, and worthwhile and that you as the caretaker are available, reliable, and responsive.</p> <p>Praise even neutral behavior.</p> <p>Be aware of your own emotional responses to the child's behavior.</p> <p>Correct when necessary in a calm unemotional tone.</p> <p>Repeat, repeat, repeat.</p> <p>Do not take these behaviors personally.</p>

2011/12 National Survey of Children's Health:
Health Care Access and Quality for CSHCN and Non-CSHCN



2011/12 National Survey of Children's Health:
Home and School Profile for CSHCN and Non-CSHCN



***Medical home:** (1) Have a personal doctor or nurse, (2) have a usual source for sick care, (3) receive family-centered care, (4) have no problems getting needed referrals and (5) receive effective care coordination when needed

Quality health care index: have a medical home, adequate insurance and at least one preventive medical visit in the prior 12 months

School success index: child usually or always is engaged in school, participates in extracurricular activities and usually/always feels safe at school (age 6-17)

Positive home environment index: watches 2 or fewer hours of TV per day (age 0-17) and does not have a TV in bedroom (age 6-17), no one in household smokes, usually/always does required homework (age 6-17), parent has met most or all of child's friends (age 6-17), child is read or sung to every day (age 0-5), child was ever breastfed (age 0-5) and family eats meals together 4 or more days/week

Neighborhood safety and support index: Children live in a supportive community and safe neighborhood with 3 or more neighborhood amenities (age 0-17) and attend a safe school (age 6-17)

[†]Usually or always feels at least one of the following three ways: (1) that child is much harder to care for than other children: (2) bothered a lot by their child's behavior: (3) angry with their child

Family to Family

Parental Resilience, Concrete Supports and Social Connections

Share

Family/Professional Partnerships Program: Family-to-Family Health Information Centers

Family-to-Family Health Information Centers

The goal of the **Family-to-Family Health Information Center (F2F HIC)** Program is to promote optimal health for children (and youth) with special health care needs (CSHCN) and facilitate their access to an effective health delivery system by meeting the health information and support needs of families and the professionals who serve them. The F2F HIC Program also assists in assuring that families of CSHCN will partner in decision making at all levels (i.e. individual, peer, community, or systems).

These statewide, family-staffed centers

- assist families of CSHCN to make informed choices about health care in order to promote good treatment decisions, cost effectiveness and improved health outcomes
- provide information regarding the health care needs of and resources available for CSHCN
- identify successful health delivery models for CSHCN
- develop with representatives of health care providers, managed care organizations, health care purchasers, and appropriate State agencies, a model for collaboration between families of CSHCN and health professionals
- provide training and guidance regarding the care of CSHCN

Making a Difference

"You have given me hope and I feel like I can deal with this now, one day at a time. You have helped me so much. I can't describe what a difference you have made for both me and my mother."

We have now talked about my child's disability and have accepted that my daughter does have special needs. We didn't talk about it before. Thank you for talking with my mother and talking to me.

*We are ready now to start learning more about what we can do to help my daughter. I felt so isolated until I talked to you. Thank you. Thank you. Thank you.**

— [Arizona Family-to-Family Health Information Center](#)

**A family contacted us who had two children with severe disabilities covered by private health insurance and Medicaid.*

The private health insurance company began requiring their enrollees to use an out-of-state mail order pharmacy.

Because the out-of-state pharmacy was not a Louisiana Medicaid provider, the family was cut off of using their Louisiana Medicaid as a secondary insurer, resulting in \$500 per month in additional costs.

*We worked with the Louisiana Medicaid Director so that this family could submit the balance of the costs and receive their benefits.**

— [Louisiana Family-to-Family Health Information Center](#)

Kentucky Family-to-Family Health Information Center

IMPACT on a Family:

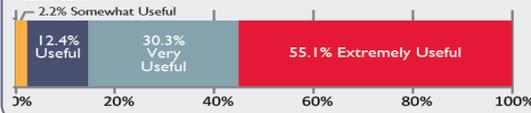
"I came to the Kentucky Family-to-Family Health Information Center at the Commission for Children with Special Health Care Needs through a social group for teens and young adults with disabilities. One of my peers in the group was the daughter of the Co-Director of Family-to-Family. She invited me to be a Mentor/Support Person.

As a Mentor/Support Person for Kentucky's Family-to-Family, I help individuals with special needs and their parents with difficult situations. I speak with them, sharing all I've learned at Kentucky Family-to-Family and what I know from my life experiences. Being a young woman with Cerebral Palsy, I can relate to the kids as someone who understands the barriers they face, and when I do, it isn't pandering, because I've gone through a lot of the same things they are experiencing. Parents can see what I have accomplished and feel hope that their children can achieve a great deal, despite their disabilities. I recently talked with a family whose daughter was having the same surgery I had several years ago—so I could speak as to how her daughter feels and share with them how it still helps me now. I also trained to be a Kynector and helped families navigate their way through what seemed like an overwhelming process in signing up for the Affordable Care Act.

What being a Mentor/Support Person has done for me is push me to be an even better person. I feel blessed in terms of my disability: I am thankful that I have come so far. I am thankful that parents can look to me as a positive example and kids can see me as a peer, a mentor, and a friend. Working as a Mentor/Support Person I am able to give back and the immense joy I feel because of that is indescribable."

IMPACT: Family/Provider Communications

Families rate the usefulness of the support/information/resources they received from the KY F2F in helping them partner with (communicate with, talk with, work with) professionals to make decisions about their child's health care.²



FY2013 F2F OUTREACH:

Total Families Served: 3,026
Total Professionals Served: 622
Materials Disseminated: 15,770
Trainings: 273

CONTACT:

KY Family-to-Family Health Information Center
310 Whittington Parkway Suite 200, Louisville, KY 40222
Phone: (502) 429-4430 • Toll-Free: (800) 232-1160
Fax: (502) 429-7161
Debbie Gilbert, DebbieA.Gilbert@ky.gov (Eastern KY)
Sondra Gilbert, Sondra.Gilbert@ky.gov (Western KY)

²National Survey of Children with Special Health Care Needs: NC-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 04/03/2014 from www.childhealthdata.org.
*FY2013 F2F data represents families and professionals served through one-to-one contact, training, and broader outreach from June 1, 2012 through May 31, 2013.

Creating a Culture of Resilience



ACEs and High School Sophomores and Seniors

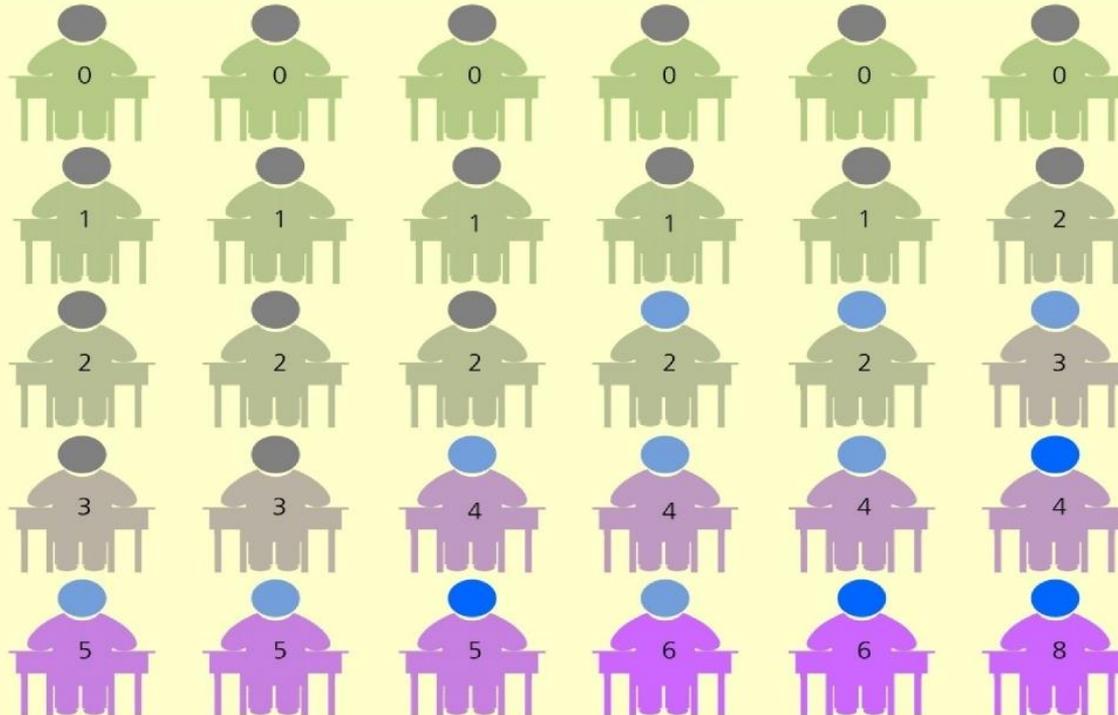
Washington School Classroom (30 Students)

Adverse Childhood Experiences (ACEs)

6 students with no ACE
5 students with 1 ACE
6 students with 2 ACEs
3 students with 3 ACEs
7 students with 4 or 5 ACEs
3 students with 6 or more ACEs

Washington State determined that 13 out of every 30 students will have toxic stress from 3 or more traumatic experiences

Population Average



Trauma-Sensitive Schools- Trauma-informed classrooms (Compassionate Schools)

- “Children with toxic stress live much of their lives in **fight, flight, or fright (freeze) mode. They respond to the world as a place of constant danger.** With their brains overloaded with stress hormones and unable to function appropriately, they can’t focus on school work. They fall behind in school or fail to develop healthy relationships with peers or create problems with teachers and principals because they are unable to trust adults. Some kids do all three.
- With despair, guilt, and frustration pecking away at their psyches, they often find solace in food, alcohol, tobacco, methamphetamines, inappropriate sex, high risk sports, and/or work and overachievement. **They don’t regard these coping methods as problems. They see them as solutions** to escape from depression, anxiety, anger, fear, and shame.”

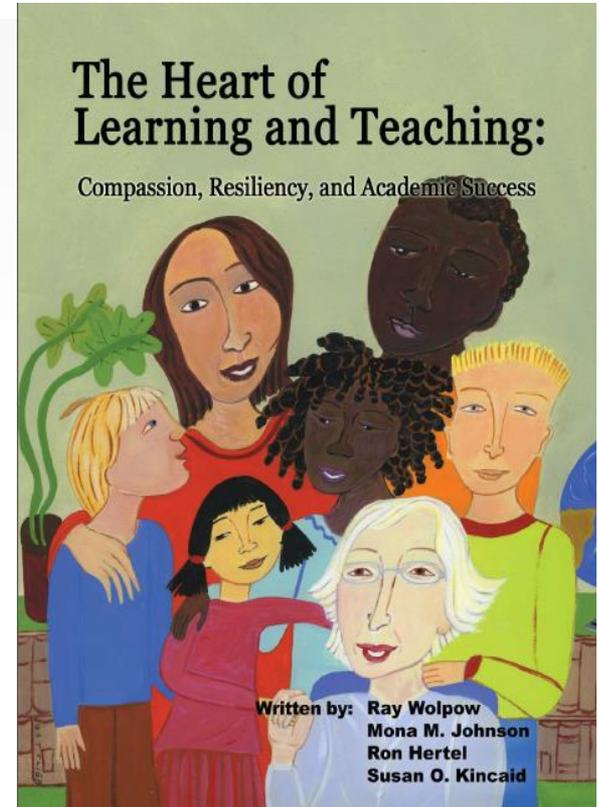
Trauma-Sensitive Schools- Trauma-informed classrooms

Compassionate Schools

- “It all boils down to this: **Kids who are experiencing the toxic stress of severe and chronic trauma just can’t learn...**

It’s physiologically impossible.”

- In trauma-sensitive schools, **teachers don’t punish a kid for “bad” behavior**—they don’t want to traumatize an already traumatized child. They dig deeper to help a child feel safe. Once a child feels safe, she or he can move out of stress mode, and learn again.





WEST VIRGINIA CENTER FOR CHILDREN'S JUSTICE

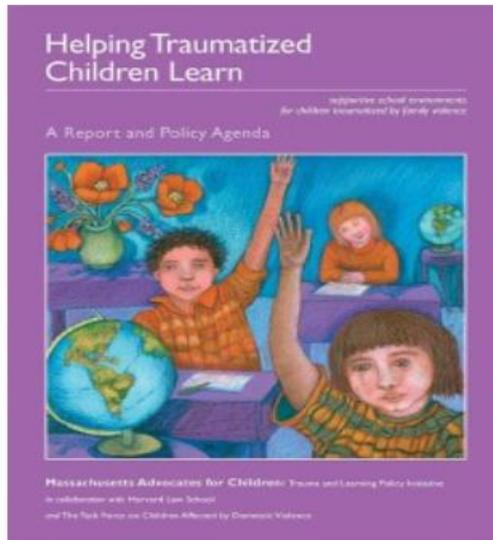
PROTECT • HEAL • THRIVE



www.handlewithcarewv.com

The "Handle With Care" Model:

If a law enforcement officer encounters a child during a call, that child's information is forwarded to the school before the school bell rings the next day. The school implements individual, class and whole school trauma-sensitive curricula so that traumatized children are "Handled With Care". If a child needs more intervention, on-site trauma-focused mental healthcare is available at the school.

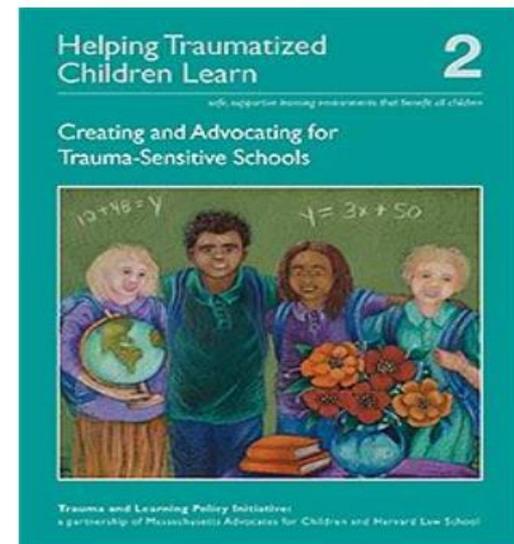


TLPI's groundbreaking publication, *Helping Traumatized Children Learn: A Report and Policy Agenda*, describes the impact of trauma on learning and proposes a policy agenda. Nearly 100,000 copies have been distributed or sold. [Download or purchase a copy.](#)

TLPI's follow-up publication, *Helping Traumatized Children Learn II: Creating and Advocating for Trauma-Sensitive Schools*, offers a guide to a process for creating trauma-sensitive schools and a policy agenda

to provide the support schools need to achieve this goal. [Download or purchase a copy.](#)

The Trauma and Policy Learning Initiative is a partnership between Massachusetts Advocates for Children and [Harvard Law School](#).





Accessible • Fair • Effective • Responsive • Accountable

HOME	FLORIDA COURTS	RESOURCES & SERVICES	ADMINISTRATION & FUNDING	PUBLICATIONS & STATISTICS
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[Home](#) | [Resources & Services](#) | [Court Improvement](#) | [Judicial Tool Kits](#) | [Family Court Tool Kit:Trauma and Child Development](#) | [The Goal](#)

T_T
TEXT SIZE PRINT SHARE

Trauma and Child Development
The Problem
The Solution
The Goal
Court Implications
Resources

The Goal

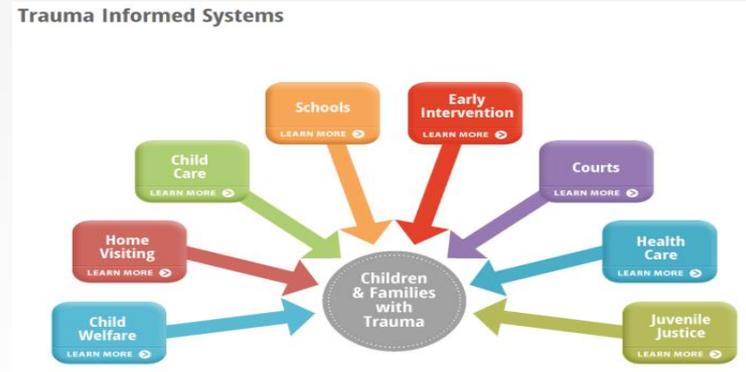
The goal of a trauma-responsive, developmentally-informed court is to change the trajectory for children and families who have experienced trauma – "...improving the long-term health and well-being of children and families and disrupting intergenerational cycles of adversity."

(Shawn C. Marsh, Ph.D. and Carly B. Dierkhising, MA, Juvenile and Family Justice Today, Summer 2013)

CHANGING THE TRAJECTORY

Community Approaches to Mitigating Toxic Stress

National Center for the Science of the Developing Child: Resilience game

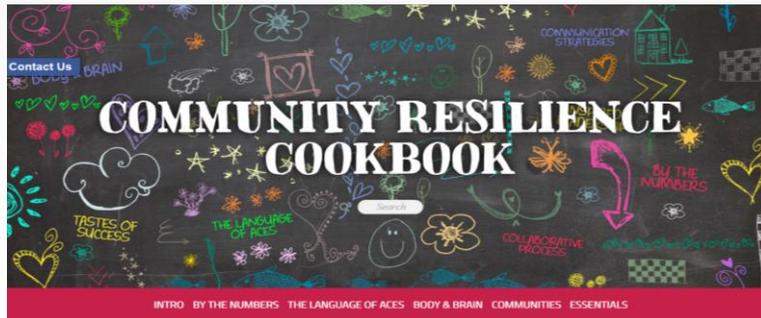


www.floridatrauma.org



Community Approaches to Mitigating Toxic Stress

Health Federation of Philadelphia
National Summit on ACEs 2013



Alberta, Canada

Arizona

Camden, NJ

Iowa

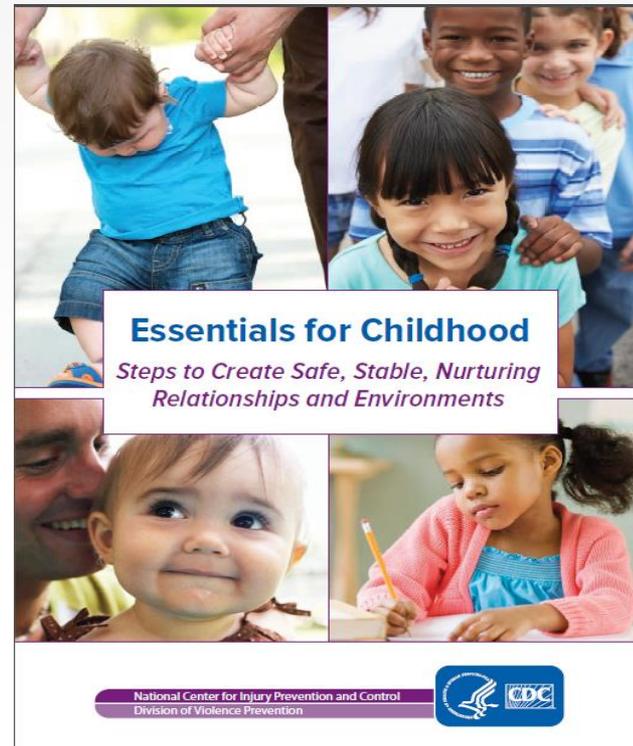
Maine

Philadelphia, Pa

Tarpon Springs, FL

Dalles, Oregon

Walla Walla WA



www.cdc.gov



Building Resilient Children and Families

2014-2017

Business
Plan

Building Resilient Children and Families

BOUNCE: Building Resilient Children and Families (formerly the Coalition for Louisville Youth) is part of a five-year initiative known as Investing in Kentucky's Future launched in 2012 by the Foundation for a Healthy Kentucky to address the state's unmet health care needs. It is a bold endeavor to improve the future health of children in Louisville, fostering the skills to bounce back from adversity with resiliency and grit. Through the collaboration of diverse community partners, we are moving "upstream" to address the root causes of poor health in our most vulnerable children by implementing a trauma-informed model for Jefferson County Public Schools (JCPS) within a Whole School, Whole Community, Whole Child Coordinated School Health initiative which the Association for Curriculum and Centers for Disease Control and Prevention provided this spring as an update to the Coordinated School Health Model. In addition, we seek to improve the knowledge and skills of providers of out-of-school time programming to help them recognize the impact of adverse childhood experiences (ACEs), ultimately equipping them to help youth develop resiliency and the ability to cope with trauma.

Louisville, KY – Louisville-Metro Health Dept and partners

- Used existing data to develop the case
 - Applied for grant from Foundation for a Healthy Kentucky
(chronic disease prevention)
 - Choose curriculum from NCTSN
 - Piloted in a high needs elementary school
 - Trained all staff – admin, teachers, food service, bus drivers, office staff, others
 - Students participate in one of three levels
 - Engaged parents in activities and training
- Engaged Community Out of School Partners
have trained over 1000 our OSP staff
working to add trauma-informed training to OSP certification

Take Home Messages

- **Exposure to violence/trauma is the single most prevalent risk factor for children today.**
- Adversity is necessary for life and learning; toxic stress disrupts life and learning
- CSHCN are disproportionately affected by adversity.
- **Relationships are necessary for Resilience.**
- The lifelong toll of unaddressed Adverse Childhood Experiences is a [*perhaps THE*] major cause of death and disability in adults. Opportunities to intervene begin in childhood.
- **Knowing what we know, we can do better in preventing, mitigating, and treating toxic stress, and building protective factors and resilience with Kentucky families.**



Questions for Discussion

1. What is the role of the Commission for Children with Special Health Care Needs in reducing Adverse Childhood Experiences for CCSHCN families?

1. Identify 3 things communities can do to break the cycle of substance abuse and reduce adverse childhood experiences for infants who experienced neonatal abstinence syndrome?