Good afternoon. Welcome everybody. My name is Sherrie Rudick, and I am the product coordinator with the HV-ImpACT And I want to welcome you to the second webinar from the HV-ImpACT. This one is called [? Prompt ?] and Informed Approaches to Support Children Families and the Home Visiting Work Force.

And it will be presented by Neal M. Horen, PhD. He's a TA specialist with the HV-ImpACT. But also really relevant for this particular webinar, Neal is the director of the Early Childhood division at the Georgetown University Center for Child and Human Development. We're going to get started in just a few minutes. Welcome to our lobby.

You'll notice up in the left-hand corner of the lobby it says chat free to everyone. And there's a question. And what we'd like you to do as you're joining us-- and right now we have about 60 participants-- we'd like you to sign in and answer the question the lobby question. That is, what is the best venue in your state for discussions around trauma-informed care?

It's 2:56, so we'll be getting started in about four minutes as you sign into the chat box. And that chat box, by the way, is a new feature that we will be using throughout our webinar, so that you'll be able to put your questions and comments in that chat box throughout the webinar. The webinar is being recorded, and it will be posted and archived on the HRSA web site.

There are four handouts with the webinar, and you can see them in the pod that says file. And it's kind of at the lower right part of your screen.

So welcome to the webinar. I see a couple of people are starting to type in their name, and signing in and answering our question, which is, what is the best venue in your state for discussions around trauma-informed care? And of course, our title for this webinar is "Trauma-Informed Approaches to Support Children, Families, and the Home Visiting Workforce."

So it's nice to see some names coming through. I think there's always a challenge with a big chat with a large audience, as we think we might have today, of getting everybody signed in and chatting. So when I look at the screen, I see that it says multiple attendees are typing. And I see you coming through. If you have a minute to answer the question about the best venue in your state for discussions around trauma-informed care go ahead and do that.

OK I'm seeing a lot of names. But I do see that the Florida Association for Infant Mental Health must be the best venue in Florida for discussions around trauma-informed care. So that's great to see.

And we'll be getting started in just another couple of minutes. We've got 82 participants joining us right now. We had a lot of people register, as in 281. So we'll see how many people actually join us in the next couple of minutes. And we'll give it just a couple minutes more for people to sign in.

I see a couple of places where people are from, in addition to names. So that's great. And let's see. 91. OK. We're growing by leaps and bounds here.

Let's see. What have I not mentioned? Webinar is being recorded. I think I did say that. And you'll find it on the HRSA web site. This chat box where you are now signing in with your names, and sometimes answering the question about the best venue in your state for decisions about trauma-informed care.

We're going to leave this chat box on for the whole webinar this time. And we'll be looking throughout the webinar as Neal is talking and as Nancy Topping-Tailby is helping guide the polls. We'll be sort of monitoring the chat, and making note of questions and some of the comments, sort of feeding them over to Neal.

There is apparently another-- there it is-- Department of Children and Families in Florida. And we've got an answer from Arkansas, where the Arkansas Association for Infant Mental Health is kind of key. We've got the Chickasaw Nation Head Start in Oklahoma joining us. And let's see. What are we up to? 114. I keep seeing the numbers grow, which is really exciting.

OK. So I have 3:01. And we're going to get started. So I'm going to turn it right over Neal.

Well thank you, Sherrie. Welcome everyone. This is Neal Horne, TA specialist with HV-ImpACT. And as Sherrie mentioned, I'm also at Georgetown, and spend my time spread across a number of National Technical assistance centers, including the Head Start National Center on Early Childhood Health and Wellness, where I work on mental health issues; the Center of Excellence on Infant and Early Childhood Mental Health Consultation; and the TA network that works with system of care sites focused on early childhood. And then I spend a great deal of my time on HV-ImpACT.

And we are excited to talk a bit about trauma today. It seems a little oxymoronic. But we want to talk about trauma. We want to talk about resilience. And one of the things we want to do is not do the same old, same old. So we'll do a little bit of that.

We feel like to get everybody on the same page, we will do a bit about what is trauma, and signs and symptoms, and things like that. And that may be somewhat repetitive for some of you. For some of you, hopefully it'll be new. We're happy to have folks sort of type in the chat box, hey, I already know this. But this is the thing that we're trying to deal with.

And then we're going to spend sort of the latter half of today's time really talking about trauma-informed approaches from sort of systems perspective, which is where I spend a fair amount of my time helping folks around the country develop their early childhood systems.

Sherrie mentioned Nancy Topping-Tailby who is my partner on this on the HV-ImpACT. Nancy's going to be sort of in and out here running polls. She and I will sort of facilitate some discussions here. And we're really hoping that you use this chat box to ask questions, make comments as we go along.

I'm going to do my best to multitask. Those of you who know me know that I'll end up getting lost somewhere in the chat, and forget that I'm actually to present, but I'll do my best. And our goal really here is to give you all information that you can use. And some of this around what is trauma, how do we build resilience, those kinds of things that some of you may have heard before, is also fodder for you as you're building your system, and you're having conversations with your partners at the state level. So that's sort of where we're heading today.

So these are our learning objectives. And we are going to do a little definitional piece. And as you can see in the files box down below, there are some files, some handouts that we have for you. But again, if you know all of this, you won't need them. Or if you know all this, you'll use them in terms of how you're working with partners to sort of fully develop your trauma-informed system.

We'll talk about a trauma-informed approach. We'll talk about some strategies to implement that approach in your current work, as well as some tools and resources that we want to share with you.

So the other thing we're going to try and do is make it as interactive as possible. I find myself fascinating, but listening to me talk for an hour and a half, I'm pretty sure that Sherrie will then be just yelling out numbers like, "We're down to three! We're down to two people!"

So we're going to try and keep this interactive. We'll do some polls. We'll have you all sort of typing in questions. All those kinds of things. I'm going to be especially nice to Tiffany, because she's typing in that she's from Kaua'i, and I just want to make sure that I keep Tiffany happy, because that's where I want to go.

So we'll start here with a little poll. And before we get started here, what I want to just sort of mention, and I always do this, and I think it's hard to talk about trauma in an hour and a half. And I think it's really hard to talk about trauma without acknowledging that there may be people on the phone who have some direct experience in this, who have worked with families, who have had some pretty traumatic things happen.

And we want people to take care of themselves. We don't want to sort of trigger anything for anyone. Oftentimes when I do a session on trauma or presentation, somebody there is sort of starting to think about something that's happened to them, and their home life or work life.

And so we acknowledge that this is sort of a quick run-through on a very complex, challenging subject that can be hard for folks to talk about. But we want everyone to take care of themselves. We want you to sort of be OK at the end of this, and feel like you got something out of it. But were going to start with a little poll. And when I sort of say what is trauma, what sort of comes to mind?

So we're going to poll. There we go. So you're just going to sort of type your answer in there. When I say what is trauma, what are the things that come to mind? So this is the interactive part. So when you start typing, it becomes a much more interesting webinar for all of us.

I see pain, domestic violence. I see on the other side Marilyn and Beverly have written down the ACEs and shock. So Nancy, you're tracking on this, right?

I am. Right.

So one of the things that we can see is that there are lots of different ways to think about trauma. And there's not a single definition, because there are lots of kinds of events that can qualify as trauma. And as we go through this, Neal is going to talk a little bit about what makes a traumatic event traumatic for one person, and perhaps not for someone else. But certainly-- yeah, you're talking about that.

These are things that we're going to get to. I see things about sort of physical, like your adrenaline. I see things about being overwhelmed. I see specific sort of kinds of events that can cause trauma-- abuse, neglect, domestic violence.

I see the kind of reaction that people may experience. Candace mentioned fear and shock. And then it's life-changing. Judy talks about this being something that affects your future understanding and comprehension of someone's behavior.

So I think these are really good, thoughtful answers. Again, not a surprise. Many of you have been through any number of sorts of trainings on this. And also lived experience, in terms of your work or your home. So we appreciate all the responses here.

OK. So why don't we go ahead and close this? That's a good start for us in terms of getting us all on the same page. Great. Thanks.

Let me just move to my next slide. Sorry about that. So I think that some of the things that you listed were traumatic events. And it may be the result of intentional sorts of things-- child physical or sexual abuse, domestic violence. Or it could be-- and I'm not sure if I saw this-- things were moving quickly. But keep in mind natural

disasters, accidents, war, the unfortunate sort of violence that we've experienced recently in this country in terms of shootings and terrorism, and things like that. And so there's lots of different sorts of ways in which to sort of think about that.

So let's go ahead and do another quick discussion about what you all think makes an event traumatic for a very young child. So again, you can type your answers in. You can go on the left. You can go here on the right. Nancy's going to sort of help us through this.

So here we're [INAUDIBLE] as looking people are talking about both what they experienced first-hand, as well as sometimes witnessing something that could be happening that they don't experience directly, but they're witnessing.

Mm-hmm. Right. Right. So we saw this. I was called in after Superstorm Sandy in the Head Start world to work with some of the folks up in New Jersey. And that was one of things that we saw quite a bit, Nancy, was that not only were the folks and the children and the families who had sort of personally experienced loss-- loss of home, things like that. But then there's sort of this secondary piece of children whose friends had moved away, children whose friends were not returning.

Folks in a home visiting program, certainly those kinds of incidents, I also was a responder after Hurricane Katrina. And we saw that the sort of shift that got made in people's lives really impacted children families workers and all these child-serving agencies, certainly the home visiting world really had some major work to do at that time.

So I'm thinking, Neal, that Sandy Peterson is talking about a painful experience that a child can't understand, where there's no adult to help them, which is something that we're going to be talking about in terms of the power relationships. And I also see that somebody here is mentioning cultural indifference as a potentially traumatic event for a young child, bringing in culture.

Yeah. And I like also that Sandy brought up, in some ways just to remind us all, that when we talk about infants, we have, and we're going to talk about that today. But we need to think about infants versus children 18 to 36 months. So that when we think about infants, there are some different things we also have to think about.

OK. So Nancy, I think we've got some really good responses here. I think this is really helpful for us to sort of keep in mind as we move through this. I think you all should keep using the chat to sort of throw in if we're not doing a poll.

And if I remember right Nancy, we have 91 polls. Is that right? About nine-- nine polls. We have a number of polls,

number of opportunities for all of you to sort of jump in here. But don't feel like you have to wait. If as I'm describing something, something comes up for you, please sort of jump in, throw in in the chat a point you want to make. Nancy and Sherrie will keep me honest and say, hey Neal, you haven't responded to this point that somebody made.

So let's go ahead and go back to the PowerPoint please. That is awesome. So moving on.

So you're not going to be surprised, because I think that this is something that [INAUDIBLE] you mentioned, that trauma is really when something happens that overwhelms the child's ability to cope or deal with what has happened. Now one of things that's important to keep in mind there is that it overwhelms that child's ability to cope. And children have different abilities to cope with events.

So that traumatic experience may be a single event. It may be a series of events. It may be chronic conditions. And it's highly individualized. It's not experienced the same way.

So just hypothetically, let's just say you were going to be doing a national webinar, and the slides weren't working correctly when you first started. The three people on the webinar whose names might rhyme with Shmary Shmancy and Shneal would react differently. I'm just saying for example, hypothetically.

And so that might not cause trauma. But it might cause some stress. And it might be different sort of levels of stress. Some might be very stressed. And some might not. And in the same way, in terms of traumatic events, children and adults perceive things very differently.

There's this interesting task that we've done with our children when they were little, where we gave them cameras when they were very young. And so when you go to Disney World, or any of these other places. Because it's always cool to see a child's perspective of what they take pictures of as a two or three-year-old, versus what we think is interesting. And that child's perspective, in terms of the impact of a traumatic experience, is really important to keep in mind, that adults may perceive something as traumatic or not traumatic.

For example, a parent may believe a hurricane that destroyed their home is most traumatic. But the young child in the same family may be the most upset because they lost their cat who ran away during the storm. And so we have to keep that in mind as we do this work.

And what I'm going to do throughout is I'm going to start here on sort of on the front line, on the ground, where home visitors are. And we'll work our way up to a sort of a systems-level perspective. But it's important at a systems level to keep in mind, what are the home visitors facing when they're going to someone's house who has experienced trauma, when a child in that home has experienced trauma? And so that perspective is really important to keep in mind.

I oftentimes, when I talk about this, I talk about a car accident. Because I think many of us have at some point in our lives. And it's interesting, because my twin 15-year-olds started drivers ed today. And so now they're asking me all kinds of questions.

But many of us have been in a car accident. And for some, that's been a very traumatic experience. For some, less traumatic-- just sort of annoying or frustrating. And so some individuals could develop symptoms such as fear of driving, or being super cautious. And others are not impacted by that.

And there are a number of factors that sort of impact how sort of how somebody experiences and reacts to that trauma. And so if you had previous trauma, you may be more likely to be traumatized. If you have some sort of a history of mental health issues-- like depression, or anxiety, or substance abuse-- those may become worse after a traumatic experience.

We did talk about how close you are to the traumatic experience. And if you are very close, you tend to be more impacted. It doesn't mean, as was pointed out, that you're not impacted if you are experiencing secondary trauma. And certainly home visitors are often, that is one of the parts of this work, is that you may hear about a great deal of trauma, and it may actually impact the home visitor.

So I think it's just important to think about, for a second, if you've been involved in a car accident, or you've been in more than one car accident, how you responded, and how you responded the second time. And did it impact you? And does it impact your driving? And those kinds of things.

The flip side of all that, and we'll certainly talk a bit about resilience, but the flip side is that you have to think about a child's support system-- their caregivers and family-- the child's temperament, their culture and the environment. Those have a huge influence on how a young child experiences events that occur around them.

And so adults can really help children from becoming overwhelmed. They also can actually in a negative way have some negative influence if they are having a great deal of difficulty. So it's important keep in mind as we sort of go through this.

There is a handout about what causes trauma that's available down below in the files part, if you are interested in sort of looking a bit more about some of the things that cause trauma.

So I want to talk about stress. Because when we talk about trauma, when we talk about toxic stress, when we talk about all these things that we'll get to, it's important to keep in mind that stress in some ways is not necessarily always a bad thing, right? So when you took a test, if you had a little bit of stress, it actually improves your performance to some degree, until you're so stressed that it decreases your performance.

But when we talk about stress and trauma, what's important to think about is sort of intensity and length. And the intensity of mild to moderate stress is fairly tolerable. Sitting in traffic is stressful. But it's not the same as being in a car accident. And so we sort of have this continuum of mild to moderate stress all the way to toxic stress, which we'll talk a bit about. And then in terms of length, if something is acute, sometimes that can not be quite as stressful as sort of ongoing things like domestic violence, like substance abuse, and those kinds of experiences.

In terms of stressful events, there's sort of another way to sort of cut this in some ways, and to start to think about this again from a systems perspective, is to think about child-based, family-based, community-based, and then things like natural disasters. And so things like chronic illness and special needs and things like that actually can be very stressful, and may even be traumatic for some children and families.

And we may not always think about it that way. I think we tend to. And when I go back to the poll that you all typed in, a lot of it was more about this sort of family-based piece, about abuse, neglect, domestic violence, parental loss, mental illness, substance use and abuse, and those kinds of things; or community based-- living in extreme poverty, being homeless, community violence, terrorism.

And then again as we've seen, earthquakes, volcanoes, hurricanes, tornadoes. I don't know if we've all seen volcanoes, but at least we've seen on the news, but those kinds of things are traumatic events, and are stressful events, and can be for some children traumatic in some way, shape, or form.

So in terms of the kinds of potentially traumatic experiences that children and families in the Federal Home Visiting Program face, we thought we'd sort of hear from all of you. What are those potentially traumatic experiences that children and families are facing? So this is another place for you to sort of type in your sense of what you've seen on the ground, or from a systems perspective, the kinds of things that you're seeing. So Nancy, want to take that away?

So it's looking like a number of the things that you were talking about. The children and families in the Federal Home Visiting Program are facing are the same kinds of issues that you identified when we had our broader conversation about what is trauma and what makes a particular event traumatic for some children. So I'm seeing--

There are a couple of other things in here that I think are really interesting as I scroll through. Sorry for interrupting.

No, that's OK. Because we're doing the same thing. So you go first, and then I'll comment, and we'll see if we notice the same things.

All right. Well the two that stood out for me, one was bullying, and the other was systemic racism.

That was mine, too.

Yeah. Well it's mine because I've been spending a lot of time talking with folks about around preschool suspension, expulsion, around issues, around equity issues. And we've been doing a lot of writing and things like that.

And in a lot of times now, what I'm hearing folks say is we need to sort of acknowledge it. Not just sort of make bullying-- oh, yeah, yeah, yeah, that's something. But to really start to think about so what does that mean? And what does it mean for our Home Visiting Programs to sort of think about equity issues and systemic racism? So that was one that sort of stood out for me. And obviously, an hour and a half presentation by phone on a computer is not the best venue to talk about it. But I do want to point out that that one stood out for me.

So I'm also seeing thinking about the constellation of families, about family members or parents being in jail. So divorce, death, but also incarceration, and having key figures that just aren't there.

I also see where Teresa has written about some very specific things that are happening within people's states. So in Colorado, flooding and fires. I assume that those are issues that have come up in California. I think that in different states especially this time of year as we're in hurricane and tornado season, folks are thinking about different sort of things that are germane just within their states and their communities.

So yeah these are really helpful for us to start to think about. Because again, from a systems perspective, as we think about the kinds of potentially traumatic experiences that folks, the families and children that we're working with, may be facing, then as a system we need to be prepared.

For example, I see here military deployment. What a great example of something. And Nancy, Sherrie, you know me well enough to know there's no way the military would ever take me. So I don't have any experience with this. So I don't know what that's like. What I do know is that military deployment certainly calls for a lot of systems-level partners at a state level. And it really sort of suggests that if we start to think about what's happening in the Home Visiting Program in terms of working with families who are addressing military deployment, how are we addressing all the other needs of those children and their families from a systems perspective.

And also a relationship perspective, thinking about substance abuse and mental illness and even lack of attachment, when a parent can't be fully present and available to try and mitigate effects of toxic stress for children. And food and security too came up a couple of times.

Right. Well so many of the things that I'm seeing-- homeless, disabilities, food insecurity, death of a family member, disabilities-- really call for the folks in the home visiting world at a state level to be connecting with the

other partners that would be addressing some aspects of that.

And so in terms of homelessness, it's how are you working with the housing folks at the state level. Because generally what's going to happen is that those children and those families going to be sort of cutting across a number of agencies. And we want to make sure that we're sort of providing support for those families in a way that doesn't give them 15 care coordinators who they have to sort of work through, but that they're sort of everything's coordinated for them. So very helpful responses. We appreciate all the responses on sort of both sides.

So we're going to go back to PowerPoint. Thank you. Thank you, Betty.

So in terms of responses to trauma, several of you mentioned this, but a part of what is happening is that there is some attempt to sort of regain control, regain sort of mastery. Because part of what happens, part of the impact of trauma, is that it feels like things are out of your control. What also happens though is that you begin to adapt, and you accommodate to that loss of control.

So there's the concept of learned helplessness, is a concept that folks need to become familiar with, of what are some of the adaptive and maladaptive responses to experiencing trauma. Because it can also lead to more significant difficulties for children. And I think I think Sandy and several other folks have mentioned this, in terms of this sort of can set children off on a sort of trajectory, as Jack Shonkoff from the Center for the Developing Child often talks about is the trajectory that children get on. Experiencing trauma early on in a child's life really can set them on a different trajectory, and home visitors are uniquely poised to help make sure that children stay on sort of that trajectory, that positive pathway.

So I don't even pretend to sort of be an expert in sort of the changes in the brain that happen. But it is important to sort of keep in mind that there are actual changes. And I know a couple of folks mentioned cortisol change, and norepinephrine changes. But suffice it to say that what we've come to learn more recently about the impact of trauma is that it really does start to change brain structure.

And the simplest way that I always like to explain it for folks who don't have as much expertise in this is that the first three years of your life-- I have a -month-old. I mean she's with her nanny. She's not up by herself. But my -month-old is playing upstairs.

The connections that are being made in that first year or the first three years of a child's life are unbelievable amounts of connections happening. And the connections that get made if you experience trauma are negative associations. It's I'm supposed to protect myself, or this is what happens to my mom, or this is what happens in my family, or this is what happens in my community. Those can affect the way the brain architecture develops.

And you'll hear somebody. We have a video of that. We'll sort of get to this. But suffice it to say that all of us at some point in our high school career learned about fight, flight, or freeze. And not really supposed to have to activate that very often in your life-- hopefully never, maybe once.

What happens for children and families who are experiencing trauma is that sort of system keeps getting activated. And it starts to change the chemistry of the brain. And our bodies keep score.

This is a very intricate drawing that took me couple days to draw. But the idea here is that our bodies keep score. And the more positive experiences-- the best way I've ever heard this explained actually was by Jan Miller-Heyl. Jan Miller-Heyl developed DARE to be You. It's like a social, emotional, social skills sort of development evidence-based practice.

And the way she talked about it, and I always, always sort of struck me that if you think about every single child, every single person is walking around with sort of a bag of poker chips. And I know we're not supposed to talk about gambling. That's probably not a good thing. But just bear with me.

That we all have a bag of poker chips. And eventually you build up your pile of chips over the course of your life. And the more positive experiences you have, every time someone says, hey, you're such a cute baby, you're sort of getting a chip from that person. Or every time someone says, wow, that's such a great job, you get a chip from that person. And if you build up a huge pile of chips, then when you have a negative experience, be it an interaction with one person, or an actual traumatic event, you can actually stand to lose some of those chips.

The challenge is is that we have a number of children and families where there's not a lot of chips. And each sort of instance of a negative interaction or a traumatic experience takes away a huge percentage of those chips so that it becomes very dangerous to even sort of put yourself out there.

And that's what I mean by our bodies keep score, is that we keep count in some way, and we register all the positive experiences, all the negative experiences. And the more we're in the business of sort of providing chips to children. And that's when I think about home visiting, that's what we're doing. Home visitors at the front-line level, at the LIA level and at the state systems level and territorial level, you all are trying to figure out when we get out and we do our work, how are we building up the stock pile of chips for children and families and helping their bodies keep score so that they keep adding? That's sort of the way that I like to think about this.

And all the things you all have mentioned-- abuse, neglect, homelessness, systemic racism, military deployment-- all these kinds of things are the kinds of things that potentially take chips away. And in the home visiting world we need to think about how are we making sure that that's not happening.

So this is actually a picture of me. This is my body after having a baby seven months ago. And it's just the idea

here is that this is the way that our bodies react to stress. And you can see that it impacts all different aspects of your functioning. And the more that that happens, the more that your heart is beating faster, that your liver is releasing sugar, that your blood pressure is rising, all those kinds of things. If that's happening over and over and over again, then you need to start to think about what is the impact on your body. And so we'll talk about that a little bit.

So when I think about this, early childhood stress can lead to chronic fight or flight, and increases in cortisol and norepinephrine. Those increases can change brain architecture, which can lead to being hyper-responsive, and decreased ability to calm or cope as a in terms of what children can or can't do, which can lead to toxic stress. And when children experience toxic stress, that can lead to this sort of vicious cycle here.

Now I stole this from Andy Garner from the American Academy of Pediatrics. But he should know that I used this. But I think that the idea here is is that folks on the front line, home visitors have a unique opportunity to recognize this very early on, and help families understand this.

So again, I think for those of you who have seen this a thousand times, like oh my god, I can't believe this guy's still talking about this. You're now a sales person. You need to be armed when you work with families to help them understand we have a chance to change this. We have a chance to sort of intervene in one of these spots so that that child doesn't grow up in a way that they experience toxic stress.

Now why is that? Well, here's one example, right? One example of just here's what happens when there's positive stimulation in terms of brain development, and when there's negative stimulation. You don't need to be a radiologist. Nancy, I don't even know who reads these things. I'm assuming it's a radiologist.

But you don't need to be able to understand exactly what this all means to see there's no lights in the temporal lobe. That's not good. The temporal lobe has a lot to do with planning and executive functioning. And so it's critical to understand how much of an impact can be had just simply by the fact that there is negative stimulation versus positive stimulation.

And so young children are really at the greatest risk if they're living in extreme poverty, if they're exposed to severe maternal depression or parental substance abuse. And so those are the kinds of negative stimulations that can occur. And again we're all in a great position to start to address this.

So I oftentimes have a slide that just shows this young child sort of with their chin resting in her hands, like, I already know this. Which is exactly what my children say to me all the time; we already know all this. Why are you telling us this?

So you may have seen this before. But again, I like to walk through this just a little bit. Positive stress is not a bad thing. It sort of you have a brief increase in heart rate, mild elevation in your stress hormone levels.

Well, I don't know how to break this to you, but anybody on the phone here who is going to go for a run today, that's what's happening. It's no different than that. And it's really not a bad thing. And the challenge is when it sort of moves down from positive to tolerable, and from tolerable to toxic.

And so on the DSM-- the Diagnostic Statistical Manual-- that we use in terms of diagnoses for children in the mental health world-- one of the things you do is you actually do a rating of stress, of stressers. And come to find out people shouldn't be surprised. Some things that are stressful are sort of positive things-- buying a house, getting married, having children.

I always tell this story in terms of stress that I have three children in 16 months. I know you look at my body and, like, there's no way he did. But I did. We had three children in 16 months. And we had a seven-month-old. And then my wife got pregnant with our twin boys.

And so I remember very distinctly going to the bank. And that's probably the last time I was ever going to the bank anyway. But I went to the bank. I parked the car. I go inside. I take out the last little bit of money we're ever going to see.

I get in the car, I put it in drive, and I drive right over that concrete sort of thing in your parking spot. And then I drive over the concrete thing in the parking spot in front of me. And because I was stressed, I then decide, boy, that wasn't good. I put it in reverse. And I back up over those two concrete abutments again.

Why did I do that? Because it was a positive experience, obviously, having children. But it was stressful. And it was tolerable. It was sort of temporary. It sort of shifts and changes and things like that. But we know that what happens is that when we move from sort of tolerable stress-- the power's out for the day, or there's a really bad storm. And that sort of goes away, and then we're good.

When we move from that to toxic stress, when there's sort of ongoing activation of your fight or flight, and there's no protective relationships, that's when we start to see toxic stress. And this has gotten a lot of play over the last few years. So I'll spend a little bit of time talking about it. And then we'll move in to talk about trauma informed systems. But I wanted to throw that in there.

I want to talk a little bit about the ACEs study. Again, I'm assuming that a number of you on the line have at some point sort of heard about this. So I won't spend a lot of time. If you haven't heard about it, we're happy from HV-ImpACT, we'll get you more information about it.

But essentially know that this actually stemmed from a study of obesity at clinics in San Diego, where they found that people would come in-- these were adults-- would come in, who were obese. They put them on a pretty stringent plan. Folks would lose weight. And they were finding that there was some subset of folks who not only gained the weight back, but gained even more weight back, which led to a study of about 10,000 people from Kaiser Permanente that suggested that things that had happened to these people very early on in their life had actually a lifelong impact.

And that lifelong impact was sort of nicely laid out by Vince Faletti and colleagues, where they found that folks who had experienced higher numbers of adverse experiences tended to then experience some sort of social or emotional or cognitive impairment which led them to adopt these sort of more risky behaviors. So think about folks who smoke, or abuse alcohol, or things like that. Those kinds of things can then lead to disease, disability, and social problems and early death. And I'm not trying to sort of minimize that. But I am assuming that most folks have heard this before.

And so the key thing in all of this is to understand that the kind of experiences we're talking about, most of us have had. We've experienced divorce. Hopefully we haven't experienced some of the other adverse experiences. But there's certainly a lot of those experiences.

And the more that you've experienced-- substance abuse, loss of a parent due to death, or divorce, incarceration of a parent, domestic violence, all those kind of things, the higher at risk you are, not just for things to happen to you in the first three years of your life, but to have them for the rest of your life-- chronic obstructive pulmonary disease, health-related issues, drug use, stroke, liver disease, all kinds of issues.

And so again, I'm assuming that most folks know this. But I'm going to give you some resources. All that work about the ACEs has been put together really nicely by the Robert Wood Johnson Foundation. So this is like this nice infographic. So as you're working at the state level to work with your partners to say we need to be a trauma-informed system, here's infographics that you can use.

Here's other information you can use. If you're working at the LIA level to sort of help make sure that home visitors understand this, there are great ways to help everyone get on the same page about this. And if you're a home visitor, same thing, that there are great ways to sort of help families understand this. Not to say look, what you're doing is going to cause your child to have health issues when they're 50, but more we have a great chance right now to change the way in which this is going to turn out.

So from the Head Start National Center on Early Childhood Health and Wellness, we have a video that sort of explains this I think kind of nicely with some folks from this is Nadine a pediatrician from San Francisco. But there's a couple of folks in here. So Betty can you pull this video up for us please?

[VIDEO PLAYBACK]

[MUSIC PLAYING]

ACEs stands for Adverse Childhood Experiences. And that comes from the real seminal study that was done in this field by Doctor Vince Valetti and Doctor Robert Anda. What they found was for those adults who had a history of adverse childhood experiences-- and these experiences include physical, emotional, or sexual abuse, physical or emotional neglect a parent with mental illness, substance dependence, or who had been incarcerated, domestic violence, or parental separation or divorce-- there were two things that they found that were tremendously striking in this study.

One was just how common it was even among their middle class population. So 64% of their population had at least one adverse childhood experience, and 12.6% of their population had four or more adverse childhood experiences. The second thing that they found was there was a dose response relationship between early adversity and numerous health and behavioral outcomes.

The more ACEs you had-- you numbered them, right-- 0 to 9 or 10-- the more likely it was that you were going to have one of these diagnoses.

What was really an eye-opener for the medical community was that if you had four or more adverse experiences, your risk of chronic obstructive pulmonary disease was 260%, as compared to someone with an ACE score of 0. For hepatitis, it was 250%. If you were a woman, and you got pregnant, your risk of having a miscarriage-- if you had four or more adverse childhood experiences was 180%-- almost double that of a woman who got pregnant and had no adverse childhood experiences. And so we've really begun to understand that there were biological and physiologic underpinnings, and a direct connection between early adversity and health problems in adulthood.

[END PLAYBACK]

OK. Thanks, Betty. We'll go back to the--

So a couple things here. I think it's just a nice explanation. I've used this video in training. I've actually seen folks from different agencies at the local level use this in training. Because I think that, again, just sort of throwing information out sometimes can sort of just be overwhelming.

But as we have folks like pediatricians and home visitors and other folks who are directly dealing with families sort of explaining this, I think it's very helpful. So always a great quote to sort of keep in mind-- "It's easier to build strong children than to repair broken men." The same idea, which is basically how are we giving children and

families enough chips that they can handle the kinds of things that they might face?

I'm going to talk a little bit about the signs and symptoms. I'm assuming again that wherever you sit in the system-- if you're a home visitor, if you're administering an LIA, if you're working at the state level-- that you've in some way, shape, or form seen this. We have a handout down here.

But I always think it's important, because I think that when folks are on home visit, when we start to think about this, one of the reasons that I like this list, is because these are signs and symptoms of trauma. There are also signs and symptoms of lots of other things. And sometimes they're signs and symptoms of nothing, in the sense of they are not nearly as sort of dramatic as they may be.

I say this to people all time, in terms of having some sleeping disturbance, there are some developmentally appropriate part of building a sleep routine in infants and toddlers that is to be expected. It's when we see sort of some of these things cluster together. It's when we see sort of the intensity of some of these sorts of signs and symptoms, that we just want to be aware, and we want to be connected to our community resources.

And we want to connect to folks in the mental health world. Or if we're home visitors who are fortunate enough to have access to a mental health, infant and early childhood mental health consultant, great ways in which to start to think about your system being effective is that if we have folks on the front line, home visitors who are seeing children and families and these signs and symptoms, are they able to engage in reflective practice. Are they able to discuss this with supervisors? Are they able to access community resources in a way that they are not being asked to be a clinician?

I say this to folks all the time. I'm a child psychologist. I'm guessing if I asked you all to raise your hand if you know a child psychologist that you would never let your child see, you'd all raise your hand. Just having letters after your name or something like that doesn't mean anything. You don't have to be a therapist. Jerry Costa says this all the time. You don't have to be a therapist to be therapeutic.

I think most of us would say-- and I'm assuming that many of us on the phone are the people that people talk about in terms of my home visitor is the person that I like to talk to you about these kinds of things. Most people don't wake up and go, I'm a little stressed today. I just want to be in therapy. And I think that sort of half joking, because most of us look to natural supports and resources. And if we have a person who comes to our home, and is working with us around issues with our children's development, that's who we want to have talk about signs and symptoms.

So preschoolers, you'll see somewhat similar. But again, now we have folks who, I think Sandy Peterson mentioned this before, that now we have children who may be old enough to actually talk about the traumatic

event. And we haven't gone into the differences between how infants and toddlers versus preschoolers experience this. But know that in terms of explicit versus implicit memory, that if I said what does Thanksgiving smell like, many of you would say, well that that's an implicit memory. You don't need words to sort of describe it. It's how something smells. It may be a trigger. It may be a reminder. Versus explicit memory, where you actually have some language attached to it. And for very young children, they may not have developed their language skills enough to even be able to put words to what was traumatic.

And so with older children, they may, and may even be able to talk about it. But they still may sort of demonstrate it through play and things like that. So I'm not going to spend a lot of time on that, because I do want to get to trauma-informed systems.

So a couple of the responses that you might see in infancy. So maybe motor withdrawal. They're not sort of as active in terms of their motor skills. Emotional withdrawal. They may not sort of connect emotionally quite as much. They may avoid interactions. They may just be disregulated. They may just sort of randomly be crying or happy, or just it's hard to see how the emotion is attached to what's happening to them.

We also see sort of chronic responses here. And so disordered attachment. There may be some sort of dramatic play that sort of demonstrates or models some of this. We mentioned disregulation.

There may be depression. And that sort of overall sort of negative world view, as a result of some of that brain architecture changing, are oftentimes what we see when there's chronic sort of trauma happening. Lastly, these are the kinds of things that you might see in terms of thinking. And so it is important for folks, for home visitors to really be aware of the kinds of things that may happen as a result of all this.

And over time it really does sort of shift in terms of rage, sadness, and absence of feeling. And it really does sort of change how folks can relate to one another. And so there's a great deal of literature about this. Lenore Terr has done some great work about this. And I certainly have plenty of suggestions for folks who are interested in even more resources.

So let's do a quick poll here about what sort of protects, because that's the flip side here. And I'm going to move through that relatively quickly so we can move on. But what are some things that you feel like protect young children from adversity, or from when they experience trauma, things like that? So, great. Thanks for starting to type in here. Nancy, I'm going to let you take over.

So people are going right to the support that is offered through relationships, right? And here is where we can also begin to think about the parallel process. Caregivers support their children, and then the [INAUDIBLE] visitors support the family. And then the agencies that support the home visitors. And it goes all the way up through the

top of the system.

Yeah. Yeah. So lots about nurturing, about positive relationships, about trust, right? Parents who listen. One healthy person. Within child protective factors; that's great, great, response.

And the concept of one person is something that you're going to talk about, Neal, when you do that other video, right? It only takes one.

It does only take one. And that sort of sounds a little sort of simplistic. But the truth is is that comes from longitudinal studies where when we think about thousands of children raised in the same environment, which is potentially a very traumatic environment, very tough circumstances, why do some children sort of come out and have sort of success in terms of their social emotional development, in terms of career, all those kinds of things? And why do some have difficulty?

And one of the findings is is that having at least one unconditionally supportive adult is a huge factor. It's not the only factor, but it's one of them. So and we will talk about that here in a bit.

OK. So we're going to go ahead and close that poll. Thanks all for the responses. Parents practicing positive self-care. Great, great response there. Quality child care settings. Obviously we have a lot in the news now about the poor pay for child care providers. And you have the critical importance of child care. And obviously all of you and the work that you all are doing.

So resilience is really sort of recovering from or adjusting to misfortune or change, and that ability to bounce back. We're going to hear a little bit. This is actually some of this is filmed from a this from a head start program. These are parents of children in a Head Start program in Kansas City. So Betty, can you pull this video up, please?

[VIDEO PLAYBACK]

The system already had got my two younger brothers. And then she found out about me, and she got me, too. So from there on, that was like that's when I felt like I actually had had a childhood. I could be a kid.

We were there maybe a year. I don't know exactly how long. But then my grandma got custody of us. And from there it was it was no more of that.

What makes a person survive? What creates resilience? What protects a person? We know a little bit. I think that we know interest in learning Is one thing. A degree of emotional intelligence is another thing. A supportive adult in the home.

I felt like I was smarter than the average child. Living with my grandma, I was put in a situations where I could

have been raped, molested, so many things that could have happened to me. But I was smart enough. I recognized danger. I could sense it.

I had a man I used to babysit for. And I remember being at his house, and I was watching his son. And he was trying to show me something in his bedroom. And just all the warning signs, I just felt it. And I was like, uh, no.

Her ability to know that danger is coming is critical for her being able to avoid dangerous situations, and reduce her cumulative life dosage of trauma. The research is telling us that social emotional buffering, being in a caring relationship, having adults in your life who are able to self-regulate, and who are able to model self-regulation, helps children to be aware of when that is not happening. And sometimes all you need is that one.

[END PLAYBACK]

Thank you, Betty. OK. So what I like about this, just so you know. I was part of developing this video, and I did not vote for the Billy Joel music in the background. But I do love what they're saying here, because it sort of gets at a number of the factors that again at every level we should be thinking about how are we supporting the children and their caregivers in terms of developing those skills.

And a number of you in terms of the chat have been mentioning how parents are taking care of themselves, how parents are listening, what communication is like. So how are we doing that? How are we sort of thinking at a state or territorial level? How are we thinking from as a home visitor at an LIA level? How are we sort of doing that? How are we sort of supporting, all of those, the development of all those, that social emotional buffering that was mentioned.

I'm a fairly simple guy, so I like to think about this in simple terms. What we're really trying to do here is we're trying to outweigh-- and for those of you who are younger than I am, this is called a scale. I know you only know digital scales. But this is a scale. And what we're really trying to do is make protective factors in resilience outweigh any of the risk factors.

Many of us have some sort of a risk factor. My mom got divorced. That's a risk factor. It doesn't mean that I'm at quite a high risk as other folks. But there's a risk factor there. So how do we make sure that there's that buffering? What are all the other factors that are put in place that sort of help the scale sort of get tipped in the other direction?

This is the still face clip. And it's quick. And many of you have seen it. And I'm going to tell you why I'm showing it. Because I think of resilience, and I think of sort of the things that we see here. So Betty if you could call this up, pull us up please, that'd be great.

[VIDEO PLAYBACK]

Babies this young are extremely responsive to the emotions and the reactivity and the social interaction that they get from the world around them. This is something that we started studying, oh, 34 years ago, when people didn't think that infants could engage in social interaction.

In the still face experiment, what the mother did was she sits down, and she's playing with her baby who's about a year of age.

I look like a girl.

And she gives a greeting to the baby. The baby gives a greeting back to her. This baby starts pointing at different places in the world. And the mother is trying to engage her and play with her. They're working to coordinate their emotions and their intentions, what they want to do in the world. And that's really what the baby is used to.

And then we asked the mother to not respond to the baby. The baby very quickly picks up on this. And then she uses all of her abilities to try and get the mother back. She smiles at the mother. She points, because she's used to the mother looking where she points.

The baby puts both hands up in front of her and says, what's happening here? She makes that screechy sound at the mother, like come on? Why aren't we doing this?

Even in this two minutes, when they don't get the normal reaction, they react with negative emotions. They turn away. They feel the stress of it. They actually may lose control of their posture because of the stress that they're experiencing.

[CRYING]

OK. OK. OK. I'm here. And what are you doing? Oh, yes. Oh, what a big girl.

It's a little like the good, the bad, and the ugly. The good news is that normal stuff that goes on, that we all do with our kids. The bad is when something bad happens, but the infant can overcome it. After all, when you stop the still face, the mother and the baby start to play again. The ugly is when you don't give the child any chance to get back to the good. There's no reparation. And they're stuck in that really ugly situation.

[END PLAYBACK]

Thanks. Thanks, Betty.

So I'm going to guess that many of you have seen this before. Hopefully you have. Again, for me it's a teaching

tool. I love using this in presentations. I've used this when I sit with a group of families to sort of talk through what do you see. And aside from pointing out that it's like a 19 1 high chair, they also sort of see a lot of other things in here.

So when you think about resilience, what did you see there? What are your thoughts? Thank you for making me feel really not helpful. Seen it a thousand times. All right. Nancy, you with me?

Yep. So it sounds like there's a mix of people who are saying, wow, and people who've seen it and know that it seems kind of basic. But for some people it may really be an eye opener who don't always know how to read the emotional cues that their children are giving them, or may misinterpret them, right?

Right. Right. Well, it's interesting, because one of the comments that really made me think about the [INAUDIBLE], Brenda Jones Harden, who's got a great series of videos herself. And one of them is a parent who it's clear that she doesn't know that you're supposed to get on the floor with your baby. What do you do when you're on the floor? And it's in some ways painful to watch as Brenda's trying to help this mom understand this is what your baby needs, and sort of working with that parent. And so some of the comments here about there's a great teaching tool. But it also like what power home visitors actually have.

And also it makes me think about the use of video in a home visit, and how you can watch something and have a parent comment and that can be a sort of opening a door to a whole different kind of conversation.

Yeah. Yeah. Definitely.

OK. So Betty, can we get back to the-- oh no. I can just do the PowerPoint. Oh no, we can't. Folks, I appreciate everybody for jumping in there. But it really is that interaction, that child uses seven different ways to get the parent back. Great example of a child who's really resilient.

This is a video that is available. It's a long video. But sort of a concept that gets laid out in this video is sort of helpful. And it's really about the plasticity of the brain. And all of you have probably heard that, that children can feel when adults who care for them are truly present. And helping children heal is all about sort of it's not sort of a done deal, even though there may be a lot of brain architecture that gets shifted if they've experienced trauma. It can also be shifted when they experience all those things that you all described.

And there's an interesting little side discussion there with a couple of folks about sort of at a systems level how many different agencies would need to be involved if we're going to really build up resilience both in the caregivers, and in the children. And so there's another video that we're not to show this. But I just want you to know about it in the resources available to you.

Bruce Perry, who hopefully if you have done any learning in terms of trauma and resilience, you've read or heard Bruce Perry talk. I will tell you, and I've told this to Bruce a number of times that we've presented together, he is the worst person to present, because he's so good at presenting. So you never want to present with him. But he's also so good to present with because he really knows his stuff.

And these are the kinds of things when we think about resilience that we need to be thinking about. And several of you have mentioned this.

So again, when you think about attachment, we have to think about it in terms of that dyad, and that while we want to be focused on what can we do to support that child's development, it's also about the adult. And how are we helping them in terms of these sorts of things as they are developing, and sort of a multigenerational approach that systems need to take. But I encourage folks who don't know about Bruce to sort of go in there and really think about this.

Let's show this video real quick, because I still want to get to a couple other comments here about the systems. Go ahead, Betty.

[VIDEO PLAYBACK]

We see that the brain can change. It's not you're traumatized, and you're traumatized forever. We know we can make change. And we have modalities and evidence-based practices that can do that. And that's hopeful. But we know it, so let's do it.

For each individual pediatrician, what you can be doing on the ground is universal screening of your patients for adverse childhood experiences. The question that we always ask is, OK, well how can you screen if you don't have a response, right?

And thinking about what that response would be for your own clinic. Who are the trusted resources in the community that you can refer to? Who do you know can get shelter for a mom experiencing domestic violence? Who is going to be a high-quality therapist in your community who you know does trauma-informed cognitive behavioral therapy.

Making those connections is going to be on the individual level critically important to even being able to screen, right? Because otherwise you're going to be overwhelmed by trying to deal with what you're finding. So finding those resources in the community, even creating a cheat sheet within your clinic of these are the five reputable agencies that we're going to refer to. That allows you to have the space to screen, because you know that you have a disposition for those patients. And that's where it starts.

We need to be able to demonstrate. And intervening in these children's lives early makes a difference. Because we know if we don't, what the kids with ACEs scores grow into without any intervention. When you see an issue and can make it better, you ought to. Because it will be with that child forever.

[END PLAYBACK]

So what I like about that is that it really sort of is a great segue to what I want to talk about next, which is at a systems level. I think that this first part may have run a little bit long, so I apologize to the folks who have heard this before. But you should know this, right, that adverse experiences can impact very young children. And you need to understand those signs and symptoms. And getting sort of mental health services can reduce that, because of what we know about sort of the negative impact, that it's critical to sort of get in there as early as possible.

How do you do that? You do it by developing a trauma-informed system. And trauma-informed care is really understanding that the impact of trauma is not just on the children and families, but it's also on service providers. And we have to emphasize the safety of everybody.

And I tell this all the time. My mom was a pre-K kindergarten teacher in the New York City school systems for 35 years. And she'd come home, and she'd fall asleep on the couch at 4 o'clock. And I was like what is wrong with this woman-- until I started going into pre-K and Head Start, and early care and education, and the home visiting programs, and understood how taxing it is, what a toll it takes.

And so we need to think about our system, not just of these children and families are experiencing trauma. We need to do something. It's how are we doing something for everybody? And so I want to spend the last little bit here talking about trauma-informed systems. And I want to do that in a way that sort of pulls some resources and things like that.

And so SAMHSA-- the Substance Abuse and Mental Health Service Administration-- has done a fair amount of work around trauma-informed approaches. And they talk about the four R's. And you have to realize the widespread impact of trauma, and that there are ways in which to address recovery.

We have to recognize those signs and symptoms that we just talked about, and we need to respond. We have to integrate knowledge about trauma into our policies, and our procedures, and our practices. And not just say that, oh, there's this group of children, or this group of families. They've experienced trauma. That's it. It's how do we do this as a system.

And we have to actively resist retraumatization. That we have administrative and emotional support, like reflective practice, so we can address things like compassion fatigue, or secondary trauma. And that folks in the field at a

state level and an LIA were aware that this is hard work. And that's not enough to say it's hard work. It's hard work because it can really be stressful and traumatic for our staff. So what are we doing? And that's the most important thing, is to start to think about how do we actively resist the retraumatization.

So there's some foundational principles here. And I'd like to make believe that I'm on top of things. But Nancy and Sherrie and other folks have been great about making sure that you have the citations here, and you can find this.

And a great example of what it means at a systems level, I want you to just think about that in the last hour, what we've done, what our HV-ImpACT center has done in terms of talking about trauma, is we've talked about work at ACF, in terms of the work in the Head Start training and TA centers. We're talking about SAMHSA. We're talking obviously about HRSA and maternal and child health. But those are all at the federal level which correspondingly you at the state level could be doing all of this.

Foundational principles. Safety. Throughout the whole organization, staff and the people they serve are physically and psychologically safe. Trustworthiness and transparency. That the organization operates and decisions are conducted with transparency. The goal is building and maintaining trust among staff, amongst your consumers, amongst family members, receiving services.

There's peer support and mutual self help, right, where sort of the key vehicle for building trust and establishing safety is that we've sort of worked in peer support and mutual self help. There's collaboration and mutuality. There's a partnering here, a leveling of that power difference between staff and consumers. And amongst organizations there from direct care staff to administrators, from LIAs to the state level across state agencies. That there's empowerment voice and choice, and that there's cultural, historical, and gender issues being put on the table.

I just did a presentation with an amazing woman, Eva Shivers, out of Indigo Cultural Center in Arizona, where we're talking about equity issues and race issues in terms of expulsion and suspension of preschoolers. And one of things that Eva talks very eloquently about is we have to put these sort of issues-- culture, historical, gender-- they have to be out on the table at every level.

And the reason they have to be out on the table is because that's the only way we're going to actually make any substantial change is by acknowledging that for some people there are issues that need to be addressed in order for them to feel safe, in order for them to have trust. And that happens at the home at the child and family level, at the home visitor level, at the LIA level, and at the state agency level.

We're going to show a quick piece here-- I think it's only like a minute or so-- that sort of talks about some of the secondary traumas. So go ahead, Betty, if you don't mind.

[VIDEO PLAYBACK]

One of the pieces that's really important about trauma-informed care is when you look at what the NCTSN says, it's children, families, and providers. That part of being a trauma-informed organization, if you look at the seven domains of being a trauma-informed organization established by the National Council of Behavioral Health Care, one of those is really addressing the trauma needs of the providers-- vicarious trauma, secondary trauma. But the chance is is they may have a high ACE score.

And there's this importance of professional [? dissidence, ?] this importance of keeping that space. But there is an integrated voice. There are many professionals serving clients with trauma who come from trauma. And if they've done work around that, it can be a strength, not a limitation.

So there's a lot of talk around the integrated voice, and really needing a space to hear that. Because that's what's going to change the system, is really hearing consumers speak out about what was helpful to them.

[END PLAYBACK]

That was a piece that's taken out of a larger trauma-informed tool that developed from work at Georgetown. Oops. sorry. That was developed from work at Georgetown for the Substance Abuse and Mental Health Service Administration.

We have a quick poll. I'm cognizant of time. I know we have a couple question things about sort of Medicaid providers doing screening, about pediatricians doing screenings. So I'm trying to watch the time, keep us moving. Nancy, I think, is trying to answer some of those things. So I'm going to keep us moving.

So what kinds of supports are the LAs providing for home visitors? Great. So reflective supervision. Fantastic. Other sorts of things that you're doing if you are thinking about a trauma-informed system? Ah. So I see that's a compassionate ear, but also an active tool that people are using, screening tool for compassion fatigue, having contracts with your infant mental health practitioners to provide reflectives. I see a lot about reflective supervision here, Nancy.

Yeah. Neal, I was going to ask you if you wanted to mention the Center on Excellence, and if they were doing anything around infant mental health consultation, that would be good to share with people relative to home visiting. I'm not sure, but I thought I would ask.

Yeah. No, they are. And shameless self-promotion. So there is a newly funded-- I say new-- this year is the first year-- Center of Excellence on Infant and Early Childhood Mental Health Consultation. And so that center is in the

midst of finishing up an online tool box that will be available really aimed at sort of state leads around how do you develop an infant and early childhood mental health consultation program.

One aspect of that work, and it's been led by the indomitable Mary Mackrain, has been about how are we providing infant and early childhood mental health consultation to home visiting programs. We're going to be selecting pilots states and tribal nations next year. There'll be a whole application process. And one of the areas in which we're going to be-- one of the areas we're going to emphasize, Nancy, is home-visiting programs.

We have a set of videos that we did at Georgetown. And amongst them is a video that is a group of home visitors in Chicago. They're actually connected with a doula program as well, that talk about their access to an infant and early childhood mental health consultant, and how critical it is. They're working with a population of Latina teenage moms.

And so I know actually some of that was some of the discussion over here. But I see several folks. I see Marilyn's mentioned infant and early childhood mental health consultation. Jennifer completely taking me off task, which I really like. But there'll be a whole application process that we're in the midst of developing. And so stay tuned.

Yeah. Child First. Oh great, Mary. Thanks for pointing that out. So these are great suggestions, and great supports. I love the sharing that's going on here. I'm going to keep us moving. So I'm going to sort of move on.

You should know that the Center for Early Child Mental Health Consultation, which is yet another example of collaboration-- this was an ACF funded Head Start project-- has a whole set of resources on dealing with stress, dealing with learning ways to relax, and things like that. There's stress posters. It's all downloadable. It's only in English and Spanish. I would love it if we can get it in more languages, but for now [INAUDIBLE]. It's here at the bottom-- ecmhc.org.

It's an important thing to remember. It's ecmhc.org. If you go to ecmhc.com, that's the East Coast Miniature Horse Enthusiasts Club. And if that's your gig, I'm not here to judge. I think it's great. But if you want to see pictures of tiny horses, then you should go to ecmhc.com. If you want stress reduction pieces and things like that, you should go to ecmhc.org.

So back to sort of this trauma-informed systems piece. And as you can see at the bottom, this from the National Child Traumatic Stress Network-- NCTSN. Fantastic resources on this website. I highly recommend that both again for any level that you're thinking about sort of taking that trauma-informed approach, there are great resources.

But when they talk about a trauma-informed system, it does sort of go back to some of the things that you all have been talking about this whole webinar, which is we need to screen for trauma exposure and those symptoms,

right? Why do we need to do that? Because that's the only way we're going to start to identify children and families who need that intervention as early as possible. And so we need to be screening.

And as Nadine pointed out in that other video-- the pediatrician-- we need to have a place that we can then refer folks to that is going to be able to address that. But that is sort of one piece here that's really important.

And you heard somebody mentioned sort of the seven aspects of a trauma informed system. Using culturally appropriate, evidence-based assessments and treatments for traumatic stress and associated mental health symptoms. I can't think of something worse than retraumatizing somebody by using something that's inappropriate for them in terms of culture, and by just sort of making up what you're going to do. Using evidence-based assessments and treatments, making sure that they're appropriate, is really a critical piece of this.

Making those resources available to children, families, and providers on trauma exposure, its impact and treatment, so that everybody is on a level playing field. So when our folks are out there doing a home visit, they need to know not only what am I looking for, but what do I do, and helping families understand them. Helping families become sort of better sort of consumers in terms of the services child services that are available.

Fourth is sort of really thinking about resilience. And for me I know that I started out by talking about trauma. But I always want folks to keep in mind that what we're really trying to do is tip that scale. We're trying to give children and families as many chips as possible. We're trying to really strengthen resilience and protective factors.

Particularly it's for all children, but particularly for children and families that we know have already been impacted by, or are at risk or vulnerable to trauma. We have to have strong parents and caregivers. A number of you have mentioned that. And if we don't address parent and caregiver trauma-- that means connecting to adult mental health services-- then we're not going to really be able to address that. And we need to think about that family system in that way.

There's got to be continuity of care. There's got to be collaboration. I spent a long time, working with states, communities, territories, tribal nations, on how you build your early childhood system. And part of building that is that everybody is sort of aware that they have a role to play in addressing trauma.

And at the state level, our HV program has a critical role to play. We are in some ways the folks who are going to have first contact. Pediatricians, home visitors are much more likely to see children and families before anybody in the mental health field is. And if we can sort of be helpful in identifying, referring, and making sure that children and families are getting what they need, that continuity of care has a much better shot.

And also thinking about our staff, that we are minimizing secondary trauma. We're increasing staff resilience. And

that we're really sort of aware that this work can have that unintended consequence of retruamatizing the [INAUDIBLE] is critical.

I do have to mention that as I'm trying to present and watch the clock and read the chat, I'm seeing unbelievable sort of conversation here on the left side of recommended readings, of things that you're just trying to give HV-ImpACT more work. But I think it's great work for you to suggest in terms of the kind of things that we can think about in terms of sending out resources and things like that. So keep it going. I think that some good suggestions.

I did mention that folks at Georgetown-- this is not me. This is some other folks at Georgetown in a different department. But they work with folks at the Substance Abuse Mental Health Service Administration to develop trauma-informed care tool. And so we want to just show just a small bit of it. Betty, if you can call that it up, that'd be great.

[VIDEO PLAYBACK]

I've seen how the systems in our community could retraumatize people. How a law enforcement officer who thinks they're really being helpful retraumatizes, or how the court system retraumatizes, or how a hospital retraumatizes. And so we had a group of stakeholders in our community that just really felt like and we need to address this. And this is something that's across the board that we can really make a difference in.

We kind of looked at all of these pieces of being trauma informed, all those things you can think about. And we started working more closely with some of our local agencies to look at their practices, and to look at their policies, to look at their systems, and say, OK, are we really trauma-informed? We've all been trained. But are we trauma-informed? And we did some informal surveys, and things like that.

And then we formed what's called change teams; what we call change teams-- you could call them a lot of different things-- where we involve a lot of different stakeholders, families, foster parents, youth, school folks, law enforcement, a lot of different people. We'd bring them around the table. And we really just kind of started to look at, OK, how is this agency doing? If we did an evaluation of how they're doing, what would we find?

And then in looking at that data, we were like, OK, what can we change? Let's try something different. And we were able to get the buy-ins sort of up the chain of command from a lot of different places to say, yeah, go ahead and try something different, and let's see what we can improve.

[END PLAYBACK]

Great. Thanks, Betty. Great, thanks Betty. Sometimes I like to say things twice by leaving my computer volume on. Sorry.

OK. So what are some examples of policies or procedures or other sort of administering practices to promote trauma informed care that you all are thinking about, or that you've sort of done? Don't fail me now folks. We've been here an hour and 20, and you've been throwing 30 and 40 answers at me.

There we go. Now we're done. We got one answer. We're on a roll. Thanks for answering. All right. So we've heard about reflective supervision. Flexibility. Nancy, I know you're busy in the chat, So i want to make sure that we're sort of tag-teaming here. Right, that CQI process so critical to some of this.

So Neal, I'm seeing about creating networks of pediatricians. And I wanted to underscore that the American Academy is one of our partners. And we can facilitate or we can reach out to them to help facilitate if anybody is trying to make connections with state chapters you should let us know if that's a need when you are talking about your technical assistant's needs with your specialist.

Yeah. speaking of technical assistance needs, boy, I'm seeing a lot of things in the chat of like do you have ideas for this? Are you guys going to do this? So I'm not sure if we're going to get every question and sort of thing there. Hey, look, somebody put the near at home toolkit that we were just talking about, Nancy.

Was that me, or somebody else?

I don't know. No, I see it written here in the answers.

So I think this is great in terms of the things that you all are laying out as examples of sort of this. I love that there's some self-help for secondary trauma. The cross-systems training is such a critically important idea. I think as somebody who sort of has worked across a lot of different systems, there's different languages. There's different cultures in home visiting than there are in head start, than there are in mental health, than there is in substance abuse, than there is in child welfare. And when we start to do cross training.

And the more successful early childhood systems that I've seen are the ones that really start to think about are we sort of talking about the same thing? Do you understand what our role is in the home-visiting world? Do you understand what our role is in the child welfare world? Do you understand what it is in mental? And when you do that cross-training, it really does start to make that system be a more seamless system.

So I'm seeing great examples here of folks in terms of your policies and procedures and other administrative practices that you're already doing some of this. And I also am seeing things on the side in terms of team-building events and focus on self care, where we're getting a lot of work on it in the head start world around staff wellness, and adult wellness, and taking care of yourself. So, great responses. Keep them coming. This is fantastic, and I really appreciate it.

So I'm going to keep us moving, because I'm aware that apparently I have a webinar debrief in five minutes. So apparently I need to be done in five minutes. So moving on. What are some specific ways that we can support you? And I think some of you have sort of been typing this in here. How can we support you, the grantees, to implement the trauma informed approach?

And I sort of laid out here very simplistically sort of these seven aspects of it. And you've heard a little bit in the videos here. But what are some ways in which HV-ImpACT can support you? What can we do as center?

So we're going to bring back a lot of this feedback to our team as we plan sort of the universal TA activities. And as Nancy pointed out very astutely, if you're working with your TA, folks, let us know, hey, I really think we should be addressing this in terms of trauma informed care. That can be part of a TA plan as well. But we'll also bring it back to our team as we start to think about some of the [INAUDIBLE] activities. But the webinars and hearing from other work that folks have done.

So Neal, I just wanted to make a quick comment here. Somebody wrote in the chat, and I did see in the chat about the near toolkit. I missed that-- is that appreciating the tools that we're offering rather than just educational webinars. And really, as we move forward, we're hoping that we with you together collaboratively can identify best practices, that some of you will join us on some of these webinars, and share kind of best practice examples with your colleagues so that we can all learn from each other.

Definitely. Definitely.

More case studies I see. OK. That's good to know. Thanks. It's really helpful feedback for us.

And again we're sort of asking you this here. Obviously our centers is open as we talk to you in monthly and quarterly calls. Any time you want to sort of let us know, hey, I heard this on the webinar, or I didn't hear this, or we'd like to hear something more about this, just keep that coming. So yeah, circle of security is a great example, Jennifer.

So I'm going to keep us moving. Thanks for all those suggestions. And we're certainly going to bring that back to the team.

Any final thoughts? We have about a minute or two left here. Any final thoughts? I know for some of you we're well aware that there was sort of a bit of review early on. We want to make sure that everybody sort of gets what they need in terms of this. But any final thoughts that sort of you wish we'd gotten to something?

You feel like I should get a raise? Is that what somebody-- oh no, I wrote that. Yeah, we're going to share the webinar. Thanks for the positives. I think that's great. Mahalo to my friends in Kaua'i that I'm going to come visit. I

should get a raise. I agree. I think these are great comments so far, Nancy.

How many people did you pay to write this, Neal?

I've just written it three times so far. My nanny does rock. My nanny is fantastic. Thank you.

We were trying to strike a balance between reviewing and presenting some information that would be new to others, but really moving towards the integrated systems work. So I'm trying to think about all levels. So thanks for your feedback. We're almost at the witching hour I think.

We are. So with that, I'm going to sort of turn it back to you, Sherrie, to sort of finish us up, let us know where we're at, what's coming next, all those kind of things. I see couple of questions about what we're doing. Are people going to be able to see this, and share it, and those kinds of things.

Thank you, Neal. So I only get to do the beginning and end. So I'm afraid no raise. But thank you everybody for joining us today. We are, as we always do at the end of a webinar, going to ask for your feedback. We'll be sending you out an evaluation. And you'll probably get it more than once. It'll come in the hour. Thank you. Because we really do want your feedback as we keep working to meet your needs.

And today is our second webinar. We had 184 people on the webinar. Most of you stuck with us the whole time. And we are going to be doing our next webinar on August 16. So tune in for that. And look for our home visiting "Home Runs" to appear in your mailbox on the first day of each month.

And thank you everybody for listening, but also for the really great participation on this webinar. We learned a lot. And we hope you did too.