CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit for a Prescription of Hope for a Vulnerable Population: Chicago

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Photography Credit: By The Hand Club For Kids

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ABOUT THE PROGRAM

Clinical Scholars is a national leadership program of the Robert Wood Johnson Foundation led by the University of North Carolina at Chapel Hill. Learn more about RWJF's Leadership for Better Health programs by visiting: rwjf.org/leadershipforbetterhealth

ABOUT THE TOOLKIT

This toolkit can be used to address violent behaviors of at-risk youth through a trauma-informed care model used in after-school programs. For more information, contact: emmanuelhealthandsocial@gmail.com

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Toolkit for a Prescription of Hope for a Vulnerable Population: Chicago

Violence is a reality in the world that we live in, however, some communities and groups are more exposed to social conditions that create a medium for violence and can make violence a normal part of life. These communities and groups are traumatized as a result of the violence. Untreated trauma in children has a long-lasting negative impact on an individual's mental and physical well-being, that can lead to increased violence within the community. Certain populations are exposed to key risk factors such as neighborhood, family structure, and socioeconomic status.

The Austin community is known as one of the most violent communities in the city of Chicago and is the largest of the city's officially defined community areas. The population is 88.1% Non-Hispanic Blacks and homicides are disproportionately higher in Non-Hispanic black communities in Cook County, Illinois. Many children on the west-side of Chicago are traumatized due to violence in their homes, communities, and schools (Wardell, 2018). These children are also overwhelmed by disparities that are contributing to a high level of stress in their lives.

Creating healthful social conditions will ensure that all children benefit from the same basic, rights, security, and opportunities. Violence and trauma affect health equity. Inequities in violence-related outcomes are related to various systemic issues, as are trauma outcomes. To achieve health equity and transform communities, violence and trauma must be proactively addressed on multiple levels.

Trauma-informed care is more than a model

It is the recognition that the vast majority of people who encounter all of our nation's systems have likely experienced multiple forms of trauma. True trauma-informed care is about changing the culture of all of our systems to do everything possible to avoid re-traumatizing individuals, and to create the conditions where people feel empowered to heal and live their best possible lives. The purpose of this project was to address violent behaviors of at-risk youth in the Austin community by:

- Providing education that infuses mental health attitudes and strategies to increase resilience;
- Working with a community-based organization to develop a trauma-informed care model that educates the community about the value and effectiveness of clinical screenings and interventions;
- Building on the body of knowledge about the effects of violence and through qualitative research; and
- Evaluating the community's perceptions about the effects of trauma and developing strategies to mitigate those effects.

Photo Credit: Emmanuel Health and Social Services – Miranda Jamison

There are varying definitions of trauma. The American Psychological Association defines trauma as "an emotional response to a terrible event like an accident, rape, or natural disaster". Because this project's population is primarily African-American children who have been exposed to trauma, the National Child Traumatic Stress Network (NCTSN) definition is most relevant for the work described in this toolkit:

> Child traumatic stress is the physical and emotional responses of a child to events that threatens the life or physical integrity of the child or of someone important to the child (i.e. a parent or a sibling).

Planning

- 1 in 4 adolescents meet criteria of mental health disorder with severe impairment
- 64% of children who need mental health services do not receive appropriate care
- Majority of students referred to school-based mental health services successfully access services

Despite the resounding evidence of the deleterious and psychological effects of trauma on a child's well-being, there is an unmet need for mental health services in this population. There is an urgency to develop models of mental health care that are tailored to the needs of children. According to the CDC, an after school program is considered a protective factor for children. Protective factors are characteristics that reduce the likelihood that adversity permanently damages an individual.

A faith-based trauma-informed care program is an applicable model because faith-based organizations play a positive role in social change designed to improve the community. The By the Hand Club for Kids is a faith-based after-school program that partners with families and the Chicago Public School system. It is in a position to mitigate the effects of trauma on a child's functioning as a social support network, including healthy family relationships, adult role models, and community support.

Pharmacists are one of the most under utilized health professionals. This project is one example of how a pharmacist can use their skill set to get involved in his/her community and be a health equity champion.

PARTNERSHIPS

Partner	Roles / Skill Sets
Emmanuel Health and Social Services	Marketing Specialist & Assistant designed brochures, website, took photos, etc. Administrative Assistant facilitated meetings between partners and followed up with parents.
By The Hand Club For Kids	Site Director contacted parents and organized workshops and presentations. Team Leader led after school program as entry point for screening process and intervention.
PCC Community Wellness	Group Facilitated group counseling for children who screened positive for trauma/mental illness
Creighton University	Consultant helped develop the project
University of Illinois OCENHP	Consultant provided guidance on how to carry out the project and helped develop network
Catholic Charities	Provided individual counseling for children who screened positive for trauma/mental illness

TEAM AND ROLES

- Lachell Wardell, PharmD, MPH* – Team Lead
- Miranda Jamison – Marketing Specialist and Administrative Assistant
- Bryant Wardell Jr. – Assistant Marketing Specialist
- William Raynovich, EdD, MPH – Consultant
- Bernadette Ballenger – Site Director
- Tevin Hayes – Team Leader
- Kelli Bosak, LCSW, CADC – Group Counselor
- Ricardo Aguinana, LCSW – Group Counselor
- Audrey Stillerman, MD, ABFM – Consultant
- Gina Young, LCPC – Individual Counselor

**Clinical Scholars Fellow*

INFORMATIVE RESOURCES

- **Interrupting Trauma's Trajectory in Schools Article**
- **SAMHSA Tools for Trauma Informed Care**

Project work

- One in four adolescents meet the criteria of a mental health disorder with severe impairment.
- Nearly 64% of children who need mental health services do not receive appropriate care.
- A great majority of students who were referred to school based mental health services successfully accessed these services.

Using an ethnographic based approach, this violence intervention project began by providing training for teachers, counselors, administrators on recognizing children who may show symptoms of trauma. The parents of the youth at the after-school program were educated on the effects of trauma on their child. The pilot program combined psychoeducation, identifying students experiencing trauma, and clinical screening services. The intervention modalities included culturally sensitive training and cognitive/behavioral approaches for treatment of post traumatic stress disorder (PTSD). This clinical model taught community members how to provide culturally sensitive trauma-based interventions. This project provided positive outcomes for student and staff, and provided the faith-based afterschool program with tools to screen and recognize at risk children who could benefit from clinical services using several domains of a trauma-informed care model.

PROJECT COMPONENTS

- Conduct early screening and assessment of youth by a Licensed Clinical Social Worker (LCSW) after a signed informed consent was completed ***(Appendix A)***
- Minimize harm by referring students with a positive PTSD score to a Federally Qualified Health Center ***(Appendix B, C)***
- Nurture a trauma-informed care work environment by the faith-based organization providing education to staff on the effects of trauma and offering tools to help staff cope with trauma
- Create a safe environment through methods taught by the NCTSN to the community-based organization
- Conduct focus groups for children to determine what they would like to see change in their community
- Collaborate with stakeholders to decide treatment for the youth in the program
- Use evidence-based and emerging best practices and strategies, such as peer support role models, to strengthen parenting skills
- Perform both individual and group counseling sessions with youth who screened positive for PTSD
- Highlight ways in which culture may be a source of resiliency and strength by recommending strategies that build upon the individual strengths
- Engage with the child, family, and community to identify cultural barriers to accessing treatment

YEAR 1

- Project in Ferguson, MO
- Developed a virtual advisory board
- Networked with community members

YEAR 2

- Project moved to Chicago, IL
- Educated parents on the relationship between trauma and health
- Provided half-day training for staff sponsored by Emmanuel Health and Social Services
- Screened staff members using the ACEs screening tool
- Developed a referral system for children to receive services
- Partnered with other community-based organizations
- Advocated for trauma-informed care services at faith-based after-school program
- Piloted screenings for youth

YEAR 3

- Continued to advocate for trauma-informed care services
- Continued to screen and assess youth for trauma
- Continued to partner with other community-based organizations
- Provided tools for parents to improve coping skills
- Developed a sustainable plan for services to continue

Evaluation and dissemination

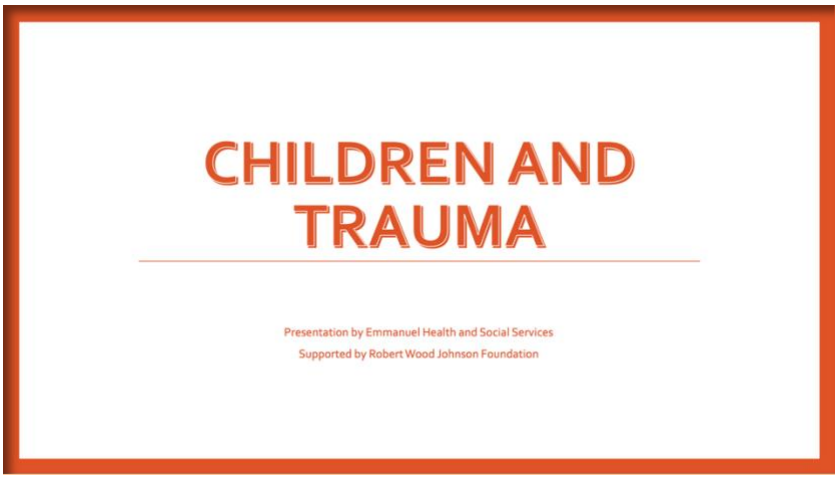
The evaluation plan included both qualitative and quantitative data:

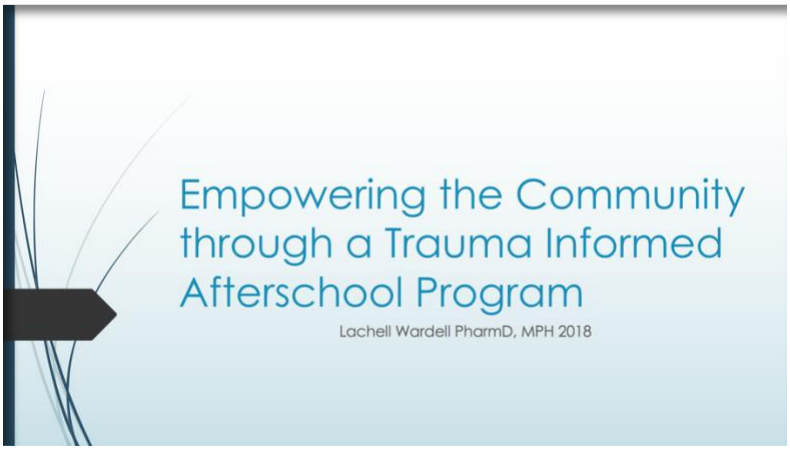
- Surveys of individuals trained for trauma informed care
- Number of participants that receive services
- Involvement of community members
- Impact program has on the community perception of violence
- Number of people trained = 103 staff members + 48 parents = 151
- Number of interviews = 12 staff interviews + 6 parent interviews = 18
- ~30 children received supportive services in the fourth and fifth grade (~16 months) and staff reported less aggressive behavior, grades improved, and disrupted behavior decreased

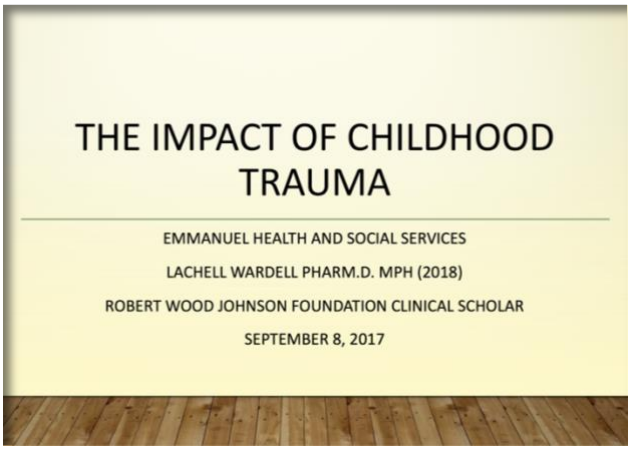
KEY MESSAGE

Trauma-informed care is more than a model. It's the recognition that the vast majority of people who encounter all of our nation's systems have likely experienced multiple forms of trauma – whether in their home or in the community, as children and as adults. True trauma-informed care is about changing the culture of all of our systems to do everything possible to avoid re-traumatizing individuals, and to create the conditions where people feel empowered to heal and live their best possible live.

Click the title slides below to access these presentations:







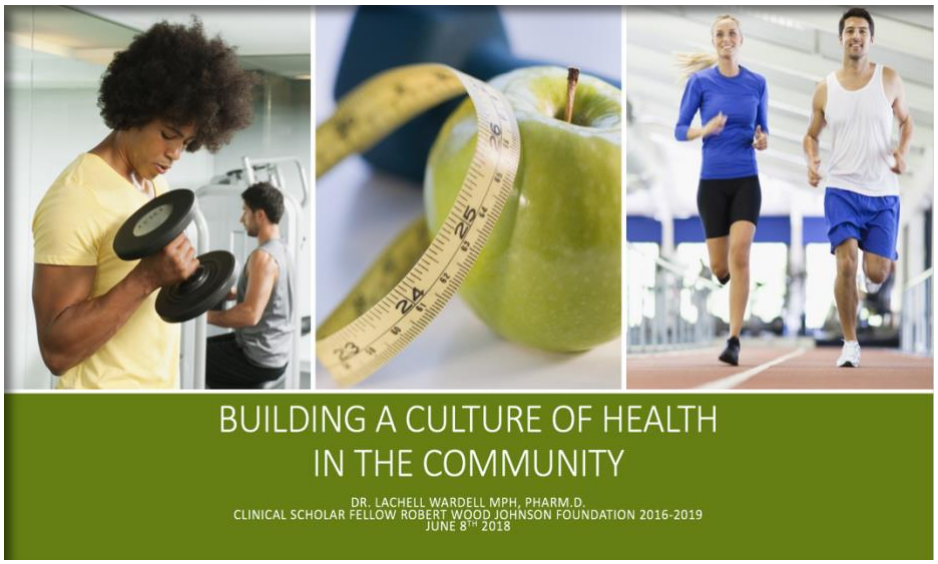
Successes, challenges, and lessons learned

As a seasoned pharmacist, I have always been intrigued by the manner in which therapeutic agents act on the intended targets. Drugs exert effects on cells and tissues within the body through varying biochemical ways. Some act at specific binding sites, through receptor activation or inhibition; some, through increasing or suppressing enzymatic activity. In the mind of a pharmacist, it all makes sense.

We live in a society where violence is prevalent. Ultimately, I began to ask myself what my role as a clinical behavioral health pharmacist who was pursuing a public health degree should be. I had witnessed the effects of overmedicating adults who had been exposed to trauma midway through my career of practicing as a pharmacist. Could that also be occurring with our children? How are we treating children who have been exposed to the trauma of neighborhoods shootings, police brutality, gang violence, and poverty? A clinical psychologist from the University of California LA, Dr. Jennifer Sumner, revealed that this type of trauma can threaten a person's sense of security. She added, **"Being exposed to that kind of violence in your neighborhood would lead to people feeling very unsafe."**

While studying at Creighton University and working for the Veterans Administration hospital, I realized a pill is not the answer – it never was. If we are going to find ways to break the cycle of violence in our communities, we must begin to look at the root causes of violence. I realized after reading books by Bruce Perry, children who are traumatized are often prescribed medications, when what they need is trauma treatment. As a Clinical Scholars Fellow, I decided to joined the movement to treat trauma as a health issue; and continue to develop a model with interventions, instead of erroneously prescribing medications. A model that recognizes the significance of treating the whole person - the mind, body, and spirit.

While practicing as a Clinical Pharmacist at a Veterans Administration hospital, the term Culture of Health was foreign. RWJF's website gives a general overview of the framework. In its simplest form it states everyone deserves to live a healthy life. We live in a fragile world that can be challenging because of its myriad of issues that prevents marginalized populations from accessing health care. Unfortunately, society has power structures that has prevented marginalized populations from living a healthy life. While completing the Clinical Scholars program, I learned the importance of recreating power structures through collaboration. The Culture of Health is a collaborative effort that recreates healthy power structures in order to bring healing to the community. The outcome is equity.



Finally, I offer a word of caution when pursuing work in this area. Providing trauma-informed screening and counseling may unmask additional experiences such as sexual or physical abuse or intentions to harm oneself. Parents must be aware of the legal reporting requirements and additional resources. They must also be told of the ramifications, which is DCFS will be alerted if a child reveals that they have been harmed. Likewise, everyone must be aware that a child could potentially reveal that they are suicidal or homicidal. In this case, the authorities must be alerted.

SUCCESSES

Children who were screened and received counseling services had improved coping skills, classroom behavior, and were better able to focus and pay attention. Staff reported less discipline referrals, physical aggression incidents, and better grades. The after-school program realized a trauma informed approach intervention was needed to effectively improve outcomes for children serviced in this under resourced community. They also reassessed their discipline policy because of this project.

CHALLENGES

A major goal of public health is to reduce health disparities. While completing this project I was a student at Creighton University in the Masters of Public Health program. As a student studying public health one of my professional goals is to address deeply entrenched inequitable policies that hinder marginalized populations and reduce health disparities in these populations. I quickly realized that as a student I did not have the background to begin to tackle some of the layers of this project, neither did my team members.

The commentary and data received from the staff revealed that the environment of working with traumatized children and the organization's structure the staff was facing a surmounting challenge, a combination of vicarious trauma and organizational post-traumatic stress. Several anonymous interviews were done with the staff as part of my public health practicum project for Creighton University's Master of Public Health program. One staff revealed he had been traumatized as a child, had insufficient tools to provide support for these children, and the support for him as an employee was inadequate. Other staff anonymously shared interacting with administration left them in a traumatized state. The stress from the environment of hearing the daily trials of the children within the community was affecting a large majority of the staff's mood and ability to sleep. Therefore, affecting the staff's health. Over time, this type of environment can contribute to chronic conditions such as hypertension, fatigue, headaches, alcohol use, mental health issues, and premature death. This opened up a new challenge of trying to advocate for support services for the staff, which was beyond the scope of this project.

RECOMMENDATIONS

Treating trauma can be difficult. As a subject matter expert, due to life experiences, I would recommend before beginning this work that your team develop a strong support system. Vicarious trauma can occur within the team. I would also recommend spending the first year to network within the community.

Recommendations for a comprehensive trauma-informed care program using Substance Abuse and Mental Health Services Administration (SAMSHA) guidelines are: realize the widespread impact of trauma and understands potential paths for recovery; recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; respond by fully integrating knowledge about trauma into policies, procedures, and practices; and seek to actively resist re-traumatization.

ACKNOWLEDGEMENTS

First, I would like to thank God and my Lord Christ Jesus for the wisdom, knowledge, grace and strength over the course of these three years. This holistic work can lead to secondary trauma if one is not grounded in their faith. I would be remised, if I neglected to thank my daughter Miranda Jamison for her tireless support.

Next, I would like to thank the Robert Wood Johnson Foundation for giving me this opportunity. Also, I wish to thank my mentor Dr. William Raynovich for encouraging me from the conception of this project, which began in my first class in the Masters Program at Creighton University. In addition, I would like to thank the staff at PCC and Catholic Charities for their time and support. Gina you saved the day. I am eternally grateful.

Last but not least, I would like to thank Bernadette Ballenger, the site Director at By The Hand for Kids Club Austin site; Tevin Haynes the team leader for the fourth and fifth grades; Donnita Travis; each parent that opened up to allow me to engage their child; and every child that participated in this pilot program.

Appendix

APPENDIX A Trauma Intervention Screening And Counseling Services

INTRODUCTION
Violence has been shown to have a lasting effect on the health of a child, even when violent events are only witnessed. Violence affects the way a child learns. It also affects a child's behavior. By the Hand and PCC Austin Family Center is offering intervention services for your child.

Procedures
- This is a pilot program
- The purpose of this program is to determine the effects that an early assessment and referral after-school program has on youth who are exposed to violence.
- Your child will be screened using the Childhood Post Traumatic Stress Disorder (PTSD) scale.
- Your child will be offered at the beginning group counseling services at PCC Community Health Center at 5245 Lake St. Chicago, IL 60644

Benefits of Participating in this pilot program
- Your child will receive beneficial care at no charge to you.
- Other children may benefit from the knowledge gained through this study.
- The information that we gain about the benefits of this model will empower us to advocate effectively for more funding for after-school programs.

Confidentiality
We will do everything we can to keep your records confidential. However, it cannot be guaranteed. We may need to report certain information to agencies but will do so only as required by law. We will always keep your name, address, or other identifying information completely private and confidential. By signing this consent form, you will not be waiving any of your legal rights that you otherwise would have as a participant in this pilot program.

Consequences of Subject's Decision to Withdraw
- You may withdraw your child from the pilot program at any time.
- If you withdraw your child from the study, your child will not receive the screening that may be needed to determine if your child need special services due to violence.

Significant New Findings
- If your child score is positive for stress By the Hand Club will notify you. Your child will be referred for group counseling services.

SIGNATURE CLAUSE
You are free to refuse to participate in this pilot or to withdraw your consent and discontinue participation in the program at any time without penalty or any effect on your involvement at By the Hand Club.

Signature below indicates that all my questions have been answered. I agree that my child may participate in the pilot program as described above.

_____
Printed Name of Child

_____ _____
Printed Name of Parent Signature of Parent and Date

APPENDIX B

Child PTSD Symptom Scale (CPSS) Scoring

Clinical cutoff: A total score of ≥12 may indicate the presence of PTSD.

The CPSS is a psychosocial screen designed to facilitate the recognition of post-traumatic stress symptoms. The first 17 items are based on the DSM-IV-TR criteria for PTSD.

Items 1-5 refer to **re-experiencing** symptoms.

- Having upsetting thoughts or images about the event that came into your head when you didn't want them to.
- Having bad dreams or nightmares.
- Acting or feeling as if the event was happening again.
- Feeling upset when you think about or hear about the event.
- Having feelings in your body when you think about or hear about the event. (Heart beating fast, upset stomach, breaking out in a sweat)

Items 6-12 refer to **avoidance** symptoms.

- Trying not to think about, talk about or have feelings about the event.
- Trying to avoid activities or people, or places that remind you of the event.
- Not being able to remember an important part of the upsetting event.
- Having much less interest or not doing the things you used to do.
- Not feeling too close to the people around you.
- Not being able to have strong feelings (being able to cry or feel really happy). Feeling as if your future hopes or plans will not come true.

Items 13-17 refer to hyperarousal symptoms.

- Having trouble falling or staying asleep.
- Feeling irritable of having fits or anger.
- Having trouble concentrating.
- Being overly careful (checking to see who is around you). Being jumpy or easily startled.

The last set of 7 items measure impairment in functioning.

- Saying prayers
- Doing chores
- Friendships
- Hobbies/Fun
- Schoolwork
- Family relationships
- General happiness

Foa, Edna B; Johnson, Kelly M; Feeny, Norah C; Treadwell, Kimberli R. H. (2001). **The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties**. Journal of Clinical Child Psychology. Vol 30(3), 376-384.

APPENDIX C

CPSS Scoring and Interpretation

For scoring severity of PTSD symptoms, each of the first 17 items is rated on a scale from 0 to 3, with total score ranging from 0 to 51 by adding them up. Items 1-5 are re-experiencing symptoms, items 6-12 are avoidance symptoms, and items 13-17 are hyperarousal symptoms.

The following is a guide to PTSD severity based on the total scores:

0 – 10 Below threshold

11 – 15 Subclinical – Mild

16 – 20 Mild

21 – 25 Moderate

26 – 30 Moderately Severe

31 – 40 Severe

41 – 51 Extremely Severe

The additional seven items that inquire about daily functioning (e.g., relationships with friends, schoolwork) are rated as either absent (0) or present (1) and yield a total impairment severity score ranging from 0 to 7.