Interim Report
of the
Task Force on Trauma-Informed Care
Pursuant to Senate Bill 1517

December 1, 2019
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1. Executive Summary

Oklahomans suffer from Adverse Childhood Experiences (ACEs) to a greater degree, on the average, than most Americans. The scars of childhood trauma have resulted in poor outcomes for many of our neighbors, as reflected in high rates of chronic disease, mental illness, incarceration, and other physical and social problems.

The economic consequences of ACEs are real. The Oklahoma State Department of Health has examined the costs associated with the children who were identified as victims of child abuse and neglect during SFY 2017. Over the lifetime of these children, the cost of maltreatment is projected to exceed $3.2 billion. That is only a part of the cost of ACEs in our state.

To respond to this challenge, our state must do a better job of providing treatment and care to reduce and mitigate the effects of Adverse Childhood Experiences. We must adopt practices that avoid the re-traumatization of people who carry trauma with them. This means implementing programs, strategies, approaches, methods, procedures, and protocols that are trauma-informed. Additionally, we need to implement programs and practices to reduce the prevalence of ACEs and provide the relationships and resources to mitigate their negative effects.

The members of the Task Force on Trauma-Informed Care are keenly focused on improving Oklahoma’s response to these challenges. We are serious about pursuing our mission -- to study and make recommendations on best practices with respect to children and youth who have experienced trauma, especially adverse childhood experiences (ACEs).

To develop our recommendations, we have launched an initiative to learn about trauma-informed practices in our state. This is an on-going effort. So far, we have identified nearly five dozen practices that are being used by a wide variety of organizations -- schools, healthcare providers, state agencies, and non-governmental organizations. The preliminary results of our research are presented in an attachment to his report: “A Sampling of Trauma Informed Practices in the State of Oklahoma.” (Attachment C)

Our sampling of practices includes several entries that are identified as “Resilience Communities.” It is notable that many communities in Oklahoma have formed themselves into local trauma-informed networks of care providers and community leaders. A Resilience Community is a community-based effort to help community leaders learn about and promote trauma-informed practices. Resilience communities are examples of leadership from the ground up.

In the months ahead, the Task Force on Trauma Informed Care will continue and expand our efforts to report our findings and make recommendations. A short description of our Agenda for Future Work is given on page 28 of this report.

Ultimately, we believe the important coordination efforts of this task force must continue after our mandate has expired. Resources should be deployed to support a dedicated team of public administrators with the skills necessary to gather and share information about trauma-informed
care, encourage interagency coordination, and promote greater efficiency in the establishment of trauma-informed practices.

In November, 2020, our task force will present an integrated task force strategy report describing how the task force and member agencies will develop a coordinated approach to preventing trauma, especially ACEs, and identifying and ensuring the appropriate interventions and supports for children, youth and their families.

As we pursue this goal, we are most grateful for the task force members who participate in our work with passion, interest, and knowledge. We are also grateful for the concerned citizens who have stepped forward to offer information, share knowledge, and support our work. Some of these key individuals are identified in Section 3.A of this report.

We are proud to submit this report on behalf of the members of the Task Force on Trauma Informed Care.

Annette Wisk Jacobi, J.D.  Jennifer Hays-Grudo, Ph.D.
Co-Chair  Co-Chair
2. Introduction

A. Task Force Mandate - Senate Bill 1517


The bill became effective on November 1, 2018.

The task force has a mandate “to study and make recommendations to the Legislature on best practices with respect to children and youth who have experienced trauma, especially adverse childhood experiences (ACEs).”

In particular, the task force is charged with gathering information on models of care for a variety of settings in which individuals may come into contact with children and youth who have experienced or are at risk of experiencing trauma. After collecting this information and considering findings from evidence-based, evidence-informed, and promising practice-based models, the task force has a duty to recommend a set of best practices to:

- The State Department of Health;
- The Department of Human Services;
- The Office of Attorney General;
- The State Department of Education;
- Other state agencies as appropriate;
- State, tribal, and local government agencies;
- Other entities, including recipients of relevant state grants, professional associations, health professional organizations, state accreditation bodies and schools; and
- The general public.

A complete description of the duties of the task force is given in Section C of this chapter.

By the terms of Senate Bill 1517, the task force is composed of seventeen (17) members, each appointed by his or her respective agency. The task force has a three-year life. The authority of the task force will expire on October 31, 2021.

This report includes the preliminary findings and recommendations of the task force during its first 12 months of operation.

A roster of task force members is provided in Attachment A of this report.
B. Background on Trauma Informed Care

In Oklahoma, the passage of SB 1517 reflects the increasing attention that is being given to children and youth who have experienced trauma. Across the globe, community leaders and policy makers are recognizing that Adverse Childhood Experiences can have life-long consequences for a person’s health and well-being.¹

Adverse Childhood Experiences, commonly referred to as ACEs, are traumatic experiences occurring before the age of 18.

ACEs are commonly divided into three categories of adverse experience:²

- Childhood Abuse, which includes emotional, physical, and sexual abuse;
- Childhood Neglect, including both physical and emotional neglect; and
- Household Challenges, which include growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, parental separation/divorce, or had a member of the household go to prison.

The first comprehensive, systematic research study of ACEs was conducted in 1998. In a groundbreaking project co-sponsored by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, Drs. Robert Anda and Vincent Filetti examined ACEs in nearly 18,000 adult patients.

The study found there was a direct link between childhood trauma and a variety of behavioral and health-related problems in adults -- including chronic disease, mental illness, doing time in prison, and work issues, such as absenteeism.

Dr. Robert Anda described his reaction the first time he reviewed the data from the survey of patients. “I wept,” he said. “I saw how much people had suffered and I wept.”³

Results of the study revealed three main findings. First, ACEs are common. Two-thirds of the population reported having experienced at least one ACE, and over 1 in 5 individuals reported having experienced 3 or more ACEs.

Second, ACEs are co-occurring. Individuals who experienced one ACE were significantly more likely to have experienced at least one other ACE.

Lastly, ACEs are cumulative with the risk of physical and mental health issues increasing as the number of adverse experiences increased.⁴

For individuals having experienced 4 or more ACEs, the study found 2- to 12-fold increases in the risk for ischemic heart disease, stroke, COPD, alcoholism, illicit drug use, early intercourse, and suicide.⁵

Individuals having experienced 6 or more ACEs, on average, died 20 years earlier compared to individuals with no ACEs.⁶
Oklahoma Data: The Highest Percentage of Children Experiencing 2 or more ACEs

In Oklahoma, sadly, we lead the nation in several categories related to Adverse Childhood Experiences.

In July, 2019, the Tulsa World identified several indicators with a link to childhood abuse and neglect: ⁷

<table>
<thead>
<tr>
<th>Oklahoma --</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 1 in female incarceration rates</td>
</tr>
<tr>
<td>No. 1 in the nation in incarceration rates when other factors such as the juvenile and jail populations are included, according to a 2018 study by the nonprofit organization Prison Policy Initiative.</td>
</tr>
<tr>
<td>No. 1 in heart-disease mortality.</td>
</tr>
<tr>
<td>No. 2 in male incarceration rates.</td>
</tr>
<tr>
<td>No. 3 in divorce with 13.1% of the state population reporting at least one marriage as ending in that manner, according to U.S. Census Bureau American Community Survey statistics for 2013-17.</td>
</tr>
<tr>
<td>No. 5 in cancer deaths per capita, according to the U.S. Centers for Disease Control and Prevention.</td>
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<tr>
<td>No. 5 in teen smoking with an estimated 12.5% of teens, according to CDC data.</td>
</tr>
<tr>
<td>No. 9 per capita in substantiated child abuse cases, according to the U.S. Department of Health and Human Services.</td>
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</table>

Using data compiled from the 2019 NSCH and Child and Adolescent Health Measurement Initiative (CAHMI), America’s Health Rankings Health of Women and Children Report indicates 28.5% of children in Oklahoma have experienced two or more ACEs. Although down from 32.9% in 2016, Oklahoma remains the state with the highest percentage of children experiencing 2 or more ACEs.⁸ Furthermore, the percentage of children living in poverty as well as the percentage of parents indicating difficulty covering necessities, such as food and housing, in Oklahoma is significantly higher than the national averages at 21% and 32%, respectively.⁹ Poverty is a significant risk factor contributing to exposure to ACEs.

These statistics reveal the need for a trauma-informed care approach, implemented in a wide-variety of settings, to best serve families and children in Oklahoma.

In the 20+ years since the ACES study by Anda and Filetti, we have learned more about the prevalence of childhood trauma in various cultures and communities. In every instance, the basic findings of Anda and Filetti have been confirmed. The results of subsequent studies have remained remarkably similar to the original study.

For example, a 2018 study looked at the frequency of ACEs in more than 200,000 participants across 23 states. The study, published in JAMA Pediatrics, found that childhood adversity is common across sociodemographic characteristics. The rates of ACEs have remained stable over the last 20 years. In addition, this study identified several groups at an increased risk for experiencing ACEs including
The ACE Pyramid represents the conceptual framework for the ACE Study. The ACE Study has uncovered how ACEs are strongly related to development of risk factors for disease, and well-being throughout the life course. Image: Centers for Disease Control and Prevention

women, young adults, individuals identifying as gay, lesbian, or bisexual, and multiracial individuals. Individuals with less than a high school education, those making less than $15,000 annual income, and unemployed individuals were also more likely to report higher exposure to ACEs. Research indicates 20 - 48% of children and teens have had more than one adverse experience before the age of 18. Similar to findings in adult populations, results indicate ACEs are common, co-occurring, and cumulative in child and teen populations. Children with 2 or more ACEs are 3 times more likely to have to repeat a grade, 3 times more likely to experience externalizing and internalizing difficulties, and at a 10-fold increase in risk for having a diagnosed learning disorder.

Several child and teen groups are at an increased risk for exposure to adverse events. Data from the 2016 National Survey of Children’s Health (NSCH) indicates 63.7% of African-American children and 51.4% of Hispanic children reported one or more ACEs compared to 40.9% of white children. Data from the 2011-2012 NSCH indicates American Indian children are significantly more likely than their white peers to have experienced 2 or more ACEs, 40% versus 21%.
Children and teens in the juvenile justice system and child welfare system are more likely to report experiencing a higher number of ACEs. A study of 65,000 youth in the juvenile justice system found 98% of females and 97% of males reported at least one adverse experience, and 92% of females and 90% of males reported having multiple ACEs. The National Study of Child and Adolescent Well-being (NSCW I) examined ACEs in children whose families were investigated by Child Protective Services. Results indicated 42% of children had experienced 4 or more ACEs before the age of 6.

Lastly, children living in poverty and/or violent neighborhoods are at an increased risk of experiencing ACEs. Findings from the Fragile Families and Child Wellbeing Study (FFCW) revealed that nearly 80% of children living in poverty had experienced at least one ACE by the age of 5. Furthermore, ACEs contributed to significantly more academic and behavioral difficulties in these same children.

**Trauma-Informed Care to Increase Resilience**

Decades of research on adverse childhood experiences has repeatedly shown that traumatic events are related to disrupted development resulting in increased health problems, risky behaviors, and cognitive and socioemotional issues. With this knowledge in hand, focus should turn to effective trauma-informed prevention and intervention efforts aimed at buffering the effects of adversity in both children and adults.

Trauma-informed care (TIC) is a model intended to increase resilience for those exposed to or vulnerable to trauma as well as prevent retraumatization. Initially used in the therapeutic setting, TIC shows promising evidence as an effective method for mitigating the harmful effects of trauma and building resilience in children and adults. Moreover, a trauma-informed approach can be effectively integrated into established agencies, programs, and organizations working directly with families and children.

One of the first frameworks establishing criteria for Trauma-Informed practices was set forth by the Substance Abuse and Mental Health Services Administration. SAMHSA defines trauma as “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.” They identified six principles of a trauma-informed approach: 1) Safety; 2) Trustworthiness and Transparency; 3) Peer Support; 4) Collaboration and Mutuality; 5) Empowerment, Voice and Choice; 6) Cultural, Historical, and Gender Issues. The National Child Traumatic Stress Network has identified several ways to integrate TIC programs into organizational models, including training staff in awareness of and response to individuals exposed to trauma, addressing the effect of trauma exposure on both the family unit as well as the individuals within the family, and providing easy access to resources, services, and treatment.
Oklahoma’s Legacy of Adversity and Resilience

“Out of adversity comes opportunity.” Those are the words of Benjamin Franklin, the early American political philosopher and humorist.

Will Rogers, another philosopher and humorist from a later century, once observed, “Even if you’re on the right track, you’ll get run over if you just sit there.”

Inspired by this venerable combination of optimism and determination, Oklahomans from across our state have begun organizing themselves into resilience communities. Their aim is two-fold. First, to understand the consequences of the trauma that our children have suffered. Second, to develop appropriate trauma-informed responses that can help to mitigate and prevent Adverse Childhood Experiences. Oklahomans have never been the kind of people who shrink from a challenge. A nascent movement of resilience communities is rising up in our state.

Creating a resilient Oklahoma at the community level can trace its origins to the Payne County Resilience Coalition. In June of 2017 approximately 100 local citizens met to create a community group dedicated to addressing the impact of adverse childhood experiences in local schools, clinics, law enforcement, and the policy initiatives that help build resilience. Since that beginning, the Payne County group has led numerous workshops on trauma-informed practices, conducted trainings in the public schools, arranged for town hall meetings, public showings and city channel airing of the film “Resilience,” and assisted other communities in developing resilience coalitions.

Other community resilience coalitions have been formed as a result of an initiative led by the Potts Family Foundation (PFF) to raise awareness of the effects of ACEs in Oklahoma and what our communities can do in response. The PFF has generated statewide engagement in this initiative by showing the documentary film Resilience: The Biology of Stress & the Science of Hope (KPJR Films, 2015) to more than 10,500 Oklahomans at 160 events. Recently, they co-sponsored showings with the Tulsa World in Tulsa and with The Oklahoman in Oklahoma City at which 200 and 600, respectively, attended to view the film and hear expert panels discuss the impact of ACEs. First Lady Sara Stitt facilitated the panel discussion at both events and is currently working with the foundation on plans for events in smaller communities around the state.

The Potts Family Foundation has also provided small grants to communities to implement community resilience coalitions. These efforts culminated most recently in a state-wide training event led by Laura Porter, one of the leaders of the state of Washington’s ACEs initiative. This 10-year initiative has been credited with saving the state more than $1.4 billion through improvements in youth arrests for violent crimes and drug use, domestic violence, births to teen mothers, school drop-outs, and other problems.

At the October 2019 event, co-sponsored by CIRCA and ten other local funders, more than 180 individuals from 21 community resilience communities attended a day-long session in developing “self-healing communities” using the model developed in Washington state. Twenty communities sent 5-8 members from multiple disciplines; communities included Ada/Chickasaw Nation, Ardmore, Bartlesville, Claremore, Canadian County, Duncan/Stephens County, Enid, Guthrie/Logan County, Lawton/Ft. Sill,
McAlester/Pittsburg County, Mid-Del Public Schools, NE OKC, Noble, Norman, Oklahoma City Public Schools, Putnam City Public Schools, Shawnee/Pott County, Stillwater/Resilient Payne County, Tulsa and Woodward. The statewide Trauma Task Force also made up a team. Teams were led through the NEAR (Neuroscience, Epigenetics, ACEs, Resilience) science, Executive Function Skills and the 6 Principles of Self-Healing Communities – Inclusive Leadership, Iterative Cycles of Learning, Emergent Capabilities, NEAR-Informed Engagement, Right-Fit Solutions and Hope and Efficacy. An additional half-day training was conducted for 60 key leaders on the leadership and civic skills needed to implement systems and policy changes. These two events in Oklahoma City were followed by a full day in Tulsa presenting the latest research findings from experts in adversity and resilience from around the world. Each community group was invited to send a member and representatives from state government were also among the 125 attendees.

Oklahoma is uniquely poised to lead the nation in promoting resilience in the face of adversity. First, there is a high degree of historical trauma and adversity in Oklahoma, a state in which a large proportion of the population are descendants of Native American peoples forcibly moved from their original homelands and others who came in desperate circumstances to claim homesteads. In 1920 Tulsa’s thriving African American community was virtually destroyed by one of the worst race massacres in U.S. history. Nearly one-quarter of the state’s population left Oklahoma during the draught and depression during the 1930s. Many families today are still struggling with the legacy of the tragedies experienced by their ancestors.

Oklahoma is also well positioned to create programs and policies that build resilience. It can be argued that Oklahomans have already proved their resilience, in that many who survived the previous calamities have created pockets of prosperity and achievement throughout the state. Foundation-funded programs are being implemented, primarily in the larger cities, that address intergenerational trauma (such as the Educare Centers in Tulsa and OKC, Tulsa’s BEST strategy and Women in Recovery, OKC’s Re-Merge).

Oklahoma State University’s Center for Health Sciences was awarded the National Institutes of Health’s only research center on adversity and resilience, the Center for Integrative Research on Childhood Adversity (CIRCA), which supports scientists and practitioners developing and testing more effective strategies to promote resilience. State agencies and organizations are nationally recognized for their efforts to deal with childhood trauma.

What has been lacking is a statewide systematic and intentional approach to create opportunities for recovery from trauma and foster resilience in all corners of the state, particularly in rural and difficult to reach communities. The purpose of this task force is to identify sustainable strategies to support and expand both local and statewide initiatives that reduce children’s exposure to adversity and increase opportunities for resilience throughout the State.

**States to Consider**

In a number of states, trauma-informed care and Adverse Childhood Experiences are topics of recent legislative measures.\(^2\)
A 2017 review by the National Conference of State Legislatures (NCSL) found nearly 40 bills that had been introduced in 18 states, all of them dealing with the topic of Adverse Childhood Experiences in one way or another. The NCSL scan found seven statutes enacted in six different states.\(^{21}\)

A more recent report from State ACES Action, an online advocacy community, identified 56 statutes and resolutions that have been adopted by the states since 2011.\(^{22}\)

As the prospect of becoming a top ten state remains on the horizon of Oklahoma’s agenda, addressing the impact of ACEs upon the state’s most vulnerable becomes of utmost importance. States such as California, Colorado, Wisconsin, and Washington have found themselves on the forefront of innovation in statewide trauma-informed care. Several efforts from these states are detailed below.

**California**

Leading the nation with the lowest prevalence of four or more ACEs, addressing the impact of ACEs is at the forefront of California’s public health policy.\(^{15}\) A plethora of programs have been implemented in the state to combat the effects of ACEs. The state’s campaign “Let’s Get Healthy California” integrates ACEs research into their 10 year plan to make California the healthiest state in the country.\(^{23}\)

**Colorado**

A significant portion of Adverse Childhood Experiences are in the category of child maltreatment. Recognizing this fact, in 2017, Colorado launched the Child Maltreatment Prevention Framework for Action in order to help local communities create a better plan for preventing child maltreatment and promoting child well-being.\(^{24}\) The framework is designed as a tool to guide strategic thinking. It includes six foundational principles and a set of “Overarching Outcomes” that can be used to measure long-term success.

**Washington**

Spurred into action in 2016 by an executive order from the governor, the state of Washington began a multidisciplinary effort to introduce trauma-informed care to both state and public agencies.\(^{25}\) Beginning in July, 2019, Washington State Healthcare Authority launched trauma-informed trainings around the state. This initiative was implemented in order for community agencies to become more trauma-informed for the citizens they serve. Likewise, community grants were issued by the Healthcare Authority to help bolster already present trauma-informed practices, and all state agencies have introduced individual plans to become more trauma-informed.

**Wisconsin**

In 2012, Wisconsin launched the Wisconsin Trauma Project (WTP) with the idea of introducing a trauma-informed child welfare system.\(^{26}\) Although Wisconsin falls in the mid-range when it comes to ACEs, progress from the Project should help to increase public knowledge and political action.

The WTP remains the stalwart contributor to the spread of trauma-informed practices across the state. The project began with two participating sites and has since expanded to 21 state and county agencies in an effort to spark organizational change.

The WTP contains three components: (1) Trauma-Focused Cognitive Behavioral Therapy Learning Collaborative; (2) Trauma-Informed Parenting Training; and (3) Trauma-Informed Systems Change. These components tackle training for clinicians, parents, case workers, and system-wide training utilized to create a more trauma-informed care system. Together, the three components model an
interdisciplinary and collaborative approach to TIC, and, within a year, allowed for 689 children to be screened and assessed for trauma.27

**Economic Impact**

Across the United States, the economic costs of ACEs are staggering.

For an adult who suffered from an Adverse Childhood Experience, the immediate cost is felt in increased out-of-pocket expenses for medical care. According to research published in the *American Journal of Preventive Medicine*, adults who lived through adversity and trauma as children pay “a disproportionate economic price related to these worse health outcomes throughout adulthood.”28 Researchers found that adults who reported three or more ACEs had a 30% higher cost of out-of-pocket medical expenses compared to adults who reported an ACE score of zero.

Of course, out-of-pocket costs are only a fraction of the total cost of medical care. The major portion of costs are payments from public and private health insurance. Additionally, one must consider the non-medical costs that are related to the behavioral problems that are associated with high ACE scores. These costs include increased expenditures for remedial education, law enforcement, criminal justice expenses, and lost worker productivity. Many of these expenses are ultimately borne by the taxpayer.

To get a sense of the total cost of ACEs over a lifetime, a 2012 study published in *Child Abuse and Neglect: The International Journal* focused on one component of Adverse Childhood Experiences. Researchers from the Centers for Disease Control and Prevention (CDC) examined the lifetime costs of child maltreatment.29 The scope of their research did not include individuals who suffered from Household Challenges (separate from child abuse and neglect).

The estimated average lifetime cost per victim of nonfatal child maltreatment was found to be $210,012, according to the study. This estimate includes long-term expenses such as childhood and adult medical expenses, child welfare costs, special education costs, criminal justice expenses, and lost productivity.

According to the report, “The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States in 2008 is approximately $124 billion.” That figure was given as a conservative estimate.

Extrapolating from this report, it is possible to get a sense of the cost of ACEs in Oklahoma. For example, we can consider the number of confirmed victims of child abuse and neglect in our state. In SFY 2017, the number of confirmed cases was 15,289. That means, Oklahoma can expect more than $3.2 billion of lifetime costs associated with only those children identified as maltreatment victims during SFY 2017 alone.30
Another way to look at the cost of childhood trauma is to consider the annual (rather than lifetime) economic impact of ACEs-related health outcomes and behaviors. Earlier this year, the Sycamore Institute published a study of this type. Titled, “The Economic Cost of ACEs in Tennessee: Medical Costs and Worker Absenteeism from Health Issues Attributed to Adverse Childhood Experiences,” the report focused narrowly on the costs in the state of Tennessee.31

The Sycamore Institute report found that, “ACEs among Tennessee adults led to an estimated $5.2 billion in direct medical costs and lost productivity from employees missing work.” This analysis considered the medical and worker absenteeism costs attributable to eight ACE-related health outcomes and behaviors: Smoking, Depression, Cardiovascular Disease, Obesity, Diabetes, COPD, Asthma, and Hypertension. The cost estimates were derived from an analysis of several data sources, including the CDC’s Behavioral Risk Factor Surveillance System (BRFSS).

Each of the reports listed above looks at the cost of ACEs from a slightly different perspective. Each analysis has its own drawbacks and limitations. In our search for information about the cumulative cost of childhood trauma, we have not been able to find a unique cost estimate that reliably encompasses all of the costs, public and private, that can be attributed to Adverse Childhood Experiences.

The best we can say is that the costs are expansive. They include medical expenses, special education costs, criminal justice expenses, and more. Reduced productivity is an additional major cost.

To reduce this drag on our state's economy, effective counter-measures are indicated. Efforts to prevent ACEs and mitigate their effects could potentially reduce these costs. Central to this effort will be the implementation of new and expanded practices in trauma-informed care.

C. **Duties of the Task Force**

Senate Bill 1517 directs the Task Force on Trauma-Informed Care to complete a number of objectives during its three-year lifespan.

The most urgent duties of the task force are described in Paragraphs 1.D.1 and 1.D.3 of the Act.

Paragraph 1.D.1 requires the task force to complete a series of tasks by November 1, 2019 “...and not less often than annually thereafter.” These tasks include:

a. *identify and evaluate a set of evidence-based, evidence-informed and promising best practices, which may include practices already supported by the State Department of Health, the Department of Human Services, the Office of Attorney General, the State Department of Education or another state agency,*

b. *recommend such set of best practices, including disseminating the set to:*

   (1) *the State Department of Health, the Department of Human Services, the Office of Attorney General, the State Department of Education and other state agencies as appropriate,*

   (2) *state, tribal and local government agencies, including State, local and tribal educational agencies,*
(3) other entities, including but not limited to recipients of relevant state grants, professional associations, health professional organizations, state accreditation bodies and schools, and

(4) to the general public, and

c. maintain and update, as appropriate, the set of best practices pursuant to this paragraph.

Paragraph 1.D.3 compels the task force to complete additional assignments within the same timeframe:

a. coordinate, to the extent feasible, among the offices and other units of government represented on the Task Force, research, data collection and evaluation regarding models described in subsection E of this section,

b. identify gaps in or populations or settings not served by models described in subsection E of this section, solicit feedback on the models from the stakeholders described in subsection E of this section,

c. coordinate, among the offices and other units of government represented on the Task Force, the preventing and mitigating trauma, and

d. establish procedures to enable the offices and units of government to share technical expertise related to preventing and mitigating of trauma.

The membership composition of the task force is intentionally designed to include people with a significant degree of knowledge and interest in ACEs and trauma-informed care. Even so, the members of the task force are not expected to rely entirely on their own expertise and resources in order to complete their duties. Rather, SB 1517 directs the task force to expand their resources by tapping the knowledge of community partners and stakeholders.

In particular, Paragraph 1.E.1 of the Act requires the task force members to "consider findings" from institutions of higher education, community practice, recognized professional associations, and others as the task force is identifying the set of best practices mentioned in 1.D.1.

Additionally, Paragraph 1.E.2 requires the task force to “engage with and solicit feedback from” a diverse group of stakeholders, including:

- Faculty at institutions of higher education including, but not limited to, the Center for Integrative Research on Childhood Adversity (CIRCA);
- Community practitioners using care models that reflect the science of healthy child, youth and family development; and
- Recognized professional associations that may be able to provide observations and practical recommendations on best practices.

Not least of all, the task force is mandated to hold at least one public meeting "...to solicit recommendations and information relating to best practices" from Oklahoma residents.
Best Practices. In terms of the “best practices” that the task force is charged with identifying and recommending, SB 1517 directs the task force to compile its recommendations in a couple of different ways.

First, as described in Paragraph 1.E.3 of the Act, the task force is required to:

“3. Recommend models for settings in which individuals may come into contact with children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma....”

The list of settings is extensive. It includes schools, preschool and early childhood education and care settings, home visiting settings, after-school program facilities, child welfare agency facilities, public health agency facilities, mental health treatment facilities, substance abuse treatment facilities, faith-based institutions, domestic violence centers, homeless services system facilities, juvenile justice system facilities, law enforcement agency facilities, hospitals, and settings where health care providers, including primary care and pediatric providers, provide services.

Second, as described in Paragraph 1.E.4 of the Act, the task force has a mandate to:

“4. Recommend best practices that are evidence-based, are evidence-informed or are promising and practice-based....”

The task force is instructed to identify best practices that include guidelines for a variety of activities and services. The scope of these best practices is broad. It includes programs and activities designed for:

- Training of front-line service providers (teachers, health care providers, providers from child-serving organizations, etc.);
- Implementing appropriate responses;
- Implementing systems and procedures to refer children and youth to services;
- Educating children and youth to understand trauma and to identify the symptoms of trauma;
- Multi-generational interventions to support parents and adult caregivers, etc.;
- Community interventions for areas that have suffered from substantial discrimination, historical or cultural oppression, etc.;
- Assisting parents and guardians in obtaining health benefits coverage, including coverage under a State Medicaid plan under Title XIX of the Social Security Act;
- Utilizing trained nonclinical providers (such as peers, mentors, clergy) to provide services.

What is a trauma-informed "practice?"

Senate Bill 1517 suggests that a trauma-informed practice may be a variety of activities and services.

In our interpretation of the word “practice,” we include activities and services that are sometimes referred to as:

- programs
- strategies
- approaches
- methods
- procedures
- protocols
- responses
- etc.

A distinguishing characteristic of a trauma-informed practice is that it is implemented with the goal of reducing, preventing or mitigated Adverse Childhood Experiences.
As can be seen from the description provided above, the duties of the task force are expansive. Within the context of SB 1517, the members of the task force are encouraged to think broadly about the scope of their work.

Ultimately, the recommendations of the task force will have the potential to strengthen and expand trauma-informed care practices throughout the state.

In the next chapter of this report, we will describe the accomplishments of the task force during its first 12 months of existence.

3. Task Force Progress

A. Task Force Meetings and Key Informants

During its first 12 months of operation, the Task Force on Trauma-Informed Care held a number of meetings that were well-attended by task force members. Members of the public attended the meetings, as well, including many individuals representing state agencies, higher education, and non-governmental organizations.

The meetings were designed to bring forth information about: (i) the impact of childhood trauma; and (ii) steps that may be taken to develop best practices in trauma-informed care.

The members used these meetings to learn about trauma-informed care and to share information about Adverse Childhood Experiences, strategies to promote resilience, and related topics.

Family Resource Centers. Early in the development stage of the task force, members heard a presentation from Andrew Russo, the director and co-founder of the National Family Support Network (NFSN). Founded in 2011, NFSN is a coordinating body for more than 3,000 family supporting and strengthening organizations, such as Family Resource Centers. It is a membership-based organization. Mr. Russo described how local member organizations work with families to enhance parenting skills, connect families to resources, increase school readiness, develop parent and community leadership, and promote family economic success, and prevent child abuse.

The most common type of family supporting and strengthening program is a Family Resource Center. These centers are known by many different names across the country, including Family Centers, Family
Success Centers, Family Support Centers, and Parent Child Centers. They may be community-based or school-based.

As described on the NFSN website, Family Resource Centers “…serve as welcoming hubs of community services and opportunities designed to strengthen families. Their activities and programs, typically provided at no or low cost to participants, are developed to reflect and be responsive to the specific needs, cultures, and interests of the communities and populations served.”

Mr. Russo outlined five protective factors which research has shown to increase family stability, enhance child development, and reduce child abuse and neglect. The five protective factors, developed by the Center for the Study of Social Policy in 2005, include:

- Parental Resilience
- Social Connections
- Concrete Support in Times of Need
- Knowledge of Parenting and Child Development
- Social and Emotional Competence of Children

**The Colorado Child Maltreatment Prevention Framework for Action.** In June, 2019, the task force heard a short report from Kendra Goldsberry Dunn of the Colorado Department of Human Services. Ms. Dunn presented information about the Colorado Child Maltreatment Prevention Framework for Action. It is a visionary framework with guidelines and strategies for communities to work collectively and locally to prevent child maltreatment. It was launched in 2017 with support from Chapin Hall at the University of Chicago and the Children’s Trust of South Carolina. Ms. Dunn discussed how the framework includes a general trauma-informed approach.

In August, 2019, several more presenters were invited to share information with the task force.

**Handle with Care.** Adrienne Elder, MPH, offered a brief description of a trauma-informed practice called, Handle with Care. This is an initiative that started in West Virginia. It is a program that is implemented when law enforcement is called to a residence where a child is present. If any children have been exposed to trauma in their home, the Handle With Care program is designed to assure that they receive appropriate interventions to help them achieve academically -- despite whatever traumatic circumstances they may have endured.

As explained on the website of the West Virginia Center for Children's Justice, the Handle With Care model works like this:

“If a law enforcement officer encounters a child during a call, that child’s name and three words, HANDLE WITH CARE, are forwarded to the school/child care agency before the school bell rings the next day. The school implements individual, class and whole school trauma-sensitive curricula so that traumatized children are 'Handled With Care.' If a child needs more intervention, on-site trauma-focused mental healthcare is available at the school.”

Ms. Elder said an effort is currently underway to implement Handle With Care across the state of Oklahoma. It is being rolled out in participating school districts. For example, it has been started in the Oklahoma City Public Schools in cooperation with the Oklahoma City Police Department. In Cleveland County, the program has been adopted by Lexington, Little Axe, and Noble public schools.
The goal of the Lemonade for Life program is to help prevent future exposure to ACEs while promoting resiliency and hope. Image: LemonadeForLife.org

**Initiatives of the OUHSC Biomedical and Behavioral Methodology Core.** A second presenter at the August meeting of the task force was David Bard, Ph.D., of the University of Oklahoma Health Sciences Center. Dr. Bard is an associate professor in the OUHSC Biomedical and Behavioral Methodology Core. He is the principal investigator for a number of pediatric research studies at OUHSC.

Dr. Bard gave a presentation on two initiatives of interest to the task force: (i) Positive parenting practices, and (ii) The “Lemonade for Life” program.

“Lemonade for Life” is a trauma-informed intervention designed to screen and address parents’ Adverse Childhood Experiences (ACEs). Developed and researched by the University of Kansas, Lemonade for Life has been specifically adapted for Hispanic populations and members of the Cherokee Nation.

Lemonade for Life is described as a training program designed to promote resiliency and hope. The goal of the program is to help prevent future exposure to ACEs.

The task force was especially interested in the Lemonade for Life initiative because the members of the task force have a duty to look for multi-generational interventions that support parents, foster parents, and adult caregivers. By supporting parents, the Lemonade for Life program aims to prevent and mitigate the effects of trauma for children and youth who have experienced or are at risk of experiencing trauma.

On a related note, Dr. Bard described several positive parenting practices that serve to prevent and mitigate the effect of childhood trauma. These include:

- Reading;
- Stories/singing;
- Playing;
- Going outside;
- Family meal time; and
- Less than 2 hours a day of TV.

These practices relate directly to another duty of the task force: To identify practices that foster safe, stable and nurturing environments and relationships that prevent and mitigate the effects of trauma.

**Protective and Compensatory Experiences (PACES).** A third presenter at the August meeting was Dr. Jennifer Hays-Grudo. As the director of the Center for Integrative Research in Childhood Adversity (CIRCA), Dr. Hays-Grudo stays current on the latest research on childhood trauma. She described some
of the physiological effects that can result from traumatic experiences in childhood. Dr. Hays-Grudo introduced the concept of Protective and Compensatory Experiences (PACEs).

As described by Dr. Hays-Grudo, PACEs serve to buffer the immediate and long-term effects of ACEs. She describes PACEs as experiences that children require in order to prevent risk and promote resilience. It is possible to measure an individual's PACE score using a survey that has been developed by Drs. Hays-Grudo and Amanda Morris. The survey is designed to identify protective and compensatory experiences that have been shown to offset the impact of Adverse Childhood Experiences. The questions identified in the survey include:

**Protective and Compensatory Experiences (PACEs)**

When you were growing up, prior to your 18th birthday:

1. Did you have someone who loved you unconditionally (you did not doubt that they cared about you)?
2. Did you have at least one best friend (someone you could trust, had fun with)?
3. Did you do anything regularly to help others (e.g., volunteer at a hospital, nursing home, church) or do special projects in the community to help others (food drives, Habitat for Humanity)?
4. Were you regularly involved in organized sports groups (e.g., soccer, basketball, track) or other physical activity (e.g., competitive cheer, gymnastics, dance, marching band)?
5. Were you an active member of at least one civic group or a non-sport social group such as scouts, religious group, or youth group?
6. Did you have an engaging hobby—an artistic/creative or intellectual pastime either alone or in a group (e.g., chess club, debate team, musical instrument or vocal group, theater, spelling bee, or did you read a lot)?
7. Was there an adult (not your parent) you trusted and could count on when you needed help or advice (e.g., coach, teacher, minister, neighbor, relative)?
8. Was your home typically clean AND safe with enough food to eat?
9. Overall, did your schools provide the resources and academic experiences you needed to learn?
10. In your home, were there rules that were clear and fairly administered?

Additionally, Dr. Hays-Grudo has developed a list of some characteristics of a trauma-informed approach to care and treatment. Elements of the list include:

<table>
<thead>
<tr>
<th>Non-Trauma Informed Approaches</th>
<th>Trauma-Informed Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Power over</strong></td>
<td><strong>Power with</strong></td>
</tr>
<tr>
<td>You can’t change</td>
<td>Your brain is &quot;plastic&quot;</td>
</tr>
<tr>
<td>People need fixing first</td>
<td>People need safety first</td>
</tr>
<tr>
<td>People are out to get you</td>
<td>People can live up to the trust you give them</td>
</tr>
<tr>
<td>Fear-based</td>
<td>Empathy-based</td>
</tr>
<tr>
<td>People make bad choices</td>
<td>People who feel unsafe do unsafe things</td>
</tr>
<tr>
<td>Behavior viewed as problem</td>
<td>Behavior viewed as solution</td>
</tr>
<tr>
<td>People are bad</td>
<td>People are doing the best they can</td>
</tr>
</tbody>
</table>
Two other presenters also spoke to the task force at the August meeting.

**Trauma Drama.** Deana Wilkinson from the Center for Children and Families, Inc., (CCFI) in Norman, OK, gave a brief presentation on “Trauma Drama.” This is a new program to help young people process any trauma they have experienced. It is being implemented by CCFI in partnership with Sooner Theatre, the OU School of Social Work, and Norman Public Schools.

The program is described in an article in the Norman Transcript newspaper:

“**Trauma Drama works like this:** The troupe goes on stage and performs a scene, which is mostly improv. The scenes cover topics that participating students may be struggling with, Wilkinson said, such as abuse, neglect, relationship issues, or bullying.

“‘The troupe will pause and let kids jump in and see how they will respond,’ Wilkinson said. ‘Then we process all of that at the end of the hour and do some down-regulating activities. As we go through the year, they develop skills of communicating, conflict resolution, and just kind of working through life issues kids face.’

“What happens in the scene is mostly up to the participants. Students can choose the roles they want to play and express themselves in the manner they choose.”

“**Mimi Sullivan, a Trauma Drama trainer who researches the program, said children who participate see the problems presented are not unique to them. By seeing that they are not alone, it helps them process their feelings.**”

Ms. Wilkinson said about 25 students, mostly freshmen students at Norman High School, will participate in the program. They will be chosen through outlets such as school counselors and the Boys and Girls Club.

**Resilience: The Biology of Stress and the Science of Hope.** A final presenter at the August meeting of the task force was Linda Manaugh of the Potts Family Foundation (PFF) of Oklahoma City. PFF supports early childhood (0-5) initiatives to address the root causes of early childhood neglect. The foundation's interest in this topic has led them to sponsor a showing of the film, “Resilience,” more than 140 times across the state.

“Resilience” is a 60-minute documentary produced by filmmaker James Redford. The subtitle of the film is, “The Biology of Stress and The Science of Hope.” Thanks to the Potts Family Foundation, “Resilience” has been seen by over 8,000 Oklahomans in the last two years.

As stated in the film, resilience is a natural counter-weight to Adverse Childhood Experiences (ACEs). It is the ability to thrive, adapt, and cope despite tough and stressful times.

A key concept of the film is that resilience is not an innate characteristic. Rather, it is a skill that can be taught, learned, and practiced. So, the more resilient a child is, the more likely they are to deal with negative situations in a healthy way. Everybody has the ability to become resilient when surrounded by the right environments and people.
The wide-ranging duties of the task force include identifying educational practices that help young people to “understand trauma” and to “identify signs, effects or symptoms of trauma.” In this regard, the showing of the “Resilience” film is a practice that the task force is naturally interested in.

At the September meeting of the task force, the members continued their pursuit of knowledge about trauma-informed practices in Oklahoma. They heard several reports from guest presenters.

**Governor Stitt’s “Front Porch” Initiative.** The first presenter was Tom Bates, Interim Commissioner of Oklahoma State Department of Health and a special advisor to Governor Stitt. Mr. Bates gave a short presentation about the governor’s new Front Porch Initiative. It is envisioned as a better way to integrate the services offered by Oklahoma’s state health and human services agencies.

The initiative, which is presently in a planning stage, is intended to simplify how Oklahomans interact with several state departments, including the Oklahoma Health Care Authority, the Department of Health, the Department of Mental Health and Substance Abuse Services, the Department of Human Services, and the Office of Juvenile Affairs.

The Front Porch initiative is not a trauma-informed practice, per se. However, the members of the task force are interested in the initiative because it intersects with the duties of the task force.

The duties of the task force include coordinating among several state agencies on topics related to trauma-informed care. In particular, the task force has a duty to coordinate “research, data collection, and evaluation” of trauma-informed practices. It also has a duty to coordinate on the prevention and mitigation of trauma. One of the duties of the task force, as stated in SB 1517, is to: “Establish procedures to enable the offices and units of government to share technical expertise related to preventing and mitigating of trauma.”

We recognize that the governor’s Front Porch initiative may be a helpful vehicle for the task force to use as it pursues its coordination duties.

**Safe Babies Court Team.** A second presentation at the September meeting was on the Tulsa County ZERO TO THREE Safe Babies Court Team (SBCT). This presentation was delivered by Steve Lewis, JD, and Sarah Beilke, MSW.

The Safe Babies Court Team is described as a systems change initiative that brings together the courts, DHS Child Welfare Services, and child serving organizations to serve vulnerable children ages 0-3. The program is focused on infants and toddlers who have been placed in foster care because they have experienced some type of abuse and/or neglect in their family of origin.

The SBCT model brings together a multi-disciplinary team of child welfare and health professionals, child advocates, and community leaders who advocate for and provide services to abused and neglected infants and toddlers and their families. Key components of the model include monthly court hearings and case reviews, provision of child-focused services, infant mental health interventions, and use of evidence-based parenting education/interventions.

In Tulsa County, the SBCT relies on the Judicial Leadership of the Hon. Judge Doris Fransein.
The task force has a specific duty, stated in SB 1517, to identify trauma-informed practices that “use partnerships that include local social services organizations or clinical mental health or health care service providers with expertise in furnishing support services.”

**Resilience Communities.** A third presenter in September was Linda Manaugh of the Potts Family Foundation.

As noted above, the Potts Family Foundation has a deep interest in early childhood development, and they have sought to educate Oklahomans about Adverse Childhood Experiences (ACEs) through the film, “Resilience.”

To promote greater community involvement in the development of local systems of trauma-informed care, the Potts Family Foundation is supporting the development of resilience communities. These are community-based efforts to help community leaders learn about and promote trauma-informed practices.

Ms. Manaugh announced that the Potts Family Foundation will host an all-day training session for resilience communities. She invited members of the task force to participate as individuals.

**The OCCY Parent Partnership Board.** Annette Jacobi delivered some information to the task force about a new program at the Oklahoma Commission on Children and Youth (OCCY). The commission has been empowered to administrate a new program: the Children's Endowment Fund of Oklahoma. OCCY has the authority and duty to administrate the Fund for the purpose of awarding grants to improve the well-being of Oklahoma's children and to reduce their Adverse Childhood Experiences.

There is not yet any money in the Children's Endowment Fund. However, when it is funded, OCCY will use the fund to stimulate a broad range of innovative programs, activities, research, and evaluation.

Ms. Jacobi pointed out that the management of the Children's Endowment Fund will be advised by a new Parent Partnership Board. The board is designed to represent the voice of parents who have direct knowledge and experience in caring for children.

After it gets up and going, the Board will make recommendations to OCCY on criteria and procedures for awarding grants. The board will also recommend grant topics and develop and evaluate grant proposals. It will inform the work of Oklahoma's child-serving systems on a broad range of innovative programs, activities, research or evaluation to reduce Adverse Childhood Experiences.

The Children’s Endowment Fund represents a potential platform for expanding Oklahoma's future investment in trauma-informed practices. The creation of the Parent Partnership Board will assure that the voices of parents are represented in important decisions about the allocation of valuable public resources.

**B. Identifying Best Practices in Trauma-Informed Care**

Oklahoma has the highest percentage of youth who have experienced four or more ACEs. As such, it is imperative to identify and employ best practices in trauma-informed care. Although there are efforts to
transform Oklahoma into a more trauma-informed state, a greater saturation of these efforts is needed in government and public agencies alike.

Literature concerning best practices suggests that a multidisciplinary, interagency effort provides the most compelling model of trauma-informed care.\textsuperscript{35} As the leading knowledge base on trauma-informed care, the National Child Traumatic Stress Network (NTCSN) recommends a trauma informed system. One in which service providers and agencies—such as law enforcement, schools, physicians, and government agencies—collaborate with all involved in the care of the child.

The NTCSN lists the core components of a trauma-informed system as:

1. \textit{Routinely screen for trauma exposure and related symptoms.}
2. \textit{Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms.}
3. \textit{Make resources available to children, families, and providers on trauma exposure, its impact, and treatment.}
4. \textit{Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma.}
5. \textit{Address parent and caregiver trauma and its impact on the family system.}
6. \textit{Emphasize continuity of care and collaboration across child-service systems.}
7. \textit{Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness.}

Likewise, the Substance Abuse and Mental Health Services Administration (SAMHSA) outlines best practices in trauma-informed care. Their concept of “The Four R’S” acts as a guideline to trauma-informed practices. The “Four R’s” assume that in a trauma-informed system, individuals will be able to:

1. \textit{Have a basic Realization about trauma and understand the effects of trauma.}
2. \textit{Recognize the signs of trauma.}
3. The system will be able to \textit{Respond} by applying principles of TIC.
4. The trauma-informed approach seeks to \textit{Resist Re-traumatization.}

The movement toward trauma-informed care has slowly migrated across our state. As outreach programs and advocates of TIC approaches continue to spread awareness, TIC practices are evolving within several communities. Examples of such practices are provided in the following sections. A comprehensive table of known practices in Oklahoma can be found in Attachment C, "A Sampling of Trauma-Informed Practices in Oklahoma."

\textbf{Trauma-Focused Cognitive Behavior Therapy (TF-CBT)}

Trauma-Focused Cognitive Behavior Therapy (TF-CBT) is an evidence based practice for treatment of childhood posttraumatic stress disorder (PTSD). TF-CBT is a relatively short-term, skills-based treatment program utilized to teach families skills to reduce distress and increase coping capacity.\textsuperscript{36}
Currently, Oklahoma is home to four nationally recognized trainers in TF-CBT who offer training to mental health professionals. As such, TF-CBT is available in many mental health agencies across the state. However, a common barrier to care is distance from service. Most agencies are housed in the state’s larger towns or cities and for many in southern Oklahoma, access to care could mean a drive of an hour or more. Further gaps in care are addressed in Section D of this report.

Handle With Care

The Handle with Care model is yet another example of a trauma-informed practice utilized in the state of Oklahoma. The Handle with Care model is a collaboration between law enforcement and local public schools in an effort to promote a safe environment for those who have recently experienced a potentially traumatic event. After responding to a call involving a child and a potentially traumatic event, an officer forwards a message to the child’s school with their name and the words “handle with care” which allows the staff to implement trauma-informed training and practices. This model is currently integrated within several Oklahoma school districts including: Stillwater, Cleveland County, Canadian County, Lincoln County, Muskogee, and the Oklahoma City metro area.

Trust-Based Relational Intervention (TBRI)

Trust-Based Relational Intervention is a methodology aimed at impacting the lives of both caregiver and child. Participants of TBRI can expect to learn healthy methods of interaction in order for them to participate in the healing process. In a 2013 article, researchers from Texas Christian University listed the three principles of TBRI as: (1) Empowerment—attention to physical needs; (2) Connection—attention to attachment needs; and (3) Correction—attention to behavioral needs.

In Oklahoma, TBRI has found its place within Moore and Edmond public schools and in a number of agencies and mental health clinics throughout the state.

C. Coordinating Research, Data Collection, and Evaluation of Models

Senate Bill 1517 directs the Task Force on Trauma-Informed Care to complete a number of objectives during its three-year lifespan.

Among the duties of the task force is to “…coordinate, to the extent feasible, among the offices and other units of government represented on the Task Force, research, data collection and evaluation…” of the models of care reviewed by the task force.

Senate Bill 1517 directs the task force to perform this duty “as often as practicable, but not less often than annually....”

As of November, 2019, the task force has begun a comprehensive review trauma-informed care models in our state. We have attempted to reach out to a broad array of state agencies, non-governmental organizations, resilience communities, and others and have compiled a preliminary analysis of trauma-informed approaches being provided throughout the state. As required by law, we have sought out information from a number of sources, including:

- Community practitioners;
✓ Professional associations;
✓ Faculty at institutions of higher education including the Center for Integrative Research on Childhood Adversity (CIRCA); and
✓ The general public.

The results of our review, to date, are preliminary but serve as an excellent starting point for assessing strengths in our state as well as gaps in access and availability of programs and services.

In terms of research, the task force has conducted a number of academic literature reviews to gain up-to-date knowledge about best practices practices in trauma-informed care. We have searched the internet to learn about evidence-based models that are in use around the world. Our research activities have also included a review of public policies that have been adopted in various states in the Union. To augment our literature reviews, we have given our attention to information provided by various presenters, as described in 3.A of this report.

In the area of data collection, the task force has begun compiling information about trauma-informed practices in use throughout Oklahoma. A structured database is being created that will include data about various practices – including the locations, settings, types of practices, etc., that we are able to identify. (See Attachment C).

The members of the task force recognize that one of the duties is to coordinate the evaluation of trauma-informed care models. In pursuing this task, given the absence of resources allocated to the task force, we have not attempted to launch any new scientifically rigorous evaluations. Rather, we have informally evaluated the models of care that we have found through surveying state and local agencies and departments. To a large extent, we have relied on the offices and other units of government represented on the Task Force to evaluate the models of care that we have reviewed.

As we learn more about the skills and capacity of our task force members and the organizations they represent, we will seek to coordinate our evaluation activities in a more comprehensive fashion.

D. Identifying Gaps in Trauma-Informed Care Practices

HB 1517 and the Task Force on Trauma-Informed Care are among the first attempts at an interagency collaborative effort to provide resources for the mitigation of the effects of childhood trauma in Oklahoma. The production of a trauma informed system is imperative for state agencies to better serve the vulnerable Oklahomans. Gaps in care exist among several populations and settings in Oklahoma and failure to address these gaps perpetuates the barriers to care.

Rural Communities
A large majority of Oklahoma residents can be found within the limits of Cleveland, Tulsa, and Oklahoma counties. For many other citizens, access to trauma-informed resources is less reliable. Largely, this is because services are less widely available. Access is limited by barriers of transportation and distance.

Such barriers are evident, for example, when we consider the availability of TF-CBT to rural Oklahomans. Although there is a wide array of care providers available to provide TF-CBT care across the state, these providers cluster around more heavily populated areas. An individual located in Stephens or McCurtain
County is subjected to an hour drive, or longer, to access the closest TF-CBT provider.\textsuperscript{27} In addition to the distance, factors such as poverty may play into an individual’s ability to travel to their services.

**Poverty**

Estimates from the United States Census indicate 15.6\% of Oklahomans are living in poverty.\textsuperscript{41} In line with current population estimates, that is approximately 615,000 citizens with probable resource restrictions. Importantly, the NCTSN notes that maladaptive parenting practices can be associated with the stress of urban poverty. Factors such as warmth, effectiveness, and understanding of needs are diminished while factors such as use of corporal punishment, harsh discipline, neglect, and reactive parenting are increased.\textsuperscript{42}

**Foster Care**

From 2010 to 2012, Oklahoma participated in efforts of NCTSN to obtain best practices in trauma-informed care to improve placement stability within child welfare. Implemented practices included training for all agency staff—including administrative staff—, training for foster parents, including a trauma consultant, and using trauma informed language in court reports.\textsuperscript{43} As a result of this, the agencies involved garnered some key takeaways:

1. *As child welfare staff and partners gain further knowledge about trauma-informed care, the demand for services grows. Unfortunately, the number of services did not grow resulting in waitlists and frustration.*

2. *Trauma issues in parents was cited as one of the most significant unmet needs experienced by the participant agencies. The gaps in care were uncovered as the child welfare agencies were unable to provide support for the parents as they are specifically child serving agencies. This bolstered the idea of a multidisciplinary effort in trauma-informed care.*

Leading to their placement, children in the foster care system have been subjected to trauma and oftentimes are faced with potential traumatic experiences while in placement.\textsuperscript{33} Foster Care and child welfare, as a whole, are an integral facet in the road to a trauma informed system.

**E. Coordinating to Prevent and Mitigate Trauma**

Another duty of the task force, as stated in Senate Bill 1517, is to “coordinate, among the offices and other units of government represented on the Task Force, the preventing and mitigating trauma....”

Members of the Task Force understand this includes actions that will promote voluntary cooperation and coordination among task force members and the agencies and offices they represent. We envision that prevention and mitigation of early childhood trauma may be achieved more effectively if interagency cooperation is improved.

The members of the task force recognize that we have no authority to compel individual agencies to adopt new procedures or to change their existing policies or practices. Even so, we believe that it will be possible to promote effective interagency activities on a voluntary basis.

As of October, 2019, we have not yet identified any coordination activities that we can formally recommend. However, as we learn more about the practices of governmental and non-governmental organizations around the state (and beyond), we will seek to promote coordination in a voluntary and
transparent fashion. In particular, we will seek to identify model policies and procedures for improving interagency communication, coordination of care, and the sharing of technical expertise.

F. Sharing Technical Expertise to Prevent and Mitigate Trauma

As a preliminary finding, the task force has observed that the various offices and units of government within Oklahoma have varying degrees of technical expertise related to the prevention and mitigation of trauma. Even within the same agency, the technical expertise of workers may vary widely depending on each individual's job position and training.

In SB 1517, our task force is instructed to “establish procedures to enable the offices and units of government to share technical expertise related to preventing and mitigating of trauma.”

With respect to this task, we have not yet (as of October, 2019) established any formal, written procedures to enable the sharing of technical expertise. However, we have tried to use our task force meetings as a forum for the sharing of information and the identification of potential connections and additional resources. We have been pleased that several offices and units of government have used our task force meetings to share information about their practices. Additionally, we are compiling a database of trauma-informed practices which includes activities, services, responses, etc., from several government agencies. As the database expands, the task force will develop appropriate mechanisms to share the practices that have been recorded.

In future meetings of the task force, we will develop procedures and methods for the sharing of technical expertise. For example, we will explore the development of an interactive online platform to facilitate the sharing of ideas and best practices.

In the next chapter of this report, we will look at the remaining tasks that must be completed by November, 2020.

4. Agenda for Future Work

Within the next 12 months, Senate Bill 1517 requires our task force to accomplish some major goals. By November 1, 2020, we must:

(a) Prepare an integrated task force strategy report;
(b) Submit the report to the chair of the Senate Health and Human Services Committee and the chair of the House of Representatives Children, Youth and Family Services Committee; and
(c) Make the report publicly available.

The report must describe how the Task Force and member agencies will work together to prevent trauma (especially ACEs). Furthermore, we must implement “appropriate interventions and supports” for children and youth (and their families, as appropriate) who have experienced or are at risk of experiencing trauma.
SB 1517 says we must do this by collaborating, prioritizing options, and implementing a coordinated approach.

As of the date of this report (November, 2019), the task force is considering and examining options for implementing a coordinated approach, but have not yet established recommendations or priorities. As we contemplate the challenge before us, and as we reflect on the knowledge we have gained in the past 12 months, several ideas suggest themselves. The following concepts will be explored:

**A Statement of Common Principles.** We believe it may be useful for the task force and member agencies to adopt a statement of common principles, including agreement on the features of a trauma-informed interagency system. The features of such a system might include, but not limited to:

- Respecting the voice of youth and families;
- Agreement on the need for services that cultivate resilience;
- A recognition that ongoing, quality staff training is fundamental;
- Recognizing the need to address secondary trauma;
- Sharing data in order to identify gaps in services;
- A commitment to implementing services that are informed by data and focused on continuous quality improvement;
- Etc.

**Trauma-Informed Staff Training.** We will examine the availability of inter-agency staff training and continuing education in order to develop a competent and capable workforce, especially when serving youth who have experienced trauma.

**The Voice of the Customer.** We will seek agreement on the need to involve parents and youth in the planning and design of new services and program activities.

**Effective cross-agency referral mechanisms.** We will seek to assure that appropriate mechanisms are in place to provide a seamless, consistent response for service delivery across systems.

**Encouraging the development of local trauma-informed Resilience Communities.** We will seek agreement on the need to encourage multi-disciplinary collaborative groups to promote trauma-informed care in communities throughout Oklahoma.

**Promote cultural competency.** We will promote trauma-informed treatments and practices that recognize and encompass differences in disability, race, ethnicity, immigrant status, sexuality, and urban/rural status.

**Seek the restoration and expansion of funding for trauma-informed care.** To the extent that we can, we will support the expansion of funding for trauma-informed care delivered through state agencies.

**Continuing and Sustainable Coordination Efforts.** Not least of all, we will seek to identify and provide resources that will allow the important coordination efforts of this task force to continue after our mandate has expired. We will work toward the establishment of a dedicated team of public administrators with the skills necessary to gather and share information about trauma-informed care, encourage interagency coordination, and promote greater efficiency in the establishment of trauma-informed practices.
Attachments

A. Task Force Membership List ... by name and representation

B. Authorizing Legislation: SB 1517

C. A Table of Trauma-Informed Practices in Oklahoma

E. End Notes / References
Attachment A.
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Attachment B.
Authorizing Legislation

An Act
ENROLLED SENATE BILL NO. 1517
By: Griffin and Floyd of the Senate
and
Bush, Lawson, Baker, West (Tammy), Osborn (Leslie), Watson, Munson, Condit and Sears of the House

An Act relating to trauma-informed care; creating the Task Force on Trauma-Informed Care to study and make recommendations to the Legislature on best practices with respect to children and youth who have experienced trauma; setting forth Task Force duties; providing for membership; specifying areas to be examined and time lines; specifying nature of recommendations; providing that Task Force meetings are subject to Oklahoma Open Meeting Act; providing that Task Force members shall not receive reimbursement; providing for noncodification; and providing an effective date.

SUBJECT: Trauma-informed care

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

A. There is hereby created until three (3) years after the effective date of this act, a task force to be known as the Task Force on Trauma-Informed Care. The Task Force shall:
   1. Identify, evaluate, recommend, maintain and update as described in subsection D of this section and in accordance with subsection E of this section, a set of best practices with respect to children and youth, and their families as appropriate, who have experienced trauma, especially adverse childhood experiences (ACEs); and
   2. Carry out other duties as described in subsection C of this section.

B. The Task Force shall be comprised of seventeen (17) members, each appointed by his or her respective agency:
   1. One member who is an employee or designee of the State Department of Health;
   2. One member who is an employee or designee of the Department of Mental Health and Substance Abuse Services;
   3. One member who is an employee or designee of the Department of Human Services;
   4. One member who is an employee or designee of the SoonerStart division of the State Department of Education;
   5. One member who is an employee or designee of the State Department of Education, other than an employee or designee of the SoonerStart division;
   6. One member who is an employee or designee of the Office of Juvenile Affairs;
   7. One member who is an employee or designee of the Council on Law Enforcement Education and Training;
   8. One member who is an employee or designee of the Oklahoma Commission on Children and Youth;
   9. One member who is an employee or designee of Indian Health Services;
   10. One member who is an employee or designee of the Oklahoma Health Care Authority;
11. One member who is an employee or designee of the Office of the Attorney General;
12. One member who is an employee or designee of the Center for Integrative Research on Childhood Adversity at Oklahoma State University;
13. One member who is an employee or designee of the Oklahoma chapter of a professional association of pediatricians;
14. One member who is an employee or designee of an association of Oklahoma physicians;
15. One member who is an employee or designee of the University of Oklahoma Health Sciences Center's Department of Pediatrics;
16. One member who is an employee or designee of an Oklahoma organization that advocates on behalf of children; and
17. One member who is an employee or designee of the Institute for Building Early Relationships at Oklahoma State University.

The members of the Task Force shall elect a chair from among the Task Force's membership.

C. Appointments to the Task Force shall be made within thirty (30) days after the effective date of this act.

D. The Task Force shall:
1. Not later than one year after the effective date of this act, and not less often than annually thereafter:
   a. identify and evaluate a set of evidence-based, evidence-informed and promising best practices, which may include practices already supported by the State Department of Health, the Department of Human Services, the Office of Attorney General, the State Department of Education or another state agency,
   b. recommend such set of best practices, including disseminating the set to:
      (1) the State Department of Health, the Department of Human Services, the Office of Attorney General, the State Department of Education and other state agencies as appropriate,
      (2) state, tribal and local government agencies, including State, local and tribal educational agencies,
      (3) other entities, including but not limited to recipients of relevant state grants, professional associations, health professional organizations, state accreditation bodies and schools, and
      (4) to the general public, and
   c. maintain and update, as appropriate, the set of best practices pursuant to this paragraph;
2. Not later than two (2) years after the effective date of this act:
   a. prepare an integrated task force strategy report concerning how the Task Force and member agencies will collaborate, prioritize options for and implement a coordinated approach to preventing trauma, especially ACEs, and identifying and ensuring the appropriate interventions and supports for children, youth and their families as appropriate, who have experienced or are at risk of experiencing trauma,
   b. submit the report to the chair of the Senate Health and Human Services Committee and the chair of the House of Representatives Children, Youth and Family Services Committee, and
   c. make the report publicly available; and
3. Not later than one year after the effective date of this act, and as often as practicable, but not less often than annually thereafter:
a. coordinate, to the extent feasible, among the offices and other units of government represented on the Task Force, research, data collection and evaluation regarding models described in subsection E of this section,
b. identify gaps in or populations or settings not served by models described in subsection E of this section, solicit feedback on the models from the stakeholders described in subsection E of this section,
c. coordinate, among the offices and other units of government represented on the Task Force, the preventing and mitigating trauma, and
d. establish procedures to enable the offices and units of government to share technical expertise related to preventing and mitigating of trauma.

E. In identifying, evaluating, recommending, maintaining and updating the set of best practices under subsection D of this section, the Task Force shall:
   1. Consider findings from evidence-based, evidence-informed and promising practice-based models, including from institutions of higher education, community practice, recognized professional associations and programs of the State Department of Health, the Department of Human Services, the Office of Attorney General, the State Department of Education and other agencies that reflect the science of healthy child, youth and family development, and have been developed, implemented and evaluated to demonstrate effectiveness or positive measurable outcomes;
   2. Engage with and solicit feedback from:
      a. faculty at institutions of higher education including, but not limited to, the Center for Integrative Research on Childhood Adversity (CIRCA),
      b. community practitioners associated with the community practice described in paragraph 1 of this subsection,
      c. recognized professional associations that represent the experience and perspectives of individuals who provide services in covered settings in order to obtain observations and practical recommendations on best practices, and
      d. the public, by holding at least one public meeting to solicit recommendations and information relating to best practices;
   3. Recommend models for settings in which individuals may come into contact with children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma, including schools, hospitals and settings where health care providers, including primary care and pediatric providers, provide services, preschool and early childhood education and care settings, home visiting settings, after-school program facilities, child welfare agency facilities, public health agency facilities, mental health treatment facilities, substance abuse treatment facilities, faith-based institutions, domestic violence centers, homeless services system facilities, juvenile justice system facilities and law enforcement agency facilities; and
   4. Recommend best practices that are evidence-based, are evidence-informed or are promising and practice-based, and that include guidelines for:
      a. training of front-line service providers including teachers, providers from child-serving or youth-serving organizations, health care providers, individuals who are mandatory reporters of child abuse or neglect and first responders, in understanding and identifying early signs and risk factors of trauma in children and youth, and their families as appropriate, including through screening processes,
      b. implementing appropriate responses,
      c. implementing procedures or systems that:
         (1) are designed to quickly refer children and youth and their families, as appropriate, who have experienced or are at risk of experiencing trauma, and ensure the children, youth and
appropriate family members receive the appropriate trauma-informed screening and support, including treatment,
(2) use partnerships that include local social services organizations or clinical mental health or health care service providers with expertise in furnishing support services including, but not limited to, trauma-informed treatment to prevent or mitigate the effects of trauma,
(3) use partnerships which co-locate or integrate services, such as by providing services at school-based health centers, and
(4) use partnerships designed to make such quick referrals, and ensure the receipt of screening, support and treatment, described in division (1) of this subparagraph,
d. educating children and youth to:
   (1) understand trauma,
   (2) identify signs, effects or symptoms of trauma, and
   (3) build the resilience and coping skills to mitigate the effects of experiencing trauma,
e. multi-generational interventions to:
   (1) support, including through skills building, parents, foster parents, adult caregivers and front-line service providers described in subparagraph a of this paragraph in fostering safe, stable and nurturing environments and relationships that prevent and mitigate the effects of trauma for children and youth who have experienced or are at risk of experiencing trauma,
   (2) assist parents, foster parents and adult caregivers in learning to access resources related to such prevention and mitigation, and
   (3) provide tools to prevent and address caregiver or secondary trauma, as appropriate,
f. community interventions for underserved areas that have faced trauma through acute or long-term exposure to substantial discrimination, historical or cultural oppression, intergenerational poverty, civil unrest, a high rate of violence or a high rate of drug overdose mortality,
g. assisting parents and guardians in understanding eligibility for and obtaining certain health benefits coverage, including coverage under a State Medicaid plan under Title XIX of the Social Security Act of screening and treatment for children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma,
h. utilizing trained nonclinical providers such as peers through peer support models, mentors, clergy and other community figures, to:
   (1) expeditiously link children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma, to the appropriate trauma-informed screening and support including, but not limited to, clinical treatment services, and
   (2) provide ongoing care or case management services,
i. collecting and utilizing data from screenings, referrals or the provision of services and supports, conducted in the covered settings, to evaluate and improve processes for trauma-informed support and outcomes,
j. improving disciplinary practices in early childhood education and care settings and schools, including but not limited to use of positive disciplinary strategies that are effective at reducing the incidence of punitive school disciplinary actions, including but not limited to school suspensions and expulsions,
k. providing the training described in subparagraph a of this paragraph to child care providers and to school personnel, including school resource officers, teacher assistants, administrators and heads of charter schools, and
l. incorporating trauma-informed considerations into educational, pre-service and continuing education opportunities, for the use of health professional and education organizations,
national and state accreditation bodies for health care and education providers, health and education professional schools or accredited graduate schools and other relevant training and educational entities.

F. The Task Force may meet as often as may be required in order to perform the duties imposed upon it. Meetings of the Task Force shall be subject to the Oklahoma Open Meeting Act.

G. Members of the Task Force shall receive no compensation or travel reimbursement.

SECTION 2. This act shall become effective November 1, 2018.
Attachment C.
A Sampling of Trauma Informed Practices in the State of Oklahoma
Across the globe, community leaders and policy makers are recognizing that Adverse Childhood Experiences can have life-long consequences for a person’s health and well-being.

1 Source: ACE Global Research Network
World Health Organization
"...WHO and the United States Centers for Disease Control and Prevention are therefore building a global network focused on understanding the long-term health risk behaviour and chronic disease consequences of ACEs, and providing technical assistance to partners in this area."

ACEs are commonly divided into three categories of adverse experience.


Dr. Robert Anda described his reaction the first time he reviewed the data from the survey of patients. “I wept,” he said. “I saw how much people had suffered and I wept.”


...ACEs are cumulative with the risk of physical and mental health issues increasing as the number of adverse experiences increased.


For individuals having experienced 4 or more ACEs, the study found 2- to 12-fold increases in the risk for ischemic heart disease, stroke, COPD, alcoholism, illicit drug use, early intercourse, and suicide.


Individuals having experienced 6 or more ACEs, on average, died 20 years earlier compared to individuals with no ACEs.

In July, 2019, the Tulsa World identified several indicators with a link to childhood abuse and neglect.

Although down from 32.9% in 2016, Oklahoma remains the state with the highest percentage of children experiencing 2 or more ACEs.

In addition, this study identified several groups at an increased risk for experiencing ACEs including women, young adults, individuals identifying as gay, lesbian, or bisexual, and multiracial individuals. Individuals with less than a high school education, those making less than $15,000 annual income, and unemployed individuals were also more likely to report higher exposure to ACEs.

Research indicates 20 - 48% of children and teens have had more than one adverse experience before the age of 18.

Children with 2 or more ACEs are 3 times more likely to have to repeat a grade, 3 times more likely to experience externalizing and internalizing difficulties, and at a 10-fold increase in risk for having a diagnosed learning disorder.

Data from the 2016 National Survey of Children’s Health (NSCH) indicates 63.7% of African-American children and 51.4% of Hispanic children reported one or more ACEs compared to 40.9% of white children.
Data from the 2011-2012 NSCH indicates American Indian children are significantly more likely than their white peers to have experienced 2 or more ACEs, 40% versus 21%.


A study of 65,000 youth in the juvenile justice system found 98% of females and 97% of males reported at least one adverse experience, and 92% of females and 90% of males reported having multiple ACEs.


Results indicated 42% of children had experienced 4 or more ACEs before the age of 6.


Furthermore, ACEs contributed to significantly more academic and behavioral difficulties in these same children.


Trauma-informed care (TIC) is a model intended to increase resilience for those exposed to or vulnerable to trauma as well as prevent retraumatization.


Initially used in the therapeutic setting, TIC shows promising evidence as an effective method for mitigating the harmful effects of trauma and building resilience in children and adults.


In a number of states, trauma-informed care and Adverse Childhood Experiences are topics of recent legislative measures.

20 A Snapshot of Statutes related to ACEs and Trauma-Informed Policy

A legislative scan in March by the National Conference of State Legislatures (NCSL) of bills that specifically include references to ACEs (nearly 40 bills in 18 states) also found seven statutes enacted in six different states. [https://www.acesconnection.com/g/state-aces-action-group/blog/a-snapshot-of-statutes-related-to-aces-and-trauma-informed-policy](https://www.acesconnection.com/g/state-aces-action-group/blog/a-snapshot-of-statutes-related-to-aces-and-trauma-informed-policy)

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A more recent report from State ACES Action, an online advocacy community, identified 56 statutes and resolutions that have been adopted by the states since 2011.

Elizabeth Prewitt, ACES Connection Staff · 4/22/19

The attached table summarizes all of the statutes and passed resolutions that contain the words "Adverse Childhood Experiences (ACES)" and trauma-informed language through the end of 2018. There are nearly 60 statutes with the earliest law enacted in Washington State in 2011. The laws are categorized by subject matter such health care, education, training, and funding.
https://www.acesconnection.com/g/state-aces-action-group/blog/snapshot-of-aces-statutes-and-resolutions

The state’s campaign “Let’s Get Healthy California” integrates ACEs research into their 10 year plan to make California the healthiest state in the country.

California Department of Public Health

Recognizing this fact, in 2017, Colorado launched the Child Maltreatment Prevention Framework for Action in order to help local communities create a better plan for preventing child maltreatment and promoting child well-being.


Spurred into action in 2016 by an executive order from the governor, the state of Washington began a multidisciplinary effort to introduce trauma-informed care to both state and public agencies.


In 2012, Wisconsin launched the Wisconsin Trauma Project (WTP) with the idea of introducing a trauma-informed child welfare system.

Wisconsin Department of Children and Families. (2015) 2015 Annual report of the WI trauma project

Together, the three components model an interdisciplinary and collaborative approach to TIC, and, within a year, allowed for 689 children to be screened and assessed for trauma.

Wisconsin Department of Children and Families. (2017). Wisconsin trauma project: 2017 annual update

According to research published in the American Journal of Preventive Medicine, adults who lived through adversity and trauma as children pay “a disproportionate economic price related to these worse health outcomes throughout adulthood.”

Adverse childhood events lead to high out-of-pocket medical costs in adulthood. (2019). Healio.com
To get a sense of the total cost of ACEs over a lifetime, a 2012 study published in *Child Abuse and Neglect: The International Journal* focused on one component of Adverse Childhood Experiences. Researchers from the Centers for Disease Control and Prevention (CDC) examined the lifetime costs of child maltreatment.


That means, Oklahoma can expect more than $3.2 billion of lifetime costs associated with only those children identified as maltreatment victims during SFY 2017 alone.


Titled, "The Economic Cost of ACEs in Tennessee: Medical Costs and Worker Absenteeism from Health Issues Attributed to Adverse Childhood Experiences," the report focused narrowly on the costs in the state of Tennessee.


As described on the NFSN website, Family Resource Centers "...serve as welcoming hubs of community services and opportunities designed to strengthen families. Their activities and programs, typically provided at no or low cost to participants, are developed to reflect and be responsive to the specific needs, cultures, and interests of the communities and populations served."


The five protective factors, developed by the Center for the Study of Social Policy in 2005, include:

- Parental Resilience
- Social Connections
- Concrete Support in Times of Need
- Knowledge of Parenting and Child Development
- Social and Emotional Competence of Children


The program is described in an article in the Norman Transcript newspaper.

Literature concerning best practices suggests that a multidisciplinary, interagency effort provides the most compelling model of trauma-informed care.


TF-CBT is a relatively short-term, skills-based treatment program utilized to teach families skills to reduce distress and increase coping capacity.


Currently, Oklahoma is home to four nationally recognized trainers in TF-CBT who offer training to mental health professionals.


The Handle with Care model is a collaboration between law enforcement and local public schools in an effort to promote a safe environment for those who have recently experienced a potentially traumatic event.


In a 2013 article, researchers from Texas Christian University listed the three principles of TBRI as: (1) Empowerment—attention to physical needs; (2) Connection—attention to attachment needs; and (3) Correction—attention to behavioral needs.


A large majority of Oklahoma residents can be found within the limits of Cleveland, Tulsa, and Oklahoma counties.


Estimates from the United States Census indicate 15.6% of Oklahomans are living in poverty.


Factors such as warmth, effectiveness, and understanding of needs are diminished while factors such as use of corporal punishment, harsh discipline, neglect, and reactive parenting are increased.


From 2010 to 2012, Oklahoma participated in efforts of NCTSN to obtain best practices in trauma-informed care to improve placement stability within child welfare. Implemented practices included
training for all agency staff—including administrative staff—, training for foster parents, including a trauma consultant, and using trauma informed language in court reports.


One of the first frameworks establishing criteria for Trauma-Informed practices was set forth by the Substance Abuse and Mental Health Services Administration.