
Trauma-Informed PA:

A Plan to Make Pennsylvania a Trauma-Informed, Healing-Centered State



Dan Jurman, MAR - Executive Director

July 2020

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"Although the world is full of suffering, it is also full of the overcoming of it." - Helen Keller

"Healing is a matter of time, but it is sometimes also a matter of opportunity." - Hippocrates

"Our sorrows and wounds are healed only when we touch them with compassion." - Buddha

"Trauma" is not singular, those who experience it are not identical, and the contexts and cultures within which each of us lives are as varied as the blades of grass in a field." - Margaret Blaustein & Kristine Kinniburgh

"It's when we start working together that the real healing takes place...

it's when we start spilling our sweat, and not our blood." - David Hume

I. Letter from the Office of Advocacy and Reform

It has been a long journey for me to be writing this letter. There were times when I was a child living in the midst of domestic violence that I wondered if I'd live to adulthood. There were times as an adult with an ACE score of 8 and untreated PTSD that I wondered if I'd amount to anything. Now I sit in the Governor's Office with the charge of reforming the way our state engages with vulnerable populations, not just to avoid re-traumatizing people, but to work towards preventing trauma in the first place. If my life has taught me anything, it's that healing is both possible and life changing.

Bessel van der Kolk declared that child abuse is "our nation's largest public health problem."¹ If he's correct, then it is not only incumbent on us to prevent it and heal its effects, and the effects of all trauma, on our population, but it would be immoral for us to do anything less. I truly believe that most of the challenges we face as a society can be traced back to unhealed trauma; mental health disorders, poverty, crime, suicide, addiction, abuse, neglect, health disparities / social determinants of health. While there's no such things as a silver bullet for these longstanding societal ills, building a society focused on creating safety and healing may be the closest thing we'll ever have.

We are pioneers together on this journey. That means we will make mistakes along the way, and we will learn. We will start down roads whose destinations we may never get to reach, but we will begin this journey. What we have written here will evolve with science and our learning, and our successes will increase, as will our ambitions. People will heal, and thrive, and we will be

¹ M.D., *The Body Keeps the Score*, 147.

amazed at what we can accomplish. In all these things there will be one constant. We will do them all together. Imagine the possibilities!

Thank you for your willingness to take this journey to build a safer and more prosperous Pennsylvania for everyone.

Sincerely,

Daniel L. Jurman, MAR - Executive Director of the PA Office of Advocacy and Reform


II. Foreword

Our Trauma-Informed PA Think Tank members gave of their time and their insights throughout the process of building this plan. Some of them also shared some additional thoughts from their various fields and experiences. We share them here to help set the stage for our work, and at the close of this plan to set us on our way.

Jeanne Elberfeld, MD, LSW- Schuylkill County's VISION, Marywood University School of Social Work -

Science may be the backbone of ACEs, trauma, and resilience, but true human connection is the hands and feet of the message, healing, and growing.

I emphasize that as a society we must do better with building families and communities; strong, trustworthy anchors for people to turn to in times of plenty and times of need. We must focus on the children, and we must focus on their caregivers, and



those who support and love those caregivers. Human relationship heals relational trauma and will be an important ingredient in the primary prevention of further abuse, neglect, and household dysfunction. Let's invest in support of young families; education, respite, and connections.


Let's also focus on those who are living trauma impacted lives with evidence informed interventions like touch, movement, rhythm, music, art, and mindfulness. Let's bolster everyone's social/emotional health and skills with trauma-informed programming that is available to all.

We can do this through the 4Rs of a trauma informed organization: Rrealize the depth and breadth of trauma's impact. Recognize trauma-impacted behaviors as symptoms of deeper wounds. Respond to those in a trauma-informed manner. Resist re-traumatization for all.

Leslie Lieberman, MSW, Senior Director Training and Organizational Development, Health Federation of Philadelphia

Sharing the science of ACEs and trauma widely is important. Primary prevention of ACEs, as well as intervention, requires a focus on healthy human relationships. I believe these are steps to becoming a trauma-informed PA, and more is needed.

My interest is in ensuring that we clearly communicate that a comprehensive, healing-centered, trauma-informed approach must include clear identification and acknowledgement of the underlying conditions (e.g. racism and other "isms", poverty, poor access to quality healthcare and education, etc.) that contribute to an inequitable distribution of ACEs and trauma in society, and an



acknowledgement that most, if not all, ACEs are preventable. We must emphasize the need for advocacy and action, and resources to create the supports and conditions that make it possible for all Pennsylvanians to thrive and flourish.

I am a big fan of activist and organizer Margaret Wheatley and often quote the tagline of the Berkhana Institute she founded which is “Whatever the Problem, Community is the Answer.”² Based on my work of the last 13 years, I believe that the answer to trauma and ACEs lies in the power of communities, along with the science and relationships emphasized by so many others on this think tank. Through the Mobilizing Action for Resilient Communities Initiative I’ve seen what communities organized around the science of ACEs, Trauma, and Resilience (ATR) can do. We must call all of PA to mobilize, organize, and advocate around ATR and build on what exists. There are at least 15 counties in PA that have ATR networks/coalitions, and surely more at local levels. I am encouraged by our recommendations to expand, support and sustain these networks.

Andrea J. Farina, Ed.D. Assistant Superintendent Upper Perkiomen School District -

As a lifelong educator, trained to be a “teacher,” this experience was both illuminating and frightening. It brought into focus what I learned from experience in the classroom, which was, the human experience of trauma has a far greater impact on a child’s trajectory than any other factor.

² *Margaret Wheatley.*

The stark contrast for educators working day in and day out on the frontlines of teaching is that as a profession, the bar for success has been set on external standardized measures, and not on the holistic, more humanistic needs of children. In the high-stakes environment that school has become, teachers must largely forgo the concentrated and sustained effort to assist students to develop the skills to be resilient, to cope, and find ways to deal with the great success and struggle that life has to offer. Educators represent a willing, able, and motivated group of professionals who want the pendulum to swing in favor of a more balanced approach to education, where teachers can take time to nurture children, teach compassion, and address trauma.

With that said, what I have learned from participating in the think tank, is that I have so much to learn! As an educator, I deeply wish that I had a greater understanding of trauma, healing-centered practices, and managing secondary trauma. If our true intention is to become a “trauma-informed” state, we must find mechanisms to educate pre-service and practicing educators to ensure they have the knowledge and skills to competently assist in being the change we want to see for our commonwealth. There are very natural methods to ensure that this occurs, which would be: college coursework for certification, to embed mandatory training hours in the Comprehensive Plan for both new teacher induction and Act 48. Utilizing these already existing elements in the educational system creates a sense of urgency and accountability for all districts across the commonwealth.

III. History

On July 31st, 2019 Governor Tom Wolf by executive order announced that an overhaul of the state services and systems to protect the most vulnerable Pennsylvanians. Governor Wolf's "Protection of Vulnerable Populations" Executive Order established an Office of Advocacy and Reform (OAR), maintained by the governor's office with an executive director that included a new Child Advocate position and integrated the Long-term Care Ombudsman; and a Council on Reform, including 25 voting members appointed by Gov. Wolf, to support this effort by looking at protecting vulnerable populations from three perspectives: prevention and diversion, protection and intervention, and justice and support. Both the Council on Reform and OAR were to identify reforms needed for Pennsylvania to better protect and support individuals relying upon services and assistance from the commonwealth.

One of the key directives from Governor Wolf was to establish Pennsylvania as a trauma-informed state to better respond to the needs of people who have had adverse childhood or other serious, traumatic experiences. In December of 2019 Dan Jurman was named as the first Executive Director of OAR. Dan had been implementing trainings on the intersection of poverty and trauma for the previous four years as the CEO of the Community Action Partnership of Lancaster County. The prospect of making Pennsylvania a trauma-informed state was one of the things that drew him to OAR.

IV. Acknowledging the Past

It is one thing to not know what you are doing may be harming another person. It is another to know it is doing harm and to allow it to continue. We know that there have been state policies and procedures that can traumatize the people we are meant to serve. We know that poverty creates trauma, and that trauma perpetuates poverty in a vicious cycle. We know that LGBTQ+ individuals experience trauma when their identity is not honored and respected. We know that systemic racism creates trauma, and not only leads to the sudden, violent deaths that capture our attention, but also to the slow deaths of individuals and communities. In the light of that knowledge, we know we must review and revise our policies and practices based on the potential for traumatization, on new and developing scientific knowledge, and our understanding of promising best practices.

In as much as the commonwealth of the past or present has contributed to policies, practices, and systems that have caused people trauma and harm, we are committing to change. For every person who has reached out to the commonwealth or a program we fund or regulate for help and found instead bureaucracy, blame, inaction, or even violence, we apologize and acknowledge that we must do better. When we know a thing is wrong and harmful, there is a moral imperative that we change to meet the challenge that knowledge imparts.

That is what we set out to do with this plan. This is our pledge to do better than we have been in the past. We do this for the sake of every Pennsylvanian who has known or may yet know trauma, and seeks the healing that leads to a full, empowered life. We can no longer afford to let the status quo, or the fear of change, keep us from what we know is the right thing to do.

V. Our Approach

Upon taking up the Governor's charge to make Pennsylvania a trauma-informed state, OAR first sought out experts who could populate a think tank to lend their knowledge and wisdom to the process. When we put out the call for volunteers, we were hoping to get enough of a response to create a team of 10 from various fields of study. Sixty-eight excellent professionals applied, from which we formed a team of twenty-five. They represent the fields of psychology, psychiatry, mindfulness, social work, clergy, community development, human development, family studies, sexual assault counseling, domestic violence counseling, sociology, education, school psychology, community organizing, family medicine, intensive care, nursing, county government, public health, intellectual disabilities, addiction, therapy, pediatrics, population health, re-entry services, philanthropy, law enforcement, academia, and research. In addition to their professional expertise, they are diverse in life experiences, ethnicity, and setting, coming from rural, suburban, and urban parts of the state.

We began with defining the very terms we would be using as a commonwealth to ensure we were all speaking the same language. From there we focused on the following priorities:

- Building a network to connect and support community-based, grassroots movements across the commonwealth.
- Prioritizing changes at the state level to affect culture, policy, and practice.
- Healing from the trauma of a major disaster like the Covid-19 pandemic.
- Healing the damage of racism, communal, and historical trauma.

Finally, the think tank members contributed some of their own writings to the plan as well as their suggestions and editing skills. That included the creation of the mission, vision, values, and core principles for action that are at the heart of this plan, and will guide the future implementation teams that will work to make it a reality. They are as follows:

Mission - To make Pennsylvania a Trauma-Informed State to better serve all residents.

Vision - Pennsylvania is a state where prevention is the norm. When people do experience emotional and psychological trauma they feel respected, safe, empowered, and supported to recover and heal.

Values -

- **Acceptance**

“Providing an atmosphere that allows every individual to feel validated and affirmed with each and every contact at the entity.”³

- **Equity**

The World Health Organization defines equity as “the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.”⁴ While equality gives everyone an equal share, equity involves everyone getting what they need to thrive at an equal level. When we don’t truly

³ “What Is Trauma-Informed Care?”

⁴ “WHO | Equity.”

have equality; when privilege exists (and especially when privilege and inequality have run rampant), we must give those outside of privilege more than we give those in privilege in order to achieve equity.

- **Inclusion**

Inclusion is an intentional effort in which different groups or individuals having different backgrounds are culturally and socially accepted, welcomed, and treated equally. These differences could be self-evident, such as national origin, age, race and ethnicity, religion/belief, gender, marital status and socioeconomic status or they could be more inherent, such as educational background, training, sector experience, tenure, or even personality, such as introverts and extroverts. It is a sense of belonging. Inclusive cultures make people feel respected and valued for who they are as an individual or group. People feel a level of supportive energy and commitment from others so that they can do their best. (Adapted from Global Diversity Practice)⁵

- **Resilience**

Resilience is seen as an ongoing social process enacted through ordinary practices of everyday life and situated in people's local contexts that enables them to achieve favorable outcomes in relatively unfavorable situations. It is traditionally

⁵ "What Is Diversity & Inclusion?"

conceptualized as “an extraordinary atypical personal ability to revert or ‘bounce back’ to a point of equilibrium despite significant adversity.”⁶

- **Safety**

“If there is one foundational principle of this approach, it is the concept of safety. By safety, we are not talking about just creating a safe therapeutic environment for the people we serve, but one across the whole organization. Safety includes physical, emotional, moral, and psychological safety of those we serve AND those in our organizations. It begins with an evaluation of the physical environment, the facility itself, and the policies surrounding a safe workplace. Ideally the overall safety of the organization is a collaborative, ongoing project that involves those we serve. For our staff to be most effective, the concepts of physical and emotional safety extend to them as well. The people employed by our organizations need to feel valued and safe. They should be able to ask for help when needed and open to express challenges with the work they do, especially those in direct care roles.”⁷

- **Self-care**

“A key component of trauma-informed care is the importance of taking care of employees; the organization taking care of its employees and helping employees take care of themselves. The impact on professionals of working with trauma is well

⁶ Vyas and Dillahun, “Everyday Resilience.”

⁷ “WhitePaper_Relias_HHS_BH_TIC.Pdf.”

documented; concepts like compassion fatigue, burnout and secondary trauma are addressed in numerous publications. It is an accepted truth that this work impacts the professionals and caregivers and therefore an effective program must have systems in place to take care of all employees.”⁸

Core Principles for Action and Planning -

- **Accountability**

We will be accountable to aspirations laid out in this plan, the decisions we make to reach those aspirations, and the outcomes achieved.

- **Data driven/Science-based**

The best available data and the latest science will guide our decision-making.

- **Evidence-informed**

Our decisions will be guided by evidence, but open to innovation and new approaches that may lead to better results.

- **Open Communication**

We will be transparent in considerations, decision-making, and outcomes.

⁸ “WhitePaper_Relias_HHS_BH_TIC.Pdf.”

- **Person-centered**

The people we serve will be at the center of our decision-making, not just abstractly, but directly through including their voices and presence whenever possible and appropriate with a focus on addressing and removing barriers that make it difficult for people to be involved.

VI. Definitions

Trauma

Trauma results from an event, series of events, or a set of circumstances experienced by an individual as physically or emotionally harmful or life threatening. Potentially traumatic events may include those directly experienced by the individual, as well as witnessing such events as threatening to others (e.g., a loved one). Depending on the presence of resilience factors, trauma can create biologically-based responses and can have long-lasting, adverse effects on the individual's learning, relationships, functioning, and mental, physical, social, emotional, and spiritual well-being. Not all individuals will experience a potentially traumatic event in the same way. An individual's reaction to the event may influence its effect on their functioning and wellbeing.

(Adapted from the SAMHSA definition)⁹

⁹ "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach," 7.

Adverse Childhood Experiences (ACEs)¹⁰

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being. The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors. ACEs are common across all populations. Almost two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs. Some populations are more vulnerable to experiencing ACEs because of the social and economic conditions in which they live, learn, work and play.

The ACE score is the total sum of the different categories of ACEs reported by participants. Study findings show a graded dose-response relationship between ACEs and negative health and well-being outcomes. In other words, as the number of ACEs increases so does the risk for negative outcomes.

ACEs Definitions¹¹

All ACE questions refer to the respondent's first 18 years of life.

¹⁰ "About the CDC-Kaiser ACE Study | Violence Prevention|Injury Center|CDC."

¹¹ "About the CDC-Kaiser ACE Study | Violence Prevention|Injury Center|CDC."

- **Abuse**

- **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.

- **Household Challenges**

- **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
- **Substance abuse in the household:** A household member was a problem drinker or alcoholic or a household member used street drugs.
- **Mental illness in the household:** A household member was depressed or mentally ill or a household member attempted suicide.

- **Parental separation or divorce:** Your parents were ever separated or divorced.
- **Incarcerated household member:** A household member went to prison.
- **Neglect**
 - **Emotional neglect:** You were without someone in your family to help you feel important or special, you didn't feel loved, people in your family didn't look out for each other and didn't feel close to each other, and your family wasn't a source of strength and support.
 - **Physical neglect:** There was no one to take care of you, protect you, and take you to the doctor if you needed it, you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

NOTE - We recognize ACEs as being just one category under the umbrella of the larger topic of trauma. Its focus within our plan is specifically tied to our strategies for prevention of trauma, and our recognition of the potential for the especially devastating effects of trauma on the developing brain of a child.

Toxic Stress

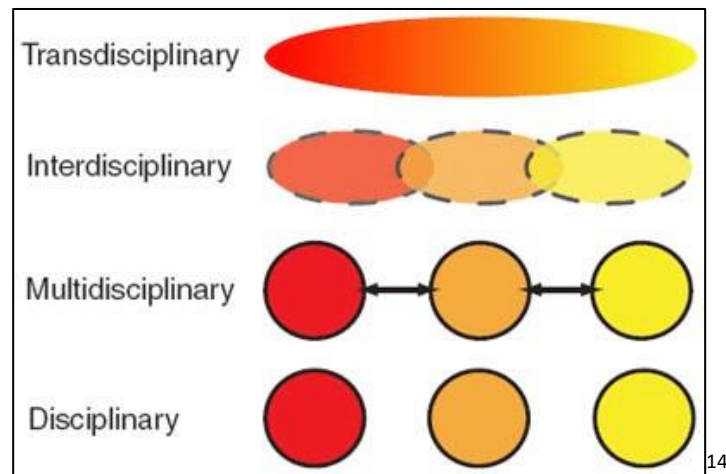
Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment, well into the adult years.¹²

Transdisciplinary Approach

Approaches conducted by professionals from different disciplines working jointly to create new conceptual, theoretical, methodological, and translational innovations that integrate and move beyond discipline-specific approaches to address common problems. (Adapted from the Harvard Transdisciplinary Research definition)¹³ A transdisciplinary team begins to focus on the common problem through the lens of each partner, and how it intersects with each discipline involved, not just through the lens of their individual silos (see the illustration below).

¹² “Toxic Stress.”

¹³ Boston and Ma 02115 +1495-1000, “Definitions.”



Trauma-Informed Care

Trauma-Informed Care is a strengths-based approach to service delivery and organizational structure grounded in an understanding of and responsiveness to the widespread impact of trauma, including historical and identity-based trauma, that:

- recognizes the symptoms of trauma and its effects on individuals, families, communities, and those who provide services or work in care settings,
- understands multiple, complex paths to recovery,
- emphasizes physical, psychological, and emotional safety for providers, survivors, and their families.
- creates opportunities for survivors to rebuild a sense of safety, control, and empowerment,

¹⁴ "Figure 1."

- responds by fully integrating knowledge about trauma and recovery into policies, procedures, and practices, and
- seeks to actively prevent re-traumatization.

(Adapted from *Shelter from the Storm*)¹⁵

Healing-Centered Practices

Healing-centered practices incorporate trauma-informed approaches and identify strengths inherent to an individual or community as the foundation for healing. They focus on the fundamental belief that the person who has survived trauma is not broken or needing to be fixed but is already whole and has the capacity to grow from what happened to them. New skills are built upon that foundation of strength and wholeness using holistic, evidence-informed tools that have been shown to increase self-efficacy, coping, and resilience. They encourage introspection to develop self-discovery, self-worth, and healing through engagement, empowerment, and self-care without guilt. If trauma-informed care is moving from “what’s wrong with you?” to “what happened to you?”, then healing-centered practices are moving on to “what’s good about you?”

Key elements of Healing-Centered Practices include:

- Cultural connectivity and restoration of identity,
- Focus on purpose and a plan for the future,

¹⁵ Hopper, Bassuk, and Olivet, “Shelter from the Storm.”


- Promotion of a plan for self-care,
- Somatic approaches to move trauma out of the body like deep breathing, yoga, dance, exercise, etc.,
- Understanding that everyone heals in a different way so there is no one-size-fits all approach,
- Awareness of the policies, practices, and political decisions that create trauma, and of the civic actions that address those conditions, and
- Understanding of activities that contribute to a sense of purpose, power, and control over our responses to life situations for individuals and communities.

(Adapted from *The Future of Healing*)¹⁶

Trauma-Informed State

A Trauma-Informed State recognizes that some behaviors and outcomes that have been seen as negative are symptoms of underlying and unhealed trauma. Working through that lens, it transforms its policies and internal systems, as well as assists all external public and private organizations across the state, to recognize, understand, and address the effects of trauma on the lives of individuals, families, and communities. It promotes transdisciplinary collaboration across both public and private sectors to establish trauma-informed approaches as the norm in an effort to minimize trauma and help people who have experienced trauma access

¹⁶ Ginwright, “The Future of Healing.”



resiliency building supports and services to improve the physical, social, and emotional health and wellness of all Pennsylvanians. It brings together representatives from all systems serving the public including, but not limited to, education, health, human services, criminal justice, law enforcement, community development, workforce development, and others, to provide education and resources to understand, treat, and heal individuals and communities impacted by trauma. It is inclusive, ensuring individuals who are served by those systems have a voice in the development and delivery of the resources that affect them.

Instead of emotionally and financially expensive, siloed systems of crisis care, chronic illness care, punitive action, stigma, and punishment, a trauma-informed state builds person-centered, transdisciplinary, holistic, and sustainable systems of prevention and early intervention founded on:

- teaching, promoting and providing wellness and resilience opportunities for individuals, families, and communities of all types,
- advancing equity in physical and mental health,
- fostering inclusion, and
- promoting thriving, safe, stable, nurturing relationships and communities for all.

Historical, Cultural, and Racial Trauma

Historical, cultural, and racial traumas are collective traumas affecting generations and groups with shared identity. They can have a cumulative effect on an individual and generations in a family or group. For example:

- The impacts of slavery, murder, and racism among African Americans.
- The impacts of massacres and forced removal from their homelands on indigenous peoples.
- The impact of the Holocaust, historical and current anti-Semitism, and hatred on the Jewish people.
- The impact of the AIDS epidemic, homophobia, and hatred on the LGBTQ+ community.

Historical, cultural, and racial trauma are related. When present, they amplify the impact of additional traumatic experiences. For example, events like removing children from their homes may trigger reminders of trauma in an individual's family, community, or racial history.

(Adapted from the Texas Department of Family and Protective Services)¹⁷

¹⁷ "Trauma Informed Care Training: Race-Based, Historical & Cultural Trauma."

VII. The Current Situation

According to estimates from a recent Department of Health study, half of all Pennsylvanians have had at least one Adverse Childhood Experience. Over nineteen percent have experienced three or more. In addition, thirty-eight percent of all Pennsylvanians have experienced either emotional or physical abuse as a child. The tables below lay out the extent of the challenges as revealed by the Department of Health.¹⁸

Researchers in Philadelphia took a more targeted look at ACEs within a more representative, urban population between 2012 and 2013. Their work led to the list of expanded ACEs we've included in this plan. Their results were striking.

Of 1,784 respondents, 72.9% had at least one Conventional ACE, 63.4% at least one Expanded ACE, and 49.3% experienced both. A total of 13.9% experienced only Expanded ACEs and would have gone unrecognized if only Conventional ACEs were assessed. Certain demographic characteristics were associated with higher risk for Conventional ACEs but were not predictive of Expanded ACEs, and vice versa. Few adversities were associated with both Conventional and Expanded ACEs.¹⁹

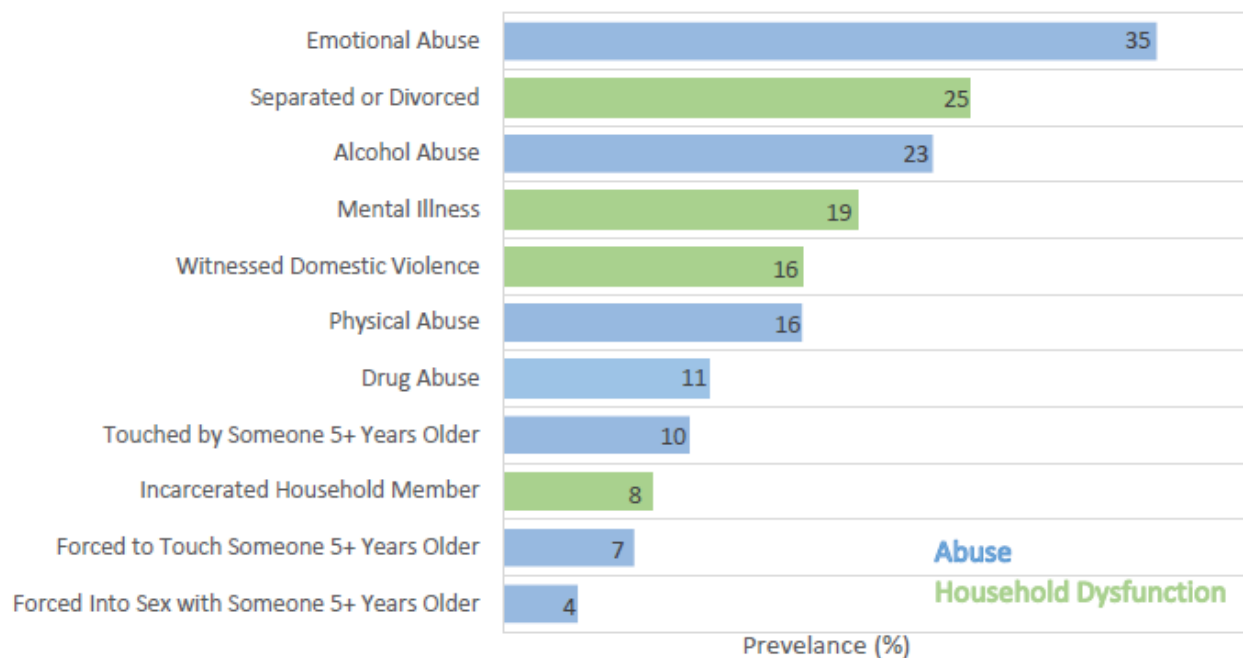
We have included tables from the Philadelphia study as well to add greater context to the trauma experienced by higher risk groups based on income, ethnicity, and other socio-economic factors.

¹⁸ Johnson, "Adverse Childhood Experience," 2016.

¹⁹ Cronholm et al., "Adverse Childhood Experiences."

Figure 1: Prevalence (%) Estimates (N=5,705) of Individual ACEs in Pennsylvania, 2016

Prevalence of Individual ACEs, 2016



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²⁰ Johnson, "Adverse Childhood Experience," 2016.

Table 1: Prevalence of ACEs by Category for Participants Completing the ACE Module Nationally on the 2011-2014 BRFSS

ACE Category	Women	Men	Total
	Percent (N = 9,367)	Percent (N = 7,970)	Percent (N = 17,337)
ABUSE			
Emotional abuse	13.1%	7.6%	10.6%
Physical abuse	27%	29.9%	28.3%
Sexual abuse	24.7%	16%	20.7%
HOUSEHOLD CHALLENGES			
Mother treated violently	13.7%	11.5%	12.7%
Substance abuse	29.5%	23.8%	26.9%
Mental illness	23.3%	14.8%	19.4%
Parental separation or divorce	24.5%	21.8%	23.3%
Incarcerated household member	5.2%	4.1%	4.7%
NEGLECT			
Emotional neglect ³	16.7%	12.4%	14.8%
Physical neglect ³	9.2%	10.7%	9.9%

Note: ³Collected during Wave 2 only (N=8,629). Research papers that use Wave 1 and/or Wave 2 data may contain slightly different prevalence estimates.

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²¹ Johnson.

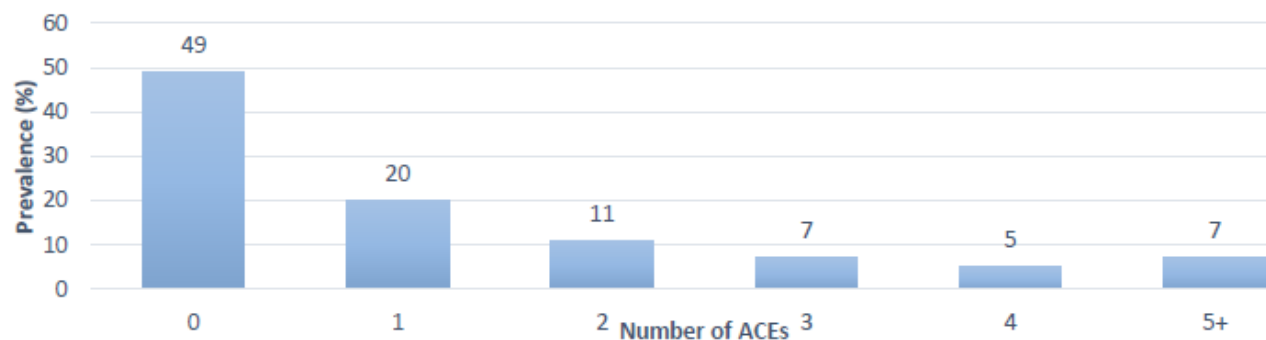
Table 2: Prevalence of ACEs by Sex for Participants Completing the ACE Module Nationally on the 2011-2014 BRFSS

Number of Adverse Childhood Experiences (ACE Score)	Women Percent	Men Percent	Total Percent
0	37.6%	39.3%	38.5%
1	22.7%	24.5%	23.5%
2	12.9%	13.9%	13.4%
3	9.0%	8.6%	8.8%
4 or more	17.8%	13.7%	15.8%

Note: Reports and articles that use data from other years and/or other states may contain different estimates.

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Figure 2: Prevalence (%) Estimates (N=5,705) of ACEs by ACE Scores, Pennsylvania adults, 2016



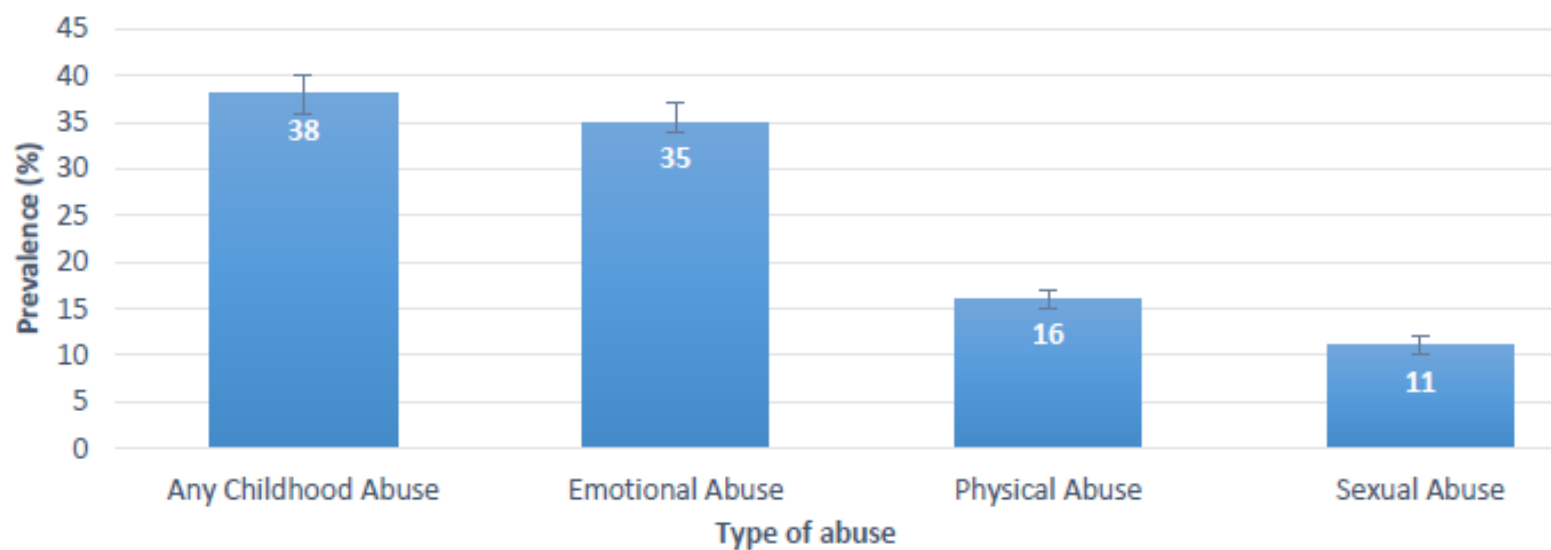
Note: Prevalence estimates may not add to 100 due to rounding.

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²² Johnson.

²³ Johnson.

Figure 3: Prevalence (%) Estimates (N=5,705) of ACEs by Type of Abuse, Pennsylvania adults, 2016



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²⁴ Johnson.

Table 1. Demographics of the Philadelphia Census, Philadelphia Sample, and the Original Kaiser Sample

Demographics	Philadelphia census (<i>n</i> =1,201,541), %	Philadelphia sample (<i>n</i> =1,784), %	Kaiser sample ^a (<i>n</i> =8,056), %
Race			
White	38.8	45.2	79.8
Black	36.1	43.6	4.8
Latino	11.4	3.6	5.4
Asian	6.2	3.7	6.3
Other ^b	7.4	3.9	3.7
Education			
Less than high school	20.0	10.3	6.0
High school graduate ^c	35.7	35.0	19.1
Some college	21.8	19.0	31.5
College graduate	22.5	35.7	43.4
Male	46.3	41.7	47.9
Age			
18–34	36.8	29.7	10.0
35–64	46.7	52.2	57.6
≥ 65	16.4	18.1	32.4

^aFrom Felitti V, Anda R, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACEs) study. *Am J Prev Med.* 1998;14(4):245–258.

^bRace “Other” category combined “other” with “biracial/multiracial” responses for Philadelphia (PHL) Sample.

^cEducation “High School graduate” is a combination of “High School Graduate” and “Technical/Vocational School” for the PHL Sample.

Table 2. Prevalence of Conventional and Expanded ACEs in Philadelphia and Kaiser Samples

Adversity exposure	Philadelphia sample (N=1,784), %	Kaiser sample ^{a,b} (N=8,056), %	p-value
Conventional ACEs			
Physical abuse	38.1	10.8	< 0.001
Substance using household member	34.8	25.6	< 0.001
Emotional abuse	33.2	11.1	< 0.001
Mentally ill household member	24.1	18.8	< 0.001
Witnessed domestic violence	20.2	12.5	< 0.001
Sexual abuse	16.2	22.0	< 0.001
Incarcerated household member	12.9	3.4	< 0.001
Emotional neglect	7.7	14.8	< 0.001
Physical neglect	7.0	9.9	< 0.001
Expanded ACEs			
Witnessed violence	40.5	N/A	N/A
Felt discrimination	34.5	N/A	N/A
Unsafe neighborhood	27.3	N/A	N/A
Experienced bullying	8.0	N/A	N/A
Lived in foster care	2.5	N/A	N/A

Note: Boldface indicates statistical significance ($p < 0.05$).

^aWith the exception of neglect data, all data are obtained from Felitti, V, Anda, R, Nordenberg, D, Williamson, D, Spitz, A, Edwards, V, Koss, M and Marks, J. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACEs) study. *Am J Prev Med.* 1998;14(4):245–258.

^bNeglect questions were not assessed on the original Kaiser ACEs survey, but they were added in Wave 2 ($n=8,667$). For comparison purposes, neglect data from the second wave Kaiser survey are provided. Data were obtained from the CDC website: www.cdc.gov/violenceprevention/acestudy/prevalence.html.

VIII. Recommendations

A. State Government

1. Culture

“Culture constrains strategy.”²⁷ If we do not embed trauma-informed and healing-centered practices and principles into the culture of every state office and agency, as well as in the culture of every county office and nonprofit social service agency and faith-based program, then they will just be trendy words that change very little in how we approach our work. To that end, we recommend embedding the following principles deep into the culture by extending them throughout state government, licensed and funded providers, and supporting the same in all social service organizations.

a) *Training*

- We recommend that all state employees and the employees of all licensed, contracted, and funded entities be required to at a minimum successfully complete a Trauma-Informed Care introductory training created, procured, or approved by OAR and a training committee with representatives from DHS, DOH, PDE, OMHSAS, PCCD, and the Trauma-Informed PA Advisory Committee.

²⁷ Schein and Schein, *Organizational Culture and Leadership*.

- We likewise recommend that current legislators from both parties receive introductory trauma training and that they incorporate introductory trauma training into the new legislator orientation process. These trainings would also be made available to county, city, and municipal elected officials across the commonwealth through multiple partners and channels.

b) Job Descriptions

- We recommend that the job descriptions of all state employees contain the following language:
“The employee understands that he/she will perform all duties while adhering to and promoting the trauma-informed care and healing-centered approaches and principles as laid out in the Trauma-Informed PA Plan of 2020.”

2. Care, Treatment, and Prevention Policy

a) Re-traumatization

Many policies and practices within services and programs have the potential to retraumatize people. Every state agency as well as every licensed, contracted, or funded provider should re-examine regulations, policies, and procedures through the lens of the people we serve or the employee who has experienced trauma.

- We recommend that we reimagine how we license and review facilities through the lens of building trauma-informed cultures based on the latest scientific knowledge, as opposed to cultures focused on compliance and liability. This would include licensing based on customer feedback, measures of quality of care, positive relationships, access to treatment, physical safety, and positive outcomes.
- We recommend that 3800 regulations for children and youth residential facilities be prioritized for the type of review and revision highlighted above.
- We recommend that family provider teams, and volunteer visitation models like those found through NAMI chapters, Mental Health America, PA Prison Society, and the Long-term Care Ombudsman be supported and expanded to ensure that the voices of people experiencing trauma and receiving services are heard and reforms happen in response to their feedback.
- We recommend minimizing the number of intrusions into people's homes by state-funded case managers and social workers by switching to a coordinated, relational model that connects cross-trained, trauma-informed home visitors to families with challenges to build consistent support that heals, builds safe relationships, and doesn't re-traumatize families.

- We recommend and support efforts to create a transdisciplinary system that uses available technology, shares data, reduces duplication, and reorganizes state agencies and services to create a “no wrong door” model of service delivery.
- We recommend that OCYF re-examine and reform policies and regulations that are not related to danger but would keep children from being placed with family members when removed from their parents. We are specifically interested in 3700.31 and 3700.66(b)(2) in regards to number of children in the home and shared bedrooms. Generally, we hope to ensure more family placements and less additional trauma to the child(ren) and families involved.

b) Prevention

The Adverse Childhood Experiences study is settled science now with 20 plus years of additional study and practice behind it. Why it has taken us this long to acknowledge what trauma does to children, and what unhealed trauma does to adults, is a question only worth answering inasmuch as it informs how we move forward now. It has become a moral and financial imperative that we shift our limited financial resources from crisis and punishment to healing and prevention.

- We recommend expanding the list of Adverse Childhood Experiences the commonwealth recognizes to include the list of expanded ACEs laid out in *Adverse Childhood Experiences:*

*Expanding the Concept of Adversity*²⁸ as well as one ACE recommended through our work. They include:

- Witnessed violence
- Felt discrimination and bigotry
- Lived in an unsafe neighborhood
- Experienced bullying
- Lived in foster care or another youth congregate care setting
- Experienced poverty for an extended period of time^{29,30}

1. Education

Given the statistic that thirty-eight percent of Pennsylvanians have experienced child abuse,³¹ the average classroom in PA has seven or eight students out of twenty-two who are struggling with the trauma that can be created by ACEs for children with fewer resiliency factors. Since public schools represent a central location where we have access to the vast majority of the students in the

²⁸ Cronholm et al., “Adverse Childhood Experiences.”

²⁹ Hughes and Tucker, “Poverty as an Adverse Childhood Experience.”

³⁰ Steele et al., “Adverse Childhood Experiences, Poverty, and Parenting Stress.”

³¹ Johnson, “Adverse Childhood Experience,” 2016.

commonwealth, as well as many of their parents and younger siblings, we believe that schools must be a central part of our strategy to prevent ACEs and heal the trauma that can result from them.

Pennsylvania's Head Start, PreK, early intervention, and childcare sites also represent an opportunity to reach children even earlier, as do evidence-based programs like Parents as Teachers.

We celebrate the strides the Pennsylvania Department of Education has made to date. State updates to the PA school code include that training related to trauma and trauma-informed approaches be provided. The Department of Education supports this update and is providing resources, training, and support. Governor Wolf has also tasked the Department of Education and Pennsylvania Commission on Crime and Delinquency to evaluate how more school districts can provide full-time counselors, social workers and nurses, along with increasing more counseling and mental health services at post-secondary institutions. We would take these steps further.

- We recommend that the Youth Risk Behavior Surveys include CDC approved ACEs questions that allow the state to track, and therefore better treat and prevent ACEs.
- We recommend that where not already implemented, trauma-informed public schools institute social emotional learning curricula.

2. Increased Therapy Intervention / Healing in Schools

While the Governor has already called for PDE to provide more counselors in schools:

- We recommend that the commonwealth invest to meet the national best practices standards ratio of one school psychologist for every five hundred students.
- We recommend that we immediately build equity in that process by prioritizing additional trauma-informed counselors, social workers, and community-based providers in public schools with higher minority populations and higher rates of poverty and crime. We also recommend that these professionals reflect the culture and diversity of the populations they're serving.
- We know that mindfulness and the creative arts as well as physical activity can be tools in healing trauma. We recommend increasing funding and time for sports, yoga, grounding exercise, play, music, theater, creative writing and other creative arts in public schools across the commonwealth. We likewise recommend that their utility to healing trauma be intentionally employed, even where the budget for these activities is not increased. We also recommend that mindfulness, which does not necessarily require any additional funding, be

actively used not only to provide self-regulation for students, but also for teachers and staff who are experiencing vicarious trauma and chronic stress.

- We recommend the use of free resources like the Professional Quality of Life Scale to measure compassion fatigue, compassion satisfaction, and vicarious trauma.
- We support revisions to Chapter 49 of the PA Code on the certification of professional personnel, and recommend trauma-informed care and healing-centered practices be included in educator preparation programs, and that these practices be mandatory professional education for current educators certified by PDE.

3. Child Abuse and Neglect Prevention Initiative

Our approaches to child abuse and neglect have mostly been reactionary. We know, however that multi-generational investments in families during early childhood are evidence-based and yield positive outcomes, that male children who have been abused are more likely to grow up to be abusers, and that financial constraints can reduce or eliminate the time that adults have available to spend with their children. For families with low incomes, time with children is constrained due to working multiple jobs, long travel times on public transportation, and time spent in human service agency lines and waiting rooms in efforts to supplement their income.

- We recommend increased investment in parent education through evidence-based prevention programs like Parents as Teachers, SafeCARE, Nurse Family Partnership, and the Triple P-Positive Parenting Program.
- We recommend the adoption of a living minimum wage, with cost of living increases commensurate with inflation, in order to reduce the number of jobs parents have to work to provide for their families, increase their transportation resources, and reduce their need for public resources and assistance.
- We recommend trauma counseling and healing therapies be made readily available for all children who are abused, neglected, or who have witnessed abuse either as a result of experiencing interpersonal violence or violence in their communities.
- We recommend greater community-level access (including schools, but also outpatient clinics and other settings) to evidence-based, trauma-informed models like TF-CBT, TST, CFTSI, ARC, C-BITS, etc.

- We recommend that licensed, certified, trauma counselors be embedded in, or partnered with, shelters, police departments, public schools, and other settings where the traumatizing of children can be flagged and assistance can be immediately offered.
- We recommend a public health education campaign to highlight the impacts of child abuse and neglect and interpersonal violence on the commonwealth: the lifelong relationship, educational, vocational and economic costs to children and adults, the immediate financial costs in public services, and the long-term projected costs the lost potential of children has on our workforce.
- We recommend that all student ID cards include the child abuse hotline and other emergency numbers (bullying hotline, etc.) on the back of the cards.
- We recommend the Governor and the Secretary of the Department of Health declare child abuse and neglect a public health crisis.

c) Healing

During Covid-19, telemedicine proved invaluable to connecting people to care beyond the barriers created by the virus. Given the barriers created by transportation, time away from work and family, lack of childcare, limited number of available providers, and days and times offered or available:

- We recommend making the coverage and acceptance of tele-medicine for behavioral health therapies permanent to reduce barriers to care.
- We recommend that the licensing boards for all helping professions (including all mandated reporters) be asked to review their credentialing policies to ensure that professionals are being trained in Trauma informed approaches as a pre-requisite to licensure or certification. We believe the inclusion of trauma-informed care principles and basic healing techniques in the curriculum for every discipline and specialty in the medical field, dentistry, psychiatric field, and social work, counseling/psychology in colleges and universities across the state would increase understanding and access to basic healing opportunities in every setting served by those professionals.
- We recommend ensuring that all Employee Assistance Programs (EAP's) staff and providers are trained in trauma-informed care and healing-centered practices, and then proactively encouraging employees to make full use of that resource for both primary and vicarious trauma and chronic stress.

- We recommend significant investments be made into expanding access to broadband internet and streaming hardware to create better access for rural populations, people living in poverty, and people reentering the community from prison.

3. Licensing

a) Continuum

- We recommend the following continuum from **Trauma-Aware**, to **Trauma-Sensitive**, to **Trauma-Informed**, to **Healing-Centered** be employed to guide all state agencies, offices, licensed, contracted, and funded entities in the steps and requirements to become trauma-informed and healing-centered.

(Informed by and adapted from the Delaware, Missouri, and Wisconsin models)

Definition	Processes	Indicators
<p>Level 1 Trauma-Aware</p> <p>Key Task: Awareness and attitudes The entity becomes aware of trauma, the prevalence of trauma and considers the potential impact on customers and staff.</p>	<p>Leadership understands that knowledge about trauma may enhance the organization's ability to fulfill its mission and seeks additional information on the prevalence of trauma for the population served.</p> <p>The entity conducts a self-assessment to identify existing strengths, resources, and barriers to change, as well as practice that is consistent or inconsistent with trauma informed care.</p> <p>Awareness training (including definitions, causes, prevalence, impact, values and terminology of trauma-informed care, etc.) is required for employees, subcontractors, and volunteers or offered to participants in other types of groups.</p> <p>People are informed about additional trauma resources and encouraged to continue their professional development or other learning.</p> <p>Opportunities are created within the organization to explore trauma and, if pursued, contemplate what this means for the agency, staff, customers, and community.</p>	<p>Most Staff:</p> <ol style="list-style-type: none"> 1. Learn the definition of trauma and its impact on people; 2. Begin the internal process of becoming aware of their own adversity and trauma; 3. Begin to recognize their own attitudes and perceptions that may be influenced by trauma; 4. Become aware that knowledge about the impact of trauma can change the way they see and interact with others.

Definition	Processes	Indicators
<p>Level 2 Trauma-Sensitive</p> <p>Key Task: Knowledge, application, and skill development</p> <p>The entity begins to:</p> <ol style="list-style-type: none"> 1. Explore the principles of trauma-informed care (safety, choice, collaboration, trustworthiness, and empowerment) within their environment and daily work; 2. Build consensus around the principles; 3. Consider the implications of adopting or not adopting the principles; and 4. Prepare for change. 	<p>Values of a trauma-informed approach are processed with all levels of internal and contracted staff.</p> <p>Leadership prepares the entity for change and assures there is a process for reflection to determine readiness for change.</p> <p>The entity examines its commitment to customer involvement and identifies next steps.</p> <p>The entity begins to review tools and processes for universal screening of trauma appropriate to the population and setting.</p> <p>The entity begins to identify potential resources for trauma specific treatment.</p>	<p>The entity values and prioritizes the trauma lens and begins to apply it. Trauma training for all staff, including new staff orientation, is institutionalized.</p> <p>Basic information on trauma is available and visible to both customers and staff, through posters, flyers, handouts, web sites, etc.</p> <p>Direct care workers begin to seek out opportunities to learn new trauma-related skills appropriate to the setting and population served.</p> <p>Management recognizes and responds to compassion fatigue and vicarious trauma in staff.</p>

Definition	Processes	Indicators
<p>Level 3 Trauma-Informed</p> <p>Key Task: Change and Integration</p> <p>The entity starts to highlight the role of trauma. Staff begins re-thinking the routines and infrastructure at all levels of the entity.</p>	<p>Continued planning and action.</p> <p>Integration of trauma principles throughout the entity continues, including:</p> <ul style="list-style-type: none"> • Staff behaviors and practices • All job descriptions • Staff supports • Addressing staff trauma • Self-care • Models for supportive supervision • Staff development • Staff performance evaluation <p>Within the organizational structure:</p> <ul style="list-style-type: none"> • Assess the environment • Assess record-keeping systems • Examine operational policies and procedures • Examine personnel policies • Incorporate self-help and peer advocacy into the workplace 	<p>Staff applies new trauma knowledge to their specific work and an observable shift in perspective occurs. Language is introduced throughout the entity that supports safety, choice, collaboration, trustworthiness and empowerment.</p> <p>Policy review finds Identification of needed changes to mitigate negative language and include trauma sensitive approaches in written documents.</p> <p>The organization's personnel policies recognize and support staff by addressing initial and secondary trauma.</p> <p>The organization presumes that all have experienced trauma and services include a trauma screening (i.e., universal precautions approach.).</p> <p>Agency policies and position descriptions allow people (employees, board members, volunteers, etc.) with lived experience to serve in meaningful roles throughout the agency.</p> <p>Changes are made to ensure the physical environment is welcoming, accommodating, and safe.</p> <p>Trauma assessment and treatment models are available for those who need them (either directly or through a referral process).</p> <p>The entity has a ready response for crisis management that reflects trauma informed values.</p> <p>Staff at all levels accept the new direction of the entity and actively participate in implementing trauma informed care.</p>

Definition	Process	Indicators
<p>Level 4 Healing-Centered</p> <p>Trauma-responsive and healing-centered practices are the norm at all levels of the entity.</p> <p>The trauma model is accepted and so thoroughly embedded in culture and practice that it no longer depends upon a few leaders.</p> <p>The entity works with other partners to strengthen collaboration around trauma informed care.</p>	<p>The entire entity has been reviewed and revised to reflect a healing approach. Systems are created and implemented to measure program progress and outcomes’:</p> <ul style="list-style-type: none"> • Impact on customers and customer satisfaction • Fidelity to a trauma-informed and healing-centered model • Corrective action plans • Staff retention <p>Policies and procedures are revised to contain trauma-informed language, values and processes.</p> <p>Personnel policies are revised to address the potential impact of secondary trauma and recommend interventions that support staff.</p> <p>Stigma related to the effects of trauma and accepting help is reduced.</p> <p>Human resources adapt processes that support hiring staff with knowledge of and expertise or lived experience with trauma. The organization and staff become advocates and champions of trauma-informed decision-making at all levels.</p> <p>The organization publicly advocates for recognition of trauma informed care as an evidence-based approach that is required by policy and eligible for financial support or reimbursement for trauma informed services.</p>	<p>The entity’s mission statement, goals or objectives include a commitment to a trauma-informed and healing-centered culture and environment.</p> <p>The entire entity demonstrates a sustainable commitment to trauma informed values (safety, choice, collaboration, trustworthiness, and empowerment) through adherence to trauma and healing principles, advocacy, training, hiring practices and recruitment of volunteers, including the Board of Directors, committees, subcontractors, etc.</p> <p>All employees and volunteers demonstrate skill and effective use of trauma-informed practice with clients, visitors, and other staff, regardless of their assigned job duties, and A process is in place to address unprofessional or insensitive words or actions by employees and volunteers.</p> <p>People from other agencies and the community routinely turn to the entity for expertise and leadership in trauma-informed care.</p> <p>The entity uses data to inform decision-making at all levels. The entity uses feedback from recipients of services to assess program effectiveness and incorporate changes where needed.</p> <p>All levels of management model trauma informed approaches and self-care, a trauma-informed supervision model has been implemented that includes ongoing coaching and consultation, and supervisory support is accessible and readily available to staff onsite.</p> <p>The business model including fiscal structures works to meet the need to address trauma.</p>

B. Community-Based, Grass Roots Movement

While action by the state is crucial, we also believe that community-based adoption of and belief in trauma-informed principles is key to their integrated use and success throughout the commonwealth. The following recommendations and goals are focused on fostering, building, and connecting community-based, grass roots movements in every municipality, county, and region of Pennsylvania.

1. ACEs Connection

- We recommend the creation of the Pennsylvania Trauma-Informed Network page on the ACEs Connection network. This would bring together and connect to community-based coalitions and movements across the commonwealth and share resources and best practices. As these networks would be run at the local level, they would be more likely to be culturally competent and reflect the differences in approaches and ideas from urban, suburban, and rural localities.

2. Community-Based Coalitions

- We recommend supporting and creating community-based, trauma-informed coalitions across the commonwealth that include representatives from all systems serving the public, including but not limited to: health, education, human services, government, law enforcement, and criminal justice.

3. Free Training and Technical Support

- We recommend the creation of a training coordinator within OAR to design and coordinate free training and technical support to entities striving to become ACEs aware and Trauma-Informed. This professional would connect with trainers throughout state government, and also work with the Trauma-Informed PA Steering Committee to assess and authorize outside vendors, trainings, and resources that claim to advance trauma-informed principles.

4. Annual Summit

- We recommend the creation of an annual, transdisciplinary, statewide Trauma-Informed PA Summit that will bring together experts and those who aspire to learn more. The summit, which will include virtual options to reduce barriers, will present continuing education from practitioners and experts, a celebration of entities that lead the way in outcomes through trauma-informed care each year, and networking to share best practices across disciplines and localities.

C. Communal Trauma

While it's crucial that we focus on healing and preventing individual trauma, we feel it's equally important to heal and prevent communal, racial and historical traumas. Communal trauma" affects social groups or neighborhoods long subjected to interpersonal violence, structural violence, and historical harms. Research suggests that the causes of

community trauma lie in the historic and ongoing root causes of social inequities, including poverty, racism, sexism, oppression and power dynamics, and the erasure of culture and communities.”³²

1. Racism, Discrimination, and Disproportionate Minority Contact

a) Core Causes

- We recommend the state more deeply examine and address the systemic structures of discrimination in housing, employment, healthcare, education, policing that impact the wealth and wellness of African Americans and Latinos.

b) Creating Safe Spaces

- We recommend that each community identify safe spaces to have conversations about racism, reconciliation, and healing led by entities that are run by African Americans, Latinos, LGBTQ+ individuals, and other ethnic and religious groups that have experienced hate and discrimination.

c) Incentivize People Who Have Experienced Racism and Discrimination to Become Healers

- We recommend creating scholarship and/or loan forgiveness programs to incentivize more African Americans, Latinos, LGBTQ+ individuals, and other ethnic and religious groups that have experienced

³² Falkenburger, Arena, and Wolin, “Trauma-Informed Community Building and Engagement.”

hate and discrimination to become trauma therapists, counselors, medical professionals, and healing-centered social workers.

d) Eliminate Policies and Practices that Retraumatize

- We recommend a deeper investigation into the disproportionate amount of contact between children and youth services and African American families, and the development of prevention strategies focused on the identification of client-specific, culturally appropriate, evidence-informed and community-based programs.
- We recommend an end to the over-policing of communities of color and the creation of more community-led and community policing initiatives.
- We recommend that all law enforcement officers across the commonwealth receive trauma-informed and ACEs training both retroactively for existing officers, and as a required part of curriculum for all future officer training.
- We recommend that all current law enforcement officers, judges, probation and parole, and corrections officers across the commonwealth receive trauma-informed and ACEs training and that it be required as a part of basic training for all new recruits.

- We recommend that law enforcement and criminal justice agencies become trauma-informed to create an environment that focuses both on providing safety for the community and equipping law enforcement/ criminal justice officials with an enhanced appreciation for their common humanity.
- We recommend enhanced de-escalation training for all law enforcement personnel using models like the Crisis Intervention Team (CIT) Model out of Memphis.

e) Shifting from unnecessary levels of policing and incarceration to social work, therapy, and healing

- We recommend that police departments partner with human service agencies and social work associations and departments in universities to begin the conversation about when situations merit police intervention and when they merit social work intervention and build models to address both more safely and successfully.

2. Natural Disasters, Crisis, and Public Health Emergencies (Learning from Covid-19)

a) Understanding Where We Are During Crisis

- We recommend building specific educational materials and links to destressing resources for Pennsylvanians that can be widely distributed during times of extreme crisis, emergency, and disaster so people understand how to manage stress and protect their mental health during these times.

b) Healing What We've Been Through

- We recommend the creation of targeted, temporary support groups in communities that have experienced trauma as well as chronic and toxic stress due to natural disasters, crisis, and public health emergencies.
- We recommend the creation of healing circles (or groups) using mindfulness and the creative arts in communities that have experienced trauma or chronic stress due to natural disasters, crisis, and public health emergencies.

c) Building on Empathy

- We recommend the creation of a statewide anti-stigma, communications campaign focused on removing the stigma from experiencing or seeking help due to Trauma, ACEs, toxic stress, chronic stress, or mental and behavioral health. The campaign could include people from all walks of life telling their trauma and behavioral health stories. This campaign would avail itself of multiple modes of communication (television and radio PSA's and interviews, social media, print, etc.) and be targeted for multiple audiences with a focus on multiple cultural competencies.

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Thank you in advance to the thousands of Pennsylvania leaders it will take to implement the recommendations herein. This plan is aspirational, but together we can make it a reality. Let's get to work!

XI. Afterword

Steve Minick, Vice President of Programs at Family Services of NW PA –

Whether traumatic events and experiences are committed by people close to us, total strangers, or nature, they are all characterized by a lack of control, unpredictability, and powerlessness. The consequences of these experiences can be devastating, negatively impacting everything from our physical health and our emotional health as well as how we view ourselves, others, and the world.

Studies suggest that nearly 3 out of 4 of us experience at least one potentially traumatic event before we reach adulthood.³³ Despite this surprising prevalence, most people will naturally recover with the internal and external resources available to them. But, what about those who have traumatic experience(s) and get stuck?

Looking at a child's behavior through a trauma lens can be very different when dealing with the behavior of children experiencing traumatic stress. Often the defiant, aggressive, detached, anxious, depressed, or distracted child can be mislabeled. With trauma-informed services the question is not "what's wrong with you" but rather "what happened to you?" and often, "what do you tell yourself about what happened to you?" What children believe about themselves can be more important in determining behavior than any facts about them. Traumatic stress elicits a survival response (fight, flight, freeze or appease). It is important to remember that this is an adaptation, a normal response to traumatic events. Therefore, children or adults experiencing

³³ "Trauma-Infographic.Pdf."

traumatic stress should not be viewed as bad, damaged, or broken. Additionally, these harmful experiences and their reactions are not a reflection of character. In recent discussions following the release of the documentary “Cracked Up,” the alternative view put forward is that trauma be described as a mental injury versus a mental illness.

Trauma and toxic stress are topics often dismissed, denied, and avoided due to their difficult nature and fear that talking about them will make it worse. We must be careful not to minimize or ridicule a person’s perception of a traumatic experience. Children, and even adults, can be harmed further when they hear comments like “you are exaggerating,” “it couldn’t have happened that way,” “your imagination is getting the best of you,” “he/she would never do that,” “you’re still young, you’ll get over it,” “consider yourself lucky,” “well maybe if you had/hadn’t ... etc.”

Judith Hermann suggested that the core experiences of trauma are disempowerment and disconnection. We do want to be patient with each other. We want to listen, comfort, and nurture. We want to set a good example for our children, and to be consistent and predictable. Establishing safety in the aftermath of any traumatic experience is always a priority. With a few changes in our perspective we can approach people in a universally sensitive manner, a form of universal precautions for our health and wellbeing.

For every direct victim of a traumatic experience, there is an expansive ripple effect impacting family, friends, first responders, community members etc., each reacting in a unique way to the experience. Trauma is a complex and often collective

experience. Trauma is complex and there are no one size fits all strategies – it is up to the individual to say what is harmful and healing for them.^{34,35}

Winden Rowe, LPC, Thomas Jefferson University Community and Trauma Counseling -

In graduate school I took a course called the Neurobiology of Trauma. And failed my first exam. But I was passionate about the content, and I wanted to learn, but beyond learning, I wanted to *understand*. Now I co-teach that very same course. Here are some of the fundamentals of that course that, in my mind, are the ties that bind us all; each and every one of us.

- We all “have” trauma. That could be latent, unexpressed generational trauma embedded in the DNA, it could be low-grade lower-case “t” trauma, or massive doses of big-“T” trauma that impacts our physiology in very, very similar, almost predictable ways... however, the expression of its behavior once it gets to the cortex is very, very hard to predict.
- The brain, and the peripheral nervous systems, will facilitate all kinds of internal mechanisms designed for safety that will override everything else in order to ensure the survival of the person regardless of comfort. Survival over comfort wins.
- We *all* have these mechanisms, and we *all* carry potential coding, for lack of a better word, from our ancestors that survived the unthinkable. That coding will turn on these survival mechanisms and engage changes in the brain in the body on the

³⁴ Herman, “Recovery from Psychological Trauma.”

³⁵ “Cracked Up.”

spectrum of possible micro/atomic levels to measurable structural changes in the brain itself, particularly in the midbrain regions, which like a domino effect will impact the integrity of the cortex... the area responsible for our “humanness”.

- The hindbrain and midbrain will do somewhat (and I say that gingerly) predictable responses to stress/trauma, but once the “it’s not safe” system is turned on, the behavioral responses that the cortex has to choose from is so vast, that those behaviors become harder to predict. This is why diagnosing based on behavior is one of the greatest crimes against humanity in my humble opinion, and I say that as a licensed clinician. This becomes the birthplace for shame, confusion, and the dangerous, *dangerous* experience of disconnecting a person from their self-knowing and intuition. And my field, although well-intended, is perpetuating maybe more than anything this trauma, the disconnection of self, by way of what we call “mental health”.
- Stress and trauma are one in the same, almost. Stress and trauma both require the same chemicals, and the same parts of the brain and the body to enact this cascade of changes in the system, just small and large doses (duration and severity on a spectrum) therefore making stress a possible trigger for trauma... *or* with enough dose over time, like drip-torture, the ongoing dosing of stress can start to rewire the system to look like a “trauma system”. We find this in all the people.
- A person can perceive their trauma as irrelevant at one point in their life, and later find it to be a completely emotionally jarring and difficult reality to make sense of; and there is no timeline for this. That can also happen in the reverse. A jarring,

terrible irreconcilable, painful experience later, through healing, can completely transmute and become a person's superpower.

- The perception of trauma is personal and should not ever be minimized, ever. And its DSM definition, I am sorry to say, is terrible. If it hurt you, it hurt you, and that is all that we need to know.
- All trauma can heal. It doesn't mean that it will, but it can. Denying a person access to that belief is dangerous, inhumane, and egocentric. The power and resilience of the human spirit is indefinable, almost as much as the trauma itself.
- The brain, the body, and the spirit of a person above all else wants health and healing. But without access to those supports, without access to that truth, without awareness, without collaboration, we will continue to see more of what we see.
- And this I believe is the most critical aspect of all of these basic 101's of trauma and the brain. Trauma, and healing, are the ties that bind us *all*. If we remove the packaging (the skin color, the gender, the political affiliations, the religious affiliations, the sexual orientation) from a person, and look at the underpinnings of the brain and the body, the insides are pretty much the same, as are what those insides do to keep us safe and to help us find ways to be loved.

Erika Brosig, LCSW – Clinical Director, Victim Services Inc. -

How to put into words what matters most about this incredibly important topic? I come to this work as a survivor of child sexual abuse myself and carry with me the experience of working with survivors for the past 17 years.

I think one of our biggest challenges is the fundamental denial that trauma exists, and especially that it impacts us. As a society, we're taught that we need to pull up our bootstraps and push through, work hard and persevere. So, I think it's important to recognize that what we're trying to accomplish in many ways goes against the very fabric on which our country and our society was built. In order to change that, I strongly believe we have to start talking about psychological/emotional trauma like we talk about physical injury (this may not be the best analogy, but I think it illustrates my point). From early on, we implicitly or explicitly teach children what to do if they are physically injured, from the smallest scrape to a broken bone or beyond. Why should we not be having those same conversations for psychological/emotional injuries? Opening those conversations for the emotional cuts and scrapes would allow greater acceptance of the larger interventions when there's a more serious trauma that occurs. Intervening and helping someone process a trauma that may be less impactful is not going to harm them, but it will prepare them for when they experience something that does impact them.

Experiencing trauma is universal. The processing of trauma should be something that is universally taught and encouraged as well. Whether that be on an internal level, with a loved one, or with a professional, depending on the need. Building resources builds resilience.

It needs to be embedded into the curriculum at every level from preschool through the highest level of graduate training. I feel strongly that there needs to be a two-fold approach in that education, bottom up and top down. We can't only focus on the children and educating them for the future. We also need to focus on re-educating adults. If we're educating the children and then sending them back into environments with adults who don't understand trauma, it's counterproductive. And in addition to education, we of course need to improve access and funding for trauma treatment, which I believe needs to be recognized strongly as a specialty. Clinicians who aren't experienced in treating trauma can do more harm than good at times.

Why are there so many people out there who are still surprised when we bring up ACEs and their impact? We've known about this now for decades and yet, it's not common knowledge! Even when training medical professionals, law enforcement, and other mental health professionals, the number of people who have never heard of ACEs is unbelievable. How can we change this? All of us doing it on a small scale every day has not worked. We need to implement something larger.

Although this is more about the implementation, I also feel it's important to mention that holding agencies and organizations accountable may be an important part of this shift. And doing that needs to look differently than it has in the past. It's very easy for upper level management to say the right things and check the boxes to become trauma-informed. It's another to live, breathe, and practice through the trauma informed lens. We need to find ways to hear from all levels of agencies (management, staff, and customers) so that it's not simply lip service. And we need to find ways to hear from the bottom up that will be anonymous and will

allow for safety for the staff and customers. This includes our government – we can say our governmental entities are becoming trauma-informed but how can we ensure that they really are? How can we make sure that this document translates into action?

I believe living and practicing through a trauma-informed lens and leading with compassion hurts no one. In fact it can still benefit people even if they've never experienced trauma, but not seeing through a trauma-informed lens has the potential to cause incredible harm to someone who has experienced trauma.

I'd be remiss if I didn't mention that all of what we're suggesting in this document also needs to come from a place of realizing that trauma (and healing) runs so much deeper than a present-day incident or cluster of incidents. Racism, inequality, oppression, poverty, generational trauma, etc. - all play a role.


How can we recognize this and make this document actionable and transformative? An important quote from Laura Van Dernoot Lipsky sums up that thought. "If we lived in a society where equity, respect, access, and justice were realized, and unearned privilege and inequality and oppression were transformed, the impact of trauma exposure in our lives would look dramatically different. Suffering would still occur. People would sustain injuries and contract illnesses and even hurt each other. The difference is that we would only have to confront that suffering at face value: an injury, an illness, a hurtful act. We would not have to wonder if disparities between rich and poor, white people and people of color, heterosexual people and gay/lesbian/bi/transgendered people, and so on contributed to the suffering."³⁶

³⁶ Lipsky and Burk, *Trauma Stewardship*.

Roberta Waite, EdD, PMHCNS, RN, ANEF, FAAN, Professor of Nursing, Drexel University

As a professional nurse I appreciate the value of health and wellness across the lifespan, and partnering with communities to support their ability to thrive. Within the trauma field, we have come to realize that traumas are pervasive and serve as a social determinant of health impeding optimal health. These traumas easily map to the United States inequitable root of colonization, which contribute to the profound adversities and health disparities witnessed today. Extending knowledge, skills and abilities of health care providers about trauma can optimize health care engagement and provide tools to support them to fulfill our goal of a trauma-informed Commonwealth. Within health care contexts, trauma is largely deduced to forms of violence and a marked trauma-inducing event from the past (PTSD). We know this is a shortsighted and lacks inclusivity to the unacknowledged and elusive traumas (e.g., discrimination, racism, microaggressions) entrenched in the normalcy of our present-day society which contributes to our current social unrest.

A glaring change in practice is needed so that health care providers recognize the health effects of everyday trauma. What is clear to me is that most students in nursing and the health professions are not prepared effectively to understand trauma, it's link to health disparities, or trauma-informed practices to bring a structural and social analysis into clinical care. Health care providers must realize that they do not necessarily need to question individuals about their experiences; instead, assume that everyone has been exposed and act accordingly. With that said, and knowing the foundation of our country, delivering trauma-informed care applying an open-minded, compassionate, and antiracist approach is requisite. An anti-racist/trauma-informed approach includes healthcare




providers, educators and students examining how their biases can induce harm, and furthermore learning how to dismantle systemic racism in healthcare. We must do better as educators to orient students understanding of trauma that is personal, communal, clinical and political.

Robert Reed, Executive Deputy Attorney General for Special Initiatives, Pennsylvania Attorney General's Office -


As we are in the midst of the worst pandemic to hit the United States and the world in over a century, we have the opportunity to use this moment to also focus on a pandemic that continues year after year, decade after decade without hope of a vaccine. The pandemic I speak about is trauma.

Since the founding of this continent, too many Americans have experienced tragedies that have defied effective solutions and even effective explanation. Communities have been ravaged by violence, crime, abuse, addiction, hunger, suicide, disease, racism, and slavery, among others. In the present day, these tragedies do not discriminate between urban, suburban, and rural neighborhoods; between black, white, Latino, and Asian; and between heterosexual and LGBTQ. Individuals are dying and are experiencing life-altering physical and emotional injuries every day at staggering levels. After a loss, we come together as families and communities to express our grief and shock; we blame and rationalize and the victims and their families pray, but often suffer alone. Life continues with tens of thousands of Americans dying and injured without a coherent plan to reduce the pain, suffering, trauma, and death.



The think tank created at the direction of Governor Wolf has sought to establish the foundation of a trauma-informed state, but the report generated by the think tank is just a beginning. Yes, it must be supported and championed by state officials overseeing our government, but a trauma-informed state must also include the thousands of people working every day in each of our 67 counties to bring trauma-informed policies and practices to the people in the communities they serve. There are already so many trauma-informed “champions” in multiple systems across Pennsylvania including medical and mental health, addiction services, education, and human services, as well as some in law enforcement and criminal justice. Even so, many well-meaning and dedicated professionals in every system have yet to learn about and be trained in trauma-informed policy and practice. This must change.

Almost everyone who I have met who has been trained in trauma-informed care agrees in the principle that adverse childhood experiences, exposure to violence, chronic stress, and trauma underlie many of our society’s most pressing and chronic issues. There is a consensus that providing awareness about these concepts to individuals serving the public in all systems is the first step to help people impacted by trauma recover, enhance their resilience, and provide them and their families with hope when they fully appreciate what “happened” to them was not their fault. The burden of guilt, insecurity, loss, and fear so many carry with them in their lives about events over which they had no control can be effectively healed. To achieve this, it is essential to break down the silos that separate one system from another so that people in every system speak in the same language with the same



understanding of trauma to enhance their capacity to serve people effectively. Bringing champions from all systems together in each of Pennsylvania's 67 counties will be a huge step forward for Pennsylvania.

As we tackle the issues of racism and criminal justice reform in the light of the recent killing of George Floyd in Minneapolis and many others, we need to use the tools provided by an understanding of trauma to bring healing to the victims and their communities. While understanding and incorporating trauma-informed policies and practices is complex and nuanced, at its heart, it is based on common sense combined with human decency, empathy, and science. The harder work requires asking each of our institutions, what is their purpose and who do they serve to assist them in making the shift in the way they see themselves and how they do their jobs. For the police, they, like all government officials, are public servants whose duty is to serve and protect all people with integrity. Police and all members of law enforcement and criminal justice should be trauma-informed and the institutions for whom they work must be trauma-informed as well. This shift will not only serve the community well, but also the members of law enforcement and criminal justice who year after year suffer from some of the highest levels of vicarious or secondary trauma.

Finally, creating a trauma-informed state begins with the individual. Everyone providing trauma-informed care needs to not only be trained to understand trauma, ACES, neuroscience, and resilience to help others, but also to reflect on whether they have been impacted by trauma in their own lives. If so, healing their own trauma is priority one. Whether or not they have experienced

trauma, incorporating an understanding of trauma in one's personal and professional lives will create trauma-informed practices in all their relationships, and that in and of itself can be life-changing.

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