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HOUSE DEMOCRATIC POLICY COMMITTEE

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE ROUNDTABLE
Topic: Adverse Childhood Experiences
Penn Medicine Lancaster General Health – Lancaster, PA
April 11, 2019

AGENDA

10:00 a.m. Welcome and Opening Remarks

10:10 a.m. Jeffrey Martin, MD, FAAFP
Managing Physician, Care Connections
Penn Medicine Lancaster General Health

10:15 a.m. Lark Eshleman, MLS, MS, PhD
Executive Director
About Child Trauma Foundation

10:20 a.m. Alice Yoder, RN, MSN
Executive Director of Community Health
Penn Medicine Lancaster General Health

10:25 a.m. Melanie G. Snyder, OWDS, MHFA
Trauma Informed Specialist
Penn Medicine Lancaster General Health

10:30 a.m. Erin Elliott
Chief Development Officer
Boys and Girls Club of Lancaster

10:35 a.m. Questions & Answers

11:20 a.m. Closing Remarks

The Impact of Adverse Childhood Events on Healthcare Utilization

Jeffrey R. Martin, MD, FAAFP

Managing Physician, Care Connections

Chair, Family and Community Medicine

Penn Medicine/Lancaster General

April 11, 2019

Good Morning, it is my distinct pleasure to testify to you today on this important topic. For more than 10 years, my clinical focus has been on the care of persons with complex health and social needs. These are people who, for a variety of reasons, have higher than expected health care utilization and account for a significant amount of the 5% of the population that generates 50% of all health care costs in any given year. At Penn Medicine/Lancaster General we have pioneered innovative health care delivery strategies to meet the needs of this population. *Care Connections* is our multidisciplinary, primary care practice that cares for persons with complex health and social needs who have been admitted at least twice to the hospital in a 6 month period. We employ unique team members, not normally a part of a primary care practice, like patient care navigators who work primarily in the patient's home, lawyers who help mitigate social determinant of health issues (like housing insecurity), behavioral health providers and social workers who work in a holistic care delivery model. We have found that addressing the causes of high utilization (like lack of transportation, food insecurity or poor social support) produces better quality outcomes, including lower hospital admissions and emergency department visits, lower costs and better quality of life for the people we serve.

In *Care Connections* we treat and get to know people in our program as individuals, helping them determine and achieve goals that they find important. We have the ability to spend time with people, develop relationships and gain a much better understanding of the issues that have led to their poor health. However, there is one unifying characteristic of this population; the high incidence of exposure to Adverse Childhood Events (ACEs). According to internal data, at least 80% of the people we serve have at least one ACE, many have toxic stress from their socioeconomic status and all have the stress of trying to control seemingly insurmountable health care issues. For more than 20 years we have understood that ACEs are associated with a wide variety of medical and behavioral health issues in adulthood that lead to poor physical and mental health. It is only recently however that we understand better the impact of ACEs on health care costs and our ability to effectively manage patients across the healthcare continuum.

Association of ACEs with Healthcare Costs

A recent study in the *American Journal of Preventive Medicine* linked greater exposure to ACEs to higher out-of-pocket medical expenses and financial burden in adulthood. Similar to rates of chronic disease where the number of ACEs someone experiences is related in a "dose response" relationship, the same is true for someone's out-of-pocket medical costs. The more ACEs someone experiences, the greater the out-of-pocket medical expenses in adulthood. Furthermore, when an adult reported three or more

ACEs, the odds were more than twice as high that annual household medical costs would exceed more than 10% of household income or 100% of household liquid assets compared with adults who reported no ACEs.

Other studies tell us that ACEs are independently predictive of high, and persistently high cost status (even after controlling for medical severity and psychiatric conditions), as compared to individuals with the same medical conditions and lacking ACEs. So there is something inherent in the history of trauma itself that causes financial burden even when you compare people with the same severity of disease.

So not only do ACEs increase the chance you will have a chronic medical and/or behavioral health problem, it also increase the financial burden to treat those problems. This financial insecurity ends up being one of the biggest challenges to health care engagement. When the decision is between medications or copays and rent or food, people tend to choose the latter. At *Care Connections* non-payment of rent ends up being the number one reason people lose their housing. Once someone is housing insecure it is nearly impossible for them to manage their medical and behavioral health problems effectively and they often end up back in the hospital compounding their medical costs.

Healthcare and Behavioral Health Burden from ACEs

Unfortunately ACEs are exceedingly common. In the original study, two-thirds of the middle class population of Kaiser members had experienced at least one category of ACE and 1 in 6 had an ACE Score of 4 or higher. I won't go into detail about this study as it has been well covered by others except to say that ACEs are associated with a broad swath of chronic medical and behavioral health issues including:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease

Over the years a staggering number of other medical and mental health conditions have been associated with ACEs, including autoimmune disorders, risk for intimate partner violence, multiple sexual partners, sexually transmitted diseases (STDs), smoking, suicide attempts, unintended pregnancies, early initiation of smoking, early initiation of sexual activity, adolescent pregnancy; all of which increase someone's exposure to the healthcare system and therefore exposure to financial risk.

Trauma Informed Care

So if we understand that ACEs place a burden on individuals trying to effectively manage their overall health and increase their financial burden from those illnesses, the next question is what can be done on the healthcare side to mitigate both the financial and medical issues. Obviously, prevention of trauma

can go far toward decreasing the associated downstream healthcare costs. For those already exposed to trauma, trauma-informed care (knowing about your patient's trauma history and implementing a care plan specific to trauma) can help place medical and behavioral symptoms in context and help provide better care. If a provider only views symptoms through the medical lens (medicalizing psychosocial issues) then patients will have unnecessary procedures, unfounded diagnoses and are prescribed potentially harmful medications. A trauma informed approach putting symptoms into a holistic framework has shown to reduce the frequency of outpatient visits, emergency room visits and inpatient stays and overall costs.

One example of where we think a trauma informed approach would enhance our ability to care for people, is the care of patients that leave the hospital Against Medical Advice (AMA). For instance we think (although not proven) that many of the patients that leave the hospital AMA (Against Medical Advice) do so because they become "triggered" during their admission due to a history of trauma. They are disrobed, poked and prodded for various procedures and lab tests and often interrupted during sleep to have vital signs taken. The "flight or fight" mechanism kicks in and patients can see no other alternative other than leaving the hospital before their conditions are stabilized. This is a scenario that has occurred with many of our patients in the past and also leads to higher readmission rates, higher costs and continued poor medical outcomes.

Clearly ACEs are associated with many detrimental issues in the lives of people growing into adulthood. Trauma leads to chronic disease and poor engagement with the healthcare system which leads to increased costs (to patients and society) which in turn can lead to poorer healthcare outcomes. An integrated approach, combining physical and behavioral health into a holistic care model, especially as it relates to ACEs and trauma can go far toward decreasing utilization and cost among persons with complex health and social needs.

Thank you

Sources

1. *Adverse Childhood Experiences and Household Out-of-Pocket Healthcare Costs*, Schickedanz, Adam B. et al. American Journal of Preventive Medicine , In Press, Corrected Proof, Available online 21 March 2019
2. *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*, published in the American Journal of Preventive Medicine in 1998, Volume 14, pages 245–258.
3. *Association of behavioral health factors and social determinants of health with high and persistently high healthcare costs,* Stacy Sterling et. Al., Preventive Medicine Reports Volume 11, September 2018, Pages 154-159.
4. *Care Connections,* Internal Data.

ABOUT CHILD TRAUMA FOUNDATION

PA House Democratic Policy Committee Public Hearing on Adverse Childhood Experiences. Testimony by Lark Eshleman, MLS, MS, PhD, Executive Director, Founder, About Child Trauma Foundation. April 11, 2019

This morning I'd like to introduce you, for 1 minute, to Isabella. Bella, was 5 years old the summer before she began kindergarten. She was a bright and happy girl, who had breezed through the pre-school interview and assessment, and was eager to begin to use her lunch box and ride the big yellow school bus.

One day in July she heard a scream from the kitchen in the apartment she shared with her mother and brother. As Bella ran into the kitchen she watched as her mother's boyfriend stabbed her mother to death, in front of Bella's eyes.

The boyfriend fled, and Bella found her way in the neighborhood to her grandmother's house, where she then lived and from which, in September, she started kindergarten.

Bella had been a gregarious child ... now did not speak a word. She did not engage with other children. She would not finger paint, could not join circle time, never played with the other 5 and 6 year olds who began to regard her as strange and started to be unkind to her.

Her academic learning stopped.

Good Morning. Thank you for the opportunity to talk with you this morning and to share information about a crisis in our country of huge proportions. You heard a one-minute story about a child who experienced several ACE's when she was 5. I am Lark Eshleman, a doctor of psychology and an international educator in the field of child trauma. My experiences include over 8 years as a school principal, was a school psychologist, am author of a book, numerous articles, and several programs to guide parents and work with children who have experienced ACEs.

And here are 3 facts that have to do with the impact of ACEs on education that I'd like to share this morning. One about child development, one about how trauma – ACEs – show up in the classroom, and one about how all of this impacts society. There are plenty more facts in the hand-out which our About Child Trauma Foundation has provided for you today, and on our website.

So, while Bella's story is a real one, and very dramatic, it is by no means the only one. Look for a minute at your list of Adverse Childhood Experiences. You undoubtedly know people who have experienced many of the ACEs on that list. You may be one of those people – in fact, statistically many of us are. ACEs, and the toxic stress they often cause, are much more common than you realize, and cost much

more – in human misery, in school failure, and in societal economic cost – than you know. But today you will find out, and probably be shocked, and wonder how we couldn't have know about this before.

Okay, three facts about the effects of ACEs on education.

Fact Number 1: For all of our children who have experienced those ACEs, **we know this**: Children with chronic stress – what happens when there are ACEs and not enough help for these children to cope with them -- concentration is constantly interrupted by survival brain function. In other words, a child's brain is **not even available** to learn math, or spelling, or listen to the story during circle time or language arts, because it is constantly scanning the room for the next life-threatening thing that is going to happen – and a child KNOWS that the next life-threatening thing is going to happen because that's what life is – a life-threatening experience. This would be for us like trying to do our taxes on our computer, but the program we need isn't on line. The computer is just trying to stay ON, but there's no program there to help with your taxes. That doesn't help much, does it?

Just like Bella's brain while she's in school … "on," but basically on survival mode – certainly not on "math, reading, or even finger painting" mode. We see this on brain scans, by the way – it's real, and it creates long-term changes to brain development if we don't prevent or intervene early. Scary, isn't it? And what do you think this does to future learning, when a child misses the foundational elements of education?

Fact 2. Students – and teachers -- are not aware for the most part of WHY they are failing, and WHY they can't focus or sustain attention, or WHY they get in trouble so often. Their early ACEs have simply programmed their brains in that way. But what do we do in schools when children don't pay attention (because they can't), or miss school or don't hand in homework or can't answer the teacher's questions, or when they act out and cause trouble? We punish them. Or we kick them out of school. Or we withhold some of the most critically helpful pieces of their school day, like recess, or gym, or free time, when they could perhaps work out some of their fear and aggression and re-regulate themselves to actually then be able to learn something. Hhhmmm…, we're truly missing something important here.

And our 3rd and final fact of my talk: Children with 3+ ACEs are 2 ½ times more likely to fail a grade, are significantly more likely to perform below grade level, participate in special education programs, be suspended, expelled, or drop out of school. BAM. This is a correlation that is crying out to be examined and addressed! Good news: we DO have programs that work, and we ARE seeing success in some schools!

More during our roundtable where I'm happy to address your questions. Thank you, and especially Chairman Sturla, for this opportunity to meet and talk with you.

ABOUT CHILD TRAUMA FOUNDATION

Additional Facts ...

- ✓ Studies of over 1000 Kindergarten children in an urban setting show K children with 3 or more ACEs (12% of studied population) exhibit
  - Below average language and literacy skills
  - Increased attention problems
  - Increased aggression
  - Increased social problems
- ✓ The impact of ACEs on school performance has a ripple effect on lifetime achievements. For high school dropouts, the unemployment and underemployment rate is significantly higher than national averages, and young adult high school dropouts were more than 2X as likely to live in poverty, according to the U.S. Dept of Education.
- ✓ 2009 statistics reflect that high school drop-outs were 63 times more likely to be incarcerated than college graduates.
- ✓ An Illinois ACE collaborative showed that 20 – 50% of all students there can be more difficult to engage consistently, require additional supports and often need more attention, thus reducing instructional time for other students.

Some great news ...

- ❖ About Child Trauma Foundation (www.AboutChildTrauma.org) is PA Dept of Ed approved to offer 8+ courses related to trauma to Pennsylvania schools! Our courses offer Act 48 credits automatically. Contact JeanneDailey01@gmail.com, Director of Operations at ACT
- ❖ Two months ago we presented at the Creating Trauma-Sensitive Schools (CTSS) Conference hosted over 1200 educators from across the US and 5 other countries, providing trauma-informed education. It was held in Washington DC in February 2019, & had 75 workshops, two keynotes and a three-room Teacher Self-Care area, where the importance of adults taking care of their own emotional health was emphasized. CTSS2020 will be at the Hyatt Regency in Atlanta, GA February 16-18, 2020, with an expected crowd of over 1700 educators (teachers, administrators, counselors, social workers and other child-serving professionals). The conference will start on Sunday this year, allowing us to offer 100 workshops and three keynotes. There will be increased emphasis on hands-on application of teaching children self-regulation, as well as strategies for implementing trauma-informed education on a system-wide scale. www.CreatiingTraumaSensitiveSchools.org, hosted by Trauma and Attachment Network. Contact Julie Beem, E.D.
- ❖ At least one elementary school in PA has shown significant decreases in aggressive and anti-social behaviors, and a steep decline in disciplinary actions and suspensions, after 1.5 years of incorporating trauma informed practices!

ABOUT CHILD TRAUMA FOUNDATION

- Teaching and implementing Mindfulness activities for faculty and students is showing significant improvement in test scores, time-on-task, and pro-social behaviors across all grades, pre-school and through college.

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Pennsylvania Democratic Caucus
Testimony on Adverse Childhood Experiences

Alice Yoder, RN MSN
Executive Director, Community Health
Penn Medicine Lancaster General Health

Thursday, April 11, 2019

Introduction

Thank you for the opportunity to testify about adverse childhood experiences and their impact on health. My name is Alice Yoder, and I am currently the Executive Director of Community Health at Penn Medicine Lancaster General Health. I am a registered nurse by training and completed my master's degree in nursing administration at Villanova University. For over 25 years, my career at LG Health has been focused on building community partnerships to improve community health and well-being. I was a member of the Governor's Health Advisory Board and actively involved in the State Health Improvement Plan.

In today's testimony, I will discuss the impact of ACEs on health through the lifespan, the implications for healthcare systems, and what healthcare systems and communities can do to become trauma-informed and help patients thrive after experiencing trauma.

When I think about this issue from a personal perspective, I think about children I grew up with, living in the projects in New York City. Although my family was not wealthy, I had positive interactions and experienced safe and nurturing environments, which helped me to succeed later in life. By chance, not design, I was exposed to more protective factors, while children around me were exposed to more risks.

The message I hope to leave with you today is this: we can no longer afford to leave this up to chance; we need to be intentional about using our limited resources on the evidence-based programs we know to be effective.

Impact of Adverse Childhood Experiences on Health and the Healthcare System

ACEs are a serious health hazard. As you have heard, when children experience ACEs, a chain of events can occur, beginning with social, cognitive, and emotional impairment caused by the interruption to normal brain development. In health terms, this impairment can lead to increased health-risk behaviors, such as smoking, risky sexual behavior, and alcohol use. These risk behaviors can lead to preventable chronic health problems, disability, and early death.[1]

[1] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V... Marks, JS (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258.

The Centers for Disease Control (CDC) and Kaiser Permanente conducted one of the largest investigations of the impacts of childhood abuse and neglect on health and well-being. This study found that people who have experienced four or more ACEs before age 18, compared to those who experienced none, are twice as likely to be smokers and seven times more likely to be addicted to alcohol.

Having four or more ACEs also increases the risk of diseases related to these behaviors (such as cancer, emphysema or chronic bronchitis, heart disease, and liver disease) *as well as* health issues *unrelated* to these behaviors (such as intimate partner violence, broken bones, unintended pregnancy, autoimmune diseases, depression, and attempted suicide).

The more ACEs a person experiences, the greater the risk of negative health outcomes – an effect we refer to as a dose-response relationship.

To put ACEs in context as a public health issue, consider that tobacco is commonly considered the leading cause of preventable death in the United States. Tobacco use shortens the lifespan by 10 years.[2] People with six or more ACEs have an expected lifespan that is *20 years shorter* than those with none.[3]

ACEs Impact on Healthcare Systems

ACEs are becoming an increasing concern for hospitals and healthcare providers. Healthcare systems in the United States are changing rapidly, due to the influence of the Affordable Care Act and new care models, such as the patient-centered medical home. In Pennsylvania and across the country, we are moving from a healthcare system that provides mostly "sick care" on a fee-for-service basis to a system that has more incentives and more capacity to keep entire populations healthy and well.

As a result, the healthcare industry is now focusing more on taking an "upstream" approach, as the public health community has traditionally done. In the healthcare context, this means that healthcare providers are recognizing the root causes of poor health and barriers to good health, and implementing interventions to help patients address those issues.

ACEs are an upstream cause of the most common chronic diseases our patients face, such as heart disease, cancer, diabetes, stroke, depression, and addiction. As a result, the cost of ACEs to the healthcare system is staggering. A 2012 study found that the estimated average lifetime cost per victim of child maltreatment is approximately $210,000, including $32,650 in childhood health care costs and

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[2] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General, 2014.

[3] Brown DW, Anda RF, Tiemeier H, Felitti VJ, Edwards VJ, Croft JB, Giles WH. (2009) Adverse childhood experiences and the risk of premature mortality. Am J Prev Med. 37(5):389-96.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V... Marks JS (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258.

$10,500 in adult medical costs, in addition to the productivity losses, child welfare costs, criminal justice costs, and special education costs.[4]

Best Practices in Healthcare & Health Promotion

Although the problem is grave, the opportunity is great. ACEs can be prevented, and people can reach their best health after experiencing trauma. Adverse experiences do not need to define the course of a child's life, if all sectors of our community work together to implement best practice interventions.

Safe, stable, and nurturing environments for children can help prevent ACEs before they occur. For example, the CDC suggests many evidence-based prevention initiatives, such as home visiting programs for pregnant women, parenting training, and support programs for teenage parents. High-quality childcare and income support for low-income families are also recommended to prevent ACEs, as well as treatment and prevention initiatives focused on intimate partner violence, mental illness, and substance abuse.[5] Investing in these prevention initiatives is a strategic upstream approach to avoid the high economic, social, and health burden that ACEs place on individuals and communities.

In the healthcare sector, organizations are making the commitment to provide better care for individuals with a history of trauma. *Advancing Trauma-Informed Care*, led by the Center for Health Care Strategies with support from the Robert Wood Johnson Foundation, is a pilot project with six health care systems across the country who are learning to implement trauma-informed approaches. These pilot sites are training clinical and non-clinical staff to create a welcoming and non-judgmental environment, transforming their physical spaces into calm and quiet places, and investing in employee wellness to avoid burnout. They are involving patients in joint decision-making and inviting patients who have experienced trauma to serve on advisory and leadership committees.[6]

Researchers and individual health systems are currently studying the benefits and potential negative impacts of screening all patients for ACEs in primary care settings.[7] Although universal screening is not yet common practice and may not be appropriate in all settings, all healthcare providers must be prepared to respond sensitively and connect patients to appropriate treatment and resources within the system or in the community when patients do disclose that they have experienced trauma.

Initiatives at Penn Medicine Lancaster General Health

At LG Health, we still have work to do, but we are building on a strong foundation of existing trauma-informed programs that help patients through the life course.

Nurse-Family Partnership, an evidence-based home visitation program where specially trained nurses visit first-time mothers from early in pregnancy through the child's second birthday.

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[4] Fang X, Brown D, Florence CS, Mercy JA. The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect. 36; 2: 2012 (156-165).

[5] Centers for Disease Control and Prevention National Center for Injury Prevention and Control, Division of Violence Prevention. *What can be done about ACEs?* April 1, 2016.

[6] Center for Healthcare Strategies. Key Ingredients for Making Trauma-Informed Care the Standard of Care. https://www.chcs.org/key-ingredients-making-trauma-informed-care-standard-care

[7] Finkelhor D. Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect.* 85: 2018 (174-179).

Lancaster County Child Advocacy Center that served over 5,000 child victims of sexual assault who no longer have to tell their traumatic stories 7-9 times to different community partners, and are immediately connected with support services to begin their healing.

A Trauma-Informed Community

Lancaster General Health first brought Dr. Robert Anda, one of the authors of the landmark ACEs study, to the community in the late 1990s. Since then, there have been individuals and organizations working to advance trauma-informed practices in all sectors of our community. Health systems alone cannot prevent and help people heal from ACEs, but we can work across sectors to create a trauma-informed community that understands the impact and signs of trauma and avoids re-traumatizing people.

In our community, a collective impact partnership called Let's Talk Lancaster was created in 2014 to improve mental health and well-being in Lancaster County. This partnership includes behavioral and medical providers, schools, county government, and community organizations. In 2017, Let's Talk Lancaster and the United Way began funding Trauma 101 community trainings to start to raise awareness about the impact of ACEs and trauma. In two years, over 1500 individuals received this training.

In November 2018, Let's Talk Lancaster hosted the first community mobilization meeting about becoming a trauma-informed community, and 49 representatives from various sectors of the community participated in identifying and developing opportunities for advancing the work of creating a trauma-informed Lancaster County. Our next steps are to continue raising awareness and trauma-informed training, to develop assessment tools for community organizations, schools, criminal justice system and workplaces to evaluate their environments, and to assist these organizations in creating a trauma-informed environments through policy and systems change.

We respectfully ask that you consider:

1. Support for Trauma-Informed Training
2. Support payment for evidence-based programs
3. Statewide commitment to become "Trauma-Informed Pennsylvania"

Public Hearing on Adverse Childhood Experiences

April 11, 2019

Lancaster, PA

Testimony by Melanie G. Snyder, MBA, OWDS

Trauma-Informed Specialist, Penn Medicine Lancaster General Health

Retired Executive Director, RMO for Returning Citizens - Lancaster County's prisoner reentry coalition

Consultant & Trainer: Reentry, Trauma, Resilience & Trauma-Informed Care

Author, Grace Goes to Prison: An Inspiring Story of Hope and Humanity

TEDx Talk: Breaking Out of Prison Thinking

INTRODUCTION

Thank you for the invitation to provide testimony about Adverse Childhood Experiences (ACEs) in the context of the criminal justice system. I commend all of you for your interest in this important topic and appreciate you taking time to be here today to hear more about trauma, ACEs, resilience and trauma-informed responses.

My name is Melanie Snyder. I currently serve as the Trauma-Informed Specialist for Penn Medicine Lancaster General Health. In this role, I am helping to advance Lancaster County's "Trauma-Informed Community" initiative by training human services and criminal justice professionals, educators, healthcare, mental health and addiction treatment providers, faith community and business leaders, and others about trauma, ACEs, resilience, and trauma-informed care.

Over the past two years, as part of an effort to make Lancaster County's criminal justice system more trauma-informed, I have trained over 600 police officers, corrections officers, and parole officers about trauma experienced by people in their "care, custody and control" and how these professionals can improve their own safety as well as the safety of justice-involved people, by responding with trauma-informed approaches. These trainings have also addressed the vicarious trauma and PTSD officers experience themselves, due to the extremely stressful nature of their jobs, and provided the officers with tools and strategies to practice good self-care. One of our trainings is titled "Safeguarding Children of Arrested Parents." In that course, I teach officers best practices and protocols for minimizing the risk of trauma for children who may be present when officers are carrying out search warrants or making arrests.

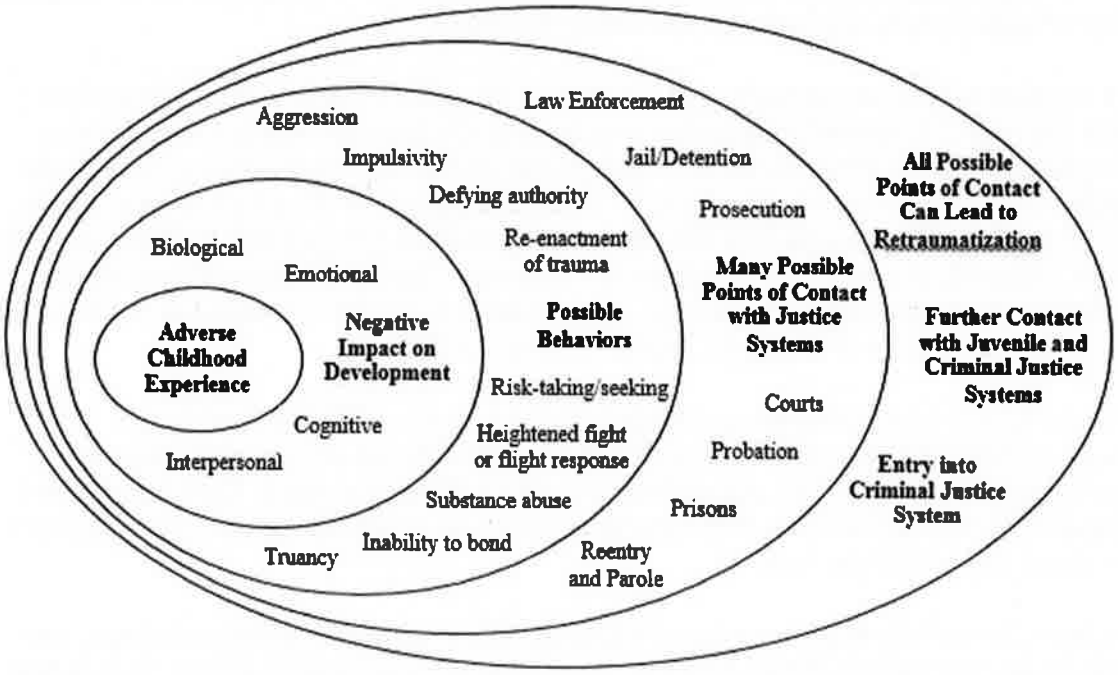
Prior to my current role with Penn Medicine/LGH, I served for eight years as the Executive Director of the RMO for Returning Citizens, Lancaster County's prisoner reentry coalition, where I worked on a daily basis with people who were incarcerated or coming out of prison, assisting them to overcome the numerous barriers and collateral consequences associated with a criminal record, by connecting them with addiction and mental health treatment, job skills training and job placement, housing, and other services.

I have served as a consultant to ten other counties in Pennsylvania to help them start prisoner reentry coalitions like Lancaster County's RMO. I also serve on the Pennsylvania Reentry Council (PARC), a statewide collaborative established by Attorney General Josh Shapiro to make communities safer by reducing recidivism and victimization through the successful reintegration of returning citizens. I'm a trained Restorative Justice Mediator, the author of the book "Grace Goes to Prison" about restorative justice and prisoner reentry programs in Pennsylvania's state prison system, and I have given a TED talk about the criminal justice system, and the need to invest in restorative justice and reentry programs.

CHILDHOOD TRAUMA AND CRIMINAL JUSTICE SYSTEM INVOLVEMENT

When I first learned about the landmark Adverse Childhood Experiences (ACEs) study and the connections between early adversity and heightened risks of addiction, mental illness, risk-taking behavior, and criminal justice system involvement later in life, the lightbulb went on for me. So many of the justice-involved people I served every day had experienced childhoods filled with abuse, neglect, violence, family dysfunction, poverty, and other trauma. It wasn't that those childhood experiences excused their criminal behavior as adults, but it got me to start asking a different question - instead of "what is wrong with you?", I started asking, "what has happened to you that led to your involvement in crime and the criminal justice system?" I was especially struck by the brain research showing how early adversity disrupts a child's brain development in ways that can affect their ability throughout the rest of their life to learn, regulate emotions, control impulses, form healthy relationships, think, reason, and make rational decisions.

Christopher Wildman, co-director of the National Data Archive on Child Abuse and Neglect, has said, "Childhood trauma is a huge factor within the criminal justice system. It is among the most important things that shapes addictive and criminal behavior in adulthood."[1] The diagram below shows the ripple effects of childhood trauma in relation to justice system contact.[2]



Sources: Julian D. Ford, John F. Chapman, Josephine Hawke & David Albert, *Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions*, National Center for Mental Health and Juvenile Justice: Research and Program Brief (June 2007); *The Trajectory of a Traumatized Youth*, Robert F. Kennedy Children's Action Corps (2016).

[1] https://www.nytimes.com/2017/10/15/us/childhood-trauma-prison-addiction.html

[2] http://www.hmprg.org/wp-content/themes/HMPRG/backup/ACEs/Justice%20Policy%20Brief.pdf

According to a National Institute of Justice study, abused and neglected children are:
- 11 times more likely to be arrested for criminal behavior as a juvenile,
- 2.7 times more likely to be arrested for violent and criminal behavior as an adult, and
- 3.1 times more likely to be arrested for a violent crime (juvenile or adult).[3]

I'd like to share just one story of a justice-involved person I've worked with, that I hope might shed some light on connections between childhood trauma, addiction, and crime.

ED'S STORY

Ed is a mentor, leader, and facilitator in the RMO's Successful Returning Citizens Mentoring Support Group. He's 54 years old and has been happily married for 33 years. He's fluent in Spanish, is a Certified Peer Specialist, a Certified Recovery Specialist and is about to complete his certification as a Family Recovery Specialist. He has been a tutor for 20 years in the Laubach Literacy Program, and is now a Laubach tutor trainer. He has an Associate's Degree in Business Administration and Accounting Management.

Ed was also incarcerated for 35 years for a violent crime he committed when he was a teenager. He was released from prison a few years ago. He makes no excuses for his crime, and has worked hard over the past three decades to understand the escalating series of experiences and actions that led to his crime.

Ed's earliest childhood memory is of witnessing his older brother being beaten by a family member. He doesn't remember exactly how old he was, but guesses he was about five years old. What he does remember is seeing his brother being repeatedly slapped hard, then kicked to the floor, then yanked up off the floor by his hair. As his brother tried to get away, he and the abuser passed little Ed standing by the stairs. The abuser stopped, stared down at Ed, and threatened, "You had better not be crying." The little boy gulped and wanted to escape up the stairs, but couldn't leave his big brother. So he continued to watch in terror, trying hard not to cry.

This was just one of numerous beatings both Ed and his brother experienced throughout their childhoods, along with extensive emotional abuse, and constant uncertainty about what might precipitate the abuse. Over the years, Ed's resentment grew until he took the attitude that he was going to do whatever he wanted and didn't care about the consequences.

As a teen, he started skipping school, hanging with a rebellious crowd, drinking, and taking drugs. He got into fights, trying to prove that no one could hurt him. He started committing petty crimes, and stealing to get money for drugs. He ran away to Florida, stealing cars on his way there. He met some adults who had just gotten out of prison. They introduced him to PCP. Ed found relief and a feeling of security in PCP, as it

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[3] D.J. English, C.S. Widom, and C. Brandford, "Another look at the effects of child abuse," NIJ Journal 251 (2009): 23–24.

numbed the pain and terror of all he had experienced, and made him feel like no one could hurt him. While high on PCP, Ed committed the crime that landed him in prison.

RESILIENCE

While Ed's story involves extensive trauma, addiction, and violence, his is also a story of resilience. What made the difference for Ed?

While he was in prison, a local family started visiting Ed regularly. They assured him that his life had value and that there was a future and hope for him. Slowly, Ed learned to trust them. Ed says, "When I realized and appreciated that I have worth and dignity, it helped me to see the worth and dignity of others." He got involved in numerous prison education programs, taught himself to speak Spanish, and became a peer mentor for other inmates. And, while in prison, he married the daughter of that family that visited him. Her unwavering love and support was another major factor in Ed's ability to survive the long years in prison and his successful transition back to the community.

Since his release, Ed has actively sought out positive people to walk with him. He has dedicated himself to giving back to the community, through volunteer work, involvement in his church, and mentoring other returning citizens. Ed has a sense of meaning and purpose for his life. Most of all, he has a sense of hope for his future.

Ed's story of resilience reflects some of what the research shows people need to heal from trauma:

* Supportive, nurturing relationships
* Opportunities to be of service to others
* Believing that your life has meaning and purpose
* Learning to trust others
* Feeling a sense of hope

Unfortunately, our criminal justice system typically works against and even strips away many of these things.

TRAUMA AND THE CRIMINAL JUSTICE SYSTEM

While we obviously can't draw extensive conclusions from just one person's story, Ed's story is not unique among justice-involved people. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), " . . . the **majority** of people who have behavioral health issues and are involved with the justice system have significant histories of trauma and exposure to personal and community violence." [4]

[4] https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals

Here are just a few statistics:

- Compared to youth in the general population, juvenile-justice involved youth have roughly three times more ACEs.[5]
- 77-90% of incarcerated women have extensive histories of emotional, physical and sexual abuse.[6]

Furthermore, "Involvement with the justice system can further exacerbate trauma for [justice-involved] individuals." [7].

Over the past four decades, "tough on crime" legislation and policies have become the default approach in how we deal with people who commit crimes. And there's no question that we must address serious issues of violence, substance abuse, and crime in our communities.

However, a 2013 report and literature review by researchers in San Diego concluded, "Childhood adversity is associated with adult criminality. We suggest that to decrease criminal recidivism, treatment interventions must focus on the effects of early life experiences."[8]

SAMHSA advises that criminal justice professionals assume that everyone who comes into contact with the justice system has a history of trauma and they recommend a trauma-informed approach at every stage of the criminal justice process.

Trauma-informed responses in the criminal justice system can increase safety for all, decrease recidivism, help to avoid re-traumatizing justice-involved people, and support their recovery. Collaborative partnerships across systems, like Lancaster County's RMO and other reentry coalitions, can also help link individuals to trauma-informed services and treatment.[9]

In Lancaster County, we've been working for several years on making our criminal justice system trauma-informed. The Appendix in your packet provides a summary of this initiative. In closing, I would like to offer several suggestions for how you can support a trauma-informed criminal justice system.

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[5] Baglivio, Michael T.; Epps, Nathan; Swartz, Kimberly; Sayedul Huq, Mona; and Sheer, Amy. (2014). "The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders". Journal of Juvenile Justice 3:2.

[6] National Institute of Corrections. Federal Partners Report on Women and Trauma. (2011).

[7] https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662280/ 2013 Spring;17(2):44-8. doi: 10.7812/TPP/12-072. Adverse childhood experiences and adult criminality: how long must we live before we possess our own lives? Reavis JA, Looman J, Franco KA, Rojas B.

[9] https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals

HOW CAN LEGISLATORS SUPPORT TRAUMA-INFORMED CRIMINAL JUSTICE?

- Fund trauma training for criminal justice professionals
- Support programs that address the vicarious trauma/PTSD that law enforcement, corrections officers, and other criminal justice professionals experience in their daily work
- Support trauma-informed policies and practices at each "intercept" point in the criminal justice system (see https://www.nasmhpd.org/sites/default/files/Women%20in%20Corrections%20TIC%20SR(2).pdf for specific ideas from SAMHSA)

Finally, while I was honored to be able to share a little of Ed's story with you this morning, I don't presume to speak for the tens of thousands of justice-involved people throughout Pennsylvania who are also your constituents. So I humbly encourage you to meet and talk with justice-involved people yourselves, to hear directly from them about their lived experiences with trauma and the criminal justice system, and to get their perspectives on how the criminal justice system could become more trauma-informed to improve safety, reduce recidivism, and promote healing and recovery.

Again, I thank you for this opportunity. It has been an honor for me to provide this testimony to you.

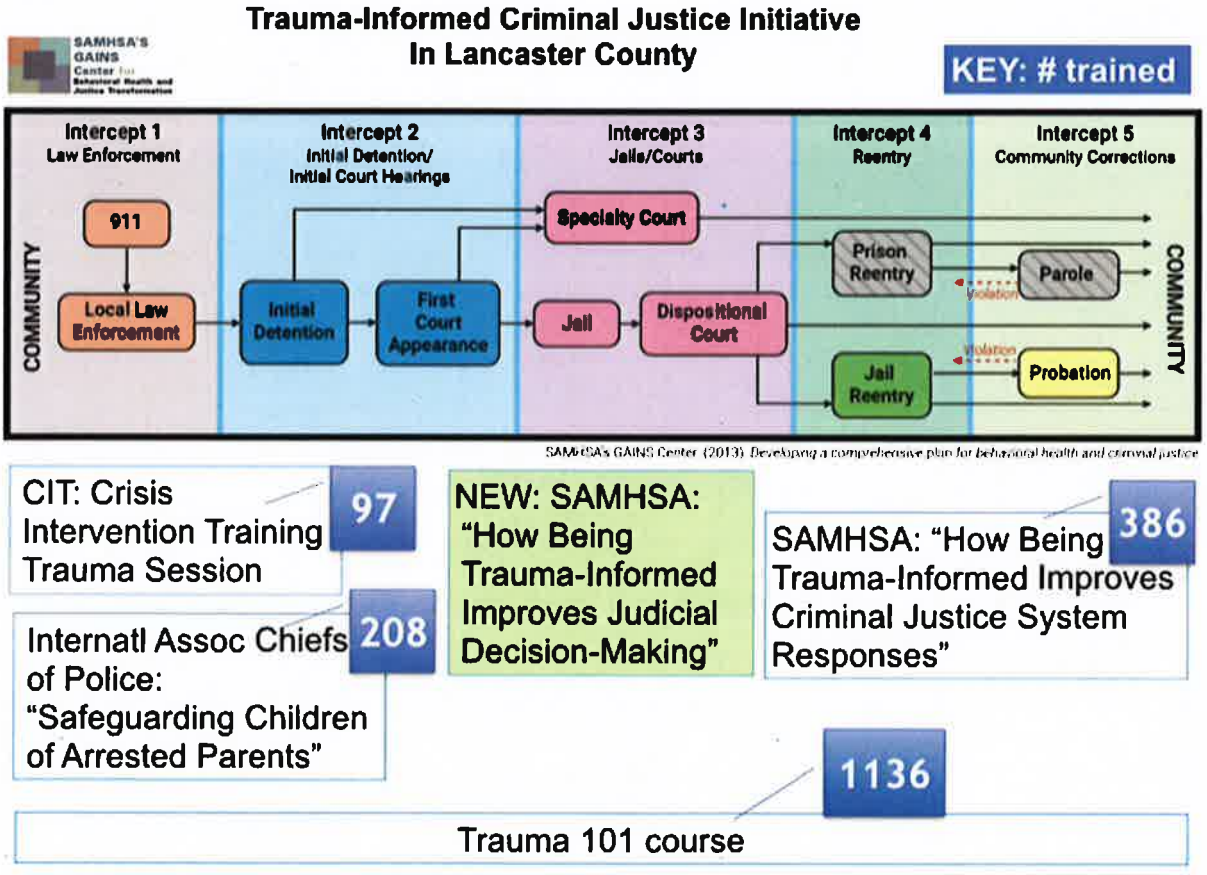
APPENDIX

LANCASTER COUNTY'S TRAUMA-INFORMED CRIMINAL JUSTICE INITIATIVE

In Lancaster County, we've been working for several years on making our criminal justice system trauma-informed by training police, corrections officers, parole officers, and other criminal justice professionals working at various stages or "intercept" points in the criminal justice system about the connections between trauma, ACEs, addiction, mental illness, and criminal justice system involvement. These trainings include examining ways in which the criminal justice system often re-traumatizes people with a history of other types of trauma.

While the initial intent of this training was to increase awareness among justice professionals about trauma experienced by people in their "care, custody and control" and to develop more trauma-informed policies and procedures in the criminal justice system, we quickly realized how much trauma criminal justice professionals experience themselves, due to the nature of their jobs and the situations they face on a daily basis. So we have also included a focus on stress, vicarious trauma, and self-care for the professionals in our trainings.

The diagram below shows the various trainings we have provided and the number of people we've trained in each of these courses to help make Lancaster County's criminal justice system more trauma-informed.



BOYS & GIRLS CLUB
OF LANCASTER

Good morning and thank you so much for inviting us here to discuss ACEs, how they affect children in our community, and what we are collectively doing to build protective factors and resiliency in our kids to ensure better health outcomes and ultimately a better community. Specifically, I would like thank Representative Sturla for your dedication to increasing awareness around ACEs and advocating for children everywhere.

My name is Erin Elliott, and I have the honor of representing Boys & Girls Club of Lancaster at today's hearing. I have been with the Club for nearly 13 years. In my capacity as Chief Development Officer, I represent the children and families we serve to inspire donors, partners, and other community stakeholders to invest in programs that change the lives of our kids.

At present, we operate after school programs at two Lancaster City locations and one in Columbia. We are opening a new site in Southeast Lancaster City in just a few weeks. We have a 100-acre summer camp site where we operate a six-week, full-day traditional summer camp program. In addition, we run a before-school program at Washington Elementary School, have a Community School Director there and at Price Elementary, and have a full-time Community Connector on staff. We are also the contracted partner for Lancaster County's Children & Youth Agency's Independent Living Program. For 80 years, the Boys & Girls Club of Lancaster has been providing critical services to ensure children in our community are given the hope and opportunity they need to be successful, productive members of our community.

Un/Under-employment is prevalent in the neighborhoods we serve. This condition creates a concentration of poverty, resulting in food and housing insecurity, reduced access to healthcare, undiagnosed or untreated mental health issues, and chronic stress resulting from the cycles of poverty and abuse. Collectively, this all makes our children especially vulnerable to ACEs. Compounding factors create extraordinary challenges for supporting children in an environment where many or all have high-ranging ACE scores.

To address this, for just $1 per year, children ages 6-18 become card-carrying members and are able to access all of our afterschool Clubhouse programs. We strive to remove all barriers that prevent children from accessing services. We are located in the neighborhoods our most vulnerable children call home, and we continuously assess and re-assess our programs to ensure they are designed to address the most serious and pressing needs of our children.

In the same way that we acknowledge that ACEs affect the whole child and their long-term physical, cognitive, and emotional health, the Boys & Girls Club of Lancaster – and Boys & Girls Clubs across the Commonwealth – deliver powerful programs designed to help youth overcome the devastating consequences of ACEs and ultimately change the trajectory of their lives. During a child's time spent at

the Club, they experience safety, stability, and nurturing – all identified by the CDC (Essentials for Childhood, pg. 6) as critical relationship qualities that:

- Reduce the occurrence of and negative effects of ACEs
- Influence many physical, cognitive, emotional outcomes throughout a child's life
- Reduce health disparities
- Have a cumulative impact on health

Our efforts are working. We know that ACEs significantly increase a child's likelihood to participate in risky behaviors, like drinking alcohol and smoking, but teens who attend a Boys & Girls Club in the state of Pennsylvania are abstaining at rates above national and state averages (see attached report from Boys & Girls Clubs Pennsylvania Alliance). Teens are also more likely to abstain from prescription drugs and marijuana.

A common misconception about Boys & Girls Clubs is that we are simply a recreational facility, when in fact we use recreation as the catalyst for building meaningful and important relationships with children who are most at risk. Through positive, stable relationships at the Club, children and teens increase their resiliency and learn to cope with the stress of their physical and emotional environments. According to Harvard's National Scientific Council on the Developing Child, "Despite the widespread belief that individual grit, extraordinary self-reliance, or some in-born, heroic strength of character can triumph over calamity, science now tells us that it is the reliable presence of at least one supportive relationship and multiple opportunities for developing effective coping skills that are essential building blocks for the capacity to do well in the face of significant adversity." For thousands of children across Pennsylvania, that positive adult and opportunity to develop skills are found every day at their Boys & Girls Clubs.

We recognize a tremendous part of our role is to combat the effects of ACEs. Our kids need food and fun. Hugs and high-fives. While the transient families may not know where their next home will be, they always know where to find the Club. As families face food insecurity, children always know there is a seat at our table. Through homework help, game room tournaments and sports leagues, our kids develop strong relationships with adults who make them feel valued. And our leadership clubs help each child and teen see that they have the skills and talents they need to help others – giving them confidence, empowering them as leaders in their community, and giving them a sense of purpose.

At the Boys & Girls Club of Lancaster, children find a caring adult to help with homework, a hot nutritious meal, a supportive coach in the gym, an inspiring art teacher, a nurturing yoga instructor. Inside the walls of the Club, it's bright, fun, and safe. The building is full of staff, interns, and volunteers who genuinely care about each child who walks through our doors. The light and love found inside the Club shines bright – and reminds our kids that their futures are bright too.

Thank you.

References:

National Scientific Council on the Developing Child. (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13. http://www.developingchild.harvard.edu

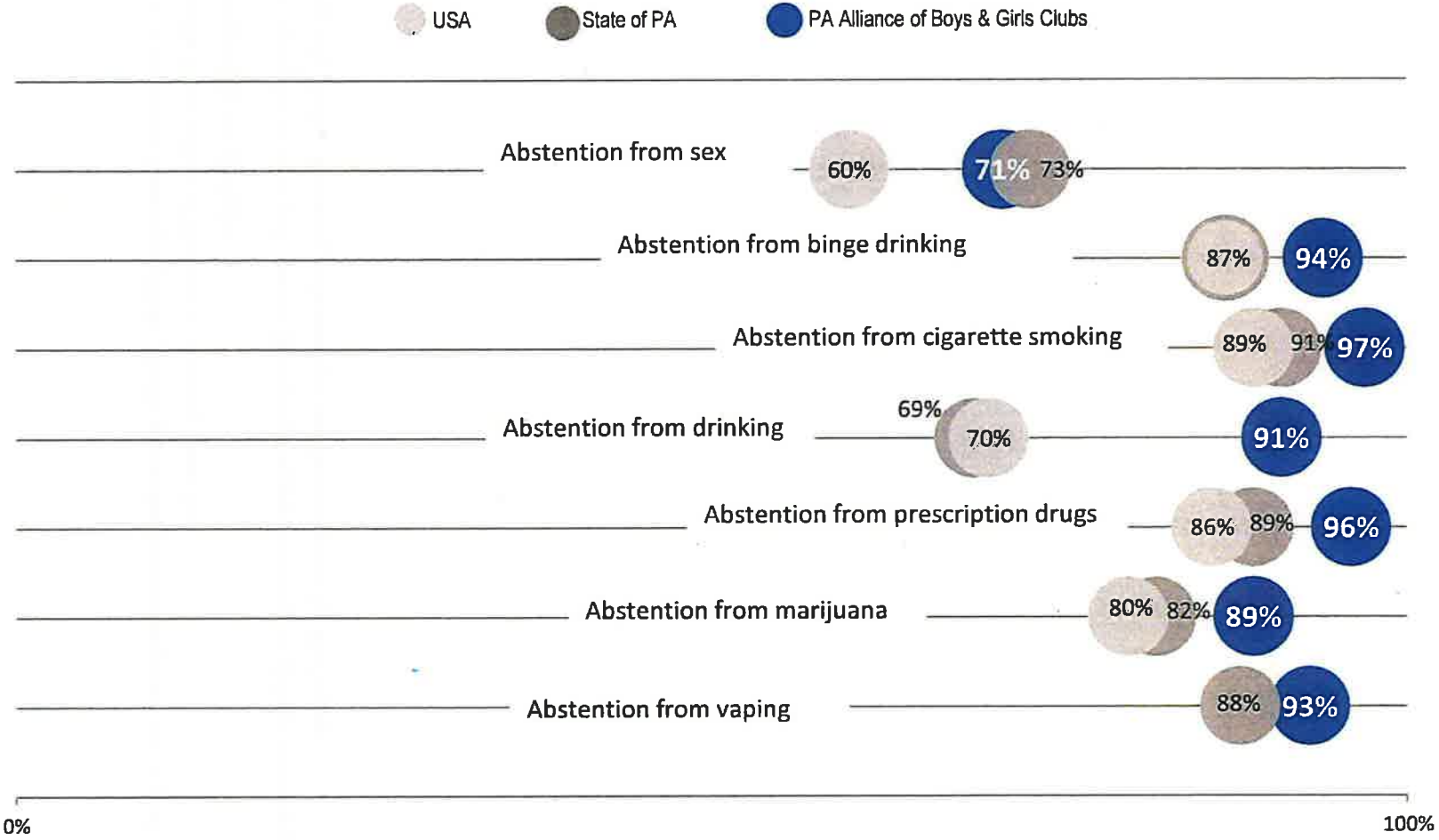
National Center for Injury Prevention and Control, Division of Violence Prevention. (2019). Essentials for Childhood: Creating Safe, Stable, Nurturing Relationships and Environments for All Children.

BOYS & GIRLS CLUBS
PENNSYLVANIA ALLIANCE

How Pennsylvania Boys & Girls Clubs Measure Up

The chart below provides an overview of Pennsylvania Alliance Club survey outcomes, in comparison to The Centers for Disease Control's National Youth Risk Behavior Survey (YRBS) at the state and national level (when available).

Each spring, PA Clubs gather outcomes data using a common tool which captures research informed indicators for its priority outcomes areas. Some questions match those in the YRBS, opening an opportunity for true apples-to-apples comparison. In 2018, 17 Clubs administered this tool to their members. 15 of these Clubs administered additional YRBS questions to 9-12th graders, with results represented below.



Participating Clubs: Allentown, Bethlehem, Chambersburg & Shippensburg, Chester, Easton, Lancaster, Northeastern Pennsylvania, Olivet, Philadelphia, Sarah Heinz House, Western Pennsylvania