

**Building Services and Supports
for Children Exposed to Domestic Violence,
Child Welfare, and Juvenile Justice**

BRIEF TOPIC SUMMARY

THE
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OVERVIEW

Children can become vulnerable to developing mental health and substance use conditions when they have experienced trauma due to domestic violence or the child welfare system or juvenile justice system. This discussion is about ways in which trauma is a factor for children in these situations, how it relates to vulnerability, and how it needs to be addressed.

For too many children, home is not a safe haven. The devastating facts of domestic violence on women are well documented, but we know far less about the impact on children,... findings show that children, who are exposed to violence in the home, may suffer severe and lasting effects, including the likelihood that they will be the victims of child abuse. Those who are not direct victims have some of the same behavioral and psychological problems as children who have been physically abused: difficulty learning and developing social skills; displaying violent, risky, or delinquent behavior; abusing substances; and/or, suffering from mental illnesses, such as depression and anxiety.

Younger children particularly are vulnerable to experiencing negative outcomes. Each year, approximately 500,000 children are engaged with the Child Welfare System, in the United States. Nearly half of these have emotional or behavioral problems. Children in foster care tend to need 10 to 20 times the rate of mental health services. Primarily, they have experienced physical abuse, sexual abuse, neglect, and abandonment.

Finally, every year children come into contact with the juvenile justice system. Of these, more one half have at least have been diagnosed with a mental health problem, and 20% to 25% have serious emotional issues. For many of these youth, contact with the juvenile justice system is a direct result of untreated mental health needs that show up in negative or delinquent behaviors. Unlike many other child-serving systems, the juvenile justice system cannot refuse to accept a youth; as a result, it is viewed sometimes as the last option for accessing needed services.

Child Trauma and Stress

Child trauma has moved from out of the shadows. In 1975, the very common belief in the mental health field was you did not talk to children about these types of things. Concern was that children would be damaged simply by bringing up the topics and entering into an open discussion. Dramatic changes have occurred over the past 25, 35 years. Children can experience several different kinds of stressors: child maltreatment — such as physical abuse, neglect, child sexual abuse, and emotional abuse — domestic violence, which includes interpersonal violence; natural disasters; terrorism; all forms of medical trauma, as when children are brought to emergency settings; traumatic loss; separation; bereavement; community and school violence; and, war-zone trauma, particularly among many of the immigrant and refugee children.

Exposure and Response Components

A fairly complex phenomenon, child traumatic stress takes into account both exposure to the types of events listed above and, also, the child's response. Typically, it is defined as physical

and emotional responses to events threatening life or physical integrity of a child or of someone critically important to a child. Children also experience traumatic stress by community and school violence. In the immediate aftermath of such an event, everybody is affected, everybody responds. Recently, the Department of Justice published findings that show, in the course of children's lifetime, one in four, or 25% are exposed to domestic violence. In the past year, one in nine, 11%, were exposed to domestic violence.

Relationship Between IQ and Exposure to Domestic Violence

Research has found that children who have had no exposure to domestic violence were in the normal range of IQ. As exposure domestic violence increased, IQ decreased; when tested, the IQ decrements were lower than in children who were exposed to lead toxicity. In the Great Smokey Mountain Study, in the general population, by age 16, it was found that two out of three children are exposed to at least one traumatic event of the type listed earlier. These findings have been replicated in other studies as well. This as a serious public health problem.

The multifaceted National Child Traumatic Stress Network's mission is to change the way traumatized children and families are treated in this country, and to raise the standard of care and improve access to services, for traumatized children and their families and communities. In collaboration with others throughout the country, they are addressing the issue of the size of the problem, one of the key things policymakers need to know in order to start to approach the problem of concern.

Aside from addressing the burden of child traumatic stress, they have many ongoing initiatives that are addressing what can be done to get evidence-based treatments and other approaches out into the community, and the costs of doing so. There are no initiatives within the Network that do not involve collaboration across child-serving systems. There are Network programs in child welfare and juvenile justice, there are first responders programs, as well as programs for mental health, substance abuse, and schools.

The Core Dataset

The Core Dataset was designed as a quality improvement initiative to help change the way that providers of mental health services to children and families do business in the community. It is a way for them to assess what going on with their child clients and to help shape the innovations that they select and the methods that they use to help children recover and heal from trauma. It facilitates finding out who is served, what types of problems and symptoms and traumas children experience, and a way to think about services provided and how to measure if children are getting better.

It collects demographic and very detailed information about children's exposure to traumatic experiences, as well as salient characteristics of those experiences. Within the Core Dataset, two Standardized Assessment Measures look at post-traumatic stress symptoms and related symptoms, the UCLA PTSD Reaction Index and the Trauma Symptom Checklist for Children; they also assess associated features, such as depression and other types of anxiety. The Child

Behavior Checklist looks at behavioral and emotional difficulties that the child may be exhibiting.

About 14,088 children are in the Core Dataset; their average age is about 10½ and the kids are evenly split between boys and girls. Over a quarter of the children are African American and Latino, and many of these children live at home with their parents. More than half the kids in the Core Dataset are eligible for either public insurance, like Medicaid, or state health insurance. Prior to their inclusion, about 64% of the children have used some type of service, whether it's educational, such as school counselors, or other types of mental health services while involved with child welfare or the juvenile justice service systems. Unfortunately, over a third of the children have been involved with multiple service systems.

About 75% of the children in the sample experienced multiple types of traumatic experiences, a quarter of the children have been exposed to a parent who has substance use or drug use problems. Of the parents, 15% or 16% have mental health problems as the indicator for impairment; others may either have cognitive impairments or other things that may keep a parent from providing the necessary care.

Most of the children report multiple exposures to a single incident, as well as multiple types of trauma; more than half have had behavioral problems at home and in the school setting. Many of them have definite academic difficulties; many of them also have attachment problems, or difficulty forming relationships with people. That kind of persistent functional impairment leads to poor outcomes later on. Fifty-four percent of the children have PTSD. Some more commonly reported problems include traumatic grief, ADHD, oppositional defiant disorder, and “the trifecta”: ADHD, oppositional defiant disorder, and conduct disorder.

Every child who has been exposed to trauma does not have symptoms. It depends on several different factors: type of trauma; severity and chronicity of their trauma; cultural beliefs and factors; other experiences the child may have had; and, the timing of those experiences — when did it happen during their developmental course. This notion has been building in the research literature around cumulative risk: when more and more is not a good thing.

Effects of Trauma

Trauma affects children's physical and mental health, and basically, increases the likelihood of morbidity and mortality. How do we impact what those experiences mean in the life course of children and families? In the vein of the cumulative risk literature, more than 44% of children in the study have reported four or more traumas. As the number of traumas increase, so do the percentage of youth who have experienced functional impairments. Health risk behaviors, suicidality, self-injury, substance use, and alcohol use: as the number of traumas increase, so does the likelihood of these problems. Kids who have experienced much trauma are at heightened risk for many negative outcomes across multiple domains.

Summary

Because the numbers of traumas kids experience are associated with serious negative outcomes, we have to pay attention to what we are learning about our profiles and risk factors in that area. The issue is how trauma affects different developmental stages, and how to understand those developmental issues to understand the sequella associated with trauma. The good news is that kids are indeed getting better. Significant drops have occurred in each of these three categories of pre- to post-treatment outcomes for these kids: behavioral problems, post-traumatic stress, and other trauma-related symptoms.

With treatment, significant improvements in functioning on our standardized assessment measures have been observed in terms of behavioral problems, post-traumatic stress disorder, and other traumatic stress related systems. What does that mean when they get better in terms of functional impairment? Do those other domains of functioning improve also?

We need to begin to infuse this information and disseminate it to the people in the frontline as well as to folks that make policy decisions around children and families. In terms of policy implications, we can see that trauma is a common experience for children in many child-serving systems. We need to work towards the integration of trauma-informed services and care and evidence-based treatments across child-serving systems. We also have to think about how we train the providers, and create system improvements that will facilitate the sustainability of those changes.

Routine screening and data collection can help us identify the consequences of traumatic events on children but, more importantly, it can help us engage children and families in treatment. It can also help clinicians support and select the effective treatments that we know will work. The ultimate goal is to restore healthy development for the children and families.