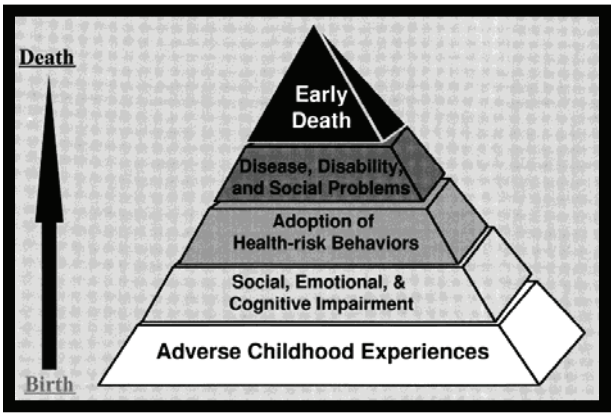
Strengthening the Response to Childhood Trauma in Montana

Final report on Senate Joint Resolution No. 30 for the Children, Families, Health, and Human Services Interim Committee



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Before the close of each legislative session, the House and Senate leadership appoint lawmakers to interim committees. The members of the Children, Families, Health, and Human Services Interim Committee (CFHHS), like most other interim committees, serve one 20-month term. Members who are reelected to the Legislature may serve again on an interim committee.*

* The following information is included in order to comply with section 2-15-155, MCA.

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Introduction and Background to SJR 30

The 2011 Legislature passed Senate Joint Resolution No. (SJR 30), which requested an interim study of ways to reduce childhood trauma and its long-term effect on children. The legislators ranked SJR 30 seventh out of 16 study resolutions. This relatively high ranking indicated bipartisan interest in learning more about the effects of childhood trauma, including the potential lifelong effects on an individual and the potential long-term effects on society.

SJR 30 emphasized the view found in childhood trauma literature that the human brain, which grows to 85% of its adult size by the time a child is 3 years old, is profoundly shaped by the child's experiences during those years, particularly by the safety, stability, and nurturing that the child's primary caregivers do or do not provide. It stressed findings that unaddressed childhood trauma affects a child's behaviors later in life and can lead to problems such as poor physical health, addiction, and mental illness.

But SJR 30 also noted that problems such as these can be prevented, especially through prenatal care, parent education, family support, and other efforts to prevent or mitigate childhood trauma. In particular, it singled out in-home nursing programs that are shown to reduce traumatic events as well as parental outreach programs that have success in reversing some of the symptoms of trauma in young children.

SJR 30 STRESSED FINDINGS THAT UNADDRESSED CHILDHOOD TRAUMA AFFECTS A CHILD'S BEHAVIORS LATER IN LIFE AND CAN LEAD TO PROBLEMS SUCH AS POOR PHYSICAL HEALTH, ADDICTION, AND MENTAL ILLNESS.

SJR 30 requested that an appropriate interim committee be designated (CFHHS was chosen), pursuant to section 5-5-217, MCA, “to study promising and evidence-based practices for the prevention of childhood trauma and for mitigating its effects on children”. SJR 30 then presented the following broad tasks:

- compile data on the prevalence of childhood trauma in Montana;
- identify the communities most in need of supportive interventions;
- inventory and, to the extent possible, evaluate the impact of *existing* childhood trauma interventions in Montana;
- identify promising and evidence-based practices, including those elsewhere in the nation, that appear most appropriate for Montana communities; and
- identify any appropriate steps that policymakers may take to reduce childhood trauma and hence its lifelong after effects in Montana.

This study resolution also urged that a number of stakeholders participate in the study process, including representatives of the Department of Public Health and Human Services (hereafter referred to as DPHHS or the department), the Office of Public Instruction, the mental health service area authorities and local advisory councils, agencies working to prevent childhood trauma, the Indian Health Service, and Montana Indian tribes, as well as other interested parties as identified by the committee.

CFHHS Committee discusses childhood trauma in August 2012.

The SJR 30 Study Plan

Childhood trauma is a vast topic encompassing many possible social issues and multiple timeframes (potential phases of intervention) as well as varied promising practices and policy choices. The outline below reflects the consensus of CFHHS committee members at their June 20 and September 19, 2011, meetings.

Outline of Study Activities

I. **Overview childhood trauma.**
Present the committee a baseline understanding of the phenomenon of childhood trauma and also provide synopses of evidence-based interventions around the country aimed at preventing or treating health issues tied to adverse childhood experiences.

II. **Overview childhood trauma in Montana**.

(a) Present fresh survey data on childhood trauma in Montana, offering some analysis of its prevalence and implications for Montana communities. "Community" may be understood in the geographical sense (such as rural communities or reservations where key services might be lacking) or the demographic sense (socioeconomic groupings that might be comparatively vulnerable).

(b) Review recent instances of child neglect and abuse in Montana and determine if any policy initiatives to improve the response by state, county, and tribal agencies would be suitable.

(c) Examine a Montana-based intervention, the University of Montana's collaboration with the National Native Children's Trauma Center. The NNCTC is charged with providing national expertise on childhood trauma among American Indian/Alaska Native children, focusing particularly on work with school communities.

III. **Discuss legislative options.**
Bearing in mind that childhood trauma and its results come to involve a wide range of private and state entities (and funds) in the fields of public health, education, corrections, and beyond, provide those stakeholders an opportunity to discuss with committee members which legislative options seem to hold the best promise.

IV. **Select and refine the option(s) chosen.**
This final phase of the study involves staff work, member feedback, and finalization of whatever option(s) that the committee has chosen.

Time Allocation for Study Activities

The table on below provides a listing of study activities and resources as well as dates for the activities and the approximate amount of committee meeting time each activity entailed.

Table 1: Study Activities and Resources

SJR-30 Study Activity	Source	Activity	Meeting Date	Committee Time
- Overview childhood trauma - Identify promising and evidence-based practices, including those elsewhere in the nation	Experts	- Presentations - Public comment - Committee Q&A with experts	Mar 19, 2012	3.00 hours
- Overview new data on childhood trauma in Montana - Review recent cases of neglect/abuse and how to improve the response by state, county, and tribal agencies - Report on UM-IERS native children's trauma demonstration projects	Experts	- Presentations - Public comment - Committee Q&A with experts	Mar 20, 2012	6.50 hours
Discuss legislative options with stakeholders	Staff Experts	- Briefing paper - Committee Q&A with stakeholders - Public comment - Committee discuss and select options	May 14, 2012	3.00 hours
Review draft legislation (if proposed)	Staff	- Draft legislation - Public comment - Committee discuss and refine options	June 25, 2012	3.00 hours
Finalize draft legislation (if proposed)	Staff Members	- Public comment - Committee discuss and finalize	Aug 20, 2012	2.00 hours
			Total	**17.50 hours**

Themes of Testimony Presented

Discussion of SJR 30 began with macro-level and descriptive testimony. This covered the currently understood science behind childhood trauma and models around the country for preventing and mitigating it. Testimony then progressed toward micro-level and prescriptive discussion. This included an overview of data on the incidence of childhood trauma in Montana, review of what has been happening in particularly hard-hit communities, and finally the work and suggestions of private and state-based caregivers in Montana.

Adverse Childhood Experiences

Childhood trauma is understood as a range of early experiences that include being abused or neglected, witnessing domestic violence, or growing up with substance abuse, mental illness, parental discord, or crime in the home.

Research shows that a range of negative events can, especially from birth to 3 years of age, stunt and alter neurological development. The "wiring" of an infant's or child's brain is physically affected in ways that "program" that young person's approach to relationships and to adaptive responses to life's circumstances for years to come. Chronic adversity, abuse, and neglect in the first 3 years can permanently alter brain functioning: what is learned at these ages cannot be "unlearned".

RESEARCH SHOWS THAT A RANGE OF NEGATIVE EVENTS CAN, ESPECIALLY FROM BIRTH TO 3 YEARS OF AGE, STUNT AND ALTER NEUROLOGICAL DEVELOPMENT.

One classification of the events and conditions associated with childhood trauma that has gained considerable credence in the last several years is that of "Adverse Childhood Experiences" or ACEs. Many people may have instinctively believed that a child who experiences a high number of traumatic events may struggle with more serious and long-lasting effects than a child who experiences fewer such events. However, longitudinal studies now empirically show this to be true. The ACE study is an ongoing collaboration between Kaiser Permanente's Health Appraisal Center and the U.S. Centers for Disease Control and Prevention.[1]

The initial breakthrough ACE studies conducted in the late 1990s included 17,337 adults and assessed eight adverse childhood experiences to determine how those experiences

[1] For more information on the ACE studies, refer to Filetti, Anda, Nordenberg, et al., "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults," *American Journal of Preventive Medicine*, Volume 14, Number 4, 1998.

affected a person later in life. The ACE study places adverse events into the categories shown in the table below.

Table 2: Types of Adverse Childhood Experiences

Category	Type of event
Abuse	Emotional abuse Physical abuse Sexual abuse
Neglect	Emotional Neglect Physical Neglect
Household Dysfunction	Witnessing domestic violence Alcohol or other substance abuse in the home Mentally ill or suicidal household members Parental marital discord Crime in the home

The ACE study showed that these experiences (especially when clustered) and the coping practices formed in response, correlate to many future medical conditions and a chain of public health concerns.

That is, such traumatic events are believed to relate to numerous health and social problems throughout an individual's lifespan. "These problems are a "Who's Who?" list of problems that [later] encompass the priorities of many agencies, public and private, that are working to prevent and treat a vast array of society's difficulties."[2] The problems include alcohol and drug abuse; behavior fostering unintended pregnancy and the transmission of HIV/AIDS; smoking that leads to pulmonary disease; depression; suicide; reduced worker performance; diabetes; hypertension; anxiety disorders; and more.

This understanding increasingly held throughout the country has caused many who work with children to view the subject in a more integrated way. As a result, they have taken steps to work across disciplines and across the continuum of treatment options in a more coherent manner.

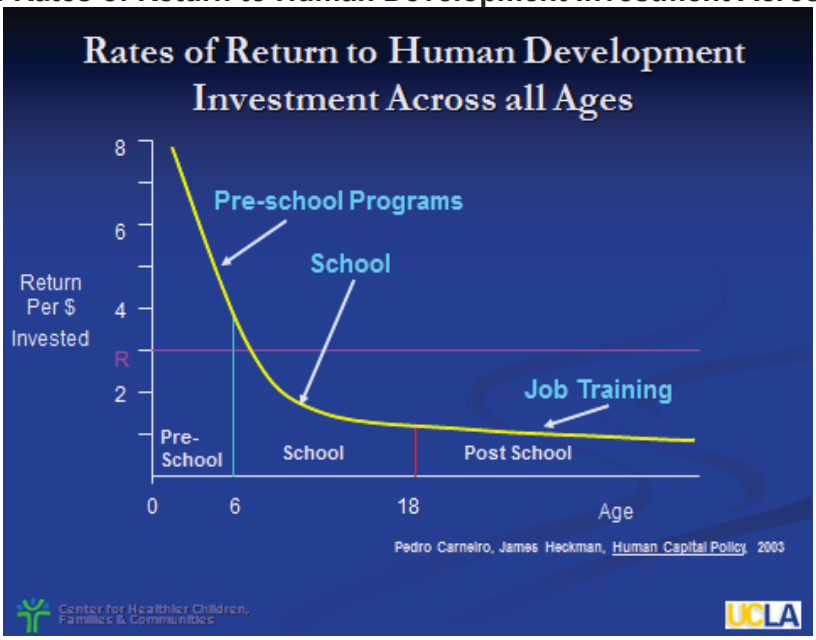
Best Practices Nationwide

Childhood trauma literature contains a recurrent theme of, "You can pay now, or pay more later." Indeed, those who work in the field say that of the rates of return on human development investment across all ages, the most pronounced benefits are in the preschool years. That is to say, many argue that early intervention can have a big impact

[2] Robert Anda, MD, MS, *The Health and Social Impact of Growing Up With Adverse Childhood Experiences; The Human and Economic Costs of the Status Quo*, 2009; p. 2.

both in terms of prevention and in avoiding exponentially higher treatment costs later in a person's life.

Figure 1: Rates of Return to Human Development Investment Across All Ages



Perhaps the dominant theme across all testimony presented was that of acting sooner rather than later and of focusing on prevention as much as, if not more than, treatment.

MANY ARGUE THAT EARLY INTERVENTION CAN HAVE A BIG IMPACT BOTH IN TERMS OF PREVENTION AND IN AVOIDING EXPONENTIALLY HIGHER TREATMENT COSTS LATER IN A PERSON'S LIFE.

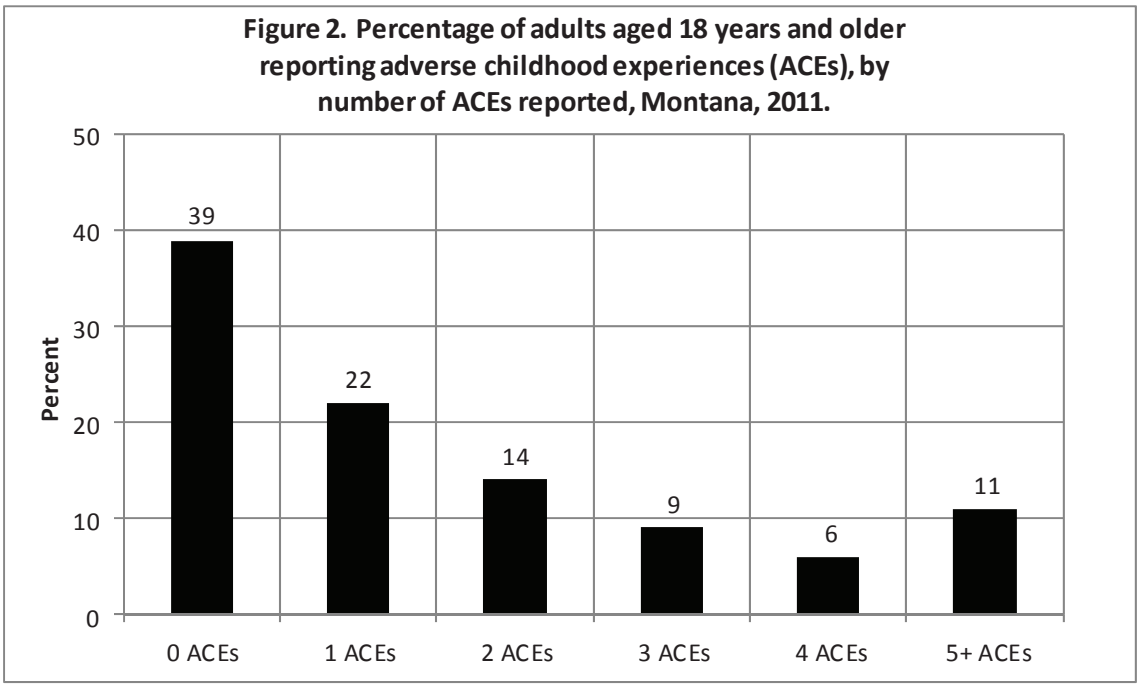
Presenters emphasized that the efforts addressing childhood trauma with the best evidence-based track records all focused on *early* intervention. The physical locus of these efforts was with the individual child, the family, and the community, with the most important outcome often being a nurturing stable relationship between an adult and a child. Another common denominator of these efforts was their integrated nature, comprising "wrap around" service from numerous providers and sectors. Ancillary to that was the repeated recommendation that these providers and sectors become more "trauma informed" in their care practices and interventions.

Childhood Trauma in Montana

The phenomenon of childhood trauma is no stranger to Montana. A statistical survey instrument known as the Behavioral Risk Factor Surveillance System (BRFSS) has been conducted in Montana in collaboration with the Centers for Disease Control since 1984. In 2012, the BRFSS included questions related to adverse childhood experiences for the

first time. The survey was completed by 5,855 Montanans—and the results can easily be termed startling: 26% of the respondents reported experiencing three or more ACEs during childhood. More than one in ten admitted to having experienced more than five ACEs.[3]

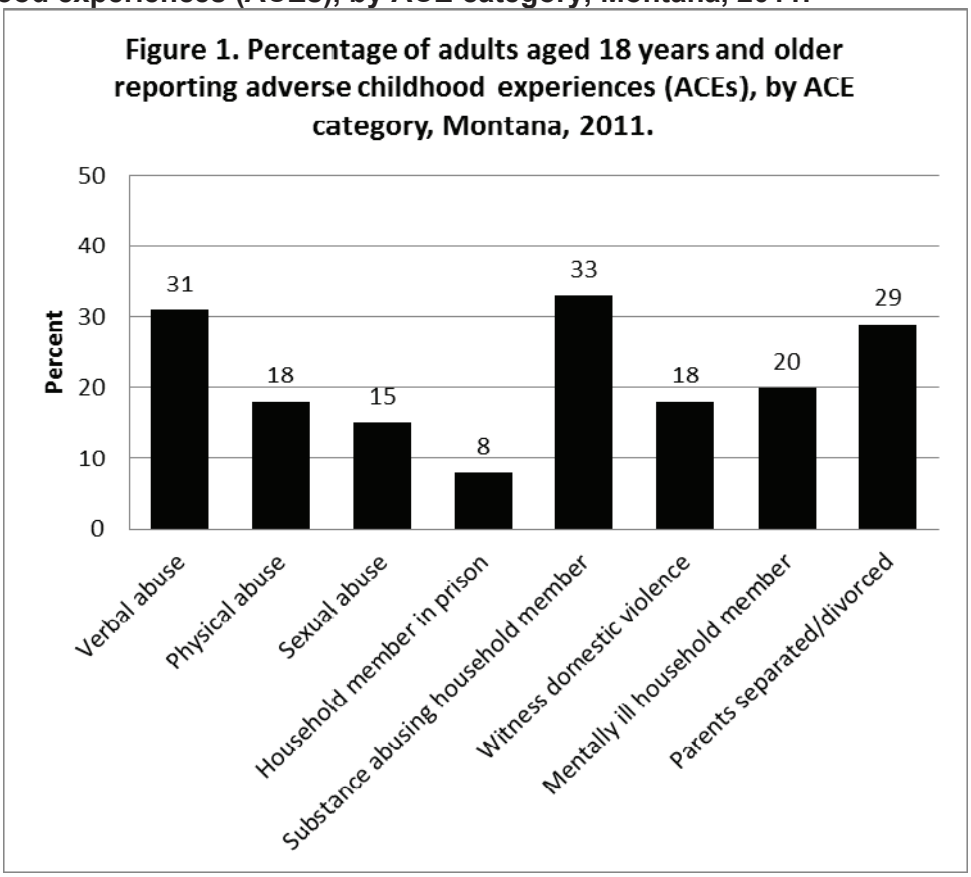
Figure 2: Percentage of adults aged 18 years and older reporting adverse childhood experiences (ACEs), by number of ACEs reported, Montana, 2011.



As striking as these numbers are, they might actually be underestimated because institutionalized adults were not included in the survey and respondents generally speaking might hesitate to report ACEs, especially the more egregious ones. In sum, a history of ACEs is not uncommon among adult Montanans. The most prevalent of adverse experiences reported were substance abuse in the household, verbal abuse, and parents who were either separated or divorced.[4]

[3] Todd S. Harwell, MPH, Adverse Childhood Experiences Reported by Adults: Montana 2011, Montana Department of Public Health and Human Services, 2012; p. 4.
[4] Todd S. Harwell, MPH, Adverse Childhood Experiences Reported by Adults: Montana 2011, Montana Department of Public Health and Human Services, 2012; p. 5.

Figure 3: Percentage of adults aged 18 years and older reporting adverse childhood experiences (ACEs), by ACE category, Montana, 2011.



Communities Facing Particular Challenges

The occurrence of ACEs is not distributed evenly throughout Montana's communities. As used here, "community" may be understood in the geographical sense (such as rural communities or reservations where key services might be lacking) or the demographic sense (socioeconomic groupings that might be comparatively vulnerable). The latter includes, for example, groupings on the lower end of income and educational attainment. In Montana, respondents with lower incomes were more likely to report 5 or more ACEs compared to respondents with higher incomes, and those without a high school education were more likely to report 5 or more ACEs (25%) compared to those with a high school education (9%).[5]

Low income and educational attainment intersect with acute family breakdown in Montana's Indian communities. Although data on ACEs in Montana does not yet elaborate upon conditions on reservations within the state, it is known that the incidence

[5] Todd S. Harwell, MPH, Adverse Childhood Experiences Reported by Adults: Montana 2011, Montana Department of Public Health and Human Services, 2012; p. 4.

of Post-Traumatic Stress Disorder among Indian youth is high. For those in the foster care system, the rate of PTSD can be higher than that of returning war veterans. A spate of suicides by Indian youth has ignited the concern of tribal and state leaders as well as among academics and mental health practitioners.

Most Indian children possess strong resilience and do not develop PTSD symptoms. However, some need additional care. When exposure to traumatic events occurs frequently or when traumatic stress is left unaddressed, children are susceptible to:

- Relationship problems
- Drug and alcohol abuse
- Violent behavior
- Suicide and depression
- Lower grades, increased school suspensions, and dropout
- Bullying and victimization

These were among the most prominent concerns reported to another interim committee of the Montana Legislature, the State-Tribal Relations Committee, in its joint meetings with tribal leadership at several reservations in the state during 2011-2012. As noted in SJR 30, the National Native Children's Trauma Center (NNCTC) has been working with the Institute for Educational Research to create trauma mitigation demonstration projects in schools serving the Blackfeet, Rocky Boy's, Fort Peck, Crow, Northern Cheyenne, and Flathead Reservations.

NNCTC staff offer training and consultation to community agencies, tribal programs, clinicians, school personnel, technicians, and families on the impacts and prevention of childhood traumatic stress.

The NNCTC asserts that in order for behavioral health interventions to be effective, they must be:

- Locally appropriate
- Culturally relevant
- Respectful of native wisdom such as those embodied in native therapeutic practices
- Integrated across agencies
- Based on community awareness of the impacts and prevalence of traumatic stress
- Practical for use by community leaders, clinicians, teachers, and family members.

Among the varied approaches emphasized in testimony were *Cognitive Behavioral Interventions for Trauma in Schools* and *Student Trauma and Resiliency*. As the latter suggests, these approaches emphasize the **strengths** of children and families in crisis. The recurrent theme in this part of the testimony was about finding ways to bolster their proven resilience and bring to bear a web of supports that do not supplant their own empowerment.

A second topic that accounted for considerable testimony was that of the death of a child in the Great Falls area in June 2011, and how the Child and Family Services Division (CFSD) of the DPHHS had handled prior reports of concern about possible abuse of this child. Division personnel had visited the child's home on multiple occasions but did not determine that she was in danger. The subsequent violent death of the child stirred concerns in the community and around the state about the performance of the child protection system. It also prompted Governor Schweitzer, in the summer of 2011, to task the Division to review aspects of its policies and procedures. Specifically, the Governor asked the Division to reappraise (1) its policy on mandatory reporters; (2) its use of Multidisciplinary Teams, Child Protection Teams, and team decisionmaking in cases; and (3) the centralized intake structure for Montana's Child Abuse Hotline.

Caregivers, Social Workers, and Child Protection Specialists

DPHHS representatives testified before the committee about steps the department has taken in the past year that pertain to:

- providing increased feedback to specified professionals and officials who are required by law to report suspected abuse or neglect;
- making changes in the department's centralized system of receiving reports of possible abuse or neglect from the public at large, including measures to improve responsiveness by integrating the function with field operations, refining the information-gathering process, and providing more staff members for the job;
- strengthening the use of Multidisciplinary Teams (MDTs) and Child Protection Teams (CPTs) and the use of team decisionmaking in handling cases; and
- improving coordination with other community partners, such as law enforcement, county attorneys, medical providers, schools, and public health agencies.

Additionally, DPHHS representatives testified that:

- CFSD has implemented a new safety assessment called the Family Functioning Assessment. This assessment is part of an evidence-based practice model that has shown improved safety outcomes for children in states where it has been in use for over a decade.
- CFSD is also partnering with the Children's Mental Health Bureau on implementing the use of high-fidelity wraparound services in CFSD cases.
- CFSD continues to advertise and fill all vacancies immediately. Additional temporary support positions have also been added to assist CPS workers in getting into the field and ensuring that thorough and timely investigations can take place even when the office is not "fully staffed".

THE CHILD AND FAMILY SERVICES DIVISION INVESTIGATES AN AVERAGE OF 8,500 REPORTS OF ABUSE AND NEGLECT EACH YEAR BUT OFTEN FINDS ITSELF UNDERSTAFFED.

Yet representatives of the organization *Montanans Against Child Abuse* testified in response that these steps are not enough. They asserted that the child protection system remains neither responsive nor accountable enough and that it tends to be defensive, secretive, and too far removed from the caregivers and communities it is obliged to work with.

For their part, DPHHS representatives acknowledged that the department still has more to do but also asked for the challenges it faces to be put into perspective and noted that the provision of more resources would greatly facilitate its work. The CFSD investigates an average of 8,500 reports of abuse and neglect each year but often finds itself understaffed.[6] DPHHS representatives noted that the CFSD has undertaken work with the University of Montana to look at ways to improve recruitment and retention in the future.

The Administrator of the CFSD contends that there are long hours, huge workloads, few resources, and little public praise that comes with the position of Child Protection Specialist—and that all this combined can take its toll.

The national experts, as well as private Montana-based caregivers, who testified before the committee highlighted this same point, describing the "secondary trauma" that caregivers often experience in their work with broken families and severely neglected or abused children. They emphasized that the challenges of the job are more multifaceted than professional ability alone can address and that the stress that child protection personnel, social workers, and other caregivers face needs to be addressed by their respective private and state agency employers.

[6] Cory Costello, Field Services Administrator, *Adverse Childhood Experiences and Child & Family Services*, presented before the Children, Families, Health, and Human Services Interim Committee, March 19, 2012; p. 2, slide 1.

Themes of Investigation Pursued

After testimony and discussion on the science of childhood trauma, its impact on segments of Montana's population, and the views of caregivers and a concerned public, the committee began to explore the following specific themes more deliberately.

Localized and interdisciplinary methods of work. Some members of the public and legislators on the committee asked about the possible benefits of having child protection response more localized (to county or community levels) and services more integrated across relevant disciplines and agencies. A worry expressed by *Montanans Against Child Abuse* was that, "Currently, centralized intake of referring children is not effective because severe cases of abuse are going unrecognized by a "stranger" on the end of a telephone line, and one that is unfamiliar with the child's location and living situation. There is no way for the central intake personnel to know the area in which the child is living."[7] The organization also claims that the initial intake operator has no ability to link the incoming call to prior referrals or reports of threats involving the same child and there is no instant integration with the work of other entities that may have knowledge of the child's welfare. It suggested countywide plans for serving children comparable to those used in emergency management and trauma systems.

Part of the response to these points, historically speaking, has been that report intake used to be localized but, as a result of perceived shortcomings, was purposefully centralized. One of those supposed weaknesses was that intake personnel who have previous experience with and perceptions of a child's family situation could themselves possibly possess a bias. That said, the department reported that since last summer it has reorganized central intake so that it is now part of field operations. It also has refined its information-gathering processes and hired more staff for intake.

In regard to interdisciplinary approaches, which are becoming more favored in view of the new science on adverse childhood experiences, department officials respond that such teamwork is found throughout the state's child protection system, particularly in its use of Multidisciplinary Teams (MDTs) and Child Protection Teams (CPTs), and its team decisionmaking processes. The department reports that there are 17 MDTs and 45 CPTs in Montana whose work is premised on collaboration with local stakeholders. CPTs typically consist of CFSD employees, school employees, law enforcement, mental health professionals, county attorneys, public health departments, youth courts, Head Start programs, drug and alcohol treatment providers, and medical doctors/pediatricians. Many teams have additional members based on local community makeup.

[7] Lois Leibrand and Lisa Stroh, correspondence to the Children, Families, Health, and Human Services Interim Committee, March 20, 2012; p. 7.

Mechanisms of oversight. Some members of the public and legislators on the committee also asked about the possible benefits of more oversight of the department with the aim of ensuring higher efficiency and accountability in its child and family service work. *Montanans Against Child Abuse* suggested a "multidisciplinary oversight board" that could hear complaints from the field and the public and that could act as another set of eyes and ears to determine if the department's response in given cases was adequate. The organization asserted that the purpose would not be to assess blame but rather to ensure more checks and balances, including better opportunity for the public voice to be heard.

Some members of the committee replied, however, that this was largely the purpose of several teams, committees, centers, boards, and councils that already exist in Montana. [See Appendix C]

The right to privacy versus the public's right to know. While some members of the public and legislators on the committee expressed concern about what they perceived to be unwarranted difficulty in obtaining information on cases in the CFSD, other members as well as some agency representative expressed equal concern about the protection of information.

Disclosure versus confidentiality under 41-3-205, MCA, involves balancing the right to know with the right to privacy guaranteed by the Montana Constitution:

> **Right to know.** Art. II, sec. 9, Mont. Const. holds that no person shall be deprived of the right to examine documents or to observe the deliberations of all public bodies or agencies of state government and its subdivisions, except cases in which the demand of individual privacy clearly exceeds the merits of public disclosure.
>
> **Right of privacy.** Art. II, sec. 10, Mont. Const. states that the right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.

A SURVEY CONDUCTED BY THE DEPARTMENT ITSELF FINDS THAT, "THE LARGEST ISSUE CITED BY REPORTERS IS THAT THEY DO NOT KNOW IF THEIR REPORT IS GOING TO BE INVESTIGATED AFTER THEY CALL."

Discussion of the subject before the committee focused on two groups of people. One was the set of professionals and officials delineated in 41-3-201, MCA, who have come to be known as "mandatory reporters", and the other set was anyone else who reports a concern about possible child neglect or abuse to the department. The fundamental question was: how much case-related information are these reporters entitled to?

Mandatory reporters have expressed dissatisfaction with the level of case information they are able to obtain on possible neglect or abuse that they have reported. A survey conducted by the department itself finds that, "The largest issue cited by reporters is that they do not know if their report is going to be investigated after they call."[8] A representative of the department testified that it has changed its policies to require that intake specialists now inform mandatory reporters who call with a concern "whether the report will be assigned for investigation". The representative also stated that the department is reviewing a bill draft request for the upcoming legislative session that would amend 41-3-201, MCA, to allow the department to share certain information with mandatory reporters. *Montanans Against Child Abuse* responded that this proposed statutory wording should be changed from permissive to obligatory.

Beyond the limited number of mandatory reporters is virtually anyone in the wider public who might call the Child Abuse Hotline with a concern and want to know what followup action has been or will be taken. There was considerable discussion within the committee as to the wisdom of making case records (which include case notes, correspondence, evaluations, videotapes, and interviews) more widely accessible.

Certification, licensure, and professionalization. Some study participants suggested that requiring a tiered system of licensure for caseworkers could help narrow the risk of lapses that result in children "disappearing" in the system. They noted that there are already a number of professions in Montana that practice under licensure or certification requirements for the very purpose of better ensuring public safety. Yet, as in the past, the department notes the challenges of attracting and retaining more highly certified or licensed social workers, especially in Montana's more rural and economically depressed areas. Department representatives did however express openness to higher qualification requirements if the state will pay for a stricter regimen of certification or licensure. The valid questions raised about capability then prompted discussion about the conditions that "front line responders" face when investigating situations involving abuse and neglect.

Conditions faced by caregivers. Among those testifying about the conditions faced by caregivers was a panel of current state social workers. They and others contended that there is an array of field and workplace conditions that can lead to the early "burn out" of otherwise professional and motivated social workers. These adverse conditions sometimes include high caseloads and workloads, insufficient training opportunity for specialized aspects of work, and what feels liked ill-founded and negative treatment from the media and public.

[8] Sarah Corbally, Administrator, Child and Family Services Division, Department of Public Health and Human Services, correspondence to the Children, Families, Health, and Human Services Interim Committee, March 20, 2012; p. 3.

Home and parent-based early interventions. At the request of committee members, a number of caregivers offered more detailed testimony on their work's accomplishments and needs. The focus was on home and parent-based interventions, especially with families having children 6 years old or younger, and how the Legislature might best support their work.

Among the policy options suggested were:

- First and foremost, further fund early intervention.
- Make childhood trauma "***the*** public health issue". Toward this end, continue supporting BRFSS surveillance and launch information awareness campaigns.
- Require more integration between stakeholders, both public and private, and help all their work become better "trauma-informed".
- Ensure that the child protection system (especially foster care) itself does not itself become a source of trauma for children. Toward this end, (1) provide better support for social workers, most especially in terms of their compensation, training, and workloads; (2) require accreditation of the department's child and family services, which would further professionalize the workforce and establish standards against which the department can be held more specifically accountable; and (3) change the practice of "vacancy savings" (meaning the difference between the cost of fully funding authorized positions for an entire fiscal year and the actual cost of those authorized positions during that period) by creating an exemption for direct care social workers.

Synopses of Resulting Committee Bill Drafts

The following bills were requested and approved by the Children, Families, Health, and Human Services Interim Committee as a result of the Senate Joint Resolution No. 30 Study on Childhood Trauma:

LC 289: Seek Accreditation of Child Protective Services. This bill requires the DPHHS to undertake the process of accreditation for its child and family services. The rationale for LC 289 is that accreditation by a national independent entity of the child and family services provided by the department could substantially improve the quality and accountability of these services. The presumed national independent entity would be the Council on Accreditation or COA. This bill appropriates $100,000 from the general fund to the DPHHS for the biennium beginning July, 1 2013. That funding would take the department through the first several steps of the COA's typical accreditation process. It would then fall to the next Legislature to provide the funding to that would see the process through to its conclusion.

LC 290: Create Office of Child and Family Ombudsman. This bill creates an independent Office of the Child and Family Ombudsman, describes the duties and powers of the office, and establishes a special revenue account for the receipt of grants, gifts, and bequests to the office. The broad purpose of LC 290 is to form an independent, impartial, and knowledgeable ombudsman that can work collaboratively with the DPHHS and together strengthen the department's child and family services. This bill appropriates $250,000 from the general fund to the Department of Justice for the biennium beginning July 1, 2013.

LC 308: Revise Confidentiality Laws. This bill broadens the list of persons to whom the DPHHS may release child abuse or neglect case records and requires the department to confirm upon request from any reporter of alleged child abuse or neglect whether or not the report of has been received and is being acted upon.

LC 309: Transfer Money to the Endowment for Children. This bill appropriates $10 million for the fiscal year beginning July 1, 2013, from the state general fund to the Endowment for Children. The Endowment provides a permanent source of funding for use by the Montana Children's Trust Fund Board to support a broad range of child abuse and neglect prevention programming, the main focus being parent education. The State Treasurer receives and deposits money in the Endowment, and the Board of Investments invests that money. Only interest generated by the Endowment is available for expenditure by the Montana Children's Trust Fund Board.

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dreq_4

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING AN INTERIM STUDY OF WAYS TO REDUCE CHILDHOOD HEALTH TRAUMA AND ITS LONG-TERM EFFECT ON CHILDREN.

WHEREAS, Montana's future depends in large part on the health, growth, and achievement of the state's children; and

WHEREAS, many physical, mental, and educational disabilities are preventable through prenatal care, parent education, family support, and other efforts to prevent or mitigate childhood trauma; and

WHEREAS, the human brain grows to 85% of its adult size by the time a child is 3 years of age, and this growth is profoundly shaped by the child's experiences during those years, particularly by the safety, stability, and nurturing provided by the child's primary care givers; and

WHEREAS, repeated childhood trauma, including chronic neglect, may cause significant physical changes to the brains and nervous systems of children that profoundly affect both their physical health and mental health as adults; and

WHEREAS, childhood traumatic stress can be either acute stress, such as community violence, serious accidents, the loss or sudden death of family members and friends, removal from the home, and physical or sexual assault, or it can be chronic stress, such as neglect, physical and emotional abuse, and domestic violence; and

WHEREAS, children who receive safe, stable, nurturing care generally reach appropriate developmental milestones, form secure attachments and satisfying social relationships, and develop effective coping skills and the resiliency to recover from traumatic events; and

WHEREAS, acute or chronic childhood trauma may prevent or reduce resiliency; and

WHEREAS, unaddressed childhood trauma may affect a child's experiences later in life and may lead to problems such as poor physical health, addiction, and mental illness; and

WHEREAS, nurses visit high-risk pregnant women in their homes as part of the Montana Initiative for the Abatement of Mortality in Infants, a program designed to provide the women with information they can use to

improve their own health and thus the health outcomes of their newborns; and

WHEREAS, the national Nurse-Family Partnership program for low-income, first-time parents and their children has been shown to reduce traumatic events, reduce child abuse and neglect, and reduce adolescent arrests by 60% and adjudications by 90% later in the child's life; and

WHEREAS, programs that teach biological and foster parents skills for responding to traumatized children have been shown to reverse some of the symptoms of trauma in young children and to improve resiliency; and

WHEREAS, the National Native Children's Trauma Center has been working with the Institute for Educational Research to create trauma mitigation demonstration projects in schools serving the Blackfeet, Rocky Boy's, Fort Peck, Crow, Northern Cheyenne, and Flathead Reservations and Missoula county public schools in low-income neighborhoods; and

WHEREAS, the projects have trained more than 1,000 Montana clinicians and educators to recognize and respond to symptoms of trauma and have helped schools develop short-term cognitive behavioral intervention programs that help to build long-term family and peer support for children, in an effort to increase resiliency and reduce the effects of trauma.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Legislative Council be requested to designate an appropriate interim committee, pursuant to section 5-5-217, MCA, to study promising and evidence-based practices for the prevention of childhood trauma and for mitigating its effects on children.

BE IT FURTHER RESOLVED, that the study efforts include:

(1) compiling data on the prevalence of acute and chronic childhood traumatic stress;

(2) evaluating the extent and impact of current efforts in Montana to prevent childhood trauma and to mitigate its effects after it occurs;

(3) identifying promising and evidence-based practices that are most appropriate for Montana communities, particularly rural communities;

(4) identifying the communities most in need of prevention and mitigation efforts related to childhood trauma as a way to prevent physical and mental health problems, substance abuse and addiction, school failure,

and involvement in the criminal justice system; and

(5) identifying any appropriate steps Montana policymakers may take to reduce childhood trauma in order to improve the mental health of Montanans.

BE IT FURTHER RESOLVED, that the study include representatives of the Department of Public Health and Human Services, the Office of Public Instruction, the mental health service area authorities and local advisory councils, groups involved in efforts to prevent childhood trauma, the Indian Health Service, Montana Indian tribes, and other interested parties as identified by the committee.

BE IT FURTHER RESOLVED, that all aspects of the study, including presentation and review requirements, be concluded prior to September 15, 2012.

BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions, comments, or recommendations of the appropriate committee, be reported to the 63rd Legislature.

- END -

SJ0030

I hereby certify that the within joint resolution,
SJ 0030, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day
of _____, 2011.

Speaker of the House

Signed this _____ day
of _____, 2011.

SENATE JOINT RESOLUTION NO. 30

INTRODUCED BY J. WINDY BOY, STEWART-PEREGOY, CAFERRO, AUGARE, VUCKOVICH, ROBERTS, ANKNEY, READ

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING AN INTERIM STUDY OF WAYS TO REDUCE CHILDHOOD HEALTH TRAUMA AND ITS LONG-TERM EFFECT ON CHILDREN.

SJR-30: Childhood Trauma
Draft Study Plan

Prepared by
Casey Barrs, Research Analyst
Legislative Services Division
October 20, 2011

INTRODUCTION

Senate Joint Resolution is an interim study of ways to reduce childhood health trauma and its long-term effect on children. It ranked #7 in the legislators' vote on interim studies.

Childhood trauma is understood as a range of early experiences including abuse, neglect, witnessing domestic violence, or growing up with substance abuse, mental illness, parental discord, or crime in the home, that correlate to numerous health and social problems throughout one's lifespan. "These problems are a "Who's Who?" list of problems that [later] encompass the priorities of many agencies, public and private, that are working to prevent and treat a vast array of society's difficulties". [Anda, 2009]

National experts, as well as many Montana practitioners who testified as proponents of SJR-30 during session, emphasize the importance of early intervention, both in terms of prevention and in avoiding exponentially higher treatment costs downstream. In childhood trauma literature there is a recurrent theme of, "You can pay now, or pay more later." Indeed, many proffer findings that of the rates of return to human development investment across all ages the most pronounced benefits are in the preschool years.

SENATE JOINT RESOLUTION 30
SJR-30 presents the following broad tasks:

- Compile data on the prevalence of childhood trauma in Montana;
- Identify the communities most in need of supportive interventions;
- Inventory and, to the extent possible, evaluate the impact of *existing* childhood trauma interventions in Montana;
- Identify promising and evidence-based practices, including those elsewhere in the nation, that are most appropriate for Montana communities; and
- Identify any appropriate steps that policymakers may take to reduce childhood trauma and hence its lifelong after affects in Montana.

CHILDHOOD TRAUMA STAKEHOLDERS AND RESOURCES

Sources of expertise on, as well as crucial participants in, a study of childhood trauma would include representatives of the Department of Public Health and Human Services, the Office of Public Instruction, the mental health service area authorities and local advisory councils, groups involved in efforts to prevent childhood trauma, the Indian Health Service, Montana Indian tribes, *and other* interested parties as identified by the committee. Additionally, the National Council of State Legislatures as well as numerous experts renown nationwide can provide the latest evidence-based research and intervention models for the committee's consideration.

OUTLINE OF STUDY ACTIVITIES

Childhood trauma is a vast topic encompassing many possible social issues and multiple time frames (potential phases of intervention) as well as varied promising practices and policy choices. *The outline below reflects the consensus of CFHHS committee members at its June 20th and September 19th meetings*.

1. **Overview childhood trauma.**
   Present the committee a baseline understanding of the phenomenon of childhood trauma and also provide synopses of evidence-based interventions around the country to prevent or treat health issues tied to adverse childhood experiences.

2. **Overview childhood trauma in Montana**.
   (a) Present fresh survey data on childhood trauma in Montana, offering some analysis of its prevalence and implications for Montana communities. "Community" may be understood in the geographical sense (such as rural communities or reservations where key services might be lacking) or the demographic sense (socio-economic groupings that might be comparatively vulnerable). (b) Review recent instances of child neglect and abuse in Montana and determine if any policy initiatives to improve the response by state, county, and tribal agencies would be suitable. (c) Examine a Montana-based intervention, the University of Montana's collaboration with the National Native Children's Trauma Center. The NNCTC is charged with providing national expertise on childhood trauma among American Indian/Alaska Native children, focusing particularly on work with school communities.

3. **Discuss legislative options.**
   Bearing in mind that childhood trauma and its results come to involve a wide range of private and state entities (and funds) in the fields of public health, education, corrections and beyond, provide those stakeholders an opportunity to discuss with committee members which legislative options seem to hold the best promise.

4. **Select and refine the option(s) chosen.**
   This final phase of the study involves staff work, member feedback, and finalization of whatever option (output) that the committee has chosen.

The table on the following page provides a listing of anticipated study activities and resources, as well as tentative dates for the activities and the amount of Committee meeting time each activity is anticipated to entail. ***The time estimates on page 5 are based on the assumption that the committee will adopt the proposal in the Draft Work Plan to devote 24% of its meeting time, or approximately 17.50 hours, to SJR-30.***

If the Committee chooses a different allocation of time, the activities would be revised accordingly.

Action Item: *Review, discuss, and adopt or revise the proposed study activities and allocation of Committee time.*

B-4

SJR-30 Study Activity	Source	Activity	Meeting Date	Committee Time
• Overview childhood trauma • Identify promising and evidence-based practices, including those elsewhere in the nation	• Experts	• Presentations • Public comment • Committee Q&A	Mar 19, 2012	• 3.00 hours
• Overview new data on childhood trauma in Montana • *Review recent cases of neglect/abuse and how to improve the response by state, county, and tribal agencies* • Report on UM-IERS native childrens' trauma demonstration projects	• Experts	• Presentations • Public comment • Committee Q&A	Mar 20, 2012	~~• 3.00 hours~~ • *6.50 hours*
• Discuss legislative options with stakeholders	• Staff • Experts	• Briefing paper • Member Q&A with stakeholders • Public comment • Committee discuss and select option	May 14, 2012	• 3.00 hours
Review draft legislation (if proposed)	• Staff	• Draft legislation • Public comment • Committee discuss and refine	June 25, 2012	• 3.00 hours
Finalize draft legislation (if proposed)	• Staff • Members	• Public comment • Committee discuss and finalize	Aug 20, 2012	• 2.00 hours
			Total	~~**17.50 14.0 hours**~~ ***17.50 hours***

Addressing Childhood Trauma in Montana: Localized Responses *and* Oversight Mechanisms

Casey Barrs, Legislative Research Analyst
Legislative Services Division
May 2012

Localized Responses

Child Protection Teams

- Established *41-3-108, MCA* in 1979.
- Mandatory: NO
- Number existing: 45
- Comprised of:
  (1) a social worker;
  (2) a member of a local law enforcement agency;
  (3) a representative of the medical profession;
  (4) a representative of a public school system;
  (5) a county attorney; and
  (6) if an Indian child or children are involved, someone, preferably an Indian person, knowledgeable about Indian culture and family matters
- Mandate:
  May assist in assessing the needs of, formulating and monitoring a treatment plan for, and coordinating services to the child and the child's family

County Interdisciplinary Child Information Teams ("Multidisciplinary Teams" or MDTs)

- Established *52-2-21, MCA* in 1991
- Mandatory: NO
- Number existing: 17
- Comprised of:
  (1) the youth court;
  (2) the county attorney;
  (3) the department of public health and human services;
  (4) the county superintendent of schools;
  (5) the sheriff;
  (6) the chief of any police force;
  (7) the superintendents of public school districts; and
  (8) the department of corrections
  With an option to expand team membership to include:
  physicians, psychologists, psychiatrists, nurses, and other providers of medical and mental health care;
  entities operating private elementary and secondary schools;
  attorneys; and
  a person or entity that has or may have a legitimate interest in one or more children that the team will serve;
- Mandate:
  Facilitate the exchange and sharing of information that one or more team members may be able to use in serving a child in the course of their professions and occupations, including but not limited to abused or neglected children, delinquent youth, and youth in need of intervention. *Also*, state

how the team will coordinate its efforts with interdisciplinary child protective teams as provided in 41-3-108 and youth placement committees as provided for in 41-5-121

Youth Placement Committees

- Established *41-5-121, MCA* in 1987
- Mandatory: YES
- Formed by the youth court in each judicial district and DPHHS
- Number existing: 22
- Comprised of not less than five members and must include persons who are knowledgeable about the youth, treatment and placement options, and other resources appropriate to address the needs of the youth:
  - (1) a juvenile parole officer employed by the department;
  - (2) a representative of the department of public health and human services;
  - (3) the chief juvenile probation officer or the chief juvenile probation officer's designee. The officer or the officer's designee is the presiding officer of the committee;
  - (4) a mental health professional; and
  - (5) if an Indian youth is involved, a person, preferably an Indian, knowledgeable about Indian culture and Indian family matters

  With an option to expand committee membership to include:
  - a representative of a school district located within the boundaries of the judicial district who has knowledge of and experience with youth;
  - the youth's parent or guardian;
  - a youth services provider; and
  - the youth's juvenile probation officer
- Mandate:

  Recommend an appropriate placement of a youth committed to the youth court or to DPHHS
  Recommend available community services or alternative placements

Accredited Child Advocacy Centers

- National model established 1985 in Huntsville, Alabama.
- First center in Montana (Butte) established 2007
- Mandatory: NO
- Number existing: 5 NCA accredited centers; 5 centers working towards accreditation
- A CAC is the home of a multidisciplinary team comprised of:

  county prosecutors, law enforcement, medical, child protection and mental health and victim advocacy
- Mandate:
  - (1) Provide evidence based trauma focused treatment to child victims served at the center (specifically, Trauma Focused Cognitive Behavioral Therapy)
  - (2) use improved evidence collection through forensic interview and forensic medical exam techniques

<u>Note</u>: Prior to 2002, DPHHS ran a localized response model of intake

- Calls routed to local/county level offices
- System reverted to centralized intake due to concerns of:
  - (1) Uneven resources and inconsistent response across the many offices
  - (2) Local intake by offices familiar with the communities or even families involved were potentially subject to bias

Oversight Mechanisms
Board of Social Work Examiners and Professional Counselors • Established *2-15-1744* and *37-22-part 1-4, MCA* in 1983. • Appointed by Governor and public • Comprised of: Seven individuals: Six appointed by Governor with consent of Senate, one appointed from and representing the general public • Nature and scope of authority: (1) ensure the ethical, qualified, and professional practice of social work; (2) set standards for those who seek to engage in the practice of social work *as licensed social workers* {NOTE} (3) establish a screening panel to determine whether there is reasonable cause to believe that a licensee has violated a particular statute, rule, or standard justifying disciplinary proceedings; deny a license and, upon a finding of unprofessional conduct by an applicant or license holder
State Advisory Council • Established in _____ • Appointed by _____ • Comprised of: (includes, but is not limited to:) chairperson of the local advisory committees, district court judge, legislator, former legislator/nurse, educator, retired chief juvenile probation officer, public defender (representing children), foster/adoptive parent, therapist, community members, state director of CASA, a former county attorney, executive director of the Montana Chapter of the National Association of Social Workers, and a member of the Native American Advisory Council • Nature and scope of authority: (1) Serves as the primary vehicle for on-going coordination and collaboration across the entire system (2) Meets quarterly, receives information about CFSD activities, and provides feedback as to those activities (3) Includes a case review process whereby an actual case is presented to the Council. Addresses how Montana statute and CFSD policies/procedures/ best practice were applied to the case. The Council provides feedback and recommendations for possible changes in statute, policy, procedure, and practice (4) The Council acts in effect as Montana's Citizen Review Panel (CRP) which meets the requirement of the Child Abuse Prevention and Treatment Act.
Regional Advisory Councils • Established: (inaugural dates of each varied) • Comprised of: Six, one in each of four regions and two in the Eastern region • Nature and scope of authority: (1) Meet quarterly (2) Advise and make recommendations to the regional managers and to the State Advisory Council about CFSD policy, procedures, need for services, gaps in services, and other issues. (3) Conduct community stakeholder meetings when needed to obtain information about community needs

Best Beginnings Advisory Council

- Established in 2011
- Comprised of:
  interested constituency groups, governmental agencies, the public at large, child care providers, state and local government, and tribal communities
- Nature and scope of authority:
  Collaborating entity for the early childhood system. The Early Childhood Services Bureau within DPHHS serves as the home for the Advisory Council.

Family Support Services Advisory Council

- Established in 2011
- Appointed by Governor
- Comprised of:
  25~ mbrs: six parents of children with disabilities, six providers of services, a legislative representative who provides liaison with the Montana State Legislature, and several state and local agencies
- Nature and scope of authority:
  (4) Meet quarterly
  (5) advise and assist the Developmental Disabilities Program (DDP) of the DPHHS in the implementation of Part C services statewide
  (6) early intervention services for infants and toddlers with disabilities and their families