SANDY HOOK ADVISORY COMMISSION
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Legislative Office Building
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AGENDA

III. Addressing Trauma

ROBERT PYNOOS, M.D. & M.P.H.; Co-Director, National Child Traumatic Stress Network

STEVE MARANS, M.S.W., Ph.D.; Harris Professor of Child Psychology/Professor of Psychiatry/Director, National Center for Child Exposed to Violence/Childhood Violent Trauma Center - Yale University

(Hearing recommences after lunch)

CHAIRMAN JACKSON: Why don't we reconvene for the afternoon session. We have a panel discussion including Dr. Robert Pynoos, Steven Marans, Julian Ford, and Robert Franks. Dr. Pynoos, the floor is yours.

DR. ROBERT PYNOOS: Thank you. I'm deeply honored to be here today to contribute to the important work of this Commission. Along with John Fairbank, it is my privilege to co-direct the UCLA Duke University National Center for Child Traumatic Stress which, for over a decade, has led -- has helped lead and coordinate the National Child Traumatic Stress Network, which is a federally funded initiative administered by the U.S. Department of Health and Human Services through SAMHSA, the Substance Abuse and Mental Health Services Administration. I speak not only today from my perspective of 30 years, also as the Director of the UCLA Trauma Psychiatry Program, but also as a dedicated clinician, parent and citizen who wants our society to provide the healthiest environment for our children, families, schools and communities.

During my presentation, I will first summarize what we've learned about children and families exposed to violence, trauma and loss and advances that have been made in approving science, improving services and intervention.

Second, I will summarize some of the many lessons we've learned over the past 30 years about planning and implementing recovery programs for children, families, school personnel and school committees after catastrophic school violence. And third, I'd like to provide some information about the National Child Traumatic Stress Initiative. I hope to provide a framework for the in-depth discussion, of key issues and recommendations from the three speakers to my right; all of whom, along with their distinguished individual work, have been critical collaborators in the National Child Traumatic Stress Network, and one of your Commission members, Dr. Alice Forrester, also directs one of our centers.

As the Commission moves more of its attention to mental health, the field of child traumatic stress, I think, has important contributions to make this discussion and set of recommendations. These contributions not only include the understanding of the psychological and health consequences of exposure to catastrophic violence, but it also includes an understanding that prevention, early identification, screening, and high quality care must be a major part of any effort to break cycles of violence that emanate from interpersonal and community violence, family violence and political violence coming, I think, full circle to some of the issues the Commission first addressed.

You know, the whole world responded in a profound manner to what occurred at Sandy Hook Elementary School, and I'd like to offer you that the profundity of the response stems not only from the unimaginable catastrophic violent deaths of school staff and young children, but from the deeply universal investment that all children, parents and society have in the expectation of what we call a protective shield in the lives of young children.

Young children look to the protection of their parents against all kinds of dangers and harm, be it from illness, accident or intentional violence. Parents expect to be able to ensure that protective shield even if they recognize there's no guarantee. For parents, a failure in their protective shield profoundly disturbs expectations, generates vigilance about danger, promotes ongoing preoccupations with prevention, safety and protection. It can be the same for children of all ages. The enrollment of one's children in school, camp or other activities outside of parental supervision represents a transfer of this responsibility into the hands of others; one that's not easy for parents and requires a balance of trust and concern.

The whole staff of elementary schools feels the enormous responsibility of this transfer of the protective shield. We know from previous catastrophic violence that elementary schools and school administrators, teachers and

all the school staff experience a deep injury to their professional identity similar to that experienced by parents when their protective shield fails. We also know it takes a long time, much longer than sometimes appreciated, to restore this sense of a protective shield. In fact, I'd suggest the work of this Governor's Advisory Commission is a critical societal response in rebuilding trust in this protective shield.

There is a growing avid science behind how our brains mature to take on the challenges of protecting ourselves against danger. Exposure to violence can have, for example, a profound effect on the startle response of children and adults. The brains of young children is designed to startle to loud noises and suddening, threatening motions to make sure that children turn from the danger and run towards others who can protect them. It's actually not until nearly eight years of age when the brain starts to develop pathways to inhabit that startle. That's eight long years, not really until 12 until it's consolidated. Now, one can consider turning, as a result, toward the danger to try to do something to protect yourself by intervening. And we have preliminary evidence that the brains of children exposed to trauma may actually be delayed in acquiring this control over the startle.

In the case of Sandy Hook, the noise of assault

weapon firings directly and through the intercom was a prominent feature of the experience with this potential impact on the control of the startle response. Repeated startle response is, I will tell you, are in themselves debilitating. They affect behavior, learning and even a child's self-image.

In the aftermath of school violence, children, parents and school personnel and whole communities live in a world of often unavoidable reminders of the traumatic experiences and the depth of loss. Trauma reminders come in many forms; a sound, like I mentioned before, a face, a situation, other persons that you were with at the time, be it teachers of the children in the classrooms, be it parents in their reunion with their children. These are reminders within the family and within the school, and of -- they're reminded by something on TV, in the movies or in the Internet of another horrific event has just happened in Boston.

It's hard enough for adults to know how to manage their reaction to reminders to find a way to tell themselves the difference between what happened before and what's happening now. Children are at even more of a disadvantage and often must count on adults to help them with this important task in managing their daily lives after catastrophic violence. When reminded, heart rates can zoom

up, and a helping hand of a parent or teacher may be critical to calming down. These reminders put the child again and again on alert, not only during the day, but in their pattern of sleep so they do not wake up rested. And it's not hard to imagine that restless sleep often accompanied by nightmares results in a child being irritable during the day, making it hard to concentrate and learn.

In adolescence, we know these reactions to reminders can take the form of aggressive and reckless behavior. If you now couple changes in the brain with the pernicious and pervasive effects of trauma reminders, you have the ingredients for a very challenging world for the developing child. Bouts of fear can make them into a different child. Parents are telling -- in Newtown will say that about their children today. It will make the school day much more difficult, and it needs to be recognized that it challenges parents in ways never anticipated; to have an eight-year-old have a bout of fear when you're in a mall and acting like a -- what seems like a three-year-old, you can't -- you aren't talking to a three-year-old. It's very challenging to parents to know how to manage and be at most help to their children in those circumstances.

Children, especially young children, often experience trauma in situations when in the company of family members and other caregivers. We have come to

recognize the powerful and long-term impact of children who witness violence to their parents and other caregivers.

In the new American Psychiatric Association DSM V, diagnosis of PTSD actually gives a special place to this form of trauma in the lives of young children. In the aftermath, both child and adult have their own unique set of trauma reactions, each responding often to different reminders that complicates their lives together.

Consider what it's like for a child and mother after the mother is raped in the presence of a child. That happens, let me tell you, thousands of times a year in the United States. The child has a nightmare in the middle of the night, runs in to seek comfort from the mother who awakens suddenly and, for a moment, reacts with a recurrence of terror of the rape. She then tries to comfort her child while her heart rate is just racing and then feels awful in not being able to be the calming mother she has always known herself to be.

I bring this up, this example up, because in addition to the individual assistance with their own private traumatic experiences, mother and child need the help to recover together. This mutual interdependence in regard to recovery is similarly important not only to families, but I will tell you to teachers and students, to classrooms, and of the school community.

Let me add one more dimension, how the minds of even young children grapple with the issues of the social contract in the aftermath of violence. A two-and-a-half year old child witnesses for the first time her mother beaten by her father. When the adults -- what the adults would like to believe is that she's too young for it to have had an effect. The next morning, this young child not only refuses to go to preschool and wants to stay with their mother whose face is all bruised, but also declares though her mother's absolute surprise daddy hit mommy. Mommy call police. It's a two-and-a-half year old. These are real events. I give this example, indeed, because it's stated in the Los Angeles Police Department's motto to protect and serve. The role of law enforcement and society's obligation operates in even the mind of the youngest children.

One of your next speakers, Dr. Marans, can speak volumes about the successful partnership in Connecticut and across the United States in child trauma and mental health programs and law enforcement in meeting the mental health needs of violent-exposed young children, and I would say for the child's sake and for society's sake, in the years to come, to restore constructive youth of the social contract.

All of these traumatic reactions to violent exposure can coalesce into reactions that we call Posttraumatic Stress Disorder. Over the past several

decades, we've learned that children and adolescents can manifest the full range of posttraumatic stress reactions; that these reactions can be validly and reliably measured and that specialized trauma-focused interventions can bring about clinically significant improvement in symptoms, behavior and daily functioning, including school behavior and performance.

DSM V now recognizes that even children six years and under can suffer from PTSD, although their presentation has unique developmental features in these very young children. In addition, studies of the mental health effects on disaster, war, terrorism and community violence indicate that PTSD is often associated with separation anxiety in young children, even older children, and that older children often suffer from depressive reactions as well.

There are very successful treatments for these young children, especially in designed parent/child interactive forms of psychotherapy, and for the older children in the kinds of interventions that Dr. Marans is going to be speaking of as well.

While much attention is given to PTSD and depression -- often that comes at the end of the discussion -- loss of life, especially under horrendous circumstance adds a whole different dimension. I spent much of my early career learning how to assist children, parents,

families and school personnel after homicide, including from violent assaults at schools. We saw over 200 children who had seen their parents murdered. We had worked at many homicides in school playgrounds and other places that I'll mention. We know a lot more now about the dual challenge of addressing the cruel and intentional manner of death and still trying to grieve the loss and how exceedingly difficult it is to address both.

It's helpful to keep in mind the unique and shared features of mourning and grief. Mourning is something public, shared and often prescribed by culture, religion, community and family practices that extends over time. Mourning serves the wider community in addition to those who are more directly grieving. Grief reaches out beyond the perimeter of the violent circumstance, and is most intensely and privately experienced based on one's closeness to the person or persons who died. This is true for children as well as adults. However, the timing of mourning rituals, what you do publicly is often quite at odds to the private course of grief after traumatic deaths. So, it's really a mismatch, often over time, of what happens under those circumstances. Something that the Newtown community will be facing.

Over the years, we've learned that even young children who lost a parent, a sibling, close friend or

teacher grieve. And just on the same side, just like we've learned to be cautious over overscribing PTSD to a large community, we have the similar caution in overscribing the need to intervene for a school or school district with grief counseling. Most children and adults may be feeling the sense of mourning shared by the community but not suffer from the private pain of grief that accompanies closeness.

Furthermore, from studies around the world, we've learned that violent deaths result in much higher rates for parents, for children, for school personnel of persistent and complex difficulties in adapting to the loss that goes on for years. And over the past decade, however, we've developed advances in both how to measure and how to intervene with children, parents and school personnel after such horrific deaths.

I know my colleague, Marleen Wong, provided you with a diagram illustrating the various -- varying course of psychological reactions over time that can occur from pre-event to the first days post-event through the next several years, but I'd like to add some additional points to her presentation.

Every disaster, catastrophic school violence, has a distinctive signature in terms of what we call a dose of exposure; that is, within an affected school community, there are differences in life threat, in being injured,

witnesses of injury and death to others, worrying about a significant other, injury to and loss of friends and family members.

Let me give an illustration from one of the earlier studies we did. I think Dr. Wong may have mentioned this, but in 1984, we worked in a school in Los Angeles where a sniper, using a semiautomatic weapon, shot from an apartment across the street onto a playground of children as they were leaving school. And we had children that were on the playground, in the school thrown into closets, who were leaving the playground -- leaving school from a different exit and not exposed, and children in this all-year school that were not in school that day, and we could follow their course.

I just want to use this as an illustration. You can see that there was a modern to high level of posttraumatic stress reactions in the first month among all of the school children; however, the most highly exposed children had the most severe reactions with a more chronic course that persisted into the second year and probably beyond. And what characterized them was not only intrusive images, but severe sleep disturbances and interference in learning in very significant ways that didn't continue among the other groups.

The in-school group, not so different than some of

the groups at Newtown Elementary School that were further back in the school, were not only sheltered in their classrooms, but they were put into closets by their teachers for protection, had the highest level of reaction -- had the next highest level of reaction initially, as you can see, but these children showed a much greater recovery over the first year. It started to really look very different than that first group that were the most highly exposed.

These and similar findings indicate that school-based mental health recovery programs need to be stratified in terms of expectations, types and duration of selective interventions, (inaudible), and learning the timing of additional educational support. So, as the exposed group, the highest exposed group, had the most interference with learning start to recover, they often need additional educational supports at a time that it can make use of them. So, the timing of those are very important in the recovery program of a school.

And then I also -- whereas the most exposed group witnessed death and injury had intrusive images of what they saw and what they witnessed to their -- to other children and injury and death, the wider school community, this whole group, shared a common fear of reoccurrence that was -- ran across exposure groups and extended for quite a period of time, but those are two very different objectives in trying

to be able to help the school recover.

And you can see that that top group is the group you're going to hear from, I think, Steve Marans and others, and Allie can speak to -- requires the kind of specialized care that our centers are really very, very good at. And you always have to ensure that level of care, which I will tell you, in schools after schools, doesn't always happen. There's more a general school response, but not a stratified approach that allows you to choose the right intervention for the right level of effect. And then you add grief to that because this shows you the experience of life threat and witnessing of injury and death, the grief affected the siblings very differently, best friends, siblings, relatives, cousins, and that had a very different pattern. That had to do with how close you were, and that needed to be well worked out and addressed as well. But we did know, and what we know from many studies is that when you have trauma and grief, that the trauma makes the grief and the recovery more difficult. And if you're trying with the resources that requires, as all of us know personally, to handle the grief, even as a young child, it makes the recovery from trauma more difficult. So, when you're faced with both, it's a very difficult challenge and requires real mental health resources and support through the school.

In disaster studies, we found the same type of

dose of exposure, varying course of recovery, impact of loss on children, parents and school personnel alike. So, the school personnel has the same kind of stratification that's needed. But we also have to recognize, and we know this, that the impact on the parents or the caregivers or school personnel has a direct relationship as well to the recovery of children. So, how well are your teachers doing in their recovery, who well are your parents doing has an effect on how well the child is recovering. And we know that children are actually really good observers about how their school personnel are doing, as much as they are observers sometimes of how their parent is doing.

Moreover, I'd like to say that we look to support professional groups that may be especially affected and critical of the recovery environment. The addition of first responders, clearly in this situation, deserve much attention. It's suggested that of such horrific loss of life, the pediatricians are one such group. They are a key part of early family life, and are likely deeply affected by the density and the intensity of loss of life within their own practices, within their own community of pediatricians. And they're a critical group, not -- so, they not only need help with themselves, but they're a critical group at the frontline to identify children and families under stress and who need additional support. And I'm sure that Dr. Franks,

who a leader in working with pediatricians, will, at least in part, address how to train and support them in this community.

Let me make a few key points to explicate some of the ones made by Dr. Wong a number of weeks ago. One, the school is a critical recovery environment where children spend much of their day. It's an academic environment, but after an event like this, it's where they're spending six to eight hours a day. It is a major recovery environment for the child, just as the family is under other circumstances. And that we know that -- what Dr. Wong had said that the studies are now unified and show that violence and traumas have a deleterious effect on school behavior and academic performance and that PTSD and depression produce even more profound effects. It means that behavioral and academic recovery go hand in hand. One can't look at one side or the other side without making a unified effort in the timing of how to support both.

It also means preparedness. If you look at this, it means preparedness and recovery plans need to include short and long-term programs. That means from day one, even prior. From day one, you're already planning for two or three years down the road. You can see that in this pattern. You need to be thinking about that, knowing who and how you're going to plan for those long-term

consequences, not only thinking that everybody runs to a school in a crisis circumstance that you're doing immediate work, you need to be thinking long term and you need to make systematic plans for that and that they're stratified and sustained interventions.

I will tell you that in an elementary school, it's the slow recovery of that sense of a protective shield means that elementary school recovery programs need to be designed to be multi-year. They can't be a single year as sometimes happens in high schools. They need to be multi-tea year, and they need critically to be designed to provide special assistance both psychologically and academically in the transition to intermediate school; one of the most important transitions in school life.

And if you just focus on the six-month period -- if you look at that middle dots, I want you just to look at that. You can see the real challenge that emerges in a recovery environment is to establish a mutual understanding and tolerance for very different courses of recovery. The same is, again, true for school personnel and for parents. They have challenges because teachers are in different places. School staff are in different places. Parents are in different places. And I'm sure the Newtown community is already experiencing some of the tensions that are so easily generated by the varying courses of recovery within a

community.

So, setting up tolerances isn't just compassion. It means people most affected understanding, and others, sort of, are ready to go ahead. And those who are ready to go ahead understanding that others have really been more seriously affected, and it's going to take them much longer to set up that kind of tolerant school, community, wider community response actually takes effort on everybody's part.

We also know that injured children and school personnel have special challenges; that reintegrating peers who have been injured requires a concerted programmatic attention and leadership from within the school. I would say that's true as well for school personnel. It has to be a very dedicated effort to reintegrating injured children back into their peer community.

We've also learned over and again that there needs to be a dedicated recovery program for school personnel that's independent of the efforts on behalf of the children. Independent means you can't be doing just workman's comp., which doesn't provide confidentiality in the same way. It has to be independent. They know they can go and get help for their own recovery at their own pace, and it's not the same person seeing the children. It's somebody who is dedicated to them because it's very hard for them to speak

on their own confidentially when you're seeing the children as well. So, that's a very dedicated line of support.

I was concerned after Newton -- I know there are a lot of effort to provide services for teachers, but you know that your state declared that all the children in that school were eligible for victim/witness, but they didn't make the teachers eligible or the school staff. I found that -- having worked with victim/witness that comes to the school the first day and registers everybody, that that was almost at first telling them that they weren't victims of the crime. Although you've made major efforts to actually provide services for teachers and resources, they were victims of a crime, no matter where they were and whatever efforts they made, the school staff, to protect their children, and they need their own dedicated program. And that's all the staff members, not just the teachers, the bus drivers, the nurses, the staff -- imagine the demands on the secretaries at the front desk and the protection that they provide every day, people coming into the school. They buzz them into school. So, they need their own assistance. They're dealing with reminders in ways that all of us in our daily lives really can't almost comprehend.

We've also learned to institute far ahead of time special systems of support to those most affected at the anniversaries, including efforts in high schools where we've

dealt with community -- school violence that, actually, in terms of suicide and substance abuse prevention at the time of the anniversary, organized whole high schools to support -- screen for and support every child with a suicidal ideation in that high school, dependent on the school violence that they experienced. And independent of that, to stabilize that school, that high school at that point, and that's a very systematic effort.

We've also learned to be very systematic about the range of reminders in that -- for schools to keep an inventory, to have a vocabulary, to keep building that, and build-up the skills individually and in groups of children, of school personnel, among parents and children, to help them manage them as a recovery -- as a key to the recovery over time. We have studies about this. We worked in Beslan, so we know from there how reminders affected that school community so effected by a horrific terrorist attack.

And in a relatively small community like Newtown, a more district-wide approach is needed to identify and support youth and school personnel who have a personal relationship to children and staff who died. We know from speaking -- we have teachers that have taught at the elementary school and have gone on to intermediate school, and they're very -- had friends, I mean, they knew. They have children who were coaches, babysitters, other things.

So, it's -- in a small town, you need to be able to reach out much more widely into the school that was seniorly effected.

And further, we have consistently found that it's a mistake to overlook that there are many other children and youth who have experienced other forms of trauma and loss that should not be overlooked and deserve renewed attention indicated by proper screening. So, you can't just go in and focus on the trauma. There are lots of children with trauma and loss issues. There are other problems. They feel kind of left out and not attended to. You need to renew your attention. You can actually do some really good work with them, and you can do that systematically afterwards. And then you have to set up an approach, as Newtown is planning to do, to see the emerging mental health problems and to make sure that you identify and provide services. That's the way to really stabilize a school community in a school district like Newtown at this point.

Let me just change a little to the studies of communities after major disasters have also indicated that the combinations after major disasters, outside external event, that what happens, the combination of adult traumatic stress and subsequent adversities like unemployment that can occur, generates an increase in family violence and substance abuse.

So that violence in the families, as you're going to hear a little later, remains the primary source of traumatic experiences for young children and with neglect, abuse and witnessing domestic violence often occurring together.

And you're going to hear from Dr. Ford, I think, about how that and additional victimizations, sexual abuse, community violence, other trauma and loss actually generates kind of a caravan of risks so that by the time you get to adolescence, you have serious mental health and health risk and adverse outcomes for adolescent functioning in the transition to young adulthood, and I'd say to the overall mission of this Commission, to good citizenship.

I know that Marleen Wong referenced Dean Kilpatrick and his colleagues seminal work relating exposure to violence and chronic PTSD among adolescents, the high risk behaviors, including substance abuse, academic failure and gang activity. I think she showed you a slide about that.

Through two other findings, I'd like to illustrate the powerful role that exposure to violence and traumatic stress plays more generally in the field of child mental health.

This, in the next slide, are from the National Comorbidity Survey Replication Study. That's a

representative sample of the U.S. Population that looked at mental health disorders with face-to-face interviews, really well done, and Dr. Putnam -- Drs. Putnam, Harris and Putnam use this information to examine the effects of physical abuse, sexual abuse and poverty on mental health outcomes.

Now, in a normal -- as they explained, in a normal odds ratio, which is the chance of having something happen to you, having a condition or not having it, which would not be one, it's an equal risk. If you reach an area that you have 30 percent more chance at 1.3, that's considered in America a public health issue. So, if you can -- if high blood pressure -- by reducing blood pressure can reduce the risks of a stoke at the level of 1.3 down to one, we make a whole public health effort in the United States.

I want you to look at these. These are attention deficit, alcohol dependence, conduct disorder, drug addiction, explosive personality, major depression and PTSD. They're up at the five levels, four and five levels. That's like an astounding public health issue when you start thinking about what exposure to physical and sexual abuse means in mental health emanating from traumatic stress.

It's the same true for boys, but I also want to move on to a second study, and which is -- let's look at a specific disorder. That's talking about traumatic stress and its outcome. Let's look at its effect on a bipolar

illness, very common disorder in the United states. It has one of the highest rates of mortality of any psychiatric disorder. But if you -- this is from an international study done to look for the first time some years ago about the effects of the frequency of child and physical/sexual abuse on adults, retrospective study, on their rates of suicide attempts. It raised the risk of suicide attempts in people with well diagnosed bipolar illness by three times from like 25 percent to 60 or 70 percent. That's an outstanding -- it's alarming. And yet that doesn't mean that this is paid attention to in the care of other people with major mental health disorders, but it indicates that it is.

So that, you know, we know from our -- from our work with more than 14,000 children, the data on them that we've seen through our National Network that indicates that suicide behavior in adolescence is often associated the cumulation of traumatic exposures in the lives of children and youth.

So, that means to this Commission that no discussion of suicide prevention including, I would say, in this case, murder/suicide -- I've studied a lot murder/suicide -- can take place without consideration of traumatic stress.

And as this Commission takes up two critical -- the critical questions regarding mental health care of our

youth in the country. I'd make two overriding recommendations to you. First, that on its own, child traumatic stress is serious and needs dedicated attention of all our child-servicing systems including early screening for the types of exposures that make them -- put them at risk.

Second, that child traumatic stress is a cross-cutting issue in all of health and mental health; and therefore, must be a part of the policy discussion in regard to all integrated health and mental health care. And you're going to hear more about the Attorney General's national task force on children exposed to violence and their recommendations, Dr. Marans is a member, but we would, obviously, endorse those as well.

I just want to tell you for the last couple of minutes, just spend three or four minutes on the National Child Traumatic Stress Network. This is a curious legislation. It was a legislation passed in 2000. It got passed in 2000, but it got put into place the day of September 11th. It was being reviewed that day. It is named after Donald J. Cohen, who was a -- the Chair/Head of the Yale Child Study Center. Imagine, it's the only mental health program ever named after a child psychiatrist, and we feel honored that it's -- so it's here in the state and it's at Yale and it's part of his legacy that we all share. But

in it, it said that we were directed to actually increase the standard of care and increase access for children and families across the United states. That's in the legislation that came out of Congress. Standard of care made us have to look at quality care and evidence to improve quality of care.

It has a broad mission. It means developing and adapting evidence-based treatments and interventions, training at all levels and multiple formats. It means that by training, we do both intervention training and advancing the skills as you're going to hear about, doing good care, but it means that we also work on all the trauma services, all the child-serving systems where children appear; child welfare, juvenile justice, health care, schools. All of them have to have a mind to understand what happens and how to identify and respond to children who have had trauma and serious loss. So, we work in all those formats. We need to have major development or dissemination of our trauma resources, partnership with government, private and public organizations, and we're funded by Congress. We feel an enormous sense of accountability to the public about how we spend our dollars and what we do and try to provide real accountability in measurable ways for our nation.

We work in all child-serving systems. The last says we're part of an effort to modernize child disaster

mental health, and we've been fortunate and privileged to be able to work with the Newtown School District to help with their Project Serve, to provide it -- being advisors as part of what we see as a national effort to really modernize disaster child mental health.

And this just shows you our centers across -- there are now 78 centers across the United States; academic centers and community service sites, all that are combined in a collaborative way. We have affiliate members who have been members before who actually continue to participate so the influence across the states, the United States, are really quite wide and provide much more expertise.

And then, you know, I don't think I need to go into more detail except that I think the last some point is that we look on ourselves and hope to be beneficial to all of you as a national resource. All of those sites, all of people working together, all of the materials that are products that are done, all our educational curriculums, all the new platforms that we have developed to enhance the training and evidence-based treatments we see as our goal to provide a national resource that can be used by communities, schools, families across the United States. Thank you.

CHAIRMAN JACKSON: Thank you, Dr. Pynoos. Do we have any questions or comments? We are going to go into some other discussions that may clarify some issues.

Dr. Schwartz.

COMMISSIONER SCHWARTZ: So, one issue I think I'm not sure of, and I possibly missed a session in which it was discussed, but with regard to the bullet on the training and availability of members to respond to events, can you, or perhaps some other member of the Panel who's speaking today, review the various resources that are turned to in general and that were turned to around Sandy Hook.

DR. STEVE MARANS: I'm happy to respond before giving my remarks. Number one, there is a great deal of experience that's built up over the last 20, 30 years in terms of coordinated responses, and I'll say more about why the coordination of various responses, not just from mental health but across the critical incident response, are so essential to stabilization and recovery.

I would add that, you know, the -- what we've learned over the last 22 years in our work in Connecticut and responding to daily events of traumatic violence and other catastrophic events as well as around the country in response to school shootings, et cetera, national disasters, natural disasters, man-made, 9/11 attacks, is that the worst time to begin new collaborations is in the middle of a crisis and that we tend to operate, understandably, in siloed approaches, and this includes typical approaches to incident command structure. We tend to think about our

roles as defined by profession often rather than being defined by the phenomenology of the impact of events on individuals, families and entire communities.

The short answer is that there are models out there for thinking along different lines. Some of them have been actually brought to bear here in Connecticut, especially post 9/11. I'm looking at Dr. Ford because we worked very closely together in thinking about preparation and response, but -- so that the simple answer is the models are there, but I think there does need to be, as we've been talking over many years, both at the federal, state and local levels, that coordination is easier said than done. But the models do exist, and there's a opportunity to take advantage of what we've learned.

DR. ROBERT PYNOOS: And, you know, it doesn't answer the full question, but you have four sites, four centers, within Connecticut that can immediately -- who have been part of our disaster response, sort of, network, and they could look to coordinate and be available with really well-trained people in a lot different, other issues regarding that stratification and start to work out how to do things and who can participate in helping the school district develop their Project Serve grant so it started to meet the varying stratified needs, that's not as immediate as sometimes people would like, but it is to develop the

resources that can sustain something over time.

So, I think, you know, in terms of our network, we have people trained, and I'm going to show you, we have a -- Buddy is the name, but Psychological First Aid For Schools, this, actually, was available and helpful at the beginning, maybe not as much because people weren't as fully trained on it. We're starting to train -- this was developed by probably 10 or 12 of the people with the most experience in the United States in doing really serious responses to disasters and violence with really, I think, good step-by-step recommendations. But schools need to be trained much more fully on those kinds of things, but they need to have the coordinated structure that you're hearing that can be provided and within the community.

We've learned -- I know it doesn't sound quite fulfilling, but we've learned as a network how to help in a crisis, but how to help to unify the response that leads to a sustained package of interventions over time, and I think our network really is a very strong resource for that, so that all of the stratified levels of care are actually available through our network. We know what to do for the general study body, let's say. We know what to do in a classroom for the generally affected groups. We know how to help with the most highly affected children and the school personnel, and we have experts in those types of

interventions that are available to really consult and to integrate that approach as a package. That really wasn't available until our network. Yep?

COMMISSIONER FORRESTER: Just to get concrete, I think also Dr. Franks will be listing all of the resources that are actually in Connecticut. And for your information, Dr. Marans of the Yale Child Study Center, Clifford Beers Clinic, are currently in the new Sandy Hook School. We have four clinicians that are there full time. And Wellmore, which is a Waterbury Child Guidance Clinic, that's not a NCTSN site but has trained in many of the new models through Dr. Franks at CHDI, and Newtown Youth & Family Services are taking the district-wide response to this school. So, currently, two NCTSN sites are in the new Sandy Hook School.

COMMISSIONER JACKSON: Question from Mr. Sandford.

MR. SANDFORD: My thoughts are this is exciting to hear that we have this here in Connecticut. What efforts are being made to bring this out to the principals that are on the front line, let's say, in a non Sandy Hook scenario, you know? What do you do to reach out to the schools in New Haven, Hartford, Bridgeport or North Grosvenor Dale so that they know that this is there and they can turn a knob when they need it?

DR. ROBERT PYNOOS: Thank you for that. You know, we have, as a national resource, a very large school

collaborative task force that works primarily in schools, works with principals, works with administrations, works with the teacher unions, the large ones, to try to make schools much more available in terms of understanding -- much more knowledgeable in terms of resources. I'm glad you meant principals. I mean, this is -- Newtown was -- because the leaders of the school were killed, it's horrifically more difficult. When we do our work at schools -- I can tell you the high schools, Santana, Springfield, Columbine -- our principal work to begin with is with the principals. It isn't actually with the children and youth at times because the principal makes or breaks the long-term sustainable program, and we know how to support principals to do that.

We did -- I've been around this too long. We did a film back in the 1980s with the Department of Education in which we gathered principals from 10 or 12 schools where there had been school shootings, and we did a round table with them, actually filmed it, actually made a video that was available to make other principals available of the more limited resources that we knew about then than now. And so we know that that's the key. So, we would -- our sites here, I'm sure, have their own coordinated effort to do that outreach. You have unbelievable sites here in Connecticut along with their partners. So, we think that that is a

national need, and we need to strengthen that anti-mental health bill in Congress right now to restore more of the monies to the Safe School Program, restore money to Project Serve to do more training like on our -- ours and others Psychological First Aid For School. There are a lot of instructions in here for principals and how to manage the decision-making. We think that that is an exceedingly important agenda.

DR. STEVEN MARANS: I would just like to add that, you know, again, going back to silos that you mentioned, some of the cities that you mentioned, and it's often -- there is so much activity that has gone on that serves as a basis for more integrated responses, and that's about -- as you suggest, not just in times of crisis. The work of Dr. James Komer over the last, you know, 35 years has been both -- and in Connecticut, and it's expended throughout the country in terms of building and strengthening school communities so that these -- that school communities are better prepared when terrible things happen. The work of Clifford Beers in the New Haven Schools is another example of the work of school-based clinics, et cetera. So, you know, this is, again, about being able to actually identify existing resources, capitalize on existing resources, and strengthen and then support them.

DR. ROBERT PYNOOS: In Connecticut, the Department

of Mental Health has applied to SAMHSA for funds to train more widely than some of those early interventions and psychological first aid for the whole state.

COMMISSIONER SANDFORD: My son is a principal. I'm going ask him tomorrow if he knows about this stuff. I don't know if he's watching television, he'll get ready. I guess my concern is that this sounds like it's -- you know, from being a firefighter, this is extremely important information that local school principals need to know. So, I guess what I go back to, Mr. Chairman, is maybe this is another one of those things that we need to put on the shelf to look at in the future, is going to the Connecticut Educational System and saying, you know, to become a principal, you need to be certified. You need to have certain credentials. Maybe this needs to be included in that educational system for principals so that they get an understanding what's out there so that they're not meeting you for the first time. I couldn't agree more with your statement that you don't want to meet someone during the disaster.

DR. STEVEN MARANS: And I hope that some of the recommendations that I'll bring from the U.S. Attorney General's task force will also resonate with your point.

COMMISSIONER LYDDY: Thank you, and good afternoon. It's remarkable to see such incredible people

here to offer us some support in our work in trying to figure out what we're doing and where we're going. I have two questions, and looking kind of 10,000 feet above what we're doing here today, there must be some coordination or a place for districts to go to say how do we coordinate the services, where does that funding come from, and who do we rely on for support to get that. Can you describe the process and perhaps what type of grant or funding is available for districts?

DR. ROBERT PYNOOS: Well, I think that one of the recommendations here should be to reinforce that the Department of Education where some of that is rested, the Federal Department of Education, has had funds removed and resources depleted so that doing it here in Newtown was actually, to my mind, more difficult and not as straightforward as might have happened, sadly, in other tragedies a few years ago. And it's taken kind of recreating some of that kind of expert consultation that the Department of Ed. would bring together very quickly to reach out and help the school district immediately. Because of our sites here, because of the -- some of the expertise like Dr. Brimer, Marleen Wong, others, that we could kind of recreate that, but I will tell you for many years that came much more coordinated from the Federal Government. Reaching out to that level of resources and having them immediately

available to be able to do that kind of assistance to school districts doesn't match the issue that Dr. Marans said about their preparing beforehand so districts are able to have their -- you know, unified as its crisis teams that have all worked together, practice, can share across schools, all that done ahead of time. So, all of that is very important, but it is important for the part of the Federal Government that can help support the kind of services that are needed, or whether it's at the state level, to have that resource, coordinated resource, there working already and available to be there, and that's taken a little more recreation here than would have been true a few years ago, but that's -- that can be with additional resources really put back into place as strongly as it has been.

COMMISSIONER LYDDY: That's a great recommendation. And you did mention earlier the Project Serve Grant. Could you just explain what that process looks like? I understand you probably can't get into details right now about the content, but the process, I think, is important moving forward for -- if we're going to make recommendation that that's a tool that districts can use.

DR. ROBERT PYNOOS: I think that -- I'm sorry because I didn't try to repeat what Dr. Wong had presented, a slide on Project Serve and what it does and how it's funded through the Department of Education. You know, you

have things like FEMA just to -- that have funding and then through SAMHSA to respond to disasters.

But the way Congress had decided some years for school violence was to have, through the Department of Education, Project Serve Grants that could be applied for and used when there's school violence or sometimes other events at school, and that can be for -- not always the first days, but it's designed to start to fill in within a few weeks and months, and it has different stages so you can get that kind of early intermediate care, and then plan long-term. It has to be actually applied for. It's a very -- it's a real rigorous -- this is federal dollars, so they want to know who's been affected, how seriously they've been affected, what other problems that the school is facing even immediately, what are the kinds of plans and detail that you want to do, how do you want to hire staff and what their purposes is. It is a real application.

So, the school, in the middle of this, actually has to put together critical information. Newtown was able to -- you know, how many kids in a high school, how many kids stopped going to school the next day after a school violent event. I mean, lots of truancy and absenteeism. You need to pull that data together. You need to pull together how many kids were exposed and to what, how many school personnel, how it's affected other schools. You need

-- Newtown had to pull all that kind of information together in the middle of everything else they were doing in order to provide -- in order to apply for the federal funding.

You can't fault the Federal Government, they want -- and then they negotiate with you over what they think is legitimate, what they think they need more evidence for, and in this case, the support, what was being asked for in Newtown -- I can say this more generally -- was for a more multi-year program in which the intermediate and long-term were not necessarily fused but more flowed into each other because of the nature of the elementary school and how it was affected and what it means for Newtown. Those had to be wrapped. They had to be given good justification. And so, you know, the school needs resources. This is not the type of grant that they had ever expected to have to write and, hopefully, schools will never have to write, but they needed resources.

So, there are -- again, the Department of Ed. used to be able to provide some more sources. You had Marleen Wong helping, Dr. Brimer helping, who have written those before, who have done those before. Someone like myself whose been around that and could help with the understanding by interviewing and going through the whole school community, everybody involved, nurses, teachers, bus drivers, parents and school psychologists, all the staff,

what they would like to see and for what reasons so that that could be -- have a voice in this type of grant. All that hard work was done in order to submit this grant, but just imagine the -- and everybody, I will tell you, in Newtown, I can just say, was unbelievably engaging with that. They understood the importance. They understood some of the delay. They wanted to see the resources. They want them well targeted for the kind of outcomes that they're looking for. But that's the kind of process that you go through, and it's very hard on a school community without -- we would hope that a national center is a network within our sites -- to have enough experience that the Department of Ed. can call on us to be able to help schools at that time and to be able to provide the additional resources they need to think through and to help them actually with the grant itself.

COMMISSIONER LYDDY: Just a few more questions. Do you know when this Commission might be able to see that grant because, for the edification of this Commission moving forward, I think what comes from that grant are probably going to be a lot of great lessons learned, that we can, in our recommendations, perhaps, make sure we highlight because of the good work that you're doing. So, you know, as we progress, can you give us some idea as to when we'll be able to see that?

DR. ROBERT PYNOOS: I don't think -- I personally don't actually have that information. The Department of Education has handled this in a confidential way in the negotiation of the school district, so they didn't want things to get -- I would guess, more than anything, made public until everything was finalized. They do negotiations with the school district over what's being asked for. I don't know when that is all finalized. I think at the point that that's finalized, it's public. It's public. It should be not only available to the Commission, but it should be available for the public to take a look at and see what's being funded in some way. I mean, that's appropriate. This is federally-funded assistance, so -- but I think during that part, they would like to be able to -- it's happened in many school districts -- to be able to talk directly to the school district and figure out the fine tuning of what that is before they release it more publicly. But I think you would need to speak to both the Department of Education federally and to your own Newtown School District about when that moment might be.

COMMISSIONER LYDDY: Thank you very much.

CHAIRMAN JACKSON: One question, Dr. Pynoos. Now, you mentioned that -- you mentioned that child trauma is a cross-cutting issue, and as such, screening for trauma or grief-related items is critical in terms of moving into

appropriate treatment or recovery efforts thereafter. I know that the pediatrician who serves my children is diligent about asking those types of appropriate questions and quite unafraid in doing it. I am not sure what your experience is, if that is common. There is also another place of congregation for young people, which is in the school. So, I'm wondering if you have a methodology, either at the level of pediatrician or at the level of the school, to sensitively approach this conflict.

DR. ROBERT PYNOOS: I think in the combined expertise of our groups here, but more widely, we know how to screen. We know how to ask questions in schools. But you're right, it's very unevenly approached even in the adult word and adult health care. It's -- even where it's been demonstrated to have really significant effects on cardiac disease, on cancer. I mean, things you wouldn't necessarily expect that they're not properly screened.

I was just at a meeting this morning with somebody who said with all those studies, it's just hard to get other professionals to screen appropriately. But Headstart -- I mean, I've done work after the civil unrest in Los Angeles. We actually screened for the more immediate issues in the family and otherwise. Headstart can meet that. Preschools, I think that Alice Forrester can speak to that. A good place to start -- I mean, there are dog bites, burns, near

drownings, things that really do have effects, measurable effects, on children. There are serious -- along with the negligent and abuse and other things that can occur.

High schools -- we worked in a -- in high schools, and so has Marleen Wong, where we screen the entire high school, and we -- it's not hard to do, actually -- and you know what we've found in places like Los Angeles, high schools where they had alternate school classrooms where kids were having problems were -- well, guess what, you screen the whole high school. And who has the most concentrated exposures to trauma and traumatic deaths and other things and some of the highest levels of posttraumatic stress were kids in the alternate school classes. And I will tell you the high school had no idea. They had no idea that that was what was happening. Same thing as she pointed out with absenteeism and school failure.

So, it is a national issue to be able to appropriately ask questions. You're not always going to get full answers. But I will tell you, you get much more answers than you think. It's like we've learned to ask adolescents on computers to give answers to mental health questions, and they'll tell you. I mean, I've worked with murder/suicides at schools and here and shooting of peers and family members. And it's hard to ask about, let's say, homicide. I mean, you had a whole thing about risk

identification from homicide. But many of them are murder/suicides, not all. If you ask an adolescent about being suicidal, even confidentially on a computer screen, they'll answer that. Now -- but they aren't asked. And I will tell you the number of school incidents beforehand, that question wasn't being asked. They might have admitted to the homicide, but they wouldn't have admitted to the suicidal issues, and you could have identified them.

So, I think that -- you know, we did -- at Santana High School, we screened the entire high school for suicidal thought two or three months before the anniversary. The whole high school. We identified 68 individuals -- Dr. Brimer did -- who had suicidal thoughts. They were paired up with peer support, teacher support, making sure there were treatments because a number of them were in treatment, were supported, and they went through that anniversary and I -- and many of the high school anniversary times after school violence have had suicides time and time again. But that was a very concerted high school approach to a very important issue. But, you know, schools can do that. They just do not see themselves moving into a mental health clinic in their own eyes, but it's part in parcel of the school functioning, we think, at this point.

DR. JULIAN FORD: And if I could just add briefly, I'll be covering some current efforts that are ongoing in

Connecticut to screen children in various systems, including pediatrics, so I'll be covering that in my presentation.

COMMISSIONER JACKSON: Any other questions? It looks like we're ready to move on to Dr. Marans, just in time.

DR. STEVE MARANS: So, first of all, as a citizen of Connecticut, I want to thank the Commission for your service to the state and I really mean that. And in many ways, it's reflective of one of the major experiences that I've had, my team and colleagues have had, is that in the wake of such a terrible tragedy that the extent to which people have stepped up and responded has been really quite extraordinary.

I'm also really pleased and actually quite delighted to be able to be with colleagues with whom I've worked for many, many years and learned from for many, many years. As Dr. Forrester mentioned, our agencies, along with our colleagues from UConn and CHDI have been involved from -- within moments of the terrible events of December 14th and have worked tirelessly and currently are involved in Sandy Hook Elementary School.

I am so enormously grateful not only to members of the Yale Child Study Center, Trauma Section, our colleagues at Clifford Beers, our colleges at the National Center because it, in fact, is an example of having the capacity to

not form new collaborations in the middle of a crisis; however, it, hopefully, can become a model for moving beyond just the collaboration that occurs around specific, more narrowly defined mental health intervention approaches.

I am reminded -- and I am also delighted that actually some of our colleagues from Clifford Beers who are working in the schools are here with us today. I am reminded of a story, and I promise it will be a brief one, but it's -- to me, it's a good one. I learned a lot from it. I was a young clinician a long, long time ago, and I was working with a five/six-year-old boy who had been severely traumatized. I'm not going into details, for obvious reasons, but I got to this point where I didn't know which time I had been kicked or spat at or chased him around a clinic, but I was consulting with a senior colleague of mine, a pediatrician, child psychoanalyst, her name was Dr. Sally Provinson. I went in and I was feeling quite despairing, and I really was despairing of my own abilities, my own competence, and I was also despairing about this boy's future and his ability to recover from the terrible experiences that he and his family had had to go through. And she said something that's always stuck in my mind which is really the, sort of, background to what I'd like to present today. She said, you know -- first of all, she helped me think technically about what to do differently, et

cetera. But she said, you know, if out of a tragedy, we're able to learn just one thing that helps the next family, the next community, the next situation, then it is not only a tragedy. I strongly believe that in the last 22 years, our work has been involved, as I said before, with dealing with tragedies and horrific incidents that have produced traumatic experiences in individuals, families and communities and nations. And that idea that we have something new to learn in order to move forward is what has sustained not only my work, but many of my colleagues' work, and I'm grateful to all of them who have taught me, but especially to the kids and families who have been our best teachers, all of us.

Next, please. So, I don't want to go into detail, and I promise I'm not going to burden us with the actual enormity because if we -- we have an opportunity here, which is to think broadly, as the questions from the Commission have already suggested, to think broadly about what do we learn from childhood trauma and terrible mass casualty events as a way of mapping on to how do we think better about serving our children, our families and our communities, and -- but it's a daunting task.

If you look at the exposure rates to violence that is based on a study done by David Finkelhor and the Department of Justice a few years back, the numbers are

really quite extraordinary in terms of the shear numbers of kids who have been exposed to potentially traumatic events. Bob has covered some of things, and I don't want to belabor them, but I want to not just set us up for a sense of failure and impossibility, but then to move into what we know about some of the things that we can do.

Next. These figures are extraordinary to me, just in terms of numbers, in terms of the domestic violence. They're a real underrepresentation. But when we start looking at the consequences and we look at the repeated victimization, which I know Dr. Ford is going to talk about, we are then not surprised that the cyclical nature of, for example, interpersonal violence is so clear, the intergenerational transmission based on the experience of being a passive victim to the people we rely upon and love the most doing damage to one another.

Next. We -- and Dr. Pynoos was referring to Dr. Vincent Colletti's study along with the Centers for Disease Control about the effects not only on psychiatric difficulties but also on general health outcomes.

Next. Again, one of the things that -- going back to the issue of silos that we -- when we don't go far enough upstream, we spend, you know, billions and billions of dollars in this country -- again, Dr. Ford will be talking about this -- on outcomes in terms of our criminal justice

system, et cetera. But we know a great deal about further upstream where these perpetrators of violent crimes, either in their neighbors or in their homes, what lies behind it.

Next. We know about the links between sexual abuse and drug abuse and depression and the like. And again, I add the dollars and cents because part of your task as a Commission is to think about how do we shift the paradigm in thinking about what we're doing not as an addition in lean times economically, but actually as a much more cost-effective approach to dealing with a broad array of issues that have a common denominator of unrecognized, untreated childhood trauma.

Next. Dr. Pynoos has already done his usual masterful job in really laying -- setting the framework for thinking about what do we really mean when we talk about trauma. It's an overused word, by the way. There's a great difference between the upset that we, as a nation, feel in the wake of overwhelming events, such as the one that occurred in Newtown, and the real traumatization that has implications for the way our brains and our minds actually operate that where our body respond, and as Dr. Pynoos pointed out, the level of vulnerability and the challenges to recovery that that kind of disregulation, the traumatic disregulation, leads to.

Next. You know, we often talk about normal

responses in the acute phase, in the early days, weeks and sometimes a few months following a potentially traumatic event. And when -- part of what we've been doing in the schools have been meeting with parents and teachers and kids and talking about normal responses, but normal doesn't mean nice.

We also know -- next -- that the longer term impact of unrecognized, untreated trauma really have life-long implications, as Dr. Pynoos has pointed out. And we also know that some of the more powerful -- the early symptoms are that, in addition to other factors, can predict some of these more serious long-term outcomes if they are not addressed.

Next. Again, we really need to be careful about thinking about what are some of the factors that we've learned about that predict good and bad outcomes. And again, what I've been so impressed by -- I know my colleagues have been so impressed by -- is that Newtown has the great fortune of not having to be challenged by many of the factors that too many of our young people, too many of our families, too many of our communities confront well before an acute episode of violent traumatization. And I say this to families and parent groups in Newtown as well. And I am so proud to be witness and feel so fortunate to be witness to the great strength that has been shown, and

that's part of what we want to mobilize in all families, all communities. But I also want to underline that some of these are self-evident by emotional proximity, obviously, the closer the relationship to the immediate victims, the more powerful. But I want to underline this last point. The secondary impact of ongoing disruption of routines of daily life. This is critical, particularly in terms of thinking and mapping out a phase-specific response when overwhelming events effect an entire community -- next -- but also individuals and families.

Again, many of these are self-evident. Boy, I really hope these are the right slides because I've had some of these italicized. So, I'm hoping it's just the computer. But, anyway, many of these are self-evident. And again, if we think about the specific community, we ought to be thinking about the entire state. And I understand that that's the function of this Commission.

I want to go to the last two items. Two of the most powerful predicters across all of our studies -- and all of our research, all of our clinical experience, I can put it in the negative or the positive. I'm going to put it in the negative. The failure to identify affected children and the failure to provide adequate family and other social supports are the best predictors of bad outcomes given other factors in terms of emotional proximity and physical

proximity and the like.

Next. So, one of the things that we -- we take the phenomenon of what we understand to be traumatic disregulation. We use that as a map for developing strategies to respond. And so, for example, we want to reduce the risk factors and build on protective factors. I know I'm stating the obvious but, you know, sometimes when we're overwhelmed, it's hard to see the obvious. And so we think about how do we strengthen familiar and caregiver emotional support. How do we facilitate the recovery of control.

And again, if the sine qua non of trauma is the loss of control, not the feeling of loss of control, the real loss of control that leads to unanticipated, overwhelming danger in which we can't flee or fight, in which there is real neurophysiologic disregulation, the idea, given what Dr. Pynoos was describing about some of the symptoms, and some of the ones that I mentioned, we actually recognize that there is a secondary lack of control, which is over our own bodies and over our responses that interfere with a return to daily life. This is really significant because it provides a map to what do we want to do in the acute phases and beyond. We want to help kids and adults get back control of their lives and to actually, in fact, mourn what couldn't have been controlled in the first place.

We also want to, as part of that aim, provide the skills and -- both in short-term and intervention that I'm going to describe in a moment, and also in terms of longer term for those kids and adults who are going to need longer term care because of the difficulties in recovering.

And the other thing is we always want to keep in mind that we want to assess what are the ongoing external stressors, and that will vary from family to family, community to community, but one of the things that has been so notable in Newtown, as has been the case in other communities where -- that have been affected by mass casualties, is that often in the best intended wishes of people wanting to be of help, there can be an instability that is perpetuated by some of those efforts, and I'm not just talking about the media. Although I was in a meeting at Columbia on Monday in which journalists and clinicians and others were addressing what is the role of the media and how -- what is a burden on a community in the wake of such events.

Next. So, when we get back to the idea of the risk factor or the protected factor, then it leads us to think about, well, who are the -- where are the opportunities for identification of the kids who are suffering acutely but may recover without any help but still suffering, can throw them off, and it's beyond them, and how

can they be identified. And this list is not your typical list. And, in some ways, it helps to identify the other partners that need to be involved in our expanded notion of what we consider to be therapeutic, what we consider to be approaches that can support recovery.

Next. And again, some of these have -- Dr. Pynoos was mentioning, but, you know, it's always interesting to me when people are thinking in a more isolated way, and I'll just use mental health professions. If somebody is acutely traumatized but the danger, the situation of danger and overwhelming danger that has led to their traumatization still exists, what's the first order of business? Well, it's not to dive in to conducting therapy alone. It's to identify what are the ongoing stressors that are making recovery so difficult. And, by the way, when it comes to safety, I've worked with law enforcement for the last 22 years, which has helped me to learn when I turn to my law enforcement partners and how we work together, which I'll describe briefly in a moment, about ensuring that we're looking into the safety issue.

Next. So, I'm going to talk very, very briefly. You have the slides, and there's more material that's available, if you like, but actually, in the face of the crack epidemic in the early '90s, both law enforcement in New Haven and colleagues at the Child Study Center recognize

that neither of us working on our own were putting a dent in this link between traumatization, early traumatization, and the perpetuation, failure in schools, et cetera. And this goes back to the silo thing. If people are not ready to say I don't know, it's hard to begin a collaboration. If you're not ready to be able to say I need you, I need your expertise, I need to learn from you, it's hard to find a common frame of reference that's going to inform the real work that might be needed together.

Again, I'm not going to go into this. This has been replicated in various places around the country, and I'm proud to say that after -- through five chiefs and many wonderful colleagues who have gone through the Child Study Center, we continue to do the work. Next. That involves training officers and the intersection between behavioral health, trauma, development, et cetera, and community policing and basic policing strategies. We have training for clinicians on basic something police procedure, and we're -- it's not just classroom. It's spending hours and hours getting to know each other, learning about what is -- not only what it's like for police to do their work, but to get a different perspective on -- a different take on what we are thinking about when we think about potentially traumatic events. We have weekly multi-disciplinary meetings in which we review and look at case disposition.

We're also -- the Department of Children & Families is very centrally involved in this.

And next. I'm sorry. This is just a very, very brief slide. We did a study a few years back in which we do follow-up visits in addition to offering clinical services in the clinic. And the follow-up involves clinicians and officers who have all been trained, cross-trained, going back to homes in which domestic violence, serious demotic violence, has occurred and going through safety planning, assessing for symptomology in both kids and adults and making linkages to other agencies in the community and -- as well as clinical services. And what we're able to establish is -- and we compared that to families that only got traditional police services, 911 driven services only. What we were able to demonstrate is, you know, you show this left hand column, blue column, to a police administrator and they say great, Marans, you're creating more work because the blue column represents calls for service. And it's much higher in the outreach group than it is in the traditional 911 driven response only. But here's the deal. They are not 911 driven. This is pager driven, message driven, calls to the officers who responded in the first place and to the officer clinician team.

What you'll in the red column, the red bar represents the severity of violence that was repeated. And

you'll see that in the outreach group, it's a third of what the control group demonstrated. This was over a 12-month period.

Next. We also saw that in the outreach group that the number of children who were entering additional services, both clinical and other, was double that than the traditional police response only.

Next, please. Now, in the course of this work, what we developed -- and I'll try to be very, very brief, is the recognition that our first job, if we've used that map of the acute response, is to help build and strengthen family ties, and that means communication which means being able to put into words and identify symptoms. And we developed an early intervention called the Child and Family Traumatic Stress Intervention, and it's currently provided in clinics. It's been -- it's being used in various sites around the country and elsewhere and is very much part of our activities involved in the National Child Traumatic Stress Network.

Next. And just very briefly -- I don't have to repeat that. You have the slides in front of you.

Next. I'm respectful of my time and others. But it's, again, to decrease posttraumatic stress reactions because they really are not only not nice. They can be immobilizing. Number two, to increase family members

engagement with one another in ongoing treatment where it's indicated. And three, to identify the need of treatment that may have never been discovered before the precipitating event once these folks are identified. In a randomized control trial, many of whom were referrals from our colleagues in the police department but also from our emergency department, et cetera.

Next. Next. Next. Next. Next.

What we were able to find is that we use the control intervention that was above standard level of care in terms of psychoeducation and assessment and that the children and families who received CFTSI were 65 percent less likely to achieve a diagnosis of PTSD than the control group. Next. And 73 percent less likely to achieve a diagnosis of partial PTSD which includes a broader array of symptom clusters around anxiety and depression. Next. Next. We have adapted this to child advocacy centers, et cetera. Next. Next.

So, I want to say that the other thing that we found -- and we are very, very big believers in evidence-based treatments and evidence-based and evidence informed, trauma-informed services so that our work with law enforcement and child protective services is not the only such collaboration. And one of the great strengths of the National Child Traumatic Stress Network has been able to

learn from and capitalize on a whole array of new trauma informed coordinated services, some of which you will hear from Dr. Ford. And one of the great challenges has been about how do you get the evidence-based treatment training out there. And Dr. Franks will talk about some of the efforts that have made the approach in the State of Connecticut so enormously successful, not only in terms of this early intervention, but longer term trauma-focused cognitive behavioral treatment for kids and families who need much more.

Now, I'm sorry to change hats and then stop. I have a great -- it was not always pleasurable, but I learned an enormous amount in my service on the U.S. Attorney General's Task Force on children exposed to violence. And this was a group of 13 members who worked together from a variety of disciplines, backgrounds, and went around the country and did hearings that was enormously instructive, not only hearing from citizens, but professionals and from various sectors that converge around the issue of violence exposure in childhood. And I thought I'd share with you some of the recommendations that came up. I've also distributed the executive summary. You will thank me that I did not distribute the complete summary or -- the complete summary, that was wishful thinking -- the complete report. But I thought I would share with you some of the ways in

which what we've learned were shaped, and I'm just giving you some of the headlines, and I'm happy to address any questions you have about specifics.

Next. So, one of the first issues -- and this has not only implications for the identifying piece, but has implications for a political piece that an informed public -- not only about the problem but about the fact that there are solutions -- there's nothing better to keep the blinders on the public and on individuals than to continue to feel overwhelmed and helpless. It's time that they not only learn about the risk factors and the connections between unaddressed childhood trauma, but actually that we've learned a great deal and that there are there are solutions that can prevent the long-term, deleterious and costly outcomes.

Next. The idea of evidence-based trauma informed principals, just to assure you that it's not just my idea, but again, a reflection of how much we've learned, and we have a great deal more to learn.

Next. Finance change by adjusting -- you may be able to see it. I don't have it in front of me, but there are ways of taking existing resources and tacking on, both at the state level and the federal level, additions that become part of requests for proposals in a whole range of sectors, whether it's direct health care, child welfare,

education, et cetera.

Next. And again, the idea that children exposed to violence are identified, screened and assessed, period, and that we use -- and that we use those more expanded view of places and people who are most likely to be able to identify kids and then equip them as to how to do that. Again, this has been talked about in terms of the need for broad-based training. Again, we have professionals who are coming out of medical training, social work training, psychology training, who -- it's much better than it was, but there's a long way to go in increasing the capacity within our state, within our country.

Next. Again, I'm not going to go through all of these because I'd much rather us spend some time on discussion, but you get the idea that -- the idea that hospital-based -- this is just one example, and we're not just talking about violence, but motor vehicle accidents, serious injuries, et cetera.

Next. Next. Next.

And I think Dr. Franks will be talking about a practical way and the steps that he and CHDI have taken in moving forward, good ideas to broader dissemination. Dr. Ford will talk about this as well.

And again, this idea of growing and sustaining, this costs money. This costs money. It's no good to simply

have training, but then not have the dollars that it costs, in fact, to do the treatment. And I'll give a very brief example. In terms of our response in Newtown immediately was, with the help of Dr. Franks, Dr. Ford and others, we were responding to requests. We were not knocking at the door. We were responding to requests in the same way our colleagues from Clifford Beers and elsewhere did. But one of the things we found in the pouring in of resources was there are wonderful clinicians, wonderful people who want to be of help, but they didn't necessarily have the training and the experience in addressing the acute phase needs or the advantage of having the knowledge to offer the acute phase services that might best fit the needs of the community.

So, one of our efforts was to build capacity. First with meeting with pediatricians, internal medicine, general medicine people about how do you take advantage of some of the wonderful screening tools that Dr. Franks and his colleagues and others have developed. How do you orient them to what they might be seeing, what they can offer. How do you take advantage of materials that have been developed within our National Child Traumatic Stress Network and give someone something to hold onto, something concrete, something instructive, and then to move forward with providing and building a capacity of local providers, local,

local, local providers who are already in practice either in agencies or in private practice with the tools and skills and training and ongoing consultation in evidence-based care.

Trauma focused CBT has been -- now there are 40 local providers who were trained about a month-and-a-half ago. They are having ongoing consultation calls, and this is a group that doesn't necessarily cog onto the -- immediately to the notion of manualized treatment, but boy, have they become fans as they have seen children and families improve under this more structured and evidence-based approach with our colleagues with whom we were working as one in the Department of Psychiatry, of which I am also a part of. The National PTSD Center offered to provide training for adult providers in cognitive processing therapy and other evidence-based treatment. They are having similar success.

Next. The home visiting is just -- we gave one example that our colleagues at Clifford Beers and around the state are involved in various home visiting. Go to where people are, and even better, when you're able to go with partners who can provide additional services.

Next. This to underline. This was not just because of me. This is about hearing from law enforcement, domestic violence advocates, et cetera, about the

alternatives to siloing our efforts is much more consistent with the complexity and the needs and demands of successful outcomes for the people with whom all of us have contact in different ways.

Next. There's a lot about domestic violence and co-occurrence. Dr. Pynoos referred to that. Again, it's in your executive summary. I won't belabor this.

Next. I think when we talk about provide support counseling to address the unique consequences for violence. I guess I would underline that this goes back to this notion of -- a broader notion of what we refer to as a critical incident command structure that in most states there is a bifurcation or a division between, for example, the public safety needs and the public health needs and the mental health needs.

And I think, again, you don't start this in the middle of a crisis. It's like, who are you? Having spent a lot of time on crime scenes, I didn't know the people I was working with and I showed up and I'm the professor of psychiatry from Yale. They'd say, what are you doing, you know, except their language would maybe be more direct than the one -- the language I'm using.

So, again, the notion of developing relationships in which we have a shared frame of reference so that even when we're talking about communication, we have an

opportunity to think together about behavioral health responses or behavior of human beings that can inform the way we communicate, the way we respond in terms of post-event security, et cetera. These are things that we have learned a great deal about, and we have an opportunity to take advantage of.

Next. I added this. There are many more, but we have a substantial and significant Indian population in the State of Connecticut. And we heard a great deal from Tribal Nations around the country, and I would encourage all of you and all of us to become more familiar with the child welfare, the Indian Child Welfare Act and to think very carefully about the specific needs of Tribal Nations not only in our own state but around the country.

Next. I think we have -- Dr. Ford is going to talk about these issues.

Next. And I think Dr. Ford, you're going to talk about the -- thank you.

Next. And there you have it. Any comments or questions, I'm happy to address.

CHAIRMAN JACKSON: Thank you. Dr. Forrester.

COMMISSIONER FORRESTER: Dr. Marans, I know that you've written an article a few years ago with Bill Harrison, Alicia Lieberman called The Best Interests of Society. Are you making that available for the Commission?

DR. STEVEN MARANS: Yes. I almost had lots of copies, but I did bring one so it can be reprinted.

COMMISSIONER FORRESTER: Okay. I just want to point out that I think it's a very good basic article in thinking about the community's response to addressing trauma, and it summarizes a lot of what you were saying in a very clear way around whose job it is to recognize and address the trauma that we see at such epidemic heights.

DR. STEVE MARANS: The only thing I'd want to add is that we need to change the way we think about therapeutic. I mean, you hear me say therapeutic, and you think about clinical, and I think about it differently. From the experiences that we've all had, which is -- it's not even humility. It's just good reality testing that when you're dealing with traumatic situations, all of the elements that we've been talking about today, they need to be addressed. And if the sine qua non of trauma is chaos and disorder, then in order to restore order, we have to have a frame of reference that serves as a unifying map that coordinates approaches from all sectors that are necessary across public safety, communication, medical resources, housing, et cetera. These are all things that are critical. And we know that when they are brought together, and not particularly in mass casualty events, but in all events, the outcomes are astoundingly different than when they don't.

Compare the results of the response to the Turkish earthquake in the '90s when the Israeli government and Turkish government worked together in the refugee camps to reestablish order to that that occurred after Katrina and the two years following.

COMMISSIONER SCHWARTZ: There are so many new -- Dr. Marans, there are so many new forms of therapy treatments and so many claims that are made for them. Can you just share with the Commission what the standard for considering something evidence-based is?

DR. STEVE MARANS: Right. Well, it's a great question, and it's one of the ones that we often are addressing these days with parent groups with whom we're working. The best treatments -- first of all, the best treatments -- all treatments have, as a basis, a solid and genuine connection between two or more people. And I know that sounds obvious, but it's really, really critical. Evidence-based really refers to -- and there's actually a whole structure that has been devised within the scientific community and within the Federal Government in terms of registries of evidence-based treatments. And while I think we have a long ways to go, there are treatments that have established some pretty solid footing to suggest as our -- our randomizing control trials suggest, that there are very good, strong predicters that with these elements of

treatment, there is a better likelihood of improvement, recovery, symptom reduction, et cetera, than those treatment approaches that don't.

We've addressed families who have said, well, I'm in this type of treatment. Do you use that? And we say, well, no, we don't. And, of course, then they get concerned that maybe they're in the wrong treatment, et cetera. But there are those treatments that have been developed over the last 10, 20 years that have a stronger evidence base than others.

DR. ROBERT PYNOOS: Can I just add? The National Child Traumatic Stress Network, the web page in our content, we actually have facts sheets on the most well-established treatments, on the most promising practices. They describe what the evidence base is, the different cultural adaptations or uses they've had, how they responded to those. So, it actually allows, certainly, a provider community, agencies, others to get a quick fact sheet on the most prominent interventions certainly being used widely, not only by our network partners but by others, and we try to keep those up-to-date. It's not an answer to you except it's to say that we see ourselves as a resource providing some access to that when it comes to children and families.

DR. STEVE MARANS: And, by the way, just to add, I think in this situation, that resource has been enormously

helpful as had been other materials that have been developed by many of us through our activities in the network.

COMMISSIONER SCHWARTZ: So, just to follow up a little bit, with regard to trauma in formed treatments for youth, does the NCTSN stand as an arbiter of evidence based, and would you say that double blind control trials are the golden standard, or are there others?

DR. STEVE MARANS: Well, I'll see what Bob would like to add to the first part of the question. We have not served as arbiters, but have a great deal of experience within the network and have some of the best people in the country who have been involved in developing the scientific approaches to testing treatments. And, as Bob said, the availability of known information has been an enormous resource that the Center has provided.

In terms of what is the gold standard, well, in many ways, the randomized control trial has long been a gold standard, but there is increasing appreciation of another approach, which is an open trial approach, where using sizable numbers, when one is able to, one is able to look at trends and to be able to sometimes combine randomized control trials with subsequent open trial approaches. And I think that, you know, this is where the ability -- not for every layperson in the public to have to learn about scientific methodology, but to know where there are trusted

sources for looking at and getting an overview about some of the standards has been enormously helpful.

COMMISSIONER SCHONFELD: This is really a question to the Panel. One of the challenges in -- you know, Steve, you mentioned that it's important that we learn from these experiences. One of the challenges, of course, is how one does research in the immediate aftermath of a major crisis event in a way that's both sensitive to those who are, you now, victims or witnesses to these events, ethically done and also scientifically valid, and the challenge of getting informed consent in those situations, particularly when you don't have a preexisting relationship with community. So, if you could give me some thoughts of what are some of the basic principals that you try and ensure are put into place because this might be an important question that we can grapple with in terms of recommendations for the state to both facilitate but also to ensure that it's done in a sensitive way.

DR. STEVE MARANS: Well, again, David, thank you for your question. You know, over 20 odd years of responding acutely and then beyond to tragic, awful events, the last thing that we would ever do is talk to somebody about informed consent. There have been lots of questions that we have not been able to answer in a systematic way that we would have loved to, but clinical care comes first.

Stabilization comes first. There is a time, however, where many people -- and, for example, in our early intervention study, everybody has told -- and we need to have informed consent even in order to use this standardized -- the data that comes from standardized instruments that are part of the treatment.

We have been really -- it's been really interesting in other communities where often the -- we shouldn't assume anything. We shouldn't assume, for example, that people are always going to experience research as exploitative because in some ways, one can often hear at a certain phase in their recovery process that people want others to be able to learn from their experience. So, I think that one has to look very carefully at the specific situations, and one has to think in a very specific way about who the stakeholders are in making those determinations even in terms of a bid.

And as a slight tangent, this also has to do with media issues. We have a policy in our work that when we're working with an individual or a community, we do not respond to media questions about what we're doing and the issues unless we're asked to by specific community members. But I think this has similar implications in terms of this idea of being extremely sensitive. What is the aim of the people who are responding and why are they doing what they're

doing, and hopefully, hopefully, if there is a gold standard, it should always be first and foremost not just do no harm, but be motivated by the possibility that we have something to offer that's being asked for.

DR. ROBERT PYNOOS: I'd just add to that that, you know, you're talking about a state -- I've been involved with doing research from very early days into long days, and hopefully that -- Oklahoma, after the bombing there, we, actually, with the governor's office, set up at the University of Oklahoma, a way to arbitrate. There were an enormous number of studies that wanted to be done and just flooding the community, so that there is a way to actually -- for the school systems, for others, to actually work through what are enormous requests and may not -- and to know that you're looking -- what you may need to look for at the beginning, what are those factors that people, even if they've been affected, want, actually, some knowledge to help guide the services afterwards. But it's open. It's transparent. It's done with good review. It's coordinated. There's IRB in the school district along with the university or others that are coordinated. That has to be all set up sometimes ahead of time, sometimes at the time, but that often doesn't happen, and it has to be supported.

So, when I talked about the signature of an event, learning what the signature of the event is, in some way,

actually helps guide the unique needs of responding to that event. That can be done in an open way with good research that has a needs assessment side to it that isn't just a one point in time because if you took one of those -- that six-month period, you'd be missing a lot. I mean, so you don't want to do research that is misguiding and overestimating or underestimating. It needs to be properly conducted with a sense of what the unique questions -- you don't want to just keep repeating dose of exposure. I mean, why do that. Why put that kind of burden on the community. But if there are some specific questions that need to be answered that can serve the community, you can do that in an open and transparent way, but it needs that pre-preparation between like a school district and the university, others, that often has to be guided by the governor's office. That's what our experience has been in a number of states.

CHAIRMAN JACKSON: Time for one more. Dr. Schonfeld.

COMMISSIONER SCHONFELD: Just to follow up because I know this wasn't something you were planning on discussing, so perhaps it's something you can follow up with the Commission and provide some information on. For one who has done schooled-based research, and I understand the importance of doing the research, I also know that this is difficult to do and it does require some pre-preparation and

some transparency, and that is very hard to do when events happen unexpectedly in school systems that, obviously, were not planning for something like this. And having been in the situation of trying to raise that question acutely after the event, it was very difficult to really be able to discuss that because of all of the other, you know, realities that had to be faced.

So, it might be an important contribution of this Commission if we could highlight some of the issues to consider so that that preparation could be done at a state-wide level and might be a model at a national level as well. There will be separate preparation that needs to be done to frame the research questions ahead of time so that they are actually relevant questions that are important questions, and that I would expect more coming from the scientific community. But in terms of policy decisions, you may be able to help lay the ground work by which this could be done responsibly, ethically and expeditiously after an event. So, perhaps -- I don't know if any of you are willing to prepare some of those recommendations and send them to the Commission. I know I'd be interested in seeing them.

(Hearing continues)

CERTIFICATE

I hereby certify that the foregoing 75 pages are a complete and accurate transcription to the best of my ability of the electronic sound recording of the meeting of the Sandy Hook Advisory Commission held on April 26, 2013 at the Legislative Office Building, Hartford, Connecticut.

Christine E. Borrelli Date
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