Webinar on Trauma-Informed Care For Abstinence Grantees
December 14, 2012

DR. OLIVIA ASHLEY: This is Olivia Ashley and I want to welcome everyone to our webinar on Trauma-Informed Care. My co-presenter today is Sandy Martin from the University of North Carolina at Chapel Hill. We're very excited to be talking to some of you for the first time.

My understanding on this call today is that we have FYSB's competitive abstinence grant program grantees, our new grantees. So congratulations to those folks on just starting your grant. We also have FYSB's state abstinence grantees and then I also understand that there are some grantees from the Office of Adolescent Health that were invited to join us as well. So we have a hybrid group of lots of different folks who are very committed to teen pregnancy prevention.

I also want to make sure that folks received the webinar slides that we sent as a PDF file, as well as some handouts that went out. There are a mix of PDF and Word files that we will be referring to today. If you did not receive these, please don't panic.

If you're a FYSB grantee, we're going to put these on the community practice website next week so that you or your sub-awardees or your staff can go in and download these. If you're an OAH grantee and you did not receive these, please send an email to the person who invited you to this webinar and we will as we get those requests be glad to send those materials out to folks.

I'm going to advance our slides here. This presentation was developed for the Family and Youth Services Bureau. And we have three folks at RIT who provided some research assistance that we want to acknowledge: Lisa Fornnarino, Kati LeTourneau, and Lara Markovits. And here is an overview of what we're going to try to cover today. We've got three main topics that we want to address, and within that lots of rich information and sub-topics. The first thing is that we want to talk about the links between trauma and adolescent sexual behavior, and how trauma might influence adolescents that you are working with, whether you're working in abstinence education programs or programs that Office of Adolescent Health services.

We also want to talk about what trauma-informed care means. And our focus today, there are lots of different components of trauma-informed care. But we're focusing today on program

delivery, for instance, the types of curricula or activities that you may be delivering directly to children or parents in your communities, as well as trauma-informed systems.

And then the third thing we're going to talk about is how to identify and address trauma when you or your staffs are implementing abstinence education programs or other teen pregnancy prevention programs.

We want to make this as engaging and interactive and useful for you as possible. So we've got a couple of features that we want to make sure that you take advantage of. One is on the bottom right hand corner of your screen, you should see a chat screen. And on the very bottom, there's a box where you can type in any questions or comments that you may have.

You can send them to everyone. You can send them to just us. You can send them to someone else who's on the participant list. If you send them or to us, we'd like to be able to read those out to folks and talk about any questions that you may give us or answers or thoughts on that and open it up for other folks to share their comments or chat.

And then the other thing is we're going to break at several points to ask if there are any questions or comments that folks want to make verbally. So at that time, we'll ask Adam the operator to announce how you can let us know if you have something you want to say or ask verbally and we'll have some verbal interactions as well.

So please don't be shy. I actually know some of the names on the participant list. I've worked with you on other grant programs and I know you have a lot of experience out there as well as a lot of really thoughtful, insightful questions when we worked together in the past. And I'm hoping that you will share that expertise and your thoughts and questions so that we can have a lot of interaction today.

So for the very first part of this, I'm going to turn this over to Sandy Martin. Sandy is a Professor at the University of North Carolina at Chapel Hill. And she is an expert in violence in the lives of children and women.

DR. SANDRA L. MARTIN: Thank you very much, Olivia. And good afternoon, everybody. This is my first webinar. So I hope I do well. And I'd like to start today's session by underlining the fact that we're going to be talking about some sensitive topics, including trauma. And many people have experienced trauma or may have a loved one who has experienced a traumatic event. And sometimes these traumatic events can be incredibly distressing and they can sometimes leave feelings like this for a long period of time.

So in talking about today's presentation, if it really stirs up any uncomfortable thoughts or feelings for you, please do take care of yourself, know that there's lots of different individuals and groups around who can help people deal with the aftermath of trauma.

And one group that I'm very familiar with is the National Domestic Violence hotline which is open 24 hours a day, every day of the week. Their number is 800-799-SAFE. That's 7233. So if you know of someone who maybe needs some assistance or yourself, you feel like this could be helpful, please do take care of yourself.

So without further ado then, we will go to the next slide and we're going to start by looking at the types of violence that can be stressful and traumatic for children and adolescents. And given today's terrible situation ... some of you may have heard that there was a school shooting this morning ... I think it really does really help underline the fact that there's many things out there that can be incredibly stressful and traumatic in the lives of children and adolescents. And our hearts certainly go out to all those families that have been affected by this terrible thing this morning.

And some of the other examples of types of traumatic events include child maltreatment, the most common form of which is child neglect, followed by physical abuse or sexual abuse. But also living with a parent who's experiencing domestic and partner violence can be incredibly stressful or traumatic for children. And some adolescents are in dating relationships in which there's violence which can be traumatic. Certainly, there's a lot of different neighborhood violence. And children who either experience or witness peer or neighborhood violence can be traumatized. And each year in our country, we also have 1.5 million kids who are in motor vehicle crashes, with about 300,000 of them being injured. And naturally, this can be incredibly

stressful. And certainly, research has shown that these children have higher rates of various types of acute stress disorders.

Certainly if a parent dies it's a traumatic event for a child. Or if a child is removed from a parent children or loved one. And in 2010, more than 100,000 kids in our country were living in foster care, about half of them with relatives and half with other non-relative families.

Certainly, natural disasters can be traumatic in the lives of adults and children. And I thought there was an interesting study in Florida after a large hurricane that showed that about a third of the children in the area evidenced symptoms of post-traumatic stress disorder all the way up to two years after that event.

And finally, war and terrorism, refugee status, can be incredibly stressful and traumatic. There was a recent report put out by Save the Children that found that the children living in Syria who've been witnessing the ravages of that war have been evidencing many symptoms of trauma.

So, not only are there many different kinds of stressful events, but stressful and traumatic events are common among the general population of children in our country. There was a survey, The National Survey of Children's Exposure to Violence, which was a representative study focused on kids between ages of birth and 17 years of age. And what these researchers did is they did telephone interviews with about 5,000 parents and asked the parents about their children's exposure to different kinds of violence.

And what they found out was that about 60 percent of the kids in our country either directly experienced or witnessed some type of violence within the past year, in other words, the past twelve months. And this included a variety of things, including like direct physical assault, child maltreatment, being bullied or witnessing violence between other people.

And almost 40 percent experienced two or more direct victimizations and more than 10 percent experienced five or more direct victimizations. So you can see in that general population of kids in our country, a lot of them are exposed to violence.

Well, and stressful traumatic events are even more common among particular groups of adolescents. And I know that several of these groups are those that are served by the teen pregnancy prevention programs. For example, research has found that about half of the children in foster care have been direct victims of violence. And children of sexual minority groups are also at increased risk of violence and other types of negative reactions. Kids who are runaways or on the streets, they have high rates of violence in their life, both before they run away and then once they get to the streets.

So since we know that these stressful and violence events are common in the lives of the general population of kids and even higher in these subgroups of kids who are served by teen pregnancy prevention programs, the question really comes up as to whether we should take these traumatic experiences of children into account when we deliver teen pregnancy prevention programs.

Well, to help us address this program, let's begin by a short discussion about our body's reaction to stressful and traumatic events. While all of us have experienced stress, and many of us have experienced traumatic events. So it's really not too surprising that our bodies are made to successfully deal with these challenging situations.

Whenever there's a physically or even an emotionally challenging event, our bodies react with this complex physiological stress response. Certain biological systems prepare our body for the fight or the flight to sort of instigate or fight that challenging event. And then once that stressor has passed, other systems sort of takeover in our body to sort of reduce our systems back to a baseline level. So that we can just go on with our day-to-day lives.

And short-term occasional activation of the stress response in children is really important for their normal development. So that those days when we take our kids to the doctor for that first immunization shot and they certainly react with a stress response, we're there to comfort them. Or when we take them to that first day of day care, they're stressed out at first and then things go back down to normal.

So it really sort of helps prepare them for everyday life in which we face many challenges. But if children experience sort of a chronic or frequent activation of that stress response in response to some extremely stressful event or if there's chronic stress in their life and sometimes people call it toxic stress. And they call it toxic stress because it can really adversely affect their development.

If this happens a lot when kids are developing, in terms of when their brain is rapidly developing, it can actually affect the growth of the brain and change the structure of the brain and change the way the brain functions. And these stress induced altered brain architecture, it really helps us to understand these associations that we see in studies between childhood adverse experiences and subsequent problems and cognitive function in emotional health, behavioral health and physical health.

Well, many of the children and adolescents who experience attacks of stress and trauma, they evidence various types of behaviors or reactions or some people might call them symptoms in response to these events. And even though they may be quite varied in how these children evidence these responses, they're sort of related to the age of the child. And so adolescents who are between 12 and 17 demonstrate traumatic symptoms somewhat similar to those as an adult. And these can include internalizing symptoms ... and those are the ones that are sort of harder for us to observe from the outside looking in ... as well as externalizing symptoms that we can observe more easily.

And examples of internalizing symptoms might be the child becoming emotionally numb, sort of as if they're not reacting to anything. Or they could have flashbacks of the situations, nightmares, disturbed sleep and other things that you can see here on this slide.

Where the externalizing symptoms are things like maybe wanting to avoid something that reminds them of the events or that they'll go out of their way not to see it anymore. Or becoming incredibly aggressive, using substances, not wanting to go to school.

Now, we know all that these trauma-related symptoms arise as their bodies attempt to cope with these abnormal situations. So some can question whether these groups of symptoms are these like psychotic problems? Or are these really normal responses to abnormal situations?

Well, regardless of how we think about it, these types of symptoms can really interfere with day-to-day functioning. So interventions may be needed if they really don't diminish.

Another thing to think about when you look at these symptoms is think about how they could interfere with children's learning, including the learning that takes place in teen pregnancy prevention programs.

So we're suggesting that folks who design and implement teen pregnancy prevention programs really should think about taking the experiences, children's stressful and traumatic experiences, into account. And we're going to say more about how you can think about doing this later in this webinar.

Well, another issue that we need to consider when we're dealing with traumatized children is what's referred to as triggering. Now, even if they're in a safe environment, children who've experienced trauma, they can encounter situations that can trigger a distracting memory that's been associated with that traumatic event that they experienced. Even if the traumatic event was years ago. And these trauma triggers and they're also called trauma reminders or trauma stimuli, they really don't need to be something that's really threatening them right now. It could be rather something that reminds the child or sets off a memory that was somehow linked to that original traumatic event.

So an example of trauma triggers could include things like a person who looked like the trauma perpetrator, some raised voices that were similar to the voices that occurred during the traumatic event, some physical touching that maybe occurred during the traumatic event that was sort of reminds the child about this. Or sometimes even thinking about the kinds of topics that might be discussed in the teen pregnancy prevention program might be a trauma trigger.

So thinking about topics such as how one could refuse sexual activity or identifying unhappy relationships might be enough to actually trigger some of these kids who've experienced trauma. So what happens when a child's memory is triggered in this way? It really often results in their experiencing intense distressing feelings just like those that occurred when they were originally traumatized.

And even though the children are having these feelings, often they don't link it to that original traumatic event. So oftentimes, they really don't know why they're experiencing these feelings. They sort of feel like they're out of control.

So we've covered some information on stressful and traumatic events, trauma triggers, re-traumatizing. So now we're going to talk a little bit about the links between trauma and adolescents sexual behavior.

As I mentioned previously, one sort of common stressful event in the lives of children is child maltreatment. And there have been many, many, many studies that have found that all forms of child maltreatment, neglect, physical abuse, sexual abuse, everything, have been associated with adolescent sexual behavior. And these outcomes include things like early sexual debut or risky sexual behaviors like having unprotected sex, having sex with multiple partners, having sex while using substances, trading sex for money, drugs or other things and also teen pregnancy has been linked to child maltreatment.

Not only has child maltreatment been linked to adolescent sexual behavior, but other forms of violence have also been associated with sexual behavior in adolescents, including being the direct victim of violence and witnessing violence directed at other people.

So, for example, there was a two year longitudinal study looking at violence exposure and sexual risk taking among girls in Chicago. And what the researchers found was something called an exposure-response relationship between adolescents number of violence experiences and the number of sexual partners. In other words, the more violence there was in their life, the more likely they were to have more sexual partners.

In addition, the violence variables most predictive of the adverse sexual behavior outcomes were being the victims of physical violence, being exposed to neighborhood violence and being in a relationship with a violent partner.

Now, here's some findings from another study. It's called the Adverse Childhood Experiences Study. Sometimes people call it the ACE study. And they found a somewhat similar exposure response type of relationship between the number of various adverse experiences in childhood and the risk of teen pregnancy.

Now, in this study, what they did was these researchers studied women who were the ages eighteen and older who were in particular clinics in San Diego. And the women were mailed a survey and it asked them about all types of things that might have happened during their childhood, all types of adverse experiences, things like sexual abuse, physical abuse, domestic violence in a household, somebody in the household using substances, incarceration, a whole list of things.

So that women were asked if these events ever occurred when they were a kid, and they were also asked about their pregnancy history. And what this graphic shows is that in the left-hand bar, sixteen percent of those women have said, no. I didn't experience any of these adverse events when I was growing up. Sixteen percent of those women were pregnant as teens.

And the next bar over shows that 21 percent of the women who said, yes, I experienced one adverse effect during childhood, 21 percent of those women were pregnant when they were teenagers. And all the way up, people who said I experienced two of these adverse events, 26 percent of them were pregnant as teens. And all the way up to the end of the chart where women who endorsed experiencing seven or more adverse events in childhood, more than half of those women were pregnant as teens. So you can see this relationship between the amount of violence that was experienced during their childhood and their risk of teenage pregnancy.

Well, we've gone through quite a bit of information here. And I thought we might like to take a little break so that you can use all those cute devices in this video chat to either write in your comments or direct some questions to us verbally. Any comments or questions that you have,

we'd love to hear them from you. So Adam, our operator, I think you're going to help us out here aren't you?

ADAM - OPERATOR: Absolutely. Again, if you'd like to ask a question over the phone, please press star one on your telephone keypad.

DR. OLIVIA ASHLEY: While we're waiting for some verbal questions, we have one question that's come in on the chat. And the question is what about the effects of dealing with violence in the media?

DR. SANDRA L. MARTIN: Well, I have to admit I am not an expert about this particular topic. But one thing that I can say is when we've seen these types of studies, there can be certainly some responses in kids when they see violence in the media. But it seems to be not nearly as strong as if there's violence in the household or sort of in their life type of thing.

So certainly, I'm not all for letting kids watch a lot of violent things. But on the other hand, if a kid's in a warm atmosphere in a home, it's probably not going to have such an adverse effect as some of these other things that are much closer to home, seeing real world violence, being in a violent family. But that's a great question and certainly a lot of people are concerned about it. Other questions?

ADAM - OPERATOR: We have not received any questions over the phone line.

DR. SANDRA L. MARTIN: Well, hopefully that means that I've been really clear. But if any other questions do occur to you all, please let us know.

Okay. Well, earlier in the presentation, I mentioned that adolescent symptoms or reactions to trauma could interfere with your learning experiences, including the learning that occurs in teen pregnancy prevention programs.

Well, in addition, even though we have well-intentioned programs, they could be inadvertently unwelcoming to folks who've experienced trauma. And they sometimes can even actually re-traumatize children who've experienced trauma.

So let's take the case of Josie. She's now 12 years old, but she never told anybody that when she was seven, her uncle had sexually abused her. Now, she recently started a school-based abstinence education program. And during this program, sexual activity was discussed. And what she found was that during these discussions, she started to feel like she was really re-experiencing the sexual abuse. She started to become incredibly distressed. And she was also really ashamed because she didn't stop the abuse when she was seven years old. But, of course, she was only seven years old when it happened. She really couldn't do anything.

But this ended up bothering her so much that she just really couldn't pay attention during these sessions. She would just sort of freeze up, tune out, that sort of emotional numbing thing. And she really wanted to quit going to school.

So in this case, discussing the sexual behavior in this teen pregnancy prevention program sort of triggered this response in Josie to re-experience this really horrible traumatic event. And she wanted to avoid those feelings again by just leaving the situation.

Well, we really can't predict exactly what will trigger someone to re-live a traumatic experience amongst all these trauma survivors. But, you know, possible triggers and an abstinence education activity could include things like discussing topics of how to avoid or get out of a dangerous or unhealthy situation or an abusive situation or discussing ways to avoid inappropriate sexual advances. So those are some things that really could set some people off if they'd had some traumatic experiences in those domains.

So in order to better serve trauma survivors like Josie, and actually people in the general community, those people who are concerned about trauma and study trauma have advocated for the development of something called trauma-informed care. The overall goal of trauma-informed care is to provide assistance in a manner that's really welcoming and appropriate for trauma survivors.

Now, there's a lot of different kinds of trauma-informed care or different levels of trauma-informed care. You could have trauma-informed program delivery. So one example might be a trauma-informed teen pregnancy prevention programs. Or you could have trauma-informed services. So you could maybe have a trauma-informed residential care. Or you could have trauma-informed treatment. There's quite a few folks now that are developing trauma-informed mental health treatment. And you could have whole trauma-informed systems.

And so these are sort of large constellations of programs, services, treatment, for example, that are all trying to be trauma-informed. So you could have things like a trauma-informed education system, a health care system.

But no matter what the level of trauma-informed care is, all of these trauma-informed units, they're trying to do several things. First, they want to understanding trauma, and how it affects people's lives. They want to identify current and past trauma experiences of their consumer or the people they're working with. So in your case, it would be the kids going through the teen pregnancy prevention program. And they also want to use that knowledge to really adapt their program delivery and design treatments, services, and systems that are appropriate for trauma survivors.

Well, in trauma-informed systems, all the components within the system have been really thought about in terms of what would it be like for a trauma survivor to come into this program? And then they're modified so that they can be welcoming for trauma survivors. So you could have trauma-informed education systems, health care systems, child welfare systems and foster care systems.

But if you're going to be developing a trauma-informed system, there are several things that you have to put in place to make sure that it works, okay? Several prerequisites. One of them being that the people who are in control of the resources have to decide, well, we're going to invest in this. We're going to put some resources into this to build our trauma-informed approach.

Another prerequisite is that all the folks who actually interact with the opportunity who are receiving that service or program, all the people who touch their lives, need a little bit of training about trauma and its effects. They don't have to be trauma experts, but they really have to sort of know about how does trauma affect people? What kind of outcomes to trauma survivors have? You know, a little bit about trauma. And this would include staff who delivering the programs, maybe recruit people, answer the phones, somehow interact with folks.

So the sort of overall goal is that all the people in the system become sensitized to trauma so that the whole system is welcoming to trauma survivors and avoiding inadvertent re-traumatization.

Becoming trained on trauma is very important. But you also have to be a little careful because sometimes when you become sensitive to trauma and you start thinking about trauma and working with trauma survivors, sometimes it can have a bit of a negative impact on your own health and wellbeing. And sometimes people call this the "impact of trauma work".

So this can sort of result in you sort of having little changes in your world view. So, you sort of feel a little bit more threats to your personal safety than you're used to. And sometimes you can become incredibly emotionally exhausted by thinking about this.

And there's an example here that we use where a clinician who was working in a homeless shelter in which there was a lot of trauma in the lives of the people who they saw, she told her supervisor, "Well, it seems like every woman I know now has been raped or battered. Now I practically assume that men are going to hurt me. I just can't take it anymore"

But fortunately, there are a few things that systems can do to help mitigate the negative impact of trauma work. First, I think we need to acknowledge that this is going to happen, at least for some people. And so we want to develop systems of care in organizations in which the staff can share their feelings if they start to feel that. Sort of provide a little reality check. And it helps the people to view their responses as sort of a normal reaction to trauma work.

And in addition, individuals really can sort of mitigate the negative impact of trauma work by engaging in self-care strategies. You know, take care of yourself, be aware of your own needs, your own limits. You can't do everything for everybody. You need to set some boundaries. And engage in what's called replenishing activities. Take vacations, practice yoga, go dancing, whatever makes you relax.

Another prerequisite for developing a trauma-informed system is that there be universal trauma screening of all the persons seen in the program, all the consumers of that service. So that would mean in teen pregnancy prevention programs that all the adolescents seen in that system should be screened for a history of trauma. Now, it's not enough just to screen them and say, oh, I think you've screened positive. You have to have things put in place so that if a child does screen positive for trauma that they be provided with or referred for a more comprehensive assessment of that and then interventions put into place if they're found to be indicated.

Now, certainly most of the teen pregnancy prevention programs are set within much larger systems of care. It doesn't mean that all of the groups really need to do this screening, but it might be good to think about is there a place within your whole larger system that such trauma screening can occur?

Well, over the years, there's been many different types of trauma screening tools developed. And I know hopefully you have some of these handouts in front of you that we email to you. And again, if you didn't get them, no worries because I know they're going to be put up on a fabulous website somewhere that the overview will tell you about.

But the first handout that we gave you sort of has a list of some trauma measures. And one of them I'd like to point out and we didn't email it to you because it's 170 pages. But if you go to that website, you can read those 170 pages. And it has a really comprehensive review of different kinds of trauma measures that can be used and it tells you all about them. So you could take a peek at that and see if it might be helpful, any of those could be helpful to your group.

But also, we included two little tiny brief screening tools. They're called the Lifetime Incidence of Traumatic Events. One is the student would fill it out and one is for a parent to fill it out. And in these questionnaires, the way that this one works is there's questions about different kinds of potentially traumatic events like car accidents or been sick and been in the hospital or seeing somebody get hurt. So they ask the parent or the child did this happen to you? Or did this happen to your child? And how many times did it happen? How old was the child when it happened? How much were they upset about it at the time? And then how much does it bother you now? So this sort of gives you a little indication of what these trauma screening tools look like.

Well, the final prerequisite for developing a trauma-informed system is that the system should take a look at how they operate. Take a look at what you do every day. What are your procedures? What are your policies? Could they be welcoming to trauma survivors? Or could they maybe be not welcoming for trauma survivors.

And the way to do this is to get a group together, maybe the people who deliver the program, some people who provide the service, maybe somebody who administers the system, all of you get together and sort of take a look at the things that you do day-to-day with the idea that could anything that we do here be improved to be more welcoming for trauma survivors?

It's also really good to include consumers in this kind of discussion. And certainly in your case, I mean, if you're dealing with small young kids, maybe it would be inappropriate, but maybe you could bring some trauma survivors in so that they could give also some input into what might be more or less welcoming for trauma survivors.

And naturally, as you identify things that are maybe inappropriate or maybe could be made a little bit better, you could replace them with more appropriate options.

So folks are just really starting to think about trauma-informed care organizational assessment tools. And we were trying to find an assessment tool that teen pregnancy prevention programs could use to sort of go to and say, oh, you know, is my teen pregnancy prevention program trauma informed?

Well, sadly we couldn't find one. There's nothing focused specifically on teen pregnancy prevention programs. But we did find a couple that were focused in a little bit different way. So your handouts include first an assessment, sort of a one-pager that sort of shows you where you can find these on the Internet.

And one of the trauma-informed care organizational self-assessment focuses on youth residential settings. And the other one was developed for mental health and social service agencies.

Again, these are in your handout. So the first handout sort of has where you can find them on the Internet. And I actually copied a few pages of each of these tools for you so you could sort of see how they work. And in general sort of how they work is you sit down with this tool. You think about your particular program in your system and then you go through the questions and sort of rate your own system.

So the one I'm looking at right now is the first one we sent you. It's called Creating Trauma-Informed Care Environments. And it was developed by the University of South Florida. And there's questions such as whether your agency leadership is really showing a commitment to trauma-informed care. Do they have a plan developed? Are they implementing a plan? Things like that.

So you go through all these sort of questions. And what it sort of really helps you do is to sort of get a picture of how trauma-informed is your system right now? And it also gives you hints as to what you might be able to do to make your system a little bit more trauma-informed.

So certainly all the questions in these two instruments, again, they were not developed for teen pregnancy prevention programs. But we thought that some of the questions might be relevant for teen pregnancy prevention programs. So you can go through and sort of pick and choose things that might help you assess your system.

DR. OLIVIA ASHLEY: Sandy, while you were talking, we did get a question.

DR. SANDRA L. MARTIN: Oh, great.

DR. OLIVIA ASHLEY: This is back on the slide about Josie, the 12 year old who was sexually abused at age seven. And the question was have there been any treatments found to aid this population? And I know you were talking about trauma-informed treatment, but I was wondering if there was anything else you wanted to say about that.

DR. SANDRA L. MARTIN: Well, there are. Fortunately, there are many mental health providers that are doing wonderful work with kids who've experienced sexual abuse or physical abuse or other kinds of trauma. Some of the treatments are somewhat similar to those that are done with adults. So you have different kinds of cognitive behavioral therapy that can be done with children that has been shown to be very effective. Often, they can be short-term type of treatments too. It doesn't really take often a long time to really help people out of this.

So I would really encourage folks if you know of someone who's had these kind of experiences, please do make sure that they try to hook up. Certainly, I think we could probably put some resources on the web of different groups. There's the National Child Traumatic Stress Network could sort of point you in the direction of certain types of treatments and interventions that have been helpful. And there's groups all around the country that deal with it. So yes, the good news is there's a lot of things that we can do.

DR. OLIVIA ASHLEY: I've got another one for you. We have another question. Can we get some other examples of non-welcoming or non-effective things a program may be doing? And I'm assuming inadvertently. All programs are trying to help teens.

DR. SANDRA L. MARTIN: Yes. Well, I know that Olivia is going to talk a little bit more about how you respond to distress in children. But some folks if they don't know about trauma and they don't know how some children can react to trauma and show these really negative behaviors, you might misinterpret negative behaviors as being something that the child is really sort of wanting to test you or to tick you off or make trouble in the classroom.

It might be that, but it might be something much deeper. And so I think having an awareness of how trauma can affect children's behavior can really be incredibly helpful. So I think that that is definitely one thing that people can sort of misinterpret kids' behavior in a negative way.

DR. OLIVIA ASHLEY: And I'm going to answer going because you and I have done this presentation a couple of other times with other groups, each time tailored for different groups. And I just wanted to throw out some things that those other groups had mentioned when we were brainstorming with them.

Some of the things that we've heard from other teen pregnancy prevention programs when they've brainstormed, things that maybe happening that they had never thought about might be re-traumatizing trauma survivors. Some programs are focused on adult mentoring or bonding with and adult facilitator or mentor who's not trained or aware that trauma survivors may have different reactions may try to rush that relationship a little bit and sort of push the teen to open up more or ask questions that for a teen who's not been through a trauma maybe very innocuous about her family or about do you like boys or things like that.

And if a teen is not responding to those types of questions or that type of intimacy, it may not mean that they're never going to do that. It may mean that they need to go at their own pace because when they open up, they have a lot to say and are not sure that they're ready to do that yet. So that was one thing that we were hearing was adults rushing mentoring or facilitation a relationship.

A second thing that we heard folks brainstorm is in group activities calling on teens to answer questions in a group when those teens may not feel very comfortable being called on. I know when we've delivered programs or we've trained implementers, we've been very cautious about asking for volunteers and making it clear it's okay if people do not want to share today. Rather than putting somebody on the spot and asking the question again that may sound very innocuous, but there may be a large trauma story behind that or maybe a trigger. And that teen is not going to be able to speak in front of a group and maintain their composure or keep from lying. So that maybe another way, just calling on teens.

And the third that I recall that we talked about is physical touch. That when the facilitators and staff are bonding with teens, it's very normal to hug or put your arm around or show affection in some way. And some teens are not going to respond to that very well.

So I think being very aware of personal physical boundaries and perhaps training staff in what is considered appropriate touching, frequently touching on the arm or the shoulder maybe okay. But putting an arm around someone's waist or touching their leg may really be a trauma trigger for some people. And it maybe that if you're sensing that the teen doesn't want any touching or doesn't want you to even stand that close, that maybe another sign to back up and let the teen show or tell you when they're ready to be that close. Those are just some things that we heard other programs talk about. I hope that answers the question. And if not, we are open if folks want more answers and want to talk about any of these topics more.

What we want to do right now is ask you some questions. So we've presented a lot of information. So it's really Sandy's done a lot of presenting right now. And so we're wondering what your thoughts are about how you might deliver your abstinence education or other teen pregnancy prevention programs' messages or activities in a manner which would be welcoming and acceptable and not re-traumatizing to all adolescents, including those with a trauma history.

So we're interested in any thoughts that you may have. It maybe something that you're already doing. There may be folks who have more expertise than Sandy or I have on this topic. Or it may be thoughts that you're thinking right now as we're talking about this. So do folks have any thoughts about that? And you see there are a couple of other questions on the screen. We're open to input on any of these questions or any comments or thoughts that you have. But we thought we might stop talking and let you tell us what your thoughts are. So feel free to use chat. And Adam, we're going to turn it over to you to see if folks have answers or thoughts about at least that first question if not other things that we've talked about so far.

ADAM - OPERATOR: And again, as a reminder, you can use star one on your telephone keypad. And we do have a question from the phone line. It's Heather Bruning from Arizona Youth Partnership. Your line is open.

MS. HEATHER BRUNY: Hi, thank you both for this presentation. It's very helpful. I just want to make a comment. I know one thing that some of us do when we're presenting in the classroom to help make participants feel a little more comfortable is when we're defining sex, we make sure to share that sex is a choice between two people. Sex is not abuse, rape or anything of that nature. The sex that we're presenting is when two teens, two adolescents, or two people are choosing to have sex with the other person.

So we do that just hoping to kind of help everybody feel a little bit more comfortable. And then we share if anybody knows of a friend or has experienced that abuse, that is something that shouldn't happen. And that we encourage them to talk to somebody about it if they haven't done so already. And that if they have questions, they can list ... we pass out anonymous question slips, stuff like that.

DR. SANDRA L. MARTIN: Great. Thank you for sharing that.

DR. OLIVIA ASHLEY: Heather that sounds really excellent. Do we have any other ideas or things that you're already doing as they're delivering programs in a way that would be welcoming and acceptable, not re-traumatizing? I think it's really helpful when grantees hear from each other on the front lines. Sandy and I do a lot of things, but we're not delivering a teen pregnancy prevention program right now. So in this case, you may have a lot more to offer your colleagues on the phone than we do.

Let me throw out the second question. How might you work with others within your larger system? And this would be the system in which you're education program or your other type of teen pregnancy prevention program is set. This could be the school system. We've worked with teen pregnancy prevention programs that are set within the juvenile justice system. They may be part of a larger service system that involves mental health services or foster care services or residential placement services.

So how can you imagine working with other people in that larger system to incorporate a trauma-informed approach? Do folks have thoughts about that or experiences that you can share with other folks on the phone?

ADAM - OPERATOR: And once more, that's star one.

DR. OLIVIA ASHLEY: I can share one of the things that we were hearing when we were talking with other groups. And Sandy, you may have thoughts about this as well. What we were hearing from folks who were delivering either in classroom settings in the school, in after school settings where there may not be such a rigid schedule as in the school when the fifteen minute bell that rings and everybody leaves the room. Or within a system that does have some limitations on people's time and freedom like in a detention center or juvenile justice center.

And that was that they were doing a lot of collaborating and planning so that there was some system for referrals, if not for screening. They were very intrigued by the idea of screening when we were talking about it and it may not be happening yet. But they were, before they started delivering services, getting together with the other folks within that system to talk about if we have someone who is experiencing the traumatization or is disclosing something that needs to be addressed or we are concerned about that child.

Who within our system or within our larger referral network should we be contacting? And what should that procedure look like? Who's going to be responsible for that child and making sure that that child is getting services or referrals or the parents being notified? So that the frontline program facilitators are not having to make that decision on the fly using their best judgment or delay action by trying to contact a supervisor and it's maybe after hours and not being able to reach someone.

So using all of the components of a system to think about where those resources and services could be obtained. Because the person who's delivering the teen pregnancy prevention program may not be a social worker or crisis intervention person or experienced enough to handle what they're seeing. They just know that that child needs some services that they can't provide themselves.

DR. SANDRA L. MARTIN: I guess the big thing is to try to be prepared. Think about it ahead of time. So that if something like that happens, you know how to respond.

DR. OLIVIA ASHLEY: We were also hearing from some systems, for instance, that are in juvenile justice that there is screening, that it's happening already before children enter the system. This maybe the case for residential care to determine whether children are appropriate for residential care or what level of residential care they should be placed in. Screening maybe happening to foster care to determine whether they need a therapeutic foster care home versus a relative foster care home and how many other children and what mix of children would be appropriate in that home.

And so what we were hearing some brainstorming there was if we're already doing screening for issues like placement and appropriateness, we may not be doing the screening that we're thinking about for trauma-informed care. But that would be the opportunity to add trauma-informed care questions to our screening.

It's not like we're burdening that child or family or caseworker with a second screening. But if we're already doing some, then we can add some of this that would help inform a treatment plan or a teen pregnancy prevention program. So that the facilitator has some awareness of the population that we're working with and/or even if the facilitator is not informed, that children who are identified as trauma survivors are getting referrals for services and treatment that's appropriate for them as they're receiving teen pregnancy prevention programs. That was another thing that we were hearing about, how to incorporate screening in a system that's already doing a different type of screening.

DR. OLIVIA ASHLEY: Yes. And I think the systems that were set with more high risk groups that people who are working with children in juvenile justice or foster care, I think some of those systems, the people working in those systems had thought about trauma. Because it's certainly something that they deal with every day. So they've probably thought about it a little bit more than people who just work in the traditional school system. Although, certainly everybody now is I think in some ways thinking about trauma.

So I think everybody has a little bit of knowledge about it. And I think the whole issue of trauma informs care now. Some people might have heard of it and some people haven't. But I think

when people hear about it, they think, yeah, that seems to make sense. That seems to make sense. Although, there's definitely barriers and challenges. People have told us we only have so many hours in a day and we need to deliver our program. So gosh, are we supposed to do the screening now too?

But I think that the solution is you need to certainly deliver your program. You need to keep with its fidelity. But think about the partners you work with and are there other places within your system where such screening might be able to take place.

DR. OLIVIA ASHLEY: So this is our last question for you and that is are there any other barriers or challenges to incorporating some of the things Sandy's been talking about into your project? And are there any strategies or solutions that Sandy or I or others on the phone can help brainstorm for you?

So again, we'll open it up to see if there are any comments or experiences that you can share in terms of barriers or challenges? And we'll also take anything about chat that we need as well.

ADAM - OPERATOR: And once more, that's star one if you'd like to ask a question or if you have a comment for the phone line.

DR. SANDRA L. MARTIN: Adam, do you have any questions?

DR. OLIVIA ASHLEY: No. Oh, no.

DR. SANDRA L. MARTIN: All right. I'll tell you the number one barrier or challenge that we heard from teen pregnancy prevention programs and that is unsure about how to handle an individual specific situation in a group setting. That very few teen pregnancy prevention programs are in a one-on-one private clinical, take all the time you need, type of situation.

And a lot of concerned I've mentioned first about time constraints. If we have fifty minutes in the classroom and our session takes 45-50 minutes, how are we going to handle that? But privacy issues as well and disruption issues as well. If we have a child, for instance, like the example

we were given with Josie, do we stop what we're doing and sacrifice the entire classroom, receipt of materials? Or do we try to pull that child aside? And if we only have one facilitator, how are we going to handle that in terms of staffing? If a child wants to talk, do we really encourage them to talk in front of the rest of the class? So I know that there are a lot of logistical barriers and challenges with having a setting.

We've brainstormed quite a few strategies and solutions with folks. I want to make sure that at least the competitive abstinence grantees know that if you have challenges or barriers or want any assistance with any of the things that we're talking about today, you should feel free to contact your project officer to request technical assistance. Because we will be happy to work with you on a one-on-one basis without your project specifications and what to do about things in your settings. And I'm sure that your project officers and folks with OAH may have a lot of other resources for getting answers to your questions.

Certainly, if you want follow-up information after today about this, please don't hesitate to reach out to your project officer. And also for folks who are with FYSB, both state abstinence and competitive abstinence, we have a community practice website with lots of other grantees who are participating there. And many of them have either received this presentation or are already thinking about trauma-informed care and have expertise. So that's another resource to get answers to your questions or brainstorm solutions to challenges. Sandy, anything else that you want to say before we move on?

DR. SANDRA L. MARTIN: No, I think I said all that I'm going to say unless there's other questions.

DR. OLIVIA ASHLEY: Okay.

DR. SANDRA L. MARTIN: Are you going to move on?

DR. OLIVIA ASHLEY: I think so. So if folks do have thoughts or questions beyond this, feel free to hit chat and we'll have another opportunity towards the end for any last comments or questions that folks have.

This last section is on identifying and responding to trauma. And we have a handout that we sent. And the title of this one is "Identifying and Responding to Requests for Help, Disclosures, and Distress." So we're going to refer to that handout now. Again, if you didn't receive the handout, please let the folks who invited you to the webinar know. So that they can let us know and we can get those to you. And we'll be posting these on the competitive abstinence and state abstinence, FYSB community practice website for those grantees.

So in the handout, we have at least three types of events that we thought might be worth taking a look at. One are just simple requests for help that frontline program facilitators may receive. Another type is adverse events. And this is where just stress is being noticed. And we will talk about what the stress actually means. As well as disclosure of past trauma. And then serious adverse events, we've put in another category. These are things that are more immediate, certainly more dangerous for children and need a very concerted response from staff for organizations. So extreme distress. Certainly suspected child abuse or neglect and imminent harm that maybe occurring.

Before we start talking through this handout, I just want to clarify the difference in terminology here when we talk about distress. On the left-hand side of the slide, you see what is not distress and that is discomfort. Discomfort is very normal. Anytime you put a group of teens together in a classroom and start talking about sex, you are going to have discomfort. There will be kids who don't want to participate in an activity. There are some who don't want to answer questions or talk about something. They may say the information's just too personal to discuss. They just are not comfortable and you will notice that. That is not what we're talking about in terms of responding to distress.

But on the right-hand side, what you see here in all of the rows is emotion. So if you are seeing emotion behind this, peers or verbalizing the child feels bad or is sad about something or starts to look nervous or anxious, those are some signs that you are looking at distress. This is more than just normal teens not wanting to talk about sex or hear about sex at that particular moment. And those are the types of things that we're going to do a handout.

So taking a look at the handout, the first row that we have here is a request for help with no distress. And this handout is something we use when we train our staff. I just want to clarify that this is not what FYSB or OAH is mandating that everybody do. This is one model that RTI uses. And we're presenting this so that you can consider what protocol you have and think about whether it is comprehensive or that you want to make changes or improvements to it. You can certainly adapt or steal anything that we do here. But the key is to make sure that you have a protocol. If you're agency already has a protocol, you certainly need to follow that. We're just trying to show you how detailed a protocol maybe and to give you some opportunities to think about things that your protocol may already do or may need to do to improve.

So the definition is in the first column. A request for help with no distress. Maybe a teen who says they want to talk to someone or they ask for some help about how to make decisions about sex or about what to do about a dating abuse experience. They're not telling they're in a dating abuse experience. They're just asking for help in making decisions. And you're not seeing any emotion or any indication verbally that there's distress.

And so we put some real examples that we've encountered in this net column. I don't know what to say or do every time my boyfriend wants to mess around. Can you tell me what I should do if my boyfriend hits me? Again, it's not a disclosure that the boyfriend has hit them, but hypothetical.

I think I need some help in finding ways to stop being violent to my dating partner. And who do I talk to about helping with friends?

So these are some requests for help. And what we tell our staff to do first of all is to pull out our hotline card. We've provided for you a second handout that has referral sources on it. We've included some local referral sources from when we've worked in specific schools. So that kids don't feel like they're calling a 1-800 number and not knowing where it's going to. And then we always provide national phone numbers and websites. Because some kids, maybe in a rural area or a small community, do not want to talk to someone in their community. They really want to talk to someone outside that area.

And so what we tell our staff to do is be sure to show this hotline card and give some information about the first responder. In this case, it was the school counselor. And we are really big on documentation when things like this happen. For this type of situation, we tell the staff that an incident report is optional. This is not a case where a child is saying there's danger. But if the staff feel like they want to document that there was no disclosure of danger for their own protection, that's totally fine for them to do.

The second row is disclosure, but still no indication of danger or distress. And so this maybe where a child discloses past trauma, past victimization or perpetration that's not by a caretaker. So again, this is not a caretaker child abuse or neglect kind of situation. And they're not asking for help or expressing emotional reactions. We've seen these types of disclosures.

For example, this summer, a girl did some sexual things that I really didn't want to have happen to me. Or a boy pushed me down the stairs last year and now he wants to sit beside me in the lunchroom. And I'm totally annoyed. We've had situations like that happen where it's pretty clear the teen is not distressed. They're talking about something that's happened in the past. And it's not their parents or someone in the family where they're not being taken care of.

And what we tell our staff to do is to acknowledge the feelings. And in this case, it's the lack of feelings, we say you don't sound upset by what you're telling me. And teens are very vocal. They will tell you if they are saying I am totally upset. I don't know why you say I'm not upset. Then you get the emotion and you're realizing you're misreading the situation. And remind the teen that participation in the activities that you're offering is voluntary. Which means that you're going to have to have an alternative activity if they say I want to step out. They may go to the back of the room and read and work on their homework. Or you may have a teacher with a study period that's going on next door that she's worked out where that teen can go.

And we always show the hotline card. And this is a case where we do want our staff to write an incident report because we're on a fine line here about did the teen tell you they're in danger or not? And we really want to make it clear that the staff's best recollection is they did not her disclosure that the child's in danger.

We have a note at the bottom of this first page and it repeats on every page. For all types of incidents, we tell our staff not to ask questions. And I know that may sound counterintuitive to people who really care about teens and want to help them. The problem with asking questions is that if our staff are not trained as social workers or crisis intervention workers and they're in a group setting under time constraints, the answer to the question maybe more than they are trained to handle.

So we make sure they know how to refer to the person who is in a private setting and has that training to ask questions. But we tell our staff not to ask questions. And when we start to get some of the more serious situations like imminent harm, unfortunately asking questions for a child who is talking about thoughts of hurting himself may further that into making a plan when you start to ask questions about how seriously they've thought about it and exactly what have they thought? So we actually don't want to unintentionally move that child into a more dangerous space.

So we ask not to ask questions, but instead document what they're hearing. Unless we're in a setting here, for instance, it is a social worker or therapeutic setting. The programs that we've been delivering are not those types. But certainly someone who's trained to do the agency protocol, by all means do that.

Now, turning to the second page on the handout, moving now to mild distress. And this is where a child makes a statement about worry, anxiousness or sadness, but there is no emotional reaction, just this verbalization that they're feeling this way. So the examples we've given are my boyfriend is tripping. He's got me all upset. But the child doesn't actually look upset. Or we've had situations where the facilitator is talking about rape or sexual coercion and we've got a child who says don't use that word. I don't like it. It makes everyone feel bad. The child was not apparently emotional, but making statements that made you think there was something going on there.

Again, we acknowledge feelings. We remind them that participation is voluntary and show the hotline card, give information about the school counselor. And we strongly encourage the teen to contact either the school counselor someone on the hotline card. And we're really paying

attention as to whether we're seeing any signs that there is more distress here than that initial statement.

The next line we have is moving into moderate distress and this is where we see tears or a child says that they feel badly or sad. And they show some emotion, but the key here is they recover. And I get moderately distressed all the time. Somebody tells me something that breaks my heart, I tear up and then I'm okay.

So if a child shows this, the things that we tend to do are to acknowledge feelings. I can tell you're upset because I see some tears. We remind them that participation is voluntary, show the hotline card. We give them information about the school counselor. But we take them to the counselor. We actually walk them down the hall and we don't leave them in the chair outside of the counselor's office. We make sure that connection is made before we walk away. And we're always paying attention to see if the child actually does not recover and are moving into a more serious situation and we always write exactly what happened as well as the actions that that person took.

The last page is our three most serious situations. One is extreme distress. This is where we have an extreme emotional reactions, statements that indicate concern about unwanted sexual activity or dating abuse to the point where the teen is consumed with worry or anger or anxiety, and any statements about extreme hopelessness, sadness or depression. This is where children are very upset. And the key to this is they can't stop this emotion and they're actually escalating to the point that you're very concerned.

We tell our staff that that point, you have to stop program delivery. It's not enough to say you can sit in the back of the room. This child is in crisis and we think that it's more important to stop program delivery rather than to harm any child. We take this teen to the school counselor immediately. We wait until that person's available. We let the school counselor make decisions about how to handle that situation. And we record anything in writing that the teen says, particularly if they start talking about harm to self or others. And we make sure that all of our frontline staff have a lot of cell numbers for supervisors that they can call and notify about what happened and then they document what happened.

The last two maybe things that you already have protocol for. What is suspected child abuse or neglect? This is where someone says something that makes that person suspect. It may not be proof of it. They may not know for sure, but they suspect there maybe child abuse or neglect or that there are some observations like bruising or something that makes a person suspect.

And so some of the things that we've heard are disclosures in the middle of class. My mom hits me when I'm mean to my little brother. We don't know. The mom may hit that child very lightly in a way that is not abusive. But that mother may hit that child in the face with a fist. We don't know.

So in this case, we want someone else to investigate it and check it out. We take the team to the school counselor immediately, wait and make sure the school counselor is available. Report immediately and then we make sure that our staff, the school counselor and the supervisor place a joint call to child protective services. We just don't walk away and trust that someone else is going to make that referral. Because we feel a responsibility if our staff heard that to be involved in that.

The last one is disclosure of immediate harm or danger. This is when someone says someone is going to get hurt today. And this is a really serious situation where we can't go home and go to bed and hope that everything works out. So we immediately notify the school counselor, immediately notify the supervisor and again we place a joint call to the authorities. And in some cases, that may be 911. So we need some immediate assistance from law enforcement or someone else. And we certainly write the incident.

I hope that these concrete examples and suggested responses are helpful for folks in evaluating protocols that you may have or thinking about protocols that you may want to develop for your staff.

Some things that we just want to point out. We distribute that hotline card to all teens, not just when teens express distress. At the beginning of session or program where there's going to be sensitive information discussed, we don't make teens express distress in order to get that

information. We give it out proactively to everybody. If anything comes up while we're talking about these topics and you want to talk to someone, here are some folks that you can talk to. And you can certainly approach me or the facilitator after class if there's something you want to talk to me about.

I think folks who work with teens a lot know that teens are not going to tell you the whole story at once. They are checking to see if you're a trustworthy person and how you're going to respond to them. And then if they stay, you may hear more.

So it's always important to be aware that there may be more to the story and to continue listening. And you can see a lot of our guidance to our staff was keep paying attention to see if there's more here than what you were originally seeing.

This last bullet, just want to make certain that folks know if you don't have memoranda of understanding with some of the agencies that you refer to, this is an excellent opportunity to go ahead and get in writing some plans for receiving services and how that will happen in some agreement for folks to prepare to receive referrals that your staff maybe making.

It's just really important to make sure that children that you're working with have an opportunity to talk with a caring parent or other adult who can listen and that they have an emotionally safe space to do that. If the group setting is not the place for that, the plan should be to refer them somewhere where that can happen. And certainly to notify parents. Our plan is to notify parents as long as the child is not saying the parent is the source of the distress. Because parents need to know when their children are spiritually distressed or have had events happen that they could be the primary caretaker in responding to that.

I'm sure that all folks o this call know that all state child welfare systems receive and respond to child abuse and neglect, reports of suspicion and offer services to teens and families and that every state has specific reporting requirements about who is mandated to report. That it's no longer a choice. In all cases, it's just really important to consider the safety of the teen. And we consider this a shared responsibility of everyone who has any knowledge of suspected abuse and neglect.

And I've mentioned that we certainly want to make sure the parents are notified, but we want to make sure that teens are notified at the beginning of your program or session where things like this may come up. So that they know if they disclose this, this is what's going to happen. We don't want teens to feel that their trust is being violated.

So we want them to make sure that they know before we start talking about teen pregnancy prevention or sex or how to refuse sexual advances, that I want to be your friend and I want to help you and we want to build an atmosphere of trust here. But if anybody tells me somebody who is going to get hurt or has been hurt or I see somebody is very upset, I'm going to need to bring somebody else to help that person. So that they know that this may happen and you and your staff are not feeling this dilemma of do I violate somebody's trust?

So here's a scenario that we've talked with other groups about that you or your staff are delivering an abstinence education program or another type of teen pregnancy prevention program to seventh graders in an afterschool setting. And during a discussion about sexual coercion, a teen blurts out that her friend was raped, that everybody at school harassed that friend, and the friend had to move away and change schools.

When the session ends, the staff person asks if the teen can stay afterwards to talk. And as that person's talking with the teen alone after class about this, they learn that this actually happened to the teen, not the friend. The teen is pretty angry and confused about what happened. The police investigated, but the family moved away and did not want to press charges. So nothing came of it.

So our question for you is in terms of your experience and if you're not sure in terms of the handout that we just went over, what are your thoughts about what's happening here in terms of the type of events? How would you and your staff respond to this setting?

So we'll open it up on any thoughts on this on chat, as well as any comments or answers that we might get over the phone through Adam. Adam, are you ready to prompt folks about verbal questions and comments?

ADAM - OPERATOR: As a reminder, hit star one if you'd like to ask a question. And we have no question from the phone line.

DR. OLIVIA ASHLEY: We're seeing a note here that at least one participant needs handouts. And we've got that person's email address. So we can absolutely send those. We've recorded that so we can make sure if there are other folks who need copies of handouts, please feel free to use chat or let us know through the person who invited you to the webinar.

What we talked about when we talked about the scenario with other folks is that we've seen here that this is a disclosure and there is some emotion here. So there is some mild distress. It doesn't sound like this teen is in danger of eminent harm. So it may not be a situation where 911 needs to be notified right this second. In fact, it sounds like law enforcement has already investigated.

So it's not a matter of reporting to law enforcement. But certainly a teen who's been through an experience like this not only the initiative violent experience, but some of the aftermath of things that happen in school and moving away from whatever potential support systems were in place there.

This teen certainly has some trauma experiences and is going to need to be able to talk to someone. They've reached out and said, first of all, that it happened to their friend. And now they're saying that it happened to them. The front line staff person may not be the person who's trained in social work or crisis intervention to help this teen. But certainly referral services and making sure that this teen who seems to have a lot of weight on her shoulders gets to someone that she's able to talk to would be very important.

We would want to make sure that our staff documents that so that it's really clear what was said here and how we responded to that. And we would always according to our handout on page two be watching and listening for escalation and how this teen was feeling at that time, to see if we're becoming more and more concerned about her or if this is something that she just needs someone to continue talking with her about.

We're seeing lots of requests for handouts. So we're writing all of those down, wanted folks to know that we're getting those through chat and we will be sending those out.

All right. I'm going to move onto the end of this and this is our Take-Home Summary. Sandy talked a lot about how prevalent trauma is and how far reaching it is in its affects. We want to make sure our message is clear.

We are not by any means saying that there are some teens who should not receive teen pregnancy prevention services or who cannot receive abstinence education services. And we are not by any means saying that healing is not possible, that once someone is traumatized that they are destined to be dealing in that traumatic moment forever.

We are trying to make sure that folks understand that teen pregnancy prevention and abstinence education are important to deliver and that healing is very possible for everyone, regardless of how vulnerable they may appear in the moment that you're encountering them.

We're just trying to make sure that as you all are delivering services that you're aware a traumatic experience maybe occurring out there, how they maybe manifesting. And we have some plan for how you and your organization can link up trauma survivors with healing services that they need and be aware of types of situations that may inadvertently trigger or re-traumatize so that she can avoid those.

We talked a little bit about some adaptations to program delivery, design treatment services or systems that maybe possible for you that are appropriate for a trauma survivor.

Of course, it's very important, as Sandy mentioned, to maintain fidelity to program's core components. But to the extent that there are things that can be done to accommodate the types of populations that you are serving as well as trauma that you may not be aware of on the first day. It may be important to consider whether those are things that can be done.

Be sure to let teens, and parents if you're working with parents, now up front before anyone discloses that you're going to have to involve other people for some type of incidents that you may learn about. So that they don't feel like their trust is being violated when you have to do that.

Make sure that all of your program delivery staff and supervisors are aware of how to identify and respond to different types of incidents that might occur when working with teens and talking about the topic of teen pregnancy prevention and abstinence education.

And we believe that healing happens when relationships are safe, authentic and positive. So the work that you're doing is invaluable with teens and the extent to which you're being sensitive to the possibility of trauma and trying not to re-traumatize trauma survivors and thinking about how to make things more welcoming for them or the steps we're doing for them.

I am seeing another question. Are there any public resources for non-licensed workers that we can recommend like books, websites, articles that discuss how to respond to distress, trauma?

DR. SANDRA L. MARTIN: You know, that's a good question. I don't have anything right here that I would recommend. But certainly I think what we can do is certainly look into that and perhaps put something on the website for those who'd like more information. So it's a very big question. There are certainly websites like the National Childhood Traumatic Stress Network. There are various websites. And please let me just peruse through some of those and try to pick a few things that could be very helpful for your situation. That's an excellent question. Thank you.

DR. OLIVIA ASHLEY: Yes, a past life like back in 1990, I was doing family therapy and working in employee assistance programs and had a long list of resources back then. Since I've moved into public health and teen pregnancy prevention, I don't have it at my fingertips. But I'll pull my resource list, pool it with Sandy's and we can follow-up on the community practice website as well as make sure that folks at OAH get some response about those with a reading and resource list. So, thank you so much for that question.

DR. SANDRA L. MARTIN: And if anyone on the webinar also has some great resources, we'd love to see what you have.

DR. OLIVIA ASHLEY: Definitely. Okay. The last slide that we have to present on before we just get into references is a message for you from Crystal.

Crystals says, "The 17 years I had had on this earth were violent and full of pain. I was raped at four years old, before I could even write my name, by some adolescent teenage boy that was a babysitter. I told no one for fear of him coming back. Then less than two years later, my father began sexually abusing me. He stopped when I hit puberty, but the pain lasted much, much longer. My house was an ongoing domestic violence situation, and fear gripped my life.

This was the first place I shared any of that. You gave me the opportunity to share my secrets so I could unbury myself from my perpetrators' lies, and discover the quick-witted, sunshine-beach loving adult that I am today."

So what we want is for you to know the power that you have when you're working with teens, that you are an opportunity for these teens that you may not know, but will let you know that they've had trauma in their lives and they're looking for someone who can change the trajectory of where their lives are going. It's a tremendous responsibility, but we know that you have a lot of expertise, a lot of resources and a lot of support to respond to these teens and to be really sensitive to their situation.

We're so appreciative of the work that you do and really want to be available to provide additional resources for support. So again, if you want to request additional information or follow-up from this webinar, let your project officer know and check out the community practice website for FYSB grantees so that we can provide more information for you.

We have a long list of references and reading materials. These do not respond to the question about resources for non-licensed workers about helping. This is more information about trauma that may be happening, prevalence of trauma and studies that have shown how trauma may manifest in the classrooms. We think these are really important things to be familiar with,

particularly on certain populations that you may be working to. But some of the materials here may not be practice oriented. So that's the resource list that we put in for you.

And the last thing, I think that's all that we have, those final five notes. That's all we have. I just want to check in and see if there are any other final comments or questions through chat or through the phone line before we wrap up. But Adam, can you make one more sweep to see if there's anything else anyone else has to say or ask.

ADAM - OPERATOR: And once again, that's star one if you'd like to ask a question. And we have no comments or questions from the phone lines.

DR. OLIVIA ASHLEY: Okay. We really want to thank you for your time and attention today and for your thoughtful comments and questions and suggestions for handing out resources. We've taken down all of the email addresses that we received. So we will follow-up with handouts for those folks. And next week, we'll be posting information on our community practice website for FYSB grantees.

There is one more question and that is can we backup a slide and show ... we have slide forty-one. And then we'll show this other slide. And I think that should take folks there. All right. Thank you all again very much. I think this concludes our webinar.

DR. SANDRA L. MARTIN: Thank you. Have a great weekend.

ADAM - OPERATOR: This concludes today's conference. You may now disconnect.

(END OF TRANSCRIPT)