IDENTIFYING, PREVENTING, AND TREATING CHILDHOOD TRAUMA: A PERVASIVE PUBLIC HEALTH ISSUE THAT NEEDS GREATER FEDERAL ATTENTION

HEARING

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COMMITTEE ON OVERSIGHT AND REFORM HOUSE OF REPRESENTATIVES

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IDENTIFYING, PREVENTING, AND TREATING CHILDHOOD TRAUMA: A PERVASIVE PUBLIC HEALTH ISSUE THAT NEEDS GREATER FEDERAL ATTENTION

Thursday, July 11, 2019

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND REFORM
WASHINGTON, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 2154, Rayburn Office Building, Hon. Elijah E. Cummings, (chairman of the committee) presiding.

Present: Representatives Cummings, Clay, Cooper, Connolly, Rouda, Wasserman Schultz, Sarbanes, Kelly, DeSaulnier, Lawrence, Gomez, Ocasio-Cortez, Pressley, Tlaib, Jordan, Massie, Meadows, Hice, Grothman, Cloud, Gibbs, Miller, Armstrong, Steube, Keller, and Maloney.

Chairman CUMMINGS. The committee will come to order. Without objection, the chair is authorized to declare a recess of the committee at any time and this full committee hearing is convening regarding identifying, preventing, and treating childhood trauma.

I now want to recognize our distinguished ranking member for an introduction of a new member of our committee.

Mr. Jordan?

Mr. JORDAN. Thank you, Mr. Chairman, and I am pleased to announce that we have our newest member is Mr. Fred Keller from the great state of Pennsylvania representing the 12th District.

Mr. Keller served in the General Assembly in Pennsylvania for over eight years. A wonderful addition to our committee and, maybe most importantly, he is married to his wife, Kay. They have two kids and, probably most importantly, have two grandchildren.

So we welcome Fred to the committee and look forward to working with him to serve the great people of our country.

Thank you, Mr. Chairman.

Chairman CUMMINGS. Thank you. I want to too extend a warm welcome to our newest member, Fred Keller, who represents the 12th District of Pennsylvania.

During his time in the state legislature he demonstrated a commitment to open accountable government, focusing on transparency. Congressman Keller set an example by posting his personal and office expenses online while he worked to establish those standards for state government.

I look forward to working with him on those and many other issues and I am pleased to welcome you, Congressman Keller, to our committee.

Thank you very much.

I will now—did you want to say something? Did you want to say something? Huh? Okay. All right. I didn't want to—on your debut I didn't want to mess it up.

[Laughter.]

Chairman CUMMINGS. I will now yield myself such time to do an opening statement.

Mr. KELLER. Thank you, Mr. Chairman. It is such a pleasure to——

Chairman CUMMINGS. Oh. I thought he said he didn't want to.

Mr. JORDAN. I thought he did. I think he did.

Chairman CUMMINGS. Okay.

Mr. KELLER. Thank you, Mr. Chairman. It is a privilege to be here and serve the people of Pennsylvania's 12th congressional District and the citizens of the United States of America. I look forward to working with the committee and all the other Members of Congress to have a positive impact in the work we do here in Washington, DC.

Thank you.

Chairman CUMMINGS. Thank you. Thank you very much.

Now I yield myself five minutes for an opening statement.

When I thought about this hearing I could not help but think about the 1997 film "Good Will Hunting." If you will recall, in "Good Will Hunting" we had Matt Damon and Ben Affleck and Robin Williams, and Matt Damon played as a troubled youth, and his psychiatrist, played by Robin Williams, was trying to help him because he kept getting into trouble. Remember that?

And for some reason, there is one sentence in that entire film that I shall never forget. When the psychiatrist, played by Robin Williams, went up to the young youth, who had been in and out of trouble and had all kinds of problems, and he said these words.

He said, "It is not your fault. It is not your fault." And so today we are examining a critical issue that does not get enough attention here in Congress or throughout the nation—childhood trauma.

Childhood trauma is a pervasive public health issue with long-term negative health effects that costs the United States billions of dollars.

In 1998, the Centers for Disease Control and Prevention published a landmark study that found that adults who suffered from adverse childhood experiences, also known as ACEs, are at a much greater risk of several leading causes of death, including heart disease, lung disease, cancer, substance use disorder, and suicide.

The study examined the effects of adverse child experiences such as abuse, neglect, or separation from a parent, and it also examined the long-term effects that these events have on children throughout the rest of their lives.

The science is powerful. Traumatic experiences can injure the developing brains of children, create lifelong impairments to their ability to manage stress and regulate emotions, and significantly increase the likelihood of negative health outcomes.

As we will hear today, a growing number of researchers, medical professionals, public health experts, and government officials warn that childhood trauma may be one of the most consequential and costly public health issues facing our Nation today.

The CDC recently estimated that cases of substantiated child maltreatment in 2015 alone will generate consequences that will cost the United States $428 billion.

As staggering as that may sound, the CDC warns that this estimate likely undercounts the true costs to our Nation because it examined only some of the types of trauma that children experience.

The good news and the reason we are holding this hearing today is that childhood trauma is preventable and treatable. The effects of traumatic experiences can be identified, damage can be healed, and children who have experienced trauma can become thriving and productive adults.

To do this, we need a comprehensive Federal approach that recognizes the severe impact of childhood trauma and prioritize prevention and treatment.

I applaud the efforts of dedicated professionals at the CDC and other agencies to address childhood trauma. However, efforts at the Federal level are still severely under-funded and they do not provide the comprehensive whole-child approach we need to combat this crisis.

Childhood trauma is a nationwide public health issue associated with an epidemic of negative health consequences.

For example, in 2017 substance abuse disorder—use disorder and suicide took approximately 150,000 lives in this Nation and reduced life expectancy for the third year in a row.

The Federal Government should be providing national leadership and resources to combat this public health epidemic. Some states and localities are implementing promising programs to help prevent and treat childhood trauma that can inform Federal solutions.

State and local health agencies are on the front lines of the childhood trauma crisis. They are confronting many of the negative health consequences that trauma produces.

Sadly, I see this every day in my city of Baltimore where far, far too many of our community's children are suffering severe trauma, including experiencing or witnessing violence or losing parents to violence, incarceration, or substance use.

As we will hear today, today state and local agencies are pioneering innovative interventions to address the crisis, and I want to thank all of our partners in this effort.

The Government Accountability Office has highlighted several of these promising efforts. However, it has also warned that states are facing limitations in funding, technical capacity, and personnel to address this complex and multi-faceted problem.

I often tell my staff that when people come into my office who are troubled that they must remember that many of the problems that they suffer today started when they were a child. Started when they were a child.

And there are two paths of life, I tell them. There is one path that is your destiny. The other path is development, and you have got to have both.

And so as a Nation, we have a significant economic incentive and, more importantly, a profound moral imperative to ensure that our children have the opportunity to thrive and succeed. That is why we are having this hearing today, and I want to thank all of our witnesses, everybody who is here.

And now I am pleased to yield to our distinguished ranking member, Mr. Jordan, for his opening statement.

Mr. JORDAN. Thank you, Mr. Chairman.

Let me first thank our witnesses—Mr. Miller and Ms. Martin, Mr. Kellibrew, Ms. Aviles-Rygg. Your stories are not easy ones to tell and it is brave of you to come here today and share them with us.

In particular, I want to thank you, Ms. Martin. It is hard to believe it has been 20 years since that tragic day in Colorado.

The topic of today's hearing is an important one. Childhood trauma is something we must all strive to better understand, work to prevent when possible, and treat when discovered.

Our children are, after all, our most precious gift. The research shows that traumatic childhood events actually alter brain development, as the chairman said, and are linked to higher rates of heart disease, mental health issues, that lead dramatically to increased rates of suicide.

Childhood trauma also leads to increased drug use. The drug use often results in a life of addiction, which itself results in trauma for the children of those affected.

We now know that devastation of the opioid epidemic is one of the most significant factors contributing to childhood trauma. My home state of Ohio has the second higher opioid overdose rate—overdose death rate in the country.

These overdoses are ripping apart families and forcing children to cope with unspeakable grief.

I want to thank the chairman for inviting Mr. Charles Patterson from Clark County, Ohio, to testify on the second panel to shed more light on these issues and what Ohio is doing to try to combat them.

The opioid problem has affected all of our districts, especially our colleague, Carol Miller's, district, which has been called the epicenter of the opioid epidemic.

I appreciate all of Carol's work in addressing this problem. I also wanted to take a minute to recognize another member of our committee. Dr. Green is not yet with us.

This is his first term in Congress and in his first term from the moment he joined the committee he has worked tirelessly to address issues related to veterans suffering from PTSD.

And I appreciate the chairman's work on this. I know you and Mr. Green have worked together and I do appreciate the bipartisan nature of addressing this, looking to see what we can do to address this problem.

Recently, the Subcommittee on National Security held a hearing addressing military suicides as well as the Department of Defense and Department of Veterans Affairs prevention efforts this was due in no small part to Mr. Green's passion for tackling this issue.

While DOD and the VA are collaborating to provide access to mental health treatment, Congress has the responsibility to oversee this process and ensure our veterans are getting everything they need.

I would also like to thank the CDC and HHS, in particular, Dr. Houry, for her testimony today and the extensive amount of time

their teams have provided to the committee staff to learn more about this critical issue.

I hope we will continue to do this on a bipartisan basis. Again, I want to thank our witnesses for traveling here and for sharing their difficult stories. It is courageous of you to do that.

And just mention that I may have to step out from time to time. We have a subpoena markup on—over in Judiciary. So but I will try to be here for as much of the testimony as I possibly can.

Mr. CONNOLLY. You don't need to be there for that.

Mr. JORDAN. Thank you, Mr. Connolly.

Mr. Chairman, thank you, and I yield back.

Chairman CUMMINGS. I want to thank you for your comments, Mr. Jordan.

I, too, want to applaud Mr. Green. He has worked tirelessly with us to address the issue of suicide in our military, and I want you to know that we will work in a bipartisan way.

I got a little bit emotional when I was reading my opening statement because I know where I could have been. I was placed in special ed from kindergarten through the 6th grade. Told me I would never be able to read or write, and I ended up a Phi Beta Kappa and a lawyer.

So it is emotional for me. This childhood thing is emotional, and I have often said it is not——

Mr. MEADOWS. And a pretty good chairman.

[Laughter.]

Chairman CUMMINGS. And I have often said it is not the deed that we do to the children; it is the memory. It is not the deed. It is the memory.

And so now, I would like to welcome our first panel of witnesses. The men and women who comprise our first panel have each suffered devastating personal trauma and they have turned the unspeakable pain they endured into passion to do their purpose.

I am grateful for their presence here today.

On panel one we have William Kellibrew, who is a founder of the William Kellibrew Foundation; Creeana Rygg, who is a survivor and activist; Justin Miller, who is the deputy executive director of Objective Zero Foundation; and Heather Martin, executive director and co-founder, the Rebels Project.

If you would all—well, you are already rising. So would you please raise your right hand?

[Witnesses were sworn.]

Chairman CUMMINGS. You may be seated, and let the record show that the witnesses answered in the affirmative, and I want to let all of our witnesses know that your microphones are sensitive. So please speak directly into them.

And what we are going to do is we are allowing—because of the sensitive nature of your testimony we are allowing each of you eight minutes or less—or less. Did you hear me? Or less.

You don't have to take it all. And so—but I beg you to stay within it and watch the lights. The lights will come on and it will indicate—you know, you have got a yellow light and then you have the red light, and then I am going to have to bang this gavel. You don't want me to do that so I—and I don't want to do that.

All right. Mr. Kellibrew, thank you.

STATEMENT OF WILLIAM KELLIBREW, FOUNDER, THE WILLIAM KELLIBREW FOUNDATION

Mr. KELLIBREW. Our values and beliefs drive our decision-making, actions, and behavior. What we say, what we do, how we behave can be directly linked to what we value and believe.

But what if—what if what we value and believe or what mattered to us the most was either lost, stolen, withheld from us or even destroyed?

That is what happened to my sister and brothers and me on the morning of July 2d, 1984, just days away from our 35th anniversary.

Home alone, I woke up to my mother, Jacqueline, screaming. I slowly rose from my bed and looked out of our living room window and saw Mom—Jacqueline's ex-boyfriend dragging her and my 12-year-old brother down the street toward our home.

I didn't think much of it. We had lived under his terror for months. So I went to find something to eat. Eventually, my mom banged on the door and I opened it. She ran toward the window, screaming to the neighbors for help, "Call the police."

My brother stood against the wall with one foot glued to the floor and one against the wall. Mom's ex-boyfriend took out a black gun and loaded it, bullet by bullet. He wasted no time.

He walked over to my mom. She frantically turned to him. He pointed the gun to her face and she yelled as loud as she could yell, "No." He pulled the trigger.

He then went to my brother, Tony, put the gun up to his head and pulled the trigger. He then walked over to me and squatted with the gun to my head in front of me.

I looked down the barrel and into his eyes and I begged fast as I can, "Please don't kill me. I will do anything." He didn't respond so I looked up to the ceiling, held my hands tightly and begged God, "Please don't let him kill me. I will do anything."

An eternity had passed. He pulled the gun back, stood, and walked to the other side of the room. After pacing, he said that I could leave. But where was I going? This was our family living room.

With my little shorts on and no shoes, I slowly rose from my seat and put one foot after another through the threshold of our door. After getting further away from our home, I ran as fast as I could screaming my mom's words, "Call the police." A three-hour stand-off, two murders, one suicide. We never returned to that rental home in Capitol Heights, Maryland, again.

A loving family member trying to make sense of it all patted me on my shoulder and told me before the funeral, "Baby, you are going to have to forget about it."

My grandmother packed what photos she had, locked them in a black and gold chest, and we all tried to forget. I took that strategy to the 5th grade, trying to imagine a world much different than what I had experienced.

Three years later in 7th grade, I could not bear the pain anymore. I woke up one morning and I put by book bag on and headed off to school. I stood on our neighborhood bridge on North Capitol Street just 22 blocks away from my seat today, having decided to take William Kellibrew, me, out of the equation.

I had lost every piece of dignity I had as a child, my voice, my soul, and my purpose empty. I was one decision away from relief but I made it to school. My assistant principal, Mr. Charles C. Christian, called my grandmother and I was hospitalized for 30 days.

When I was discharged, I met my first ever therapist, Christine Pieaerrs. Instead of having the session in her office, she took me to the cafeteria at Children's Hospital and asked me, "What do you want for lunch?" On a one-to-one I said to myself, "I am going to clean you out." I started at the ice cream machine and I must have built the biggest ice cream cone you can build on this side of earth.

No adult had ever listened so intently to what I had to say. It was the beginning of my healing journey and my first introduction to the mental health system.

Thirty years later, I sit here reminded of the long journey of hope, healing, and resilience. I stand today alongside my fellow survivors with a sense of purpose, dignity, and respect for the shoulders I stand on and a sense that healing is absolutely possible.

Two professors from my university, the University of the District of Columbia, where I earned my first degree, started the William Kellibrew Foundation in 2008. They recognized my passion for service and invested in supporting victims of crime and my career as a victim and survivor advocate.

Today, I have taken my passion to my role as a director for the Office of Youth and Trauma Services at the Baltimore City Health Department, where my mom was born in the 1950's.

I am afforded the opportunity to work alongside brilliant and dedicated colleagues and under the leadership of the city's health commissioner, Dr. Letitia Dziraza, to continue to build a trauma-informed and responsive city at the forefront of a national violence, trauma, opioid, and substance use epidemic claiming precious lives each day.

We have trained over 3,100 city employees, community members, small businesses, and nonprofits in a trauma-informed approach and now we are working to ensure a longer-term impact with solid metrics in place.

The journey for me, like so many children, young African-American males, and families I engage in Baltimore and D.C. and across the country is not an easy journey of recovery.

My grandmother, who is sitting here today, said to me as a little boy, "If you can handle your mom and brother's death, you can handle anything." I didn't know what she meant by that at age 10, or 21, but I held on to her faith because I did not have much growing up. I had hoped that she knew what she was talking about.

When I first started my job in Baltimore, I met a young boy around the age of seven who had been shot in his head. He was playing in his neighborhood as nothing had happened.

He told me a story, but what I took away was that while lying in the hospital fighting for his life he said that he was trying to stay alive for his family.

Families cannot be left to grapple with the aftermath of trauma. We need sound support through leadership and governance, effective policies and practices, mental health and substance use sup-

ports and treatments, a knowledge base in addressing trauma, and the caring and compassion that I know we are all capable of delivering that can reduce the stigma of experiencing trauma, mental health, and substance use challenges.

Trauma can strip us of our values, our voice, and our dignity. Trauma can be dehumanizing. But our role as survivors, as human beings, is to bring humanity back into its space.

That is what the U.S. Congress has done today. Thank you to the Honorable Congressman Elijah Cummings and to the honorable congressional colleagues and staff of the Committee on Oversight and Reform.

And I have always wanted to say this. I yield my time—my time to my grandmother, who worked on her job for 38 years, was late less than 10 times, and never used an alarm clock, with a mission to give her family a chance at life.

Please just stand and be recognized, to my grandmother behind me. Will you stand please?

[Laughter.]

Chairman CUMMINGS. Please stand up.

[Applause.]

Mr. KELLIBREW. Thank you.

Chairman CUMMINGS. Thank you for your statement and thank you for recognizing that beautiful lady that just stood up. Thank you, and thank you for being here.

Ms. Rygg?

STATEMENT OF CREEANA RYGG, SURVIVOR AND ACTIVIST

Ms. RYGG. I would first like to thank Congressman Cummings and Ranking Member Jordan, and the members of the House Committee on Oversight and Reform for this opportunity to speak about the lasting effects of childhood trauma.

I am 28 years old and from Helena, Montana, where I have lived for most of my life. I am Portuguese, Filipino, and Hispanic. My family is all from the Hawaiian Islands and moved to the mainland before I was born in hopes to give my mother, who became pregnant with me at the age of 16, a fresh start and a chance at a better life.

Both my grandmother and my mother are victims of abuse. Neither of them had ever received help or justice for their trauma. In fact, abuse became something that wasn't acknowledged in our family because it was considered normal or the price you paid to be supported and have a place to live.

My mother's first marriage was to a man who physically and verbally abused her. Although she tried to shield my siblings and I from it, we witnessed her being hit, shoved, and even sat on by him in order to prevent her from being able to leave.

After several escape attempts, she finally got us away from him. I was nine years old at the time and we settled down in a new town where she met her second husband, Raul.

Raul was kind to my mom and seemed to love my siblings and I. However, as I got older, he changed. I was 11 years old when Raul began abusing me. It started with him groping my body in a sexual way and pretending he mistook me for my mother.

At the time, I didn't know that this was a form of sexual abuse and I didn't know how to tell my mom. I didn't want to be the one to break up our family after all we had already been through.

As the abuse continued, I began to distance myself from him, which made him lash out at me in violent ways. He once had beat me so badly that our neighbors had heard my screams and called the police.

This was my first open case with the Department of Family Services. They came and took pictures of the bruises all over my body and Raul was arrested.

But, unfortunately, the case was closed and he was back in our home by the next week. By the time I was 12 years old I was so depressed I had stopped eating and was beginning to self harm.

Still unable to tell my mom what was going on, she became worried and had me admitted into a children's hospital. There, I was diagnosed with bipolar depression and heavily medicated for three months until I was behaving well enough to go home.

I was released, and just before my 13th birthday Raul raped me. This time, I did tell my mom and we went to the police. I was examined at a hospital and Raul was arrested the next day.

They found him with scratches all over his face and body, just as I had described, as I fought to be free. All of the evidence of what he had done was there. But he knew my mom could not live with herself knowing she had allowed me to get hurt.

He knew she was vulnerable from the day that he met us and he manipulated her once again into believing I was just a bad child trying to ruin her happy life for my own selfish reasons.

Eventually, she was in denial that he had ever done anything wrong and I was taken by DFS and placed in group homes. I was on juvenile probation and then I lived in foster care before being placed in the Florence Crittenton Home for pregnant teens.

I was 14 years old and four months pregnant when I arrived. It was at Florence Crittenton that I was finally treated for the traumatic experiences that I had survived.

I attended therapy sessions and I learned that more than half the girls living there at the time were also survivors of sexual and/or violent crimes.

After my case had gone to trial and Raul was sentenced to prison, I was able to go back home with my mother. Everything had happened so fast and now I had a baby to take care of. Mine as well as my mother's mental health was put on the back burner.

We did what we knew best and we moved forward. Raul was unable to hurt me anymore but I still lived in fear every day. I had a hard time developing healthy relationships as an adult. I had major trust issues with every man that came into my life, including my third step-father.

I was 22 years old when I met my husband, Jason, and I was still having night terrors regularly. My husband would have to calm me down and help me back to sleep and it took me years to be calm in my own house and not jump every time he walked up behind me.

We are now raising three children together and, like any parent, I fear that the worst could happen to them. I try to have open conversations about abuse with them so that they can recognize it if

they experience or witness it and help them understand how they can tell someone.

I am determined to end the cycle of abuse in my family with me. I am now involved in national advocacy work for young parents and survivors of adverse childhood experiences through National Crittenton.

I have held group meetings at my local Crittenton agency where I share my story and give the participants a safe judgment-free space to talk openly about their experiences and I try to support them in their journey to healing.

Looking back, I feel as though I slipped through the cracks in the agencies that are designed to protect children from trauma. I was labeled as a troubled youth when really I just needed someone to recognize I was being hurt.

Sexual abuse is an epidemic in our Nation. Studies have found that up to 89 percent of sexual abuse victims are female, and of all the females raped in the U.S. 41 percent are under the age of 18.

For youth who are involved in the juvenile justice system, the girls' rate of sexual abuse is four times higher than the boys in juvenile justice, and the girls' rate of complex trauma is nearly twice as high.

What Congress can do to help is make sure that schools, foster homes, group homes, and juvenile justice facilities provide services that support girls in healing from experiences that cause trauma they faced and make a change from just looking at what we did and ask first what happened to us.

Hundreds of thousands of girls will and have faced similar experiences as I did and they each deserve a chance to be valued, respected, and supported when asking for help in healing. They deserve a chance to live happy and healthy lives.

Thank you for listening to my story. I hope it will provide insight to this subject and a sense of urgency to provide more resources to survivors of traumatic experiences.

Chairman CUMMINGS. Thank you very much.

Mr. Miller?

STATEMENT OF JUSTIN MILLER, DEPUTY EXECUTIVE DIRECTOR, OBJECTIVE ZERO FOUNDATION

Mr. MILLER. My name is Justin Miller. I am a veteran of the United States Army. I was medically retired after serving over 11 years in the military and I am now serving our veterans and their loved ones as a civilian.

I am the deputy executive director and co-founder of the Objective Zero Foundation. We are a 501(c)(3) that has created a free app that instantly and anonymously connects veterans, service members, their family members, and caregivers to one of almost a thousand of our trained suicide prevention ambassadors in a time of need.

I faced many challenges growing up as a child of divorced parents. I was exposed to many things at a young age that I shouldn't have been. I had several instances of childhood trauma that I knew weren't normal to most, but I hadn't realized the impact they had

on my life until I became an adult and started seeking help to deal with my PTSD and depression.

In the fall of 2018, I went to a program called Save a Warrior where they gave me the adverse childhood experience test. It was then I realized or I remember playing doctor with these girls as a kid. There were three sisters who lived nearby me. The middle sister was old enough to be developing but the youngest sister was my age.

The middle sister would have us get undressed and play doctor with each other at the age of four. I was later threatened by their father when he found out and punished by my parents.

Then other inappropriate moments with an adult came a couple years later. My best friend accidentally shot and killed himself when we were in 4th grade. I was supposed to be at his house that night.

By doing group therapy in school, I mentioned that, and how things could have been different. Someone then said it was my fault because I didn't go over to his house, and that always stuck with me.

My dad went to prison for three years when I was seven. I would always get laughed at because my dad didn't make it to Career Day at school.

When my dad finally did get out of prison, I would do anything to have that bond with him and gain his approval. At 11 years old I was introduced to marijuana and alcohol in the same day by my dad. He wanted me to do the things he was doing with him so that I wouldn't tell on him for doing them.

When I was in the 7th grade my 18-year-old uncle hung himself in the basement of his house. I was a wreck. My teachers could tell something was wrong and sent me to the office.

I started to open up to my counselor and told her what had happened. She asked me if I could say one last thing to him what would it be and how did I feel. I told her I didn't know what to feel. My dad always told me boys don't cry, that if I wanted something to cry about he would give me something to cry about.

Before I could even think about it, the lunch bell rang. She said, ″well, there is the lunch bell. You should probably go. Think about what it is I said,″ and she walked me to the door.

After my traumatic childhood I tried to stay numb and intoxicated all the time. During SAW is when I realized I was repeating the cycle with my children and then decided it was time to break that cycle.

I went to war for the first time at the age of 20. I spent a total of 27 months in Iraq between two deployments. During that time, I was involved in many explosions, causing back injuries and traumatic brain injuries. I saw things that one should never see - that leave me with nightmares, depression and anxiety.

I was also left behind in a house during a mission and had to physically fight to get back to my men. I was later punished and pushed to another platoon to save them. This left me with trust and abandonment issues.

Two deployments had me feeling completely broken and like a piece of me will always be missing no matter how hard I try to put myself back together.

One of the major events that sticks in my mind was 11 November of 04 when a VBID killed Staff Sergeant Huey. A young boy and his sister were also killed in front of me. I also had to shoot a warning shot at a man that was carrying his son that was critically wounded and later died.

That warning shot crushed me. I felt like I took everything away from that man and it destroyed my life.

Not long before that day those two kids were playing in an alley when we were on a dismounted patrol. As we were walking toward them, they grabbed our hands and started pulling us in a different direction.

We called the interpreter after setting security and found out that there was a bomb buried in the middle of the road that we were about to walk over, and these two little kids with no worry of their own safety pulled us aside and let us know, saving all of our lives.

It has been torture knowing that I wasn't able to do the same for them in return. That specific incident changed me or changed things for me as a father for years to come. I believe that if I wasn't able to help those kids how would I ever be a good father to my own.

For years I tried to stay distant to my two young kids. I had a short fuse with them. When they would cry they would trigger old memories from war and I would become angry.

I made myself believe that they would be better off without me. However, SAW taught me that the best way to help others is to help yourself.

Once you learn the process and understand that childhood trauma wasn't your fault, you then begin the healing process. This healing process will affect seven generations in the past and seven generations ahead.

Once I realized it was okay to talk about what I have been through and started dealing with my PTSD, my relationship with my kids started to change.

I now make an effort to make time for my children and connect with them over things that they are passionate about, i.e. coaching their softball and baseball teams.

I also make an effort to remind my children that they are enough, that I am proud of them, and that I fully support them in the paths they choose. I want them to know that they should never feel that they need to do anything life to gain my approval.

I make it a point to start conversations with them about random topics so I can get an insight on the people they are becoming. This also makes them more comfortable to sparking up future conversations with me.

My hope is for more veterans to open up about the struggles they are dealing with day to day so we can end the suicide epidemic. My nonprofit, Objective Zero, was started after I almost took my own life.

I felt like I had no one to talk to that would understand what I was going through at the time. Because of my darkest moments, we created an app to do just that. Nearly a thousand people have signed up to lend a nonjudgmental ear and talk through the hard times with those who have dedicated their lives to this country.

It is going to require a culture shift for us to see a difference. People need to quit feeling ashamed and embarrassed about their trauma. By not talking about our trauma, it gives that event power over you.

The more we talk about these issues, the more people will feel open to asking for help and talking about their struggles.

What made the difference for me is when I was going to church looking for an answer and I was having it down right out with God and I was mad at him.

And I heard clear as day, quit feeling sorry for yourself. Look at everything I pulled you through. What good is it to know an answer to a secret if you keep it a secret? Share your struggles to give others hope and strength to push forward.

Thank you.

Chairman CUMMINGS. Thank you very much.

Ms. Martin?

STATEMENT OF HEATHER MARTIN, EXECUTIVE DIRECTOR AND CO-FOUNDER, THE REBELS PROJECT

Ms. MARTIN. Thank you so much for listening to my story.

On April 20th in 1999, I was a senior at Columbine High School when two gunmen killed 12 students, a teacher, and then killed themselves.

Today, I am approaching my seventh year as a high school English teacher and I am also the executive director of a nonprofit called the Rebels Project, named after the Columbine Rebels.

It supports survivors of other mass traumas. It took me a little over 10 years to confront and reflect on how the shootings at my high school impacted me. But I have learned some valuable lessons.

One that sometimes needs reminding is that trauma recovery has no timeline. Another is that we can help by providing children with the tools to support them as they build resilience.

During the shooting, I was barricaded in a small office with 59 other students while the gunmen rampaged the school. Three hours after barricading we were escorted out by SWAT team members and passed the bodies of two students who were shot outside, Danny Rohrbough and Rachel Scott.

Much later, I learned that the SWAT team, thinking there were still gunmen loose in the building, decided to save us instead of seeking out Dave Sanders, who eventually bled to death just a few rooms down the hall from where we hid.

Sometimes these details are enough for the average person to be horrified enough to keep their judgment of my recovery to themselves. However, many times I still find myself having to justify the depth and complexity of my trauma and why I struggled for so long.

Later that evening, I arrived home physically uninjured but a completely different person. My sister, a freshman in 1999, hugged me in the driveway, feeling grateful and guilty that she got out of the school relatively quickly.

I graduated and went off to college where I experienced being blind-sided by a trigger for the first but certainly not the last time.

You see, what didn't remember was that the fire alarm had been going off while I was trapped in the office. So when the fire alarm sounded in my English class to signal a drill, instead of evacuating like everyone else, I started sobbing uncontrollably.

I tried to advocate for myself to my professors and was told I still had to write my final English paper about school violence or fail the class, even after confessing that I had been at Columbine.

I ended up failing that class and actually I failed English class twice in college, which makes my students now laugh. My first semesters of college were some of the hardest times in my life.

After being surrounded by loved ones and by a support system made up of people who understood what I had gone through, I was now embarrassed, shameful, and isolated.

I was also really angry, not surprising to anyone who knows anything about grief or trauma. For me, the manifestations of that trauma were that I developed an eating disorder and I tried drugs.

The drugs were fairly short lived and, lucky for me, they weren't addictive. As for my sister, she just celebrated three years clean and sober and will continue to fight each day for her recovery through her trauma and through her drug abuse.

I did attend formal therapy and received validation from my therapist, someone my family was lucky enough to afford, that it was okay that I was traumatized even a year later.

Silly me. I thought I should have been over it in months. Eventually, I dropped out of college completely and I worked full time. For anniversaries I went out of town to avoid the memories, much like many of my students feel now when they are reminded of the traumas they have experienced.

Once I had a student who stopped coming to class because the anniversary of their traumatic experience was approaching. Later, they told me that they had to buildup enough courage to come talk to me about it because they were so embarrassed. I imagine this is similar to how I felt when I attempted to talk to my college professors.

Other tragedies also impacted me. 9/11 sent me into hysterics and prompted severe flashbacks. Virginia Tech resulted in several debilitating anxiety attacks and I embarrassingly had to call into work. I mean, that was even eight years after the attacks at Columbine.

Though the company I worked for was pretty understanding, I could tell that there were frustrations when I couldn't show up.

In 2009, 10 years after the shooting, I reconnected with people who knew what my struggles entailed. As a result of these renewed connections and acceptance I felt when returning for the anniversary, I went back to college.

At first, my brother had to come to campus with me to help me navigate and feel comfortable. But, eventually, I was a full time student again, majoring in English and working toward my secondary teaching license.

Now my struggles were mostly in math because I teach English. [Laughter.]

Ms. MARTIN. After co-founding the nonprofit in 2012 and having the opportunity to travel and connect with other survivors across

the country, I began to see more clearly the ripples of trauma and the similarities that exist no matter the circumstances of the event.

Columbine and my story are often sensationalized, one of the reasons I imagine I am here today. But the feelings I experienced in the months and years following Columbine—anger, loneliness, isolation, and embarrassment—are not unique to mass shooting survivors.

For my students who have been traumatized in other ways, no less valid or less seriously—they are sometimes too young to be able to reflect on why they are reacting the way they are.

Survivors are blind-sided by triggers all the time. Right now, the survivors in my support network who are from more recent shootings are asking about fireworks and how long it will be until they stop diving for cover.

For children and for my students, they may be blind-sided while reading a short story or they might tune out and stop listening to instructions. They may need choices of topics to research, to write about, or to study in order to avoid their freak outs.

I have also heard countless stories of survivors trying drugs and alcohol to help them numb the pain and blur the memories, and not many of my students' families can afford therapy like my family could. The school therapists' schedules is always jam packed and many of those who could benefit from therapy are embarrassed about it because the stigma and many times they have convinced themselves or have been convinced that whatever they are going through doesn't warrant therapy.

I also consider how triggering events might impact my students. Would they react like me and avoid talking about it? Would they react in anger and in defiance?

These questions and concepts are explored during trauma-informed professional development so teachers can best support the needs of their students.

As a teacher, I wear many, many hats. But I am not always qualified to provide the support needed. Schools need more counselors, more social workers, and more psychologists. They need programs that teach children how to build resilience, how to avoid or—I am sorry, how to use coping skills and how to practice self care.

At my school, we average one counselor to every 400 students. Increasing these services will not only help children who have experienced trauma but also help provide the skills necessary to build resilience before a traumatic event.

Trauma is, in fact, a universal part of the human experience and because of this universal experience, it is critical that we address this underlying issue that connects many of our current problems. Trauma is connected to suicide, to abuse, to drug addiction, and even to classroom management issues.

Please consider these needs in order to ensure that all children who need mental health support in schools and in communities have access and not just after a traumatic event but before as well.

In closing, and I understand that this might be really hard to do, but please do not compare our traumas and our experiences on this panel. Our stories and experiences are very different. But trauma is trauma across the board.

Chairman CUMMINGS. Thank you very much.

Let me, before we go into questions because I want to be clear—I want the witnesses to be clear and the witnesses coming up to be clear—you will see members going in and out.

It is no disrespect to you. It is because on Wednesdays and Thursdays is when we have our hearings and all members that I know of sit on at least two committees and a lot of it is conflict.

They are conflicting with each other. There are votes. And so we want to make sure you are clear. It is not out of disrespect but, you know, we try to do more than one thing at a time.

I also want to let the members know that to ensure that we have time to hear from all of our witnesses and out of respect for the highly personal stories that the members of our first panel have just shared with us, we are limiting questioning to this panel to a total—listen up—a total of 10 minutes, total.

And I just want to also thank our ranking member for his cooperation in working this out. You have been extremely helpful and I deeply appreciated all that you have done to help us out.

With that, I am going to—and let me show you how we are going to do it. I am going to just have one question and then I am going to go to the other side. I am going to flip back and forth until we have exhausted 10 minutes on both sides.

All right. You got that? So if you are going to ask a question we need to know that you are going to ask one, and if we don't get to you don't be mad. We are just trying to respect our witnesses, all right?

All right. I am going to be quick.

Mr. Kellibrew, I want to thank you for being with us today. Mr. Sarbanes and I, of course, represent Baltimore and we are always trying to figure out ways to help young people and go through what they are going through and difficulties.

In your experiences both of trauma survivor and as a practitioner working with traumatized youth in Baltimore, let me ask you this. How critical is expanding services to help prevent trauma and support children who have experienced trauma to enabling Baltimore to reduce the violence in our city?

STATEMENT OF

Mr. KELLIBREW. I think it is extremely important and I think that building on the strengths of our young people is important. I think realizing that our young people have the innate ability to succeed.

I actually was once in special education as well and I didn't believe that I could get out there. Failed many times in college and high school. Didn't graduate. Got my GED. But here I am leading a public health approach in the city that my mother lived in and was born in, and I think that believing in our kids and modeling what resiliency looks like I think is an important thing in our programs that we have at the health department and across the city, ensuring that they are consistent trusting programs and that they have the metrics behind them to show that they actually work and then believing in community.

The community has the ability to do that. So the partnerships and collaboration is part of a trauma-informed approach. So collaboration is really important all across the board.

Chairman CUMMINGS. I now yield to Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

Again, I just want to thank the witnesses for your courage and your story and for your service—Mr. Miller, your service to our country, all of you, of your service to students, the impact you are having on people and to your families.

We had this wonderful grandmother introduced, but I think we have got other family members for the other—I know we have a husband here and Mr. Miller and maybe Ms. Martin, if you have family here I think the chairman would probably like for them to stand up too so we can all recognize them if you have——

Chairman CUMMINGS. Absolutely. You all—any of you all have family here please——

Mr. JORDAN. Yes. Thank you.

[Applause.]

Mr. JORDAN. Thank you all for coming. I yield back, Mr. Chairman.

Chairman CUMMINGS. Very well.

Ms. Wasserman Schultz, for one question?

Ms. WASSERMAN SCHULTZ. Yes. Thank you, Mr. Chairman.

Ms. Martin, thank you for—Ms. Martin, I am over here. I am over here.

[Laughter.]

Ms. WASSERMAN SCHULTZ. Yes. It is a very broad dais. I really appreciate you sharing your story. I represent the community directly adjacent to Marjorie Stoneman Douglas High School.

So our community has been through really a very similar trauma and we are dealing with the aftermath of students who also survived, and there will be many years that that is—those are challenges that we are going to have to help them through. So your being here is really important.

And I could hear the resilience through the pain in your story. I have not experienced trauma myself so it is difficult for me to directly sympathize. I can certainly empathize.

But, first of all, it is incredible that you became a teacher—that you—that you put yourself professionally in a school environment and that that is where you go to work every day and are nurturing our young people.

So I want to ask you my question based on your experience as a teacher. Can you share more about why you think it is so important that we provide training and resources to enable teachers to recognize trauma and support children who have experienced it so they don't get the reaction that you got from your college professor?

And like I said, I know that we are struggling to make sure that we can do that for our students in Broward County as well.

Ms. MARTIN. Thank you for your question.

I have been down to speak to the students several times.

Ms. WASSERMAN SCHULTZ. Thank you.

Ms. MARTIN. They are hanging in there.

Ms. WASSERMAN SCHULTZ. Yes.

Ms. MARTIN. They are right where they should be.

Ms. WASSERMAN SCHULTZ. They should—absolutely.

Ms. MARTIN. To your question, at my school we have an extremely diverse population. So our professional development sometimes vary from what I hear goes on at different schools.

But it is so important for teachers at every school to take part in these professional developments and they need to be meaningful because professional developments for teachers are, like, just check the box, like, oh, I have to go to this meeting and sit there and listen.

But they need to be aware, I think, that because a student is acting out in class or challenging you, there is a good chance that it is not—it is not you. It is not something that you are doing. It is something that they have been through, and it is so critical that teachers understand that and reflect on that because the ripples of that can—I mean, it can change a child's life.

If you can connect with a child—I mean, if they are acting up, like, instead of writing them a referral or sending them out you just say, are you okay today—what is going on today. And chances are they are going to open up.

I tell them my story every year, and the purpose for that was I just wanted them to take, like, lock down drills seriously, and the unintended consequence of that was that they opened up to me about their stories and then I was able to put them in touch with the appropriate resources.

So teachers and really anybody in the education field really needs to be educated on trauma-informed instruction and what that looks like and what that means.

Ms. WASSERMAN SCHULTZ. Thank you very much.

Chairman CUMMINGS. Mr. Massie?

Mr. MASSIE. Thank you, Mr. Chairman.

Mr. Miller, thank you for your service but, more importantly, thank you for signing up to help the people who have served and the people who have gone through experiences like all of you have shared.

Could you just briefly tell us a little bit more about this app that you worked on that could help other people who are contemplating taking their own lives?

Mr. MILLER. Yes, sir.

So the night that I almost committed suicide it was 4 o'clock in the morning. So you don't want to be a burden to somebody. I had no clue who to talk to so I just tried to do what I was always told, just to suck it up, drink water, and drive on.

So after calling the VA, telling them that I almost killed myself, was placed on hold, scheduled an appointment for two days later, I just felt like I was completely abandoned.

A phone call from an old leader lasted about six hours and he kind of just gave me a different purpose and a direction. So we got my story published. You know, let others know that they weren't alone.

The app idea was given to us. Originally, it was like Yelp for veterans. But while doing research, I found that most veterans, when they decide to commit suicide to do it within the first five minutes.

So, really, we don't have time for them to try to find a resource, call, be put on hold, sent a voicemail. We are, like, we need some-

thing that is instant. And people that are active duty are afraid to go get help, you know, because if you get, you know, diagnosed with PTSD you are non-deployable. Once you are non-deployable they don't need you anymore.

So we are, like, you know, we need something that is instant and anonymous, something that they can just pick up the phone, touch of a button, be connected to somebody who cares. Not there for a paycheck; somebody who just wants to listen to you and let you know that you are loved and how important you are and how needed you are.

So right now we have almost a thousand trained volunteers that are there just to answer a phone. We have over 4,000 people that are using the app. Like I said, touch of a button, voice video or a text, they can instantly connect with somebody. The app is live. So if it is 2 o'clock in the morning, you open the app, you can see who is available to answer that call.

Mr. MASSIE. Can you—can you tell us the name of the app before I yield back my time?

Mr. MILLER. Objective Zero.

Mr. MASSIE. Thank you very much, Mr. Miller.

Chairman CUMMINGS. Thank you.

Mr. MILLER. Thank you.

Chairman CUMMINGS. Thank you.

Mr. Connolly?

Mr. CONNOLLY. Thank you, Mr. Chairman.

I just want to say to all four of you, I have been to a lot of hearings. This is the bravest panel I have ever heard.

Chairman CUMMINGS. Thank you.

Ms. Kelly?

There is nobody on there. I am sorry. Is there anybody——

Ms. Kelly?

Ms. KELLY. I just wanted to thank all of you, first of all. I used to work at Crittenton Care and Counseling Center in Illinois, believe it or not, and part of that was I worked with parents who had the propensity to abuse their kids—to stop that cycle.

Mr. Miller, I too wanted to thank you for your service and your commitment to this country.

What kind of supports do you think would help other parents suffering from the effects of trauma to break the cycle with their own children?

I know you, you know, have SAW but everyone is not, you know, a military person. But what would you recommend?

Mr. MILLER. My recommendation is to make the ACE exam more common. It needs to be given to children in school, you know, by a counselor so that way the teachers and the counselors understand, you know, why a student may be acting out the way they are.

And along with parents. I had no idea all the trauma that I went through. I just thought that I had a normal childhood until I had this test and then everything started coming back to me.

And, you know, the ACE exam they say if you score a four or higher you are, like, 50 percent more likely to commit suicide than your average citizen, along with the drug addictions and all that.

So I think having even the parents and the families know and understand that, you know, this stuff happened, people might have just thought you are doing it and you are being a troubled child, you know, years ago.

But now, if they would have just said, well, let us look at the root of why he is doing these things. You know, why were these girls even having these ideas? Who was doing this to them?

Where did they learn this from, you know, instead of just jumping straight to the conclusion of you were doing something wrong and punishing them. You know, try to figure it out, talk to them, and then you let them know that, you know, this isn't your fault. It shouldn't have happened. But we are going to talk about this. We are open about let us work through it as a—as a family, just to get give them a better understanding.

Chairman CUMMINGS. Thank you very much.

Mr. Hice?

Mr. HICE. Thank you, Mr. Chairman.

And I just want to reiterate and say thank you, each of you, for being here today and sharing your stories, and for family and friends who are here as well.

Ms. Martin, you are so right that every story is different. My background—I was a pastor for over 25 years before coming to Congress and cannot tell you how many people over the years that personally we have been involved with and trying to help through multiple different kinds of traumatic experiences.

And hearing your stories this morning, quite frankly, is difficult for me just in reliving so many other experiences in precious people's lives that we have personally been engaged with.

And every time, to be honest, I felt so inadequate and I cannot—I mean, just like in every person's life that we dealt with I was just crying out to God for wisdom to help—to help these people in whatever circumstance it was.

And so thank you to each of you.

Mr. Miller, I do want to specifically ask you—you mentioned personally an encounter you had with the Lord and, you know, I look—just personally going back and back in the 1990's, I believe it is, only about 7 percent of Americans said they had no religious affiliation. Now that is well over 20 percent, and I think that is rather significant.

I was just curious how important your faith was in dealing with and finding some healing from the traumatic experience you went through.

Mr. MILLER. If it wasn't for my faith, none of this would happen. I was—my leadership—my friend, Chris, tried to convince me to write my story and I procrastinated. I didn't think I had a story. I just thought that I was in the infantry and did my job.

So it wasn't until my mother-in-law asked me to come to church, and I was, like, why. You know, what type of God would actually let this crap going on in the world? What type of God would let me see this stuff and survive?

What type of God would let my friends die and me make it back and have to suffer and remember this all my life? And I was having it down right out with him.

I was cussing him out and I heard it clear as day, you know, and once I heard that I am, like, I have to share my story. I mean, how do you have someone tell you that with nobody around and then not go home and do it?

And that is when I realized that, you know, our stories provides healing for others. It lets others know that what they are going through is not—you know, they are not alone, that there is others out there that experienced it. So, you know, my religion has been key.

It has helped keep my family together. It has given me the belief that if you just wake up every day and put one foot in front of another that things will eventually work out as long as you don't quite.

Chairman CUMMINGS. Thank you very much.

Ms. Pressley, this will be our last——

Mr. HICE. Mr. Chairman, can I finish my five minutes?

Chairman CUMMINGS. No, you don't have five minutes. You weren't here at the beginning. I limited it. We were—we have—so that you will be clear, we gave each side 10 minutes and each—and I asked members out of due respect for them and—this was already worked out and—okay?

All right. This will be our last person.

Ms. Pressley?

Ms. PRESSLEY. Thank you, Mr. Chairman, first of all, for your partnership with my office in scheduling this hearing. In my eight-year tenure on the Boston City Council I convened seven hearings on trauma because it takes many iterations and manifestations and because it is all interconnected. Violence begets violence and trauma begets trauma, and so many families and communities like my own are passing along, unfortunately, the legacy of intergenerational trauma.

I thank each of you for being here. In order for us to work on it we have to first speak on it. But one of the things that I think stands in the way of our speaking on it is the stigma and the shame that survivors carry when it is not your shame to carry.

As hard as it is for people to conceive of the fact that someone they love could be traumatized or violated in such an egregious way, it is harder for us to accept that there are people in our own family and our community and in society that we know that could perpetrate such vile acts.

I was just wondering if you could speak to and, first of all, I also just want to say it is so important—I am sorry you have to weaponize your pain in order for this survivor tribe to be seen and to be heard but it is so critical that this work be survivor led.

But could you just speak to the stigma aspect and how that is a barrier to addressing what is a public health—a pervasive public health issue in our country?

Ms. Rygg?

Ms. RYGG. I know I really believe that the stigma around not talking about trauma within your families and with my family it was you just kind of moved on. The women in my family, going back to my grandmother, they didn't work. They didn't support themselves, and so it was kind of just something that you dealt with and that is kind of what carried through my family, and the

importance of just being open with it and having open conversations.

That is what I am trying to do with my children and to share my story with other survivors and with young parents with what I am doing with National Crittenton within the YPAC is to help other parents understand that aside from being a young parent if you have that trauma in your life that is also something that you need to address in your life and share with your children so that they know and are aware if they do see it and recognize it.

And I think the importance of making sure that we have those resources and that we can heal ourselves first so that we can help heal the next generation is extremely important.

So with National Crittenton that is the one thing that we—that I really pride myself that we are working in and that group is just making sure that we are there to support each other through that healing first so that we can help others and help our children heal.

Chairman CUMMINGS. Thank you very much.

Let me—we will now—we are going to change panels. But let me say this before you go.

I agree with my distinguished colleague from Virginia, Mr. Connolly. This has been some of the most chilling testimony that I have heard in my 23 years in Congress.

But I want to leave you with a message. You know, when bad things happen to us, we should not ask the question why did it happen to us but we should ask the question why did it happen for us.

I know that is a tough one. I know it is tough. But, you know, when I think about you, Mr. Miller, and what you are doing today, and the idea—Mr. Miller, there is somebody—in all of you there is somebody watching you right now on C-SPAN whose life is going to be saved.

And I know that, you know, you may say, I paid a high price for this to save somebody's life. But I guarantee you there is somebody.

And Mr. Kellibrew, there is a little boy who has experienced the same thing in Baltimore where we live who is saying, you know what, I think I can get through this. I think I can.

And so to you, Ms. Martin and to Ms. Rygg, the idea that you would come in and lay some of the most personal things in your life on the table so that the world can understand it.

And so sometimes I think that when you—when you are going through all of this, remember my words—I love these words—pain, passion, purpose.

You have gone through a pain and many of you are still going through pain. It leads you to your passion to do your purpose. A lot of the people that are sitting behind you—I notice you got family members here—they have gone through this pain with you, right? Am I right?

They have been supportive. And you know what? Guess what? They have learned to be even more compassionate. You got me?

So I want you to know that you are—I know it is hard to—I know it is hard to—for this to get through. But you are gifts that keep on giving, and we need you to continue your advocacy.

And, Mr. Miller, you said something that I just can't let this go by because I would feel like I had committed malpractice if I didn't.

You said there came a point in your life where you wondered, who needs to hear my story, or, you know, do I want to really share this story.

Yes, you need to share—all of you need to share your story. Maybe you need to write a book. I am serious. So that somebody can see what you went through and how you got to where you got to.

And, finally, let me leave you with this. There is nobody who has lived the life that you have lived. You have lived it. A lot of people come and talk about—you know, they write theses and all this kind of stuff.

No, you have lived it. But, more importantly, you are willing to share it, and more important than that, you are willing to make somebody's life better.

And we all—we all appreciate you.

All right. Did you have something else, Ms. Rygg?

All right. Thank you very much. We are going to move on to the next panel.

[Applause.]

Chairman CUMMINGS. We are going to go to our members, we are going to start back in three minutes. Three minutes.

While we are waiting, I want to thank the committee for adhering to our time limitations on the first panel. You have been very helpful.

Do we have everybody? Castanova, do we have everybody?

All right. All right. Kelly?

Our second panel is comprised of Federal, state, and local officials and medical experts who will discuss the prevalence and—you may—you can sit down for the time being—discuss the prevalence and the consequences of childhood trauma and the steps that we urgently need to take to address this epidemic.

I would like to thank all of our witnesses but I especially want to thank Dr. Houry from the CDC. I know that there is a general preference for agency witnesses to sit on their own panel. So I really appreciate you working with us to make this happen.

I hope this hearing will be a continuance to be informative, collaborative, and productive. We are honored to have all of these extraordinary individuals before us today on both panels.

Dr. Debra Houry, director of the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, will be our first witness.

Dr. Christina D. Bethell, director of Child and Adolescent Health Measurement Initiative, Johns Hopkins Bloomberg School of Public Health, which is located in my district; Dr. Denise Shervington, clinical professor of psychiatry, Tulane University School of Medicine; Dr. James Henry, former deputy Governor and chief of staff, state of Tennessee; and Mr. Charles Patterson, health commissioner, Clark County, Ohio.

Now, if you would all please rise and raise your right hands.

[Witnesses sworn.]

Chairman CUMMINGS. Let the record show that the witnesses answered in the affirmative. Thank you, and you may be seated.

I remind you—I guess most of you were in the room earlier—but the microphones are very sensitive. Your statements will be limited to five minutes.

Please know that we already have your written statements but we are, basically, looking for a summary of your most significant points and I beg you to stay within that five minutes.

You have a lighting system, as I explained a little bit earlier, and now we will hear from Dr. Houry.

STATEMENT OF DEBRA HOURY, DIRECTOR, NATIONAL CENTER FOR INJURY PREVENTION & CONTROL, ON BEHALF OF CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. HOURY. Good morning, Chairman Cummings, Ranking Member Jordan, and members of the committee. Thank you for bringing attention to the important problem of childhood trauma, and thank you to the brave survivors who just shared their stories with us.

I am Dr. Deb Houry, and as an emergency physician, I was honored to join CDC in 2014 as the director of the National Center for Injury Prevention and Control.

In the ER I have seen firsthand the impact that trauma has on children. I still remember the toddler I saw for fever and cough. When I looked at his chest x-ray and diagnosed pneumonia, I almost missed the multiple fractures he had on his rib x-ray. It became clear he had suffered trauma over a long period of time. I did my best to console him and contacted Child Protective Services to assess his home environment and safety.

And cases like this kept me up at night and I wished I could have prevented this and other childhood traumas. Now I know, by focusing on prevention and building the resilience of our communities, we can meet the immediate needs of those already affected, reduce the long-term effects of trauma, and prevent trauma.

Major sources of childhood trauma are called adverse childhood experiences, or ACEs. Examples are child abuse and neglect or witnessing violence, mental illness, or substance misuse in the home.

As the number of ACEs increases, so does the risk for long-term negative effects on learning, behavior, and health. CDC research shows that more than 60 percent of American adults have experienced at least one ACE and almost a quarter of adults have experienced three or more.

ACEs have been linked to the leading causes of death including suicide and drug overdoses, shortening a person's life-span by almost 20 years.

The total economic costs of ACEs is conservatively estimated in the hundreds of billions of dollars each year. There is a need for action to prevent ACEs and their health and social consequences.

As the Nation's public health agency, CDC is positioned to lead coordinated efforts to prevent ACEs. This starts with using data to understand the scope and burden.

Our state-based behavioral risk factor surveillance system is a key source of data. Recent analysis of these data found some groups are at high risk of experiencing ACEs and should be prioritized for prevention and response efforts.

In addition to collecting data, we work with health departments to prevent ACEs in their communities. For example, we released

several resources that include evidence-based strategies communities can use such as encouraging and developing positive parenting skills and providing quality care and education early in life.

We also fund an Essentials for Childhood program where states can use community-level strategies to prevent child abuse and neglect, a major contributor to ACEs.

In Washington, a coalition of schools, city government, social services, and law enforcement launched an initiative to raise awareness of ACEs and brain development, and to foster resilience.

This lead to the community adopting trauma-informed practices in schools, increasing community awareness of ACEs by fivefold, and reducing expulsions in the high school by 85 percent in a year.

CDC also works with the Office of National Drug Control Policy to fund public health public safety interventions at the local level. One example, the Martinsburg Initiative in West Virginia is an innovative police-school community partnership focused on identifying children with high ACE scores and linking them to necessary resources and supports to prevent future opioid misuse.

To date, nearly 400 school staff have been trained in ACEs recognition and trauma-informed responses.

Understanding ACEs is essential as we collectively pursue strategies to address two of the most pressing public health threats facing our nation—overdose and suicide.

The connection between ACEs, substance use, and suicide can lead to a continuous cycle for generations. By preventing ACEs through coordinated comprehensive strategies, we can avoid exposure in future generations.

CDC and public health bring a unique and important perspective to ACEs prevention and can help communities implement strategies that promote safe, stable, and supportive environments for children and families.

CDC is committed to working with Congress, other Federal, state, and local agencies and partners to address these complex issues and, ultimately, to save lives.

Thank you.

Chairman CUMMINGS. Thank you very much.

Ms. Bethell? Dr. Bethell?

Your mic is not on. We really want to hear you.

STATEMENT OF CHRISTINA BETHELL, DIRECTOR, CHILD AND ADOLESCENT HEALTH MEASUREMENT INITIATIVE

Ms. BETHELL. I got it. Okay.

Good morning——

Chairman CUMMINGS. Good morning.

Ms. BETHELL [continuing]. Chairperson Cummings and Ranking Member Jordan, and members of the committee, and thank you for inviting me here to speak with you today and for your leadership on this important issue.

As you know, my name is Christina Bethell. I am a professor at the Bloomberg School of Public Health at Johns Hopkins University and also a board member of the nonprofit and nonpartisan Campaign for Trauma-Informed Policy and Practice.

I am also a person with lived experience of the majority of childhood traumas that are measured in the ACEs study and a grateful

recipient of nearly every Federal program supporting vulnerable children and families.

The science of ACEs and resilience shine a light on the importance of the moment-by-moment relational experiences of children to their healthy brain, body, and social emotional development not only of our children but our entire population.

The science requires a paradigm shift in how we think about child development, human health, social problems, and the skills and requirements for our own well being, which we can learn.

Like an eddy in a river that stops the flow of water, we now have, through biological research, understand that trauma also stalls healthy brain, body, and social emotional development of children, and these impacts cut across life and across generations.

We then go on to diagnose, medicate, treat, and the illnesses that are often very predictable - outpicturings of unhealed trauma without any awareness of their origins, the biologic drivers of this, or the possibilities for healing.

When enough people such as the two-thirds of adults in the country and nearly half of U.S. children are exposed to ACEs, we have what we call a synergistic epidemic where we can't deal with what ails us unless we also deal with the long reach of trauma and proactively promote relational health, emotional and stress regulation skills and all of the factors essential to health and well being.

Addressing childhood trauma and promoting well being is our greatest public health challenge and in this work we are the medicine that we need. We must foster "through any door" cross sector strategies to build engaged healthy communities that work together, shift social norms to support healthy parenting, eliminate stigma and shame, and build a trauma-informed work force, and in this we need a stronger and more robust Federal policy response.

We are fortunate today that many people understand these issues but most do not. It is still new. Just last month, in a room of 600 early education, health care, and social service workers, only 30 raised their hand that they had ever heard of the adverse childhood experiences study, and upon learning it they realized the lack of coordination among them, all of whom served the same families, were re-traumatizing the families and also by not engaging the families and ignoring the issues that they knew, once they learned about it, were really the underbelly of the problems the families faced.

So while ACEs connection and change in mind and many of our other systems engage hundreds of communities, most communities are not engaged and need much more support for data, measurement, training, personnel, and research.

So my written testimony includes much more data and recommendations related to the committee's area of jurisdiction in each of the areas.

But before I close, I do wish to mention just a few more recommendations related to our growing evidence base. First, we need a population wide approach. This is all of us. We need an era of experimentation and investment to build personnel and shift our work force.

We need quality well childcare services and early care and education as our top opportunities to prevent and mitigate ACEs, and

we need to invest in building a national caring capacity that is trauma-informed. We also need immediate shifts in Federal-supported programs and services that can perpetuate trauma unwittingly.

Family centered coordinated services across health care, legal, education, and social service systems are needed but are often blocked by Federal policies or lack of leadership.

We also need access to high-quality what we call neuro repair and other methods that can reestablish disrupted neural connections and rebuild the often lost capabilities and skills for something as simple as recognizing your own body and emotional experiences, re-frame disruptive thinking that can perpetuate trauma, and recognize impacts on self and others.

So, to close, the distinct fields of science are coming together to create an integrated science of thriving and we need to use the knowledge and tools we have of all of them and conduct rapid cycle research to drive innovation and implementation, shift how we train, incentivize, and pay for programs impacting our population's health and well being.

I feel very fortunate to live in a time when our science-lived experience and now our policies will meet to catalyze an epidemic of well being that will place the U.S. in the top rather than the bottom few of developing countries in child well being.

Grateful to be part of your leadership toward creating a well being nation and I look forward to your questions.

Chairman CUMMINGS. Thank you very much.

Dr. Shervington?

STATEMENT OF DENESE SHERVINGTON, CLINICAL PROFESSOR OF PSYCHIATRY, TULANE UNIVERSITY SCHOOL OF MEDICINE

Dr. SHERVINGTON. Chairman Elijah Cummings, Ranking Member Jim Jordan, and other distinguished members, I am deeply humbled and honored to testify before such an esteemed group of leaders who have come together as concerned Americans to address this troubling and ever-growing epidemic of childhood trauma.

I also would like to pay my respect for those who came before us being so willing to share their pain.

I applaud your efforts and hope that I can add a little bit of science and maybe much more about my underground experience to assist in the decisions that I know that you will make.

My colleagues before have talked a lot about the ACEs so I am going to skip that. But what I would just like, there is a metaphor that keeps coming up for me that pediatrician and psychoanalyst D.W. Winnicott used to describe children who were suffering, unfortunately, from the trauma of their parents, and he called it that they were suffering primitive agony.

And, unfortunately, we sometimes have children in communities or in the societies in which they belong where there are not the protective factors and resilience-building conditions for them to heal and ultimately thrive and reach their potential.

I have lived and worked through the impact of the natural disaster Katrina that decimated New Orleans in 2005, and, unfortu-

nately, some of those effects are still being felt by certain communities.

And now, today, we are on the threat of another flood and I know that the people in New Orleans are re-traumatized and are triggered.

The lessons that we have learned from Katrina are very applicable to disasters in other places—California, the earthquakes, the fires in the West, the tornadoes, the blizzards and the snows in the Atlantic and Northeast and any other extreme weather event.

Because, unfortunately for children, it shatters their view that the world is safe, and oftentimes it shatters the view that the adults can protect them because oftentimes the adults themselves become disregulated.

And when you add that to children who are living in spaces with chronic adversities, where they have to deal with the impact of violence on a daily basis or being bullied excessively or being in foster care systems as was added to the conventional ACEs.

We know that this becomes even more difficult for them. The impact of exposure to a natural or technological disasters happened in the Gulf can be profound when that is added for communities that are under served and living with community trauma.

There is evidence now, as was earlier said, that there are these very potentially disabling negative proximal and distal physical and mental health outcomes of childhood trauma and that it costs so much.

So what I, as my distinguished colleagues before me have said, the Centers for Disease Control, the academic centers who are studying this, the professional organizations like the ones I belong to—the American Psychiatric Association—we have a role to play with those who have the lived experiences of trauma, and the community members who need to understand that trauma is not normal. In many of our communities—and I have a case of a young man who, after he witnessed someone being killed in front of him, his mother told him, "It is okay, baby. You will get over it. Don't worry."

And so he didn't know that he was going to get worried and ended up with a life in prison doing all the things because of his disregulation.

But lucky for him, he found another pathway and is now a teacher. And so I think about him and I think about the need for us to inform our communities that trauma is not normal, we can keep it moving, and that we need then to think about the services that we will need when our children have these experiences.

Thank you.

Chairman CUMMINGS. Thank you very much.

Mr. Henry?

STATEMENT OF JAMES HENRY, FORMER DEPUTY GOVERNOR & CHIEF OF STAFF, STATE OF TENNESSEE

Mr. HENRY. Thank you, Mr. Chairman. It is certainly an honor for me to be here today, too.

Chairman CUMMINGS. Is your mic on?

Mr. HENRY. It is certainly an honor for me to be here today and I look forward to my testimony.

In January 2015, I got a call from the First Lady, and she said, "I want you to go to a meeting in Memphis. They are talking about ACEs."

And I was the commissioner of the Department of Children's Services that I think in most terms would have been called a disaster when I went there, and four years later we ended up winning ChildHelp award and appearing before this Congress. So we made some progress and we are still making progress.

But I went to that meeting and one of the things you have to do as a community before you can get anything done is have the right people at the meeting.

Well, when I got there everybody that was anything in Memphis was at that meeting, and I wasn't looking forward to the meeting. I didn't think it was going anywhere. I have been to a thousand of them, if you know what I mean, and none of them mean anything.

But at that meeting, I heard a presentation by Robert Anda about ACEs, and it was so clear to me, even clear to me, a guy born in east Tennessee, seventh generation east Tennessean, born between the mountains, born in a little town. My mother and dad were married for 65 years. I never experienced any trauma other than my grandmother getting mad at me a couple of times. They helped raise me. My aunt drove, you know, me back and forth to school. My other aunt taught school. My uncle ran the drug store. There was 50 relatives that helped raise me within 25 miles of Madisonville, Tennessee.

And if you don't think that makes a difference, it does, and I realize for the first time that, well, maybe you just didn't pull yourself up by the boot straps—you had some help.

And so as I came back, you know, I began to think about it and then when I got promoted to—quickly after that I got promoted to chief of staff and took over that, I gave our chief, our cabinet, an ACEs test.

Well, guess how many people had ACEs that were over two? Two, out of 22 cabinet members. Well, how do I get across the problems that inner city Memphis or Appalachia has with drugs and poverty? How do I get that across to people that have never experienced it?

And it is not an easy—it is not an easy task but you can. But we—the first thing we did is you have to have the Governor involved and they have to have some dollars. We got the legislature to approve dollars. We have made it recurring dollars. We got into everybody. We went to see the newspapers.

We did editorial boards just like you do in a campaign, and we got them to hold a summit not long after that that brought together everybody in Tennessee that was something. The congressional offices were recognized and they came, and we wanted them to see what would really make a difference in the $5 billion deficit in economic development that ACEs was costing Tennessee.

Five billion dollars, because we don't have trained people that have trauma, and most of the health care comes from, you know, smoking and drug use.

And, you know, it was amazing to me to see how much similarities there were between Memphis and Appalachia, and I mean drugs, poverty, not moving forward. It was almost the same.

And, of course, you know, in Oak Ridge, Tennessee, where we are lucky to have the highest concentration of doctorate degrees in the world, right across the mountain is where we have got the most abject poverty in Appalachia. It is even worse than the inner cities.

So we set out to make a difference. We got the appropriations. We got people involved. We adopted but we need Congress now to help us move forward with this.

We have got it on such a stage. Forty-two thousand people in Tennessee have been trained on this. Six thousand—over 6,000 teachers, and, you know, we have got 2,000 Baptist churches in Tennessee and if all of them would take responsibility for one child we could really make a difference.

We are making a difference in Tennessee. We are going to make the next generation much better.

But Congress, we need your help. We need your help.

Chairman CUMMINGS. Thank you very much.

Mr. Patterson?

STATEMENT OF CHARLES PATTERSON, HEALTH COMMISSIONER, CLARK COUNTY, OHIO

Mr. PATTERSON. Thank you, Chairman Cummings, Ranking Member Jordan, members of the committee. I really appreciate you taking the time today to talk about this topic because this is one of those things in public health that we call a root cause.

We are trying to figure out why we have had an incredible opioid epidemic in Ohio and in Clark County. We are trying to figure out, you know, why we can't fill the jobs that we have.

We have good-paying jobs in our community now. We can't fill them. And why can we not fill them? It goes back to the ACEs. It goes back to the childhood trauma that we have not treated properly, we have not informed our community, and we are just figuring that out in Clark County, Ohio.

We are figuring out that this multi-generational poverty that we have is actually multi-generational trauma-driven.

Because there is a way to get out of poverty. There are good jobs. There are—you know, we are not talking minimum wage jobs. We are talking about $20 an hour jobs and you don't have to have a college degree.

But we can't put people in them because they don't have driver's licenses from the drug use and they can't pass the drug test.

We have got teachers in schools that are trying to teach and they are trying to go toward STEM and doing that work. But they can't teach the top kids. They can't teach the middle kids.

They are spending their time dealing with the childhood trauma. They are dealing with the child that is coming to school with all that trauma who is disrupting the classroom.

And we have always thought that it was because Johnny was a bad kid, and now we figured out it is because Johnny has lived with stuff that most of us can't even imagine.

We are seeing it in our court system. Our court system is full and our court system is full of folks with mental health problems and with opioid problems.

We review drug deaths for the last several years since 2015 in our community because we are trying to figure out why. We are trying to do, once again, a root cause analysis.

But when you review a mother's death and then later on you review the death of the son, and you wonder could it have been ACEs, could it have been the trauma that the child lived with the mom going through drug abuse for many years and then sitting at the kitchen table doing opioids together.

It is very sad when we are looking at and we have got the data that shows us that we are seeing generation after generation.

So what are we doing locally? We actually have a steering committee on trauma. It met yesterday and it has a strategic plan. But that plan is basically what the—what the CDC said earlier.

Let us make everyone provide trauma-informed care. So not everybody is going to see a doctor. Not everybody is going to see a clinician.

We need everyone in the community to be able to begin to build the relationships because the relationships are key and that is what—that is where the healing can begin.

We haven't talked about it enough, and so our community—you are right. When you said, you know, only a handful out of 600 people knew about trauma-informed care, we are seeing that in our community as well.

And so we need to get that message out that anybody in this room can provide trauma-informed care. You don't have to be a medical doctor or a clinician or a psychiatrist. You can begin just by building that friendship.

What do we need the Federal Government to do? What you are doing now, is talk about is and come up with a comprehensive approach. What we don't need is Department of Education say we need to do this and then law enforcement is going to do this and the medical community is going to do something else.

We need it to be a coordinated effort so that they are all playing from the same handbook. We need work force development because right now, we have open positions for clinicians, psychiatrists, psychologists in our community and we can't fill them because those people just don't exist. We don't have enough of them.

And the other thing is continue to talk about trauma-informed care because what we—what we can ask you to do is provide hope. There is hope the brain can heal itself and we really appreciate your time today.

Thank you.

Chairman CUMMINGS. Thank you all very much. I really appreciate your testimony. I am going to yield myself a few minutes to ask questions, and I just want to let you know that I am going to step out for about a half an hour and then I am coming back. Maybe a little bit longer.

But I have got something that I have got to do. I rarely miss out on a second of our hearings. It is hard. Sometimes they are six, seven hours but I am here. So I don't want you to see that as any way disrespectful.

Now, Mr. Henry, I keep—for some reason I keep going back to a question that Congresswoman Pressley asked a little bit earlier of the other panel, and she talked about stigma.

And when I heard you say that you all were able to gather everybody in a room, that people who make a difference—I assume the people can make decisions, and I guess you are talking about the business community too, I guess—how did they do that?

Because you—Mr. Hice and I were just talking about how you all have apparently been able to do something to get past this thing of, oh, it is their fault, or when you see a child in need, there they go again—you know, that kind of thing.

How do you get past that? And living in the inner city of Baltimore myself, going back to something that you said, Mr. Patterson, I look at some of the children and I wonder how they even get to adulthood, I mean, with all the forces going against them.

So I am just—how did you do that, Mr. Henry?

Mr. HENRY. Well, I think, No. 1 is they have to be aware of what is going on. I mean, there is so many people. There are a lot of kids involved here and a lot of impact from this.

But not many people really recognize it. It is a lot like dealing with people with disabilities. You know, for a long time in this country we didn't realize exactly what we were dealing with.

You know, we did just the opposite of what you ought to do with those kind of things. I mean, we hid people with disabilities. We segregated them. We did all those things.

I had a son with disabilities who passed away but—and had terrific disabilities but the best thing for him was when he got out with people and they treated him normal, and you have got to have mentors.

You have got to have these organizations that are willing to step up and you have got to have somebody at the head of it that can draw that kind of crowd.

The Governor of our state took the lead and his wife took the lead.

Chairman CUMMINGS. By leadership.

Mr. HENRY. And there is no—you know, no substitute for that. And in Memphis it was A.C. Wharton and, you know, A.C. took the lead, and the Pyramid Foundation and, you know, we brought all those people together and some of my best friends in the legislature.

I have served as Republican leader for a number of years under Governor Alexander—Senator Alexander. And the way we did things was that we worked together. I mean, there are very few partisan issues when you look at kids, education, these kind of things.

I mean, it is bigger than partisan. So we agreed on those things and we used part of that coalition and we still do today, I mean, to bring people together and tackle these terrible problems.

I mean, Tennessee has got huge problems. They are one of the biggest perpetrator of drugs, you know, alcohol. Smoking causes 42 percent of our total health problems.

Chairman CUMMINGS. Wow.

Mr. HENRY. Smoking. And, you know, and because we have got a history of raising it and being it and it was the manly thing to

do when my dad grew up was to smoke. But he had a heart attack when he was 56 years old, you know, and didn't——

Chairman CUMMINGS. Did he pass?

Mr. HENRY. He survived for another 20 years and then he got poisoned working up at Oak Ridge, and thank goodness that the Congress appropriated the money in the 1980's to take care of some of those folks that died of exposure to radiation.

But those—it has got to be an all-out effort. It can't be four or five people in a state.

Chairman CUMMINGS. I just have one other question, and that is to you, Dr. Bethell. Piggybacking on what Mr. Henry just talked about, you said that so often folks are doing things that actually are hurting the kids instead of helping them.

Can you elaborate on that? And he said—I want to hear from everybody now. But go ahead.

Ms. BETHELL. Yes. I mean——

Chairman CUMMINGS. You did say that? And make sure your mic is on. Go ahead.

Ms. BETHELL. I did, and I can give you a very concrete example on that same——

Chairman CUMMINGS. Yes, that would be wonderful.

Ms. BETHELL [continuing]. same meeting that I was at a month ago where most people didn't know about ACEs. When they learned a Title 5 special health need specialist that was going into the home to treat a child with autism and noticed that the mother was under extreme distress, and also that the child was not able to focus by continuing to look at the mother and cry, and he wouldn't have gotten paid and he would have been reprimanded if he hadn't executed those exercises for autism treatment and had no way of addressing the issue because it was not in his purview nor did he have any information about the other home care visitors and others that were treating the same family and neither did the mother know all of the services that she was receiving.

There was no way for them to work together, coordinate, and deal with this cross-cutting issue. Probably the traumatization to that child by being forced to do exercises that were not really what the issue made him feel like he had actually hurt those children, and when we talked about this in a later break out it went on for a good while what we could do. That is a concrete example.

Chairman CUMMINGS. My mother used to say—my mother used to say there is nothing like a person who don't know what they don't know.

Ms. BETHELL. That is right.

Chairman CUMMINGS. And she only had a 4th grade education.

Ms. BETHELL. Yes. But this person knew and couldn't do anything.

Chairman CUMMINGS. And so you got almost the blind——

Ms. BETHELL. That is right.

Chairman CUMMINGS [continuing]. leading the blind. They are not only leading them, they are leading them in the wrong direction.

Ms. BETHELL. Right.

Chairman CUMMINGS. Yes, sir, Mr. Henry?

Mr. HENRY. Just one final thing and I will quit preaching to you, Mr. Chairman.

But, you know, kids are not inadvertently mean. That is a learned behavior. And, I mean, if you raise them in the wrong environment they are going to turn out unsuccessful most of the time, and we see a lot of times where somebody somehow pulls themselves up and then you say, well, you can do it if you would pull yourself up.

Well, that is not reality. If you are raised in a bad environment you are probably not going to turn out too good.

If killing and drugs is the norm, that is what you are going to, you know, head toward. If not working is the norm, that is what you are going to——

Chairman CUMMINGS. My last question is what—some of you have talked about this briefly—but what would you like to see us in the Federal Government do to help children?

I mean, us in Congress.

Dr. Shervington, did you have something?

Dr. SHERVINGTON. Yes. Government can really assist the coordination of these services. Like the gentleman said, we don't need the Department of Ed on one said, law enforcement on one side. I think we have our public health agency, the Centers for Disease Control.

We have the more clinically oriented services in HHS SAMHSA. I think that if those efforts were better coordinated, and I am looking to the population level approach to even bring SAMHSA in, I think that it would be really helpful to communities when we have one message, almost one kind of science about how we are going to go ahead and heal.

Thank you.

Chairman CUMMINGS. Mr. Patterson?

Mr. PATTERSON. Having the hearing today, that is the start, right? Talking about it and letting people know that it is out there, understanding that it is a root cause and then continuing to provide evidence-based programming that folks like the CDC present to us so that we can implement it on the ground at the local level.

We don't have the resources at the local level to try something that might work. In most cases, we need to put our local resources into an evidence-based practice that if we do it to fidelity we are going to bet a result.

And so you can—you can direct your research funding at programming that provides that local evidence-based practice.

Chairman CUMMINGS. Dr. Houry?

Dr. HOURY. I think it is important not to lose sight of prevention—really, primary prevention. All too often in the ER I would see it. We would see that trauma, and I focus on how do I save that life.

How do I prevent that injury from coming in the first place is key, and there are so many ways that can be done through early childhood education, promoting social norms, parenting skills, really connecting youth to caring adults and we have evidence-based programs that do this.

We need better evaluation of them. I think as Mr. Patterson was saying, looking at some of the local innovations, being able to

evaluate them and scale them up, and CDC is ready and poised to really work with Congress on this.

Chairman CUMMINGS. Mr. Henry?

Mr. HENRY. Mr. Chairman, I would just like to say I think the best thing you could do is bring—is what you are doing today. And, you know, I think states need to make a commitment. The Federal Government doesn't just need to do this.

If you can't get a commitment from the state to understand they have got a problem out there, you are just going to be wasting your money.

But, I mean, these—there ought to be some barometer of how a state—how they appeal—I mean, whether a legislature understands this issue. Are they willing to appropriate recurring money?

Chairman CUMMINGS. Right.

Mr. HENRY. Not one time.

Chairman CUMMINGS. Right. Sustained.

Mr. HENRY. But recurring them.

Chairman CUMMINGS. Yes. Thank you.

And finally, Dr. Bethell?

Ms. BETHELL. Yes. First of all, there is a way to we need to leverage existing programs and policies that are not fully implemented or brought to scale including EPST, CAPTA, and many of the other programs that serve children already that do not integrate this information or are paying and training in ways that support their implementation.

We also, I think, need the Federal Government to take the lead in creating a "through any door" awareness by being the leader like in Tennessee and being relentless in that.

And then also all of the—all of the NIH programs that study any disease practically know that this is a factor but it is not included in RFPs as a requirement for measurement.

We have a lot of things that are and we can start to learn more by integrating information about ACEs as well as protective factors, positive health, and engagement of communities and people, which is essential.

And finally, to really help the communities that are out there that need an emergent process. Even though there is evidence-based, the truth is that this has to be tailored to the real people in a real community owned by them.

And so we need common element approaches and supports to implement them with data, measurement, tools, and models that then can be used by communities where they adapt and make it their own because unless we make it our own nothing will change. This is relational and engagement-based.

Chairman CUMMINGS. Thank you very much.

Mrs. Miller?

Mrs. MILLER. Thank you, Mr. Chairman.

Oh, my goodness. You all have made my brain go all over the place. I certified to teach a long, long time ago. But just due to various life experiences I didn't teach. But I volunteered in the school system anywhere between 10 and 17 years in some fashion.

And the things that you have talked about—I remember one little boy that I had been with on and off for years who played ball

with my son, and he had terrible life experiences, and he had been shot and he—I mean, just many things.

He made really bad choices, and I can remember one day being in the mall and he was hanging out with a group of people you wouldn't want him to hang out with, and he saw me and he walked away from that group and came up and hugged me and just put his head on my shoulder because he knew I loved him and he knew I believed in him.

And I have been involved with the Three Branch Initiatives that they have tried. There are so many programs out there that you all have touched or been involved with while we are all trying to reach those children.

We have alternative schools in West Virginia that, if you talk to the kids, nearly all of them have seen someone in their family doing drugs, just like you said.

But now I will go back to what I was really going to talk about. In our committees in previous discussions we have had many, many discussions about the opioid epidemic, and I have talked about my home state of West Virginia multiple times because it is ground zero for this epidemic, as you know.

We are now seeing second and third generation effects from this epidemic—children that are being neonatally exposed to drugs. They are in the school system. The principals and the teachers are trying to find the correct way to deal with their behavior.

So listening to the things you have to say it is just so important. Many children are being raised by other family members, grandparents, even great grandparents because Grandma is on drugs. It is just—it is happening.

We have now seen how the environment increases their proclivity for behavioral problems and attraction to drugs themselves.

Mr. Henry and Mr. Patterson, you could be my next door neighbor—you know, just the experiences you have had, what you are doing, the way you talk. We are—in West Virginia, Ohio, Kentucky, we all touch—Tennessee—we are all cousins. You know, we all touch the same problems.

And so hearing what you have done in Tennessee sounds wonderful and I relate to what you are trying to do in Ohio because we have been fighting this in Huntington, West Virginia, a long time.

Dr. Houry, you have been home. You have been where I am. Can you discuss how the rise in the opioid epidemic has led to an increase in trauma with children?

Dr. HOURY. Absolutely, and I think Huntington has really—although it has been the epicenter, I think it is really up and coming when you look at all of the great——

Mrs. MILLER. Yes. Yes.

Dr. HOURY [continuing]. activities that are going there. I left there so impressed and inspired by the work that was being done there. There was Lily's Place to where——

Mrs. MILLER. Yes.

Dr. HOURY [continuing]. you saw newborns that were in an appropriate comforting environment and parents were taught how do you parent.

You know, how do you really nurture those stable nurturing relationships which are the fundamentals to protect against child maltreatment and to protect against childhood trauma. So I think that is one of the most significant things you can do.

When you just look at ACEs in general, if you have six or more ACEs, it has been shown that men are 46 times more likely to inject drugs with that much exposure to trauma.

And so one of the things that I always say that keeps me up at night is we have good treatment for opioids; we don't have good treatment for meth and cocaine and these other drug epidemics that are coming.

So if we don't focus on childhood trauma and the exposure to substances in the home, we are going to be in a whole lot of trouble 20 years from now, 10 years from now.

And so we have to focus on, again, primary prevention of these childhood traumas linked with opioid misuse and we are seeing more kids entering foster care as a result of exposure to opioids.

So I think, again, looking at protective factors like looking at how do you have youth-linked caring adults. Well, it is a Big Brother Big Sister program, After School Matters, the programs in Martinsburg.

I think all those things we can do to put in protective supports for kids you are exposed to opioids will really help buffer those effects.

Mrs. MILLER. Well, what evidence is available to show the role of the faith-based and the family based that can help these victims?

Dr. HOURY. So what I would say is it is about that safe stable nurturing relationship and it is any caring adult. And so there is a program called Powerful Voices really focused on women and girls to give them that leadership and that courage and that resiliency.

Faith-based communities are an important partner. I would say police are an important partner. Education is an important partner. Honestly, we need all sectors to be partners at the table.

And I would defer to my colleagues to really add to that.

Mrs. MILLER. May I have some more time, please?

Mr. DESAULNIER.

[Presiding.] If you could. Anyone who wants to address that specific issue.

Ms. BETHELL. I just want to say one thing that many might not know about. But in the mid–1950's, the Harvard Mastery of Stress study asked college students what—how to rate—rate their parental caring and worth, and they did a 35-year followup study that was published the year before the ACEs study was published showing that those that had low ratings had—87 percent had illnesses and diseases, many of which was addiction, and when they rated it high it was 28 percent.

And so what we know is it is the absence of the positive which we can nurture that really is the buffering and the support that we need, so even with ACEs when we have positive childhood experiences and warrant the nurturing.

So any program that can facilitate that we can expect it to reduce addiction, which many top NIH NIDA researchers now call repetitive compulsive self-soothing, which will occur. The nervous

system will win, and we need to help people understand that they are not bad; they are trying to soothe their nervous system and there are other healthy ways to do it.

Mrs. MILLER. One of the things that I have observed in our hospitals who are dealing with these precious babies is there are cuddling programs where people come in and rock the babies, and I made the point to the particular people in the hospital it is as important for men to come and rock these babies as it is for women, because the babies need the feeling of that man holding them close just as much as they do the female.

It is so important that our children feel that warmth and that—just that love that you get from sitting and rocking a baby, particularly those that are drug exposed that cry incessantly because they—you know, things aren't firing exactly right and they don't know what is wrong.

But, to me, the programs that you all are coming together with and the communities that come together it takes us all to do this, and I am—I could ask you about the Support Act and the opioid epidemics and, you know, are there other ways that our administration can help address trauma?

So do you all have any suggestions of additional things? Do you think ACEs is the answer? Are there more things that we should work on?

Mr. DESAULNIER. And I would encourage you to answer that, Mrs. Miller. I appreciate your interest and your passion. If we get a chance we can come back for more time if you are here. But if you could just concisely maybe respond to the Congresswoman's comments and questions.

Mr. HENRY. I think there is many things you could do. You know, you could visit those places. You can make that a topic when you visit.

You can bring the argument home. You can have hearings on it. You know, not necessarily everything comes from money but it helps. But, I mean, don't send any money to a place that is not committed to solve this problem, and being committed it means that everybody is in.

I mean, the whole future—whatever we are dealing with around this world is not as important as this. I can tell you the future of America depends on how our children are raised, and if we don't make a difference in them then we are going to lose all the battles.

So, I mean, you know, you draw a lot of attention when you go somewhere.

Mr. DESAULNIER. I appreciate that.

Mr. HENRY. And if you were—if you were well versed and, you know, just had the training and relayed it to our churches across this state—I mean across this country about, you know, this is what you can do. Tennessee has 2,000 children in custody. There is 2,000 churches in Tennessee.

Why don't you take one child? I mean, more than just Baptist churches. But, I mean, there are places everywhere and we are doing a lot of that.

But there needs to be bigger attention to it and there is no bigger chess—I mean, no bigger chess game going on between special interests and this because, you know, you are talking about drugs

and the use of drugs and the—you know, the good people and the bad people.

It is like the old-time preachers and the whiskey dealers getting together and being sure that there weren't any license put out. But, you know, we need to be sure that we have got all these people on the same side.

I will tell you, if you are out there in the community there is nothing more important than this and, I mean, I would love to have all the funding you could give. But that commitment is what we need more than anything.

Mr. DESAULNIER. Thank you, Mr. Henry.

We are going to recognize Ms. Wasserman Schultz for five minutes.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

Dr. Bethell, I want to direct my questioning to you but I have a sort of a preamble before I ask you the question. You mentioned in your opening statement that we need a paradigm shifting evolution to address childhood trauma and I have been thinking about childhood trauma a lot this week, about the kids at the border being traumatized by dehumanizing treatment in detention facilities, about the women who experienced sexual abuse as children at the hands of Jeffrey Epstein and then had their rights violated by our Secretary of Labor Alex Acosta denying them any justice or accountability, about the kids in Parkland in my home county and around the country whose lives have been altered dramatically by senseless acts of gun violence, and in addition to everything else, the outrage that these are flagrant public health issues.

These are young people in our country that we are categorically failing, and I appreciate so much the courage of Ms. Rygg from the first panel when she testified that she felt she, quote, "slipped through all the cracks" in the agencies that are designed to protect children from trauma. Those cracks feel like chasms.

I want to ask about one of the systems that failed Ms. Rygg. Approximately 90 percent of children in the juvenile justice system have at least two adverse childhood experiences and, you know, why do we sanitize all of these terms?

Adverse childhood experiences is a lot, you know, blunter, more rounding the corners way to call the trauma that she described what it is. I won't repeat the words, but it is hard to feel the same impact that her—like her testimony gave us with the term ACE. ACE is benign.

Nearly half of the girls in the system have five or more ACEs. Under the Trump administration, the Office of Juvenile Justice and Delinquency and Reform rescinded guidance about trauma-informed reforms for girls in the juvenile justice system, and OJJDP Administrator Caren Harp said the agency is too focused on therapeutic interventions and has questioned the validity of neural science regarding adolescent brain development science.

So, Dr. Bethell, why are trauma-informed approaches to discipline important? And I will ask Dr. Shervington as well. Your organization's Sad Not Bad campaign focused on shifting public understanding of the behavior of young people who have experienced complex trauma, and if you could describe why that is important as well.

Ms. BETHELL. Okay. I will say just a couple things and then we can elaborate on it if you would like. But we do things to try to help children who we think need our help. But if they are not able to be present and in their own body, let us say, able to take in information even, they are not able to learn or do anything.

And so what happens under ACEs is we get something that may be called developmental trauma disorder, and trauma is as trauma does.

Even if people who don't have ACEs they can have trauma, and this leads to disregulation of emotions and body systems around stress of any kind where small stresses start to feel very big when you have had a history of trauma.

So even a small request can be difficult to manage and you can start to feel the panic and the trauma in your system without even knowing that you are—you are not even having any thoughts that is happening.

Ms. WASSERMAN SCHULTZ. Can I just ask you briefly, do you—do you agree with Administrator Caren Harp when she says the agency is too focused on therapeutic interventions and is there any doubt over the validity of neuroscience effect——

Ms. BETHELL. There is no doubt over the validity of neuroscience——

Ms. WASSERMAN SCHULTZ. Okay.

Ms. BETHELL [continuing]. and also the biologic sciences, even in epigenetics now. But if we don't have the environment and all the people interacting with the child and not just in a therapeutic setting demonstrating the care and understanding around trauma-informed practices we can undermine any therapeutic approach.

If you are met in a traumatizing way most of the day, an hour of therapy is not going to help you. And so we have to have the "through any door" and also there is a lot of self-care and engagement that has to happen.

So giving somebody a therapy versus engaging them and helping them with their own reworking of their nervous system and their identity that can be often devastatingly damaged, sell a positive sense of identity and the ability to even reach out and have positive relationships.

These are the hallmarks of trauma. So we have to have it be where we have relational positive relationships and constant affirmations that help us learn how to regulate our emotions and bodies and not be constantly triggered by most of what we are confronting, especially in the juvenile justice system.

Ms. WASSERMAN SCHULTZ. And if Dr. Shervington can respond as well.

Dr. SHERVINGTON. Yes. So after Katrina there were no plans made for the children, and so what we started seeing in the schools was a lot of disregulated behaviors. And so when my organization went in, we felt that the little things that we were doing as a community-based public health organization would not be enough.

So I was going into the schools. The teachers—and thank you for mentioning the importance of teachers—doing professional developments for them, having them understand that the kids that we use in our public will campaign that they are really sad.

They are emotionally disregulated, which is why we are seeing the behaviors, and they are not bad. And when we used that language, that hashtag, I think people began to see and I think that is what we are all saying, that if you could ever understand the suffering that some children are made to experience and that they can still get up and go to school, that if we could create these safe spaces in the schools, in the community, and when needed because they are so damaged they have to have the kind of professional help that, together, we could all change this problem.

Mr. DESAULNIER. Thank you.

Ms. WASSERMAN SCHULTZ. Mr. Chairman, can I just ask unanimous consent to enter this letter into the record from the Jewish Federations of North America? They are expressing support, addressing the impact of childhood trauma on older adults.

We have 74 million Baby Boomers, many of whom will, unfortunately, have experienced trauma in their childhoods, and there is a need to conceptualize and address childhood trauma as a lifespan issue and create person-centered trauma-informed systems of care across health and social service systems for children and older adults, and that has never been more urgent because of, obviously, the size of the Baby Boom generation.

So if I could ask unanimous consent to enter that into the record.

Mr. DESAULNIER. Without objection, so ordered.

Ms. WASSERMAN SCHULTZ. Thank you. I yield back.

Mr. DESAULNIER. With that, we will recognize the gentleman from Georgia, Mr. Hice.

Mr. HICE. Thank you very much, and let me begin just—I hate that he had to leave early but a big sincere thank you to Chairman Cummings—his final words to the first panel, words of great heartfelt support and appreciation for them coming forward with their stories.

I think I speak on behalf of both sides of just genuine thanks to him and I hope that will be relayed to him.

Mr. Patterson, let me begin with you. I was extremely intrigued with, and think you are spot on with, talking about how trauma is a root cause of so many other issues, and you mentioned poverty itself being trauma driven.

I am just curious, now that we are seeing record low unemployment and so many different positive results in that regard if having a dignified stable job in and of itself can help either prevent trauma or promote healing.

Mr. PATTERSON. Well, sir, you are exactly right. It is one of those supporting factors that we need as an adult to deal with the situations that we have had.

Unfortunately, we are unable to get a lot of those people into the work force because of very high ACE scores so that—and, you know, directly we are talking about way too much trauma to be able to not be involved in drugs.

The employers—many employers still have to have—for their workers compensation they have got to have a drug test on file. They have got to have a driver's license to get back and forth to work.

Where we live we don't have a massive transportation system. So you pretty much have to have a car to get to work. So the jobs are there and it is certainly a supporting factor.

But we need to be working early—I agree with Dr. Houry we have got to do prevention work so that we don't have to deal with it.

But for those traumas that have already occurred, we have got to do work early and often because the earlier we begin to intervene the better the results of the therapy is. So you are absolutely right.

Mr. HICE. That does——

Mr. PATTERSON. A job—a job helps. But if you can't get the job——

Mr. HICE. Exactly, and it is not a cure-all. I mean, all of you, you have spoken of family and faith and community and a host of other factors that are all involved and necessary, and again, just—I won't have time to get to all of you but thank each of you for the roles that you have in addressing this issue.

Dr. Houry, let me ask you, and this is—dealing with Generation Z there was a recent—in the age 15 to 21-ish, somewhere in that ballpark—I saw a recent survey that said that this particular generation lives with constant fear and anxiety since Donald Trump's Presidential election. That is one thing.

My question is does CDC fall into that type of anxiety as being trauma? Seems like we are talking two pretty diverse emotional experiences here.

Dr. HOURY. When we are looking at adverse childhood experiences it is things like, you know, child abuse or something you witness in the home. So that is how we define trauma.

Mr. HICE. Okay. So stress in this regard anxiety would not fall under trauma?

Dr. HOURY. I think if you look at what childhood trauma in itself is if something does engender stress that could have a physiological or physical or mental health reaction then you could say that it would be a trauma. But it wouldn't fit into one of the——

Mr. HICE. Not to the same extent. Okay. All right.

Yes, ma'am?

Ms. BETHELL. I just wanted to say that, you know, we want to address ACEs because we would like to promote flourishing, which has to do with having a sense of meaning and engagement in life and having hope and optimism.

So anything that detracts from our ability to have a sense of hope and optimism in our lives and the ability to move forward and contribute in ways we think are valuable will diminish flourishing.

And for people with trauma, which is about half of U.S. children to on top of that start to live in a world where they think their opportunities are not there and that they can't quite figure out what the point is anyway, which is the bulk of the friends of my nephew who is in that age bracket, that they can't figure out what there is to live for a lot of them.

And this is not a small number. So we do need to lift up a sense of meaning and hope and optimism as a way to prevent even future ACEs even for kids who don't have them today.

Mr. HICE. No question.

Ms. BETHELL. I think it is important.

Mr. HICE. No question about that. I have probably a 10-second—while I have got you probably a 10-second or less answer. You mentioned in your opening statement about illnesses that actually come from unaddressed trauma and that caught my attention.

Can you give an example or, like, what kind of illness?

Ms. BETHELL. Yes. I mean, there is a book called "The Autoimmunity Cure," which documents in very clear scientific manner the way that the toxic stress from ACEs and childhood trauma directly impacts inflammation in the body and how that goes throughout all of the body systems.

There is a book coming out called "The Angel and the Assassin" soon that is examining the power of the microglial cell as an explanation for the brain pruning under stress that leads to mental illness.

And so we have very strong ways that we know that toxic stress gets embedded in the body and outpictures in autoimmune conditions inflammation and mental illness. This is very important that we understand how we function biologically based on our relational and lived experiences.

Mr. HICE. Another example of root cause.

Thank you very much.

Mr. DESAULNIER. Thank you, Mr. Hice.

I am going to just remind members, we have members—we would all like to spend more time on this issue and I would suggest that we need to.

But we have got members who have commitments at other committees who are trying to manage their schedules. So I am going to keep people to the five-minutes. And this is not an admonition to the next speaker.

Ms. Ocasio-Cortez, you have—recognized for five minutes.

Ms. OCASIO-CORTEZ. Thank you so much, Mr. Chair. Thank you to all of our witnesses both in our first panel and to you all right now for coming.

I think, as was echoed earlier on both sides of the aisle, this is one of the more powerful and one of the most powerful and brave hearings that we have had in a very long time and I think there is a reason for that, not only due to the expertise and the courage of our witnesses but thanks to the tireless work of our chairman and the work of Congresswoman Ayanna Pressley.

This is our first hearing on childhood trauma in the history of the Oversight Committee, and I just want to commend her and to commend our chairman for having the foresight and seeing that this is a macro issue of national consequence.

Dr. Bethell, was I correct in hearing you say that half of children have some form of childhood trauma?

Ms. BETHELL. Yes. So using the CDC's definition and adapting it for—as appropriate for the National Survey of Children's Health, which we have an entire paper on if you want to read about it, we estimate that about half——

Ms. OCASIO-CORTEZ. Half?

Ms. BETHELL [continuing]. almost 47 percent of children have exposure to one or more ACEs. And, of course, there is things that

aren't measured in there, but because they are very co-occurring we don't expect that we are missing children overall.

Ms. OCASIO-CORTEZ. Half?

Ms. BETHELL. Yes, half, and that most of our children who are bullied, who have special health care needs, 70 percent who have an emotional mental behavioral condition that we also identify have ACEs. So it is half. But for the systems that we serve children in through Federal programs, most have ACEs.

Ms. OCASIO-CORTEZ. Yes. And I think it is important that we note for the record and for all people that childhood trauma, as was noted by my colleague earlier, is a lifelong issue for people to live with and deal with, which means at some point in this country at least half of an entire generation will be dealing with trauma.

And when I think about this on a macro level, we think about how intergenerational trauma is not just familial but it is cultural. Right now when we talk and what was alluded to earlier, when we think about the childhood trauma induced by the opioid epidemic.

Dr. Shervington, I have to thank you so much for pointing out specifically the role of natural disasters informing childhood traumas—Hurricane Katrina, Hurricane Maria.

We are already seeing children in schools in Puerto Rico exhibit signs of post-traumatic stress. Child separation at the border, the traumatic impacts of poverty alone, post-traumatic stress, domestic abuse—this is half of our country. Half of our country's children.

And so the health of our children is reflection of the health of our Nation, and how we are going to have to deal with these traumas is a collective responsibility on the public policy across all of our issues, whether it is homelessness, immigration, what have you.

Dr. Shervington, how does—you know, I want to zoom in on an issue that, as I mentioned, you highlighted—the effect of climate change and natural disasters on childhood trauma.

Can you highlight how does a hurricane like Katrina or Maria, particularly one that has caused a lot of destruction, affect a child's mental health as they approach adulthood?

Dr. SHERVINGTON. Yes. Children need two things: to have caretakers who make them feel safe and to continue to feel that the environment in which they also live is safe.

When Hurricane Katrina happened in New Orleans, all of that was shattered for the children and, likewise, I know, in Puerto Rico and some of the other natural environments that happened all around.

Unfortunately, what—children are in a, like, double whammy because usually they don't have the language to talk about how they are feeling and oftentimes the adults they are dependent on they are disregulated. They are just trying to figure out how to cope.

Many families in New Orleans talked about, and in particular, say, mothers who are breastfeeding, that it was very hard for them to connect with their child that usual loving warm affectionate bond that children need—that they weren't capable of doing that.

We even had some kids that we have identified there, and there is some science done by Dr. Yehuda, of what happens with mothers who are experiencing a trauma such as a natural disaster and how that gets transmitted in utero to the kids.

So a couple years ago I was asked to deal with some kids who were just being born during Katrina and they were extremely disregulated. The principal had enough wherewithal to know there is something going on there.

So we have to remember that when a natural disaster happens and, in particular, where we have communities where the families are just barely making it—they are on the edge—so they don't have the comfort of thinking oh, my insurance company is going to take care of this—that it really complicates and makes more complex what would naturally happen like we saw in New York. A lot of families came back. There was so much support.

We are still reeling from that in New Orleans and I am sure in Puerto Rico where we did not get the amount of psychosocial and financial supports.

Ms. OCASIO-CORTEZ. Thank you.

Mr. DESAULNIER. Thank you.

The chair now recognizes the gentleman from Wisconsin, Mr. Grothman, for five minutes.

Mr. GROTHMAN. Yes. A very interesting hearing. I would like to thank you all for being here.

Percentage wise, say, of people high school age in this country—I don't know whether I will start with Ms.—Dr. Shervington or Dr. Bethell—how many people do you think should come in contact with a professional in this country to deal with their potential problems?

Dr. SHERVINGTON. I think that what we need to do is make families——

Mr. GROTHMAN. No. No. I wanted kind of a number, like percentage wise how many, say, Americans high school age—say, 14 to 18—you think should be coming into contact with a professional.

Ms. BETHELL. When we look at the data for youth who are in school who have two or more ACEs and the high prevalence of any number of conditions that they have, that is about 28 percent of all children age 12 to 17 and much, much higher for certain subgroups according to income and race/ethnicity.

So it is a large group. But about one in four children in the country.

Mr. GROTHMAN. Is that 28 percent for anything under the sun or 28—because I am sure there are problems people have in addition to——

Ms. BETHELL. Twenty-eight percent have the exposure of two or more ACEs where we see high rate—much higher rates of special health care needs, emotional mental behavioral problems, and lack of engagement of school at very high rates at that level—almost more than half.

So and in certain populations it is much higher. So I am estimating that about 28 percent of youth 12 to 17 need some kind of special intervention probably right now.

Mr. GROTHMAN. By a professional?

Ms. BETHELL. Yes.

Mr. GROTHMAN. Okay. And how many—how many do you think are getting help?

Ms. BETHELL. Well, we know something from the National Survey of Children's Health that less than half of children who we al-

ready think need that kind of service, which means we are already diagnosing them, which we often don't find, are not getting the mental health and treatment services that they need.

So my guess is that when you also add in those who are at risk that it is probably upwards of 60 to 70 percent.

Mr. GROTHMAN. Let us talk to somewhere numbers that are harder—you know, more hard numbers to get at. Do we have numbers like over the last 50 years, say, the number of children who commit suicide or attempt suicide?

Ms. BETHELL. We do have that data, actually. It is, of course, measured in the national vital and health statistics, and for youth 15 to, I think, 23 suicide is the number-one cause of death.

Mr. GROTHMAN. Can you tell me where it is, say, today compared to 20 years ago or compared to 40 years ago? I guess that is what I am looking for, you know, for some time comparisons.

Ms. BETHELL. Yes. Dr. Shervington may know more, but I do know that it has increased and I would be happy to followup with giving you very specific numbers on that.

Mr. GROTHMAN. Dramatically increased, all of the——

Ms. BETHELL. Suicide rates have dramatically increased across the board. Actually, they are high for also middle aged adults and are dying from the diseases of despair generally in this country with higher death rates than most other developed countries.

So suicide has become an epidemic that is characteristic of our generation.

Mr. GROTHMAN. Dramatically increased?

Ms. BETHELL. Yes.

Mr. GROTHMAN. Okay. Do you know the percentage of the population on medications designed to deal with depression or to try to push of suicide? Do we know the percentage of the population both kind of in the youth population, the high school years, and the adult population as a whole? Do we know what those numbers are?

Ms. BETHELL. I don't have all those numbers but we do collect data on the proportion of children, say, with ADHD and depression who receive medications, and once they are in treatment, which is a whole another thing of getting into treatment, the top priority treatment is medication.

However, many of the symptoms overlay with trauma. So one of the movements we would like to see is that before we medicate our kids and put the numbers of kids on foster care on Abilify, which generally can prevent them from even engaging in school, first we need to assess and treat the trauma, and if we do use medications to use them in a complementary way because there are so many needs and opportunities to help deal with the symptoms of mental health rather than treat and just medicate them.

Mr. GROTHMAN. What I would like, because, you know, in analyzing this problem it is nice to see over time what we are doing and how things are changing over time, is the number of, I suppose, both adults but and particularly children, say, high school to college years, say, 14 to 22, committing suicide, attempting suicide, and people taking legalized drugs for depression or that sort of thing, and perhaps the number of professionals out there over the last 50 years so we can kind of get a handle on what we are doing and——

Ms. BETHELL. I am going to defer to Dr. Houry on some of that from the Youth Risk Behavior Surveillance Survey. But I do know that about half of youth say that they have thought about——

Mr. DESAULNIER. Dr. Houry, we will let you——

Mr. GROTHMAN. Okay. Well, she has got an assignment, thanks to—Dr. Bethell has given you an assignment.

[Laughter.]

Dr. HOURY. Happy to do it.

Mr. DESAULNIER. And we are going to allow you to complete that assignment as long as it is done in a timely fashion.

Dr. HOURY. Got it.

So we released the vital signs this past year on suicide in the United States and saw that in 49 of the 50 states suicide rates went up in the past 20 years. More than half the states went up 30 percent, so significant rates.

We are seeing it going up highest in middle aged adults but we are seeing it go up in youth as well and we have completed several outbreak investigations of youth suicides in the United States, most recently in Stark County, Ohio, where we saw that youth that had three or more adverse childhood experiences 30 percent of them disclosed suicidal ideations, and if they also had said they were using opioids plus had those adverse childhood experiences 80 percent disclosed suicidal ideation.

I want to just say one thing, though, about the medications. I think it is important to realize suicide is not just about mental illness.

More than half the people who died by suicide did not have a diagnosed mental illness. Oftentimes, it is precipitated by a traumatic event—loss of a job, partnership issues, economic issues. So it is not just mental illness, which is why, I think, resiliency is so key.

Mr. DESAULNIER. Thank you.

The chair recognizes the gentleman from Maryland, Mr. Sarbanes, for five minutes.

Mr. SARBANES. Thank you, Mr. Chairman.

I want to thank the panel. I apologize. I have not been here for a lot of this testimony. I was here for the earlier panel, which was a very powerful one.

It was occurring to me as we were hearing from the earlier panel that the—this trauma, trauma gets delivered in a lot of different ways and what I mean by that is there is these, in a sense, collective events of trauma like a mass shooting or the effect of a natural disaster. Then there is trauma that is delivered in a very kind of specific and often hidden way.

And the response to those, I guess, professionally and clinically may be different. But I wondered if you could speak to—and if this is has come up already again I apologize—but I wonder if you could speak to how critical—I have just come from a hearing in the Energy and Commerce Committee where we are re-authorizing community health centers, and many of them are connected to school-based health centers.

And I have been an advocate for a long time trying to strengthen school-based health centers and really aspire to where every school has a health suite that is there at every level—elementary, middle,

and high school—and then making sure that among the professionals that are serving those centers are mental health professionals and counselors and so forth.

I can't think of—maybe you can—but I can't think of a better place to bring those services to address many of the trauma situations that we have discussed today than into our schools, because you have a captive audience.

You have the audience that is the most impacted at a young age from trauma whether it is something that has been experienced at home, whether it is one of these collective impacts, et cetera.

Could you just speak to the value of school-based health centers, how we can make them more robust in terms of the mental health component and if you view that as a place where we can make tremendous progress in terms of addressing childhood trauma?

And it is open to anybody on the panel who would like to address the topic.

Mr. PATTERSON. Well, I would like——

Dr. SHERVINGTON. I just——

Mr. PATTERSON. Go ahead.

Dr. SHERVINGTON. As what I would like to consider myself a community psychiatrist who is on the ground with our people after disaster and just people who have lived chronically through trauma that schools are one of the most protective places if we can make them that for children.

A lot of traumas happen in the home. We have situations, say, for example, where a kid is being exposed to domestic violence. The police comes, take a parent—whomever was the perpetrator.

One goes to the hospital, one goes to jail, and you know where the kid goes? To school. And that kid in school is not going to be able to concentrate and work that day.

So I strongly support and beg for us seeing schools as having health centers that can respond to their needs—social workers and also doctors are important in that, too.

And, again, having schools—the climate in the schools being trauma-informed. If we could do that, we would go a long way. Many stories of survival I hear from adults when they look back it was a teacher. A teacher saw something. A teacher did something. So I just want to say how important health services in the schools are.

Mr. PATTERSON. The federally qualified health center in Clark County is a comprehensive medical home, and so we have already heard about how the mental health issues and the trauma affects long term the health of the children.

And so we take this federally qualified health center that is a wraparound service for the children and their families and then we extend it into the schools, which means the captive audience that you are talking about, right, and then we have comprehensive mental behavioral physical health all in one, not just for the children but for their families as well, and the school is a walkable place for most of our communities.

And so then you have the ability for this all to happen in one place. It is a perfect fix. It doesn't fix everything because we have to train the entire community to be trauma informed. But if we are able to expand that into the schools, it really is a no-brainer.

Ms. BETHELL. I would just like to say a few more things.

One is that you mentioned acute stresses. But chronic daily stress, actually, in the literature has been shown to be even more impactful over life, especially when the acute stressors are often—more often addressed because they are more obvious.

So it is very important to know that, and also for schools that don't eliminate expulsion that, you know, when children act out it is very important that we consider not no expulsion from school but instead dealing with trauma, and that the first response is not reporting to child welfare because often the issues can be found earlier and if teachers' only response is to be a first reporter, then they may not want to say anything because they don't want to destroy the family.

And so we need a lot of ways to support children and families without expelling children from school and without reporting families to child welfare first.

Mr. DESAULNIER. Thank you.

The chair recognizes the gentleman from Pennsylvania, Mr. Keller, for his first questions on this committee. And we are not always this bipartisan. Hopefully, this is—you are going to change things.

Mr. KELLER. I hope to be able to do that.

Thank you, Mr. Chair, and I want to thank the panel and also the panel this morning. You know, it is hard—you can't even imagine people that have suffered the things that have happened to the people here today and people—are continuing to happen around our Nation. It is—it is tragic.

And I just heard a couple things that I want to make sure I understand and it dealt with some of the issues with ACEs and I heard poverty mentioned quite a few times, and just—and Dr. Bethell, I read through the graphs that you had and it seemed that in cases of poverty, if I understood what we were given, that the ACEs tend to be higher for, I will say, kids and young adults that live in poverty.

Is my understanding correct from the information?

Ms. BETHELL. Yes. The information I gave you was for those for 200 percent or below the Federal poverty level, which is 43 percent of children. They represent 57 percent of children with ACEs.

Mr. KELLER. And then as you saw the income increased then a decline in the ACEs?

Ms. BETHELL. Yes, except for it is still very high in all income groups. And I will say that it is very agnostic according to income once experienced in terms of the effects on health.

Mr. KELLER. Okay. The other thing you mentioned during—I think it was Mr. Hice was asking some questions—you mentioned about young adults a sense of purpose and being able—you know, that is creating some issues too with young adults. Is my understanding of that correct, too?

Ms. BETHELL. Yes. We just published a paper in Health Affairs about a child flourishing, one of which is whether children are curious and interested in learning, able to devise and fulfill tasks and goals that they have and remain calm and in control when faced with a challenge, and only about 40 percent of school-aged children in the country meet all three of those criteria.

So we need to proactively promote flourishing to help children grow into adults that can have a sense of meaning, purpose, positive relationships, hope, and optimism, and that is a cross-cutting need regardless of ACEs.

Mr. KELLER. Yes, I would—I would agree and, you know, there is also a study from the "Early Childhood Poverty and Adult Attainment Behavior and Health."

University of Chicago did a report that showed that when there is an increase in income that helps the children's future income increase—a modest increase in income helps a children's—or a child's income later on increase by 17 percent, which I think would help some of those issues, particularly for the kids in poverty.

Ms. BETHELL. Absolutely.

Mr. KELLER. Is that—is that something you are familiar with and do you agree that that might be helpful?

Ms. BETHELL. Well, the literature is pretty clear about that. There is a lot of co-occurring issues for children in poverty, and so when you parse them out it can be difficult to isolate. Is it the income? Is it the things that the—you know, other things that have gone on?

But a researcher, Renee Joynton Barrett, has researched a lot how there is mobility in poverty and often dealing with the issues of trauma that are intergenerational can help families actually move out of poverty and take advantage of the supports that are available to them.

We do have an issue of getting people to take advantage of supports that are offered because one of the things trauma does is it can stall the self-care instinct and the ability to actually activate the will to be well.

And so we offer things and then they don't necessarily able to follow through and use the resources. So I think hand in hand we have to deal with the trauma of poverty and the trauma of ACEs simultaneously.

Mr. KELLER. I think, you know, there is a lot of value in making sure that people have more income and more money to take care of the needs they have which, you know—you know, getting back to that, that small increase in 2017—end of 2017 the tax cut, you know, was passed and more families, according to the Tax Policy Center, you know, are keeping $1,600 more a year or getting $1,600 more a year back in their income taxes, which I think has to be a benefit to some of the poor families to be able to take care of themselves and have some more of those—help them create more of a sense of a worth because they have more control over what is happening in their lives.

So I guess I would—I would just say I think that is a positive impact, the fact that President Trump got that through Congress and people are keeping more of the money they earn. So that should be helpful.

I would say are there other things that we could do or policies that we could enact that would help people be able to direct more of their own—their own resources, that give them more sense of worth rather than, you know, just—I think it takes everything.

I think there is a lot of things we talked about but what other things—you know, should we make those tax cuts permanent?

What kind of things should we do to have an ongoing—an ongoing success of people coming out of poverty?

Mr. PATTERSON. Anything that we can do to build resiliency in our children to be able to handle the adverse childhood experiences that they have is going to be positive.

And so if we are able to put prevention programs in place, if we are able to—you know, a rising tide does float all boats. But your boat—if your boat has holes in it, it is going to be pretty tough for that to take effect.

So we need to help the people patch up the holes so that that rising tide can help everyone.

Dr. HOURY. I would just add we have technical packages on a lot of our violence prevention strategies and economic supports is one of the pillars. Things like earned income tax credit, child care subsidies, have been shown to reduce child maltreatment or associations with it.

Mr. KELLER. So that, coupled with tax savings, are a positive things for our families and for people in poverty.

Mr. DESAULNIER. Thank you. I want to thank the gentleman. His time is up.

Ms. BETHELL. I would say if they are working then they can benefit from that. But having a living wage and being able to actually manage to where you even earn enough to have much taxes taken out I think is probably preliminary even for many of the families we are discussing.

Mr. DESAULNIER. Thank you, Doctor.

Now the chair now wants to recognize the Congresswoman from Massachusetts and also acknowledge her leadership on this issue.

Ms. Pressley, your five minutes.

Ms. PRESSLEY. Thank you.

I did want to also just thank Representative Sarbanes for his leadership and partnership on the issue of school-based health centers. There but for the grace of God go I.

I can say with certainty that it was a school nurse that saw the signs of trauma and abuse in my own life, and it is so important that the school community are trained in these indicators, because, yes, there are children that act out but there are many more that shut down, and I was one of those children.

I do want to say, though, I have always taken issue with the term that children are resilient because I think it infers for people that they get over things. And the reality is that no child, no person, is really that resilient.

What we are is delayed, and these things do all show up in some way, form, or shape in our lives. It presents differently for everyone, and I think ultimately what we want to see in our school communities is a paradigm shift in culture where people will ask, what happened to you, instead of, what is wrong with you, and that is a distinctive shift that needs to occur.

But it is also important to note that our children are not independent contractors. You know, they are part of a broader ecosystem of family and community, and the best gift that we can give any child is a stable adult. But most adults are also destabilized, right.

And so when you talk about the issue of trauma and the stigma and the stereotyping and the one-dimensional narrative, I want to say when I first started talking about this issue in running for the Boston City Council that people were worried that I was coddling children or that I was feeding a stereotype of who is impacted by trauma.

And that is why the testimony of our witnesses earlier is so important and what you have offered her today is that hardship and trauma do not discriminate. There are some disruptions and hardships that are disproportionately bore by others based on historical legacies and systems and structures.

But it does not discriminate. And so bearing that in mind, this is a public health issue, an epidemic, and it must be treated as such. And we need to be not only coordinated but equitable.

There is no hierarchy of hurt, and I appreciate you are pushing for us to address this in a comprehensive way. I convened the first hearing in the Boston City Council, a listening-only hearing to hear from 300-plus families who are survivors of homicide victims, and that was where it was underscored for me that it is critical that this work be survivor-led.

My district is coming off of the heels since July 3d of 18 shootings, and so I recently convened and assembled civic leaders, faith leaders, survivors, advocates, family members of offenders, to all come together.

And so I request unanimous consent to enter into the record written testimony from the Office of Suffolk County District Attorney Rachael Rollins, the Louis D. Brown Peace Institute, which has an incredible national model and blueprint for this work, Wellspring Mentors, Mass General Hospital, and residents and community leaders across the Massachusetts 7th.

Ms. PRESSLEY. Picking up on that note of the need for us to be coordinated, there were medical professionals that were in this meeting and they said that they have been trained to stitch up victims, and many of them were repeat victims.

But it was only recently they thought to ask about who are they and what are the needs of those victims that were coming in to their ER and they were stitching up and why is that they keep coming back, right.

So I just wanted to lift up something from the Administration for Children and Families. It says African-Americans experience generations of slavery, segregation, and institutionalized racism that has contributed to the physical, psychological, and spiritual trauma.

Dr. Shervington, when the root causes that often lead to trauma are so entrenched in our very infrastructure—discriminatory housing, policies, health and racial disparities—how do we respond?

Dr. SHERVINGTON. I think, as you said, a real comprehensive approach. I tend to see these issues across the social ecological models. So as a physician, as a psychiatrist, at the individual level when the harm is done we need to fix that for the person.

And I would just like to underscore what you said. How many times can you kick someone down and expect them to get back up? And usually it is in those systems and those structures.

And so as public health practitioners or clinicians, we have to advocate for those kinds of policies that are going to look at those inequities and try to fix them.

We can't do them alone and so we have to be in partnership with those in our communities and it has to be community driven how these inequities play out.

We have to work with them. We are not isolated. So in our emergency room in New Orleans—the public emergency room—there are trauma surgeons.

They have this—they have built in some supports where at least they are screening for PTSD in the victims who are coming in, or I should say survivors. They are working with them.

But they are also going into the community, working with community-based advocates who are really looking at these structural factors that help to perpetuate the poverty and the violence that can happen when communities are disconnected.

Ms. PRESSLEY. Thank you.

Mr. COOPER.

[Presiding.] Thank you. Your time has expired and Mr. Gibson is recognized for five minutes.

Mr. GIBBS. Gibbs. Thank you.

Mr. COOPER. Gibbs. Excuse me. Of Ohio.

Mr. GIBBS. Thank you, Chairman.

First of all, I want to associate myself with Chairman Cummings' closing remarks on the first panel. And I see some of the witnesses are still here and you really are heroes for what you are doing, and God bless you.

You know, sitting through listening to all of this it has been interesting and very educational for me. But I think about the trauma it causes, you know, from a couple categories—poverty, abuse, drugs. I think we are all in agreement on that.

So I just want to be clear because it came up in an earlier question. In the—in the tax bill that we passed here in late December •17 we did put a—we doubled the child tax credit from $1,000 to $2,000.

But even if you don't owe any taxes—a family doesn't owe any taxes there is a refundable tax credit of $1,400 per child for their dependent children, and they just need to file, I guess. So that is important to help on the poverty side, even if they aren't working. Just want to make that clear.

What I want to followup a little bit on is—and Mr. Henry and Mr. Patterson, and welcome from Ohio, too, and I know Springfield. You know, I live about two hours from there.

But just to followup, talking about coordination and I know Mr. Henry talked about more money is always nice but then we got to make sure that the local people or entities are committed and but then this coordination thing.

And I just got a couple of examples. I know we have the WIC program—the Women, Infants, and Children program under USDA—and those social workers go out to those lower income families after a child is born and help with those nutrition needs.

As an example, if they see something as their followup, like if Mr. Patterson had been the health commissioner there in Clark County in Springfield, Ohio, what kind of followup coordination?

And then I guess another example would be all my children are now in their 30's. They are all grown up, and I remember one time when my oldest child broke his arm and we went to the emergency room about—at 9 o'clock at night, and I felt like I was on the 5th degree—you know, the questions—questions to make sure it wasn't child abuse.

And so I just want to see if we are not in silos, what kind of followup, and then also followup with a faith-based community, you know, if it is needed because I think there is a lot of good things.

I know Mr. Henry has talked about if one church stood up one child it would make a big difference and we know one person can make a big difference.

And so what I am trying to say is with the coordination we have is there something more that we could do at the Federal level to help with that coordination?

So I will just open it up to you two gentlemen since you have got the experience. Go ahead.

Mr. PATTERSON. What I would first say is that the WIC program model in Ohio is typically that the families come to us, and so sometimes we see things and then as mandated reporters we do what we need to do.

We are lucky in Clark County that our WIC division and our early childhood divisions are co-located, and so if there is an issue they can literally walk the people down the hall and do a warm hand-off to make sure that there is followup there. So that can happen pretty easily.

The issue, you know, in that case really becomes we are not seeing them in their homes and that is why we have an early childhood division that does home visiting, which is in fact funded by you and that is a major impact for us to be able to go in.

We know—the research tells us that us being in the home actually prevents child abuse. It doesn't prevent all of it but it reduces the incidence of child abuse because we are in the home. And so we continue to do that to work with the families and build the programming so that they can be successful and we do have the relationship.

We have talked several times—you have heard today about one of the ways that you deal with trauma is you have a caring adult, you have a relationship with someone, and that is what that home visiting program actually does is provides a caring adult who gets to know the family, the family gets to know them, they build a trust, they build a relationship, they build accountability, and they build a plan on where they are going in the future.

Mr. GIBBS. How is your relationship—I know you are semi-rural. Kind of you are a rural county but you got Springfield, not a large city, with a faith-based community involvement and try to—and try to——

Mr. PATTERSON. Our faith-based community is involved in lots of ways. One of the things they are doing is they help supplement where the programs can't purchase certain items for the families either for comfort or for safety.

Our faith-based communities are contributing that to our programming. But they are also beginning to work more with our community health improvement plan and being involved in the results.

So they are actually from the pulpit sending the messages about health, about trauma, about mental health, about opioids, and that is making a big difference.

Mr. GIBBS. I have seen it in my stakeholder meetings, especially on the opioid crisis. The faith-based community definitely has a role to play and in partnership with all the other stakeholders, and that is—I think we are trying to—I think in Ohio in the opioid issue we are starting to turn the corner on the aspect of awareness and education.

You first got to be aware of the problem and recognize the problem and I think we have turned the corner with that aspect, even though we still have a crisis. Don't get me wrong.

So go ahead.

Ms. BETHELL. Yes, I just wanted to speak to this, and I think it really relates to what you are saying about faith-based organizations and the role they can play, which is we really don't ask families themselves to reflect on what their assets and needs and their current concerns are, and to set their agenda for the priorities and the things they think they need help with that can then be shared with a wide array of professionals that help them.

So that we base what we are doing on the needs of the family and also support them in a reflective process to start to see what are the things that they have as strengths but also the things they need help with, and we can do a lot of standardized screening to bring it right to the table so we don't spend all of our time and all of our time in these programs asking families multiple times about ACEs every door they walk in would be a disaster and not trauma-informed.

I think churches could be a great place to work with and help coach families in thinking through what is happening for you, what are your strengths, what do you want, what are your hopes, and also what do you need from the systems that serve you.

And if we use IT platforms—we have been working on something called the Care Path for Kids—it is family driven where they own this tool and they can send it to whoever they want.

And so the WIC program, the Head Start, their home visitor, their doctor all can see in one place what is it that we are dealing with, what is it we have strengths, and what do we want to have happen.

So this is very important and I think churches would be a great place to implement that.

Mr. GIBBS. Thank you.

Mr. COOPER. I thank the gentleman.

I now recognize Ms. Kelly of Illinois for five minutes.

Ms. KELLY. Thank you so much. Thank you for your testimony and, again, thank the witnesses earlier.

All too often in communities across the country, especially for communities I represent—I represent the Chicagoland area, the south side of Chicago and I go 100 miles south so I am urban, suburban, and rural—and in Chicago alone, and the number might have changed because it is a new day, there have been 240 people shot and killed already this year and 1,116 shot but not killed—shot and wounded—since January.

And can you imagine being a child? I know we talk a lot about mass shootings, but these are everyday occurrences in some of our neighborhoods. So imagine being a child and having to witness your loved one lose their life or dramatically limit their physical capabilities.

It is an ongoing occasion, and I know one of my ministers—we talk about PTSD, post-traumatic, and he always says, no, it is present traumatic because we live with this every day. You know, we don't send our kids outside. They can't play in the park. They are scared to walk to school. Some don't feel safe in the school because of the relationship with the police in some of the areas in Chicago.

So from your research, what are some of the characteristics that can be observed from children who grow up in this—in these conditions? Do they graduate from high school? Are they likely, you know, to have successful careers? Because too many of them, when you say, what do you want to do, they don't even see themselves living past 20 possibly.

Dr. SHERVINGTON. Yes. Sometimes we would be surprised with our kids who have those experiences when you ask them where they will be in, say, 10 years they say, on a tee-shirt, RIP. And so it has a tremendously profound effect on children growing up in this violence.

We have done some work in our organization where we have looked at the data because we screen kids for signs and symptoms of PTSD, and I agree with you, it is present. It is persistent. It is not really post.

And we find a large number, similar to Chicago, exposed to violence. At least 20 percent of the kids in our public schools have actually witnessed someone being killed. It gives them a very shortened sense of their own lives. One kid said to me, I don't know where I am going to school. You know, I am not learning. I am thinking about can I get home safely.

We do know that if we can intervene when children are exposed to this level of violence, if we can intervene with them and help them process how it makes them feel, what it does to their feelings and to their thoughts, we can shift into that space where they are more thriving and flourishing because they can understand this is in the past but maybe there are things that can be better in the present and the future.

Ms. KELLY. I just—I talk about the south side of Chicago but actually in my rural area I just met with 50 children from the 7th grade to seniors in high school and the things they shared with me, and someone asked about suicide, and farmers are a fast-growing group that are committing suicide because of what is happening, you know, in their lives lately.

The other concern is one of the witnesses today talked about—I think she said they have one counselor for 400 kids, and some of our schools it is one counselor per—or social worker per two or three schools.

You know, so that is something that is imperative that we get more counselors in to schools. And in Chicago some of the mental health facilities—I think there were six—shut down so not even access, you know, in the neighborhoods to go and get help.

So that is something that we definitely—and I know the new mayor is interested in changing that so people have someplace to go to get help. And in my rural communities they are doing telehealth to help with that also.

But just the effect of not having, you know, counselors to turn to is a very big issue. But I just want to thank all of you for your commitment and we are seeing the same thing. There are jobs but, you know, people don't have the technical acumen to take the job.

They don't have to have a college degree. They could have high school. But because of the other things going on in their lives it has been very difficult for a lot of my manufacturers in particular to fill positions.

I yield back.

Mr. DESAULNIER.

[Presiding.] Thank you.

The chairman recognizes the gentleman from North Dakota, Mr. Armstrong, for five minutes.

Mr. ARMSTRONG. Thank you. I really appreciate the opportunity for this hearing today.

You know, my grandmother was actually the head of the North Dakota Mental Health Association for 25 years. So I grew up dealing with this, and when you are talking about farmers you want to talk to rural German farmers in the 1970's and 1980's about talking about their feelings. That is a job that was—it is difficult to do now. Imagine doing it almost a generation ago. So we dealt with that.

I also spent 10 years as a criminal defense attorney and I can tell you without a doubt that 85 to 90 percent of my clients, particularly first-time offenders under the age of 25, you can trace back to lots of different reasons and I think, ideally, we don't like to see a school nurse, a school counselor, and a school resource officer in every school all across the country.

But we also know that the pipeline for those, even if we fully funded it for every rural school, every urban school, every whatever, we know the pipeline of the people coming in to those degrees doesn't fill those things.

So what I think we have done both in criminal justice and in schools, which I think is great, is we have gotten law enforcement and teachers to be better at recognizing some of these things at an earlier age.

I think one of the things—I mean, the number-one issue for North Dakota teachers is teacher safety right now. I mean, that is—that is about as heartland and as rural as it gets. So this is not only an urban issue. This is not only an East Coast or a West Coast issue.

What I get concerned about is that we ask them to do too much often. I mean, if they are getting too—doing an in-service every six months that does not make them a child psychologist. It does not make them a child social worker and it actually chases teachers out of the profession.

And we are dealing with—like I said, I mean, if you are in a rural area in North Dakota you are a thousand miles away from a counselor, and tele-medicine and those types of things can help. I am glad we are talking about faith-based treatment because of-

tentimes in those small communities that is where the communal resource is.

But there is also—I mean, there is other challenges. I mean, if you have done this for a long time and you walk around, I think we could walk into any 4th grade class and watch it for a week and have a pretty good idea of who we would probably want to talk to.

But and we have talked about—you were talking about absent family base but, unfortunately, a lot—I mean, holding parents accountable only works if the parents are involved and want to be held accountable.

So we end up dealing with some of these constitutional issues. We deal with some of these issues about family involvement and often are most at-risk kids, one of the reasons they are most at-risk is because their parents aren't involved for whatever reason.

I mean, there is good reasons. There is bad reasons. There is all of those things. But we have been doing—so we have had to get creative. We have explored innovative ways to improve services for students through interconnected systems framework and blend school mental health and positive behavioral interventions for schools.

I mean, it reduces barriers to learning, identifies needs early, engages in effective treatment options and improves educational life and outcome for students, which—and I do have to give a shout out to Jason Hornbacher, who is doing this in the Bismarck public school system, because all the policy in the world doesn't work unless you have really great people advocating this.

So, I mean, my questions are one of the key tenets of that model is a broad network of connectivity for children.

Dr. Houry, I suppose, but anybody can answer this, can you give us any detail on, I mean, how we integrate community and faith-based and just the different—I mean, every community has different resources available. We just have to look to them.

I mean, are there programs and models that have worked in other places that everybody should be looking at?

Dr. HOURY. So a couple things. One is we are doing this right now in Cincinnati, Cleveland, and Detroit to where we are working with some of the cities to look at what programs we already have in place and really helping convene them because overtimes, I think, like Mr. Patterson was saying, there is lots of programs out there and you need to convene them and link appropriately.

So I think that is really a key role for public health with the school system. I think even taking a step back earlier and looking at within schools it is great to have that response but really integrating things like social emotional learning like Good Behavior Game, Incredible Years type programs.

That is primary prevention and gives kids coping skills, empathy, conflict management, life skills. So that when these stressors do occur, they are already prepared and that helps with the need for counselors.

Ms. BETHELL. I would like to speak to the issue that you raised about if you can't involve the families and the way that we really need to leverage well child care visits and others earlier on before children are even in school so the parents are really supported in their own well being and their own understanding about being in-

volved without—and de-activating the shame of having issues so that we really create a norm that is more compassionate and so that they can stay involved through school and it is not just Band-aiding kids.

But I also want to raise something called the self-healing communities model, which was implemented in about 42 communities in Washington State, and through these programs when they evaluated them that those communities that were able to come together and integrate school and child welfare and health care and churches and others really saw a reduction in at least five kinds of outcomes, things like youth violence, substance abuse, teen pregnancy, and suicide. The reduction in caseload alone for child welfare and juvenile justice yielded about $176 per dollar invested.

Mr. ARMSTRONG. Wow.

Ms. BETHELL. So $3.4 million invested and $601 million just for the few things that you could measure. So the power of self-healing communities coming together. But what they need is support.

Process needs to be supported in this time to be invested, and then once we get those under our belly, you know, and we know how to do it, it can be self-perpetuating. But right now, these skills are not in place.

Mr. ARMSTRONG. And I agree with that and I know my time is up, and I would say the process needs to be supported but we also always have to recognize it needs to be flexible because we have to deal with these things with the resources we have, not the resources we wish we had.

Ms. BETHELL. And that is the self-healing community's model. I encourage you to look at it.

Mr. ARMSTRONG. Thank you.

Mr. DESAULNIER. In the spirit of self-healing, the chair will now recognize the gentleman from Tennessee, Mr. Cooper.

Mr. COOPER. I thank the chair, and I would first like to add my congratulations to our colleague, Ms. Pressley, for the historic nature of this hearing.

I wish attendance were better because every one of my colleagues needs to hear your testimony, and not just as often happens in Congress—not just pay it lip service—because this is pretty rare to have an entire panel that is genuinely on the side of children, the angels.

It is also pretty rare to have an entire panel these days that is on the side of science, which translated means government-funded research. So people have to get over it and support it.

I have a particular need to single out my friend and colleague, Mr. Henry from Tennessee, a remarkable public servant. Now, how he ever overcame the handicap in Madison, Tennessee, of having been raised by, I am guessing, 50 Republican relatives that is quite—that might be an ACE. I don't know.

[Laughter.]

Mr. COOPER. But his career in our state legislature where he was a giant, his career in the business community serving the underserved, his career in the executive branch not only in the cabinet but as a deputy Governor is extraordinary.

So I thank you. I wish we had more people like you. In fact, if you want to run for office in Tennessee statewide since Democrats

have a difficult time doing that you might be the best we can get. But I don't want to hurt your campaign with an endorsement right now.

But the elephant in the room is this. Can we really help our kids in states that have refused to even extend Medicaid? Mr. Henry worked hard. Governor Haslam's Insure Tennessee plan, which you and I were both strongly for but our legislature would not even give the time of day—so our state is giving up a billion dollars a year in health care for poor families and the kids.

So I would first like to ask our three doctors on the panel is it possible to help kids as you suggest in a state that refuses to even extend Medicaid and to give up all that money that could be used for health care for these poor families? What is the answer to that question? Because that is politically the most pressing question that at least 14 states face.

Dr. SHERVINGTON. And my response is not political. It is just human. As a physician, I have seen when a child really needs help, that because they don't have the insurance and for poor children it is usually Medicaid, they do not get the type of service they need, the quality of service they need.

Unfortunately, what I have seen in another experience when I worked in forensics where there were people on death row, and as a psychiatrist I was asked to see them. I could get a lot of money at that point when all the damage had been done. And so I would like for us to really think about back to prevention.

For many of those men that I saw, the traumas that they experienced, if there had been access to health care at that time and they perhaps would have been referred to some therapist, psychiatrist, psychologist, maybe they wouldn't end up now with someone like myself trying to get them mercy and not the death penalty.

So we need to have our children have access to health care.

Ms. BETHELL. So I would like to address your question from a data point of view but first from a personal point of view.

I was one of the first babies on Medicaid in California and I was hospitalized 11 times and saw a lot of ER doctors, and I would be dead without Medicaid.

There is no question about it, and I can tell you my story another day. But I would be dead. Now, I wish the providers were more trauma-informed because they could have done a lot to help my mother, which is really what—who needed help, right.

So we need to integrate Medicaid services to be family based, not only just for children but to allow pediatricians and family physicians to cut across and help the mother or the father because that is often what needs to happen. To help children we have to help adults.

Now, for a data picture, this is in my testimony written. There is wide variation across states in how many children have special health care needs based on whether they have ACEs, wide variations in terms of whether they have emotional mental behavioral problems, bully, whether they are flourishing, whether their families stay hopeful in difficult times, and I can show you that in the states that do not have more generous Medicaid benefits that there tends to be higher rates of these problems.

Mr. DESAULNIER. Thank you. Thank you, Mr. Cooper.

The chair will now recognize Mr. Raskin of Maryland for five minutes.

Mr. RASKIN. Mr. Chairman, thank you very much.

I also want to salute Ms. Pressley for having the idea for this excellent and important panel discussion.

Let us see. Ms. Bethell, I want to start with you. Are you at Johns Hopkins?

Ms. BETHELL. I am.

Mr. RASKIN. You are? Good. Okay. So you are a Marylander so I want to start with you. The question before us today is important, obviously, for humanitarian reasons, and this is a week where a lot of us are focused on the condition of children in our care and custody.

But it is also important in terms of the future. I saw a documentary about abuse of kids at a Catholic girls school in Baltimore, which is just utterly horrifying and shocking. But how do you break the—how do you break the cycle of trauma? Because the people who are—who are the victims of it can themselves become the perpetrators, right, later.

So what do we know about that?

Ms. BETHELL. I mean, I would like Dr. Shervington also to contribute. But what we know is that when people experience trauma and become perpetrators, they are deep in their own self-shame and their lack of self-worth, and the inability to imagine it could be different and have a lot of hopelessness.

And so one of the first things we need to do is recognize that until people have something to live for and they can have their shame deactivated so they can understand that something happened to them because that is what the pattern is that we are not going to be able to really engage them in the kinds of healing processes that they have to go through to not be facing an amygdala that basically hijacks them with anger and leads them to lash out that they often regret later but it does damage, because these are very basic biologic mental and neural capacities to be able to handle stress, and when you have had that happen to you as a child and you become a parent it can be almost impossible to control yourself if they are on the perpetrating side.

So, you know, we really need to protect children and we also need to help the perpetrators in very clear ways who are often really suffering themselves.

Mr. RASKIN. Thank you.

Mr. Patterson, the Cincinnati Enquirer says that 1.2 million Ohio residents have gotten health care coverage through the Medicaid expansion. Of those, about 630,000 receive treatment for mental health or drug abuse problems and 290,000 people left Medicaid after getting a job or increasing their income.

What would the impact be of rolling back the expansion of Medicaid coverage in Ohio today for children who have experienced trauma?

Mr. PATTERSON. It would be a devastating impact because those perpetrators who are able to now seek treatment through mental health services through—for their—for their mental illness or their substance abuse illness would no longer have that capacity.

And I will tell you that in our community if you don't have Medicaid or you don't have another insurance, you are not getting treatment. There is no free treatment, and so the cycle will continue or will actually get worse if we pull back what happened.

I am sure you know in our state, you know, our legislature didn't act on that either.

Mr. RASKIN. Right. Well, I appreciate that answer.

Mr. Henry, the program that you led in Tennessee is called Building Strong Brains Tennessee, emphasizing that brain function and neurological resiliency can be strengthened through specific interventions, a theory that was informed by several scientific symposia and studies and findings.

Can you discuss the importance of drawing on scientific data to create public policies that address the impact of childhood trauma?

Mr. HENRY. I think that it is incumbent upon all of us to draw from everywhere we can and, you know, the impact of us not getting the expansion dollars, I mean, it is kind of a amazing what we would be—where we would be right now if we did, and——

Mr. RASKIN. Did you try to use science in the process of convincing people in Tennessee of the——

Mr. HENRY. We couldn't get it on the agenda. Neither speaker would bring it to the floor.

Mr. RASKIN. Maybe you are the right person to comment on this first—anyone else who has expertise on it. But I was fascinated by the finding that kids who experience trauma are more than doubly more likely to be bullied by other kids, which was a shocking thing to read. You would think it would be the opposite, that the kids would be more sympathetic and tender.

But what is the basis for that finding and what can be done about that problem?

Mr. DESAULNIER. And before you go ahead, Mr. Raskin, I am advised that votes are about to be called. So I want to get as much testimony and questions as possible in. So if you could be concise in your response so I can go to Mr. Rouda.

Ms. BETHELL. Yes. I will just say that actually someone earlier said that, you know, there is different ways that people act out in trauma. They act out and it is more assertive and aggressive and we can see those behaviors.

But there is also an acting in, and children who have ACEs can often appear to be very vulnerable and to be victims of people who are more perpetrating. But they both share probably a lot of ACEs.

Most of the children who bully have ACEs and most of the children who are bullied have ACEs. It is both.

Mr. DESAULNIER. Thank you. An important point.

Mr. Rouda?

Mr. ROUDA. Thank you, Mr. Chairman, and thank all of you as well as the previous panel for joining us today, and as Chairman Cummings said at the very beginning, I apologize. I haven't been able to be here for the entire testimony. But, fortunately, we have had the opportunity to read it in advance and dig into this issue deeper.

I would like to talk about homelessness because it is an issue that has been very important to my wife and I. When we were in our 20's my wife read an article about the plight of homeless fami-

lies, and at that time the typical situation is you lose your job, you lose your home, you live in a motel, hotel. You live in your car.

When that money runs out, and then you go to a shelter where often they would take the families and they would send the men and boys 15 years and older to the men's shelter and the women and the children to the women's shelter, when all that they really have left at that time is the family unit. And we know separating kids from their parents is not good, whether it is due to homelessness or due to being on the—on the border.

We right now in America have 550,000 Americans experiencing homelessness and about one-third of that population is children. In my county, Orange County, California, it is 7,000 homelessness and 1,000 homeless children with approximately 27,000 children experiencing home insecurity on an annual basis.

The annual report on the conditions of children in Orange County states, "The high mobility, trauma, and poverty associated with homelessness and insecure housing creates educational barriers, low school attendance, developmental, physical, and emotional problems for children."

And Dr. Shervington, in your written testimony you identified homeless youth as showing higher and multiple rates of exposure.

Would you agree that reducing the number of homeless families and youth must be part of the effort to reduce childhood trauma?

Dr. SHERVINGTON. I can be brief. Absolutely.

Mr. ROUDA. Thank you.

And the Center also stated children in previously homeless families receiving rental assistance vouchers changed schools less frequently and are much less likely to be placed into foster care than other homeless families, one study found.

Their families also experienced significantly less food insecurity and domestic violence. And, again, Dr. Shervington, why is having a safe and stable home so important to a child's development?

Dr. SHERVINGTON. Children really do rely on the capacity of their caretakers to create an affectional bond with them. It is within that experience that they are going to learn that the world is safe, that it is secure, that they can begin to create their own identities of themselves and other people.

When that is interrupted, then we set the foundation for the inability of that child to pull on their own inner ability to be resilient, plus all the other factors that they will——

Mr. ROUDA. Thank you.

And, Mr. Chairman, I ask unanimous consent to enter into the record reports that show childhood homelessness and housing insecurity is associated with the factors I pointed out, and the stories regarding critical and innovation work being done by organizations across Orange County including the Family Solutions Collaborative, Families Forward, Mercy House, First Five Orange County, Orange County United Way, and Jamboree Housing to get families off the streets and connect them with the services that they need to succeed.

Mr. DESAULNIER. Without objection.

Mr. ROUDA. Thank you, Mr. Chairman.

Also, I think what is very important too in this discussion is that when we have preventive opportunity to address homelessness it is

actually a lot cheaper than dealing with the consequences of that trauma down the road.

And I do want to take the remainder of my time and yield to Congresswoman Pressley for the remaining time.

Mr. DESAULNIER. Go ahead, Congresswoman Pressley.

Ms. PRESSLEY. Thank you so much.

I want to talk about the criminal justice system. An estimated 90 percent of children in the juvenile justice system have at least two ACEs, which is what was testified to earlier, with 27 percent of boys and 45 percent of girls in the justice system having five or more ACEs.

What is the impact of a punitive response to trauma rather than a public health approach?

Ms. BETHELL. Well, I think—I wish we had a lot more time but, basically, when you are traumatized you already—your sense of self-worth and hope in life is often very diminished, and when you continue to be treated like that it is diminished further.

And the neurobiological effects of those identities of I am not worth anything, I don't have hope, basically perpetuate continued pruning in your brain, a lack of ability for self-care, and you are not able to really take advantage of any of the supports that might be given in the justice system to help you.

So on the one hand we are saying help yourself, fix yourself, do all these healthy behaviors, and then being treated like that, which it systematically prevents a person from being able to even take advantage of the support they are being offered.

So until we help people understand it is not what is wrong with you—it is what happened to you, and it is not what happened to you, it is how it impacted you and getting close to that, and it is not how it impacted you, it is what can we do about it, and they are onboard with that because they feel like somebody cares about them and they are valuable while they are learning to care about themselves again, which they may have never even felt that I am worth anything, and that is a very common report that we hear from young people today.

Ms. PRESSLEY. And I am sorry. I just wanted to pick up, and again, I thank—Harley, thank you.

I wanted to ask you—you referenced a self-healing and community model, which does need to be the goal ultimately so that we have something that is self-perpetuating and has that agency and is sustainable because not only do we need a response that is coordinated and comprehensive, that is equitable for everyone from a survivor of sexual assault to the survivor of a shooting on a city block to a mass shooting to PTSD from war—comprehensive and equitable.

But it has to be sustainable and I do worry about our ability to just have systems, which have often already failed people, right—broken systems creating broken people—and whether or not they can even offer a sustainable solution in the long run.

So how do we get to that and could you tell me the model where is it from—the self-healing community model?

Ms. BETHELL. The self-healing communities' model——

Mr. DESAULNIER. And Dr, if—once again, admonition. Just try to be concise, just because votes are about to be called.

Ms. BETHELL. Okay.

Ms. PRESSLEY. Yes. I am so sorry.

Ms. BETHELL. I can——

Mr. DESAULNIER. No, I appreciate it.

Ms. BETHELL. I can provide you with the specific reference from that but it is in Washington State and it is easily found.

Ms. PRESSLEY. Okay. Great.

Ms. BETHELL. Robert Wood Johnson Foundation has published on that. So I can definitely provide that.

Ms. PRESSLEY. Okay.

Ms. BETHELL. But until the community is engaged in driving the change and working with systems who are receptive to their needs and ideas about what they need, I don't think we will ever have a sustainable system.

Ms. PRESSLEY. Okay. Thank you so much.

Mr. DESAULNIER. Thank you.

I want to acknowledge Ms. Pressley once again and her leadership. Having been a resident of Boston many years ago and having worked for the Boston juvenile court many, many years ago, Massachusetts, the Commonwealth, has done a lot of great work and you have been at the forefront of that.

I also want to recognize the witnesses from the first panel and the one who is still here. In my view, you are so powerful and what you did today made you and your three colleagues at the first panel the most powerful people in Washington, DC, and it is transformative.

Having had this experience, multiple generation of addiction and abuse in my—with my parents, with my siblings, and with children in my family, I have visited this issue as a personal issue and a private issue.

I am reminded, sitting here with this panel, many years ago when I was a county supervisor and then Governor Pete Wilson, a Republican, introduced the California Continuum of Care for Children and Families, and an advocate at one of the hearing saying this is like a metaphor for there is a group of parents by the side of a rushing river and children—young children are drowning in the river going downstream, and the parents, the adults, kept jumping in the river saving one at a time and then finally one of the parents said, somebody needs to go upstream and find out why these kids are going in the stream.

And 30 years later, I still think of that. So in this context of knowing, the 30 years since my father took his life to now, we are at this inflection point.

The exponential research Dr. Houry and I talked about yesterday—being from the Bay Area we talk about Moore's Law and technology—the research in neuroscience puts that to shame.

I tell my kids when we look back at this period of time—when they do and their kids—they will look at us as both barbaric but as transformative if we do what we need to do.

So we know with the ACA and with parity we have 75 percent more requests for referrals even with this broken infrastructure, but to the point from the gentleman about 25 percent less people going into the professional classes to serve these people.

So the two things I would question, Dr. Houry and Dr. Bethell, in particular are costs. We talked about this yesterday when we met. CDC says that—estimates in 2015 that maltreatment of kids, going upstream, is $2 trillion a year in the United States.

And besides the human costs that we have heard about and for all of the examples that we heard today about people overcoming, and I would recommend "Supernormal" by Meg Jay, a wonderful researcher, or anything written by Kate Jameson, who is a survivor of our own suicide.

The more we go upstream it is—but we are losing people because we don't have the infrastructure to match the increasing neuroscience and evidence-based research.

Now, in this—in this Congress we were able to do bipartisan good work on evidence-based research when it came to the criminal justice system. It wasn't perfect, by my standards, but we agreed that the science would inform our decisionmaking process.

So we have that cost, and then as a survivor of cancer I am very appreciative. I went to see my oncologist today. The cancer I have 15 years ago I would be dead. But now I have got an extended lifetime.

NIH says that $77 trillion since 1974 their research has contributed to the U.S. economy. Seventy-seven trillion dollars, because investments in science and research.

So how do we take the fact that people lose their lives 14 to 32 years sooner if they don't have the treatment they need, and then the costs, both individually and to the whole society.

And then the other—the examples of when we got this right, cancer being one of them—cardiovascular disease. When we accepted what you did at CDC and what people did at NIH and then deployed it, Dr. Bethell, using the infrastructure as best we can that we have, to Ms. Pressley's comments about juvenile justice.

Recently, I was in our juvenile hall, which I was an advocate to rebuild when I was a county supervisor 15 years ago, the judges and the DA told me it is not big enough; we are going to have to find another space.

It is now 60 percent to capacity. I asked a former presiding juvenile chief, who is a friend of mine, what happened and she said, we took all those programs that were evidence-based research and now the kids aren't in here. They are out in the community getting the services they need, and they are not hurting themselves or anyone else.

So those two things, first, Dr. Houry, how does the Congress approach this from an evidence-based research, use that research as we did with criminal justice reform, and get to savings and the life expectancy changing in our lifetimes or sooner?

Dr. HOURY. Thank you.

Well, I would say prevention saves lives. When you look at number of adverse childhood experiences, we have seen that if you have, like, six or more decreases life expectancy by, you know, 18 or 20 years.

So I think that is one thing right there. If we can, you know, impact early on, reverse these traumas, buffer them, that will impact life expectancy.

On our website, we have information on evidence-based programs—child-parent centers and nurse-family partnership. Every dollar spent on a nurse-family partnership saves $6.38.

I plugged in the chairman's state of Maryland just to see what would happen if they implemented it statewide. They would save over $200 million in substantiated child abuse cases. That saves money.

And you look long term, all the other health impacts that Dr. Bethell and Dr. Shervington talked about with cardiovascular disease, diabetes, substance use, that early investment in prevention will have that long-term impact.

Mr. DESAULNIER. Dr. Bethell, we are having the bells ring so we want to go vote.

Ms. BETHELL. Okay. Great.

Mr. DESAULNIER. I feel sorry that I have had to tell people to be concise for something we, clearly, all want to talk about for a long period of time.

Ms. BETHELL. I just want to really support your statement that this is a crisis. The Children's Hospital Association has put out a report on how it is a matter of national security what is happening even just when we look at the lack of flourishing of children and how that might play out for adulthood.

We need a stream of launch and learn supports that allow us to use the best evidence we have and create citizen science platforms and in every NIH RFP that is about human health needing to look at this to advance the science in all of our systems and professional associations.

But most importantly, healing is prevention. We are at a point in this syndemic, meaning it has escalated to a point that even if you don't have ACEs you are impacted.

And so it is all of us, and healing has to lead the process for prevention, because if we offer things and they are not used because there is too much trauma it is not going to really work.

But the "through any door" investments need to happen like we built the roadways. We had to invest in those roadways so that we could build this Nation.

We need to build social infrastructure and that will play out, and it is time for that investment when our sciences and our lived experience can finally meet policies that pay for and invest now, because we will save later and we will also have a lot more joy and well being as a country.

Mr. DESAULNIER. Well said. I think that is as good a place as any to conclude, but also say that I want to thank the chairman, Mr. Cummings in particular, and again, Ms. Pressley, for their interest, and my colleagues on this bipartisan very important hearing, and again to the panelists on this panel and the previous panel.

So with that, without objection the following statements will be part of the record: a statement on childhood trauma from the National Education Association and a statement from the National Juvenile Justice Delinquency Prevention Coalition.

Mr. DESAULNIER. Okay. The ranking member says no, he wants to get to vote. So with that, I would like to thank once again our witnesses for testifying. It was incredible.

Without objection, all members will have five legislative days within which to submit additional written questions for the witnesses to the chair, which will be forwarded to the witnesses for their response.

I ask our witnesses to please respond as promptly as you are able.

This hearing is adjourned. Thank you, again.

[Whereupon, at 1:38 p.m., the committee was adjourned.]

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