ISSUE BRIEF

Children's Defense Fund

JULY 2015

ADDRESSING CHILDREN'S TRAUMA: A TOOLKIT FOR OHIO SCHOOLS

The place was cramped, with hardly any room for 10-year-old Jackson to move around, let alone space for his mother, brother or the other roommates who shared the small apartment.[1] Unfortunately, it was the best Jackson's family could afford. His mother, the sole caregiver and breadwinner of the family, worked long hours, struggled to put food on the table, and often felt she was barely keeping it together.

The stress of their poverty and the violence Jackson and his brother witnessed daily in their neighborhood often overwhelmed them. Jackson acted out in school, expressed little to no interest in learning, and got bad grades. During class, he routinely checked out, staring off into space. At other times, he was disruptive; unable to sit still and be quiet, he started talking and walking around. His teachers assumed his "bad" behavior was deliberate and something he could control. Even if they had known about his home life, his teachers might have dismissed it, missing the connection between the trauma of an overburdened parent and Jackson's behavior and test grades.

In fifth grade, Jackson was sent to the principal's office for ignoring his teacher's instructions, where the principal suspended him from school. Jackson's case is not exceptional; 95 percent of suspensions nationally are attributed to "disruptive behavior" or "other" while only five percent are due to violent or drug-related behavior.[2] In Ohio, more than half of all out of school suspensions are for "disobedient or disruptive behavior."[3]

Photo © Photo © Biljana Milenkovic

These punishments are doled out carelessly, disregarding the risk to the child: one single suspension doubles the likelihood of repeating a grade and triples the chances of becoming involved with the juvenile justice system.[4]

In sixth grade, a school with better trauma-related practices reached out to Jackson. They convinced him to meet with a mental health counselor and to study with a tutor every day. They worked with his mother to attend the school's group sessions for parents. Jackson's new teacher kept a close eye on him and made sure that her positive reinforcement far outweighed any stern talk.

Some days Jackson still feels unfocused. Unlike his previous school, his new one allows him to take breaks and move around when he feels restless, distressed, or overwhelmed. This way, instead of getting sent to the principal's office, Jackson can regroup and get back to learning. By the end of the first full year at the new school, Jackson made tremendous progress: he started taking ownership of his work and finally reached grade level in math. Jackson is on track to graduate, along with 97 percent of his classmates, compared to the 68 percent district-wide graduation rate.

Jackson is one of the lucky ones. In a more common narrative, he would have gone back to the same school only to be suspended again and again, funneled into the school-to-prison pipeline.[5] His academic progress would have continued to decline, his juvenile and eventually adult criminal record would have grown, his health — physical and psychological — would have deteriorated.

At a school that doesn't respond to the cognitive, emotional, and physical demands of trauma, a student like Jackson barely stands a chance. Especially when parents are incapable of providing the necessary care and support or are the source of trauma, schools are essential to the success of a trauma-affected child. By simply being aware and sensitive to the impacts of trauma, schools can serve an important and missing role for vulnerable children. For a child like Jackson, trauma-sensitivity could mean the difference between a high school diploma and the trauma-reinforcing downward spiral of a juvenile record.

This issue brief follows up on Children's Defense Fund-Ohio's January 2014 issue brief, Building Trauma-Informed Systems of Care for Children in Ohio, to explain how trauma affects brain development, school behavior, school performance, and how schools across the country and in Ohio are addressing this issue and seeing results. The brief provides an extensive guide to the role schools can play in preventing, dealing with, and recovering from trauma. In an accompanying appendix, there is a comprehensive list of resources that Ohio schools and communities can use to more effectively address trauma, help children perform well and achieve in school, and empower teachers to better meet student needs. These resources will assist schools charged with helping children like Jackson thrive.

WHAT IS TRAUMA?

Trauma is the emotional, psychological, and physiological damage caused by heightened stress during a threatening, violent, or life-changing experience.[6] Trauma might be caused by physical abuse, but it could also come from an over-extended caregiver, food insecurity, unemployment, prejudice, crowded living, evictions, unsafe neighborhoods, witnessing violence, or other stressors — many of which are common experiences of children living in poverty.[7] Researchers use the term "chronic stress" to describe stress that is ongoing, resulting in prolonged activation of the body's stress response system. A related term, "toxic stress" refers to stress — often resulting from strong, frequent, or prolonged adversity — that negatively affects the brain and other organ systems. Therefore, a single severely distressing event, chronic stress, or toxic stress can all result in trauma.

Even after a stressful or traumatic event has passed, a child's brain and body continue to react as if the stress were present due to chronic activation of the body's stress response system.[8] This chronic stress response can disrupt development of brain architecture, increasing the risk for stress-related diseases and cognitive impairment, which can persist into adulthood.[9] Fortunately, research has demonstrated that supportive, responsive relationships with caring adults early in life can prevent or reverse the damaging effects of toxic stress.[10] Therefore, for a trauma-affected child, early intervention is critical.

Poverty has been linked to poorer student performance in Ohio schools[11] and has also been shown to affect

brain development.[12] Poverty can dramatically enhance stress by increasing stress on parents, reducing resources available to address that stress, and increasing the likelihood of hunger, over-crowding, instability, and many other disadvantages that accompany insufficient resources to take care of basic needs. Poor families are also more likely to be exposed to violence.[13] However, research suggests "that poverty itself cannot fully account for differences in executive function among children" and that "stress — above and beyond poverty — has a significant impact on how well a child can engage his or her executive capacity."[14] Traumatic experiences extend beyond economic hardship and impact students at every socioeconomic level. Ameliorating poverty and changing school practices are essential to reducing child trauma exposure.

TRAUMA AND THE BRAIN

Trauma can physically alter normal development of brain structures and their connections. A trauma-affected child exhibiting troubling behavior, emotions, or abnormal cognitive performance does so not by conscious choice but because trauma has impaired the brain networks responsible for these abilities. Blaming a trauma-affected child for having an outburst in class is like blaming a child who has the flu for having a fever.

WHAT DOES TRAUMA IN SCHOOL-AGED CHILDREN LOOK LIKE?

BEHAVIOR

Emotional damage from a traumatic event may result in physical symptoms like headaches and stomachaches, inconsistent or impulsive behavior, sleep disturbances, depression, angry outbursts, over- or under-reaction to loud noises or sudden movements, rage, lashing out, hurting oneself or others, hypervigilance, or physical and emotional withdrawal.[16] Trauma-affected children often feel anxiety and fear that the trauma could happen again. Due to this heightened sensitivity to danger, any form of stress can be seen as a threat. As a result, trauma-affected students might react aggressively when they think others are violating their personal space, feel inclined to fight when criticized or teased by others, be resistant to changes or transitions, or blow up when an authority figure corrects them, tells them what to do, or punishes them.[17]

Trauma Symptom	Brain Etiology[15]
Impaired intellectual ability and worse academic performance	Decreased cerebral volume and reduced connective tissue between hemispheres (corpus callosum)
Difficulty regulating emotions	Hypersensitivity and increased volume of brain regions involved in emotional arousal and reactivity (anterior cingulate, amygdala, prefrontal cortex)
Difficulty focusing, remembering instructions, multi-tasking, and controlling impulses	Impaired executive function (prefrontal cortex, striatum)
Selective attention to and difficulty disengaging from threat-related cues	Dysfunction in brain regions implicated in processing emotional and social clues (amygdala, superior temporal gyrus)
Impaired verbal, visual, and global memory	Impaired memory networks (hippocampus, frontal cortex)
Low energy, apathy, lack of motivation, reward-seeking behavior, and substance abuse	Dysfunction of reward pathways (mesolimbic dopamine, basal ganglia)

For example, one little boy in a kindergarten in Canton, OH repeatedly talked about suicide.[18] When something unexpected happened he would scream at the top of his small lungs and go into a fetal position. His teacher had to hold him in his lap to calm him down.

SCHOOL PERFORMANCE

Trauma makes learning difficult because it affects brain networks involved in learning, emotion, and behavior. Trauma-affected children have trouble paying attention or sitting still; others struggle to control their anger or fear, causing them to lash out. This can lead to poorer school performance and greater risk of suspension.

How trauma plays out depends on a number of factors including age, personal and family history, and type and severity of trauma.[19] Regardless of the specific presentation, trauma creates challenges that students struggle to overcome each day, inside and outside of the classroom. Table 1 describes how trauma impairs brain function and impacts school performance.

Table 1. Impacts of trauma on cognition and educational goals[20]

Negative Effects of Trauma on Cognition (the mental processes of learning and understanding)	**Impacts of Trauma on Educational Goals** [21]
• Impaired attention, memory, concentration, and other cognitive domains • Reduced ability to focus, organize, reason abstractly, and process information • Interference with problem solving, planning, and retaining and recalling information • Overwhelming feelings of frustration and anxiety	• Lower grades • More negative remarks in student's records • More absences • Decreased graduation rates • More suspensions and expulsions • Decreased reading ability

All children can be affected by trauma, and how trauma manifests itself can depend on the age of that child. Table 2 provides some common ways that trauma can impact behavior and school performance by school age group. Understanding that trauma can manifest itself very differently in each child is critical for a teacher to be able to consistently identify trauma-affected students.

Table 2. Effects of trauma on behavior and school performance[21]

School Age Group	Behavior	School Performance
Preschool	Bed-wetting, thumb-sucking, regressing to simpler speech, clingy behavior, separation anxiety, temper tantrums, becoming withdrawn or subdued, difficulty falling or staying asleep, nightmares, angry outbursts, fears, distress	Lack of developmental progress, decreased attention, unexplained absences
Elementary School	Stomachaches, headaches, pains, irritability, aggression, anger, inconsistency, whining, moodiness, increased activity level, withdrawal, statements and questions about death and dying, difficulty with authority or criticism, anxiety, fear, worry, avoidance behavior, emotional numbing	Reduced academic performance, impaired attention and concentration, more school absences
Middle and High School	Feelings of shame and guilt, fantasies about revenge and retribution, self-destructive or accident-prone behaviors, recklessness, shifts in interpersonal relationships, irritability, withdrawal, avoidance behavior, emotional numbing	Changes in academic performance, attendance, and behavior

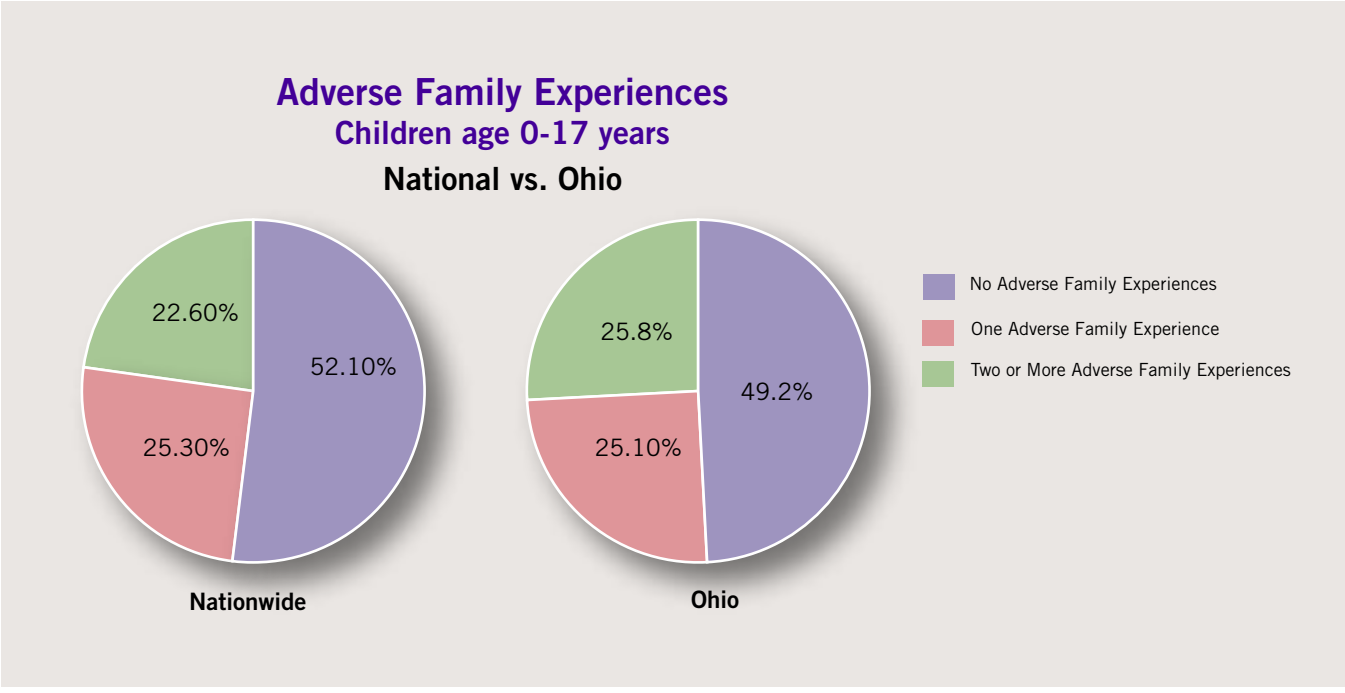
THE LIFE-LONG IMPACTS OF CHILDHOOD TRAUMA

PREVALENCE OF CHILDHOOD TRAUMA

According to the 2011-12 National Survey of Children's Health (NSCH), about one in four children in the United States ages 0-17 have experienced one adverse family experience[23] and 22.6 percent have experienced two or more adverse family experiences.[24] This translates to nearly 35 million children nationwide who may have encountered some degree of early childhood trauma, although some of these experiences may be far less severe.[25] Ohio is similar to the nation: more than half, or about 1.3 million, of Ohio's children have experienced at least one traumatic experience, and about one in seven children has been exposed to three or more traumatic experiences — each with various levels of adversity.[26] The Adverse Childhood Experiences (ACEs) Study found a relationship between the number of adverse early experiences and poor health outcomes in adulthood.[27] The authors of a recent analysis of the survey data also reported that for "41 percent of kids who have had at least three of these experiences, their parents say they are demonstrating these negative behaviors like bullying, arguing frequently with their parents and others" and that "almost half are showing signs of low levels of engagement in school, and 20 percent have repeated a grade."[28] Ohio is in the highest quartile for state prevalence of adverse experiences related to violence, domestic violence, incarceration, and death, and that Ohio has the highest prevalence in all 50 states of children aged 0-5 witnessing violence (6 percent).[29] The actual numbers may be higher, due to under-reporting and the fact that the survey only covered nine types of traumatic experiences.[30]

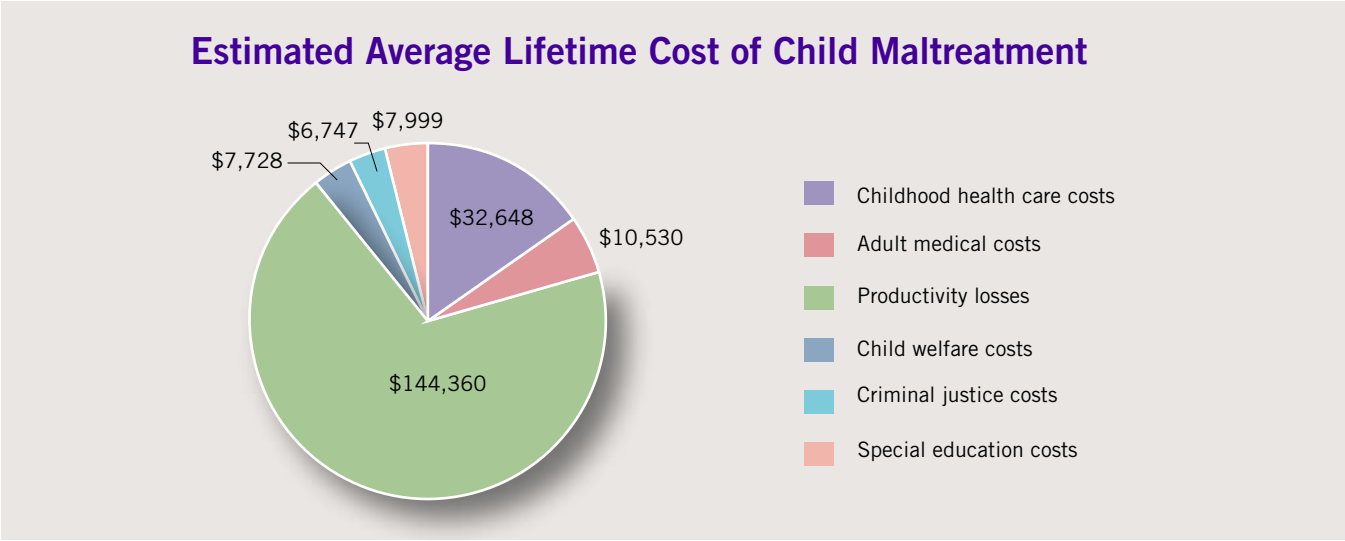
IMPACTS OF TRAUMA ON CHILDREN AND SOCIETY

Exposure to trauma is associated with a higher risk of school dropout, which increases the probability of other risks, such as imprisonment.[31] Trauma-affected children are often labeled as disruptive, defiant, and poor learners, and are at high risk of disconnecting from school.[32] Given that trauma interferes with behavior and cognition, it is not surprising that 25 percent of abused children need special education services[33] and that trauma-affected children are often mislabeled as having diagnoses such as attention deficit disorder (ADD), oppositional-defiant disorder, and conduct disorder.[34]



The negative impacts of childhood trauma do not stop at high school graduation. The ACEs Study found associations between early trauma and increased drug use and abuse, disease, disability, and social problems across a person's lifetime.[35] Low-income students and students of color are particularly vulnerable, in part because of differential access to mental health care.[36] Addressing childhood trauma is a way to deal with many crucial issues, including, but not limited to, success in school.

The following chart displays data from Centers for Disease Control and Prevention Press Release 2012 on the breakdown of costs to society per child affected by child abuse and neglect, which is, on average, $210,012 per child.[37] Total costs of trauma in children are estimated at well over $100 billion annually.[38]



SCHOOLS CAN MAKE A DIFFERENCE

Children spend much of their day in school. Schools are a crucial place for children to begin to understand others and interact with the world,[39] and are sometimes the most accessible way for children to obtain mental health treatment and services.[40] Even in the absence of mental health services, schools can play an important role in a child's healing process by creating a safe and secure environment, promoting healthy relationships, and teaching self-management and coping skills.[41] Various evidence-based practices reduce stress and improve academic performance;[42] and, most importantly, any caregiver or teacher can implement them.

On the other hand, schools that fail to recognize and respond appropriately to trauma can re-traumatize children who are already suffering and struggling to make it through their days. Removing students from the classroom, suspending or expelling them, and subjecting them to contact with school resource officers are counter-productive disciplinary responses in general, but are particularly harmful when used in response to behaviors caused by trauma. Zero tolerance policies and practices in schools like suspension and expulsion are major contributors to the school-to-prison pipeline — pushing children out of school and into the juvenile justice system. Many of these children likely have experienced trauma — research shows that the majority of youth involved in our nation's juvenile justice systems have experienced traumatic events. At least 75 percent have experienced traumatic victimization.[43] Schools are in a position to stop this trend, and reverse the harms caused by trauma in children's lives.

Understanding the role of trauma in behavioral, social, and cognitive problems is the first step to creating a school environment where students affected by trauma can succeed. Susan Cole, director of the Trauma

Learning Policy Initiative, described understanding trauma as the "missing piece to school reform."[44] By providing a stable, supportive environment, a trauma-informed school can reduce the adverse effects of trauma on brain development and behavior to help every child succeed in school and after.

WHAT IS A TRAUMA-INFORMED SCHOOL?

Trauma-informed care means that every adult who interacts with a child at school understands and responds appropriately to the impact of trauma on the child. Trauma-sensitive schools acknowledge the prevalence of traumatic occurrences in students' lives, foster an environment of support, are sensitive to unique needs of students, and are mindful of avoiding re-traumatization.[45] Trauma-informed care should be school-wide. It should involve all school personnel so that children feel safe and supported in the classroom, in the halls, on the bus, in the cafeteria, and on the playground. A trauma-informed school works with the local police department, including any school resource officers assigned to the school building; departments of children and family services; mental health services; youth services; counseling agencies; and other community and national resources to help children succeed.

Trauma-informed care is not the same as a new reading program with a specific set of instructions.[46] Rather, it is a more informed lens an educator can look through when determining the right activity or approach. The more a person understands how the brain functions, the better decisions she or he can make.

DISCIPLINE IN A TRAUMA-INFORMED SCHOOL

To implement a trauma-informed approach, schools must first re-examine disciplinary policies. Suspension and expulsion policies ignore underlying causes of behavior, like trauma, and focus only on removing students from school. For vulnerable children without a stable, nurturing home environment, removal from the safe haven of school exacerbates trauma occurring at home.[47] Exclusionary discipline should not be used when so many children have been affected by trauma, especially because "there is no research base to support frequent suspension or expulsion in response to non-violent and mundane forms of adolescent misbehavior; large disparities by race, gender and disability status are evident in the use of these punishments; frequent suspension and expulsion are associated with negative outcomes; and better alternatives are available."[48] Trauma-informed schools de-emphasize suspension and expulsion, and instead regard disobedient and disruptive behavior as possible manifestations of trauma. In trauma-informed schools, staff try to understand roots of behavior and figure out what they can do to make children feel safe and supported, as the following anecdote from a school in Washington state describes:

When Ashley blew up at her teacher and dropped the F-bomb, she was sure it meant automatic suspension,[49] but when she went to the principal's office, he didn't yell at her, he didn't send her home. Instead, he asked her what was wrong, what she was feeling, and why. Ashley was shocked, but just seconds passed before words of anger and frustration about her alcoholic father and unmet promises came tumbling out. She ended with an apology to the principal. She also made her own choice to apologize to the teacher. Rather than being kicked out of school, Ashley was sent to in-school suspension in a quiet and comforting room where she could talk to a teacher, catch up on homework, and think. Under a zero-tolerance policy, Ashley would have been unsupervised during an out-of-school suspension; she would have fallen behind her classmates on her schoolwork; and her teacher might never have received an apology. "Just by asking kids what's going on with them, they just started talking. It made a believer out of me right away," reported the principal. Zero tolerance doesn't work; treating students with dignity does.

BENEFIT TO SCHOOLS

A trauma-informed approach is essential for student success and will boost school performance and effectiveness. Trauma-informed schools can expect improvements in academic achievement, test scores, school climate, and teacher satisfaction, safety, and retention. Trauma-informed care can reduce behavioral outbursts, absences, detentions, suspensions, and dropouts. It can ease bullying, harassment, the need for special education services, and stress for students and staff.[50]

Trauma-informed care also reduces the risk of compassion fatigue or secondary stress, which can occur when teachers feel unable to cope with their students' intense needs. Providing teachers and other school staff with the training and resources to help students, therefore, also benefits the well-being of teachers.

WHAT DOES A TRAUMA-INFORMED SCHOOL LOOK LIKE?

Various experiences can prompt schools to try trauma-informed approaches. A single individual may start a program after learning about childhood trauma at a conference. Some schools investigate trauma when confronted with challenging behaviors, or when teachers begin voicing frustration about their inability to reach children. Other schools have long histories of violence, poverty, disability, emotional disturbances, drug abuse, or homelessness among students. With the help of resources and specialists, most schools have found success through staff training in trauma-awareness and practices that emphasize trauma-sensitivity, which can be implemented by any caregiver.

While there is variation in how schools implement trauma-informed care, there are several common characteristics that every trauma-informed school should incorporate. The Substance Abuse and Mental Health Services Administration recommends adherence to six key principals that can be applied to any trauma-informed care setting, including schools':

1) **Safety:** School personnel and students should feel physically and psychologically safe in their physical environment and interpersonal interactions.
2) **Trustworthiness and transparency:** Organization decisions should be conducted with transparency with the goal of building and maintaining trust.
3) **Peer support:** Individuals who have experienced trauma should support one another and use their lived experience to promote recovery and healing.
4) **Collaboration and mutuality:** Schools should foster healthy relationships in the classroom and at all other levels of the organization to promote healing.
5) **Empowerment, voice, and choice:** School personnel and students should feel empowered to voice their feelings and opinions and share in decision-making.
6) **Cultural, historical, and gender issues:** Schools should create an accepting environment that incorporates policies, protocols, and processes sensitive to racial, ethnic, and cultural needs of individuals.[51]

Each of these characteristics can be fostered by a positive, supportive school environment that nurtures students and the adults who teach and work in schools.

Appendix 1 describes some of the trauma-informed care programs being tried across the United States and in Ohio. Some prominent examples are Arnone Elementary in Brockton, Massachusetts and Lincoln High School in Walla Walla, Washington, which have seen dramatic drops in school suspensions (40 and 83 percent, respectively) among other benefits, including reduced teacher stress and increased graduation rates.[52] Some exemplary schools in Ohio that have implemented trauma-informed practices are also detailed in Appendix 1. Among these are Luis Muñoz Marin K-8 School, Lincoln-West High School, Belden Elementary, Westerville City Schools, and South-Western City Schools. Cleveland's social emotional learning program, an effort with deep support from school administrators and the teacher's union,

has been cited as a national model.[53] Cincinnati's Community Learning Centers have helped to transform 34 Cincinnati schools and ensured that human services and wraparound services can be accessed through the school building, setting in place the groundwork to deepen their trauma-informed approach.[54]

To implement these programs, schools used online resources, books, manuals, self-training, in-state training, out-of-state training, and consulting services. Appendix 2 provides an annotated list of resources about the impacts of trauma on children, including tools for implementing trauma-informed care, and funding opportunities for developing trauma-informed practices.

POTENTIAL CHALLENGES FOR IMPLEMENTING TRAUMA-INFORMED CARE

Staff and administrative resistance to change

Educators and school staff may resist implementing trauma-informed practices for various reasons: a lack of resources to effectively introduce new tactics and skills, a commitment to existing practices, and insufficient time, energy, or fear of change. Educators, staff, administrators, and other caregivers must be open to learning and changing the way they interact with students for trauma-informed care to be effective, especially when it comes to disciplinary practices. Additionally, school staff who do want to make changes must be afforded the time and resources to acquire new skills and implement new practices. To minimize resistance, school leaders and administrators must encourage staff feedback, consider their concerns, and adapt recommendations in response to their needs.

Misconceptions about the meaning of trauma-informed care

"Trauma-informed" could be misinterpreted as "soft." This can be an especially challenging perception to overcome when teachers and school staff have always used harsh discipline, like suspensions, to address undesirable behavior, and they don't have systems in

Photo © Dean Alexander Photography

place to implement alternatives. Trauma-informed care is not a substitute for discipline, and discipline need not exacerbate trauma to be effective. Rather, trauma-informed discipline begins when schools attempt to understand a child's viewpoint, recognize that certain disciplinary actions only re-traumatize children, and seek alternative ways to teach appropriate behavior. Suspensions and expulsions should be reserved for extreme, emergency circumstances involving violent behavior, and should never be a first line response to disruptive or disobedient behavior, especially when the child in question has suffered trauma. A trauma-informed approach deals effectively with disruptive or rude behavior, without requiring harsh, exclusionary disciplinary measures.

Misinterpretation of intentionality of children's behaviors

Educators often see willful or malicious intentions as the cause of children's disobedient or disruptive behavior. However, in the vast majority of situations, this is not the case. For children who have experienced trauma, brain architecture changes impair their

ability to exercise full control over their behavior and emotions, and consequent inappropriate actions stem from a physiologically heightened stress response system. Trauma-informed educators are careful to recognize this distinction so they don't take the act personally and can respond appropriately to help children process stress.

Compassion fatigue and secondary traumatic stress
Compassion fatigue and secondary traumatic stress set in when adults or other students in the classroom or school are physically, mentally, or emotionally worn out, or are feeling overwhelmed by students' traumas.[55] Schools must be sensitive to the fact that working with trauma-affected children can have negative effects on other students and staff. Part of being trauma-informed means being aware of secondary trauma, and building support systems for staff to prevent and address secondary trauma.

Staff turnover
A trauma-sensitive environment should create a sense of continuity and dependability, where teachers and staff can develop trustworthy relationships with their students. This is difficult to cultivate with high turnover. A study of over 85,000 New York City fourth- and fifth-grade students over eight years found that students who experienced higher teacher turnover had lower test scores in English and math and that the effects were strongest in schools with more low-performing and minority students. This suggests that trauma-affected students would be particularly vulnerable to the negative effects of teacher turnover.[56] Moreover, each time a new staff member comes to a school, that member must be trained in trauma-awareness, which costs time and money. Reducing teacher turnover should be a priority for trauma-informed schools. A trauma-sensitive school takes care of its staff by equipping them with the skills and resources to minimize stress, implementing teacher support programs, and encouraging self-care to minimize secondary trauma.[57] Trauma sensitivity improves a school environment for students and staff alike, which may translate into reduced turnover.[58]

Resource constraints
Formal training and certification programs for trauma-informed care can be costly, but many resources are free, such as the Trauma and Learning Policy Initiative's (TLPI) two volumes of Helping Traumatized Children Learn, training materials in Cognitive Behavioral Intervention for Trauma in Schools (CBITS), as well as many articles and websites. Positive, preventive approaches to teaching, as well as modeling behavior standards that require an investment of time or money — like Positive Behavior Interventions and Supports (PBIS) — have been shown to be cost-beneficial in the long run.[59] Information about funding opportunities and available resources can be found in Appendix 2.

POLICY RECOMMENDATIONS

Many teachers, counselors, and administrators have taken the lead in schools all over the country to put in place creative, low-cost, effective practices to help address the impacts of trauma on their students. Motivated leaders can make great strides in improving their school's approach to traumatized students, even in the absence of systemic solutions. Some states, however, have taken steps toward a more systemic approach. In 2000, Massachusetts held the first conference on the impact of trauma on learning and in 2004 the Massachusetts state legislature created the Safe and Supportive Learning Environments grant program to provide funds for schools to experiment with trauma-sensitive approaches.[60] Washington State has initiated several pilot school programs and fostered collaboration among educational professionals from public schools, universities, and the Washington State Office of the Superintendent of Public Instruction to publish a comprehensive book to further the trauma-sensitive schools movement.[61]

Ohio has the potential to be a national leader in trauma-informed care. The Public Children Services Association of Ohio (PCSAO)[62] and the Ohio Trauma

Consortium[63] have both worked to bring more attention to how trauma affects foster children. PCSAO has also advocated for policy changes and funding to confront this issue and has partnered with other agencies to further this cause. In 2013, Akron Children's Hospital was awarded a $1.6 million federal grant over four years to create the Akron Children's Center for the Treatment and Study of Adverse Childhood Events. This effort trains clinicians and educators in identifying and helping trauma-affected children, conducts research, and provides services and support to children and families who have experienced psychological trauma.[64] The Greene County Educational Service Center in Yellow Springs has pioneered the Stakeholders to Partner Project, which creates an enhanced continuum of care between Greene County schools, the juvenile justice system, and community mental health agencies. Collaboration helps school and juvenile justice personnel identify early warning signs and symptoms of youth mental health and trauma issues, make referrals for services, and link youth to mental health resources in the community.[65] The Ohio Department of Mental Health and Addiction Services recently launched a statewide trauma-informed care initiative to broaden access to trauma-informed interventions by helping practitioners, facilities and agencies become competent in trauma-informed practices.[66] As part of the plan, the department organized a Trauma-Informed Care Summit in July 2014. Although both the initiative and the summit focused on mental health, substance abuse, and developmental disabilities, schools have attended regional meetings to learn about trauma and how best to respond at the district and building level.[67] The effect of trauma on learning and behavior was also a key topic at the 2014 Ohio Department of Education Office of Exceptional Children's Special Education Leadership Conference.[68] These are all promising signs of deeper and more holistic approaches addressing the impact of trauma on children throughout Ohio.

Below are policy recommendations to bring about more comprehensive change in Ohio.

Ohio has the potential to be a national leader in trauma-informed care. The Public Children Services Association of Ohio (PCSAO) and the Ohio Trauma Consortium have both worked to bring more attention to how trauma affects foster children.

1. **The Ohio legislature must provide Ohio public schools with funding to develop school-wide plans addressing the needs of traumatized children**. These plans should include administrative infrastructure to integrate trauma-informed approaches throughout the school day; training for staff; clinical support; strategies to partner with parents, who may also be suffering from trauma; teaching techniques that help traumatized students master academic work; ways to use nonacademic activities to support traumatized children; individual and group supports to help students control emotions and behavior; links to mental health services; reviews of existing school policies to improve trauma-sensitivity; and collaborations with community organizations, including domestic violence agencies.

2. **Encourage early identification of trauma-affected children, and implement interventions to reduce ineffective, punitive responses to children who are already suffering**. Some good work is being pioneered in Ohio, providing a foundation upon which to build and expand current efforts. Ohio should convene trauma experts, educators, executive and legislative leaders, and advocates to

develop a statewide plan that addresses the impact of trauma on learning and behavior, outlines what schools can do to respond effectively, and works toward eliminating punitive approaches like suspension, expulsion, and referral to the juvenile justice system.

3. **Teachers, school administrators, and other adults who interact with children in school must have access to training to learn how to work with children who have experienced trauma**. State certifications for administrators and teachers should require courses on issues such as identifying trauma, understanding the impact of trauma on learning, partnering with parents of traumatized children, and enabling traumatized children to succeed. Administrators and teachers should also be educated about collaborating with mental health professionals and other experts. Finally, teachers and other adults in schools should have resources to prevent and treat secondary trauma.

4. **Community Learning Centers should be examined as a model approach.** This model integrates trauma-informed approaches throughout the school environment, and delivers wraparound services on site, using existing funding mechanisms available through Medicaid, federally qualified health centers, and other sources.

5. **Where mental health professionals are already working with schools through partnerships and mental health school-based responder programs, they should be trained in how to respond to trauma-related behavioral problems and should assist educators in identifying and referring trauma-affected students for treatment. Where such partnerships are not already in place, schools and communities should work toward creating opportunities to integrate mental health services into schools.** State licensing for mental health professionals and other school personnel should include training on the impact of trauma on learning and behavior. Professionals with expertise in child trauma should develop guidelines for assessing student needs. Reimbursement for mental health and special education evaluations should be sufficient to ensure that trauma can be considered. Programs already in place that provide school-based mental health responders in Ohio schools — such as those in Summit County[69] — should be replicated and adapted to address concerns about trauma.

6. **The Ohio Department of Education should provide ongoing information and support to schools and should incorporate trauma informed care into its school climate guidelines.** Massachusetts recommended developing an office on trauma and schools to provide best practices and curricula for traumatized students; consulting on how to connect schools to families and to other resources in the community; and reviewing school policies and state law to integrate them with the best current research on trauma.

CONCLUSION

Childhood trauma can adversely impact academic achievement, social and emotional development, and mental and physical health in extensive and life-long ways. Among other risks, a trauma-affected child is 150 percent more likely to use illicit drugs, 59 percent more likely to be arrested as a juvenile, 28 percent more likely to commit criminal behavior in adulthood, and 25 percent more likely to experience delinquency, teen pregnancy, or low academic achievement.[70] Despite these odds, a more promising future is possible. Supportive relationships with caring adults early in life can prevent or even reverse trauma's harmful effects. Schools can make this difference. By becoming trauma-informed, educators and school staff can create a compassionate, sensitive, and safe environment where all children can succeed.

Endnotes

[1] This story was adapted from "Teaching Through Trauma: How poverty affects kids' brains" written by Annie Gilbertson at Southern California Public Radio (http://www.scpr.org/blogs/education/2014/06/02/16743/poverty-has-been-found-to-affect-kids-brains-can-o/).

[2] Stevens, Jane Ellen. "Lincoln High School in Walla Walla, WA, Tries New Approach to School Discipline — Suspensions Drop 85%," ACES Too High, April 23, 2012. http://acestoohigh.com/2012/04/23/lincoln-high-school-in-walla-walla-wa-tries-new-approach-to-school-discipline-expulsions-drop-85/.

[3] Ohio Department of Education, Ohio School Report Cards, iLRC Power Reports, available at http://reportcard.education.ohio.gov/Pages/Power-User-Reports.aspx.

[4] Stevens, supra note 2.

[5] Children's Defense Fund – Ohio. "Zero Tolerance and Exclusionary School Discipline Policies Harm Students and Contribute to the Cradle to Prison Pipeline®," November 2012. http://www.cdfohio.org/assets/pdf-files/issue-brief-zero-tolerance.pdf.

[6] Australian Childhood Foundation. "Making Space for Learning: Trauma Informed Practice in Schools." 2010. http://www.childhood.org.au/~/media/Files/TRAINING%20FILES/Resources/Making%20space%20for%20learning%20ACF%20PDF.ashx

[7] Walkley, M., and T. L. Cox. "Building Trauma-Informed Schools and Communities." Children & Schools 35, no. 2 (April 1, 2013): 123–26. doi:10.1093/cs/cdt007.

[8] Making Space for Learning, supra, note 6.

[9] Harvard University. "Brain Architecture." Center on the Developing Child. 2014. http://developingchild.harvard.edu/key_concepts/brain_architecture/.

[10] Harvard University. "Toxic Stress." Center on the Developing Child. 2014. http://developingchild.harvard.edu/key_concepts/toxic_stress_response/.

[11] Siegel, Jim. "Data Link Poverty, School Performance in Ohio." The Columbus Dispatch. September 22, 2014. http://www.dispatch.com/content/stories/local/2014/09/22/data-link-poverty-performance.html.

[12] Hanson, Jamie L., Nicole Hair, Dinggang G. Shen, Feng Shi, John H. Gilmore, Barbara L. Wolfe, and Seth D. Pollak. "Family Poverty Affects the Rate of Human Infant Brain Growth." PloS One 8, no. 12 (2013): e80954; Hanson, Jamie L., Amitabh Chandra, Barbara L. Wolfe, and Seth D. Pollak. "Association between Income and the Hippocampus." PLoS One 6, no. 5 (2011): e18712.

[13] American Psychological Association. "Violence & Socioeconomic Status." Accessed September 30, 2014. http://www.apa.org/pi/ses/resources/publications/factsheet-violence.aspx.

[14] Kirwan Institute, Community Research Partners, Champion of Children, and United Way. "2014 Franklin County Children's Report: How Toxic Stress Threatens Success." 2014. http://liveunitedcentralohio.org/download/initiatives/champion_of_children/2014_FCC_Report_140620.pdf.

[15] Pechtel, Pia, and Diego A. Pizzagalli. "Effects of Early Life Stress on Cognitive and Affective Function: An Integrated Review of Human Literature." Psychopharmacology 214, no. 1 (2011): 55–70.

[16] Ohio Department of Mental Health and Addiction Services. "How Does Trauma Impact a Child?" MHAS: Promoting Wellness and Recovery. Accessed June 13, 2014. http://mha.ohio.gov/Default.aspx?tabid=285; Bath, Howard I. "The Three Pillars of Trauma-Informed Care." Journal of Safe Management of Disruptive and Assaultive Behavior. 2009; Committee, National Child Traumatic Stress Network Schools. "Child Trauma Toolkit for Educators." Los Angeles, CA & Durham, NC: National Child Traumatic Stress Network, 2008. http://rems.ed.gov/docs/NCTSN_ChildTraumaToolkitForEducators.pdf.

[17] Child Trauma Toolkit, supra, note 16; How Does Trauma Impact a Child, supra, note 16.

[18] Private correspondence with Barbara Oehlberg, July 2014.

[19] Pechtel, Pia, and Diego A. Pizzagalli. "Effects of Early Life Stress on Cognitive and Affective Function: An Integrated Review of Human Literature." Psychopharmacology 214, no. 1 (2011): 55–70.

[20] Child Trauma Toolkit, supra, note 16; Jaycox, Lisa H., ed. "How Schools Can Help Students Recover from Traumatic Experiences: A Tool-Kit for Supporting Long-Term Recovery." Technical Report TR-413-RC. Santa Monica, CA: Rand Gulf States Policy Institute, 2006; Making Space for Learning, supra, note 6.

[21] The National Child and Traumatic Stress Network. "The Effects of Trauma on Schools and Learning." Accessed June 13, 2014. http://www.nctsn.org/resources/audiences/school-personnel/effects-of-trauma#q3; Ko, Susan J., Julian D. Ford, Nancy Kassam-Adams, Steven J. Berkowitz, Charles Wilson, Marleen Wong, Melissa J. Brymer, and Christopher M. Layne. "Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice." Professional Psychology: Research and Practice 39, no. 4 (2008): 396; Child Trauma Toolkit, supra, note 16.

[22] The Effects of Trauma, supra, note 21; Child Trauma Toolkit, supra, note 16.

[23] The NSCH survey inquired about nine different types of adversity: socioeconomic hardship, divorce/parental separation, lived with someone who had an alcohol or drug problem, victim or witness of neighborhood violence, lived with someone who was mentally ill or suicidal, domestic violence witness, parent served time in jail, treated or judged unfairly due to race/ethnicity, and death of a parent. It is important to note that this survey groups together a range of situations: from experiencing divorce or prejudice — from which many children emerge unscathed — to experiencing or witnessing severe violence. Research suggests that most children recover from divorce, with perhaps 15% of adult children of divorce experiencing serious social, emotional, or psychological troubles above and beyond those from stable families. Arkowitz, Hal, and Scott O. Lilienfeld. "Is Divorce Bad for Children?" Scientific American Mind 24, no. 1 (2013): 68–69. We do not equate these experiences and we recommend that schools and surveys are cautious about separating severe trauma from more routine traumatic events. The techniques and resources described in this report can be helpful for traumatic experiences at multiple levels of severity.

[24] National Survey of Children's Health. "NSCH 2011/12: Adverse Family Experiences, Nationwide vs. Ohio." Accessed July 28, 2014. http://www.childhealthdata.org/browse/survey/results?q=2614&r=1&r2=37&chart=pie.

[25] Stevens, Jane Ellen, "Nearly 35 Million U.S. Children Have Experienced One or More Types of Childhood Trauma." ACES Too High. May 13, 2013. http://acestoohigh.com/2013/05/13/nearly-35-million-u-s-children-have-experienced-one-or-more-types-of-childhood-trauma/.

[26] National Survey of Children's Health, supra, note 24; Zeltner, Brie. "Almost Half of U.S. Kids Suffer Traumas; Exposure Linked to Bullying, Problems in School as Early as Age 12." July 30, 2014. http://www.cleveland.com/healthfit/index.ssf/2014/07/almost_half_of_us_kids_suffer.html.

[27] Zeltner, supra, note 26.

[28] Id.

[29] Sacks, Vanessa, David Murphey, and Kristin Moore. "Adverse Childhood Experiences: National and State-Level Prevalence." Child Trends. July 2014.

[30] Stevens, supra, note 25.

[31] UCSF National Center of Excellence in Women's Health. "UCSF HEARTS Program: Healthy Environments and Response to Trauma in Schools." October 2013. http://coe.ucsf.edu/coe/spotlight/ucsf_hearts.html; Children's Defense Fund – Ohio, Zero Tolerance, supra, note 5.

[32] Making Space for Learning, supra, note 6.

[33] Ohio Department of Mental Health and Addiction Services. "Trauma & Children: Scope of the Problem." MHAS: Promoting Wellness and Recovery. Accessed June 13, 2014. http://mha.ohio.gov/Default.aspx?tabid=285.

[34] Walkley and Cox, supra, note 7.

[35] Felitti, V J, R F Anda, D Nordenberg, D F Williamson, A M Spitz, V Edwards, M P Koss, and J S Marks. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine 14, no. 4 (May 1998): 245–58; Trauma and Children, supra, note 33.

[36] Ko et al., supra, note 21.

[37] CDC Division of News and Electronic Media. "Child Abuse and Neglect Cost the United States $124 Billion." Press Release. Centers for Disease Control and Prevention. February 1, 2012. http://www.cdc.gov/media/releases/2012/p0201_child_abuse.html.

[38] Engel, Chris. "Trauma's Monetary Costs to Society." ACEs Connection. September 1, 2013. http://acesconnection.com/profiles/blogs/monetary-costs-to-society.

[39] Ziegler, Dave. "Optimum Learning Environments for Traumatized Children: How Abused Children Learn Best in School." Retrieved February, 2014.

[40] Cronn, Shannon, and Barb Iversen. "Essential Trauma Informed Practices in Schools." n.d. http://www.azed.gov/prevention-programs/files/2013/12/trauma-informed-schools-barb-iversen.pdf.

[41] Bath, supra, note 16.

[42] Moroz, Kathleen J. "The Effects of Psychological Trauma on Children and Adolescents." Report. Department of Health. 2005.

[43] Mental Health and Juvenile Justice Collaborative for Change. "Trauma Among Youth in the Juvenile Justice System." Resources. Accessed June 11, 2015. http://cfc.ncmhjj.com/resources/trauma-among-youth-in-the-juvenile-justice-system/.

[44] Stevens, Jane Ellen. "Massachusetts, Washington State Lead U.S. Trauma-Sensitive School Movement." ACES Too High. May 31, 2012. http://acestoohigh.com/2012/05/31/massachusetts-washington-state-lead-u-s-trauma-sensitive-school-movement/.

[45] Cronn and Iversen, supra, note 42.

[46] Personal correspondence with Suzanne Kile, June 2014

[47] Children's Defense Fund – Ohio, Zero Tolerance, supra, note 5.

[48] Losen, Daniel. "Discipline Policies, Successful Schools, and Racial Justice." 2011.

[49] Narrative adapted from "Lincoln High School in Walla Walla, WA, tries new approach to school discipline — suspensions drop 85%" by Jane Ellen Stevens, supra, note 2.

[50] Oehlberg, Barbara. "Becoming a Trauma Informed Educational System: Going Beyond Emotional Intelligence." In Ending the Shame: Transforming Public Education So It Works for All Students, 65. Dorrance Publishing, 2012.

[51] Substance Abuse and Mental Health Services Administration. "Trauma-Informed Approach and Trauma-Specific Interventions." Last updated June 3, 2015. http://www.samhsa.gov/nctic/trauma-interventions.

[52] Stevens, supra, note 2.

[53] Collaborative for Academic, Social, and Emotional Learning. "Cleveland Metropolitan School District." Collaborating Districts. Accessed June 11, 2015. http://www.casel.org/collaborating-districts/cleveland-metropolitan-school-district/.

[54] Cincinnati Public Schools. "Community Partnerships—Transforming Schools and Revitalizing Communities." CPS' Community Learning Centers. Accessed June 11, 2015. http://www.cps-k12.org/community/clc.

[55] Child Trauma Toolkit, supra, note 16.

[56] Ronfeldt, Matthew, Susanna Loeb, and James Wyckoff. "How Teacher Turnover Harms Student Achievement." American Educational Research Journal 50, no. 1 (2013): 4–36.

[57] Treatment and Services Adaptation Center. "Managing Secondary Traumatic Stress for Educators." Resiliency, Hope, and Wellness in Schools. Accessed August 1, 2014. https://traumaawareschools.org/secondaryStress.

[58] Stevens, Jane Ellen. "San Francisco's El Dorado Elementary Uses Trauma-Informed & Restorative Practices; Suspensions Drop 89%." ACES Too High. January 28, 2014. http://acestoohigh.com/2014/01/28/hearts-el-dorado-elementary/.

[59] Scott, Terrance M., and Susan B. Barrett. "Using Staff and Student Time Engaged in Disciplinary Procedures to Evaluate the Impact of School-Wide PBS." Journal of Positive Behavior Interventions 6, no. 1 (2004): 21–27.

[60] Massachusetts Department of Elementary and Secondary Education. "Trauma Sensitive Schools: Grants and Funding." Last updated January 29, 2013. http://www.doe.mass.edu/tss/grants.html.

[61] Wolpow, Ray, Mona M. Johnson, Ron Hertel, and Susan O. Kincaid. "The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success." Office of Superintendent of Public Instruction (OSPI) Compassionate Schools, 2009.

[62] Public Children Services Association of Ohio. "PCSAO Behavioral Health Leadership Group – 2013 Year In Review." December 11, 2013. http://www.pcsao.org/BHmaterials/BHLG%202013%20Year%20In%20Review%20Final.pdf.

[63] Ohio Trauma Consortium. "What and Who Is the Trauma Consortium?" Trauma Consortium Resources. https://sites.google.com/site/traumaconsortiumresources/what-is-the-ohio-trauma-consortium.

[64] Pupino, Holly. "Grant-Funded Program Will Help Kids Touched by Trauma - such as School Shootings, Domestic Violence and Illness." Akron Children's Hospital. March 17, 2013. https://www.akronchildrens.org/cms/sharing_blog/ec7ae9153b11b08b/.

[65] Cornwell, Samantha, and Anya Senetra. "Stakeholders to Partners Project." Greene County Educational Service Center. Accessed September 30, 2014. http://www.greeneesc.org/our-services/mental-health/stakeholders.html.

[66] Ohio Department of Mental Health & Addiction Services. "Trauma-Informed Care 'Creating Environments of Resiliency and Hope.'" MHAS: Promoting Wellness and Recovery. Accessed September 30, 2014. http://mha.ohio.gov/Default.aspx?tabid=104.

[67] Personal correspondence with Kim Kehl, September 29, 2014

[68] "Ohio's 2014 Special Education Leadership Conference - Agenda." Cvent Online Event Registration Software. Accessed October 1, 2014. http://www.cvent.com/events/ohio-s-2014-special-education-leadership-conference/agenda-43ca77833b534e43bb28943bdad53220.aspx?i=ff820908-7617-4135-b3b0-0ddbbcd019b4.

[69] Giudi Weiss, Kathleen Skowyra. "Schools Turn to Treatment, Not Punishment, for Children with Mental Health Needs." Models for Change: Systems Reform in Juvenile Justice. December 2013. http://www.modelsforchange.net/publications/510/Innovation_Brief_Schools_Turn_to_Treatment_Not_Punishment_for_Children_with_Mental_Health_Needs.pdf.

[70] Centers for Disease Control and Prevention. "Child Maltreatment: Consequences." Centers for Disease Control and Prevention. January 14, 2014. http://www.cdc.gov/violenceprevention/childmaltreatment/consequences.html.

CDF Mission Statement

The Children's Defense Fund Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities.

CDF provides a strong, effective and independent voice for *all* the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor children, children of color and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown.

CDF began in 1973 and is a private, nonprofit organization supported by individual donations, foundation, corporate and government grants.

Acknowledgments

The Children's Defense Fund-Ohio thanks the following individuals for providing assistance leading to the production of this issue brief:

Annie Racine, MPA

Neuroscience and Public Policy Graduate Student and Policy Matters Intern

This work was supported by the University of Wisconsin La Follette School Summer Internship Award Program. We deeply thank Sarah Biehl and Piet van Lier for the conception of and their contributions to this project. We gratefully acknowledge all the school personnel who were interviewed for this brief and to everyone who provided input and guidance including — but of course not limited to — Barbara Oehlberg, Gayle Channing Tenenbaum, Kim Kehl, Sue Berger, Hilary Shager, and the fantastic team at Policy Matters Ohio, especially Zach Schiller, Wendy Patton, Mike Shields, all the summer interns, and, of course, Executive Director Amy Hanauer. Annie would also like to thank her Ph.D. mentor Dr. Sterling C. Johnson and graduate program director Dr. Ronald Kalil at the University of Wisconsin for their continued support during her graduate career in the Neuroscience and Public Policy Program. Lastly, we would like to thank all our readers as well as all the people who are already promoting and utilizing trauma-informed care in schools and elsewhere.

This research was funded by the Annie E. Casey Foundation. We thank them for their support but acknowledge that the findings and conclusions presented in this report are those of the author(s) alone, and do not necessarily reflect the opinions of the Foundation.

Columbus	395 E. Broad St., Suite 330, Columbus OH 43215	p (614) 221-2244	f (614) 221-2247	www.cdfohio.org
Cleveland	431 E. 260th Street, Euclid, OH 44132	p (216) 650-1961		www.cdfohio.org
National Office	25 E Street, NW, Washington DC 20001	p (202) 628-8787	f (202) 662-3510	www.childrensdefense.org