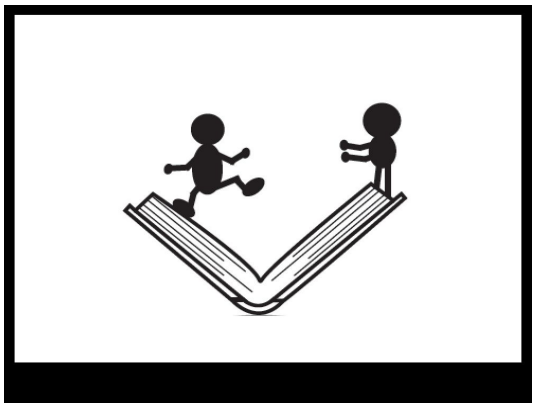
We Know How to Close the Reading Gap



Findings & Recommendations of the **Maryland Task Force to Study the Implementation of a Dyslexia Education Program**

Dyslexia Task Force Members

- Maryland Legislature
- MSDE: MD State Dept. of Education
- MSEA: MD State Education Association
- MABE: MD Assoc. of Boards of Education
- PSSAM: Public Schools Superintendent's Assoc.
- MSPA: MD School Psychologists Assoc.
- Literacy Specialist/Teacher, Calvert Co. PS
- Teacher, Anne Arundel Co. PS
- Heads of Private Dyslexia Schools in MD: Jemicy, Odyssey & Summit
- Decoding Dyslexia MD/ parents

Exploring Best Practices for Reading

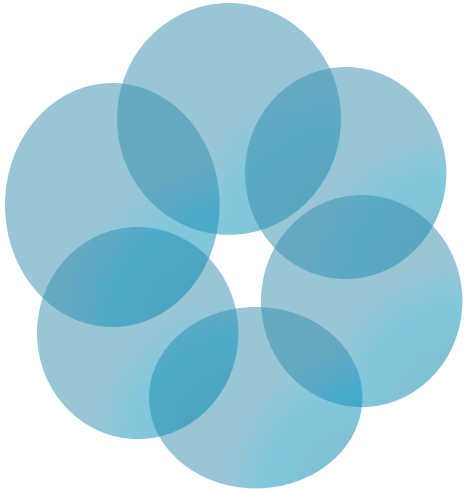
→English learners, students with reading disabilities, students in poverty and other at-risk communities

Researchers	Laurie Cutting, Ph.D., Vanderbilt
	William Stixrud, Ph.D., MD
	Emily Phillips Galloway, Ed.D., Vanderbilt
	Julie Washington, Ph.D., CCC-SLP, Georgia State University
	Margie Gillis, Ph.D., CCC-SLP, Literacy How, CT
	Carol McDonald Connor, CCC-SLP, Arizona State University
	Wayne Foster, Ph.D., CCC-SLP/A, Special Education Director, North Carolina
Consultants	Kelli Cummings, Ph.D., NCSP UMD
	Alan Dunklow, MSDE
	Linda Farrell, M.Ed., Readsters, VA
	Marsye Kaplan, MSDE
	Rebecca Silverman, AP, UMD

Dyslexia Task Force Recommendations

Implement & fund a READING PILOT program in a MD School District/s

Use evidence based, structured literacy reading instruction



Develop an effective multi-tiered system of supports (MTSS)

Identify Reading Difficulties in K

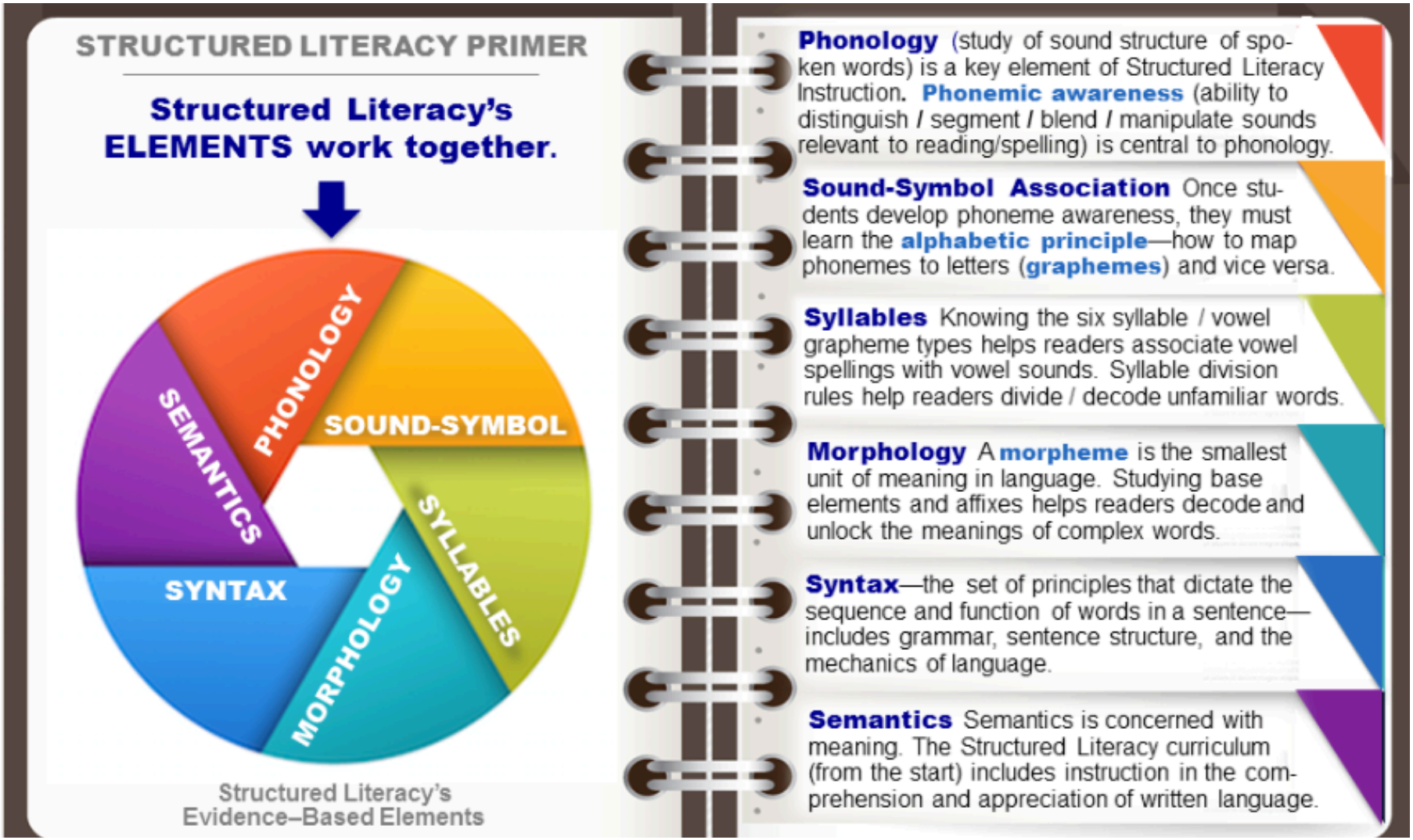
Recognize and address the needs of students with dyslexia

Transform pre-service & in-service teacher preparation in reading

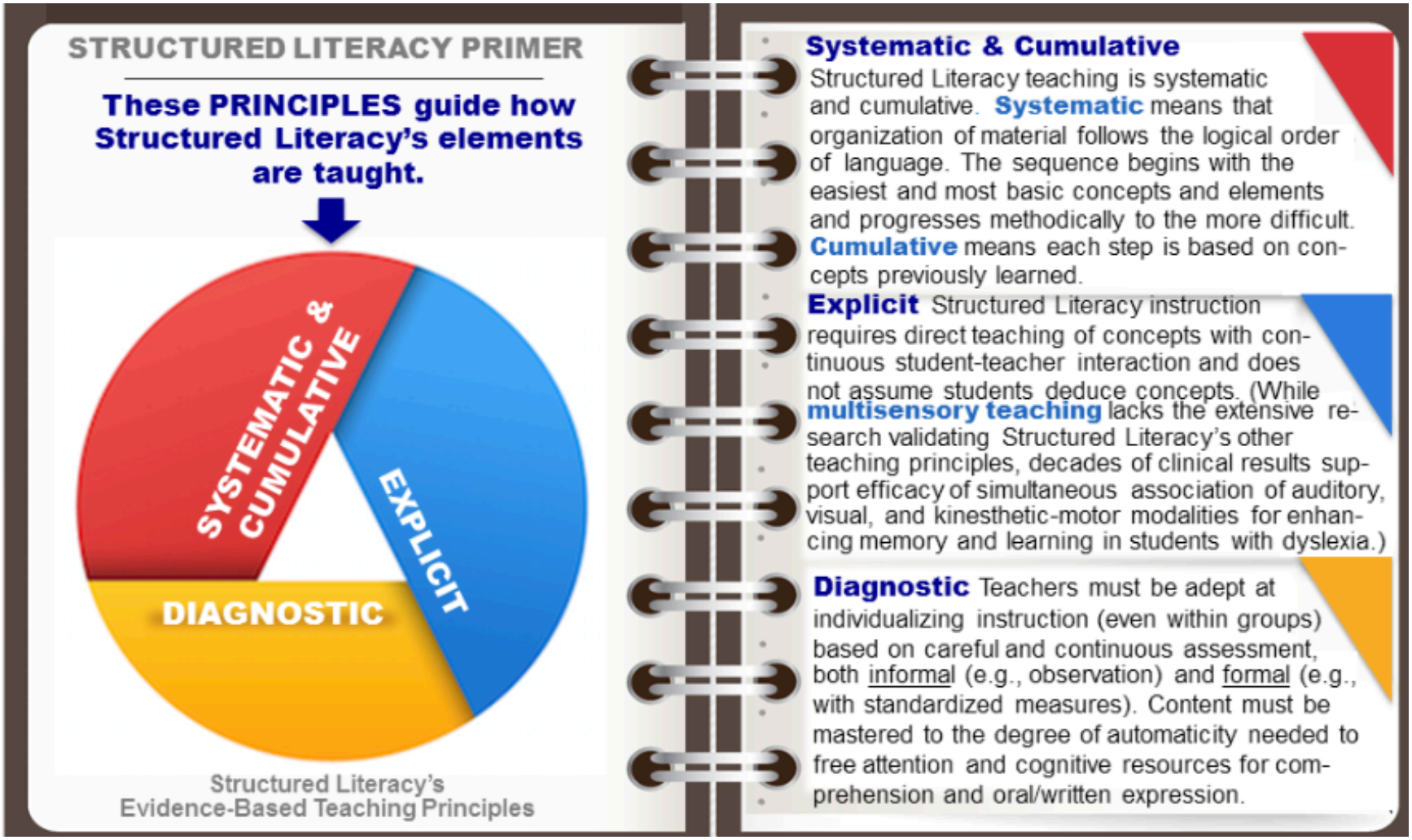
Links & Resources

Task Force Information
• Task Force Report: http://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/021600/021654/20170046e.pdf
• Task Force Research Presentations, school district surveys, handouts, minutes/agendas: http://www.livebinders.com/play/play?id=1817779
• Knowledge & Practice Standards for Teachers of Reading: https://dyslexiaida.org/knowledge-and-practices/
• What is Structured Literacy? https://dyslexiaida.org/what-is-structured-literacy/ (see slides 6,7)
• What are the Essential Components of Reading Instruction? https://www.law.cornell.edu/uscode/text/20/6368
• Pilot Program Information: Budget & Details available in the Task Force Report, p. 80 and slides 8,9
• Contact: Laura Schultz, Decoding Dyslexia Maryland: decodingdyslexiamd@gmail.com

Structured Literacy: Pt. 1: Elements of Instruction: What is taught



Structured Literacy, Pt. 2:
Principles of Instruction: How it's taught



The Reading Pilot

Scalable model to identify and teach students who struggle with reading

- 6 year program
  - Begins w/ a pre-year for teacher training
  - Three years of instruction: Year 1: K, Year 2: K,1 Year 3: K,1, 2
  - 2 years of data collection on progress
- Scalable for a 2 district or 3 district program

- Teacher Training
  - 45 hour paid summer institute
  - 174 teachers trained (2 district pilot)
  - Supervised Practicum to ensure fidelity
  - Monthly in-service workshop for entire school staff
  - Coaching by master teacher

The Cost of Early ID & Effective Instruction

Two District Pilot → $10.5 Million

- $1.9M teacher training
- $7M for personnel
- $1.6M administration and materials

- Three District Pilot→ $16.5M
  - $3.2M for teacher training
  - $11.7M for personnel
  - $1.6M for administration and materials

Illiteracy is costly: emotionally, socially, economically.
Change literacy, change lives.

What Is and What Could Be: The Reading Gap

A story repeated over and over in every district in every school in every classroom. We all know "a Jared."

Meet Jared

- This is Jared's first day in Kindergarten.
- He's happy.
- He likes school.

Now Meet Jared in Fourth Grade

- Jared is no longer smiling. He told his friends and family that he hated school.
- He was sad and detached
- His teachers said that he couldn't keep up with the other students.
- His friends laughed when Jared was called on to answer questions.
- His report card indicated that he was falling behind in reading and written language.
- Jared's parents didn't know what to do with him. They tried to get him to do his work but he was resistant most of the time, and began lying to them, telling them that he had no homework.

Jared in Late September of Ninth Grade

- Jared was told to leave his history class and sit in the hall for being disruptive in class.
- The teacher had called on him to read aloud from the text book.
- Jared refused and spoke disrespectfully to the teacher.
- The school had several meetings with Jared and his parents regarding his inappropriate behaviors.
- He was assigned to in-school suspension three times in the first month of school.

Jared in Ninth Grade After Intensive Reading Instruction

- Jared was called upon to read aloud in his reading class.
- His friends began to laugh at Jared, expecting him to begin his typical avoidance behaviors.
- One friend spoke up and stated, "We can't laugh at Jared any more. He can read now!"
- Jared had no discipline referrals for three months.
- His teacher's reported that he continued to read below grade level, but his reading skills had improved to a level that he needed minimal help in class to complete grade level work.

Jared Today

- Jared has been working in the construction field.
- He has a home and family.
- He has often had conversations with his family telling them that he wishes he had had more reading instruction in elementary school so that he could have done better in high school.
- He wants to set a good example for his son and is reading to him nightly.

Funding Priorities for Reading Instruction in MD

- **In-service education** must be a funding priority and must include foundational reading skills/structured literacy training, especially for K-2 teachers
  - Teachers must be able to recognize and identify the cascading indicators of reading failure;
  - Teachers must be able to teach the foundational elements of reading, writing and spelling;
  - Teachers must have excellent mentoring and a supervised practicum;
- Provide Funding for the Reading Pilot Program – the pilot will provide a sustainable teacher training pipeline with a practicum and mentoring. A six year program in two school districts, with 6 pilot schools and three control schools is estimated to cost $10.5M – this includes the costs of personnel, training, administration and materials.

We Know How to Close the Reading Gap

- What we've been doing for more than 20 years isn't working -- we have a responsibility to deliver effective, early reading instruction to all students.
- When teachers are provided training in structured literacy, they have the tools to identify and help "all Jareds". How might his life have been different had he received effective, early instruction?
- By funding teacher training in foundational reading instruction, training that includes mentoring and a practicum, we can help students attain grade level reading skills. Funding the pilot program will help get this process started.
- I cannot bear to watch one more Jared walk out the door of my high school.

KIPP BALTIMORE

TESTIMONY OF MAVIS JACKSON, KIPP BALTIMORE BOARD MEMBER

Commission on Innovation and Excellence in Education Meeting

August 30, 2017

Thank you Mr. Chairman and Members of the Commission for the opportunity to speak today and thank you for all the work you are doing on behalf of Maryland's children. My name is Mavis Jackson. I am a resident of Baltimore City and currently a board member and parent of a 7th grader at KIPP Baltimore, a public charter school that serves the children and families of Northwest Baltimore. In addition, my "day job" is serving as a public school teacher at Vivien T. Thomas Medical Arts Academy in Baltimore City.

Today, I speak on behalf of KIPP Baltimore and the parents and families of the 1,500 children and over 900 alumni we serve. For those of you who don't know KIPP, we are part of a national network of public charter schools and operate an elementary and middle school in the Park Heights community in Baltimore. Our commitment to our students is to ensure they get to and through college. I am proud to tell you that in the last 15 years, more than 90% of our students have graduated high school in four years and 70% have matriculated to college.

Unfortunately, despite that success, our future is far from certain. If we do not see a change in the public funding for K-12 education, in charter and traditional schools, KIPP Baltimore will not be able to continue to serving students and families in Baltimore.

The last three years have been the most challenging in our school's history:

- Baltimore City Schools cut their per pupil allocation for charter schools by a total of $393 per pupil which represented a reduction of $1.1 million dollars over the last two school years.
- In the 2016-17 school year KIPP Baltimore cut $1.2 million from its budget just to breakeven.
- In addition to these cuts, City Schools has announced new mandatory fees to charter schools for 2018. . The newly imposed mandatory fees represents $189,000 to KIPP, money which could be spent to have two additional educators supporting our students.
- Because students and families are our only priority, the KIPP Baltimore Board of Directors approved a budget with a $1.3 million deficit which we are covering with our limited reserves as we advocate for a better solution.

You are part of that solution. This Commission is leading the discussion on adequate funding of public education. That discussion must include all public schools and all public school students. As a public school educator and a charter school parent, please consider two specific recommendations:

1. School funding must be adequate, equitable and predictable. One path to this would be direct funding of schools. Should the Commission recommend direct funding, we ask that public charter schools be included in this recommendation. If this is not the path you choose, we recommend that the Commission codify the State Board of Education's funding formula for public charter schools and prohibit Districts from requiring fees or buy-backs of services beyond the 2% administrative fee adopted by the State Board.

2. Second, we ask that the Commission give charter schools direct and equitable access to state facility funding as well as a per pupil facilities allocation for charter schools. If we are to have adequate funding for our schools, it is critical that the Commission include the costs of creating safe, suitable learning environments for our students.

   KIPP currently has a 30-year lease with the District for a facility built in the late 1960s. KIPP's leadership and Board has raised over $6 million in private dollars to do basic renovations in the building – these are not bells and whistles – basic renovations to the building's heating and cooling systems, for example.

   However, without a facilities allocation or direct access to state improvement funds, every year we are forced to choose between teachers and building repairs.

   Too often, our Kippsters sit in 90 degree classrooms in February and 50 degree classrooms in May because we need a new HVAC system we cannot afford. No child can learn when overheated and effective instruction does not happen with 2nd graders in a hallway so they can cool off – Maryland has a responsibility to these children, and currently we're not meeting it.

Given my limited time today, I focused on two requests specific to public charter schools. However, I want to be clear that we support and are advocating for adequate funding for ALL students, ALL schools, and ALL teachers, and students in Maryland. The work is critically important and I respectfully request that you honor your charge and ensure that there is adequate funding for **all public schools including charter schools**. All of these students are our kids. We want to work with you to ensure they have the resources they need to thrive.

Thank you for your consideration.

Commission on Innovation and Excellence in Education

August 30, 2017

Robert Hull, M.A.Ed., Ed.S., M.H.S.

Without effective, sustainable interventions that focus on the economic hardships and other adversities that students struggle with additional funding for under resourced schools alone will not significantly impact longstanding issues facing so many of our students; such as chronic absenteeism, academic under performance, low literacy rates, social emotional concerns and dropout rates.

There has been a significant movement across the United States to respond to these issues by developing, distributing and providing support for the implementation of trauma informed education. It will require additional funding to, at the very least, add staff and training resources that would allow districts to take this approach to scale. Maryland could benefit from the efforts of other states by learning from their work and adapting trauma informed education to the unique needs of students in Maryland schools.

These efforts have been provided by state education agencies, the National Education Association, local districts, non-profits, universities and individuals such as myself in partnerships that have enabled them to move from trauma informed mental health supports to trauma informed education.

Maryland has existing resources that would enable them to implement these strategies. These include Johns Hopkins School of Public Health, various non-profits and local expertise.

I have enclosed three attachments that I believe establish the evidence of the effectiveness of trauma informed education as well as the prevalence of state level efforts to promote its use:

- A review of three pilot trauma informed education efforts that was published last year in a peer reviewed journal
- A state by state review of laws and resolutions by various states related to trauma informed education
- A PowerPoint that I delivered recently to the legal issues in special education conference that considered the impact of a recent lawsuit on trauma informed education

As a national expert on this issue, and with my professional roots in Maryland, I want to be a resource to you, local education agencies around the state, and my fellow educators in order to bring about the scaled implementation of trauma informed education.

Snapshot of ACEs/Trauma-Informed Statutes and Resolutions

(Compiled April 2017)

Statutes

Education Laws passed in Illinois, Massachusetts, Missouri, and Oregon

Illinois SB 565, Public Act 99-0927
Signed by Governor on January 20, 2017
Legislation to require social and emotional screenings for children as part of the their school entry examinations.
http://www.acesconnection.com/blog/illinois-governor-signs-law-to-include-social-emotional-screening-in-school-health-examinations

Massachusetts Safe and Supportive Schools No. 4376
Signed by the Governor August 13, 2014
https://traumasensitiveschools.org/wp-content/uploads/2015/11/MGL-Title-XII-Chap-69-Sec-1P.pdf
These provisions establish a statewide "safe and supportive schools framework" to assist schools to create safe and supportive learning environments "that improve educational outcomes for students."
http://acestoohigh.com/2014/08/13/massachusetts-safe-and-supportive-schools-provisions-signed-into-law-boosts-trauma-informed-school-movement/
Update on implementation of the law:
http://www.acesconnection.com/blog/massachusetts-implements-the-two-year-old-safe-and-supportive-schools-framework-law

Missouri Trauma-Informed Schools Initiative
Missouri Revised Statutes, Chapter 161,
Department of Elementary and Secondary Education, Sections 161.1050 & 161.1055.1
Missouri statute (2 sections)—Effective July 1, 2017
Section 161.1050.1 - Initiative established, department duties--definitions
http://www.moga.mo.gov/mostatu...tml/16100010501.html
Section 161.1055.1 - Pilot program established, selection of schools--fund created--definitions.
http://www.moga.mo.gov/mostatu...tml/16100010551.html
Bills as introduced (House bill Nos. 2565 & 2564)

http://www.house.mo.gov/billtracking/bills161/hlrbillspdf/6260H.02C.pdf

In 2016, Missouri enacted the "Trauma-Informed Schools Initiative" that requires the Department of Elementary and Secondary Education (DESE), in consultation with the Department of Mental Health and Department of Social Services, to provide information on the trauma-informed approach to all school districts, to offer training on the trauma-informed approach to all school districts, and create a website for schools and parents with information on the trauma-informed approach and a guide for schools to become trauma-informed.

The law's definition of trauma-informed approach says it "involved understanding and responding to the symptoms of chronic interpersonal trauma and traumatic stress across the lifespan." Other descriptors reflect the SAMHSA definition of trauma-informed.

The law also calls for a specific pilot program for five schools to receive intensive training in the trauma-informed approach. The legislature allocated $200,000 for implementation of the pilot but the Governor withheld the funds. The other directives to the DESE will be implemented using existing staff and volunteer resources. The website is under construction now but will be populated by the July deadline.

Oregon law to address "chronic absences of students" in the state's public schools

H.B. 4002 (Chapter 68)
Signed by Governor on March 29, 2016

The law requires two state education agencies to develop a statewide plan to address the problem and provides funding for "trauma-informed" approaches in schools.

https://acestoohigh.com/2016/04/03/oregon-governor-kate-brown-signs-landmark-trauma-informed-education-bill-into-law/

Preventing and Mitigating the Effects of ACEs in Washington State

Wash. Rev. Code § 70.305.005 et.seq.: (Finding- of Adverse Childhood Experiences Purpose/Definitions/Preventing and Mitigating the Effects of Adverse Childhood Experiences)

Washington State HB 1965
Enacted June 15, 2011
Click here to view legislative history.

The law established a statutory definition of adverse childhood experiences that is consistent with the ACE study and codified the state's commitment to addressing ACEs in state policy. It also sunsetted two organizations devoted to children and

families—Washington State Family Policy Council and the Council for Children and Families—and provided a framework for a private-public initiative to address ACEs.

Trauma-Informed Training in Arizona, Minnesota, and Texas

Ariz. Rev. Stat. § 8-471: **D.** The department, in coordination with the Arizona peace officer standards and training board, shall provide child welfare investigators with training. The training shall be, at a minimum, in the following areas:
7. Impact and intervention practices related to adverse childhood experiences, culturally and linguistically appropriate service delivery, domestic violence, family engagement, communication with special populations and trauma informed responses.

Ariz. Rev. Stat. § 8-802: **D.** All child safety workers shall be trained and demonstrate competency in: 3. Impact and intervention practices related to adverse childhood experiences, culturally and linguistically appropriate service delivery, domestic violence, family engagement, communication with special populations and trauma informed responses.

Minn. Stat. § 245.4889. Children's Mental Health Grants
(b) The following services are eligible for grants under this section:
(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive Web site to share information and strategies to promote resilience and prevent trauma;

Texas S.B. 1356, Juvenile Justice trauma-informed training
Statute
Signed by Governor 6/14/2013
Effective Sept. 1, 2013

Requires the juvenile justice department to provide trauma-informed care training for probation officers, juvenile supervision officers, and court-supervised community-based program personnel. The training "must provide knowledge, in line with best practices, of how to interact with juveniles who have experienced traumatic events."

Texas H.B. 2789 (https://legiscan.com/TX/text/HB2789/id/ 1160053)
Trauma-Informed Training for Employees
Passed 9/1/2015, 84th Legislature (2015-2016)
https://legiscan.com/TX/text/HB2789/id/%201160053
Statute
https://legiscan.com/TX/text/HB2789/id/1238251

Relating to trauma-informed care training for certain employees of state supported living centers and intermediate care facilities.
Law (Chapter 161 Human Resources Code) requires the Department of Aging and Disability Services to develop or adopt trauma-informed care training for employees who work directly with individuals with intellectual or developmental disabilities in living centers and intermediate care facilities.

ACEs in Healthcare in Oregon and Vermont

Or. Rev. Stat. § 414.629: (2) A community health improvement plan must be based on research, including research into adverse childhood experiences, and must identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan. The plan must also:
(a) Evaluate the adequacy of the existing school-based health resources including school-based health centers and school nurses to meet the specific pediatric and adolescent health care needs in the community;
(b) Make recommendations to improve the school-based health center and school nurse system, including the addition or improvement of electronic medical records and billing systems;
(c) Take into consideration whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;
(d) Improve the integration of all services provided to meet the needs of children, adolescents and families;
(e) Focus on primary care, behavioral health and oral health; and
(f) Address promotion of health and prevention and early intervention in the treatment of children and adolescents.

Chronology of ACEs-related legislation in Vermont 2014-15

In 2014, the Vermont legislature passed a bill to require the Blueprint for Health (a state-led health care program that includes practices providing healthcare to the majority of Vermonters) to do a study to address "whether, how, and to what extent" ACE-informed medical practice should be incorporated into Blueprint practices and community health teams. This study was based on legislation introduced by Dr. George Till (H. 762) that also included a provision to require Blueprint practices in the state to use the ACE questionnaire as a tool to assess health care. Only the study authorization was included in the final legislation (S. 596, Act 144, signed by Governor on May 27, 2014). The text of that law follows:

"On or before January 15, 2015, the Director of the Blueprint for Health and the Chair of the Green Mountain Care Board or their designees shall review evidence-based materials on the relationship between adverse childhood experiences (ACEs) and population health and recommend to the General Assembly whether, how, and at what

expense ACE-informed medical practice should be integrated into Blueprint practices and community health teams. The Director and the Chair or their designees shall also develop a methodology by which the Blueprint will evaluate emerging health care delivery quality initiatives to determine whether, how, and to what extent they should be integrated into the Blueprint for Health."

As the result of that legislation, a report, "Integrating ACE-Informed Practice into the Blueprint for Health," (http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/ACES-Report-Final-1-14-15.pdf) was issued in January 15, 2015.

In subsequent legislation (H. 481, signed by the Governor on June 5, 2015, Vt. Act 54 of 2015, in Section 56.), the legislature directed the Blueprint for Health to "work collaboratively to begin including family-centered approaches and adverse childhood experience screenings consistent with the report entitled "Integrating ACE-Informed Practice into the Blueprint for Health." Considerations should include prevention, early identification, and screening, as well as reducing the impact of adverse childhood experiences through trauma-informed treatment and suicide prevention initiatives." Here is the link to the Act (see page 67 of 71): http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT054/ACT054%20As%20Enacted.pdf

Timeline:
—Legislation (H. 762) introduced by Dr. Till in 2014; the legislature passed a bill that included a provision to require a study about ACE-informed medical practice, but not to require Blueprint practices in the state to use the ACE questionnaire as a tool to assess health care (Act 144, Sec. 16, p.11-12, signed May 27, 2014)

See two 2014 reports in ACEs Too High.com:
http://acestoohigh.com/2014/03/17/vermont-first-state-to-propose-bill-to-screen-for-aces-in-health-care/

http://acestoohigh.com/2014/05/26/vermont-legislator-hopes-to-transform-his-adverse-legislative-experience-ale/

ACEs in Home Visiting in New Mexico

N.M. Stat. § 32A-23B-2
http://www.acesconnection.com/clip/new-mexico-home-visiting-accountability-act-docx
As used in the Home Visiting Accountability Act:
D. "home visiting" means a program strategy that:
(1) delivers a variety of informational, educational, developmental, referral and other support services for eligible families who are expecting or who have children who have not yet entered kindergarten and that is designed to promote child well-being and prevent adverse childhood experiences;

Brighter Futures in Wisconsin

Wis. Stat. § 48.545

Brighter futures initiative(2) Awarding of grants. (a) From the appropriations under s. 20.437(1)(eg), (kb), and (nL), the department shall distribute $2,097,700 in each fiscal year to applying nonprofit corporations and public agencies operating in a county having a population of 750,000 or more, $1,171,800 in each fiscal year to applying county departments under s. 46.22, 46.23, 51.42, or 51.437 operating in counties other than a county having a population of 750,000 or more, and $55,000 in each fiscal year to Diverse and Resilient, Inc. to provide programs to accomplish all of the following:

1. Prevent and reduce the incidence of youth violence and other delinquent behavior.
2. Prevent and reduce the incidence of youth alcohol and other drug use and abuse.
3. Prevent and reduce the incidence of child abuse and neglect.
4. Prevent and reduce the incidence of nonmarital pregnancy and increase the use of abstinence as a method of preventing nonmarital pregnancy.
5. Increase adolescent self-sufficiency by encouraging high school graduation, vocational preparedness, improved social and other interpersonal skills and responsible decision making.(am) From the amounts allocated under par. (a), the department may distribute an amount determined by the department to a nonprofit corporation or public agency to provide a program that accomplishes all of the following:

1. Prevents and reduces the incidence of ***adverse early childhood experiences*** in children 8 years of age and under and reduces the effects of those experiences through behavioral health and other services.
2. Provides professional development, training, and research in serving children 8 years of age and under for practitioners serving those children.
3. Provides direct services for children 8 years of age and under.
4. Provides child care, including a special care nursery, for children 8 years of age and under that has achieved the top rating provided under the child care quality rating system under s. 48.659.
5. Provides early intervention services under s. 51.44, early childhood education services, in-home treatment services, family services, and outpatient occupational therapy, physical therapy, and speech therapy services for children 8 years of age and under.

Priority for Trauma-Informed Services provided by Child Protective Services in Florida

Chapter 2015-79, Committee Substitute for SB No. 7078
Enacted March 21, 2015

Florida Law to require community-based organizations that provide child protective services for the state to "give priority to the use of services that are evidence-based and trauma-informed."

Click here for the complete legislative history including staff analyses

Resolutions

Resolutions approved in California, Utah, Virginia, and Wisconsin
California ACR No. 155
Approved August 18, 2014

"This measure would urge the Governor to identify evidence-based solutions to reduce children's exposure to adverse childhood experiences, address the impacts of those experiences, and invest in preventive health care and mental health and wellness interventions."

http://acestoohigh.com/2014/08/21/ca-senate-unanimously-approves-aces-reduction-resolution/

Utah H.C.R. 10
https://le.utah.gov/%7E2017/bills/static/HCR010.html
Signed by the Governor March 22, 2017
A concurrent resolution to encourage state policy and programs to incorporate ACEs science to address "severe emotional trauma and other adverse childhood experiences" in children and adults and implement evidence-based interventions to increase resiliency.

https://acestoohigh.com/2017/04/02/utah-gov-gary-herbert-signs-resolution-to-encourage-state-policies-and-programs-based-on-aces-science/

Virginia
House Joint Resolution No. 653
http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+HJ653ER+pdf

Tracker: http://lis.virginia.gov/cgi-bin/legp604.exe?ses=171&typ=bil&val=HJ653&submit=GO

To commend Trauma-Informed Community Networks for their work to promote best practices, to address childhood trauma and toxic stress, and to become trauma-informed, resilient communities

Wisconsin Senate Joint Resolution 59
Report enrolled 1/17/2014

https://docs.legis.wisconsin.gov/2013/proposals/sjr59

"Resolved by the senate, the assembly concurring, That policy decisions enacted by the Wisconsin state legislature will acknowledge and take into account the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, early adversity, and buffering relationships, and note the role of early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing in human capital."

Helping Students Heal: Observations of Trauma-Informed Practices in the Schools

Lisa Weed Phifer & Robert Hull

School Mental Health
A Multidisciplinary Research and Practice Journal

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Number 1

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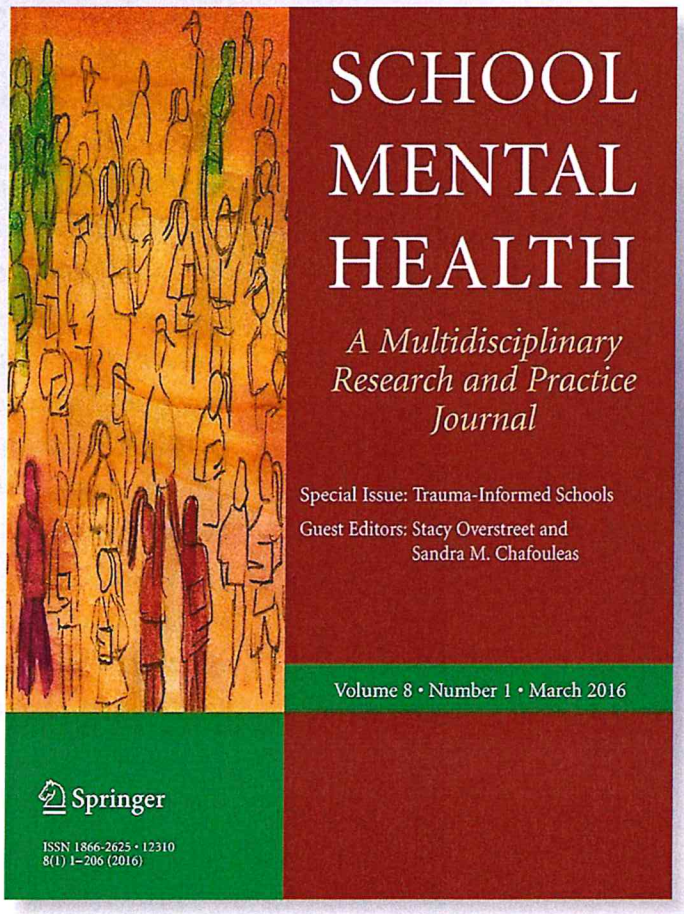
DOI 10.1007/s12310-016-9183-2



Springer

School Mental Health (2016) 8:201–205
DOI 10.1007/s12310-016-9183-2

ORIGINAL PAPER

Helping Students Heal: Observations of Trauma-Informed Practices in the Schools

Lisa Weed Phifer[1] · **Robert Hull**[1]

Published online: 10 February 2016

Abstract From the city streets of New Haven, Connecticut, the rural mountains of Appalachia, and the heart of San Francisco, students across the nation are coming to school with traumatic histories that are greatly impacting their school performance. Schools are recognizing the impact of trauma and beginning to adopt trauma-informed practices. When school systems approach students through a trauma lens, they are better equipped to provide the educational and social–emotional supports necessary to help students reach their potential. The following commentary reviews the implementation efforts of three different trauma-informed school programs and their use of the multitiered interventions to address the differing needs of trauma-exposed students. Implications for future directions are addressed, including the need for support for more intensive educator professional development.

Keywords Trauma-informed schools · Multitiered system delivery · Trauma · Behavior interventions · Collaborative practices · Mental health

Introduction

The promotion and provision of trauma-informed practices are at the highest levels ever. A recent court ruling in California has brought national attention to the role of schools in educating students experiencing trauma. In addition, the recently signed Every Student Succeeds Act (2015) acknowledges the importance of schools using "trauma informed practices that are evidence-based" (section 4108). Exposure to complex trauma can inhibit an individual's ability to learn, and such impairment may make students eligible for services in the school setting (Turner, 2015). The promotion of trauma-informed education is supported by the National Education Association, which recognizes the importance of trauma-informed practices and the need for approaching students' behaviors from a more constructive manner (Cevasco, Rossen, & Hull, n.d.). The movement in schools has been spearheaded by leaders such as Ron Hertel with the Compassionate Schools Initiative in Washington State, Susan Cole with the Massachusetts Advocates for Children and the Trauma and Learning Policy Initiative, Nic Dibble with the Wisconsin Department of Public Instruction, and Jennifer Sanders with the Ohio Department of Youth Services. These agencies have developed guidelines for best practices and have been implementing organizational change across school systems and juvenile justice education settings. With the publication of the case studies in this publication, schools and practitioners can move evidence-based examples of trauma-informed education into the mainstream of educational interventions.

This commentary is a reflection on three different attempts to implement trauma-informed practices within school settings. The case studies demonstrate the potential for trauma-informed practices to improve school outcomes for students whose poverty and other adverse events have led to chronic stress. The targeted outcomes go beyond symptom relief and attempt to build capacities within students and schools that lead to changes in otherwise intractable problems such as the achievement gap. While the sources of trauma or stress may differ across region, city, or street, the impact is just as great. From the urban streets of New Haven, CT, to rural Appalachia, and to the

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heart of San Francisco, students are coming to school with traumatic histories and are walking around wounded in their school environment. Including case studies from very different locales provides the ability for school districts to connect with these case studies and leads to a greater understanding of the different needs, implementation strategies, and outcomes that are prioritized. These case studies allow us to understand various approaches and learn about their potential effectiveness through preliminary evaluation data.

They also provide a framework for understanding the meaning of what success looks like in working with students impacted by trauma. Often the first symptoms of exposure to trauma are acting out behaviors and defiance due to the inability of traumatized students to regulate emotions and trust others. In the typical school setting, these types of behaviors lead to discipline that can be impact self-worth, lead to social isolation, and can be retraumatizing to students. When school systems approach students with a trauma lens, they are better equipped to provide educational and social–emotional supports needed to help students reach their potential and enter schools ready to learn.

The success of the programmatic efforts reported in these case studies lies in part with the expertise of the implementation teams in understanding the context of school-based interventions. The programs were formed within existing structures in the school and community and implemented through a tiered approach developed for all students. They recognized that professional development is the gateway to trauma-informed practice and emphasized that relationship building is the guiding principal in trauma-informed service delivery.

Trauma in Schools

One common theme in this section of the special issue is the impact of childhood trauma on a student's ability to be resilient and overcome adverse experiences. Trauma exposure encompasses uncomfortable emotional experiences paired with physiological and behavioral changes, which often occur over a prolonged period of time. Layne et al. (2009) developed a list of 7 potential trajectories following traumatic experiences, which included decline, stable maladaptive functioning, severe persisting distress, post-traumatic growth, protracted recovery, resilience, and stress resistance. Students experiencing a stable yet maladaptive response are surviving, not thriving; they encounter significant challenges to learning and developing. The complex interactions between individual and environmental factors shape the trajectories, and trauma-informed schools can be an important environmental factor in determining how these trajectories develop and transform over time. Therefore, the priorities of schools should be to create a safe learning climate, identify students in need of support, and provide interventions to avoid retraumatization. Schools can help strengthen student's ability to cope with the effects of trauma. The rich descriptions and preliminary data provided by the case studies in this issue demonstrate that the adoption of a trauma-informed approach can potentially impact the trajectory of emotional, behavioral, and social responses to trauma.

Trauma-Informed Approaches within a Multitiered System

Adopting a trauma-informed approach means creating shifts of thought at the organizational level, no small task. It is more than rewriting discipline policies or in-servicing educators on the symptoms of trauma among students. SAMSHA (2014) defines the trauma-informed approach as one that realizes the impact of trauma, recognizes the symptoms of trauma, and responds by integrating knowledge about trauma policies and practices and seeks to reduce retraumatization. Six key concepts that need to be addressed include safety, trust, peer support, collaboration, empowerment, and cultural, historical, and gender issues (SAMSHA, 2014). Not all individuals experience trauma in the same way, and thus, different students require different levels of intervention.

An emerging trend in trauma-informed approaches in school is the use of a multitiered service delivery model (Chafouleas, Johnson, Overstreet, & Santos, 2015; Lane et al., 2007; Sugai & Homer, 2006). Each of the studies in this article used a leveled approach to meet the differing needs of the students. Similar to what is already used in schools and the public health system, the tiered approach provides effective practices to all students and intensive support to those who need it.

The primary tier focuses on preventive measures including system-wide measures to promote a safe learning environment in all classrooms. This includes informing school staff about the signs and impact of trauma on learning, implementing social–emotional components within the curriculum, teaching students positive coping skills, engaging teaching practices, etc. Ongoing data monitoring allows for the identification of at-risk students who are in need of targeted small group interventions, also referred to as secondary interventions. These interventions focus on psycho-education about trauma, reinforcing social support systems, and strengthening self-regulation skills. Tertiary interventions are individualized to the needs to the students who are in need of more intensive support such as cognitive behavior therapy, wrap around support, or other community-based strategies (Chafouleas et al., 2015).

Dorado, Martinez, McArthur, and Leibovitz (2016) modeled the HEARTS program on Blaustein's (2013) Attachment, Self-Regulation and Competency (ARC)-tiered intervention framework, a research-based approach that has been used in creating trauma-informed schools. The first level of intervention referred to as attachment, focuses on creating a safe learning environment by setting routines and maintaining consistency, being attuned to the function of a student's behavior, and being attuned to caregiver affect regulation. The HEARTS program accomplished this by providing training to both staff and students to increase their knowledge of trauma-informed practices and how to remediate stress symptoms in the classroom. The program complimented pre-established practices such as Positive Behavior Interventions and Supports. The secondary level of intervention, self-regulation, focuses on preventative measures to help students and teachers manage emotional, psychological, and physiological responses. The HEARTS program identified at-risk students and provided small group interventions to reinforce skill building. Tertiary intervention targeted individuals and families that needed more intensive therapy based on the ARC model. Crisis support was provided for teachers with students in need, and families were involved in therapy provided in the school.

Perry and Daniels (2016) took a slightly different approach within the service delivery system. The primary professional development focused on both direct instructions to staff but also to entire classrooms. Students were explicitly taught how stress can impact behavior and how to advocate for their own needs. These skills were taught over a 3-day intensive session, but not incorporated within the schools' curriculum. Secondary and tertiary interventions were provided by a Care Coordination Team that involved collaboration between school faculty and mental health clinicians. The team identified students in need of additional support and designed plans of care to meet specific needs. Additionally, research-based interventions such as Cognitive Behavior Intervention for Trauma in Schools (CBITS) were offered to a small group of students who needed additional trauma-informed support. The case study was in the pilot year of implementation, making strong steps to introduce trauma-informed approaches within the school setting but recognizing the challenges with implementing systems-level change.

The third case study by Shamblin, Graham, and Bianco (2016) implemented the tiered approach for trauma-informed instruction but within an early education setting. Collaboration was crucial to the sustainability of this program given the rural area the schools were located in and the need for specialized mental health support to children and families. Similar to the other case studies, the program included a trauma-informed training component; additionally, a social–emotional curriculum was implemented. The unique focus on this study was on relationship building with the teachers. While initial training focused on trauma signs and symptoms, it also taught teachers strategies to build teams among faculty members as well as recognizing and addressing their own needs in response to trauma. Further, targeted classroom consultation focused on arming teachers with proactive strategies to reduce the occurrence of negative behaviors. Consultants worked in collaboration with teachers to create plans to address issues. The tertiary tier provided assessment and on-site mental health support to children and families. Trauma-Focused Cognitive Behavior Therapy and Parent–Child Interaction Therapy were used as intensive research-based interventions.

Whether it be rural or urban areas, it is often difficult to connect families with trauma-informed mental health services. Particularly for the participants in the Shamblin et al. (2016) case study, the rural residents were experiencing greater levels of poverty and mental health issues than national averages. The need for services was high; however, access to resources was limited due to factors like physical distance. Urban families also faced difficulties accessing services despite being physically closer to facilities. The scarcity of trauma-informed mental health supports for children puts students at-risk for future negative outcomes. Providing these services in schools helps connect with families and increases factors such as program completion and in return, helps build stronger students. Furthermore, trauma-informed approaches build or reestablish a relationship of trust between the school and families who have experienced adverse events.

Real-Life Applications

Individual case studies can illustrate how a trauma-informed system can lead to significant improvement for individual students and the entire system. For example, many school districts struggle with the number of students in highly restrictive settings due to emotional/behavioral conditions. Consider how the use of a trauma lens can lead to appropriate interventions in the least restrictive educational setting.

A middle school student, age 12, was an average student who demonstrated a rapid decline in his engagement in school and started to exhibit externalizing behaviors. The school's initial response to his behavior was a discipline approach, when that was found to be ineffective he was referred to the school psychologist for intervention. With the trauma-informed approach in mind, the school psychologist consulted with the student's family regarding his pattern of behavior and any potential exposure to adverse events. The family disclosed that the student had been dealing his mother's chronically abusive boyfriend and financial instability in the home. With this knowledge, his teachers and building administrators were

about the potential impact of stress stemming from family factors and consulted on how to approach the problematic behaviors taking into account the student's ongoing traumatic experiences. For example, it was advised that the student not be suspended for minor offenses rather provide a student an alternative place in the school to calm down and complete his work. A mentor was assigned to complete weekly check-ins and provide encouragement. Additionally, the school psychologist completed targeted counseling following cognitive behavior strategies providing the student psycho-education pertaining to stress and trauma, recognizing emotions and triggers, and relaxation techniques that could be implemented in the classroom. Within 6 months the student's maladaptive behaviors decreased and his engagement in school had returned to the level it was prior to the adverse events. In the past, this student would have been referred for a psychological assessment and given his symptom level, likely identified as a student with an emotional disability in need of special education services. The three case studies in this issue offer various models for schools to provide these kinds of supports to schools to engage in trauma-informed decision making when students are exhibiting increased levels of social and behavioral problems rather than resort to a discipline or disability approach adding a "distress" model for responding to externalizing behaviors.

Future Directions

While the studies in the issue provide compelling arguments in support of trauma-informed practices in schools, there are several issues that need to be addressed before jumping into the movement. Adopting a trauma-informed approach involves system-level changes across the entire school, which requires changing mindsets, policy, and classroom practices. Schools need to develop a comprehensive plan to identify the needs of the school system, review strategies for how to approach behavior issues, and garner available funding and time (and patience) for implementation. Professional development is needed to understand how trauma impacts the classroom and to mobilize ongoing support to help create and sustain change. Furthermore, schools must review their staffing limitations and, when necessary, seek out collaborative relationships with available mental health professionals to best meet the needs of the school.

Systems-Level Change

Systems-level change can be difficult, but it is certainly not impossible. Each of the case studies reviewed programs that took several years to establish. The HEARTS program (Dorado et al., 2016) was implemented for 5 years in one school, while the program described by Perry and Daniels (2016) was in the pilot year, focusing on relationship building among staff to produce system-wide change in future years. Instead of looking at time as a barrier, consider it an investment. How many times does a school system adopt a new curriculum or program only to move on to the next big thing? A comprehensive plan and timeline developed through a collaboration of teams such as educators, administration, school board, and school mental health providers can create better buy in, help set realistic time frames, and lead to better sustainability.

Professional Development Needs

Current teacher pre-service training programs do not consistently address the social–emotional health of students or trauma-informed instruction. Teachers are left to learn on the job how to approach challenging behaviors and are not always cognizant of how trauma may be impacting students. Commitment to calm, matter-of-fact response to challenging behaviors enables teachers to avoid retraumatizing students through the all too common overly reactive responses to student noncompliance that often lead to social seclusion and peer ridicule.

One of the important next steps in the trauma-informed schools movement is to develop more intensive and sustained professional development opportunities and to assess whether the professional development leads to changes in educator behavior and decision making. As several researchers have noted, teacher professional learning can be of the highest quality and yet fail to lead to significant changes in teaching practice (Johnson, 2006), or improvements in student learning (Fishman, Marx, Best, & Tal, 2003). According to Darling-Hammond, Wei, Andree, Richardson, and Orphanos (2009), student achievement increases when professional learning is sustained over time and directly related to and embedded in the daily practice of teachers. In addition, research demonstrates that engagement in collaborative professional learning results in better student outcomes (Darling-Hammond et al., 2009; Poekert, 2012).

Collaboration

A key element in establishing trauma-informed practices is collaborating with school-based mental health professionals (i.e., school psychologists, school counselors, and social workers), universities, health systems, and/or community mental health agencies. All three case studies partnered with universities and mental health programs existing within the community (New Haven Coalition University of California, San Francisco, and the Partnerships Program for

Early Childhood Mental Health and Project Launch). Schools benefit from additional resources provided by master's level clinicians used as part of mental health initiatives. Better still is staffing with school-based professionals such as counselors, school psychologists, and school social workers in sufficient number to assist with delivery of multiple tiers of these needed interventions.

The case studies in this issue evaluated programs that aimed to support students who have a high probability of exposure to traumatic experiences. Although poverty is highly associated with trauma, there are other populations of students who also have a high probability of being exposed to trauma. We need to recognize that institutions that provide education to incarcerated juveniles probably have the highest number of traumatized students. These students typically receive minimal educational supports but have the most need. Other groups of students with a high trauma load include immigrants and refugee populations who have fled war torn countries and may have impaired abilities to assimilate and engage in school.

Conclusion

The three case studies showcased in this issue are strong examples of what it takes to move toward a trauma-informed educational system. It takes community partnerships, alignment with school goals, and the implementation of evidence-based interventions using qualified support staff. It also involves expanding the outcome measures of field research beyond symptom relief to examine how these practices can help close the achievement gap, support social–emotional health, and promote a positive school climate. Interventions need to be tiered and include a universal design to address the needs of all students, including those who have a trauma history, those who have a high probability of being exposed to trauma, and those who may experience vicarious trauma through family members with trauma histories. In order to establish a multitiered service delivery system, schools need (1) professional development for all school staff, students, and families, (2) provision of expert consultative services, and (3) direct clinical supports using evidence-based interventions.

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Compliance with Ethical Standards

Conflict of interest Lisa Weed Phifer declares that she has no conflict of interest. Robert Hull declares that he has no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

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B2: The Potential Impact of Trauma on Special Education Policies

Presented by: Robert Hull, M.A.Ed., Ed.S., M.H.S.

Monday, April 24, 2017
10:15 a.m. - 11:30 a.m.

Objectives

- Review recent updates on Compton, Calif., class-action lawsuit concerning trauma-related interventions for students
- Review current efforts in trauma-informed education
- Review evidence for impact of trauma-informed education on educational outcomes

P.P. v. Compton Unified Sch. Dist., 66 IDELR 121 (C.D. Cal. 2015)

The Court simply acknowledges the *allegations* that exposure to traumatic events *might* cause physical or mental impairments that *could* be cognizable as disabilities under the two acts. In other words, the District Court has determined that, for purposes of surviving a motion to dismiss, the allegations in the complaint suffice for now.

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Compton Unified School District

- One of the most socioeconomically distressed cities in southern California
- Experiences high rates of violent crime
- Complaint posits that trauma stems from multiple causes, including exposure to adverse childhood events associated with poverty and violent crime

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Plaintiffs and Class Members

- Mentions each individual student
- Lists the multiple exposures to adverse childhood events of a chronic nature
- States that these events have caused neurobiological effects, which have impacted
  - Learning
  - Thinking
  - Reading
  - Concentrating

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Plaintiffs Request that Compton Have Trauma-Sensitive Schools

- Training educators to recognize, understand, and proactively address the effects of complex trauma, in part through building students' self-regulation and social-emotional learning skills
- Developing restorative practices to build healthy relationships and resolve conflicts peacefully and avoid re-traumatizing students through the use of punitive discipline
- Ensuring consistent mental-health support is available to appropriately meet student needs

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Lawsuit Claim

Plaintiffs contend that defendants "have ignored and affirmatively breached their responsibility to accommodate students whose access to education is fundamentally impaired by reason of the trauma they have endured;" rather, defendants are alleged to have "subject[ed] trauma-impacted students to punitive and counter-productive suspensions, expulsions, involuntary transfers, and referrals to law enforcement that push them out of school, off the path to graduation, and into the criminal justice system."

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Violation of the ADA and Section 504

Section 504 provides, in relevant part: "No otherwise qualified individual with a disability ... shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. ..." 29 U.S.C. § 794(a).

Similarly, Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

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DSM-5 and Trauma-Related Disability

- Criterion A2 (response involves "fear, helplessness, or horror") removed from DSM-5.
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties. This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.
- Preschool Subtype: 6 Years or Younger.

www.istss.org/ISTSS_Main/media/Webinar_Recordings/RECFREE01/slides.pdf.

DSM-5 vs. the IDEA: Trauma-Related Disorder

Compton Unified

- Only amounts to "environmental, cultural, and economic disadvantages not considered a physical or mental impairment"
- Complaint is not a "mental disorder" because it "amounts to nothing more than expected, culturally approved responses to a 'common stressor or loss, such as the death of a loved one."

Advocacy Lawyers

- Plaintiffs further posit that "[t]he fact that a disability is caused by an external factor — and is not congenital or hereditary — does not make the impairment itself 'environmental'"
- Specifically, plaintiffs discuss the complaint's allegations that "complex trauma results in physiological impairments affecting the 'neurological' and 'endocrine' systems"

DSM-5 vs. the IDEA: Trauma-Related Disorder

"In light of such allegations, the Court concludes that Plaintiffs have adequately alleged, at least, that complex trauma can result in neurobiological effects constituting a physical impairment for purposes of the acts."

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Substantially Limits Life Activities

- The ADA includes "learning, reading, concentrating, thinking, [and] communicating."
- The court concludes that the complaint alleges sufficient facts regarding the consequences of complex trauma with respect to "major life activities" to survive a motion to dismiss.

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Substantially Limits Life Activities

- **Symptom list noted in court**
  - Flashbacks
  - Uncontrollable Anger
  - Problems with Concentration
  - Problems with Recall
  - Intrusive thoughts
- **"Student Plaintiffs have experienced particular limitations in their abilities to perform tasks such as learning, reading, concentrating, thinking, and communicating — limitations which are alleged to be causally related to the trauma"**

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Assessment Devices

- Flashbacks
  - What assessment measures are available?
- Uncontrollable Anger
  - Hostility, anger, and anger expression assessments
- Problems with Concentration
- Problems with Recall
  - Available, similar to ADHD, executive functioning
- Intrusive thoughts
  - What is available?

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Potential Trajectories of Trauma Response

- Post-traumatic growth
- Stress resistance
- Protracted recovery
- Temporary resilience
- Severe persisting distress
- ***Stable maladaptive functioning***
- Decline in functioning

Source: Layne, C. M., et. al (2009). Promoting "resilient" posttraumatic adjustment in childhood and beyond. "Unpacking" life events, adjustment trajectories, resources, and interventions. In Brom, D., et. al. *Treating Traumatized children. Risk, Resilience, and Recovery* (pp.32–33). Routledge.

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Limited Availability of Positive Outcome Assessment Devices

- **Post-Traumatic Growth Inventory**
- **Resiliency**
  - Limited to no formal measures
- **Pro-social thoughts, emotions, and behaviors**
  - Limited to no formal measures
- **Emotional Intelligence**
  - Multiple measures of variable validity

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Assessment Devices

- **Dissociative Experiences Scale**
  - Assesses most symptoms listed on the complaint
  - https://secure.ce-credit.com/articles/102019/Session_2_Provided-Articles-1of2.pdf
- **Anger Regulation and Expression Scale**
  - http://journals.sagepub.com/doi/pdf/10.1177/0734282912447762
- **Resilience**
  - What assessment measures are available?
- **Post-Traumatic Growth**
  - https://ptgi.uncc.edu/wp-content/uploads/sites/9/2015/01/A-short-form-of-the-Posttraumatic-Growth-Inventory.pdf

Short Form of Post-Traumatic Growth Inventory

- **Answer these questions in relationship to a highly stressful event in the last two years**
- **Rate the event severity on a 1-5 level; 1 is not stressful, 5 is extremely severe**
- **Rate each question on a 1-5 scale**

Short Form of Post-Traumatic Growth Inventory

- I changed my priorities about what is important in life
- I have a greater appreciation of the value of my own life
- I am able to do better things with my life
- I have a better understanding of spiritual matters
- I have a greater sense of closeness with others
- I established a new path for my life
- I know better that I can handle difficulties
- I have a stronger religious faith
- I discovered that I'm stronger than I thought I was
- I learned a great deal about how wonderful people are

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"Denied Meaningful Access"

- In the *Compton* case, "[t]he Court is satisfied that the Complaint alleges how the Student Plaintiffs have been denied meaningful access to CUSD's program as a result of their trauma-induced disabilities, as required for a violation of Section 504."
- "Further, it is clear from the allegations in the Complaint that, to the extent it is required, Plaintiffs are asserting that the educational services provided by CUSD do not and are not designed to meet the needs of students with trauma-induced disabilities as adequately as the needs of students without these disabilities."

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Trauma-Sensitive Schools

- Training educators to recognize, understand, and proactively recognize and address the effects of complex trauma, in part through building students' self-regulation and social-emotional learning skills
- Developing restorative practices to build healthy relationships, resolve conflicts peacefully, and avoid re-traumatizing students through the use of punitive discipline
- Ensuring consistent mental health support is available to appropriately meet student needs

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Current Available, Vetted Attempts at Meeting Expectations of Lawsuit

- Efforts developed by state departments of education
  - Washington State materials
  - Wisconsin Department of Public Instruction materials
- Public access clinical materials
  - TF-CBT materials Medical University of South Carolina
- Internal efforts by public agencies or non-profits
  - Prince Georges County Public Schools
  - Ohio Department of Youth Services
  - PESI

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Results of Three Field Trials

- **San Francisco**
  - Hearts Program. See video at https://drive.google.com/file/d/0B0A-6niGhKfLLVBQODN3MF9ka3c/view.
- **Connecticut**
  - Perry, D., & Daniels, M. (2016). Implementing trauma-informed practices in the school setting: A pilot study. ***School Mental Health***.
- **Ohio**
  - Shamblin, S., Graham, D., & Bianco, J. (2016). Creating traumainformed schools for rural Appalachia: The partnerships program for enhancing resiliency, confidence, and workforce development in early childhood education. ***School Mental Health.***

See: http://link.springer.com/article/10.1007/s12310-016-9183-2

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Aspects of Interventions

- **Focus on professional development for all staff**
- **Provide evidence of trauma-informed practices on educational outcomes**
- **Utilize a whole-school approach with a three-tiered system**
- **Adapt clinical approaches into educational practices**
- **Utilize a partnership between outside agencies and school-based services**

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Content vs. Delivery Mechanism

- Content is available and for the most part is free
- Hard to customize in order to focus on system-level data
- Comprehensive but to some degree scattered
- Not aligned with state requirements to use as recertification credits for staff
- Provided in a face-to-face format

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Current Suggestions

- Adapt trauma-oriented professional development to all educators
- Create a professional development plan that is comprehensive
- Assess local data before choosing professional development
- Develop a delivery mechanism that is workable
- Move to local sustainability
- Provide recertification credit for professional development

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