Implementing Trauma-Informed Approaches in New Orleans Schools:

A Toolkit

COALITION FOR COMPASSIONATE SCHOOLS

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About the Toolkit

This guide is designed to serve as an informational resource for schools to implement, sustain, and continue to improve the delivery of trauma-focused services.

COALITION FOR COMPASSIONATE SCHOOLS

The Coalition for Compassionate Schools (formerly the New Orleans' Trauma-Informed Schools Learning Collaborative) consists of representatives from the New Orleans Health Department, Children's Bureau of New Orleans, The Institute of Women & Ethnic Studies, Louisiana Public Health Institute, Mercy Family Center's Project Fleur-de-lis, NOLA Public Schools, and Tulane University.

Learn more about the history of the Coalition for Compassionate Schools.

Funders

Our work has been supported by several local and federal funders, listed here. We are deeply grateful to our funders and partners for their contributions, all of which were essential in making the creation of this toolkit possible.

> *In New Orleans and other urban areas, children are regularly exposed to trauma, and it's important to have all adults in the school understand the educational implications of such exposure.*

Dr. Stacy Overstreet, Tulane University

Background

A study on adverse childhood experiences conducted by The National Survey of Children's Health (NSCH) reports that nearly half the nation's children have experienced at least one or more types of serious childhood trauma. Experts further assert that negative responses to these traumatic events can impact a child's physical and mental health, as well as interfere with their ability to learn (Massachusetts Advocates for Children et. al).

Acknowledging the high prevalence and potential exposure to violent crime, familial incarceration, and natural disasters in the Greater New Orleans area, the City of New Orleans and its partners routinely mobilize resources to support schools in the immediate aftermath of public-facing traumatic events. However, these efforts have generally fallen short of transforming day-to-day practice in schools, many of which remain insensitive to the needs of traumatized students.

In response, the New Orleans' Trauma-Informed Schools Learning Collaborative, recently renamed the Coalition for Compassionate Schools (TISLC) was formed to help build the capacity of project partner schools to more effectively address the needs of students affected by traumatic events. Learn more about the history of the Coalition for Compassionate Schools.

The Context

Defining Trauma

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed a conceptual framework for trauma-informed approaches. The following are included in SAMHSA's definition of trauma:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening, and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Three "E's" of Trauma

1. Trauma **event(s)** include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events may occur once or repeatedly over time.
2. An individual's **experience of the event(s)** helps to determine whether it is identified as a traumatic event. A particular event may be experientially traumatizing for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic.
    - Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. How the event is experienced may be linked to a range of factors including the individual's cultural beliefs, availability of social supports, or the developmental stage of the individual.
3. Trauma can have long-lasting adverse **effect(s)**, which may present immediately or may have a delayed onset. The duration of the effects can range from short to long term. The individual may not always recognize the connection between the traumatic event and its effects.
    - Examples of adverse effects include: an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions.

- Adverse effects may also be attributed to neurobiological and environmental factors. Traumatic effects, which may range from hypervigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

The National Child Traumatic Stress Network (NCTSN) provides a list of potentially traumatic events in their Educators' Toolkit. The list includes:

- Physical or sexual abuse
- Abandonment
- Neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., shootings, stabbings, robbery, or fighting at home, in the neighborhood, or at school)
- Witnessing police activity or having a close relative incarcerated
- Life-threatening natural disasters
- Acts or threats of terrorism (viewed in person or on television)
- Living in chronically chaotic environments in which housing and financial resources are not consistently available

How Trauma Affects School-Aged Children

Adverse Childhood Experiences

- Trauma-informed care and its research history is tightly intertwined with the foundational publication of the Adverse Childhood Experiences (ACEs) Study (Felitti et al., 1998).
- Kaiser Permanente and the Center for Disease Control and Prevention (CDC) conducted this study investigating ACEs and the effects of individuals' exposure to trauma in childhood on their future health and well-being.
- According to the CDC, ACEs have been linked to an increased risk for a wide range of health problems such as risky health behaviors, chronic health conditions, low life potential, and early death.
- ACEs refer to traumatic stressors experienced before the age of 18, such as childhood abuse, neglect, and exposure to violence. The ACEs study and its expansions and replications define ACEs in the following ways:
  - Abuse
    - Emotional abuse
    - Physical abuse
    - Sexual abuse
  - Household Challenges
    - Mother treated violently
    - Household substance abuse
    - Mental illness in household
    - Parental separation or divorce
    - Criminal household member
  - Neglect
    - Emotional neglect
    - Physical neglect

- The results of the ACEs Study were monumental, with data showing that over half of the participants had experienced one or more ACEs which was much higher than was commonly thought at the time.

- Further, it has been revealed by more recent research that the actual number of individuals experiencing ACEs is higher than the ACEs study found, especially considering the increased risk for ACEs that marginalized populations face that was not accounted for in the original sample. Vulnerable populations like racial minorities, low-income individuals, and those struggling with mental illness, substance abuse, and involvement with child welfare systems face a greater likelihood to have at least one ACE as well as being more likely to experience multiple ACEs.
- Of significant importance, the ACEs study identified the relationship between exposure to ACEs and long-term physical, mental, and social consequences. These include increased risk for chronic diseases (cancer, heart disease, COPD), mental illness, substance abuse, and academic issues such as poor attendance, poor academic and cognitive performance, behavioral problems, and not completing high school.
- The effects of ACEs build upon each other over time, impairing children's developing processes by causing dysfunction in the nervous system and thus creating barriers to healthy development.
- Calculate your ACE score.

Signs of Trauma

- Responses to traumatic events vary from child to child. What can be traumatic for one child does not necessarily cause the same response in another.
- Signs of a traumatic response include but are not limited to:
  - Withdrawal from others or previously enjoyed activities
  - Excessive worrying about the safety of self or others
  - Inability to follow or deliberate breaking of rules
  - Physical symptoms, such as chronic headache, upset stomach, nausea or diarrhea
  - Difficulty focusing on learning materials or inability to retain new information
  - Sudden changes in friendships or relationships
  - Depression, self-harm, and suicidal ideation
  - Anger, violent outbursts, and homicidal ideation
  - Engaging in risky behavior
  - Using drugs or alcohol

Effects of Trauma

It is not difficult to imagine that a child who was physically or sexually abused the night before arriving in his/her classroom on a Monday morning might show clear signs of distress or solicit the support of safe adults in the school setting. What is surprising to many educators is what that distress looks like in a typical child. While some children may present as tearful and tell an adult what occurred, the more likely scenario is that a child does not disclose the traumatic event and the emotional distress that they experience manifests in their behavioral presentation, affecting their academic performance and relationships with peers and staff at the school. Research has documented the impact of traumatic experiences on emotion, behavior and academic performance (Overstreet & Mathews, 2011; Perfect et al., 2016). The efforts of the Coalition for Compassionate Schools are to build bridges between the research and practitioners. Because reactions are so varied, it is impossible to detail with the full range of potential responses in a summary document. However, this toolkit provides numerous resources that help to translate a growing body of social, educational, and neurobiological research to meet the needs of direct service practitioners, policy makers, and classroom teachers.

Many of the training resources for educators include an overview of development and a basic review of the biological basis for the body's stress response system housed in the limbic-hypothylamic-pituitary-adrenal (LHPA) axis in the brain. The biological basis for a child's response to trauma is linked to the activation of this system and the brain's ability to regulate that response and bring the body back to baseline once the perceived threat has subsided. For children growing up in homes or communities where chronic exposure to violence is a reality, the brain is managing the demanding task of development alongside chronic activation of the LHPA axis, which is a taxing and often damaging load. Unsurprisingly, the impact is seen across multiple domains of development and functioning that are especially relevant for educators, such as a child's emotional and mental health, behavior, and academic performance. As schools increase their understanding of trauma and its impact, they are better able to identify opportunities for increased social emotional learning, rework overly-punitive or zero-tolerance disciplinary policies, and enhance access to clinical services that bolster support for students who have experienced a traumatic event.

Emotional/Mental Health

Not all children exposed to a traumatic event develop a diagnosable mental health condition. While the research literature ranges widely on prevalence rates of mental health diagnoses following trauma exposure, the lifetime rates center around 10% for girls and 6% for boys (Copeland et al., 2007), with rates increasing for children with multiple trauma exposures and those with a history of interpersonal violence and sexual abuse (Finkelhor et al., 2007). Even without a diagnosable condition, children exposed to trauma may demonstrate a marked change in mood and mental health functioning. These symptoms may include increased sadness, withdrawal, or emotional numbing. Students may also show elevated levels of worry. For adolescents, in particular, depression symptoms also include increased irritability and disruptions in sleep and appetite. In a school setting where teachers interact with dozens to hundreds of students in a day, changes in emotional presentation or increased irritability may go unnoticed, unless the problems rise to the level of affecting academic performance or social relationships in such a way that it disrupts the educational environment.

Behavior

Trauma exposure is also linked with externalizing behaviors such as defiance, oppositionality, delinquency, aggression, and hyperactivity. These behaviors have been observed in students exposed to a range of different types of trauma exposure including natural disasters (Overstreet, 2011), direct and indirect violence exposure (Lamers-Winkelman et al., 2012), and sexual abuse, (Daignault & Hébert, 2009). In younger children these behaviors may look slightly different, with teachers and caregivers often reporting prolonged tantrums that require an extended period of time, or intensive staff or caregiver resources to calm children down. Behavioral symptoms are better understood by looking at the brain science associated with trauma exposure. For example, students exposed to trauma often experience hyperarousal and are reactive to environmental triggers that may remind them of a traumatic experience. Negative feedback from authority figures in the environment often exacerbate the behavioral response rather than help de-escalate it.

Educational Outcomes

Unsurprisingly, both internalizing and externalizing problems associated with trauma exposure underlie trauma's impact on educational outcomes. The research literature has documented a correlation between cognitive functions associated with academic performance such as attention, memory, and verbal and quantitative abilities (Finzi-Dottan et al., 2006). It also shows links with decreased attendance with increased incidents of suspension and expulsions for trauma-exposed youth (Ramirez et al., 2012). The theoretical underpinnings of this body of work asserts that a brain in "survival mode" is allocating resources to scan the environment for danger and not focused on typical tasks of development necessary for learning.

The Impact of Trauma

- Up to 34% of American youth are estimated to have experienced at least one traumatic event, and 75-93% of youth in the juvenile justice system have experienced some level of trauma (Adams, 2010).
- A study of children aged 6-12 reported that 85% had seen someone beaten up, 40% someone shot, and 31% reported having seen a dead body.
- Preliminary research in schools suggests that at least a third of students are experiencing symptoms of depression and PTSD.
- A study of youth living in a low-income urban environment found that just 3% with no ACEs displayed a learning or behavior problem, compared to 20.7% of youth with one to three ACEs and 51.2% of youth with four or more ACEs. For each additional type of ACE reported, the risk of violence perpetration increased from 35% to 144% (Burke et al., 2011).
- Children who are exposed to more violence and victimization are more likely to become engaged in delinquency, such as drug use, theft, or truancy.
- **Cultural Context:** For children in New Orleans, this may include exposure to neighborhood violence, bullying, abuse, involvement in the juvenile justice system, or natural disaster.

Countless resources document the negative impact of trauma on the development of children. The range of impact spans short-term adjustment to long-term health outcomes, including early mortality. Given estimates that a quarter to two-thirds of children are exposed to a traumatic event before the age of 16 (Copeland et al., 2007), it is imperative that educators understand what trauma is, it's impact on the youth they serve, and how to foster learning environments that do not cause further harm; rather, ideally promote healing and build resilience.

This resource does not attempt to fully summarize decades of research on trauma exposure in youth and the role of schools in responding, but rather provides an overview of potential resources that may aid schools in tailoring information for their own settings.

Context Matters

The tools in this toolkit were developed for schools in New Orleans, an urban educational environment with several unique features such as being composed primarily of charter schools. Students in New Orleans have an elevated risk for trauma exposure, particularly community violence (IWES, 2015), and many students and their families have been impacted by weather-related disasters such as hurricanes, tornadoes, and flooding.

Additionally, issues of race and equity have played a major focus in our collaborative's understanding of trauma. Racism serves as a source of trauma for many youth in the New Orleans school system. Racism also plays a significant role in maintaining and/or exacerbating symptoms related to other types of trauma exposure. For schools, it is particularly important to understand the role of race as it relates to their understanding of trauma-informed systems of care. Ethnic minority youth living in impoverished urban communities are at a higher risk of experiencing many types of trauma exposure (Neiman & DeVoe, 2009) and data shows schools respond more punitively (e.g., suspension or expulsion) to minority youth than their non-minority peers. It is essential that when schools are learning about trauma and its impact, issues of race and equity are embedded throughout the discussion, as they are essential components of a trauma-informed system of care.

Interplay of Racial Equity and Trauma

Childhood trauma combined with the dysregulation of the biologic stress systems can adversely impact brain development in children (De Bellis, 2001). Meta-analysis of several studies strongly suggest that childhood trauma negatively impacts emotional and behavioral regulation, and motivation (De Bellis, 2001). Such impairment ultimately can result in poor academic performance. Compounding the traumas for youth of color, the educational system itself can be a source of inequity and injustice.

A 2014 report from the US Department of Education's Office of Civil Rights found significant racial disparities in the educational system – that youth of color have disproportionately lower access to preschool, higher rates of suspension from preschool onward, and limited access to advanced classes and college counselors as compared to their white counterparts (US Dept. of Education, 2014).

Given the structural inequities that plague inner-city youth, the majority of whom are black or brown, the Philadelphia ACES' study went beyond the conventional ACEs questionnaire and added five community level traumas that contribute to ACE's in children: witnessing violence, experiencing racism / discrimination, living in an unsafe neighborhood, experiencing bullying, living in foster care (Cronholm et al., 2015). A study of an urban pediatric population in San Francisco, the majority of whom were children of color, found that exposure to four or greater ACE categories was associated with increased risk for learning/behavior problems (Burke et al., 2011).

The trauma of racism has been noted to result in increased vigilance and suspicion, increased sensitivity to threat, sense of a foreshortened future, and more maladaptive responses to stress such as aggression or substance use (Comas-Diaz, 2016), all of which impact mental and cognitive well-being. This has been noted to be particularly true for youth in low-income urban communities where there is an increased risk for community violence and victimization (Wade et al., 2014).

Local data collected by the Institute of Women and Ethnic Studies (IWES) supports many of these observations. IWES has screened over 6000 youth in New Orleans since 2012, a majority (95%) of whom are African American. The data shows that these young people endorse post-traumatic stress disorder symptoms and depression at three times the national rate; 38% have experienced domestic violence; 54% have experienced the murder of someone close; 18% have witnessed someone being killed; and over 33 percent worry that they are not loved, appreciated or valued. This local data is very troubling as it further shows that high levels of youth exposure to domestic and community violence is highly correlated to experiencing symptoms of post-traumatic stress disorder and depression (Institute of Women and Ethnic Studies, 2015).

Indeed, in their 2016 position paper, the National Child Traumatic Stress Network stated:

It is clear that interventions to serve children and families in the United States in the 21st century must incorporate the current historical context in which they live. In spite of progress, the legacy of slavery has been carried forward in many areas of American society, including the racially related injustices that persist, such as mass incarceration, and the lethal violence directed disproportionately towards African Americans. As such, the impact of the unresolved historical trauma of slavery on intergenerational trauma and community trauma should be addressed within a child services framework.

In conclusion, childhood trauma has been described as 'an environmentally-induced complex development disorder' (De Bellis, 2001). One therefore cannot approach trauma in youth of color at the individual level solely. Applying a social ecological framework to address the compounding and catalytic impact of historical trauma, and ongoing structural violence with the resultant community trauma is a must.

Due in part to the reauthorization of the Elementary and Secondary Education Act (currently, Every Student Succeeds Act), which requires provisions for trauma-informed approaches in student support, academic enrichment, and in the training school personnel, trauma-informed care has become a national movement (Prewitt, 2016). Currently, trauma-informed schools exist in 36 states.

A trauma-informed school is a school in which SAMHSA's guiding principles for trauma-informed care provide the foundation for creating an inclusive learning community. In a trauma-informed school, faculty, staff, and administrators understand that, in addition to demographic diversity, students with traumatic experiences may have acute, chronic, or multigenerational exposure to trauma. More specifically, in a school that is trauma-informed, stakeholders (SAMHSA, 2014):

1. ***Realize*** the prevalence and impact of trauma.
2. ***Recognize*** signs of trauma and the need for learning supports.
3. ***Respond to avoid re-traumatization*** by integrating principles of trauma-informed care into classroom practices, while also responding to caregivers' needs for self-care.

A critical component of educators' work in trauma-informed care involves the ability to understand the unique experiences and perspectives of each child with whom educators work (Beloved Community, 2018; see Appendix A). To be effective within trauma-informed schools, educational stakeholders must work together and understand how they can best support each other in meeting children's needs. A racial equity lens is an essential part of implementing trauma-informed services within schools. It is important to consider how African American and Latinx youth, particularly those living in urban areas, disproportionately experience childhood trauma (Safe Schools NOLA, 2017). Systems of oppression such as structural racism and intergenerational poverty compound African American and Latinx youths' experiences with childhood trauma.

Research shows that in the United States, 1 in 8 impoverished children, and 1 in 9 African American children have an incarcerated parent (Eversley, 2015). Likewise, in 2015, unarmed Black people were killed by police at a rate of five times that of unarmed White people. Finally, the Department of Education's Office of Civil Rights indicates that starting in preschool, Black children are suspended at significantly higher rates than their White counterparts. While such disparities are often not the outcome of malicious intent on behalf of teachers or administrators, they do call into question the role that institutionalized racism and implicit bias play in perpetuating community-level trauma in schools (Mapping Police Violence, 2015).

Becoming more self-aware and reflective about one's identity and one's own implicit bias is a necessary first step to engaging in trauma-informed care for racial equity (Weir, 2016). To understand the role that adverse community experiences have on youth of color, educators, administrators, and school personnel must become more self-aware of how their identities influence their experiences in the world and their perceptions of others, and inform the ways they engage with and make decisions about others.

Trauma-Informed Approaches for Schools

Trauma-informed schools use a universal approach to meet the needs of trauma-exposed youth—and to create a safe and supportive school culture and learning environment for all students. This framework offers effective practices, interventions, and systems-change strategies.

A trauma-informed school also addresses the needs of the adults in the building and helps foster self-care to avoid secondary traumatic stress. The environments that we create in our classrooms and throughout the school play a significant role in preventing re-traumatization and allowing children who have experienced trauma to heal.

Trauma-Informed Approaches in Schools:

- Foster academic, social, and emotional learning and growth. They are safe, predictable, and consistent places for children and youth.
- Built on the understanding of the prevalence and impact of trauma on children's development and school functioning.
- Acknowledge the diversity of student responses to trauma.
- Provide a continuum of evidence-based services designed to effectively identify and manage the mental health needs of students impacted by trauma, increase school safety, and prevent future trauma.
- Important for all school staff, not just counselors and social workers. Trauma-sensitive approaches can help students with trauma in many ways including:
- Train personnel to recognize signs and symptoms of trauma in order to provide effective interventions and responses.
- Linkage to appropriate services, such as mental health treatment or counseling.
- Create a school environment in which students are comfortable sharing their experiences.
- Decrease discipline and unnecessary suspensions or expulsions.
- Support families experiencing a traumatic event.
- Foster a predictable educational environment to provide consistency during a time of change.
- Provide modifications to accommodate a child's reaction to trauma without negatively impacting their education.

How Does It Work?

A trauma-informed school is based on the six key principles of trauma-informed care developed by the Substance Abuse and Mental Health Services Administration (SAMSHA) over 20 years and modified to meet the unique needs of schools:

- Safety
- Trustworthiness and transparency

- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

For a school to be truly trauma-informed, the use of these six principles must not only guide the behavior of teachers in a classroom setting, but also be evident in the policies and procedures that guide the decisions made at every level. This approach and trauma-specific interventions are designed to address the consequences of trauma in the individual and to facilitate healing.

1. The foundation of a trauma-informed school is **cultural humility**. Cultural humility is a commitment to and active engagement in a lifelong process of learning, self-reflection and self-critique. To have cultural humility requires that you are open to learning and recognizing the importance and consequences of the cultural, historical, racial and gender issues of yourself and the students and families you work with. Exploring implicit biases and issues around privilege and oppression is an integral part of this work. It is essential to practice cultural humility in order to realize the prevalence of trauma in a community, particularly community traumas of institutional racism and oppression and to respond in a manner that allows students to avoid re-traumatization and heal.
2. Built upon this foundation of cultural humility, the core components of a trauma-informed school are **safety, trustworthiness and transparency**. A sense of psychological safety and trust in the adults at the school, allows students to calm their survival brain and actively engage in learning. Research shows relationships and physical and emotional regulation are necessary to provide safe and supportive environments in trauma-informed schools that emphasize these components.
3. To create strong relationships between adults and youth and cultivate meaningful peer relationships among the students in the school, a trauma-informed school utilizes the principles and practices of **collaboration and mutuality, empowerment, voice and choice and peer support**. These principles are also used to build emotional and physical self-regulation.

Implementation

Strategy

Preparation

- Discuss trauma-informed approaches with school leaders.
- Identify an implementation team including school leaders, teachers, and mental and behavioral health staff.
- Look at available funding for programmatic costs.
- Gather school data reports for use as comparison data to assess implementation success.
- Contact the Coalition for Compassionate Schools for further assistance (see Appendix for Important Contacts).

Elements of School Involvement

- School Leadership
- Professional Development
- Access to Resources and Services
- Academic and Nonacademic Strategies
- Policies and Protocols
- Collaboration with Families

Stages of Implementation

Exploration

- Identify the need for change with assessment of needs, fit, and feasibility
- Create readiness for change in staff, using education of prevalence and impact to build shared sense of urgency and motivate commitment to achievable priorities
- Learn about possible strategies and what it takes to implement them effectively

Installation

- Gather data to create TIS action plan
- Develop infrastructure to support sustainable trauma-informed practices on individual and organizational levels through partnership with program developers, external consultants, and intermediary organizations.

- Provide skill-building PDs with follow-up coaching
- Develop staff capacity to support teacher skill development

Initial Implementation

- Support high fidelity implementation
- Use data to assess initial implementation
- Use data to identify solutions to problems that arise
- Engage with other schools for learning and support

Full Implementation

- New practice is fully integrated at all levels
- Practitioners able to skillfully provide new services, such that more than 50 percent of early childhood practitioners are implementing the innovation with fidelity to the model, and expected outcomes are being achieved
- Assess efficiency and effectiveness of outcomes, practitioner training and competency, and enhancements to original implementation

(Metz et al., 2015; Safe Schools NOLA, 2017)

Data Gathering and Program Evaluation

Data gathering and program evaluation play a central role in the implementation of trauma-sensitive schools. In general, the gathering and use of data allow schools to engage in data-based decision making – understanding areas of strength and areas of weakness that facilitate targeted use of time and resources such as staff training, teacher coaching, and student-level interventions.

Gathering data early in the process of implementing trauma-informed schools provides valuable information about readiness for trauma-sensitive school implementation, facilitates a needs assessment on which to base the school's action plan, and provides a baseline time point for future comparisons. Data gathering as trauma-sensitive school implementation proceeds can serve to monitor how the intervention is going, including what is working well and what might need increased attention. Finally, data gathering after the trauma-sensitive schools implementation is mostly complete and is in maintenance phase can be helpful to evaluate the outcome of the effort and, in the longer term, whether the outcome has been sustained over time.

Trauma-sensitive school implementation is driven by an action plan, which will be different for each school depending on that school's needs and priorities. There are several examples in the literature of how to create the school's action plan, including examples found on the Trauma and Learning Policy Initiative website resources, which can be found at https://traumasensitiveschools.org. Additional guidance is provided in their book, which is free to download, called Creating and Advocating for Trauma-Sensitive Schools (Cole, Eisner, Gregory, & Ristuccia, 2013).

The Coalition for Compassionate Schools used the following to structure the action planning process: **Action Planning Tool**

The result of the action planning process is the identification of a series of steps that will be taken across each of the four areas of trauma-informed schools implementation:
1) Leadership consultation
2) Staff training
3) Ongoing coaching of staff after training

4) Identification and treatment of children with symptoms of post-traumatic stress disorder

In addition to identifying targets, the action plan also identifies who is responsible for gathering data and when it will be gathered. Tools that can be used for data gathering and program evaluation for each of these four pillars of implementation are described below.

Leadership Consultation

Leadership consultation typically precedes other areas of trauma-informed schools implementation by six or more months and focuses on conducting a needs assessment to identify policies, practices, and procedures that may need to be shifted and developing the school's action plan.

Tools

Additional tools used in leadership consultation within the Coalition include the Walkthrough Tool, Policy/Discipline Checklist, and the School Health Assessment and Performance Evaluation System (SHAPE) Trauma Responsive School Implementation Assessment.

The **Walkthrough Tool** assists with an evaluation of the structural environment of the school with a focus on elements common to trauma-informed schools, such as calm-down corners in the classroom and well-monitored spaces on the playground. This tool is typically used by the leadership and other individuals on the trauma-informed schools committee together in a group or individually.

The **Policy/Discipline Checklist** assists with an evaluation of the policies, procedures, and practices at the school with a focus on those policies, procedures, and practices most commonly associated with trauma-informed schools, such as the discipline policy. Like the Walkthrough Tool, it is similarly completed either together in a group or individually.

Finally, the **SHAPE assessment** is a nationally, free available tool that is completed together by the team. Each time the team completes the assessment, they have access to a free, customized report with easy-to-read red, yellow, and green indicators across a variety of trauma-informed schools-relevant domains, such as whole school safety planning.

These three tools are useful early in the process of trauma-sensitive schools implementation, as they can serve as important inputs to the needs assessment. They are also useful later in the process, to evaluate whether targets identified in the school's action plan have been achieved and, down the line, maintained over time.

Staff Training

All teachers and school staff participate in professional development trainings, which occur in two phases. First, all staff participate in a foundational trauma training (see appendix), in which they learn about the prevalence of trauma, its impact on students and school staff, and the core principles of trauma-informed schools. Skill-focused trainings are delivered throughout the school year to bridge the gap between the foundational didactic learning and their implementation in the classroom.

It is typical to evaluate the effectiveness of the training by gathering data from the teachers and staff who are trained before and after the foundational training. Additionally, the same instruments are often used at the end of the school year to understand the impact of the full trauma-informed schools implementation model or to evaluate maintenance over time.

Tools

The tools that are used typically aim to evaluate what people may have learned or how they may have changed as a result of the training, including whether they gained knowledge about trauma-informed schools, changed their attitudes to be more favorable to trauma-informed schools, or gained some perspective on their well-being as it relates to working with a population of students who have experienced trauma.

The **knowledge about trauma-informed schools measure** is typically a quiz that is based on the professional development training content. It is important to include a "do not know" option if the knowledge measure is used at baseline, because many trainees will be unfamiliar with the content of the trauma-sensitive schools intervention. Each question is scored correct or incorrect, and "do not know" is also scored as incorrect. The final score that each teacher or school staff earns can be presented as a percentage (e.g., 8 out of 10 correct is an 80%).

The knowledge measure must match the training, so there are different knowledge measures for the foundational training and each of the skills-focused trainings.

The measure that the Coalition for Compassionate Schools uses to gather data about staff attitudes is the **Attitudes Related to Trauma-Informed Care** (ARTIC; Baker, Brown, Wilcox, Overstreet, & Arora, 2016) **scale**. There is a version of the scale that has been validated for educators, and it can be used in its longer, 45-item form or in its short, 10-item form. The ARTIC can be purchased at the following website: https://traumaticstressinstitute.org/the-artic-scale/.

Finally, the **Professional Quality of Life scale**, developed by Beth Stamm, is used to gather data about staff wellness (ProQOL; Stamm, 2005). The scale includes three subscales: compassion satisfaction, or the pleasure that staff derive from their jobs; burnout, or exhaustion, frustration, anger, and sadness about their jobs; and secondary traumatic stress, or the negative feelings driven by fear and work-related trauma. As opposed to the knowledge and attitude measures, it is not typical to administer the ProQOL both before and after the foundational trauma training. The reason for this is that there is no reason to expect that longer term issues such as burnout will be resolved after only one or a few days of training. The ProQOL is well-validated but has mostly been applied to staff who work in clinical settings. The ProQOL can be downloaded for free at https://proqol.org/Home_Page.php.

Instruments

Instruments are also used to evaluate how trainees felt about the training, including whether they can see themselves actually using the information they learned, which is called acceptability and feasibility, and whether they were satisfied with the training.

The Coalition for Compassionate Schools uses the Usage Rating Profile – Intervention, Revised (URP-IR; Chafouleas, Briesch, Neugebauer, & Riley-Tillman, 2011) to evaluate the feasibility and acceptability of the trauma-informed schools intervention. The measure has several subscales relevant to whether the intervention will be successful in the school, including acceptability, understanding, home school collaboration, feasibility, system climate, and system support. The URP-IR is well-validated with educators and can be downloaded for free at https://urp.uconn.edu/forms.

Finally, the Coalition for Compassionate Schools uses a **generic satisfaction measure** to evaluate whether participants in the professional development trainings liked the trainings and found them helpful. In addition to several Likert-scale measures that ask teachers and school staff to rate the training, there are also several open-ended questions aimed at understanding either how to make the training better in the future or what resources staff felt they might need to implement trauma-informed schools.

Ongoing Coaching of Staff after Training

Ongoing coaching support of teachers who are implementing trauma-informed schools interventions in their classrooms is essential to full and high-fidelity implementation. The goal of coaching is for teachers to move the skills and strategies they learn in professional development into the real-life complexity of the classroom. Evidence-based coaching models create opportunities for practice, an accountability system for implementing the intervention, and reinforcement contingencies related to the work, including both positive reinforcement (i.e., receiving praise) and negative reinforcement (i.e., avoiding a discussion about increasing fidelity of implementation). Many schools have coaching systems already in place that help teachers improve their instructional quality and behavior management. Therefore, applying existing coaches and systems to trauma-informed schools may be an option for some schools.

The Coalition for Compassionate Schools trains coaches to use a coaching model adapted from the Classroom Check-up, developed by Wendy Reinke. The model features a structured observation, structured feedback targeting trauma-informed schools-relevant classroom behaviors, collaborative goal setting between the coach and the teacher, performance feedback, and ongoing coaching support to reach goals. All of these activities are accompanied by tools adapted from the Classroom Check-up to help structure and systematize the coaching interactions. More information about the Classroom Check-up can be found in the book Motivational Interviewing for Effective Classroom Management: The Classroom Check-up (Reinke, Herman, & Sprick, 2011).

Identification and Treatment of Children with Post-Traumatic Stress Disorder

Finally, schools typically screen children for post-traumatic stress disorder symptoms and treat those children who screen positive using evidence-based group or individual interventions.

It is important to use validated measures to screen students, gather pre-post data to monitor the impact of the intervention, and gather process data to ensure that the intervention is being implemented with fidelity. In some areas, schools develop partnerships with outside agencies to provide these clinical services. In others, school- or district-level leaders may be responsible for providing these services, in which case they most likely seek support from trained professionals. It is typically these professionals who are clinically trained to not only select the appropriate measures, but also implement the appropriate interventions to address students' post-traumatic stress disorder symptoms.

Several excellent compendiums of tools associated with this pillar of trauma-informed schools exist, including the one provided by the National Child Traumatic Stress Network which can be found at https://www.nctsn.org/treatments-and-practices/screening-and-assessment.

Steps to Sustainability

The primary approach to sustainability adopted by the Coalition for Compassionate Schools is to develop a Train the Trainer model to build capacity of the New Orleans public school system to overcome workforce and structural challenges to creating and sustaining trauma-informed schools. This approach is being piloted in a project funded by the Department of Justice (2018 – 2021) and led by the Coalition for Compassionate Schools.

Appendix

Appendix A. Impact of Racial Equity and Trauma Tools

- Equity in Schools Training for Trauma-Informed Schools
  - Workshop **One**
  - Workshop **Two**
  - Phases of Racial Equity That Addresses Trauma: **Values Continuum**

Appendix B. Existing Models of Trauma-Informed Care Schools

California

University of California San Francisco HEARTS (UCSF HEARTS)

UCSF HEARTS aims to promote school success for trauma-impacted youth by creating more trauma-informed, safe, supportive, engaging, and equitable learning and teaching environments that foster resilience and wellness for everyone in the school community. Like HEARTS utilizes a multi-tiered system of supports (MTSS) framework to address trauma and chronic stress and is largely aimed at school climate and culture change through building capacity of school personnel around implementing trauma-informed practices, procedures, and policies. Thus, supports and services are planned and implemented in close collaboration with school leadership and with a regularly-meeting team of key school staff (e.g., coordinated care teams), along with the rest of the school community (e.g., administrators, credentialed and classified staff, students and their caregivers). Systems change typically requires 2 to 5 years, depending upon the degree of a school site's level of need, and the intensity of HEARTS services provided.

For more information, visit https://hearts.ucsf.edu/our-team.

Massachusetts

Trauma and Learning Policy Initiative (TLPI)

The TLPI is a collaborative effort between Massachusetts Advocates for Children and the Harvard Law School. It was created to ensure that children exposed to adverse childhood experiences succeed in school.

Toward that end, TLPI employs several strategies including support for schools to become trauma-sensitive environments; research and report writing; legislative and administrative advocacy for laws, regulations, and policies that support schools in developing trauma-sensitive environments; coalition building; outreach and education; and limited individual case representation in special education when trauma exposure is impacting a student and his or her disabilities.

For more information, visit https://traumasensitiveschools.org.

Missouri

The Missouri Model: A Developmental Framework for Trauma-Informed Schools Initiative

The Missouri Model views the implementation of a trauma-informed approach as an ongoing organizational change process rather than a program model that can be implemented and monitored by a fidelity checklist. The model's aim is a profound paradigm shift in knowledge, perspective, attitudes and skills that continues to deepen and unfold over time. Some leaders in the field are beginning to talk about a "continuum" of implementation, where organizations move through stages. The continuum begins with becoming trauma aware and moves to trauma sensitive to responsive to being fully trauma-informed. The model may be used in a wide range of settings, including but not limited to behavioral health services.

For more information, visit https://dese.mo.gov/traumainformed.

Pennsylvania

Trauma-Informed School Practices

THE SCHOOL DISTRICT OF PHILADELPHIA

The School District of Philadelphia asserts that schools should be sanctuaries and function as a place of refuge for the students who attend them. Their program description focuses on building skills in adult staff to create a trauma-informed learning environment.

They posit that a trauma-informed school is one where staff understand the function of trauma-induced behaviors (and do not mistake them as intentional or provocative) and use objective, neutral language as opposed to language that labels. Schools that are trauma-informed employ policies aimed at not re-traumatizing students, minimizing control issues, and promoting a culture of care and safety with an individualized approach.

For more information, visit https://www.philasd.org/prevention/programs-and-services/trauma-informed-school-practices.

Wisconsin

Trauma-Sensitive Schools Initiative (TSS)

TSS is an initiative in which schools infuse the core values of trauma-informed care: safety, trust, choice, collaboration, and empowerment into their Multi-level Systems of Support (MTSS). TSS acknowledges the high prevalence of traumatic exposure for students, the importance of staff well-being. TSS describes their initiative as a process and not a product that uses implementation science. It includes an online learning system and is intended to integrate into schools existing MTSS to promote sustainability and ensure meaningful and manageable implementation.

For more information, visit https://dpi.wi.gov/sspw/mental-health/trauma.

Appendix C. Additional Resources

- Race & Equity in Schools, Beloved Community
- **Child Trauma Toolkit for Educators**, The National Child Traumatic Stress Network
- **Helping Traumatized Children Learn**, Massachusetts Advocates for Children
- **Creating and Advocating for Trauma-Sensitive Schools**, Massachusetts Advocates for Children
- Implicit Bias Resources:
  - Implicit association test (under 5 minutes)
  - Blindspot, well-written, easy to understand text written by the researchers who designed IAT at Harvard
  - The Science of Equality (Perception Institute) this issue focuses on bias, stereotype threat and school performance

Appendix D. Foundational Professional Development Curriculum

Creating Trauma-Informed Schools
Foundational Professional Development Training

Instructions for Use
April 2019

Foundation of the Curriculum

This professional development training has been developed over a number of years through the work of the Coalition for Compassionate Schools and the Safe Schools NOLA project. Use of these slides, in their entirety or part, should acknowledge these groups as the source of these materials. To gain access to the most recent PowerPoint slides, please contact Stacy Overstreet at soverst@tulane.edu

The curriculum is grounded in SAMHSA's (2014) Concept of Trauma and Guidance for a Trauma-Informed Approach. The document outlines key assumptions and principles of trauma-informed approaches and identifies ten implementation domains (see below) that must be considered in creating trauma-informed systems:

1. Governance and Leadership
2. Policy
3. Physical Environment
4. Engagement and Involvement
5. Cross Sector Collaboration
6. Screening, Assessment, Treatment Services
7. Training and Workforce Development
8. Progress Monitoring and Quality Assurance
9. Financing
10. Evaluation

Content (e.g., logos, visual images of the organizational structure, etc.) specific to those projects remains embedded in the slide deck to provide the user with the context of the work. We encourage users to incorporate their own logos and visual representations to accurately reflect the context in which the foundational professional development training is being delivered.

Goals of the Curriculum

The primary goal of this training is to focus on workforce development, one of the ten SAMHSA implementation domains, by providing all school personnel with a framework that:

- Creates a common understanding of trauma and its impacts.
- Builds consensus around the need for trauma-informed schools.
- Highlights the importance of school-wide strategies to create safe and supportive environments for all students.
- Reinforces the responsibility of all school staff to engage in self-care.

More specific and comprehensive skill building sessions focused on building relationships, creating supportive learning environments, and de-escalation techniques should follow this training. In addition, school leadership teams should work to ensure the organizational capacity necessary for a trauma-informed school using the guidance provided by the Trauma and Learning Policy Initiative:

Learning Objectives

- Summarize national and local prevalence rates of exposure to adverse childhood experiences (trauma).
- Understand the wide-ranging impacts of trauma exposure and describe the specific impacts on biology, behavior, mental health, academic functioning, and social relationships.
- Describe key principles of trauma-informed care and understand how those principles apply to creation and implementation of trauma-informed schools.
- Utilize a trauma framework to interpret student behavior.
- Analyze classroom management strategies through a trauma lens.
- Demonstrate the use of two self-care strategies to manage your own emotions.

Structure of the Training

Ideas for setting the tone for the training can be found here. Important considerations include:

- Creating a safe space for open engagement.

- Recognizing the difficulty of the topic, especially for those with a trauma history.
  - Communicate participant choice to participate or not participate in activities.
  - Allow participants to control their exposure to content—granting permission to use fidgets to help regulate attention/emotions, leave the room, use safe place exercise.

The training can be delivered over the course of a day, but it can also be delivered over the course of three modules. Sample training schedules can be viewed here and here, respectively. Supplemental training materials can be accessed via the following links:

- Self-Care Activity
- Role Play Scenarios
- Start Stop Continue Action Worksheet
- Relationship Activity

The training content and language should be embedded within the cultural context of the school. For example, specific school-based data on relevant adverse childhood experiences could be included and school values could be used to help frame the trauma-informed principles. Within the Coalition, faculty representatives conduct a “cultural audit” of the school a few months prior to the training to ensure the best possible fit between the training and the school culture. The cultural audit can be viewed here.

Publication Page

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References

Adapted from McIntosh, P (1990). Working Paper #219: Interactive phases of curricular and personal re-vision with regard to race. Wellesley College Center for Research on Women (now Wellesley Centers for Women).

Adams, E. J. (2010). (issue brief). Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense. Justice Policy Institute. Retrieved from https://justicepolicy.org/research/healing-invisible-wounds-why-investing-in-trauma-informed-care-for-children-makes-sense/.

American Psychiatric Association. (2015). Diagnostic and statistical manual of mental disorders (5th ed.). American Psychiatric Press: Washington, D.C.

Baker, C. N., Brown, S. M., Wilcox, P. D., Overstreet, S., & Arora, P. (2016). Development and psychometric evaluation of the attitudes related to trauma-informed care (ARTIC) scale. School Mental Health, 8(1), 61-76.

Beloved Community (2018). TISLC: Equity in schools training for trauma-informed schools: Workshop #1. Google Slides presentation.

Beloved Community (2016). The phases of racial equity that addresses trauma continuum.

Burke, N.J., Hellman, J.L., Scott, B.G., Weems, C.F., & Carrion, V.G. (2011). The impact of adverse childhood experiences on an urban pediatric population. Child Abuse & Neglect, 35(6), 408-413.

Chafouleas, S. M., Briesch, A. M., Neugebauer, S. R., & Riley-Tillman, T. C. (2011). Usage Rating Profile–Intervention (Revised). Storrs, CT: University of Connecticut.

Cole, S. F., Eisner, A., Gregory, M., & Ristuccia, J. (2013). Creating and advocating for trauma-sensitive schools. Massachusetts Advocates for Children.

Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), The cost of racism for people of color: Contextualizing experiences of discrimination (pp. 249–272). American Psychological Association. https://doi.org/10.1037/14852-012

Copeland, W. E.; Keeler, G.; Angold, A.; & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. Archives of General Psychiatry, 64, 577-584.

Cronholm, P.F., Forke, C.M., Wade, R., Bair-Merritt, M.H., Davis, M., Harkins-Schwarz, M., Pachter, L.M., & Fein, J.A. (2015). Adverse childhood experiences: Expanding the concept of adversity. American Journal of Preventive Medicine, 49(3), 1-9.

Daignault, I. V., & Hébert, M. (2009). Profiles of school adaptation: Social, behavioral and academic functioning in sexually abused girls. Child Abuse and Neglect, 33, 102-115.

De Bellis, M.D. (2001). Developmental traumatology: the psychobiological development of maltreated children and its implications for research treatment and policy. Development and Psychopathology, 13(3), 539-564.

De Bellis, M.D. & Zisk A.B. (2014). The biological effects of childhood trauma. Child and Adolescent Psychiatric Clinics of North America, 23(2),185-222.

Eversley, M. (2015). Report: One in 14 children has had incarcerated parent. USA Today. Retrieved from: http://www.usatoday.com/story/news/2015/10/27/report-one-14-children-have-had-incarcerated-parent/74663774/ as cited in Safe Schools NOLA (2017). Creating trauma-informed schools: Rationale and school-wide approach. Google Slides presentation at School Schools NOLA Project, Tulane University.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M., Marks, J.S., (1998). 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(4), 245-258. http://dx.doi.org/10.1016/S0749-3797(98)00017-8

Finzi-Dottan, R., Dekel, R., Lavi, T., & Su'ali, T. (2006). Posttraumatic stress disorder reactions among children with learning disabilities exposed to terror attacks. Comprehensive Psychiatry, 47, 144–151.

Institute of Women and Ethnic Studies. (2015). Emotional Wellness and Exposure to Violence from New Orleans Youth Age 11-15. Retrieved from https://www.iwesnola.org/s/EWS-Report-2015.pdf

Lamers-Winkelman, F., Willemen, A. M., & Visser, M. (2012). Adverse childhood experiences of referred children exposed to intimate partner violence: Consequences for their wellbeing. Child Abuse and Neglect, 36, 166–179.

Mapping Police Violence (2016). 2015 unarmed victims. Retrieved from http://mappingpoliceviolence.org/unarmed as cited in Safe Schools NOLA (2017). Creating trauma-informed schools: Rationale and school-wide approach. Google Slides presentation at School Schools NOLA Project, Tulane University.

Metz, A., Naoom, S. F., Halle, T., & Bartley, L. (2015). An integrated stage-based framework for implementation of early childhood programs and systems (OPRE Research Brief 2015-48). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services as cited in Safe Schools NOLA (2017). Creating trauma-informed schools: Rationale and school-wide approach. Google Slides presentation at School Schools NOLA Project, Tulane University.

National PTA (2017). Position Statement on Trauma-Informed Care. Downloaded on 18 February 2019 from https://www.pta.org/docs/default-source/uploadedfiles/trauma-informed-care-ps.pdf

Neiman, S., & DeVoe, J. F. (2009). Crime, violence, discipline, and safety in U.S. public schools: Findings from the school survey on crime and safety: 2007 08.Washington, DC: National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education.

Overstreet, S., & Mathews, T. (2011). Challenges associated with exposure to chronic trauma: Using a public health framework to foster resilient outcomes among youth. Psychology in the Schools, 48, 738–754.

Prewitt, E. (2016). New elementary and secondary education law includes specific "trauma-informed practices" provisions. Retrieved from: http://www.acesconnection.com/g/aces-in-education/blog/new-elementary-and-secondary-education-law-includes-specific-trauma-informed-practices-provisions.

Ramirez, M., Wu, Y., Kataoka, S., Wong, M., Yang, J., Peek-Asa, C., & Stein, B. (2012). Youth violence across multiple dimensions: A study of violence, absenteeism, and suspensions among middle school children. Journal of Pediatrics, 161, 542-546.

Reinke, W. M., Herman, K. C., & Sprick, R. (2011). Motivational interviewing for effective classroom management: The classroom check-up. Guilford Press.

Safe Schools NOLA. (2017). Creating trauma-informed schools: Rationale and school-wide approach. Google Slides presentation at Safe Schools NOLA Project, Tulane University.

Stamm, B. H. (2005). The ProQOL manual: The professional quality of life scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales. Baltimore, MD: Sidran.

Substance Abuse and Mental Health Services Administration (2014). SAMHSA's Concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Tough, P. (2016, June). How kids learn resilience. The Atlantic. Retrieved from: http://www.theatlantic.com/magazine/archive/2016/06/how-kids-really-succeed/480744/

Wade, R., Shea, J.A., & Wood, J. (2014). Adverse childhood experiences of low-income urban youth. Pediatrics,134(1), 13-20.

Weir, K. (2016). Inequality at school: What's behind the racial disparity in our education system? American Psychological Association, 47 (10). Retrieved from http://www.apa.org/monitor/2016/11/cover-inequality-school.aspx as cited in Safe Schools NOLA (2017). Creating trauma-informed schools: Rationale and school-wide approach. Google Slides presentation at School Schools NOLA Project, Tulane University.


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