

QUICK FACTS

Trauma is Common:

It is estimated that one half to two-thirds of children experience trauma.

What is Trauma?

A response to a negative external event or series of events which surpasses the child's ordinary coping skills. It comes in many forms and includes experiences such as maltreatment, witnessing violence, or the loss of a loved one. Traumatic experiences can impact brain development and behavior inside and outside of the classroom.

Importance for Schools

All schools and educators work with children who have experienced trauma, but you may not know who these students are. Schools have an important role to play in providing stability and a safe space for children and connecting them to caring adults. In addition to serving as a link to supportive services, schools can adapt curricula and behavioral interventions to better meet the educational needs of students who have experienced trauma.

Trauma-Informed Approaches

Evidence-supported, trauma-informed models have been developed in other fields and can be implemented in schools. A list of models, training tools, and additional resources is provided.

Unlocking the Door to Learning: Trauma-Informed Classrooms & Transformational Schools

***Maura McInerney, Esq. Senior Staff Attorney
Amy McKlindon, M.S.W.***

Childhood trauma can have a direct, immediate, and potentially overwhelming impact on the ability of a child to learn. Yet, this issue has largely been ignored by our education system. This issue brief discusses how educators can begin to understand the role of trauma, its effect on children and learning, and how educators can change methods of interacting and responding to children impacted by trauma. By adopting a trauma-informed approach, schools undertake a paradigm shift at the staff and organizational level to recognize, understand and address the learning needs of children impacted by trauma. This requires a commitment to shaping school culture, practices, and policies to be sensitive to the needs of traumatized learners. This effort positively impacts schools and changes the life-trajectory of vulnerable students.

The first step is to understand who experiences trauma and why, and how it impacts learning.

It is well documented that a child's reaction to trauma can "commonly" interfere with brain development, learning, and behavior -- all of which have a potential impact on a child's academic success as well as the overall school environment. By understanding and responding to trauma, school administrators, teachers, and staff can help reduce its negative impact, support critical learning, and create a more positive school environment.

“Trauma-informed” approaches are not new – they have been implemented in many fields including the medical profession and our judicial system. The lessons learned from these evidence-based approaches can be directly applied to classrooms and schools. At the heart of these approaches is the belief that students’ actions are a direct result of their experiences, and when students act out or disengage, **the question we should ask is not “what’s wrong with you,” but rather “what happened to you?”**¹ By being sensitive to students’ past and current experiences with trauma, educators can break the cycle of trauma, prevent re-traumatization, and engage a child in learning and finding success in school.

Defining Trauma – What happened to this child?

Childhood trauma has been conceptualized as a response to a negative external event or series of events which render a child “temporarily helpless” and surpass the child’s “ordinary coping and defensive operations.”² A wide range of experiences can result in childhood trauma, and a child’s response to these potentially traumatizing events will vary depending on the characteristics of the child (e.g., age, stage of development, personality, intelligence and prior history of trauma) environment (e.g., school and family supports), and experience (e.g., relationship to perpetrator).³

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines traumatic events as those in which an individual experiences, witnesses, or is confronted with actual or threatened death or serious injury, or threatened physical integrity of self or others.⁴ Importantly, the event need not be violent and need not be directed at the child who experiences trauma. One well-known study describes traumatic experiences in childhood as Adverse Childhood Experiences (ACEs), which may include physical, psychological, or sexual abuse; violence against one’s mother; or living with household members who are mentally ill, suicidal, substance abusers, or were ever incarcerated. This study linked ACEs to many common adult medical and psychological problems.⁵ In response to a traumatic event, a person may feel intense fear, horror, or helplessness, and in response, a child may display disorganized or agitated behavior.⁶

Who Experiences Trauma?

Children from all races and socioeconomic backgrounds experience and are impacted by trauma. Research suggests that **between half and two-thirds of all school-aged children experience trauma**⁷ as they are exposed to one or more adverse childhood experience that can be trauma-inducing.⁸ Trauma can come in many forms. There are obvious examples of trauma. For example, in 2011, there were 4,566 reports of abuse or neglect in Philadelphia, with 2.1 substantiated cases of abuse or neglect per 1,000 children.⁹ However, there are also other hidden examples of exposure to trauma. Here are some statistical examples:

- Among 769 students sampled in the LA Unified School District, the average number of violent events experienced in the previous year was 2.8, and the average number of witnessed events was 5.9. In this context, 76% of surveyed students experienced or witnessed violence involving a gun or knife.¹⁰ In another study of this cohort by Flannery et al., between 56% and 87% of adolescents had witnessed someone being physically assaulted at school during the past year.¹¹
- In one representative sample of children in western North Carolina, 68% of 16-year-olds had experienced trauma and 37% had experienced two or more traumatic events. More specifically:
 - 25% had been exposed to violence.
 - 15% had experienced the violent death of a sibling or peer.
 - 7% had experienced physical abuse by a relative.
 - 11% had experienced sexual trauma in the form of sexual abuse, rape, or coercion.

- 33% had experienced another injury or trauma (e.g., serious accident, natural disaster).¹²
- According to the 2008 National Survey of Children’s Exposure to Violence, 61% of children and adolescents age 17 and younger have been exposed to violence in the past year. Over one-third of children experienced two or more direct victimizations, and 11% had experienced five or more direct victimizations.¹³

Children and adolescents in urban environments experience higher rates of exposure to violence.¹⁴ In one unnamed urban community, 41% of 6th, 8th, and 10th grade students reported witnessing a shooting or stabbing in the past year.¹⁵ In addition, young children are also exposed to trauma, and by age 4, parents report that 26% of young children have been exposed to violence or a non-interpersonal traumatic event such as a car accident.¹⁶ Recent research has disclosed the devastating impact of exposure to trauma on the brain development of very young children.

Exposure to Violence: Young Children in Philadelphia

- In a sample of 119 seven-year-old children in Philadelphia, frequent exposure to violence was reported:
 - 75% had heard gun shots.
 - 60% had seen drug deals.
 - 18% had seen a dead body outside.
 - 10% witnessed a stabbing or shooting in their homes.¹⁷
- Notably, in an older study comparing middle school students in the Philadelphia metropolitan area attending an urban middle school and a suburban middle school, researchers found a strikingly high prevalence of exposure to violence and victimization in both groups:
 - 89% of suburban and 96% of urban middle school students knew someone who had been robbed, assaulted, or murdered.
 - 57% of suburban and 88% of urban middle school students had witnessed someone being robbed, assaulted, or murdered.
 - 40% of suburban and 67% of urban middle school students had been a victim of violence.¹⁸

Impact of Trauma on Brain Development and Learning

Children and adolescents are continually developing, and life experiences influence their development in both positive and negative ways. Physiological changes to children’s brains as well as emotional and behavioral responses to trauma have the potential to interfere with children’s learning, school engagement, and academic success. Because most brain development occurs during a child’s early months and years when the brain is most “plastic,” traumatic experiences in the early years, such as abuse and neglect and exposure to violence, can profoundly impact and limit brain development, resulting in cognitive losses, physical, emotional and social delays, all of which undermine learning.¹⁹

Brain imaging shows that the brain continues to develop into early adulthood, with ***peak times of development in early childhood and adolescence.***²⁰ More specifically, areas such as the hippocampus which is involved in learning and memory develop rapidly in early childhood, while the prefrontal cortex which regulates thoughts and attention matures more rapidly during adolescence.²¹ As a result, ***trauma experienced during these sensitive periods has the potential to be particularly harmful*** to brain

development.²² Traumatic experiences can actually change the structure and functioning of a child's brains through the activation of stress response systems. When exposed to a stressor, the body responds through a "fight," "flight," or "freeze" response that activates several systems in the body and releases stress hormones that are designed to be protective for survival.²³ However, this response becomes dangerous to the brain, rather than protective, when ***repeated traumatic experiences lead to an over-reactive stress system. As described by one pediatrician, these children are living in a "constant state of emergency,"***²⁴ and it has very real implications for their brain development and social functioning.

Toxic stress has been defined as the "strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship."²⁵ The American Academy of Pediatrics cautions that extended exposure to toxic stress can lead to functional changes in several regions of the brain involved in learning and behavior including the amygdala, hippocampus, and prefrontal cortex.²⁶ Further, ***neurological imaging indicates that several regions of the brain may actually reduce in size as a result of childhood maltreatment.***²⁷

In addition to neurological changes, trauma may impact students' learning and behavior at school. ***Children who have experienced trauma may find it more challenging than their peers to pay attention and process new information, and evidence suggests that some of these children develop sensory processing difficulties which can contribute to problems with writing and reading.***²⁸ In a sample of high-risk children at a pediatric clinic in California, children who were exposed to four or more adverse experiences were 32 times more likely to have learning/behavioral problems than their peers with no adverse experiences.²⁹ Another study found that six and seven year-old children who have been exposed to violence and have suffered from trauma-related distress score significantly lower on IQ and reading ability tests.³⁰ Researchers have also found that maltreated children are more likely than their peers to be retained a grade, have irregular attendance, and be placed in special education classes.³¹ Children with higher exposure to violence also had lower grade point averages and more absences than those children with less exposure to violence.

Trauma Changes the Way Children Interact with Others

Trauma may also impact children's relationships with peers and teachers in the classroom. Children who have experienced trauma may be distrustful or suspicious of others, leading them to question the reliability and predictability of their relationships with classmates and teachers. Research indicates that ***children who have been exposed to violence often have difficulty responding to social cues and may withdraw from social situations or bully others.***³² For example, when compared to their classmates, children who have been physically abused have been found to engage in less intimate peer relationships and tend to be ***more aggressive and negative in peer interactions.***³³ Further, students who have experienced trauma may feel that authority figures have failed to provide safety for them in the past and may therefore be ***distrustful of teachers.*** Teachers' rules and consequences may be viewed as punishment by children who have experienced trauma, increasing the potential for re-traumatization,³⁴ while at the same time increasing the likelihood that these children will be subject to school discipline and exclusionary practices on a repeated basis.

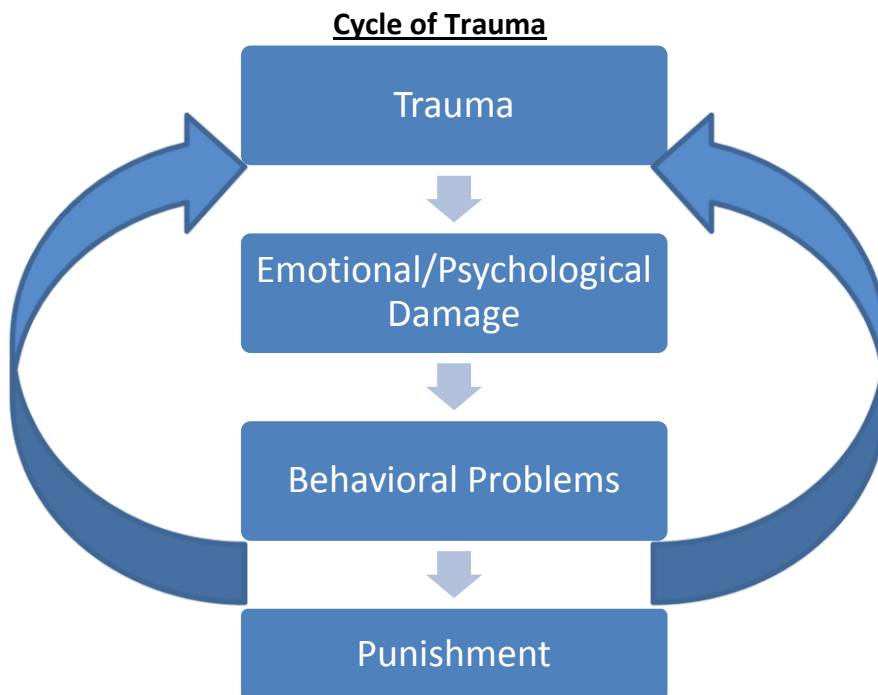
Long-Term Impacts of Childhood Trauma

The consequences of traumatic experiences have the potential to be long lasting and devastating to individuals and society. Children who have experienced trauma and adverse experiences may be at elevated risk for mental and physical health problems,³⁵ substance abuse,³⁶ and criminal justice involvement³⁷ in adolescence and adulthood. However, ***this does not need to be the long-term impact.***

Breaking the Cycle of Trauma

When trauma causes emotional or psychological damage to children, they may adopt a set of behaviors or patterns of thinking that put them on a path for further trauma. Either directly through their own repeated actions (*e.g.*, they are quicker to resort to violence) or as a result of consequences for their actions that do not fit within societal rules and norms (*e.g.*, punitive measures after violation of rules/laws), ***children may become re-traumatized and their problems are only compounded.***

We need to understand the “cycle of trauma” (see figure below) which is particularly important to keep in mind in the school environment, where students may display problem behaviors related to past trauma and ***then become re-traumatized through punishment for those behaviors – embedding the trauma further and continuing the cycle of behavioral problems rather than lessening them.***



Breaking the Cycle: Evidence-Supported and Evidence-Based Approaches

Given the high prevalence of childhood trauma, many systems working with children have had to confront this issue. From medical centers to courts to child welfare systems, several evidence-supported and evidence-based approaches to address trauma have been developed and have proven to be effective. These approaches can be broken into two categories: ***trauma-informed systems approaches*** that aim to shape organizations to be more trauma-sensitive in their work with children and families and ***trauma-specific treatment interventions*** that can be implemented at the individual-level to address trauma and its symptoms. Both types of approaches are explained in more detail and applied to school settings below.

Becoming trauma-informed requires a paradigm shift at the staff and organizational level to re-focus on understanding what happened to a child, rather than focusing on the conduct alone.³⁸ Trauma-informed approaches represent a holistic approach to shaping **organizational culture, practices, and policies** to be sensitive to the experiences and needs of traumatized individuals.

Several models have been developed to guide the design and implementation of trauma-informed systems that take these key elements into consideration. One well-known approach is the **Sanctuary Model**[®], developed by Dr. Sandra Bloom, Associate Professor at Drexel University in Philadelphia. This model engages organizational leaders and staff to develop an organizational culture where staff model and clients build skills in key areas such as safety, emotional management, self-control, and conflict resolution. At the same time, open communication, healthy boundaries, healthy social relationships, and growth and change are promoted. The model also utilizes the S.E.L.F. curriculum to guide individual treatment and organizational change. S.E.L.F. stands for “safety, emotions, loss, and the future.”³⁹ The Sanctuary Model has been used across a variety of settings including residential facilities, juvenile justice facilities, mental health programs and schools.⁴⁰ Links to information about the Sanctuary Model and other trauma-informed systems approaches are included in the resources at the end of this publication.

Evidence Supporting Trauma-Informed Approaches at the Organizational Level

The use of trauma-informed systems and methods in other fields, including medicine and child welfare, has had very promising results. Positive outcomes of these “trauma-informed” systems include client engagement and retention, staff and client safety, staff development, and increased supportive environments. Here are some examples of measurable positive outcomes:

- When staff in a child and adolescent inpatient psychiatric facility were trained on trauma-informed care, the facility experienced a 67% reduction in the number of times children were placed in seclusion and/or in restraints.⁴¹
- In a study that compared units at a residential treatment facility that implemented the Sanctuary Model[®] with units that provided services as usual, staff in the Sanctuary Model[®] units were more likely to report community environments that promoted support, autonomy, safety, open expression of feelings, and personal problem-solving.⁴²
- Women receiving substance abuse treatment that was trauma-enhanced (*i.e.*, promoted physical and psychological safety, provided culturally competent and individualized services, and involved staff training on trauma) were less likely to leave treatment early, compared to women receiving services as usual.⁴³
- Child welfare supervisors in Arkansas who attended a two-day training on trauma-informed services reported a significant increase in their knowledge of trauma-informed practices, as well as a significant increase in their active support of trauma-informed assessment and trauma-informed care among the staff they supervise.⁴⁴

Researchers and practitioners in the field agree that trauma-informed approaches at the system level make intuitive sense, and a growing body of research supports their implementation as evidence-supported approaches. However, rigorous evaluations are still needed to build on this evidence and further establish the efficacy of these approaches.⁴⁵

SEVEN ELEMENTS OF TRAUMA-INFORMED SYSTEMS⁴⁶

Trauma-Informed Approaches: What Schools & Educators Can Do

Implementing Trauma-Informed Approaches in Schools

Similar to other child and family-serving organizations, being trauma-informed in schools means being informed about and sensitive to trauma, and providing a safe, stable, and understanding environment for students and staff. A primary goal is to prevent re-injury or re-traumatization by acknowledging trauma and its triggers, and avoiding stigmatizing and punishing students. At the state level, Massachusetts and Washington are two states that have undertaken a systemic approach to incorporating trauma awareness and trauma-informed practices in their school systems. At the school level, some schools have pursued training and certification in trauma-informed approaches such as the Sanctuary Model®.

In ***Massachusetts***, the Massachusetts Advocates for Children, Harvard Law School, and the Task Force on Children Affected by Domestic Violence launched *Helping Traumatized Children Learn*, a policy agenda for the state, in 2005. Schools are encouraged to adopt a “Flexible Framework” for trauma-sensitive practices and supports at the school-wide level. More specifically, schools are asked to incorporate an understanding of trauma in the following domains:⁴⁷

Massachusetts’ “Flexible Framework” for Trauma-Sensitive Practices in Schools

Domain	Specific Strategies
School Culture and Infrastructure	<p>School administration should support and promote trauma-sensitive approaches school-wide through:</p> <ul style="list-style-type: none"> • Strategic planning • Assess staff training needs • Confidentially review and plan for individual cases • Review policies (e.g., school discipline policies) to ensure they reflect an understanding of the role of trauma in student behaviors • Develop community partnerships • Evaluate these efforts on an ongoing basis
Staff Training	<p>Incorporate staff training on trauma that addresses how to:</p> <ul style="list-style-type: none"> • Strengthen the relationships between staff, children who have experienced trauma, and their caregivers • Identify and access outside supports • Help traumatized children regulate their emotions to ensure academic and social success

Seven Key Elements of Trauma-Informed Systems (National Child Traumatic Stress Network)

1. Screen routinely for trauma exposure and symptoms.
2. Implement culturally appropriate, evidence-based assessments and treatments for traumatic stress and symptoms.
3. Provide resources to children, families, and providers on trauma, its impact, and treatment options.
4. Build on the strengths of children and families impacted by trauma.
5. Address parent and caregiver trauma.
6. Collaborate across child-serving systems to coordinate care.
7. Support staff by minimizing and treating secondary traumatic stress, which can lead to burnout.

<p>Links to Mental Health Professionals</p>	<p>Schools should create links to mental health consultation and services for staff, students, and families.</p> <ul style="list-style-type: none"> • For staff, clinical supports include the opportunity to participate in sessions with their peers and a clinician to confidentially discuss specific cases, reflect on experiences of secondary trauma, and learn and practice strategies for working with children and families. • For students and families, school staff should refer families to appropriate mental health resources and following up on referrals. Trusting relationships between parents/caregivers, school staff, and mental health providers can help to ensure success. Be sure to secure the necessary authorization for release of information between parties to facilitate communication and collaboration.
<p>Academic Instruction for Students who have Experienced Trauma</p>	<ul style="list-style-type: none"> • Specific strategies can be used to support the learning needs of students who have experienced trauma, including discovering and building on the student’s individual interests and competencies; maintaining predictable routines and expectations; maintaining expectations for the student that are consistent with those of his/her peers; and providing positive behavioral supports. • Language-based teaching approaches can help students process information and alleviate their fears. Students who have experienced trauma often pay more attention to nonverbal cues than verbal communication, so using multiple forms of communicating information and helping students identify and verbally express their feelings are important strategies to support learning. • School evaluations, including psychological, speech and language, functional behavioral, and occupational therapy evaluations, should assess the role of trauma and identify needed supports.
<p>Nonacademic Strategies</p>	<ul style="list-style-type: none"> • Build nonacademic relationships with students. • Support and facilitate participation in extracurricular activities.
<p>School Policies, Procedures, and Protocols</p>	<p>School discipline policies are trauma-informed when they:</p> <ul style="list-style-type: none"> • Balance accountability with an understanding of traumatic behavior; • Teach students the school and classroom rules while reinforcing that school is not a violent place and abusive discipline (which students who have experienced trauma may be accustomed to) is not allowed at school; • Minimize disruptions to education with an emphasis on positive behavioral supports and behavioral intervention plans; • Create consistent rules and consequences; • Model respectful, nonviolent relationships. <p>Communication procedures and protocols are trauma-informed when they:</p> <ul style="list-style-type: none"> • Respect confidentiality; • Involve open communication and relationship-building with families; • Ensure ongoing monitoring of new policies, practices and training.

Source: *Helping Traumatized Children Learn*⁴⁸

In addition to the systemic approach outlined above, Massachusetts has taken its interest in promoting trauma-informed school environments to the legislative level. In 2004, the legislature established a grant program administered through the Massachusetts Department of Elementary and Secondary Education to support school-based efforts to address the educational and psychosocial needs of students whose behavior interferes with learning, with a particular emphasis on those students who

Trauma-Informed Student Engagement: Ford Elementary School, Lynn, MA

After receiving a state grant to focus on youth traumatized by violence, Ford Elementary School trained staff and established a “trauma committee” that works to identify children whose behaviors may be impacted by trauma at home. These staff members then identify the strengths, interests, and talents of those students experiencing trauma, and use this information to help engage students in school. For example, in one case, a teacher recognized a student’s passion for baseball and facilitated an arrangement where this student, who was struggling academically and experiencing domestic violence at home, was able to join the team provided he improved his grades. Recognizing and building on the student’s strengths led to improved behavior, grades, and self-esteem.

have witnessed violence and experienced trauma.⁴⁹ Schools have implemented innovative trauma-informed practices utilizing these funds⁵⁰ For example, Framingham School District offered a 12-hour course for credit for teachers and school staff on the impact of trauma on children’s learning, and the Academy for Strategic Learning Charter School instituted bi-weekly meetings for staff to discuss implementation of trauma-sensitive school practices, provide training, and conduct case consultations with a psychologist.⁵¹ Trauma committees have also been formed to better meet the needs of students experiencing trauma in some schools, as highlighted in the adjacent textbox.

Washington State has taken steps at the state-level to bring special attention to the needs of students who have experienced trauma. The Washington State Office of the Superintendent of Public Instruction’s Compassionate Schools Initiative released the second edition of its handbook *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic*

Success in 2011. In addition to providing background information on trauma and the importance of self-care for school staff, this handbook outlines six principles which should guide interactions with students who have experienced trauma:

1. **Always Empower, Never Disempower**: Avoid battles for power with students. Students who have experienced trauma often seek to control their environment to protect themselves, and their behavior will generally deteriorate when they feel more helpless. Classroom discipline is necessary, but should be done in a way that is respectful, consistent, and non-violent.
2. **Provide Unconditional Positive Regard**: As consistently caring adults, school staff have the opportunity to help students build trust and form relationships. For example, if a student tells you, “I hate you. You’re mean,” respond with unconditional positive regard by saying “I’m sorry you feel that way. I care about you and hope you’ll get your work done.”
3. **Maintain High Expectations**: Set and enforce limits in a consistent way. Maintain the same high expectations of a student who has experienced trauma as you do for his/her peers.
4. **Check Assumptions, Observe, and Question**: Trauma can affect any student and can manifest in many different ways. Realize when you are making assumptions, and instead, talk with the

student and ask questions. Make observations about the student’s behaviors and be fully engaged in listening to his/her response.

5. Be a Relationship Coach: Help students from preschool through high school develop social skills and support positive relationships between children and their caregivers.
6. Provide Guided Opportunities for Helpful Participation: Model, foster, and support ongoing peer “helping” interactions (e.g., peer tutoring, support groups).⁵²

The Washington State Compassionate Schools Initiative recommends applying these principles to three curriculum domains – safety, connection, and assurance; emotional and behavioral self-regulation; and competencies of personal agency, social skills, and academic skills – and provides specific strategies to do so. To create a feeling of safety in the classroom, teachers may implement strategies to create consistency and routine.⁵³ Examples from the handbook include posting the Monday schedule on the board (students experiencing trauma may be returning to school from a weekend of chaos at home) and creating spaces where students can go to calm down. To promote emotional and behavioral self-regulation, the handbook emphasizes the importance of helping students learn to recognize and identify their emotions. Example exercises include discussing the emotions of characters in books and engaging in relaxation exercises. Finally, in the domain of competencies and skills, students who have experienced trauma may need additional opportunities to build their sense of personal agency, social skills, academic skills, and executive functions (e.g., setting goals, anticipating consequences). Sample exercises are provided including journal writing and training on non-violent communication.

Actions Taken in Other States. In addition to the systematic frameworks developed in Massachusetts and Washington, other states have promoted education on trauma-informed practices. For example, states such as Illinois,⁵⁴ Wisconsin,⁵⁵ and Massachusetts⁵⁶ have included resources on trauma on their State Department/Board of Education websites. Information on trauma can also be incorporated into mental health training received by school staff. In Idaho, three out of four school districts have attended the “Better Today, Better Tomorrow” training on children’s mental health which is offered by Idaho State University and includes education on trauma.⁵⁷

Trauma-Informed Discipline Policies: Lincoln High School, Walla Walla, WA

Jim Sporleder, principal of Lincoln High School, recently implemented an approach to school discipline that looks to the underlying factors prompting student behaviors. Rather than automatically suspending students for behavioral problems, school leaders sit down with students to check in and ask “what’s going on?” Students still receive consequences for their actions, including in school suspensions where they have access to a teacher and a comforting environment. Sporleder reports that students are very receptive to this approach and open up to staff about underlying trauma and stress that are contributing to their behavior. Suspensions and expulsions have also dropped dramatically, from 798 suspensions and 50 expulsions in the 2009-2010 school year (prior to implementing this trauma-informed approach), to 135 suspensions and 30 expulsions in 2010-2011.

[Links to the resources from Massachusetts and Washington highlighted here are included in the resources at the end of this publication.]

Evidence Supporting Trauma-Informed Practices in Schools

Evidence supporting trauma-informed approaches is continuing to grow, but few studies have been published to-date on the effectiveness of this approach in schools. As the Lincoln High School case example above illustrates, when this school implemented a trauma-informed approach, suspensions dropped by 83 percent and expulsions dropped by 40 percent in the year following implementation.⁵⁸ It is hypothesized that trauma-informed practices in schools will help to identify and address the impact of trauma on students' learning and behaviors, ultimately leading to improved educational outcomes.

In Pennsylvania, the Sanctuary Model has been implemented in residential and public schools. The Pace School, an approved private school and partial hospitalization program in Pittsburgh, reported an increase in student attendance and an increase in the percentage of students meeting or exceeding benchmark targets in math and writing following implementation of the Sanctuary Model.⁵⁹ The Sanctuary Model is also utilized by several residential programs with on-site schools, including Wordsworth and Carson Valley Children's Aid.⁶⁰ Highlands School District in Allegheny County, Pennsylvania was the first public school district in the United States to implement the Sanctuary Model in all of its schools.⁶¹

Implementing Trauma-Specific Interventions in Schools

In the context of trauma-informed school systems, evidence-based trauma-specific interventions can be implemented to address the trauma needs of individual students. These treatments target individual students affected by trauma to promote recovery. School-based mental health services have grown in recent decades⁶² and have been promoted by the President's New Freedom Commission on Mental Health in 2003 as an important strategy for early screening and intervention for mental health problems.⁶³ Trauma-specific mental health services may be provided by school-based health centers or community mental health providers co-locate in schools, and schools may also refer students to outside mental health providers for these services.⁶⁴ Research indicates that receiving trauma-specific treatment can lead to improved school attendance and academic outcomes.⁶⁵

A number of trauma-specific treatments have shown promising results for reducing trauma symptoms and behavior problems in children. For example, according to The National Child Traumatic Stress Network, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has the strongest research evidence of any treatment program for children who have experienced trauma.⁶⁶ Through individual sessions with the child and joint sessions between the parent and child, TF-CBT interventions can be remembered using the "PRACTICE" acronym: psychoeducation and parenting skills, relaxation skills, affect regulation skills, cognitive coping and processing skills, trauma narrative, in vivo exposure, conjoint parent-child sessions, and enhancing safety.⁶⁷

Trauma-specific interventions have also been designed specifically for use in schools. For example, Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is an evidence-supported intervention designed for use in schools with children who have experienced trauma. It includes group and individual sessions, as well as psychoeducational sessions for parents and training for teachers. CBITS has also been modified to be delivered by teachers and school counselors to middle school students. The modified program is called Support for Students Exposed to Trauma (SSET), and preliminary research findings indicate that students and parents are satisfied with the program and students show a small reduction in student-reported symptoms of depression and posttraumatic stress disorder (PTSD). More research is warranted to evaluate the effectiveness of SSET.⁶⁸ When trained clinicians are not available at a school to provide trauma-specific treatment, school staff should consider implementing programs

such as SSET designed for non-clinicians or refer students to outside interventions to promote healing from past traumas.

More information on these treatment interventions is available in the resource list at the end of this publication.

Becoming Trauma-Informed in the Classroom: What It Looks Like

The following case examples illustrate the difference between school staff’s response to students in a trauma-informed system, compared to a traditional approach.

<p>Case 1. Tom is walking to lunch in the cafeteria when his classmate Marc bumps into him in the crowded hallway. The students’ eighth grade math teacher, Ms. Clark, hears Tom and Marc begin to yell at one another and steps into the hall just as Tom punches Marc in the face. Ms. Clark and her colleague Mr. Jones step in to break up the fight. This is the third fight Tom has been in this school year.</p>		
	Traditional Approach	Trauma-Informed Approach
Initial Response	Ms. Clark and her colleague verbally reprimand Tom and Marc and call for the school security guard. The boys are escorted to the principal’s office by the security guard and Ms. Clark returns to her classroom.	Ms. Clark and her colleague separate Tom and Marc and bring them each to an empty classroom to calm down. Ms. Clark has developed a strong relationship with Tom and, once he has calmed down, asks him “what’s going on?” It takes a few minutes, but Tom eventually opens up to let Ms. Clark know that he is feeling “on edge” due to instability and violence in his home life. While Ms. Clark is talking with Tom, Mr. Jones deescalates Marc and begins a conversation with him about his behavior.
Disciplinary Action	Both students meet with the principal who quickly gathers the facts and determines that the level of severity of the altercation warrants a 3-day suspension for Marc (as this was his first offense) and a 9-day suspension for Tom. Tom is labeled as a “repeat offender” and told that he will be expelled for his next offense. Both students’ parents are called and told that their child has a discipline problem.	Following their individual conversations, Ms. Clark, Mr. Jones, Tom, and Marc meet with the school principal. In a non-confrontational conversation, both students apologize for over-reacting. Consistent with school discipline policies, both students receive an “in school” suspension; Tom for 3 days (as this was his first offense) and Marc for 6 days (as this was his third offense).
Short- and Long-Term Implications	Marc misses three days of class and Tom misses nine days of class. As a result, both fall behind in their classwork and their grades suffer. Tom and Marc feel that the school	During their time in in-school suspension, Tom and Marc are able to complete their coursework while receiving extra supports.

	<p>has labeled them, and their parents begin to feel that they are working in opposition to the school staff, as opposed to cooperating to better meet their children's needs.</p>	<p>Ms. Clark and the school counselor set aside time to meet together with Tom during his in-school suspension to discuss the instability and violence Tom is experiencing at home, and they learn that Tom was recently placed in the care of his grandmother due to his father's physical abuse of Tom and his mother. The school counselor reaches out to Tom's grandmother to involve her in developing a behavioral plan for Tom at school, and Tom is referred for therapeutic services at a local community mental health agency. Ms. Clark also encourages Tom to join an after-school mentoring program for young men focused on social skills development and academic support.</p> <p>Over time, Tom's behavior and his grades begin to improve.</p>
--	--	---

<p>Case 2. At the beginning of her fifth grade year, Denise was a very outgoing and engaged student. However, lately she has been very quiet in class and rarely raises her hand or speaks unless prompted directly by the teacher. She has started complaining of stomach pains and headaches and frequently visits the school nurse. Denise has also recently missed several days of school.</p>		
	<p>Traditional Approach</p>	<p>Trauma-Informed Approach</p>
<p>Initial Response</p>	<p>Denise's quietness is noticed but in the busy environment of the classroom it is quickly forgotten. With many children in the classroom, there is no time to assess what is going on with each of them individually.</p>	<p>Denise's behavior is noticed but the teacher is responsible for many students and does not have an opportunity to investigate further. On one of her visits to the nurse, Denise is questioned about how she has been feeling and if anything happened recently that has been bothering her. She admits that on the way home from school a few weeks ago she witnessed a child from another school being hit by a car. Since then she has felt intimidated walking to and from school and this has caused significant anxiety that carries into the school day.</p>
<p>School's Response</p>	<p>Denise's stomach pains are written off as an excuse to leave the classroom, and eventually the</p>	<p>The nurse talks with Denise's teacher and her family and she is referred to the appropriate services. The nurse emphasizes the importance of Denise</p>

	teacher and nurse become frustrated with her.	feeling safe while going to and from school.
Short- and Long-Term Implications	On her school evaluations, Denise’s parents are told that she needs to be more attentive in class and that she does not take school seriously. Denise’s grades gradually slip.	Denise’s family makes arrangements for her to walk to/from school with her older sister. This change in her daily routine, combined with counseling services, leads to a decline in Denise’s headaches and stomach pains and an increase in her attendance and engagement in school. A collaborative relationship between Denise’s parents and teacher is formed, and the teacher develops a lesson plan on transportation safety for the class.

These sample cases are similar to the situations faced by many students and teachers every day. In becoming trauma-informed, we look at the “why,” not just the “what” of children’s behavior. In the long run this can lead to better academic performance, fewer disciplinary actions, and a more nurturing school environment where both students and staff feel safer.

The Post-It Note Story: a teacher shared this story as an example of what it means to be trauma-sensitive in the classroom. One day, a student in his World History class placed a post-it note on her forehead reading “I’m bored and I hate this class!” In the past, Mr. Smith explained, he would have sent the student out of class immediately and recommend a one-day suspension. Instead, as part of the school’s trauma-informed approach, he turned to the student and asked her to hand out post-it notes to all of her classmates. He told the students to write down how they felt at that moment, and then place the post-it note on their foreheads. Then, he went around the room and asked each student to explain what they wrote and why. One student wrote “I’m angry my father left.” Mr. Smith was shocked to read notes stating “I am sad that Mr. Smith doesn’t even know my name” or “I wish Mr. Smith liked us.” The experience gave Mr. Smith new insights and the opportunity to connect to his students and share his own perspective in a way he never had before. He explained that the exercise of post-it notes changed his relationship with his students and made them feel more connected. It improved the classroom dynamic and re-engaged students in learning. “It was a great investment of time that continues to pay dividends.”

Creating Trauma-Informed Schools

Creating trauma-sensitive, safe and supportive schools requires a mind-shift by teachers, administrators and school staff. It also requires holistic changes to transform school culture, build a supporting infrastructure and alter curriculum content and interventions. Here is one example of such an approach:

Mastery Charter Schools: Trauma-Informed Learning & Transformational Culture

Since 2010, Mastery Charter Schools, a network of 17 schools (15 located in Philadelphia and two in Camden, NJ), have focused on “turning around” low performing community schools, many of which are located in areas with deep levels of poverty. Many students attending these schools have frequently been exposed to traumatic events, toxic stress, and childhood adversity.

Starting at the beginning of the 2014-2015 school year, Mastery began implementing a plan to become a trauma-informed (TI) network of schools. The TI plan is embedded in a larger “transformational culture” strategy that includes infrastructure changes and an increased emphasis on developing students’ non-cognitive skills (e.g., “growth mindset” –a belief that intelligence is developed–, self-efficacy, and social-emotional skills) as well as an emphasis on exploring and learning from cultural context. The plan includes a set of five principles: deep belief & direct influence; self-awareness & significant relationships; caring communities & restorative learning; student voice & empowerment; and joy. This “transformational culture plan” includes a blending of Mastery’s traditional discipline approach with Restorative Practices that repair relationships, engage parents, and empower students.

In order to implement this trauma-informed approach, Mastery required all staff members to participate in two-hour trainings led by Sanctuary⁶⁹ Institute faculty during the first month of the school year; with three other trauma-informed content trainings planned for the remainder of the school year. Mastery’s instructional standards were also changed substantially to reflect a greater emphasis on creating social belonging and nurturing positive student-teacher relationships. In addition, about once every two weeks, all school-based staff members participate in professional learning communities (PLCs). These are peer-led groups designed to facilitate thoughtful reflection about the ways in which staff members’ individual experiences and background affect their work and relationships with students. The ultimate goal is to have PLCs influence staff members’ interactions with one another, students, and caregivers. Furthermore, as part of a renewed focus on teaching social and emotional skills to its students, Mastery began implementing the Second Step[®] program, a violence prevention curriculum designed to reduce impulsive and aggressive behaviors in children and adolescents by increasing their social competency skills. Mastery uses the Second Step program for all students in its elementary schools, and began implementing an additional SEL program (STEPS-A) at the secondary level. Finally, in order to coordinate and oversee all of these transformational culture changes, each school formed a transformational culture committee (TCC) to provide feedback, guidance, and recommendations for continuous improvement.

Conclusion

An estimated ***two in three children are exposed to traumatic experiences that have the potential to impact brain development, social functioning, and ability to learn and engage in school.*** Recognizing and addressing this issue must become a focus for our educational system. Trauma-informed approaches, which have been supported by research evidence in fields such as mental health and child welfare, recognize and address the implications of traumatic experiences for students. ***Trauma has the potential to affect all students,*** and implementing a trauma-informed approach in Pennsylvania’s schools that builds on the frameworks presented above has the potential for widespread positive effects and students’ academic outcomes.

The U.S. Attorney General’s National Task Force on Children Exposed to Violence recommends that “every school in our country should have trauma-informed staff and consultants providing school-based trauma-specific treatment.”⁷⁰ The recommendations that follow offer a roadmap for how Pennsylvania can take steps towards fulfilling this goal and better meeting the needs of its most vulnerable students.

Statewide Recommendations

1. ***Take legislative action.*** In 2012, Pennsylvania legislators introduced House Resolution No. 659 which called for recognition of youth violence as a public health issue.⁷¹ Had it passed, the Resolution would have supported the establishment of statewide trauma-informed education. Reintroducing this legislation, coupled with a state grant program to fund the development of trauma-informed practices in schools (such as in Massachusetts) would promote the development and integration of trauma-informed practices into Pennsylvania schools.
2. ***Provide professional development for school staff on trauma,*** including a resource guide on the Pennsylvania Department of Education website and offer training opportunities statewide on evidence-based trauma-informed practices.

Recommendations for Administrators & Teachers

1. ***Learn to recognize the symptoms of children who have experienced trauma.*** Children react to trauma in many different ways. The National Child Traumatic Stress Network recommends that teachers be sensitive to the following signs of potential trauma:
 - Fear and anxiety
 - Changes in behavior (e.g., decreased ability to concentrate; increased or decreased activity levels; regressive behaviors; withdrawal from family, peers, and extracurricular activities; anger and irritability; and changes in school performance)
 - Increased complaints about headaches, stomachaches, and other somatic complaints
 - Absenteeism
 - Difficulty responding to redirection and authority⁷²
2. ***Obtain a trauma history.*** This is the first and most important step towards meeting the needs of children who have experienced trauma.
 - According to a recent survey by The National Child Traumatic Stress Network, few schools have protocols in place to obtain trauma histories or further information from transfer students.⁷³ Children often transfer schools because of events that occur downstream from trauma such as a change in living situation or disciplinary action. By creating a standardized protocol to assess past trauma among new students, the school can better meet the child’s learning and behavioral needs from the start.
 - While most, if not all, schools are vigilant in watching for signs of abuse and reporting it, there is often little training on exposure to trauma and there is no standard screening procedure to survey for trauma in all students. An annual screening that assesses either directly or indirectly for trauma would be a helpful primary way of obtaining information and moving towards being trauma-informed. If the screen uncovers an experience of trauma, further assessment and referral to specialized services should take place.
 - It is important for school staff to recognize that children who are system-involved – either with the dependency and/or delinquency system have a high likelihood of being impacted by trauma.

3. **Avoid re-traumatizing.** Know the child’s triggers and avoid the need for punitive action. By recognizing children who have been exposed to trauma and creating an environment that allows them to feel safe, many behavioral problems and disciplinary measures such as detentions, suspensions, and expulsions can be avoided.
4. **Build school-community partnerships with mental health organizations.** Schools are often regarded as an ideal point of entry to mental health services for children.⁷⁴ By developing partnerships between your school and local mental health service providers, you can help to connect students to additional supportive services. Consider developing school-based mental health services provided by school staff or partner providers.
5. **Learn more** about the various trauma informed models that have been developed and consider adopting one. Trauma-informed care is occurring across multiple systems, presenting opportunities for cross-systems learning and collaboration.
6. **Follow These Principals**
 - Take care of yourself. Exposure to others’ trauma can lead to vicarious trauma and compassion fatigue. Identify self-care activities that help you relieve stress (e.g., physical exercise, creative outlets, getting adequate rest). By taking care of yourself first, you will be in a better position to help others while avoiding burnout.
 - Empower students by offering choices and praising positive choices. Avoid power struggles with students by offering choices for participation and encouraging their sense of agency and control over their lives. When students make positive choices, praise them on a job well done.
 - Check in with students. Never underestimate the difference you can make by genuinely asking “what’s going on?” as highlighted in the Lincoln High School example above. This simple question can open up a dialogue and provide you with information you need to better understand and meet students’ needs. Let the student know that you care and the school cares.
 - Remember anniversaries. Students may reveal that a particular date or time of the year reminds them of a traumatic experience (e.g., the date a student was placed into foster care or the anniversary of a loved one’s death). If a student shares this information with you, check in with him/her around the time of the anniversary to see if he/she needs any additional supports. Be sensitive to the fact that learning and behavioral challenges may arise during this time.
 - Be sensitive to the fact that not all children have a “traditional family.” Recognize that students have many different family settings and shift language from “parent” to “caregiver.” Shape your lesson plans to be as inclusive as possible.
 - Identify a mentor for a student. Connect students to programs and adults that can provide additional support.
 - Be sensitive to the fact that students’ parents/caregivers may also be trauma survivors. When working with parents and caregivers, recognize that their past experiences may influence how they interact with you and the school. Build trusting relationships and make the school a safe place for parents/caregivers in order to foster collaboration.

Recommendations for Revising School Discipline Policies

1. Avoid exclusionary school discipline practices that push away the child already impacted by trauma and clearly communicate messages of rejection which are likely to re-traumatize the child. Consider developing school discipline policies that offer alternatives to out-of-school suspensions.
2. Implement school-wide positive behavioral supports. See Education Law Center's "School-Wide Positive Behavior Support: A Plan for Pennsylvania", available at http://www.elc-pa.org/wp-content/uploads/2014/03/ELC_PBSBrief_9_8_10.pdf
3. Approach discipline with the assumption that children are always doing the best that they can, working from where they are emotionally, intellectually, and developmentally right now. Their behavior is a product of their past experiences, good and bad.
4. Consistent with current training for many educators, de-escalation and redirection should be the first line response any time discipline is needed.
5. Form relationships with parents/caregivers and families. They can be valuable allies and almost always have the child's best interest at heart.
6. Avoid "criminalizing" children. Children understand and internalize a lot of what is going on around them. Telling a child that they are in detention for an hour is incredibly similar to sentencing a criminal to a certain amount of time in prison. This often leads to either conscious or unconscious labeling of the child as "bad" both by the staff and students. Going to talk to a counselor instead to investigate why a student has acted out may be more appropriate and less likely to cause further trauma. "Bad" behavior is always a symptom of a larger issue
7. Promote consistency and safety when enforcing school discipline policies.
8. Work to prevent future behavioral problems. Follow a plan of learning, reassessing, and re-integrating. When a child has a behavioral issue, take him/her aside in private and ask "what can we learn from this?" By doing this, incidents become learning opportunities that can improve how the child relates to others and views his/her time in the classroom. Next, reassess how the child sees himself/herself and what has changed as a result of this incident. Finally, the reintegration of the child into the classroom can occur.

For more information, see the Resources Page.

Resources

TRAUMA-INFORMED APPROACHES

National Resources

- *The National Child Traumatic Stress Network* (<http://www.nctsn.org/>) provides resources for a variety of audiences, including school personnel. A “Trauma Toolkit for Educators” (http://www.nctsn.org/sites/default/files/assets/pdfs/Child_Trauma_Toolkit_Final.pdf); information about responding to a school crisis, school safety, the effects of trauma, disaster response, and service interventions; and a list of web resources are available.
- *The National Center for Trauma-Informed Care* (<http://www.samhsa.gov/nctic/about.asp>) is operated by the Substance Abuse and Mental Health Services Administration (SAMHSA). The website provides information on trauma-informed care, links to models that could be adapted for implementation by schools, and information on training and technical assistance support.
- *The Safe Start Initiative* (<http://www.safestartcenter.org/>) is operated by the Office of Juvenile Justice and Delinquency Prevention and works to prevent and reduce children’s exposure to violence and expand understanding of evidence-based practices. The Toolkit for Schools (http://www.safestartcenter.org/infographics/infographic_cev-in-school.php) is a collection of resources for teachers and school administrators that provide information on the prevalence and consequences of children’s exposure to violence and ways they can help.

State Resources

- Massachusetts’s *Helping Traumatized Children Learn*:
http://www.massadvocates.org/documents/HTCL_9-09.pdf
- Washington’s *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success*:
<https://www.k12.wa.us/CompassionateSchools/pubdocs/TheHeartofLearningandTeaching.pdf>
- Wisconsin’s *Creating Trauma-Sensitive Schools to Improve Learning Toolkit*:
http://sspw.dpi.wi.gov/sspw_mhtrauma

Trauma-Informed Models¹

- *Sanctuary Model*[®] (<http://www.sanctuaryweb.com/schools.php>): This model focuses on changing organizational culture to be more sensitive to the impacts of trauma on individuals and families served as well as staff members.
- *Risking Connections*[®] (<http://www.riskingconnection.com/>): This trauma-informed model emphasizes the importance of “RICH” relationships (i.e., relationships marked by respect, information sharing, connection, and hope) and self-care for service providers working with individuals who have experienced trauma.
- *Trauma-Informed Organizational Self-Assessment* (<http://www.familyhomelessness.org/media/90.pdf>): This self-assessment tool was designed for use by homeless services providers but could be adapted and used in the school setting to evaluate and improve practices to better support students who have experienced trauma.

¹ **Note:** As described above, further research is needed to build the evidence base for these models and establish the efficacy of these approaches. They are provided here as examples of current approaches utilized in the field.

Training Resources

- *National Child Traumatic Stress Network Learning Center* (<http://learn.nctsn.org/>): Registering for this free online learning center provides access to several archived sessions of interest to education professionals. The Schools and Trauma Speaker Series has five archived sessions:
 - (1) Trauma-informed IEPs
 - (2) Evidence-based practices
 - (3) Sudden death on a school campus
 - (4) Trauma-informed understanding of bullying
 - (5) School/mental health partnerships

Classroom Tools

- *Southwest Michigan Children's Trauma Assessment Center's School Intervention Project Curriculum* (<http://homepages.wmich.edu/~atchison/School%20Intervention%20Project%20CD%20Revised%20%28SIP%29.pdf>): This resource includes background information on trauma and trauma-informed principles and provides several trauma-informed lesson plans that can be adapted for use with different age groups.

TRAUMA-SPECIFIC INTERVENTIONS

Several online resources profile evidence-based and promising practices for trauma intervention that can be adapted and used by schools, including:

- *National Child Traumatic Stress Network's Empirically Supported Treatments and Promising Practices* (<http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>): These fact sheets summarize program information and research literature on clinical treatment approaches utilized by the National Child Traumatic Stress Network centers.
- *RAND Corporation's "How Schools Can Help Students Recover from Traumatic Experiences Toolkit"* (http://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR413.pdf): This toolkit provides a menu of programs that schools can implement to help children recover from trauma, categorized by type of trauma. Recommendations for securing program funding are also provided.
- *Support for Students Exposed to Trauma* (http://www.rand.org/pubs/technical_reports/TR675.html): This trauma-specific intervention was designed for implementation by teachers and school counselors, and the program manual including lesson plans is available for download.

ENDNOTES

- ¹ SAMHSA (2012). About the National Center for Trauma-Informed Care. Retrieved from <http://www.samhsa.gov/nctic/about.asp>.
- ² Terr, L.C. (1991). Childhood traumas: An outline and overview. *The American Journal of Psychiatry*, 148(1), 10-20 (p.11).
- ³ Cole, S.F., O'Brien, J.G., Gadd, M.G., Ristuccia, J., Wallace, D.L., & Gregory, M. (2005). *Helping Traumatized Children Learn: Supportive School Environments for Children Traumatized by Family Violence*. Boston, MA: Massachusetts Advocates for Children. Retrieved from http://www.massadvocates.org/documents/HTCL_9-09.pdf.
- ⁴ American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- ⁵ Felitti et al. (1998)
- ⁶ American Psychiatric Association (2000).
- ⁷ Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to any of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245-258.; Copeland, W.E., Keeler, G., Angold, A., & Costello, E.J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, 64(5), 577-584.
- ⁸ Felitti et al. (1998); Copeland et al. (2007)
- ⁹ Pennsylvania Department of Public Welfare (2012). *2011 Pennsylvania Department of Public Welfare Annual Child Abuse Report*. Retrieved from http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/report/p_012532.pdf.
- ¹⁰ Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Eliot, M.N., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trial. *JAMA*, 290(5), 603-611. Retrieved from <http://www.youthandfamilyservices.org/wp-content/uploads/2013/10/Stein-et-al-2003-A-Mental-Health-Intervention-for-Schoolch.pdf>
- ¹¹ Flannery, D. J., Wester, K. L., & Singer, M. I. (2004). Impact of exposure to violence in school on child and adolescent mental health and behavior. *Journal of Community Psychology*, 32, 559-573. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/jcop.20019/abstract>.
- ¹² Copeland et al. (2007)
- ¹³ Finkelhor, D., Turner, H., Ormrod, R., Hamby, S., & Kracke, K. (2009). Children's exposure to violence: A comprehensive national survey. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Retrieved from <https://www.ncjrs.gov/pdffiles1/ojdp/227744.pdf>.
- ¹⁴ Campbell, C., & Schwartz, D.F. (1996). Prevalence and impact of exposure to interpersonal violence among suburban and urban middle school students. *Pediatrics*, 98(3), 396-402.
- ¹⁵ Schwab-Stone, M.E., Ayers, T.S., Kaspro, W. & Voyce, C. (1995). No safe haven: A study of violence exposure in an urban community. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 1343-1352.
- ¹⁶ Briggs-Gowan, M.J., Ford, J.D., Fraleigh, L., McCarthy, K., & Carter, A.S. (2010). Prevalence of exposure to potentially traumatic events in a healthy birth cohort of very young children in the Northeastern United States. *Journal of Traumatic Stress*, 23(6), 725-733.
- ¹⁷ Hurt, H., Malmud, E., Brodsky, N.L., Giannetta, J. (2001). Exposure to violence: Psychological and academic correlates in child witnesses. *Archives of Pediatrics & Adolescent Medicine*, 155, 1351-1356.
- ¹⁸ Campbell & Schwartz (1996)
- ¹⁹ Center on the Developing Child at Harvard University. (2007). A science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behavior, and health for vulnerable children. Retrieved from http://developingchild.harvard.edu/index.php/resources/reports_and_working_papers/policy_framework/.
- ²⁰ Andersen, S.L., & Teicher, M.H. (2008). Stress, sensitive periods and maturational events in adolescent depression. *Trends in Neurosciences*, 31(4), 183-191.
- ²¹ Weber, D.A., & Reynolds, C.R. (2004). Clinical perspectives on neurobiological effects of psychological trauma. *Neuropsychology Review*, 14(2), 115-129.

-
- ²² Pechtel, P., & Pizzagalli, D.A. (2011). Effects of early life stress on cognitive and affective function: An integrated review of human literature. *Psychopharmacology*, *214*, 55-70; Impact of Maltreatment on Brain Development available through the Child Welfare Information Gateway at https://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf.
- ²³ Shonkoff, J.P., Garner, A.S., & The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232-e2456 (p. e236). Weber & Reynolds (2004).
- ²⁴ Glass, I. (2012, Sep 13). *This American Life Episode 474: Back to School*. Interview with Dr. Nadine Burke Harris. Podcast retrieved from <http://www.thisamericanlife.org/radio-archives/episode/474/back-to-school>.
- ²⁵ Shonkoff et al. (2012); Center on the Developing Child at Harvard University. Key concepts: toxic stress. http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response.
- ²⁶ Shonkoff et al. (2012)
- ²⁷ McCrory, E., De Brito, S.A., & Viding, E. (2010). Research review: The neurobiology and genetics of maltreatment and adversity. *Journal of Child Psychology and Psychiatry*, *51*(10), 1079-1095.
- ²⁸ Streeck-Fischer, A., van der Kolk, B.A. (2000). Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development. *Australian and New Zealand Journal of Psychiatry*, *34*, 903-918.
- ²⁹ 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*, 408-413.
- ³⁰ Delaney-Black, V., Covington, C., Ondersma, S.J., Nordstrom-Klee, B., Templin, T., Ager, J., Janisse, J., & Sokol, R.J. (2002). Violence exposure, trauma, and IQ and/or reading deficits among urban children. *Archives of Pediatric and Adolescent Medicine*, *156*, 280-285.
- ³¹ Shonk, S.M., & Cicchetti, D. (2001). Maltreatment, competency deficits, and risk for academic and behavioral maladjustment. *Developmental Psychology*, *37*(1), 3-17.
- ³² Van der Kolk, B. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America*, *12*(2), 293-317.
- ³³ Margolin, G., & Gordis, E.B. (2000). The effects of family and community violence on children. *Annual Review of Psychology*, *51*, 445-479.
- ³⁴ Streeck-Fischer & van der Kolk (2000)
- ³⁵ Copeland et al. (2007); Felitti et al. (1998)
- ³⁶ Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., & Anda, R.F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatric*, *111*(3), 564-572.; Dube, S.R., Miller, J.W., Brown, D.W., Giles, W.H., Felitti, V.J., Dong, M., & Anda, R.F. (2006). Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *Journal of Adolescent Health*, *38*, 444.e1-444.e10.
- ³⁷ Weeks, R., & Widom, C.S. (1998). Self-reports of early childhood victimization among incarcerated adult male felons. *Journal of Interpersonal Violence*, *13*(3), 346-361.; Smith, D.K., Leve, L.D., & Chamberlain, P. (2006). Adolescent girls' offending and health-risking sexual behavior: The predictive role of trauma. *Child Maltreatment*, *11*(4), 346-353.
- ³⁸ SAMHSA (2012).
- ³⁹ Bloom, S.L. (2007). The Sanctuary Model of trauma-informed organizational change. *The Source, The National Abandoned Infants Assistance Resource Center*, *16*(1), 12-14. Retrieved March 5, 2013 from http://www.sanctuaryweb.com/PDFs_new/Bloom%20The%20Sanctuary%20Model%20The%20Source%20Articles%20Sanctuary.pdf.
- ⁴⁰ The Sanctuary Model (2013). The Sanctuary Model: An integrated theory. Retrieved March 5, 2013 from <http://www.sanctuaryweb.com/sanctuary-model.php>.
- ⁴¹ Azeem, M.W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R.B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, *24*(1), 11-15.

-
- ⁴² Rivard, J.C., Bloom, S.L., McCorkle, D., & Abramaovitz, R. (2005). Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, 26(1), 83-96.
- ⁴³ Amaro, H., Chernoff, M., Brown, V., Arevalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862.; Huntington, N., Moses, D.J., & Veysey, B.M. (2005). Developing and implementing a comprehensive approach to serving women with co-occurring disorders and histories of trauma. *Journal of Community Psychology*, 33(4), 395-410.
- ⁴⁴ Kramer, T.L., Sigel, B.A., Conners-Burrow, N.A., Savary, P.E., & Tempel, A. (2013). A statewide introduction of trauma-informed care in a child welfare system. *Children and Youth Services Review*, 35, 19-24.
- ⁴⁵ Conradi, L., & Wilson, C. (2010). Managing traumatized children: A trauma systems perspective. *Current Opinion in Pediatrics*, 22, 621-625.
- ⁴⁶ NCTSN (2013). Creating trauma-informed systems. Retrieved March 5, 2013 from <http://www.nctsn.org/resources/topics/creating-trauma-informed-systems>.
- ⁴⁷ Cole et al. (2009)
- ⁴⁸ Cole et al. (2009)
- ⁴⁹ MGL c. 69, sec. 1N
- ⁵⁰ Cole et al. (2009)
- ⁵¹ Massachusetts Department of Elementary and Secondary Education (2009). *State Safe and Supportive Learning Environments Grant Program: FY2008 Summary*. Retrieved March 18, 2013 from <http://www.doe.mass.edu/tss/fy08eoyreport.pdf>.
- ⁵² Wolpow, R., Johnson, M.M., Hertel, R., & Kincaid, S.O. (2011). *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success*. Olympia, WA: Office of Superintendent of Public Instruction. Retrieved from <http://www.k12.wa.us/CompassionateSchools/Resources.aspx>. (p. 78).
- ⁵³ Stevens, J.E. (2012, Jun 26). Trauma-sensitive schools are better schools. *Huffington Post*. Retrieved from http://www.huffingtonpost.com/jane-ellen-stevens/trauma-sensitive-schools_b_1625924.html.
- ⁵⁴ Illinois State Board of Education (n.d.). Comprehensive System of Learning Supports: Trauma. Retrieved from <http://www.isbe.state.il.us/learningsupports/html/trauma.htm>.
- ⁵⁵ Wisconsin Department of Public Instruction (2013). Mental Health: Creating Trauma-Sensitive Schools to Improve Learning: A Response to Intervention (RtI) Model. Retrieved from http://sspw.dpi.wi.gov/sspw_mhtrauma.
- ⁵⁶ Massachusetts Department of Elementary & Secondary Education (2011). Trauma Sensitive Schools. Retrieved from <http://www.doe.mass.edu/tss/>.
- ⁵⁷ Idaho State University (2011). Institute of Rural Health: Better Today's. Better Tomorrows. Retrieved from http://www.isu.edu/irh/projects/better_todays/.
- ⁵⁸ Stevens (2012)
- ⁵⁹ Pace School Programs (2011). Impact of the Sanctuary Model. Retrieved from http://www.paceschool.org/wp-content/uploads/2011/06/Microsoft-PowerPoint-TIC-Conference_2011.pdf
- ⁶⁰ Andrus Center for Learning and Innovation (2011). Sanctuary Institute. Retrieved from http://andruschildren.org/?page_id=834.
- ⁶¹ Highlands School District (2013). The Sanctuary Model. Retrieved from <http://www.goldenrams.com/Page/15>
- ⁶² Paternite, C.E. (2005). School-based mental health programs and services: Overview and introduction to the special issue. *Journal of Abnormal Child Psychology*, 33(6), 657-663.
- ⁶³ President's New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Retrieved from http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/New_Freedom_Commission/Default1169.htm.
- ⁶⁴ Jaycox, L.H., Morse, L.K., Tanielian, T., & Stein, B.D. (2006). *How Schools Can Help Students Recover from Traumatic Experiences: A Tool Kit for Supporting Long-Term Recovery*. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR413.pdf.
- ⁶⁵ SAMHSA (2011). Helping Children and Youth Who Have Experienced Traumatic Events. National Children's Mental Health Awareness Day. HHS Publication No. SMA-11-4642. Retrieved from http://www.samhsa.gov/children/SAMHSA_Short_Report_2011.pdf.

-
- ⁶⁶ NCTSN (2012). Trauma-Focused Cognitive Behavioral Therapy: General Information. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf.
- ⁶⁷ SAMHSA (2013). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). *SAMHSA's National Registry of Evidence-based Programs and Practices*. Retrieved from <http://www.nrepp.samhsa.gov/viewintervention.aspx?id=135>.
- ⁶⁸ Jaycox, L.H., Langley, A.K., Stein, B.D., Wong, M., Sharma, P., Scott, M., & Schonlau, M. (2009). Support for Students Exposed to Trauma: A pilot study. *School Mental Health, 1*, 49-60.
- ⁶⁹ Bloom, S.L. (2007).
- ⁷⁰ Listenbee, R.L., Torre, J., Boyle, G., Cooper, S.W., Deer, S., Durfee, D.T., James, T., Lieberman, A., Macy, R., Marans, S., McDonnell, J., Mendoza, G., & Taguba, A. (2012). *Report of the Attorney General's National Task Force on Children Exposed to Violence*. U.S. Department of Justice. Retrieved from <http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf>.
- ⁷¹ Pennsylvania H.R. 659. (2012). Retrieved from <http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2011&sessInd=0&billBody=H&billType=R&billNbr=0659&pn=3339>.
- ⁷² National Child Traumatic Stress Network Schools Committee (2008). *Child Trauma Toolkit for Educators*. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/Child_Trauma_Toolkit_Final.pdf.
- ⁷³ Taylor, N., & Siegfried, C.B. (2005). Helping Children in the Child Welfare System Heal from Trauma: A Systems Integration Approach. Los Angeles, CA & Durham, NC: National Child Traumatic Stress Network, Systems Integration Working Group. Retrieved from http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/A_Systems_Integration_Approach.pdf.
- ⁷⁴ Ko, S.J., Kassam-Adams, N., Wilson, C., Ford, J.D., Berkowitz, S.J., & Wong, M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*(4), 396-404.