Trauma-Informed Schools: A Journey

By Joseph Fantigrossi, EdD, and Jay Roscup

Trauma is not the event. Trauma is the response. Each individual responds to chronic or acute stress differently and that response determines the level of traumatic impact. Maya Angelou said, “Do the best you can until you know better. Then when you know better, do better.” At least as early as 2011, critical research outlining the impact of trauma on young people was shared out by NYS; as educators who now know better, we are tasked with changing the conversation in our schools from “what is wrong with this student?” to “what has happened to this student?”

The ACEs (adverse childhood experiences) research study was conducted by the health maintenance organization Kaiser Permanente and the Centers for Disease Control and Prevention. The study produced several remarkable findings, but the most unexpected was the impact of childhood trauma on not only social-emotional health, but on physical health as well. It was found that adverse childhood experiences disrupted the child's neurodevelopment. This disruption led to social, emotional, and cognitive impairment, which led to the adoption of health-risk behaviors due to the compromised functioning of the brain's decision-making process. The impact of the risk behaviors contributed to disease, disability, and social problems for those with high ACE scores and ultimately to early death. However, even without risky behaviors, ACEs alone were enough to impact health outcomes.

In a parent survey of 554 incoming kindergarten students in 11 districts in Wayne County, New York, in 2016, 10 percent of our students were identified by their parents as having had two or more traumatic experiences. When we cross-referenced those results with their responses on other survey questions, we came away with a concerning picture. Incoming kindergartners with two or more ACEs were:

- 13 times less likely to be able to focus on an activity other than TV or computer
- 7 times more likely to have moved four or more times
- 6 times more likely to ignore rules at home
- 4 times more likely to never read with a parent/adult.

We were eager to know more about how this impacted our students as they matured. Across Wayne County, sixth, eighth, tenth, and twelfth graders from all 11 school districts participated in the Evalumetrics Youth Survey, a locally created version of the Hawkins and Catalano tool. Students who self-identified as having two or more ACEs were significantly more likely to adopt high-risk behaviors. This included the following:

- 2 times as likely to have used alcohol in the past 30 days
- 4 times as likely to have used any drug other than marijuana in the past 30 days
- 3 times as likely to inflict self-injury (e.g., cutting)
- 5 times as likely to have a suicide plan.

Trauma is often associated with poverty; poverty alone or trauma alone is sufficient to disrupt positive youth development, so when a young person experiences complex trauma while living in poverty, the natural chances for positive outcomes drastically diminish. Middle school students who scored at-risk for food insecurity and had two more ACEs had a remarkably higher likelihood to participate in the aforementioned risky behaviors:

- 8 times as likely to have used alcohol in the past 30 days
- 9 times as likely to have used any drug other than marijuana in the past 30 days
- 6 times as likely to inflict self-injury (e.g., cutting)
- 10 times as likely to have a suicide plan.

With this knowledge, we knew we had a moral imperative to address our students' trauma in an efficient and effective manner. NYSED defines our consortium of districts as high-needs, low-resource districts. In practical terms, this means we have to raise the level of service we provide all students so our more intensive intervention systems are not flooded. We concluded that the best way to do so would be to implement a tiered-intervention model. The key was to view the theory of a multitiered system of support through a trauma-informed lens. To organize our efforts, we utilized the ARC framework.

ARC stands for the domains of attachment, regulation (self), and competency. Blaustein and Kinniburgh identify this framework as a "flexible, components-based intervention developed for children and adolescents who have experienced complex trauma, along with their caregiving systems." We consider our graduates successful if they have developed skills in each one of the three domains.

Attachment is helping students understand that they are part of something bigger than themselves and that they have impact and importance. It begins with positive relationships with caregivers and blossoms in connections with groups in their community. Regardless of the chosen activity, it is critical for the young person to feel a sense of belonging and commitment to the success of their organization. The common refrain of the impact of "just one caring adult" is supported by this model, and it is true that one significant relationship can be the seed for resilience for a young person.

Self-regulation "emphasizes cultivating youth awareness and skill in identifying, understanding, tolerating, and managing internal experience." Students understand that they are not in control of the stimulus but that they can be in control of their response. We support this for all students with clearly articulated, and taught, PBIS expectations and by implementing the second-step curriculum in our elementary school.

The competency domain speaks to providing an opportunity for all students to uncover their strengths. When surveyed, many of our young people have low levels of self-efficacy, as they do not believe their decisions have an impact on their future. We address this by building resilience through empowerment and student choice. Our commitment to the principles of personalized learning has led to more relevance for our students and helped them build skills for today and tomorrow.

A prerequisite to accomplishing this important work with our students was building capacity for our staff. We are asking our educators to make a huge paradigm shift in how they view the very nature of our profession. Understanding, and perhaps even more importantly, accepting that we must meet Maslow's hierarchy prior to addressing Bloom's taxonomy is extraordinarily uncomfortable for those who were traditionally trained.

We began with several book studies to build a body of knowledge and stoke interest in successfully meeting the needs of our students. This included *Reaching and Teaching Children Who Hurt*

by Susan Craig and *Helping Traumatized Children Learn* by the Trauma and Learning Policy Initiative. The former helped us look at classroom-specific strategies and the latter provided a structure for us to consider how we could systematize our interventions. It was never the case that we were not responding to the needs of our students. It was that we were fighting the fires one at a time instead of developing and implementing a comprehensive prevention plan.

Training our staff in research-based practices has also been a key component in our process. In collaboration with Cornell University, we had several staff members participate in a train-the-trainer model for Therapeutic Crisis Intervention for Schools (TCIS). TCIS is a crisis prevention and intervention model developed to assist schools in the following:

- Preventing crises from occurring
- De-escalating potential crises
- Effectively managing acute crises
- Reducing potential injury to children and staff
- Learning constructive ways to handle stressful situations.

In our consortium districts, we found an inverse correlation between the number of staff trained in a school and the number of office disciplinary referrals written in that school.

Youth Mental Health First Aid USA (YMHFA) training also played a critical role in supporting our staff. YMHFA trains staff in recognizing the signs and symptoms of mental health problems and learning how to offer help before, during, and after a mental health crisis occurs. More than 600 staff in our consortium were trained in the last three years and 100 percent of the participants recommended this training for others. It is important to emphasize that we train any staff member who comes in regular contact with our students, regardless of their position.

We would be remiss if we did not mention the importance of self-care for those who work with traumatized students. Compassion fatigue, or vicarious trauma, is a well-documented result of the work educators in high-stress environments perform. We recommend that every educator have a self-care plan and that they frequently ask themselves the following questions: “How do I recharge and heal?” and “Who do I go to when I need help?”

Trauma-informed schools will not be accomplished with a district-purchased canned program or another committee. It is best done as an adaptation of the good things we are already doing for our students. While consultants can be helpful in organizing current practices, districts should be careful of anyone peddling “trauma-informed” care in a single package. It is not doing more but approaching our work through the lens of creating a safe and supportive environment for all of our young people. When we present in different venues, we are often asked, “How do you know a student has faced trauma?” Our response is always the same: “You don’t, so treat every student with care, respect, and dignity.” And isn’t that what we want for all students anyway?

JOSEPH FANTIGROSSI, EdD, is the PreK-12 intervention coordinator in the Lyons Central School District.

JAY ROSCUP is the consortium grants administrator in the Lyons Central School District.

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