THE IMPORTANCE OF TRAUMA-INFORMED PRACTICES IN EDUCATION TO ASSIST STUDENTS IMPACTED BY GUN VIOLENCE AND OTHER ADVERSITIES

HEARING

BEFORE THE

SUBCOMMITTEE EARLY CHILDHOOD, ELEMENTARY, AND SECONDARY EDUCATION

COMMITTEE ON EDUCATION AND LABOR
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C O N T E N T S

THE IMPORTANCE OF TRAUMA-INFORMED PRACTICES IN EDUCATION TO ASSIST STUDENTS IMPACTED BY GUN VIOLENCE AND OTHER ADVERSITIES

Wednesday, September 11, 2019
House of Representatives,
Subcommittee on Early Childhood,
Elementary, and Secondary Education,
Committee on Education and Labor,
Washington, DC

The subcommittee met, pursuant to call, at 10:18 a.m., in Room 2175, Rayburn House Office Building, Hon. Gregorio Kilili Camacho Sablan (Chairman of the subcommittee) presiding.

Present: Representatives Sablan, Schrier, Hayes, Shalala, Davis, DeSaulnier, Morelle, Scott, Allen, Thompson, Grothman, Taylor, Timmons, and Foxx.

Also Present: Representatives McBath, Bonamici, Wild, Trone, and Lee.

Staff Present: Tylease Alli, Chief Clerk; Ramon Carranza, Education Policy Fellow; Emma Eatman, Press Assistant; Mishawn Freeman, Staff Assistant; Christian Haines, General Counsel; Stephanie Lalle, Deputy Communications Director; Andre Lindsay, Staff Assistant; Jaria Martin, Clerk/Assistant to the Staff Director; Max Moore, Office Aide; Jacque Mosley, Director of Education Policy; Veronique Pluviose, Staff Director; Lakeisha Steele, Professional Staff; Loredana Valtierra, Education Policy Counsel; Joshua Weisz, Communications Director; Ashley White, Education Policy Fellow; Cyrus Artz, Minority Parliamentarian; Kelsey Avino, Minority Fellow; Courtney Butcher, Minority Director of Member Services and Coalitions; Bridget Handy, Minority Communications Assistant; Dean Johnson, Minority Staff Assistant; Amy Raaf Jones, Minority Director of Education and Human Resources Policy; Hannah Matesic, Minority Director of Operations; Audra McGeorge, Minority Communications Director; Carlton Norwood, Minority Press Secretary; Brandon Renz, Minority Staff Director; Chance Russell, Minority Legislative Assistant; Mandy Schaumburg, Minority Chief Counsel and Deputy Director of Education Policy; and Brad Thomas, Minority Senior Education Policy Advisor.

Chairman SABLAN. Good morning. The Committee on Education and Labor will come to order. Welcome, everyone.

I note that a quorum is present.

The committee is meeting today in a legislative hearing to hear testimony on the importance of trauma-informed practices in education to assist students impacted by gun violence and other adversities.

I note for the subcommittee that Ms. Bonamici of Oregon, Mrs. McBath of Georgia, Ms. Omar of Minnesota, Mr. Trone of Maryland, Mrs. Lee of Nevada, Ms. Wild of Pennsylvania and Mr. Castro of Texas are permitted to participate in today's hearing, with the understanding that their questions will come only after all Members of the subcommittee on both sides of the aisle who are present have had an opportunity to question the witnesses.

Pursuant to Committee Rule 7(c), opening statements are limited to the Chair and the Ranking Member. This allows us to hear from our witnesses sooner and provides all Members with adequate time to ask questions.

Can you hear me? Can you hear me all right?

I recognize myself now for the purpose of making an opening statement. I want to begin by acknowledging that this morning marks 18 years since the terrorist attacks that struck New York, Pennsylvania, and the Pentagon on September 11, 2001. Let us please take a moment to remember the 2,977 lives lost in those attacks.

[Moment of silence.]

Chairman SABLAN. Thank you. This morning, we are here to discuss the Federal Government's responsibility to ensure that every child from the Marianas to Maine has a nurturing learning environment.

Today, many children are prevented from reaching their full potential because they are suffering from the significant long-term effects of trauma. In fact, 34 million children, or 45 percent of children, have endured an adverse childhood experience that can hinder their ability to learn and grow.

Extensive research show that children who have experienced trauma and toxic stress are more likely to be forced into fight or flight mode. In school, this can often manifest in trouble, paying attention, an impulse to fight and depression or anger. These challenges can be further compounded by harsh school discipline instead of helpful support if a school is unaware of the science of trauma and toxic stress. My third grade teacher should have known this.

But seriously, the trauma and stress of natural disasters have also affected student learning and well-being. For the over 950 Hopwood Middle School students in my district who lost their campus to Super-Typhoon Yutu, starting the new school year in FEMA-built tents is certainly not an ideal learning environment, especially when the students themselves have their homes lost or damaged.

Damages from the storm have also forced schools to send their students to attend half-day sessions at other school campuses, robbing them of a full day of learning and the emotional security of having a campus community of their own.

While we do not yet fully understand how the students will fare over time under these circumstances, studies show that over a life-

time, victims of trauma can face a higher risk of drug and alcohol abuse, greater risk of suicide, and shorter lifespan.

Dr. Robert Block, a former president of the American Academy of Pediatrics, has been widely quoted as saying, quote: "Adverse childhood experiences are the single greatest unaddressed public health threat facing our Nation today," end quote.

Children across the world experience trauma; the United States is not unique in that regard. But there are specific preventable forms of trauma that our children experience more frequently than anywhere else in the world. The most notable example is gun violence. America's gun homicide rate for 15- to 24-year-olds is nearly 50 times higher than in other high-income countries, 50 times.

According to a database maintained by the Washington Post, 228,000 students have experienced gun violence at school since the Colombine tragedy in 1999, 228,000 students. Americans, of course, are not 50 times more violent than citizens of other developed countries, of course not. But what distinguishes us from other developed nations is that we have failed to pass basic gun violence prevention laws that are supported by an overwhelming share of our constituents.

The consequences of that failure are felt in communities like Odessa, El Paso, Dayton, and Virginia Beach, which have all experienced mass shootings in the past 3 months. They are also felt by residents in Chicago, St. Louis, Detroit, and other cities where families live under the constant threat of gun violence.

And while this hearing is about implementing trauma-informed school practices, we cannot ignore the reality that most of this trauma is preventable. Reducing gun violence, ending family separations, improving access to mental healthcare, quickly rebuilding schools lost to natural disasters, addressing poverty are some of the many challenges we can make to improve the quality of life for children across the country.

But given that we have shown little ability to address these issues, the very least we can do is help schools educate children who shoulder the burden of our inaction. More than 70 percent of children who need mental health services do not receive the appropriate care. Low-income students of color, who are more likely to experience trauma, are often concentrated in segregated public schools that cannot afford critical mental health resources; and as a result, children of color disproportionately suffer the physical and emotional effects of trauma.

In addition, the report by the Government Accountability Office found that States are facing numerous issues supporting children affected by trauma, including funding challenges. And to make matters worse, President Trump and the congressional Republicans are further restricting mental healthcare at schools by repeatedly moving to slash funding for K to 12 education. This includes the elimination of Title II funding for teachers' professional development and the critical Title IV-A program, which is designed to improve school conditions for student learning.

The experts here today will broaden our understanding of how trauma-informed care can be integrated into learning practices, student discipline, and support services, to improve graduation rates, student achievement, and school climate. They will also help

us understand how Congress can support trauma-informed practices that are proven to help students succeed.

Today's discussion is an important step towards addressing a pervasive public health issue that is affecting communities throughout and across the country. Thank you to all the witnesses for being here. I now yield to the Ranking Member, Mr. Allen, for his opening statement.

[The statement of Chairman Sablan follows:]

Prepared Statement of Hon. Gregorio Kilili Camacho Sablan, Chairman, Subcommittee Early Childhood, Elementary, and Secondary Education

I want to begin by acknowledging that this morning marks eighteen years since the terrorist attacks that struck New York, Pennsylvania, and the Pentagon on September 11, 2001. Let us please take a moment to remember the nearly 3,000 lives lost in those attacks. Thank you.

This morning, we are here to discuss the federal government's responsibility to ensure that every child—from the Marianas to Maine—has a nurturing learning environment.

Today, many children are prevented from reaching their full potential because they are suffering from the significant, long-term effects of trauma. In fact, 34 million children, or 45 percent of children, have endured an adverse childhood experience that can hinder their ability to learn and grow.

Extensive research shows that children who have experienced trauma and toxic stress are more likely to be forced into "fight-or-flight" mode.

In school, this can often manifest in trouble paying attention, an impulse to fight, and depression or anger.

These challenges can be further compounded by harsh school discipline, instead of helpful support, if a school is unaware of the science of trauma and toxic stress.

The trauma and stress of natural disasters has also affected student learning and well-being.

For the over 950 Hopwood Middle School students in my district who lost their campus to Super Typhoon Yutu, starting the new school year in FEMA-built tents is certainly not an ideal learning environment especially when the students themselves had their homes lost or damaged.

Damage from the storm has also forced schools to send their students to attend half-day sessions at other schools, robbing them of a full day of learning and the emotional security of having a campus community of their own.

While we do not yet fully understand how these students will fare over time under these circumstances, studies show that over a lifetime, victims of trauma can face a higher risk of drug and alcohol abuse, greater risk of suicide, and shorter lifespan.

Dr. Robert Block, former president of the American Academy of Pediatrics, has been widely quoted as saying, "Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today."

Children across the world experience trauma; the United States is not unique in that regard. But there are specific, preventable forms of trauma that our children experience more frequently than anywhere else in the world.

The most notable example is gun violence. America's gun homicide rate for 15–24-year-olds is nearly 50 times higher than in other high-income countries.

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What distinguishes us from other developed nations is that we have failed to pass basic gun violence prevention laws that are supported by an overwhelming share of our constituents.

The consequences of that failure are felt in communities like Odessa, El Paso, Dayton, and Virginia Beach, which have all experienced mass shootings in the past three months.

They are also felt by residents in Chicago, St. Louis, Detroit, and other cities where families live under the constant threat of gun violence.

While this hearing is about implementing trauma-informed school practices, we cannot ignore the reality that much of this trauma is preventable.

Reducing gun violence, ending family separations, improving access to mental health care, quickly rebuilding schools lost to natural disasters addressing poverty, are some of the many changes we can make to improve the quality of life for children across the country.

But – given that we have shown little ability to address these issues – the very least, we can do is help schools educate children who shoulder the burden of our inaction.

More than 70% of children who need mental health services do not receive the appropriate care.

Low-income students of color, who are more likely to experience trauma, are often concentrated at segregated public schools that cannot afford critical mental health resources.

As a result, children of color disproportionally suffer the physical and emotional effects of trauma.

A recent report by the Government Accountability Office found that states are facing numerous issues supporting children affected by trauma, including funding challenges.

To make matters worse, President Trump and Congressional Republicans are further restricting mental healthcare at schools by repeatedly moving to slash funding for K–12 education.

This includes the elimination of Title II funding for teachers' professional development and the critical Title IV- A program, which is designed to improve school conditions for student learning.

The experts here today will broaden our understanding of how trauma-informed care can be integrated into learning practices, student discipline, and support services to improve graduation rates, student achievement, and school climate.

They will also help us understand how Congress can support trauma-informed practices that are proven to help students succeed.

Today's discussion is an important step towards addressing a pervasive public health issue that is affecting communities across the country.

Thank you to all the witnesses for being here. I now yield to the Ranking Member, Mr. Allen, for his opening statement.

Mr. ALLEN. Thank you, Mr. Chairman, and thank you for recognizing the anniversary of 9/11, and note that this discussion is particularly poignant, given this day. Sadly, far too many children are affected by trauma. Because of their age and reliance on adults to keep them safe, children are more vulnerable to trauma. Studies show that 26 percent of children in the United States will witness or experience a traumatic event before they turn four, and more than two-thirds of children reported at least one traumatic event by age 16.

Even more disturbing are the statistics surrounding children in the welfare system. Ninety-five percent of children reported psychological and physical abuse, and 99 percent reported psychological and sexual abuse. This is absolutely heart-breaking. Trauma can include any variety of frightening event, such as physical and sexual abuse, cyberbullying, bullying, or the death of a loved one. These can be caused by events at home, in the community, or around the world.

Children that face more than two traumatic experiences in their life can develop reactions that negatively impact their daily life. In fact, trauma can affect a child's education and impair their learning. Research shows that there is a correlation between traumatic events and cognitive and behavioral issues.

A study of more than 1,000 children from 20 large cities in the United States found that traumatic events in early childhood were associated with below-average academic and literacy skills. In fact, I have been told in my district that if a child isn't reading at the level of third grade by the time they finish the third grade, he is

more likely to drop out of school and he has an 85 percent chance of being incarcerated.

Educators and school staff can serve as a critical support system for traumatized children and their families. If a student is acting out, failing tests, or having difficulty concentrating, it may be a sign of trauma. If teachers understand what is a traumatized student and what they are facing, they can better accommodate and address those child's needs in the classroom.

However, teachers in the education system are no replacement for family and faith. Moms and dads and grandpas and grandmas cannot be replaced in the life of a child. Faith cannot be replaced in the life of a child. Education is just one piece of supporting and shaping children. All of us in this room today want to see our Nation's children and make sure that they are loved, happy, safe and successful. In fact, my goal when I ran for office, it is time to quit losing our children.

There is not a person here that does not care deeply about their futures. That is why we shouldn't turn any kind of trauma experienced by a child into a political platform. Instead, we should focus on equipping families, schools, and communities with the tools they need to shape young Americans to be successful leaders. After all, we have a vested and sincere interest in the well-being of our Nation's children. They are our future.

This hearing will examine the effects of trauma on school children and how to identify and address them and, most importantly, how we can help students have access to a safe, supportive, and healthy learning environment.

I had as a point of personal privilege, I had the opportunity while we were on our district work period to visit with many school officials. I will not name the superintendent, but had the opportunity to visit with him as tears came to his eyes and he described three suicides of young people in that school system last year. And I asked him why. And he said, they are without hope. Where is the hope?

It is interesting too that I was given a book at a meeting two weekends ago. It is called Death on Hold. I never thought somebody on death row would teach me what this gentleman, Mitch, taught me in reading this book about what he went through as a child, what he experienced in the streets, why he was on death row, and why now he is making an impact on so many lives, particularly young people who are making bad choices. I highly recommend this book. It is required reading for Members of Congress, because I think they will see where the real problem lies.

Thank you, Mr. Chairman, and I look forward to hearing our witnesses today.

[The statement of Mr. Allen follows:]

Prepared Statement of Hon. Rick W. Allen, Ranking Member, Subcommittee Early Childhood, Elementary, and Secondary Education

Thank you for yielding.

Sadly, far too many children are affected by trauma. Because of their age and reliance on adults to keep them safe, children are more vulnerable to trauma. Studies show that 26 percent of children in the United States will witness or experience a traumatic event before they turn four, and more than two thirds of children reported at least one traumatic event by age 16. Even more disturbing are the statistics surrounding children in the welfare system. Ninety-five percent of children re-

ported psychological and physical abuse, and 99 percent reported psychological and sexual abuse. This is absolutely heartbreaking.

Trauma can include any variety of frightening events such as physical and sexual abuse, cyber bullying, or the death of a loved one. These can be caused by events at home, in the community, or around the world. Children that face more than two traumatic experiences in their life can develop reactions that negatively impact their daily life.

In fact, trauma can affect a child's education and impair their learning. Research shows that there is a correlation between traumatic events and cognitive and behavioral issues. A study of more than 1000 children from 20 large cities in the United States found that traumatic events in early childhood were associated with below-average academic and literacy skills. In fact, I have been told in my district that if a child isn't reading at level by third grade, he is more likely to drop out of high school and be incarcerated.

Educators and school staff can serve as a critical support system for traumatized children and their families. If a student is acting out, failing tests, or having difficulty concentrating it may be a sign of trauma. If teachers understand what a traumatized student is facing, they can better accommodate and address those child's needs in the classroom. However, teachers and the education system are no replacement for family and faith. Moms' and dads' and grandmas' and grandpas' cannot be replaced in the life of a child. Faith cannot be replaced in the life of a child. Education is just one piece of supporting and shaping children.

All of us in this room today want to see our nation's children are loved, happy, safe, and successful. There's not a person here who doesn't care deeply about their futures. Which is why we shouldn't turn any kind of trauma experienced by a child into a political platform. Instead we should focus on equipping families, schools, and communities with the tools they need to shape young Americans to be successful leaders. After all, we have a vested and sincere interest in the wellbeing of our nation's children – they are our future.

This hearing will examine the effects of trauma on school children, how to identify and address them, and most importantly, how we can help students have access to a safe, supportive, and healthy learning environment. I look forward to hearing from our witnesses today.

I yield back.

Chairman SABLAN. Thank you very much, Ranking Member Allen.

Without objection, all other Members who wish to insert written statements into the record may do so by submitting them to the Committee Clerk electronically in Microsoft Word format by 5 p.m. on September 25th.

I will now introduce our witnesses. Dr. Nadine Burke Harris is the surgeon general of California. She is also an award-winning physician, researcher, and advocate dedicated to changing the way our society responds to one of the most serious, expensive, and widespread public health crises of our time: Childhood trauma.

Previously, she founded the Center for Youth Wellness and subsequently grew the organization to be a national leader in the effort to advance pediatric medicine, raise public awareness, and transform the way society responds to children exposed to adverse childhood experiences and the toxic stress. She also founded the Bay Area Research Consortium on Toxic Stress and Health, to advance scientific screening and treatment of toxic stress. Dr. Nadine Burke Harris has published academic articles on adverse childhood experiences and trauma. She also published a book entitled The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. Wow, you've been busy, Dr. Harris.

Next, Dr. Ingrida Barker is the associate superintendent of McDowell County Schools in West Virginia. She is in her 16th year as an educator, 6 of which were dedicated to teaching at Sandy River Middle School, and 3 spent as a high school administrator in

charge of the curriculum and instructions at River View High School. Two of my youngest happen to be public school teachers, so Dr. Barker.

Currently, Dr. Barker works as an associate superintendent in McDowell County Schools. She also serves as the county's testing and Title IX coordinator and works extensively to support the development of comprehensive student supports in the county. Dr. Barker earned her Bachelor of Arts degree from Latvia in English and French, and completed a Master of Arts degree from West Virginia University in secondary education. And Dr. Barker received a doctoral degree in leadership studies at Marshall University.

Ms. Joy Hofmeister—I got that right? Ms. Hofmeister is the State Superintendent of Public Instruction in Oklahoma. She was originally elected to serve as State Superintendent of Public Instruction in November 2014, and began her second term as Oklahoma State Superintendent in January of this year. Since taking office, the State has repealed its ineffective State exams, released a more meaningful and new user-friendly accountability system, and bolstered student safety.

With an emphasis on collaboration and a focus on ensuring Oklahoma students have access to opportunities to achieve academic success, Hofmeister has strengthened academic standards and testing, revamped teacher evaluation, and brought statewide attention to the need for trauma-informed instructional practices that meet children where they are.

And finally, but not the least, Dr. Janice Jackson is the chief executive officer of Chicago's Public School system. Archer. She has been immersed in CPS her entire life, as a former student, teacher, principal, network chief, chief education officer, and now as a parent to CPS students.

As CEO of the third largest school district in the country, Dr. Jackson is a forward-thinking educator who is focused on improving excellence, equity, and access in all CPS schools. Her efforts, along with those of Chicago's dedicated teachers and principals, have propelled CPS students to record-breaking academic gains, and education experts from across the country regard Chicago as a national leader in urban education. She holds a master's degree in leadership and administration and a doctorate in urban school leadership from the University of Illinois at Chicago.

Welcome, all of you. We appreciate all the witnesses for being here today and look forward to your testimony. Let me just remind the witnesses that we have read your written statements, and they will appear in full in the hearing records.

Pursuant to Committee Rule 7(d) and committee practice, each of you is asked to limit your oral presentation to a five-minute summary of your written statement. Let me remind the witnesses that, pursuant to Title 18 of the U.S. Code, Section 1001, it is illegal to knowingly and willfully falsify any statement, representation, writing, document, or material fact presented to Congress or otherwise conceal or cover up a material fact.

Before you begin your testimony, please remember to press the button on the microphone—we ourselves forget doing that once in a while—the microphone in front of you, so that it will turn on and the Members can hear you. And as you begin to speak, the light

in front of you will turn green. After 4 minutes, the light will turn yellow to signal that you have 1 minute remaining. When the light turns red, your five minutes have expired and we ask that you please wrap up.

We will let the entire panel make their presentations before we move to Member questions. When answering a question, please remember to once again turn your microphone on.

I will first recognize Dr. Nadine Burke Harris. You have five minutes.

STATEMENT OF NADINE BURKE HARRIS, MD, MPH, FAAP, CALIFORNIA SURGEON GENERAL, STATE OF CALIFORNIA, SAN FRANCISCO, CA

Dr. BURKE HARRIS. Good morning and thank you for the opportunity to participate in this hearing on trauma-informed practices. A robust body of literature demonstrates that adverse childhood experiences, or ACEs, are highly prevalent, strongly associated with poor childhood and adult health, mental health, behavioral and social outcomes, and demonstrate a pattern of high rates of intergenerational transmission.

High levels of adversity, without the buffering protections of a trusted caregiver and safe, stable environments, lead to overactivity of the biological stress response and changes in brain structure and function, how genes are read, the functioning of the immune and inflammatory systems, and changes in growth and development. These changes are what comprise what is now known as a toxic stress response.

Sixty-two percent of American adults have experienced at least one ACE and 15 percent have experienced four or more. Those with four or more face double the risk of seven out of ten of the leading causes of death in the United States, including heart disease, stroke, and cancer. And the original CDC research was done in a population that was 70 percent Caucasian, 70 percent college-educated. There is no sociodemographic or geographic group that is spared.

The higher the ACE score, the more likely an individual is to also struggle with depression, PTSD, sleep and eating disorders and substance abuse. A national study of more than 35,000 adults found that even after adjusting for the impact of sociodemographics and substance use, ACEs are independently associated with as much as four times the risk of incarceration. Similarly, research has indicated that a common factor among individuals committing mass shootings is a history of multiple ACEs.

Among the most notable and perhaps well-studied effect of ACEs are the impact on learning and behavior. Compared to children with no ACEs, kids with four or more ACEs are as much as 32 times as likely to experience learning and behavior problems and are 3 times as likely to repeat a grade.

The science is clear; adverse childhood experiences are a public health crisis that require coordinated, cross-sector response. Scientific consensus supports two core principles: One, early detection and early intervention improves outcomes; and two, safe, stable, and nurturing relationships and environments are healing. Schools

and our educators are a critical part of an ecological and public health response to ACEs and toxic stress.

Trauma-informed practices in schools involves ensuring that all personnel are trained to understand that disruptive behaviors may be possible symptoms of toxic stress and respond with compassionate buffering care. In addition, trauma-informed training and practices and policies include establishing systems that enable safety, including predictable routines and social interactions, a calm physical environment, transparent and predictable rules, having clear nonpunitive consequences for violating rules, teaching social and emotional skills, participatory decision-making by students in school policies, and explicit family and community involvement, including support for families who are managing stress.

Restorative disciplinary practices and programs to prevent retraumatization should be the norm. Programs to support vulnerable children and youth can align with the six pillars of mitigating the toxic stress physiology, which include promoting healthy nutrition, physical exercise, mindfulness, mental health, sleep hygiene, and supportive relationships.

In addition, prevention of vicarious traumatization and supports for educator well-being are essential elements for trauma-informed educational environments. Important elements also include workforce training, dissemination of best practices, data reporting and rigorous evaluation.

As noted by authors in a recent commentary in the journal Pediatrics, both the World Health Organization and the Centers for Disease Control and Prevention recognize that schools are not only places to transmit academic knowledge, but also a place for vulnerable children to connect with supportive adults and peers outside of their families. Supportive relationships with peers, teachers, and coaches as well as school connectedness and belonging have been shown to protect against depression, substance use, and other risky behaviors and also support and promote academic success.

The opportunity ahead of us is about the true intersection of healthcare and education. Thank you for this opportunity to share the science, and I urge you to use this information to inform your actions on behalf of the American people.

[The statement of Ms. Burke Harris follows:]

Written Statement of Dr. Nadine Burke Harris
Surgeon General of California
Before the Committee on Education and Labor
United States House of Representatives
Full Committee Hearing:
Trauma-Informed Care in Schools
September 11, 2019

Good Morning. Thank you for the opportunity to participate in this hearing on Trauma Informed Practices. My name is Dr. Nadine Burke Harris and I'm a pediatrician, toxic stress researcher and, now, California's Surgeon General. I also was member of the National Academies of Sciences, Engineering and Medicine (NASEM) committee on applying Neurobiological and Socio-behavioral Sciences from Prenatal through Early Childhood Development: A Health Equity Approach that recently released the report Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity. My work has been dedicated to changing the way our society responds to one of the most serious, expensive and widespread public health crises of our time: childhood trauma.

Adverse Childhood Experiences prevalence and impacts in today's society

An overwhelming scientific consensus demonstrates that cumulative adversity, particularly during critical and sensitive developmental periods, is a root cause to some of the most harmful, persistent and expensive health challenges facing our nation.

The term Adverse Childhood Experiences or "ACEs" comes from the landmark study of the same name published by the CDC and Kaiser Permanente over two decades ago and specifically refers to the ten categories of stressful or traumatic events assessed in the study. These include physical, emotional or sexual abuse, physical or emotional neglect or "household dysfunction" including parental incarceration, mental illness, substance dependence, parental separation or divorce, or intimate partner violence. A robust body of literature demonstrates that ACEs are highly prevalent, strongly associated with poor childhood and adult health, mental health, behavioral and social outcomes and demonstrate a pattern of high rates of intergenerational transmission.

According to the most recent published CDC data reporting from the Behavioral Risk Factor Surveillance System (BRFSS) in 23 states, 62 percent of American adults have experienced at least one of the eight ACEs tracked by the BRFSS, and 15 percent have experienced 4 or more.[i] ACEs are associated, in a dose-response fashion, with significantly increased odds of negative health outcomes, including 7 out of 10 of the leading causes of death in the United States.

	Leading Causes of Death in US, 2015	Odds Ratio Associated with ≥ 4 ACEs
1	**Heart Disease**	**2.1**
2	**Cancer**	**2.3**
3	**Chronic Lower Respiratory Disease**	**3.0**
4	Accidents	
5	**Stroke**	**2.4**
6	**Alzheimer's**	**11.2**
7	**Diabetes**	**1.5**
8	Influenza and Pneumonia	
9	Kidney Disease	
10	**Suicide**	**30.1**

All odds ratios from Hughes et al, 2017 except stroke (Felitti et al, 1998) and Alzheimers (Center for Youth Wellness, 2014).[ii]

Research has also indicated that the higher the ACE score, the more likely the individual is to struggle with mental health issues such as depression, post-traumatic stress disorder, anxiety, sleep and eating disorders, and to engage in risky behaviors such as early and high-risk sexual behavior and substance abuse.[iii],[iv],[v]

Individuals with six or more ACEs have a life expectancy that is 19 years shorter than individuals with none.[vi]

In childhood, high doses of adversity are associated with increased risk of respiratory infections, asthma, atopic diseases, poor growth, obesity, learning and attention disorders, sleep disorders, teen pregnancy, teen paternity, STIs, mental health disorders, substance use and high risk behaviors (among other conditions).[vii],[viii] For example, a child with 4 or more ACEs are twice as likely to develop asthma as children with no ACEs.[ix]

In addition to these health and mental health outcomes, ACEs are also associated in a dose-response fashion with increased social risks as well. Research looking at more than 60,000 youth in the Florida juvenile justice system found that 97% had experienced at least one ACE and 52% had experienced 4 or more ACEs.[x] In fact, a national study of more than 35,000 adults found that even after adjusting for the impact of socio-demographics and substance use, ACEs are independently associated with as much as 4 times the risk of incarceration.[xi]

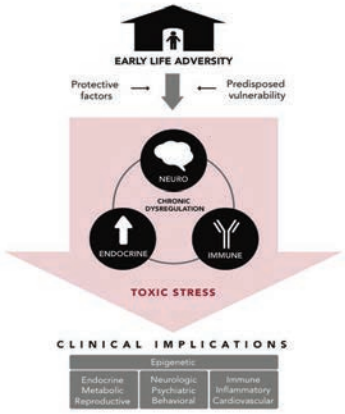
The Toxic Stress Response

Advances in science over the past several decades have demonstrated that long-term changes to the body's stress response system play an important role in the clinical progression from ACE exposure to negative short and long-term health and social outcomes.

When any one of us experiences something scary or threatening, our brains and bodies activate our stress response which leads to the production of high levels of stress hormones including adrenaline and cortisol and is responsible for many of the feelings we associate with being terrified. The amygdala, the brain's fear center, is activated and the prefrontal cortex, which is responsible for executive functioning including attention, judgement and impulse control, is inhibited. Stress hormones stimulate our hearts to beat stronger and faster, raise blood pressure and blood sugar, and activate our immune system, among many other effects. The stress response is a normal and, in fact, essential part of our biological evolution, and allows us to respond and adapt to challenging circumstances.

However, severe, intense or prolonged adversity may lead to overactivity of a child's stress response. In addition, children require the nurturing care of a trusted adult and safe environments to shut off the stress response and restore normal functioning. Without these buffers, the biological stress response becomes overactive. Children are uniquely vulnerable to the effects an overactive stress response because their brains and bodies are just developing. High levels of adversity, without the buffering protections of trusted caregivers and safe, stable environments, lead to changes in brain structure and function, how genes are read, functioning of the immune and inflammatory systems, and growth and development. These changes comprise what is now known as the toxic stress response.

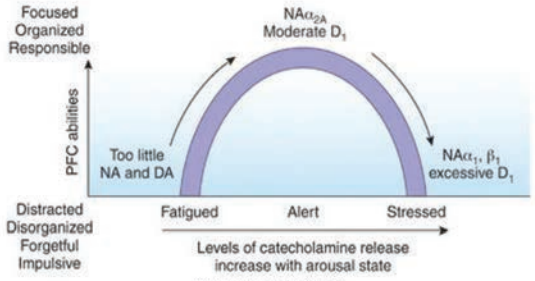
While the term ACEs refers specifically to the 10 categories identified in the ACE study, it is recognized that other social determinants of health such as discrimination, economic hardship, food and housing insecurity (among others) are also risk factors for toxic stress.



Bucci et al, 2016[xii]

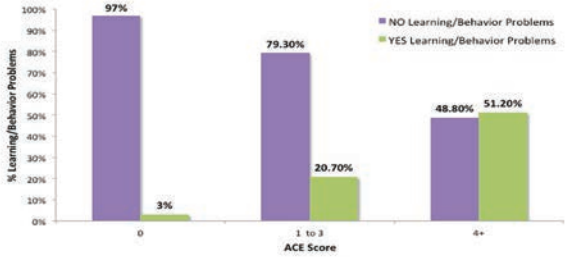
ACEs, Toxic Stress and Learning

Among the most notable and perhaps well-studied effects of ACEs are the impacts on learning and behavior. As ACEs increase, we see alterations and impairment of several brain regions including the hippocampus — where new memory formation takes place, an area critical to learning; as well as changes in the amygdala (the brain's fear center) leading to enhanced vigilance, startle, and aggressive behavior.[xiii] Importantly, the prefrontal cortex, which governs executive function, demonstrates an "inverted U" response curve in relation to stress hormones. While too little PFC activation can lead to symptoms of Attention Deficit Hyperactivity Disorder (ADHD), as stress hormones increase beyond healthy levels, the prefrontal cortex is inhibited, leading to similar symptoms of distraction, disorganization, forgetfulness and poor impulse control[xiv].



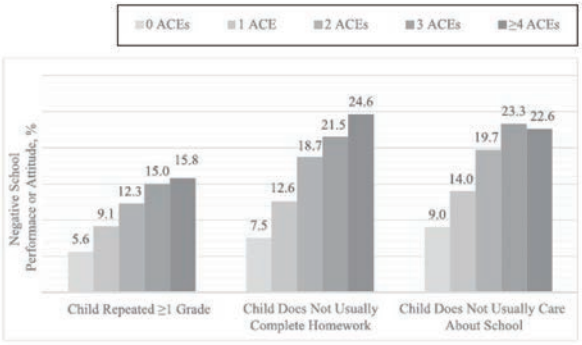
Armsten et al, 2009[xv]

These brain changes underlie the clinical observation that a child's exposure to ACEs increases, learning and behavior in children are impaired in a dose-response pattern. Children with 4 or more ACEs are as much as 32 times as likely to experience learning and behavior problems as compared to children with 0 ACEs. [xvi]



Burke, et all 2011[xvii]

A recent study looking at data from more than 65,000 children also found that as ACE scores increase, risk of repeating a grade increases and homework completion as well as school engagement declines.[xviii]



Prevalence of negative school performance and attitude outcomes by number of ACEs among children ages 6 to 17 (2011-2012 NSCH).
Robles et all, 2019[xix]

How can we support learners exposed to adversity?

The good news is that we have a clear opportunity to mitigate or reverse the impacts of ACEs and Toxic Stress and increase positive outcomes. Though there is still much work to be done to understand the precise mechanisms of the toxic stress pathways, scientific consensus supports two core principles: 1) **early detection and early intervention improve outcomes**, and 2) **safe, stable and nurturing relationships and environments are healing**.

An extensive body of literature demonstrates that the earlier interventions take place, the more likely they are to be effective and the less intensive and costly they need to be. Safe, stable and nurturing environments are associated with improved immune functioning, hormonal functioning, DNA regulation and brain development.[xx] In fact, MRI studies found that institutionalized children randomized to high quality nurturant caregiving showed **normalization of the developmental trajectory of white matter structures** as compared to children who received care as usual.[xxi]

The recently released NASEM report Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity recommends a range of short- and long-term changes to practice, policy, and systems and a suite of strategies crucial to advancing health equity. To facilitate early detection, the NASEM Report recommends that health providers:

> *"Adopt and implement screening for trauma and adversities early in life to increase the likelihood of early detection. This should include creating rapid response and referral*

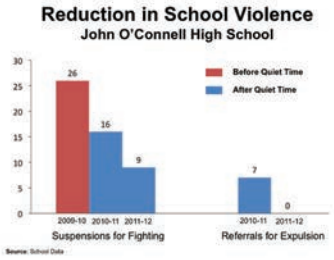
> *systems that can quickly bring protective resources to bear when early-life adversities are detected, through the coordination of cross-sector expertise."*[xxii]

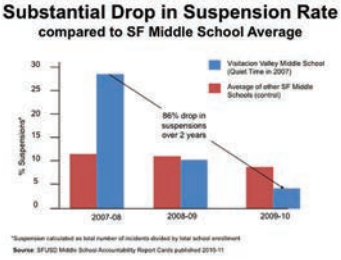
Educational systems have an important role to play in early detection and early intervention by collaborating and coordinating with trained health providers to ensure that children are screened for trauma and adversities and by providing interventions that are appropriate for educational settings such as school-based mental health.

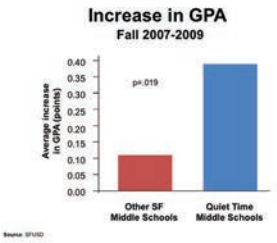
In addition, given the significant prevalence of ACEs in all regions, socio-economic and demographic populations, trauma-informed training, practices and policies in the educational setting are fundamental to ensuring that all children have the best opportunity to learn. This includes establishing systems that enable safety, including predictable routines and social interactions, a calm physical environment, transparent and predictable rules, having clear, non-punitive consequences for violating rules, teaching social-emotional skills, participatory decision-making by students in school policies, and explicit family and community involvement, including support for families on parenting or managing stress.[xxiii],[xxiv],[xxv] Restorative disciplinary practices and school structures that support physical and emotional safety, the effective building of such relationships, prevent re-traumatization, and optimize children's cognitive and social-emotional learning should be the norm.

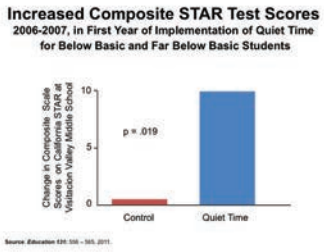
Stable, safe, and nurturing relationships and environments are known to buffer the toxic stress response.[xxvi] Trauma-informed practices in schools involves ensuring all personnel are trained to understand that 'disruptive' behaviors may be possible symptoms of toxic stress and respond with compassionate, buffering care.[xxvii],[xxviii] Programs to support vulnerable children and youth can align with the six pillars of mitigating the toxic stress physiology, which include promoting sleep hygiene, healthy nutrition, physical exercise, mindfulness, mental health, and supportive relationships.[xxix] In addition, prevention of vicarious traumatization and supports for educator well-being are essential elements for trauma-informed educational environments. There is a natural alliance between the health and education sectors in responding to ACEs.[xxx]

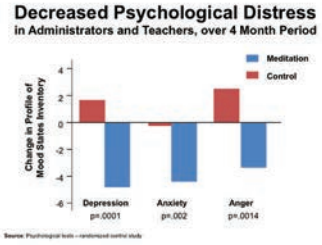
Pilots of programs that have implemented interventions to help target the toxic stress response in school environments, such as the Quiet Time program implemented by the Center for Wellness and Achievement in Education (cwae.org), have demonstrated improvements in educational outcomes including GPA, standardized test scores, and measures of teacher well-being, while reducing negative indicators such as school violence, suspension, expulsion and the African American achievement gap.[xxxi]

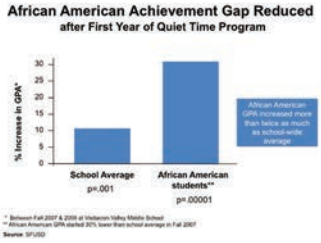






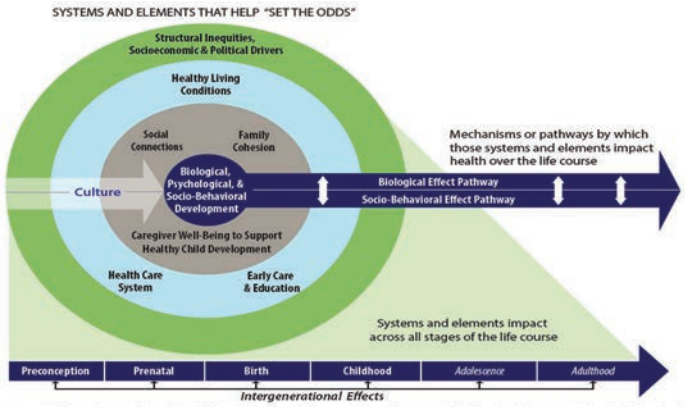






Longer-term, we need to begin building systems that allow for more easily sharing data that will allow for iteratively improving quality and integration of care across institutions like education, healthcare, childcare, welfare, and juvenile justice. [xxxii], [xxxiii], [xxxiv]

Finally, the NASEM Report elaborates a conceptual framework that recognizes that individual and familial outcomes are nested in and influenced by neighborhood, community, and structural factors that "set the odds" of either adverse or enhanced health and developmental trajectories.



NASEM report Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity, 2019[xxxv]

A true public health response to ACEs and toxic stress involves intervention at all levels and includes the following key principles, as noted in the report[xxxvi]:

- Intervene early. In most cases, early intervention programs are easier to implement, more effective, and less costly.
- Support caregivers. This includes both primary caregivers and caregivers in systems who frequently interact with children and their families (such as those in our educational system).
- Reform health care system services to promote healthy development. Redesign the content of preconception, prenatal, postpartum, and pediatric care while ensuring ongoing access, quality, and coordination.
- Create supportive and stable early living conditions:
    - Reduce child poverty and address economic and food security,
    - Provide stable and safe housing, and
    - Eliminate exposure to environmental toxicants.
- Maximize the potential of early care and education to promote health outcomes.
    - Research shows that early care and education (ECE) affects children's physical, emotional, and mental health. To maximize the potential of ECE to promote improved health outcomes, **the committee recommends a comprehensive approach to school readiness that explicitly incorporates health outcomes, developing and strengthening curricula that focus on key competencies of educators,** and improving the quality of ECE programs and expanding access to comprehensive high-quality and affordable ECE programs.
- **Implement initiatives across systems to support children, families, other caregivers, and communities. Ensure trauma-informed systems, build a diverse and supported workforce, and align strategies that work across sectors.**

  - No single sector can mitigate the early-life drivers of health inequities. The complex, interconnected root causes of health disparities call for coordination across multiple sectors and a systems approach. For this reason, **the committee provides recommendations for sectors to collaborate and align their work.** Child- and family- serving sectors specifically should enhance detection of early-life adversity, improve response systems, and **develop trauma-informed approaches**, among other systems level efforts outlined in the report.
- **Integrate and coordinate resources across the education, social services, and health care systems, and make them available to translate science to action.**

Schools and our educators are a critical part of an ecological and public health response to ACEs and Toxic Stress. As noted by authors in the recent commentary published in the journal *Pediatrics* on ACEs and educational engagement, "Both the World Health Organization and the Centers for Disease Control and Prevention recognize that schools are not only places to transmit academic knowledge but also a place for vulnerable children to connect with supportive adults and peers outside of their families. Supportive relationships with peers, teachers and coaches as well as school connectedness and belonging have been shown to protect against depression, substance use, and other risky health behaviors. These positive connections also promote academic success." [xxxvii]

There are initial steps being taken in my home state and across the country by passionate advocates, healthcare providers, community leaders, government officials, educators and others to more systematically address ACEs and Toxic Stress. Early movers are not only focused on solutions for their communities, but also in creating models, best practices and protocols that can easily be replicated or tailored nationally and globally.

California has been a leader in advancing health and health equity for our communities. We are currently taking historic strides to battle ACEs and Toxic Stress with programs across sectors including healthcare and education.

The role of California Surgeon General was created explicitly marshal the insights and energy of the medical professionals, public health experts, public servants and everyday Californians to address the upstream factors including toxic stress and early social determinants of health that are the root causes of many of the most harmful and persistent health challenges facing Californians.

Specifically, California is preparing to implement ACEs screening among 88,000 primary care providers serving Medicaid patients in California starting in January of 2020, and we are also creating a State-wide, data-driven quality improvement collaborative and related infrastructure for sharing best practices, challenges, and iterating upon initial successes. By deploying a well-formulated public health approach to prevention, screening, and intervention, our objective is to cut the burden of ACEs and toxic stress in half in the next generation.

In support of this effort, the Governor Newsom's signed budget includes:

- $40.8M to reimburse providers for performing Adverse Childhood Experiences (ACES) screenings of children and adults on Medi-caid
- $50M to train primary care providers on how to screen for ACEs and respond with trauma-informed care
- Investments in evidence-based interventions including >$130M for Home Visiting Programs

In addition, California seeks to build a multidisciplinary network of systems that provides doses of buffering relationships, environments, and treatment to kids and their caregivers through as many touchpoints as possible. In order to truly combat ACEs and Toxic Stress, there must be a trauma-informed and a trauma-sensitive workforce in our schools, after-school programs, doctors' offices, hospitals, faith groups, justice system, welfare agencies, and throughout our communities.

For example, in education, California has allocated:

- $195m to the early learning and care workforce in education/training grants
- $50m in After School Education and Safety Programs
- $31.4m ($124.9m ongoing) to increase access to State Preschool for 10,000 income-eligible children in community based organizations
- And $5m investment in developing a Master Plan for Early Learning and Care

Collaborating across sectors creates accountable communities and builds more effective collective and equitable action. Services need to be focused on supporting the family, while also enhancing the quality and quantity of the buffering care systems throughout society.

Conclusion

The science is clear. Adverse Childhood Experiences are a public health crisis that require a coordinated public health response. This involves public education, routine screening to enable early detection and early intervention, and cross-sector coordinated care.

The opportunity ahead of us is about a true intersection of healthcare and education. This collaboration is vital to look at how health and education programs, when paired together, can truly have an impact on the individual child, their families and the broader community.

As we embark on the ambitious effort to reduce ACEs and toxic stress on a national scale, important considerations include workforce training, continual quality improvement, dissemination of best practices, data reporting and utilization, and rigorous research and evaluation.

Breakthrough improvements in the health and well-being of communities exposed to ACEs and experiencing toxic stress are possible with coordinated clinical, research and public health efforts to prevent and heal the impacts of ACEs and toxic stress.

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Chairman SABLAN. Thank you very much, Dr. Burke Harris.

I would like to now recognize Dr. Barker for five minutes, please.

STATEMENT OF INGRIDA BARKER, ED.D., ASSOCIATE SUPERINTENDENT, MCDOWELL COUNTY SCHOOLS, WELCH, WV

Ms. BARKER. Good morning. I work in one of the poorest districts in the United States. According to the 2019 Kids Count data, we face the highest rates of children living in poverty, low birth weight babies, and children in kinship care or children living with grandparents. These numbers alongside mounting drug overdose rates create the perfect storm of issues that impedes our students' well-being and subsequently their academic achievement.

Besides battling the issues associated with drug misuse, we face the challenges brought to us by generational poverty, ranging from kinship care issues to generational trauma our students' families face. The schools see the adverse impact of these challenges on student attendance, behavior, and academics. For many students whose main focus is on survival and managing their basic needs, all the mental capacity is used up on managing the stress in their lives. Instead of thinking about reading or doing math, they need to think about their physical and emotional health needs.

Stability and social structures lack in many of our students' lives, and that is why our schools face increasingly challenging behaviors and have to use a variety of resources to provide continuous learning opportunities for all of our students. Hence, the importance of trauma-informed practices and health supports in our schools. The need to help our students overcome trauma and focus on learning is immediate, overwhelming, and complex.

It is known that students who are born to low socioeconomic status tends to lag behind academically when they enter our schools. They also come to us with several ACE scores. Many of our kids witness abuse, parent drug overdose, parent incarceration and violence early on. Schools can break the cycle of chronic stress and

trauma by helping provide protective factors, such as strengthening social connections, providing concrete support in the time of need, and helping children develop social and emotional competence.

We as educators have a choice: Wait for somebody else to come and help our families and children, or we can do something now while we have our kids in our schools. In McDowell County Schools, we choose the latter. Of course, the school staff cannot do the job alone. We have degrees in education, not in mental health, psychiatry, or social work. Therefore, we are applying community school strategy to leverage and coordinate resources with the school and the community providers to help our kids. School community strategy is also an equity strategy. It creates collaborative partnerships with various community organizations to meet the unique needs of the whole child, including family and kinship supports. Of course, building and maintaining so many partnerships requires the full-time position of the community schools coordinator, as the principals or central office staff struggle to find time to do this in addition to their direct instructional duties.

Southside K8 in our district has been using community school strategy for several years, and now we see that we can keep our teachers. Instead of having a 40 percent turnover every year, we have very few teachers leaving. So it contributes to that stable environment and great culture in the school.

As a district, we have an emphasis on securing collaborative partnership on a district level, because we are so remote and the schools frequently don't have the opportunities to get on the partnerships themselves. But funding for all these positions in addition to the graduation coaches, nurses, social workers is a challenge for a rural county with a diminishing tax base. Therefore, increases in the funding formula for education, like Title I and IDEA as well as Title IV, is needed.

When faced with choices of directing these funds to meet students' needs, we should not have to choose between helping students to learn and do math and hiring nurses, mental health therapists and social workers. Both types of services are vital for our students to succeed, as the schools have become hubs of community and, therefore, have to meet the needs of the whole child instead of engaging in a piecemeal approach, having to choose between funding academics or social and emotional supports.

The implementation of trauma-focused practices and wraparound services serves as a solid strategy to prevent students from engaging in destructive behaviors of drug misuse, violence, and risky behavior. These practices also can break the cycle of generational poverty and generational trauma in our students' lives, because their parents often coped with that trauma themselves and cannot help our students as much as they could.

Thank you so much for your time to listen to my statement.

[The statement of Ms. Barker follows:]

Written Statement of Dr. Ingrida Barker
Associate Superintendent, McDowell County Schools, WV

Before the Committee on Education and Labor
Early Childhood, Elementary, and Secondary Education Subcommittee
United States House of Representatives
Full Committee Hearing:
The Importance of Trauma-Informed Practices in Education to Assist Students Impacted by Gun Violence and Other Adversities
September 11, 2019

Thank you for the invitation to participate in the hearing aimed at discussing trauma-informed care in rural schools and the importance of supporting children affected by trauma. My name is Ingrida Barker. I hold a position of an associate superintendent of McDowell County Schools. In my line of work, I oversee various aspects of schooling, ranging from direct academic guidance to working with principals, counselors, and other stakeholders to ensure student success. I also work closely with mental health support delivery in our county schools.

Our school system has been the recipient of Now Is The Time (NITT) Project Aware funds geared toward establishing mental health supports in McDowell County Schools. In five years of receiving the grant, we were able to establish partnerships with various mental health providers and bring mental health services to our students in each of our schools. Even though our foremost goal is to provide educational opportunities for our students regardless of their background and socio-economic status, I understand that helping students meet their basic needs before they step into the classroom is vital to achieving any of their learning goals.

Therefore, I am honored to be here today to discuss trauma-informed practices in our rural district and their importance in supporting students affected by trauma in order to help them become productive citizens of tomorrow.

Effect of Adversity and Trauma on students in McDowell County Schools

It is known that students who are born to low socio-economic status tend to lag behind academically, as they are not read to or spoken to at the level that their higher socio-economic status counterparts are. That means that our students come to us having been exposed to millions of words less than their more affluent peers. Besides academic challenges, many students come to us with several Adverse Childhood Experiences (ACE) scores. ACEs are traumatic events that occur in a child's life prior to the age of 18 and can harm the child's brain and development, consequently resulting in long term health issues. It is even more important to discuss ACE scores in this statement because research shows the link between opioid addiction and early childhood adversity. Many of our children witness abuse, parent drug overdose, parent incarceration, or violence early on. According to the Adverse Childhood Experience Coalition of West Virginia, 52 percent of children from low-income families have at least one ACE score. The study performed by the coalition also found that **58 percent** of West Virginia residents reported exposure to ACEs, identifying substance abuse as the most common adverse childhood

experience. Schools can break the cycle of chronic stress and trauma by helping provide protective factors identified by ACE research. School can help strengthen social connections, provide concrete support in the time of need, and help children develop social and emotional competence. These supports are already embedded in trauma-informed practices at schools, the home visiting project in McDowell County Schools, and Handle with Care supports provided in collaboration with local law enforcement.

Many of our students live with their grandparents who frequently struggle with raising today's youth. Many also live in single-parent homes or bounce from a friend's house to a relative's home. Stability and social structures lack in many of the students' lives and that's why our elementary schools face increasingly challenging behaviors and have to use a variety of resources to be able to provide continuous learning opportunities not only for the children who exhibit these behaviors but also to other students in class. Teaching and classroom management strategies are not enough when working with students with various diagnoses, and often schools have to call on special needs specialists to help them troubleshoot issues and come up with needed solutions. It is still important to note that we are not mental health professionals. We are merely educators trying to help our students become ready to learn. However, we have to take so many more steps to get the students to that readiness stage and engage a variety of community partners just to be able to help our students pay attention to the instruction in class.

Taking these steps also means involving community partners and funding resources to help our students' families with job training, healthcare including prevention and treatment (dental, mental, and physical health included), as well as strengthening the social safety net for the families our schools serve. Often, our parents and grandparents do not have a sounding board and continue the cycle of trauma and adverse experiences if not provided with support groups. Our county Title I director does a marvelous job with parent and grandparent support groups as well as home visiting to build positive relationships between school and home. However, those dollars are also used to focus on helping improve reading and mathematics teaching and learning, which is a wise investment considering the gaps that our students face when starting PreK and Kindergarten. When the district is faced with a choice to use funding for academics or social emotional supports, the choice is always a challenging one and one we should not be forced to make.

Relationships with community partners can also help bring professional development resources to teachers in terms of blending classroom management approaches with specific knowledge about various disabilities or trauma informed care. As I have stated before, education professionals do not get provided with training on trauma, ACES, or extreme behavior management in college classes. However, they need this knowledge in order to build compassionate relationships based on understanding trauma and promoting high expectations for student success. The community schools strategy is an effective way to bring those supports by helping establish collaborative leadership to include families and community partners in decision-making, staff and student capacity building through integrated student supports, as well as providing expanded time for learning opportunities.

Trauma-Informed Care in Rural Schools

McDowell County Schools is located in one of the poorest districts in the United States. The district provides meals to all students through the Community Eligibility program, so the percent of low socioeconomic status (SES) students who qualify for free and reduced lunch is calculated by using direct certified data from the WV DHHR instead of using the data from free and reduced lunch applications. According to the WV DHHR percentage of direct certified students receiving benefits through the DHHR, 71% of students in the district are of ow SES. However, when applying a USDA approved multiplier of 1.6 for Title I low SES percentages, the district is at 100% low SES. According to the 2019 Kids Count "The State of Our Children" data book, McDowell County has the highest rates of children living in poverty (54.3%), low-birth weight babies (12.9%), and children in kinship care/living with grandparents (13.3%). These numbers alongside mounting drug overdose rates, with McDowell County showing as a county with significantly higher rates of overdose (81.2 per 100,000 according to the WV DHHR data review from 2014-2016), create a perfect storm of issues that impedes student well-being, and, subsequently, their academic achievement.

Besides battling the issues associated with drug misuse, the county schools face the challenges brought in by general poverty, ranging from kinship care issues to generational trauma students' families face. The schools see adverse impact of these challenges on student attendance, behavior, and academics. For many students whose main focus is on survival and managing the basic needs, all the mental capacity is used up on managing the stress in their lives. Learning to read or multiply is not on the forefront of their attention due to chronic stress and trauma, and their families usually don't have the knowledge or sufficient academic experiences themselves to be able to alleviate stress in the lives of their children and help them focus on the academic goals. Hence, the importance of trauma-informed practices and health supports in schools. The need to help our students overcome trauma and focus on learning is immediate, overwhelming, and complex.

We as educators have a choice- wait for somebody else to come in and help families and children in our district address issues coming from generational poverty and chronic stress or we can help our students now, while we have them in our schools. In McDowell County Schools, we choose the latter. Of course, the school staff cannot do it alone. We have degrees in education, not in mental health, psychiatry, or social work. Therefore, applying the community schools strategy to leverage and coordinate resources between the school and the community provides access to supports and opportunities for our students beyond what the school system could provide with its limited resources. The Community Schools strategy involves creating collaborative partnerships with various community organizations to meet the unique needs of the whole child, including family and kinship supports. Wraparound services within the framework of community and school partnerships serve as an equity strategy. Most of the students in our school district lack access to the most basic resources. Providing them with mental, dental, and physical health resources as well as helping with clothing or housing ensures that the student readiness levels to experience the world around them are similar to the experiences as their more affluent counterparts.

Living and working in a remote, mountainous district provides additional challenges. School system and other employees in the area struggle with recruiting and retaining employees, which provides additional challenges with providing stable, effective, and knowledgeable staff to already vulnerable student population. Therefore, we have to be creative and explore a variety of approaches to helping provide and sustain trauma-informed care in our schools. The Community schools framework helps put in place collaborative leadership and engage in mutually supportive work with community agencies and other key institutions. We are currently working with four (4) mental health providers to support mental health services in our ten (10) schools, using face to face or telehealth services. Mental health providers, such as Southern Highlands, KVC, Family Options, and Crittenton help provide mental health therapists for our schools. Tug River School-Based health centers at the two of our high schools also alleviate the need for students, staff, and community to travel to medical appointments, which can take students or staff out for a day due to lengthy travel to any other medical establishments. We are currently working with Tug River to secure the services from their mobile unit with a goal to provide preventative and treatment services to all of our schools. Our district also secured grants to provide weekend food backpacks for the students identified by schools as in need for weekend food supplies.

Building and maintaining so many partnerships requires the fulltime position of the community school coordinator, as principals or central office staff struggle to find time to do this in addition to their primary responsibilities. Southside K8 in our district has been employing a community school coordinator for 7 years, and during this time, the school's teacher turnover rate went from 40% on the worst year to very few teachers leaving positions to look for a placement in another school or district. The school is at 87% fully certified teacher rate this year, which is a tremendous improvement from previous years. The student attendance has hovered steadily at 91% for the last few years, and the serious behavior infractions reduced. The school has a more welcoming climate, and the school's administration is finally able to work on addressing academic achievement and establish a laser focus on quality instructional services for their students while maintaining a solid approach to helping students with their basic needs. Implementing the community school strategy with fidelity and having a full-time community school coordinator to facilitate the partnerships has helped us to achieve these improvements at Southside K8

McDowell County Schools district places an emphasis on securing collaborative partnerships at the district level, as the remote nature of the district and the schools within it frequently narrow the schools' opportunities to secure partnerships on their own. Being able to engage local and state resources at the district level allows the schools to implement the processes and structures to provide students with wraparound services without principals and teachers taking great amounts of time from instruction and instructional supervision. The county school system employs a community school coordinator for one of the schools in the district, using Title I funds while the county mental health coordinator is currently supported by Project AWARE funds. With Project AWARE funding ending next month, in October 2019, the county has to search for alternative means to sustain the position, which proves very challenging due to financial constraints the school system is already facing. Funding these positions in addition to social workers or graduation coaches is a challenge for a rural county with a diminishing tax base. Therefore, increases in funding formula for education like Title I and IDEA, as well as funding for Title IV of the Every Student Succeeds Act are needed, so that the schools can direct more

funding to support the social and emotional needs of students and help school staff members build more productive and personal relationships with students. When faced with choices on directing these funds to meet students' needs, the school districts should not have to choose between helping students learn to read and do math and hiring nurses, mental health therapists, and social workers. Both types of services are vital for our students to succeed, as schools become hubs of community and therefore have to meet the needs of the whole child instead of engaging in a piecemeal approach, having to choose between funding academics or social emotional supports.

Conclusion

The challenges and opportunities presented to us in today's society are unprecedented in the whole history of our nation. Technology, changing family structures, childhood poverty, as well as many other parts of our lives contribute to the daily happenings in our schools. The goal of the schools has not changed. We still strive to educate every child to reach his or her full potential and become a productive citizen of tomorrow's society. However, our students come from increasingly more fragile or broken family structures, affected by drug misuse, violence, or living in generational poverty. In order for the schools to continue on their mission to help their students succeed, students' basic and comprehensive health needs must be addressed before teachers can ask thought-provoking questions, analyze literary and informational texts, or solve multi-step word problems in mathematics. This effort cannot be managed by the school systems alone. It requires a multi-faceted approach, using community partnerships and leveraging resources through the community school strategy to ensure the school staff can do their job of teaching and building positive relationships based on trust and high expectations.

The implementation of trauma-informed practices at schools serves as a solid strategy to prevent students from engaging in destructive behaviors of drug misuse, violence, and risky behavior. These practices can also break the cycle of generational poverty and generational trauma our student families face on a daily basis and allow for improvements in overall wellbeing and welfare of our students and their families.

Chairman SABLAN. Thank you very much, Dr. Barker.

Now I recognize Ms. Hofmeister for five minutes, please.

STATEMENT OF JOY HOFMEISTER. OKLAHOMA STATE SUPERINTENDENT OF PUBLIC INSTRUCTION, OKLAHOMA STATE DEPARTMENT OF EDUCATION, OKLAHOMA, OK

Ms. HOFMEISTER. Good morning. Thank you, Chairman Sablan, Ranking Member Allen, and Members of the committee. My name is Joy Hofmeister. I was elected State Superintendent of Public Instruction in 2014 by the good people of Oklahoma and reelected in 2018. Thank you for the opportunity to appear before you to discuss the effects of childhood trauma on student academic performance and the social-emotional growth of our school children.

Oklahoma has made tremendous strides in various fronts in public education: Academic standards, national comparability, accountability and more. But these improvements cannot remedy every challenge. There are, of course, the stark realities of poverty, childhood hunger, domestic strife and more. The world outside the classroom has an undeniable impact on the world inside the classroom.

A recent national survey of children's health reports that Oklahoma's youngest children suffer more trauma than those in any other State. According to the Annie E. Casey Foundation, Oklahoma ranks 42nd in the Nation in child well-being. Seventy-five percent of our students suffer moderate or serious depression and

a growing number admit to a low commitment to school and a high risk for drug abuse.

Bearing this in mind, how can we equip teachers to move students toward resilience and a bright future? We believe the key is trauma-sensitive instruction. Recent work on the science of hope makes clear that the connection with a stable, caring adult is a common factor in moving our children from trauma to hope.

In October 2018 and February 2019, through grant assistance, Title IV funding, and community and agency partners, the Oklahoma State Department of Education held two statewide trauma summits. Both were heavily attended. Next February, we will hold another trauma-focused opportunity for all educators in the State. With approximately 42,000 classroom teachers, we expect to serve 10,000 at that event.

Providing increased support to address the implications of trauma among our State's youth is a priority of our State agency. The agency provides professional development opportunities for educators to better understand the connection between trauma, the science of the brain, and the negative impact on student performance.

In addition, we began a more cross-agency collaboration to address trauma and its connectedness to student academic performance, chronic absenteeism, and behavior. Our Office of Student Support provides on-site interventions and professional development to schools and districts. Developed last spring, it consists of directors of social-emotional counseling, academic counseling, prevention services, college and career readiness, work-based learning, family and community engagement, and suicide prevention. We will soon add a specialist devoted to bullying prevention and a statewide crisis response team. Since July, our student support team has provided educational opportunities and classroom interventions for more than 4,000 Oklahoma educators.

Through our work toward college and career readiness, a new focus on Individual Career Academic Planning, or ICAP, we are learning that students who intentionally plan for their future are more hopeful and resilient. The results can mitigate the negative implications of trauma. ICAP is required statewide beginning this school year, but already students in our ICAP pilot study tell us that their friends are coming to school more, feeling more purposeful in their work and more optimistic about life after high school.

Through heightened trauma awareness among our educators, we see rich learning environments and increased trust and support between teachers and students. Trauma-informed instruction is working. One teacher said, "After attending trauma-informed instruction professional development, our school brought back classroom intervention strategies. We started implementing them in a few of our classrooms and noticed that student discipline referrals went to zero with these teachers. We are already seeing the change in our student behaviors and test scores."

Such results are hardly surprising. When we ask students what they need from their teachers, their message is consistent: Get to know us. Connect with us. Care about us as people. When we empower teachers with evidence-based strategies and greater aware-

ness of trauma, we allow them to harness their creativity to develop positive connections with students.

In closing, the trauma expert Peter A. Levine said: Trauma is a fact of life; it doesn't have to be a life sentence. And we believe we can move our children from trauma to hope.

[The statement of Ms. Hofmeister follows:]

TESTIMONY OF JOY HOFMEISTER

STATE SUPERINTENDENT OF PUBLIC INSTRUCTION

OF THE STATE OF OKLAHOMA

BEFORE THE HOUSE EDUCATION AND LABOR COMMITTEE

SUBCOMMITTEE ON EARLY CHILDHOOD,

ELEMENTARY AND SECONDARY EDUCATION

ON

"The Importance of Trauma-Informed Practices in Education to Assist Students

Impacted by Gun Violence and Other Adversities"

September 11, 2019

Good morning, Chairman Sablan, Ranking Member Allen and members of the Committee. My name is Joy Hofmeister, and I was elected State Superintendent of Public Instruction by the great people of Oklahoma in 2014 and again in 2018. Thank you for the opportunity to appear before you to discuss the effects of childhood trauma upon student academic performance and the social-emotional growth of our schoolchildren.

In February 2016, I had the honor of appearing before this subcommittee to share testimony on strengthened state accountability for student academic performance after passage of the Every Student Succeeds Act (ESSA). Flexibility under ESSA has enabled us to develop programs and systems that align with our vision to ensure every child in our schools has access to a well-rounded education.

Through our state strategic plan, which we call *Oklahoma Edge*, we are already demonstrating success. New academic standards for mathematics and English language arts lifted us from 47th nationally to 17th in terms of quality and rigor. Last month, we were recognized by the National Assessment of Educational Progress (NAEP) for significantly reaching national comparability, thereby narrowing the so-called "honesty gap." In so doing, we have catapulted from one of the lowest positions nationally on the NAEP mapping study to the top one-third of states. We can now say with confidence that our expectations for kids are

setting them up to be nationally competitive for college and the workforce by the time they graduate high school.

These changes, facilitated by the flexibility afforded by ESSA, are dramatically improving Oklahoma schools, but these changes cannot remedy every challenge.

There are, of course, the stark realities of poverty, child hunger, domestic strife and more. The world outside the classroom has an undeniable impact on the world inside the classroom. A recent National Survey of Children's Health reports that Oklahoma's youngest children suffer more trauma than those in any other state. According to the Annie E. Casey Foundation, Oklahoma ranks 42nd in the nation in child well-being. The Oklahoma Department of Mental Health and Substance Abuse Services indicates that 75 percent of our students suffer moderate or serious depression, and a growing number admit to a low commitment to school and a high risk for drug use.

Oklahoma last November elected a new governor, Kevin Stitt, who has championed the idea of transforming us into a Top 10 state. It is an admirable goal and we are making progress, but a critical pathway to any Top 10 must begin at the schoolhouse door.

How can we equip teachers to move students toward resilience and a bright future? We believe the key is trauma-sensitive instruction.

What do we mean by "trauma-sensitive instruction"? A trauma-sensitive school is a place where students feel safe, welcomed and supported, and where addressing the impact of trauma is central to the educational mission. Trauma-sensitive instruction, therefore, is how that approach is reflected in the professional practice of educators.

Recent work on the science of hope, some of which is being led nationally by Oklahoma native Professor Chan Hellman and researchers at the University of Oklahoma, makes it clear that a connection with a stable, caring adult is the common factor in moving children from trauma to hope.

In October 2018 and February 2019, through grant assistance, Title IV funding and community partners, the Oklahoma State Department of Education (OSDE)

organized two statewide trauma summits. Both were heavily attended. Next February, we will hold another trauma-focused opportunity, free and open to all educators. In a state of approximately 42,000 classroom teachers, we expect attendance of up to 10,000 people.

The Oklahoma Legislature has provided much-needed policy support for our schools. A state law signed this spring requires that candidates in teacher preparation programs study trauma-informed instruction practices. Another recent law directs our agency and the Oklahoma Department of Human Services, in consultation with school boards and district superintendents, to develop professional development and resources to help school staff recognize and address the mental health needs of students.

Providing increased support to address the implications of trauma and adverse childhood experiences among Oklahoma youth is a priority of the OSDE. The agency provides professional development opportunities for educators to better understand the connection between trauma, the science of the brain and the negative impact on student performance.

In addition, we began a more cross-agency collaboration to address trauma and its connectedness to student academic performance, chronic absenteeism and behavior. Our Office of Student Support provides on-site interventions and professional development to schools and districts. Developed last spring, it consists of directors of social-emotional counseling, academic counseling, prevention services, college and career readiness, work-based learning, family and community engagement and suicide prevention. We will soon add a specialist devoted to bullying prevention and a statewide crisis response team. Since July, our Student Support team has provided educational opportunities and classroom interventions for more than 4,000 teachers – nearly 10 percent of the teachers in our state.

Through our work toward college and career readiness and focus on Individual Career Academic Planning, otherwise known as ICAP, we have learned that students who intentionally plan for their futures feel more hopeful and show more resilience. For students, the results of intentional career planning can mitigate the negative implications of adverse childhood experiences. ICAP is required statewide beginning this school year, but already students in our two-

year pilot ICAP study tell us that their friends are coming to school more, feel more purposeful in their work and are more optimistic about life after high school.

Through heightened trauma awareness among our educators, we are seeing richer learning environments and increased trust and rapport between teachers and students. Trauma-informed instruction is working.

One teacher said, "After attending trauma-informed instruction professional development, our school brought back classroom intervention strategies. We started implementing them in a few of our classrooms and noticed student discipline referrals went to zero with these teachers. We are already seeing a change in student behavior and test scores."

From another: "Everything you said regarding trauma-informed instruction has resonated with me. These sessions, these words – they are life-changing."

And finally, "Going through this professional development has completely changed my way of thinking. I am more positive and can think about the 'why' with my students. I have already seen an improvement in my classroom in just the first three weeks of school."

But no conversation about the impact of trauma-sensitive instruction is complete without students. When we ask students what they need from their teachers, their message is consistent: "Get to know us. Connect with us. Care about us as people."

When we empower teachers with evidence-based strategies and greater awareness of trauma, we allow them to harness their creativity to develop positive connections with students.

Trauma expert Peter A. Levine said, "Trauma is a fact of life. It does not, however, have to be a life sentence." Among the most critical of our missions in public education is ensuring our students have the opportunity to achieve academic excellence. Through meaningful and consistent connection, our educators can help our students move beyond trauma to hope — and the promise of the bright future they deserve.

Chairman SABLAN. Thank you very much, Ms. Hofmeister.
And now I would like to recognize Dr. Jackson for five minutes.

STATEMENT OF JANICE K. JACKSON, ED.D., CEO, CHICAGO PUBLIC SCHOOLS, CHICAGO, IL

Ms. JACKSON. Good morning, Chairman Sablan, Ranking Member Allen, and Members of the committee. My name is Janice K. Jackson and I am the Chief Executive Officer for Chicago Public Schools, which serves 361,000 students and is the third largest school district in our Nation. I am grateful for this invitation today to talk about one of the greatest challenges that we face in Chi-

cago. Many of our students are growing up in communities that struggle under the weight of poverty and have been significantly impacted by violence.

The purpose of my testimony today is to explain how exposure to violence and poverty creates trauma for Chicago's children, and more importantly, to share the steps that CPS is taking to combat the damaging effects of trauma.

First, I would like to tell you about two students, Rodney and Kimyatta. These are children who live in a world where trust is scarce and anger is overly abundant. They describe their communities in their own words as places where no one can be trusted.

For these children, navigating violence and poverty is a way of life. This can mean that they are exposed to gun violence, gang activity, substance abuse, incarceration of a loved one and loss of loved ones. And because of that, they are far more likely than their peers to experience multiple traumas during their formative years.

This repeated exposure to trauma can have far-reaching effects on youth. Like teachers all over the country, Chicago educators also feel the pain and uncertainty right alongside the students that they serve every day, and this is referred to as secondary trauma. For both students and teachers, trauma becomes a form of toxic stress in their brains when it is left untreated. For students, it can lead to behavior problems, poor mental health, drug and alcohol abuse, and unhealthy sexual behavior, not to mention constant struggles in the classroom.

Children exposed to this type of trauma are at risk for lower grades, poor attendance, behavior issues and an increased likelihood of dropping out of school. This sobering fate could easily have befallen Rodney and Kimyatta, but thanks to one of the many programs that CPS and the City of Chicago has invested in, their situation is changing.

This summer, CPS and the City launched a first-of-its-kind program called Summer for Change, targeting students exactly like the ones mentioned before, students from underserved urban communities who are at risk for being impacted by violence. During the 6-week program, 430 youth participated in enrichment opportunities and were given access to mentoring and trauma-informed therapy that they needed.

The program gave these students access to something that they were missing: Caring and trustworthy adults who they could open up to. Not one of the 430 students who participated in the Summer for Change program was a victim of violence this summer. We also saw an overall reduction of almost 50 percent in gun violence victimization among students who are enrolled in our alternative school systems during the summer of 2018.

We hope that the Summer for Change program and programs just like it contribute to this type of success, and that we can continue to provide students in Chicago with a safe haven to avoid some of the outcomes we discussed earlier.

Summer for Change is one of many initiatives that CPS has launched around social-emotional learning. Others include restorative discipline practices that are moving us away from suspensions and expulsions and toward uncovering the root cause of negative behavior while keeping kids in school where they belong. This has

resulted in a sharp decline in out-of-school suspensions and expulsions in CPS and has led to the lowest ever dropout rate in our district's history.

Other targeted trauma-informed intervention support our students in everything from coping with anxiety and depression to managing their emotions and taking responsibility for their choices. And this helps them ensure that they are prepared for success after high school.

One other example that I would like to share is for a student whom I will call Cara. She is growing up without her mother and any other female adult in her home. She struggles with isolation and was constantly getting into conflicts with the peers in her school. Cara was recruited to join a Structured Psychotherapy for Adolescents Responding to Chronic Stress program, otherwise known as SPARCS, and things have started to turn around. She is learning to talk through her emotions and make better decisions, and this is helping her to develop the coping skills necessary to better manage her stress.

Chicago has been fortunate to receive Federal grant support to manage the needs of children exposed to trauma. The impact of this funding is significant, particularly as our students continue coping with the stress of poverty and violence. But to keep this vitally important work going, CPS and other school districts around the country need additional support. There is a serious need for increased Federal funding to combat the effects of trauma on our youth.

Only when our country's leaders unite behind this cause can the range of quality treatment services for these students begin to fully meet their needs and put them on the road to recovery and a productive and fulfilling life.

I thank you for listening to my testimony and your time and look forward to your questions.

[The statement of Ms. Jackson follows:]

Written Statement of Dr. Janice K. Jackson
Chief Executive Officer of Chicago Public Schools

Before the Committee on Education and Labor
United States House of Representatives
September 11, 2019

Introduction

Chairman Sablan, Ranking Member Allen, and Members of the Committee, thank you for your invitation to participate in this hearing. My name is Dr. Janice K. Jackson, and I am the Chief Executive Officer of Chicago Public Schools (CPS), which is the third largest school district in the United States. Before assuming this role in 2018, I served as a CPS teacher, principal, network chief, and Chief Education Officer for this district. I was also a student in Chicago Public Schools from Head Start through high school graduation, and am now the parent of two children who attend CPS schools.

Chicago Public Schools serves 361,000 students in 644 schools, the majority of whom are children of color, and many of whom live in communities that are significantly impacted by violence. The purpose of my testimony is to explain the extent to which that violence, and the subsequent trauma it causes, is negatively impacting the children of Chicago, and share the steps CPS is taking to combat this effect, specifically through the use of social-emotional learning (SEL) and trauma–informed policies and programs.

Violence and Poverty in Chicago

Many of Chicago's students come from low-income families who are struggling under the weight of poverty. Research shows that children living in these situations are more likely to experience multiple traumas during their youth, and that this repeated exposure can lead to long-term developmental risks.

Studies of children living in poor, inner-city neighborhoods document extremely high rates of exposure to trauma. This exposure can include gang and drug activity, house fires, incarceration, the death of a family member, and violence in their communities.

In too many of Chicago's neighborhoods, that violence has become a fact of life. During the first half of 2016, Chicago logged more homicides than New York City and Los Angeles combined. The gun-related homicide rate for the city's African-American male population is 18 times greater than the national average, and homicide is now the number one killer of Chicago's youth.

A recent study by the Erickson Institute reported some startling statistics regarding our city's youngest children. According to this research, 60 percent of children under 5-years-old live in the Chicago communities where the vast majority of homicides—90 percent—are taking place. Many of these children are or will become our students, therefore the effects of this trauma must be addressed at the school level.

Impact of Trauma on Chicago's Youth

Repeated exposure to violence is distressingly common in several Chicago neighborhoods, and many of the victims are children. Research shows that this exposure can literally change the architecture, chemistry, and development of a child's brain, particularly when the trauma is not balanced by healthy relationships with adults.

Left untreated, trauma becomes a form of toxic stress in the minds of our children, leaving them at greater risk for behavior problems, poor mental health, drug and alcohol abuse, and unhealthy sexual behavior. They are also at a higher risk of committing violent crimes and becoming part of the juvenile justice system.

Not surprisingly, children repeatedly exposed to violence are also more likely to struggle in school. The effects of trauma on their education can include low grade point averages, decreased standardized test scores in reading and math, poor school attendance, increased suspensions and expulsions, and a decreased rate of high school graduation.

This is the fate of students exposed to trauma if that trauma is not addressed. Even those children who appear to be managing their trauma exposure successfully are at higher risk of chronic unemployment, depression, alcoholism, and heart and liver disease, among other physical and mental health challenges, once they reach adulthood.

Impact of Trauma on CPS Educators

CPS educators, counselors, and support staff who work with students exposed to trauma are also at risk of being traumatized themselves, both by hearing about what their students have experienced and by witnessing the negative effects of trauma on those children. Symptoms can include fatigue, anxiety, feelings of hopelessness about their work, and in the most severe cases, a diagnosis of Post-Traumatic Stress Disorder (PTSD).

This reaction by educators is known as Compassion Fatigue, and CPS is working to combat that phenomenon with trauma training that includes various pathways to self-care. This training helps our teachers learn to identify signs of secondary trauma, and gives them resources to help address how that trauma is impacting them physically and emotionally. We also recommend that our teachers and principals engage in the same kind of talking circles that are now common among CPS students. In addition to building positive school culture and climate, this method of communication can help build resiliency among our educators and buffer the effects of Compassion Fatigue.

CPS' Response to Trauma

Children are resilient, and that resiliency is what makes healing possible. This is why Chicago has prioritized SEL right alongside instruction in reading, science and math. SEL exercises those critical skills that help children direct thoughts, feelings, and actions in a way that leads to their sense of mastery and success. When implemented correctly, SEL supports can keep negative social forces from permanently harming the physical and mental health of our children. Simply put, it can serve as an antidote to the effects of trauma that are plaguing CPS students.

CPS is actively working to address the impact that exposure to trauma is having on our students and school communities. We are using a combination of safety initiatives, staff trainings, and SEL

learning supports to help students who have been exposed to trauma begin to heal and move toward a place where they can reach their full potential.

Safe Passage

Since 2009, the CPS Office of Safety and Security has partnered with community-based organizations to recruit people who will patrol designated routes in certain Chicago neighborhoods as students travel to and from school. People like Ricky Jones, who sees his job as more than keeping students safe. He believes it is about building positive relationships in his community, and about connecting with children who need the support and guidance of caring adults to help keep them on the right path.

Safe Passage began 10 years ago with 35 CPS schools and has grown to serve 80,000 children in 166 schools. There have been no serious incidents along Safe Passage routes involving a student while workers have been present, and attendance at schools with this program have experienced a significant boost. Additionally, according to an analysis of crime statistics by the Chicago Police Department, crime along Safe Passage routes during school hours has decreased by 32 percent since 2012.

Summer for Change

In 2019, CPS launched the first-ever Summer for Change (S4C)program for students at high risk of being impacted by violence. These youth had the opportunity to earn a stipend, participate in enrichment opportunities, and access mentoring and trauma-informed therapy during their summer break from school.

Two students who participated in S4C were Rodney and Kimyatta, both of whom live in a world where trust is scarce and anger is overly abundant. These youth describe their Chicago communities as places where “no one can be trusted, because everyone lies.” For these children, and others like them, trusting relationships with adults are extremely rare.

The S4C program gives these children that which they are missing—caring, trustworthy adults who they can truly open up to. Rodney and Kimyatta were successful in the program and have expressed their desire to continue with it throughout the school year if funding is available. Rodney has even expressed an interest in becoming a teacher, and I have pledged to help guide him through that process.

We also offered these students a $200 per week stipend to attend this program. This was not charity. Rather, we acknowledged these children live lives without a safety net and could simply not afford to forsake the opportunity to earn a living. Children recruited for this program have the greatest need and are at the greatest risk of falling victim to the cycle of violence. Providing them with a financial incentive simply lowered the barrier to entry for them to access critically needed trauma-informed therapy and other positive outlets during their summer break.

Not one of the 430 students who participated in the 2019 S4C program was a victim of violence while in the program this summer. Our hope is that this program has contributed to an overall reduction of almost 50 percent in gun violence victimization among students enrolled in our Options Schools compared to the summer of 2018.

Staff Trainings on Trauma

Since 2016, the CPS Office of Social and Emotional Learning has provided training to our educators and community members on creating trauma-sensitive schools. Participants learned about the prevalence and impact of trauma on Chicago's youth and created plans for the implementation of trauma-informed practices and policies. Elements of this training have since been folded into the district's trainings on school climate.

A cadre of CPS social workers, counselors, and other support staff also offer a whole-school training on trauma awareness. Educators who have gone through this training learn how to better recognize the signs of trauma in their students and develop effective strategies for supporting their needs. These educators also learn how working with students who have been exposed to trauma can impact their own lives, and develop a self-care plan to reduce their stress. Since 2016, more than 1,000 CPS educators have completed this whole-school trauma training.

Move to Restorative Discipline Practices

One intervention that has shown promise with students affected by trauma is our move toward restorative discipline practices. These practices are focused on building positive relationships among youth and strengthening the bond between educators and their students. This method has moved CPS away from punitive, exclusionary practices like suspension and expulsion and focused instead on working with students in school to identify the root causes of negative behavior, one of which can be exposure to trauma. This change has contributed to a sharp decline in the number of expulsions and out-of-school suspensions issued by CPS and has helped us achieve the lowest drop-out rate in district history.

Both the CPS Student Code of Conduct and the Administrators Guidelines for Effective Discipline have also been updated to reflect the fact that exposure to trauma may impact a student's brain development, learning, and behaviors. The language in these policies now identifies trauma as a possible root cause of negative behaviors and reflects our commitment to a trauma-sensitive approach to student discipline.

SEL Interventions for Students Exposed to Trauma

The CPS Office of Social and Emotional Learning provides training in targeted trauma interventions that are implemented by school counselors, social workers, and psychologists. These include:

SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress) – A skill-building program for students in grades 6-12 who have been exposed to trauma and may be living with chronic stress.

Bounce Back – A program for young learners in grades K-5 who have been exposed to trauma and who need help managing anxiety and coping with post-traumatic stress.

CBITS (Cognitive Behavior Intervention for Trauma in Schools) – A group intervention to help reduce symptoms of depression, anxiety, and PTSD in students in grades 3-12 who have been exposed to trauma

Lumity – A pilot program that helps students in high-risk situations prepare for success after high school.

These and other SEL programs are designed to help children learn to control their emotions and take responsibility for their behavior. Take Kayla, who is growing up without a mother or any other female adult in her household. This has caused her to become isolated and has resulted in Kayla getting into many conflicts with her peers while at school. Her participation in the SPARCS program has allowed Kayla to begin turning things around. She is learning to talk through her emotions and decision-making processes, and is developing coping skills that will allow her to better manage stressful situations. Kayla has now become a strong advocate for the SPARCS program, as the interventions provided have helped her learn to slow down her reactions and better manage situations that before would have seen her immediately lashing out.

Then there is Rayshawn, who was working to complete high school while caring for himself and his younger brother. Their mother is incarcerated and the boys have moved frequently, struggling to make ends meet while keeping up with school. The stress of this situation caused Rayshawn to turn to substances, so while he did graduate from high school, it was difficult for him to get a job.

We ensured Rayshawn enrolled in the Lumity program so that he could work through his issues and build the skills to be successful in the workplace. Rayshawn also entered into a treatment program for substance abuse and has now landed a permanent job with a software application company.

Impact of Federal Funding on Supporting Students Exposed to Trauma

Chicago has been fortunate to receive federal grant support to help us manage the needs of children exposed to trauma. One such grant has provided us with the Healing Trauma Together (HTT) program for the past three years.

This program targets high school students living in communities that are particularly prone to violence. The goals are to facilitate recovery from trauma, improve mental health, and create safe and supportive learning environments for students. Interventions include the training of staff and parents to recognize the signs and symptoms of trauma along with individualized and group therapy for students struggling with chronic stress.

The CPS HTT grant expires on September 30, 2019, however we have received a grant of $100,000 from the Michael Reese Trust to continue this work in the coming school year. This grant will allow us to keep the SPARCS program going in our 10 HTT high schools as well as implement it in an additional 10 schools. It will also make it possible for our district to work with more trauma leaders on developing resources and tools for our teachers to use in their classrooms.

I am grateful for federally-funded opportunities like the HTT program. The impact on our students is significant, particularly as they continue to cope with the reality of violence in their communities. To keep this vitally-important work going, CPS and other school districts around the country will need additional federal funding for programs like this one—programs that allow our professionals to identify those students whose lives have been upended by trauma and provide them with the supports they need to heal.

Conclusion

Trauma is a complex community health issue that requires an integrated solution. Resources must be leveraged from all stakeholders, including schools, community partners, and government. There is a serious need for increased federal funding to combat this epidemic. Only when our country's leaders unite behind this cause can the range and quality of treatment services for students exposed to trauma fully meet their needs and put them on the road to recovery and a productive, fulfilling life.

Chairman SABLAN. Thank you very much, Dr. Jackson. Oh, God, how much you four make me miss my grandmother growing up.

But under Committee Rule 8(a), we will now question witnesses under the five-minute rule. As Chair, I have decided to go at the end, so I will yield to the next senior Member on our side, the Majority side, who will be followed by the Ranking Member or his designee, and I would recognize. And so let's start with Ms. Schrier. You have five minutes.

Ms. SCHRIER. Thank you, Mr. Chairman. And thank you to all of our witnesses today. I was thrilled to read all of your testimonies last night and then hear them today, and I am so grateful that we are talking about this.

I am also a pediatrician, and so I come at this with a little bit different perspective. And I have been thinking about kind of how we can really address this, because ACEs are a particularly difficult problem because so many of the adverse childhood events happen at home. And so when a patient comes into the office, we try to partner with parents to make things better. But when there is so much dysfunction at home, whether it is hunger or parents are separated or abuse or a parent is sick with a horrible chronic disease or drug abuse, that makes it much harder to solve in the exam room. And so a lot of it really ends up being left, of course, to the schools, which is the other safe place for kids.

So I wanted to talk—I have a couple questions. One is going to be for you, Dr. Jackson, about the difference between expulsion/suspension, kind of traditional responses to misbehavior in school, and then how that contrasts with now.

But I wanted to first talk with you, Dr. Burke Harris, about what we can do to help these families and sort of catch things upstream. And in Washington State, there's a couple really exemplary programs that meet families where they are. So it addresses these exact situations to help them build their children's health.

One of them is called the triple P program or Washington State's Positive Parenting Program, and it aims to assist parents in preventing a lot of the serious behavioral and emotional problems that we are seeing in kids.

The other one is the Guiding Good Choices program that helps parents of kids 9 to 14-year-old, who are just entering a really turbulent period, to make good choices through adolescence.

And the triple P's positive outcomes on reducing child abuse and neglect, limiting out-of-home placements of children, and academic success are outstanding and result overall in taxpayer savings of about $1,400 per participant. And the Guiding Good Choices program demonstrates increases in the number of positive interactions between parents and children, lower rates of substance abuse, lower rates of delinquency, and effects that last even 40 years out.

And so I was going to ask if there are some other programs that you really like and would recommend, and then maybe even add what some of the challenges are, other resources in rural communities.

Dr. BURKE HARRIS. Thank you. So we recognize that when we are talking about addressing adverse childhood experiences, we have to break the intergenerational cycle, right? Kids who have ACEs have parents who have ACEs.

In California, we are implementing universal screening for adverse childhood experiences in children and adults and responding

with trauma-informed care, and our governor has allocated $40 million to reimburse providers for doing that and $60 million over 3 years to train providers on how to do that and how to respond to trauma-informed care.

So ensuring that adults also have access to mental health services and supports for vulnerable families who are under stress, it has to be a two-generation approach.

Ms. SCHRIER. Thank you very much. And are there particular programs that I should look into to bring home to my State of Washington? I love that you are implementing the screening program, so we in Washington will be learning from you in California.

Dr. BURKE HARRIS. One program I also recommend is CPP, Child-Parent Psychotherapy, which is a clinical intervention that I have used in my clinical practice, and as well as any trauma-focused therapy that can be used for kids and adults.

Ms. SCHRIER. Thank you. Then I still have time so, Dr. Jackson, I just wondered if you could paint a picture for my colleagues about what it would look like traditionally if you had a child who was misbehaving so much in school that they would be sent home—of course, then being sent to a home where there is drugs or neglect or a sick parent or whatever else—versus how you handle that in a school that is focused on trauma-informed behavior modification and education.

Ms. JACKSON. Thank you. In short, in Chicago Public Schools, we first started by looking at the policies that led to not only outrageous numbers of students being suspended and expelled from school, but the disparity between African American students and their peers.

And we changed the policy to make teachers, principals, and administrators have to go deeper to identify the root cause and also show an effort to address those root causes through other practices, such as restorative justice, in some cases giving students access to mental health professionals, either in the school or outside of the community.

And what this has resulted in, unlike some of the skepticism that we heard in the beginning, is fewer students being suspended and expelled from school resulted in higher attendance rates, which also had a direct impact on student achievement, which has been addressed here today.

And I am happy to say that, you know, we have been engaged in this work for about 6 or 7 years now and now we have the data to show that when we invest in our students and look underneath to figure out what is going on and provide them with the trusted adult or individual, we can really change the pathway for our students.

So I would recommend those folks listening to think about the policies first and then make sure that there is an investment in training for the educators who are working with students every single day so that they can implement them with fidelity and care for students.

Ms. SCHRIER. Thank you.

Chairman SABLAN. Thank you very much, Dr. Shrier.

At this time, the designee of the Ranking Member, Mr. GT Thompson of Pennsylvania, is recognized for five minutes, sir.

Mr. THOMPSON. Chairman, thank you so much. Chairman, Ranking Member, thank you for really hosting this critical hearing on a topic that is extremely important to me.

Trauma is such a destructive force from so many different perspectives of how it impacts a human being when it comes to impacting our children, who, quite frankly, maybe have not developed the resiliency, the strategy, the skills to be able to prevent the real destructive force of trauma long term. I want to thank each of the Members of this panel for bringing your professional expertise, your passion—very obvious to me, from what I have heard and what I have read—to this hearing today.

And thank you for bringing your best practices too. I have already heard a lot of information that gives me hope. And the fact is I love that it was framed the science of hope. That really is what you all are all about. It is about building and establishing resiliency within our kids. It is sad what they have to experience.

And I would argue that there are so many different forms of trauma, and what has really made it present in absolutely every school district, I think in every school in the Nation is the number one public health crisis of our lifetime, which has been substance abuse and the trauma, the loss of loved ones, you know, what that does. And so thank you for being here and sharing.

Ms. Hofmeister, in your testimony you mentioned the importance of professional development and teacher preparation programs focusing on trauma-informed instruction. Can you provide some specific examples as to what this looks like?

Ms. HOFMEISTER. Yes. It is based on the science of hope. Dr. Chan Hellman at the University of Oklahoma has done many studies related to this. And we teach and work with our teachers through professional development that it is about relationships. It is about building and fostering trust, trust and respect between the student and the teacher, between families and the school.

And when we give our teachers more information to better understand behavior, recognizing that all behavior has meaning, sometimes I think teachers have viewed the behavior as something else when it could be an expression of trauma. And having new eyes to see that, instead of a child that is sleeping at the back of the classroom in middle school and a teacher might ask maybe in the past, what is wrong with that kid, we want to ask, what has happened and what can we do to give them confidence and build that relationship?

And when our kids have that strong strengthened relationship with their teachers, they are going to be able to be more engaged and also have that one caring adult that we know is paramount for moving beyond trauma to hope and a brighter future.

Mr. THOMPSON. I appreciate those observation skills. It is a world I come out of in healthcare for 28 years and it is a method I use here, root cause analysis, really finding out what is at the root cause of the behavior that you are seeing versus just condemning the behavior. And I am heartened by the fact that I have heard that this committee, working in a bipartisan way, and past Congresses, with the Every Student Succeeds Act, we have recognized the need. We have authorized programs. I have heard those

mentioned a few times, how they have been helpful. I think there is obviously more left to be done.

You mentioned a few examples of how this helped your students and faculty. Can you discuss that in more detail for us, and specifically what impacts has this had on students, both in performance outcomes and their overall classroom experience?

Ms. HOFMEISTER. What we are seeing is that our students are more engaged, and we know that student engagement is key for academic success. This is something, of course, that starts and begins with teachers, but we also know that there is a collective impact when there is a strong relationship, and that community that is created in a classroom that starts with teachers engaging students. And it can be as simple as the difference when a teacher greets children at the door, knows their name, is there to support them as people, not just teaching a subject. And our students tell us this makes all the difference in the world.

One of our students on our Student Advisory Council that we have at the State level told us that she accidentally got in a classroom that did not have an interest for her and was a mistake on the schedule, but the teacher was so engaging and cared and communicated that care about her as an individual that it was something she actually stayed in, didn't change. And it helped her at a time in her life when she needed an adult who would be there for her. This is something teachers can do. Teachers can foster hope, and that builds resiliency. But without hope, we do not have that ability to bounce back.

Mr. THOMPSON. Thank you. Thank you, Chairman.

Chairman SABLAN. Thank you. Thank you, Mr. Thompson. We alternate sides in questioning, so I would like to now recognize the Chairman of the full committee, Mr. Scott of Virginia, for five minutes.

Mr. SCOTT. Thank you, Mr. Chairman. And I want to thank all of our witnesses for your testimony.

Dr. Harris, you mentioned that early detection could improve outcomes. When you have someone showing up with multiple ACEs, what do you do?

Dr. BURKE HARRIS. So several things. First of all, what the science shows, the safe, stable, and nurturing relationships and environments are key, and so those nurturing relationships are absolutely critical.

And the opportunity in trauma-informed educational systems is for everyone, every adult in that child's educational environment to be a dose of a buffering relationship, if you will. In clinical practice, what we see, sleep, exercise, nutrition, mindfulness, mental health and healthy relationships are the clinical pillars for addressing a toxic stress physiology, and that is what we see improves both health and also mental health and behavioral outcomes.

Mr. SCOTT. Thank you. Dr. Jackson, if a child is subject to trauma, does it have an effect on achievement and how do you measure that?

Ms. JACKSON. I had the mike on the whole time.

Thank you for that question. There is definitely a correlation between students' exposure to traumatic events and their readiness and achievement and proficiency in the school system. I think that

a few things we have been able to measure after changing policies around keeping students in school and reducing the amount of time that they are excluded from school is that we were able to see the correlation between increases in student attendance, access to healthcare professionals in the school and outside the school, resulting in students achieving higher on standardized assessments that they were taking.

We have also been able to track our students over time and look at graduation rates, where we have experienced about a 20 percent increase in the past 8 years. Much of that can be attributed to the changes that we have made around addressing the root cause analysis of what is going on with our students and making sure that we are intervening early and appropriately to keep them on track for schooling.

I think some of the other ways that we try to measure this is that in Chicago Public Schools we have a Safe School Certification, which is a deep analysis of the practices as well as the data in schools where we look at the amount of time students have been suspended, access to resources that they have, and also the interventions and supports that they have received at three different tier levels.

And because that information is tracked and made publicly available, parents are able to see that and they are able to use that to make determinations about schools, for example. It has really incentivized the educators within those buildings to really make sure they have organized their schools to be safe and supportive environments for students.

And just to give you a quick data point, since we have instituted the Safe and Supportive School Strategy five years ago, we went from having a third of our schools receiving kind of the seal of approval on that certification to now having close to 75 percent of our schools meet that. And our goal is obviously 100 percent, but that is pretty dramatic progress in a five-year period.

Mr. SCOTT. That is what happens if you intervene. What happens if you do not intervene and a child is subject to trauma?

Ms. JACKSON. I think a lot of that has been covered today, but just to reiterate, students that have been exposed are more likely to repeat the behaviors that they have either experienced or, you know, been exposed to.

One of the things that we have also focused on in addition to gun violence and the effect of poverty and some of the other things that have been talked about a lot today is also looking at some of the challenges that many of our LGBTQ students experience. Many of them have a higher likelihood of being exposed to traumatic incidents in their lives, and so this has become a bigger priority here in CPS.

What we tend to see if this is untreated is students drop out of school. Students are at a higher risk for unproductive behaviors. They are also at a higher risk for suicide and some other things that can be really traumatic. And so one of our goals is to really intervene as soon as possible to try to reverse some of those negative outcomes.

Mr. SCOTT. Very quickly, can you tell me the importance of Title IV-A student support services under ESEA?

Ms. JACKSON. I think the importance, we talked a lot about this today. Projects like the Project Prevention funding and others that the district has been able to apply for really provide us with additional funding and support, or could provide us with additional funding and support so that this is sustained. We now know better, so it is incumbent upon us to do better. And I think that our educators need training, they need support in order to do this.

And I would even say once we get to a place where we have really reached a utopia, if you will, we will be providing support for the educators who work with our students as well. I talked a little bit about secondary trauma earlier, and I really want to lift that up. We have a teacher shortage in the country, and we know that is even greater in some of our more challenging schools where there is a higher rate of students who have experienced traumatic episodes and incidents. And if we do not adequately train the teachers who work with them every single day, we will continue to see turnover and we will continue to see these cycles persist.

Mr. SABLAN. Thank you, Dr. Jackson. Thank you very much. Thank you, Mr. Scott.

And as we alternate sides again, this time I recognize Mr. Timmons for five minutes.

Mr. TIMMONS. Thank you, Mr. Chairman. And I want to thank all of the witnesses for coming to testify before the committee today.

Ms. Hofmeister, it is often the case that children struggling with trauma do not communicate with teachers the stress and other trauma-related problems they face. In your experience, what have you found to be common indicators of a child struggling with trauma or traumatic stress?

Ms. HOFMEISTER. You know, often a child who appears disengaged, as I mentioned earlier, does have a story behind that. And that is something that, as teachers begin to foster the connection, they begin to understand a little deep—more deeply what is occurring.

So that could be an older sibling that is in middle school that is taking care of the younger children who got them to school on time. Or there could be barriers that occur that we can see as we dive a little deeper about those who are chronically absent.

So it is incumbent upon us in schools to meet our kids where they are and to look for ways to remove barriers, first identify those and remove them so that our students are able to be successful.

I think we focused a lot in the last number of years on student achievement, and we want and have set a high bar for student achievement. But we also have not had the expansive conversation we are having now about all aspects of the student, thinking about the whole child. And that is something that we are doing differently.

And those types of indications that a student is having struggles can look different for every child. We need teachers and educators and school leaders and school board members to have new eyes, a new lens to view the students that they are serving and then act on evidence to create trauma-sensitive school policy.

Mr. TIMMONS. Thank you.

You talk about removing barriers to getting children help. What can be done to encourage kids to actively seek help?

Ms. HOFMEISTER. Well, I think it is about being sensitive to where our kids are. It can look different in different settings. I am thinking of an example just this start of the school year. You have tornado drills. And I was reaching out. And one of my school superintendents mentioned how they had, in El Reno, a very significant tornado that had devastation throughout that community just in May. So an example of what can we do was what they did. And it was a trauma-informed policy.

What they had—the new eyes to see kids that were going to go through that tornado drill. And there were 15 of them that were very affected and impacted by that May event. And they had a caring adult holding their hand through that entire exercise. And they just were there for them through the rest of the day. And it is a small thing, but it made a great difference in those children's lives. And it also allowed them to at least stay as focused as possible on learning that day.

But the superintendent told me learning was not taking place for them that day. It brings back triggers. And as we think about those triggers, we can't make assumptions about what those will be. Students who have endured abuse at home or they have witnessed violence in the home.

Oklahoma has a high level of incarcerated men and women. In fact, the largest incarcerated population in the world per capita in our State. And this is something that impacts families, of course, and means many of our children have a high incidence of adverse childhood experiences.

So having eyes to see the child where they are and being willing to not try to use more of a blanket cookie cutter approach to trauma is the call. We want simply to build a relationship. And it unfolds from there.

Mr. TIMMONS. Thank you.

What role does the family play in this process?

Ms. HOFMEISTER. A significant role. We believe that strong families make strong communities and make strong schools. We want to strengthen families. And we also, as educators, want to reach out to families to meet them where they are. We want to find ways to include them where, perhaps, they also had a negative experience in school and don't want to come to school. They don't want to be as engaged as we know that they need to be and that it will, in fact, benefit their children.

So we will meet them where they are in a more welcoming way intentionally welcoming of our families and finding new ways to do that.

When you are homeless, when you are a mother who is homeless and has a child who is in school and you are moving from district to district or school to school as the trauma, means that you have to be more fleeing, for example, we still have to have a way to connect. And those are some of the examples.

Mr. SABLAN. Thank you.

Mr. TIMMONS. Thank you for your testimony.

Mr. Chairman, I yield back.

Mr. SABLAN. Thank you, Mr. Timmons.

I will now recognize Mrs. Hayes for five minutes.

Ms. HAYES. Good morning, everyone. And thank you so much for being here for this very important hearing.

I taught in and I now represent a congressional district that has been defined by tragedy. Newtown Sandy Hook is in my district. And in my own school district, the Waterbury Public School System, we did extensive work on trauma training all of our social workers on adverse childhood experiences and hosting a series of symposiums for trauma in early childhood.

All of our teachers and faculty members went through professional development on social and emotional learning. One of the presenters, I remember this very clearly, told us as a group that our children were scoring just as high as veterans on the trauma scale. And I know personally that once educators begin to see children through a trauma-informed lens, they can shift from blaming them for the behavior to beginning to understand the root causes of those behaviors.

But what I want to talk about today is the fact that trauma extends beyond the point of impact. Grief counseling happens, you know, the day after something happens at a school. But the grief resulting from those tragedies extends into our communities. And I see that every day in Connecticut 5. Just this spring, one of the parents of the students at Sandy Hook tragically took his own life.

So I ask you, if the parents are still struggling or if adults are still struggling, imagine what children are going through. We recently did a study in Connecticut, and the results were astonishing. Ninety percent of kindergartners reported experiencing ACE events, but only 23 percent were currently displaying symptoms. What this tells us is that 67 percent of students are experiencing ACEs but are unidentified and untreated allowing them to worsen over time.

So I cringe to think that these children are coming of age and they have all of these experiences that they do not know how to address.

Actually, Mr. Chair, I would like to introduce this testimony that I just cited into the record.

Thank you.

Mrs. HAYES. So my question today—I have two questions. First for Dr. Burke Harris. What can we do post trauma for families to make sure that they have the supports that they need, you know, 2 years, 5 years down the road to make sure, especially in communities that have polarizing targeted issues that we can identify? Because I think the one thing that we can all agree on is that it is not the children's fault, the families that they come from.

And then my next question, if you could follow up, is for Dr. Jackson. What do you think the impact of secondary trauma is on the educators who have to, year after year, stand in front of children. You know, oftentimes we think of events like the one I just described, but we have children with prolonged trauma as a result of their daily interactions, and teachers who see this year after year. And it is kind of hard to feed hope into someone when you are just repeating the cycle every single year.

So Dr. Burke Harris.

Dr. BURKE HARRIS. Thank you. Those are excellent questions.

I think there are a couple of critical pieces. Number one, a recognition that trauma in our communities, right, is so common that a true public health approach involves universal precaution, if you will. This is why trauma-informed care in our educational systems is so critical, because we have to be providing these supports and services routinely as part of our way of doing business in education in order to respond to the endemic levels of trauma that we are seeing.

Another piece is the role of screening and partnership, cross-sector partnerships. The prevalence of trauma is so high that—you know, I hear educators saying, okay, what can we do? I hear doctors saying what can we do? I hear law enforcement saying what can we do? How can we be part of the solution?

And when each of us takes our little piece, right, there is a tremendous amount that we can do to support resilience and buffering across our communities and increasing that cumulative dose of buffering making sure that every adult in the environment understands not only how they are managing their own history of adversity, because as you mentioned, it is not just vicarious trauma for educators but the fact that educators are—

Mrs. HAYES. I am sorry. I don't mean to cut you off, but I cannot let my time expire without speaking to what happens to teachers.

Dr. BURKE HARRIS. Absolutely.

Ms. JACKSON. Sorry. I will be quick, but I feel just as passionate.

Teachers—we see higher turnover rates and burnout. We also see depression. We have had teachers report depression as a result of some of the things that they have been able to hear.

And not because—not only because the stories are so challenging but because, in some cases, it is feeling of hopelessness. When we don't have the resources, when we don't have a place to point students and families to, when they have the courage to share with us what is going on, teachers feel hopeless in that regard. And that can contribute to some of the depression and things that have been reported.

Mrs. HAYES. Thank you.

Mr. Chair, with that, I yield back.

Mr. SABLAN. Thank you, Mrs. Hayes.

And at this time, I am going to recognize the Ranking Member of the full committee, Dr. Foxx, for five minutes please.

Ms. FOXX. Thank you, Mr. Chairman.

And I want to thank our witnesses for being here today. Ms. Hofmeister, in your testimony, you discussed the State's working conducting cross agency collaboration to help address the needs of students experiencing trauma.

Can you, please, explain in more depth why this collaboration—what this collaboration looks like and why it is a critical component in helping these students?

Ms. HOFMEISTER. Thank you very much, Representative.

Yes, this is essential. We are working in Oklahoma in the Department of Education to work with our partners in the Department of Mental Health and Substance Abuse Services. With that work, for example, we are able to be—have more of our students participate in the Oklahoma prevention needs assessment survey.

Actually, just for the last reported school year that we have data from, we had 47,940 students participate in the grades of 6th, 8th, 10th, and 12th grades. That is one example. From that we were able to learn a lot about the evidence that they are providing us with input and then develop strategies to meet needs.

And as we have partnerships, it goes beyond just one or two agencies. Actually, it is across the board. We are working with the Department of Corrections. I want to see those parents engaged that are able to be engaged in the lives of their children even through something unique with parent conferences virtually where that is appropriate.

We are grappling with health issues, and we are working with other entities within the State agency to work with Department—DHS and with the Health Department as well to work on battling the physical aspects of health as well. So it is paramount.

Ms. FOXX. You mentioned in response to Representative Timmons' questions about the family, that you have the largest per capita incarceration rate in Oklahoma in the country.

I would assume from that there are a lot of single-parent families in Oklahoma. Have you done anything to look at the impact of single-parent families on what is happening with students and how to deal with that as trauma?

Ms. HOFMEISTER. Yes. Thank you as well, Representative, for that question.

What we know on the ACE index, having a divorce within the family impacts children as an adverse childhood experience. So it does contribute. And in Oklahoma we have, among States, the leading and very high divorce rate as well. We also have, because of the high incarceration rate, many children in foster care. Again, at the top of the list, we are wanting to reverse.

But all of that said, it is about strengthening families. And we see in Oklahoma the need for loving family members, parents, grandparents, extended family. And where we don't have that we see community stepping in to bridge that gap for students. And this is part of this work as we think about trauma-informed practices in communities.

Ms. FOXX. Thank you.

Ms. Hofmeister, in your testimony, it says that 75 percent of your students suffer moderate or serious depression. That is a staggering number.

Is the work you are doing around trauma-informed instruction developed to address this issue? And how much does the data about student needs drive the development of the instruction program?

Ms. HOFMEISTER. Thank you again.

And, yes, this is that needs assessment where we did receive that very compelling information from students. And we also know that it doesn't have to simply be a program about mental health. We see crossover impact with our career pathway work and post-secondary planning with the individual career academic planning which is now State law, it is a requirement for graduation. But it starts early, 6th grade, 7th grade, 8th grade, as our student tell us as we have spent 2 years piloting this, that those students who engaged

in this had purpose and an awareness of a future beyond the tassel and graduation. That it is about something more.

And teachers who now aren't just delivering tests at the end of a course but are looking beyond that at the student and their strengths. This actually has had an impact on hope and on trauma-informed practice that was unexpected, and we are studying with our researchers.

Ms. FOXX. Thank you, Mr. Chairman. I yield back.

Mr. SABLAN. Thank you, Dr. Foxx.

I am going to be more strict on time, because we do have Members in line for questioning.

At this time I would like to recognize Mr. Morelle for five minutes, please.

Mr. MORELLE. Thank you, Mr. Chairman.

Mr. SABLAN. I am sorry, Mr. Morelle. I am really sorry. I need to—Dr. Shalala, please. I apologize, Mr. Morelle. Take it out on me later on.

Dr. Shalala, please.

Ms. SHALALA. Thank you.

Madam Surgeon General, last week HHS's office of the inspector general published a report, which I will submit for the record, following an investigation of immigrant children in detention centers.

[The information follows:]

U.S. Department of Health and Human Services

Office of Inspector General

Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody

OEI-09-18-00431
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Joanne M. Chiedi
Acting Inspector General

Report in Brief
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U.S. Department of Health and Human Services
Office of Inspector General

Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody

Facilities that care for children in the Office of Refugee Resettlement's (ORR's) custody face the difficult task of addressing the mental health needs of all the children in their care, including children who have experienced intense trauma. According to those who treat them, many children enter the facilities after fleeing violence and experiencing direct threats to their safety during their journey to the United States. Some children also experienced the trauma of being unexpectedly separated from their parents as a result of U.S. immigration policies. Facilities must promptly address children's mental health needs—not only to stabilize each child in crisis, but also to reduce the risk that the child will negatively influence or harm others.

Key Takeaway
Facilities struggled to address the mental health needs of children who had experienced intense trauma and had difficulty accessing specialized treatment for children who needed it.

What OIG Found

Facilities described the challenges inherent in addressing the mental health needs of children who had experienced significant trauma before coming into HHS care. Facilities reported that challenges employing mental health clinicians resulted in high caseloads and limited their effectiveness in addressing children's needs. Facilities also reported challenges accessing external mental health providers and transferring children to facilities within ORR's network that provide specialized treatment. Policy changes in 2018 exacerbated these concerns, as they resulted in longer stays in ORR custody and a rapid increase in the number of younger children—many of whom had been separated from their parents after entering the United States.

What OIG Recommends and How the Agency Responded

We make six recommendations for practical steps that ORR can take to assist facilities. ORR should provide facilities with evidence-based guidance on addressing trauma in short-term therapy. ORR should also develop strategies for overcoming obstacles to hiring and retaining qualified mental health clinicians and consider maximum caseloads for individual clinicians. Finally, ORR should address gaps in options for children who require more specialized treatment and take all reasonable steps to minimize the amount of time that children remain in custody. Specific recommendations are in the report. ACF concurred with all six of our recommendations.

The full report can be found at oig.hhs.gov/oei/reports/oei-09-18-431.asp

Why OIG Did This Review

By law, ORR, which is within the Department of Health and Human Services, has custody of and must provide care for each unaccompanied child, including addressing their mental health needs. ORR-funded care provider facilities are required to provide counseling to children and arrange for more specialized mental health services, as needed. We conducted our fieldwork during a time when ORR was experiencing an influx of children. Our findings could inform the Unaccompanied Alien Children Program's preparation for future surges.

How OIG Did This Review

In August and September 2018, OIG conducted site visits at 45 ORR-funded facilities, nearly half of all facilities in ORR's network at the time. These facilities were purposively selected and may not represent the experiences of staff in all ORR-funded facilities.

This report relies primarily on data collected from interviews with: approximately 100 mental health clinicians who had regular interaction with children across the 45 facilities; medical coordinators in each of the 45 facilities; facility leadership in each of the 45 facilities, including the program director and lead mental health clinician; and the 28 ORR federal field specialists assigned to the 45 selected facilities. We conducted qualitative analysis to identify the most significant challenges that facilities faced in addressing the mental health needs of children in ORR custody. This report does not determine whether challenges resulted in care that failed to meet ORR requirements, nor does it assess the quality or appropriateness of mental health care provided to children.

TABLE OF CONTENTS

BACKGROUND

Objective
To identify challenges that care provider facilities faced in addressing children's mental health needs.

The Department of Health and Human Services (HHS), Office of Refugee Resettlement (ORR), is the legal custodian of unaccompanied alien children (UAC) in its care. In this role, ORR is responsible for providing for the needs of these children, including addressing their mental health needs. For example, a child may have experienced significant trauma or other adverse life experiences that warrant attention while a child is in ORR's custody.[1] To address the needs of the children in its custody, ORR enters into grants or contracts with care provider facilities (facilities) to house and care for the children. These facilities provide counseling to children and arrange for more specialized mental health services, as needed. Any significant challenges that facilities face in addressing mental health needs could have serious immediate and long-term ramifications for children's well-being.

Background

Unaccompanied Alien Children Program

ORR, a program office of the Administration for Children and Families (ACF) within HHS, manages the UAC Program. UAC are minors who have no lawful immigration status in the United States and do not have a parent or legal guardian available to provide care and physical custody.[2] The UAC Program serves children who arrive in the United States unaccompanied, as well as children who, after entering the country, are separated from their parents or legal guardians by immigration authorities within the Department of Homeland Security (DHS). A child remains in ORR custody until an appropriate sponsor, usually a parent or close relative, is located who can assume custody.[3] Children also leave ORR custody when they turn 18 and "age out" of the UAC Program, or when their immigration status is resolved.[4] In Federal fiscal year 2018, the UAC Program received appropriations of $1.6 billion and cared for at least 49,100 children.[5] About 12,400 children were in the UAC Program at the time of our review.[6]

Care Provider Facilities

ORR funds a network of more than 100 facilities that furnish care for children until they are released to a sponsor or otherwise leave ORR custody. These facilities, generally, are State-licensed and must meet ORR requirements. Facilities provide housing, food, medical care, mental health services, educational services, and recreational activities.

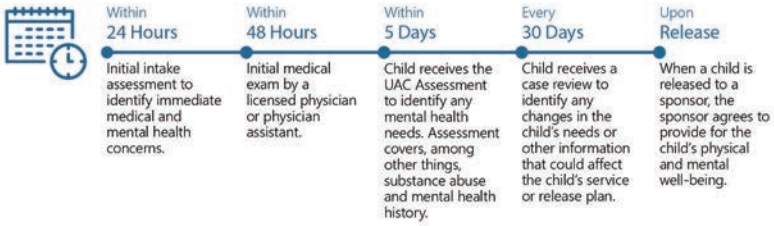
Federal law requires the safe and timely placement of children in the least restrictive setting that is in the best interest of the child.[7] To that end, ORR has several different types of facilities in its network that provide different levels of care. Shelter facilities represent the least restrictive setting for children and comprise the majority of ORR's network. ORR's network includes two residential treatment centers (RTCs) that provide therapeutic care and services that can be customized to individual needs through a structured, 24-hour-a-day program. RTC placements are intended for children with mental health needs that cannot be addressed in an outpatient setting.[8] Additionally, ORR's network includes nine staff secure facilities, including one that provides therapeutic care in combination with a higher level of security. ORR also funds two secure facilities that operate within existing juvenile detention facilities. See Appendix A for a complete list of the facility types that the Office of Inspector General (OIG) visited and their descriptions.

Required Mental Health Services in Care Provider Facilities

According to the terms of the 1997 *Flores* Settlement Agreement, which sets national standards regarding the detention, release, and treatment of children without legal immigration status in Federal custody, children must receive necessary medical and mental health services.[9] Within 24 hours of the child's admission, facility staff must perform an initial intake assessment to identify, among other things, any immediate medical or mental health concerns that may require prompt intervention.[10] Within 5 days of arrival, a child must also undergo a UAC assessment to more fully examine the child's mental health history and concerns. This assessment forms the basis of the child's service plan.[11]

At a minimum, each child in ORR custody must receive at least one individual counseling session per week from a trained mental health clinician. The objective is to review the child's progress, establish new short-term objectives, and address both the developmental and crisis-related needs of the child. Additionally, facilities must provide children at least two group sessions per week, which allow staff and children to discuss whatever is on their minds and to resolve problems. Facilities also must ensure that children receive emergency health services, prescribed medications, and appropriate mental health interventions.[12] Exhibit 1 describes the mental health assessments and care that facilities must provide.

Exhibit 1: Facilities are required to provide mental health services throughout a child's time in care provider facilities



Source: OIG analysis of *ORR Guide: Children Entering the United States Unaccompanied*

At times, the number of children referred to ORR surges, and as a result, ORR uses temporary "influx" facilities to provide short-term care. ORR does not require that these influx facilities provide the same level of mental health care services as do other facilities. Specifically, influx care facilities are not required to provide ongoing individual and group counseling services.[13]

Providers of Mental Health Services

Children in ORR's custody receive mental health services in two ways. Every child receives care from in-house mental health clinicians. When needed, children also may receive care from external mental health care providers, such as psychiatrists and psychologists.

In-house Mental Health Providers. Mental health clinicians are employed at every facility and are responsible for providing in-house mental health care for children. ORR requires that each facility employ at least 1 mental health clinician for every 12 children in care, although individual mental health clinicians could be responsible for more than 12 children.[14] These in-house mental health clinicians are responsible for conducting mental health assessments, providing counseling services, providing crisis intervention services, and recommending care from external providers.

ORR requires that mental health clinicians have a master's degree in psychology, sociology, social work, or another behavioral science requiring direct clinical experience, or a bachelor's degree plus 5 years of clinical employment experience.[15] Additionally, all mental health clinicians must be licensed or eligible for licensure. Lead mental health clinicians are responsible for coordinating facilities' mental health services, training new mental health clinicians, and supervising the mental health clinical staff. They must have at least 2 years of post-graduate service-delivery experience, supervisory experience, and be licensed to provide mental health clinical services in the State where the facility is located.[16]

Other facility staff who may participate in coordinating or providing mental health care include medical coordinators and specialists employed by some facilities. Medical coordinators arrange care from external providers and coordinate other services related to children's medical and mental health care, including managing medications.[17] See Appendix B for more information about other facility staff.

External Mental Health Providers. In addition to in-house staff, facilities can access external mental health providers through an insurance company (insurer) that ORR uses to authorize and coordinate reimbursement of these external services. The insurer maintains a network of doctors, hospitals, and other health professionals to provide mental health services to children in ORR custody. Facilities typically rely on external providers to prescribe psychotropic medications when warranted; in most States, such medications must be prescribed by certain types of licensed professionals, such as physicians or psychiatric nurse practitioners, who are not generally on staff.

Federal Policy Changes Affecting Care Provider Facilities

In 2018, facilities were addressing the mental health needs of a changing population of children, including younger children and those who had been separated from their parents, in part due to changes in immigration policies. As a consequence of heightened immigration enforcement beginning in 2017, DHS separated many more migrant families at the border, with the adults being held in Federal criminal detention facilities and their minor children—now "unaccompanied"—transferred to ORR's care.[18] This policy, deemed "zero-tolerance" and formally adopted in May 2018, was curtailed in June 2018 by Executive Order and by order of the presiding judge in *Ms. L v. ICE*, a class action lawsuit.[19] By that time, thousands of families had been separated.[20]

ORR's specific requirements for screening potential sponsors has varied over time, as ORR balanced safety concerns with the need for the timely release of children from HHS custody. For example, before June 2018, ORR required all potential sponsors who were not parents or legal guardians of the child to submit fingerprints for processing by the Federal Bureau of Investigation (FBI). Parents or legal guardians (who comprise a large percentage of sponsors) and adult household members were required to submit fingerprints only in specific circumstances, such as when there was a documented risk to the safety of the child. However, in June 2018, ORR began requiring all parents or legal guardians and adult members of their households to submit fingerprints for FBI criminal history checks before a child could be released to that parent or legal guardian. According to ORR, this policy change was intended to better protect children from human trafficking and other exploitation; however, it also increased the number of fingerprints being submitted and their processing time, which delayed children's release from facilities.[21] Along with this change, ORR also began sharing with Immigration and Customs Enforcement (ICE) the identifying

information and fingerprints of all potential sponsors and adult household members.[22] Until February 2019, this information could be used for immigration enforcement purposes, which also may have discouraged potential sponsors from coming forward.[23]

OIG Oversight Efforts

Since responsibility for the UAC Program was transferred to HHS by the Homeland Security Act of 2002, OIG has provided ongoing oversight of the Program. OIG has examined various aspects of the Program, including whether ORR grantees met safety standards for the care and release of children in their custody, and the efforts of ORR to ensure the safety and well-being of children after their release to sponsors. OIG issued several reports that made recommendations to address issues we identified. See Appendix C for a list of the related reports issued by OIG.

In 2018, OIG intensified its oversight of the UAC Program related to child health and safety in care provider facilities. Given the seriousness of the concerns about the treatment of children in ORR custody, including children who had been separated from their parents, OIG completed a large, multifaceted review of the UAC Program focused on the health and safety of children in HHS's care. The review gathered information from facilities across the country, including information from facility management, staff responsible for caring for the children, and ORR federal field specialists who help to oversee individual facilities.

This report is focused on the challenges that facility-interviewees reported in providing mental health care. Another OIG report addresses background screening of the facility employees who have direct contact with children.[24] Other reports will address child safety, facility security, and family reunification.

Methodology

Scope. To meet our objective to identify challenges that facilities faced in addressing children's mental health needs, OIG conducted site visits at 45 of the 102 ORR-funded facilities that were in operation across the country at the time of our review. All site visits lasted 2 or 3 days and occurred in August and September 2018, with the majority in August.

We visited facilities to learn about the challenges that they faced in addressing children's mental health needs. We interviewed key personnel about the challenges that made providing mental health care more complicated. We did not gather data to determine whether these challenges resulted in care that failed to meet ORR requirements. We did not assess the quality or appropriateness of mental health care provided to the children.

We conducted our fieldwork during a time when ORR was experiencing a rapidly expanding population of new groups of children in its custody. This timing allowed us to understand challenges related to addressing the

mental health needs of separated children and younger children, in addition to challenges associated with seasonal influxes of children transferred to ORR care.

Selection of facilities. We used a purposive selection process to achieve wide coverage of facilities participating in the UAC Program. In order to ensure a diverse set of facilities, our selection included facilities that:

- varied in size,
- operated in different geographic locations,
- operated as shelters or as specialty facilities,
- cared for children of varying ages, and
- cared for separated children.

The 45 visited sites included facilities that cared for 72 percent of the children in ORR custody at the time of our review. We visited 19 of the largest facilities in ORR's network. Of the facilities that we visited, about two-thirds (28) were shelter facilities, the most common type of facility in ORR's network. We also visited every RTC (2), staff secure (9), secure (2), and influx (2) facility in ORR's network at the time. Most facilities (29 of the 45) cared only for teenagers, but we also visited 16 facilities that cared for younger children. Additionally, 37 facilities that we visited cared for at least one child who had been separated from a parent after entering the United States. See Appendix A for more information about the facilities that we visited.

Data Collection

Facility site visits. Multi-disciplinary teams of OIG staff conducted each site visit. Each team consisted of at least one evaluator, auditor, investigator, and attorney. These teams were trained in advance regarding their responsibilities specific to this fieldwork. Onsite activities included, among other things, interviewing key facility personnel, examining facility employee records, and conducting structured assessments of facility premises.

This report focuses on challenges that facilities reported in addressing the mental health needs of children in their care, and relies primarily on discussions with:

- approximately 100 mental health clinicians who had regular interaction with children across the 45 facilities;[25]
- medical coordinators in each of the 45 facilities;
- facility leadership in each of the 45 facilities, including the program director and lead mental health clinician;[26] and
- the 28 ORR federal field specialists assigned to the 45 selected facilities.[27]

Combined, these were the key personnel who provided and coordinated mental health care, and those responsible for facility operations and oversight, at the time of our visits.

Key personnel interviews. We interviewed key personnel in private using standardized interview protocols. Each protocol included a variety of questions intended to help us learn more about how facilities address children's mental health needs and any challenges they face in doing so.

- *Program directors* responded to a series of questions about children's mental health needs, the care they received from in-house staff and external providers and challenges their facilities faced meeting children's needs. Program directors also discussed their facilities' recruiting and staffing.
- *Lead mental health clinicians* responded to a series of questions about the mental health needs of the children in their care, the type of mental health care provided both in-house and from external providers, challenges they faced in addressing the mental health needs of children, and any concerns they had about children's mental health treatment, including psychotropic medications.
- *Medical coordinators* responded to questions about coordinating care with external providers and managing medications, including psychotropic medications.

Case discussions with mental health clinicians. To better understand the nature of facility challenges, we discussed the mental health care of three specific children at each facility. Facility staff selected up to three cases for discussion; OIG requested that they choose:

- one case representing mental health issues the facility saw frequently,
- one case representing an example of the most serious mental health issues the facility faced and,
- where available, one case representing a child who had been separated from a parent after arrival in the United States.

For each case, the mental health clinician assigned to the child discussed the case with OIG staff while referencing the case file. We completed 123 case discussions with 96 mental health clinicians. The case discussions helped to inform our understanding through real-world examples of challenges that mental health clinicians encountered. OIG staff did not independently review individual children's health records or services as a part of these discussions, nor did we assess the quality or appropriateness of mental health care provided to the children.

ORR federal field specialist interviews. In the weeks following the site visits, OIG staff interviewed the 28 ORR federal field specialists who worked directly with each of the 45 selected facilities. During these interviews, we gathered information and insights from ORR federal field specialists about challenges and concerns with how facilities addressed the mental health needs of children in their care.

ORR data and policies and procedures. We reviewed ORR data, and policies and procedures concerning mental health care. We reviewed information about bed capacity and availability at each facility in the ORR network as of August 31, 2018. We collected and reviewed ORR policies and procedures for facility transfers, and processes for authorizing and reimbursing care provided by external specialists. We also interviewed ORR headquarters staff to clarify other policies and procedures related to mental health services.

Analysis

We performed qualitative analysis of the interviews conducted during the site visits. The analysis identified themes related to challenges in addressing the mental health needs of children in ORR's custody. We aimed to identify the most significant challenges impacting mental health care, as reported by facility staff and ORR federal field specialists. A challenge was considered significant if it was identified by multiple staff across multiple facilities. As such, the report does not reflect every challenge that facility staff mentioned during interviews.

Qualitative analysis involved multiple steps carried out by OIG staff. The analysis team used qualitative analysis software to organize interview responses related to mental health care and categorize themes that emerged. Results were examined to identify significant challenges reported by facility personnel and ORR federal field specialists. Additional quantitative analysis of ORR data focused on the number of younger children referred to ORR in 2018 and the average length of stay in ORR care from January 2018 to April 2019.

Limitations

The facilities that we visited were purposively selected and may not represent the experiences of staff in other facilities. We did not independently verify information provided by facility staff during interviews and did not reconcile conflicting information from different employees within a facility.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Care provider facilities described the inherent challenges of addressing the mental health needs of a population of children who had experienced significant trauma

Intense trauma was common among children who entered care provider facilities

Facility managers and mental health clinicians reported that many children who entered facilities in 2018 had experienced intense trauma from a variety of events before and upon their arrival in the United States.

In their countries of origin. According to mental health clinicians and program directors, some children had experienced physical or sexual abuse and other forms of violence while in their country of origin. Staff in multiple facilities reported cases of children who had been kidnapped or raped, some by members of gangs or drug cartels. In one case, a medical coordinator reported that a girl had been held in captivity for months, during which time she was tortured, raped, and became pregnant. Other children had witnessed the rape or murder of family members or were fleeing threats against their own lives. In one case, a mental health clinician reported that, after fleeing with his mother from an abusive father, the child witnessed the murder of his mother, grandmother, and uncle.

On their journey to the United States. According to mental health clinicians and program directors, some children experienced or witnessed violence during the trip to the U.S. border. For example, a mental health clinician in one facility shared the story of a child who, while attempting to cross from Guatemala to Mexico, was abducted by a gang and held for ransom. The gang held the child in a compound, where another individual was shot in the head. Later, a woman who helped the child escape from the compound was shot by the gang.

Once in the United States. According to mental health clinicians and program directors, some children experienced additional trauma after they arrived in the United States. Some children faced additional trauma when they were unexpectedly separated from a parent. Even for children who entered the United States without their parents—those not separated—some found it traumatic to adapt to new and unfamiliar situations in facilities. As one mental health clinician explained, adapting was difficult because children "lose friends, staff, the routine. And if they have to move somewhere else, it's just one more loss."

Mental health clinicians reported concerns about their ability to address children's significant trauma

Given the level of intense trauma that children had experienced before coming into HHS care, mental health clinicians expressed concerns that they were not able to address the children's mental health issues. In part, these concerns derived from the fact that mental health clinicians did not know how long a child would be in their facility. Many children had a relatively

short stay at a facility, from a treatment perspective, and the amount of time was often unpredictable. Given this uncertainty, mental health clinicians reported being wary of having children revisit traumatic incidents that they might not be able to address adequately through continued therapy. For example, mental health clinicians described intentionally not probing into past events, but instead staying focused on helping children to cope and remain stable. Mental health clinicians referred to this as a "Band-Aid" approach, akin to psychological first aid; the goal is not to treat children's underlying issues because children will not be in the facility long enough to make meaningful progress.

Mental health clinicians expressed concerns about feeling unprepared to handle the level of trauma that some children presented, despite their prior training and experience. As detailed in a separate report, OIG found that virtually all mental health clinicians whose records we reviewed met established educational requirements.[28] Further, all facilities reported that they provided training for their staff—including mental health clinicians—to help them work with children who had experienced trauma. Nonetheless, mental health clinicians discussed how challenging it was to hear about children's traumatic experiences, which sometimes caused the clinicians to become overwhelmed or suffer their own mental distress. Further, mental health clinicians said that colleagues hired without previous experience in caring for children in ORR custody may have been especially unprepared for the severe trauma of children in their care. Both program directors and mental health clinicians expressed that more training on trauma-informed care could be beneficial.

Addressing children's mental health needs was especially challenging in 2018 due to an influx of separated children and longer stays in care provider facilities

Care provider facilities reported that separation from parents and a hectic reunification process added to the trauma that children had already experienced and put tremendous pressure on facility staff

Facilities reported that addressing the unique mental health needs of separated children was particularly challenging. According to program directors and mental health clinicians, separated children exhibited more fear, feelings of abandonment, and post-traumatic stress than did children who were not separated. Separated children experienced heightened feelings of anxiety and loss as a result of their unexpected separation from their parents after their arrival in the United States. For example, some separated children expressed acute grief that caused them to cry inconsolably.

Children who did not understand why they were separated from their parents suffered elevated levels of mental distress. For example, program directors and mental health clinicians reported that children who believed their parents had abandoned them were angry and confused. Other children expressed feelings of fear or guilt and became concerned for their parents' welfare. The difficulties that some facilities had in locating parents

in detention and scheduling phone calls also contributed to children's anxiety and fear for their parents' well-being.

A 7- or 8-year-old boy was separated from his father, without any explanation as to why the separation occurred. The child was under the delusion that his father had been killed and believed that he would also be killed. This child ultimately required emergency psychiatric care to address his mental health distress.

–Program director

The level of trauma and unique experiences of separated children made it more difficult to establish therapeutic relationships through which facilities could address children's mental health needs. Program directors and mental health clinicians described challenges gaining the trust of separated children. For example, one program director noted that separated children could not distinguish facility staff from the immigration agents who separated them from their parents: "Every single separated kid has been terrified. We're [seen as] the enemy." Program directors and mental health clinicians also noted that some separated children isolated themselves and took longer to adjust to the facility and its routines, for example, refusing to eat or participate in activities.

Adding to the challenge of addressing the mental health needs of separated children was the uncertainty that came with a hectic reunification process for children covered by the *Ms. L v. ICE* lawsuit. This lawsuit established a different reunification process for *Ms. L* class members and their separated children, along with fixed court-imposed deadlines for family reunification. Program directors reported that the guidance that ORR provided to facilities in 2018 on how to carry out reunifications for children covered by the *Ms. L* case changed frequently and with little notice. Changing guidance resulted in uncertainty around how or when reunification would happen. For example, case managers in facilities were not always able to let children know when, or even if, they would be reunified with their parents, or whether that reunification would happen in the United States. This type of uncertainty added to the distress and mental health needs of separated children.

Physical symptoms felt by separated children are manifestations of their psychological pain. You get a lot of "my chest hurts," even though everything is fine [medically]. Children describe symptoms, "Every heartbeat hurts," "I can't feel my heart," of emotional pain.

–Medical director

Even when they were prepared to reunify separated children covered by the *Ms. L* case with their parents, facilities reported that logistical issues introduced further uncertainty that could lead to emotional distress. Facilities reported that some reunifications were scheduled with little advance notice, or suddenly canceled or delayed, which increased the levels of uncertainty and anxiety in separated children and other children in the facility. In one case, a child was moved from a facility in Florida to a facility in Texas to be reunited with her father. However, a mental health clinician reported that after the child made several trips to the detention center, she was returned to the Florida facility "in shambles" without ever seeing her father.

Care provider facilities described challenges providing age-appropriate mental health services, especially when faced with an unexpected increase in children age 12 and younger

As shown in Exhibit 2, facilities cared for an increasing number of younger children in 2018. The number of young children, age 12 and younger, in

ORR's care increased sharply in May 2018 when DHS formally adopted the zero-tolerance policy of criminally prosecuting all adults for illegal entry into the United States. This policy led to children, some of them quite young, being separated from their parents. The proportion of young children in ORR care rose from 14 percent of referrals to ORR in April 2018 to 24 percent of referrals in May 2018.

Exhibit 2: The number of young children referred to ORR increased sharply in May 2018, when DHS formally adopted the "zero-tolerance" policy

Source: OIG Analysis of ORR referrals data.

> The little ones don't know how to express what they are feeling, what has happened. Communication is limited and difficult. They need more attention.
>
> –Program director

Faced with a sudden and dramatic increase in young children, staff reported feeling challenged to care for children who presented different needs from the teenagers they typically served. Facilities noted that elementary-school-aged children had shorter attention spans, lacked the ability to comprehend the role of the facility, and more commonly exhibited defiance and other negative behaviors. Facilities noted the difficulties associated with completing assessments and other screenings for pre-school aged and younger children who could not accurately communicate their background information, needs, or the source of any distress.

Care provider facilities reported that longer lengths of stay resulted in deteriorating mental health for some children and increased demands on staff

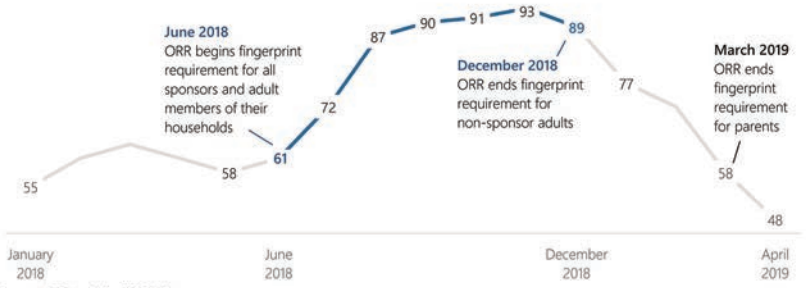
Facilities reported that children with longer stays experienced more stress, anxiety, and behavioral issues, which staff had to manage. Some children who did not initially exhibit mental health or behavioral issues began reacting negatively as their stays grew longer. For example, one mental health clinician explained that even children who were outgoing and personable started getting more frustrated and concerned about their cases around the 70th day in care. According to facility staff, longer stays resulted in higher levels of defiance, hopelessness, and frustration among children, along with more instances of self-harm and suicidal ideation. One mental

health clinician, for example, remarked that even children who come into care with good coping skills become disillusioned after a lengthy stay. Facilities also reported that children who had arrived in the United States on their own felt a sense of frustration in the summer of 2018 as they witnessed the expedited reunification of separated children, while seeing little movement in their own cases.

Facilities attributed longer stays for children to ORR's new sponsor screening requirements. As mentioned earlier, in June 2018, ORR revised its sponsor screening requirements and began mandating fingerprint-based FBI criminal history checks of all potential sponsors, including parents, and all adult members of their households.[29] Further, these fingerprints were shared with ICE and could be used for immigration enforcement purposes.[30] Facilities reported that it became more difficult to identify sponsors willing to accept children after the new fingerprinting requirements were implemented, which delayed placing children with sponsors, adding further stress and uncertainty.

As shown in Exhibit 3, children's average length of stay in ORR custody increased markedly after ORR implemented the new fingerprinting policy in June 2018. The average length of stay reached a high of 93 days for children who were released from ORR custody in November 2018. The average length of stay that children spent in ORR's custody began to decline after December 2018, when ORR ended the requirement for fingerprint background checks for all non-sponsor adult members of households. In March 2019, ORR further modified its policy, ending fingerprint background checks for parents or legal guardians, in most circumstances. By April 2019, the average length of stay had declined to 48 days.

Exhibit 3: In June 2018, ORR began requiring fingerprint background checks of all potential sponsors and adult members of their households, which affected the average number of days children spent in ORR care



Source: OIG Analysis of ORR data.

Care provider facilities reported high caseloads due to challenges recruiting and retaining mental health clinicians

> The most challenging thing is the lack of time due to the caseloads. Our concern is always whether the quality of therapy suffers... Some [children] have behavioral issues or are going through difficult times and you need to see them more during a given period. It becomes a strain on us.
>
> –Lead mental health clinician

Mental health clinicians expressed that high caseloads limited their effectiveness in addressing children's needs. ORR's required facility-wide staffing ratio is 1 mental health clinician for every 12 children. However, facilities reported that some individual mental health clinicians managed caseloads of more than 25 children. According to mental health clinicians, high caseloads hurt their ability to build rapport with children and allowed less time for counseling. They also reported facing challenges when trying to provide longer or more frequent counseling sessions to children with greater needs, while also attempting to ensure that other children assigned to them received enough attention.

Clinician rotations addressed some challenges and introduced others

One grantee rotated mental health clinicians among five facilities for short-term assignments in response to mental health clinician shortages. However, mental health clinicians at these facilities believed that rotations disrupted clinical relationships with the children and inhibited therapeutic progress. Together, the facilities cared for more than 2,500 children at the time of our site visits.

High caseloads largely resulted from facilities' challenges hiring and retaining mental health clinicians. Program directors reported difficulties in finding qualified candidates, especially those who were fluent in the languages spoken by children in their care.[31] Program directors explained that these challenges were heightened for facilities in remote or rural areas, reflecting a shortage of mental health professionals in certain geographic regions.[32] Further, program directors also reported experiencing challenges with retaining mental health clinicians because of low compensation, demanding work schedules, and competing job opportunities. These challenges made it difficult for facilities to retain staff even in urban centers with more potential candidates.

Care provider facilities faced challenges accessing external specialists

Program directors, medical coordinators, and mental health clinicians noted that they had difficulty accessing external mental health specialists. Although a few facilities (4 of the 45 that we visited) employed a mental health specialist, such as a psychiatrist, psychologist or psychiatric nurse practitioner, most facilities turned to external specialists when in-house mental health clinicians could not meet the mental health needs of a child.[33] To help facilities access needed specialists, ORR officials reported that its healthcare insurer maintains agreements with several geographically dispersed, licensed healthcare providers to serve children.

Nonetheless, facilities reported challenges accessing these external mental health specialists. For example, some facilities were in underserved areas with relatively few practicing specialists. Mental health clinicians and an ORR federal field specialist also expressed their concerns that specialists hesitated to continue treatment of children, or initiate new treatment,

As the population in the area grows, the existing providers get more saturated with work, so it becomes more difficult to get appointments... We need more psychiatrists, neurodevelopmental psychiatrists, and psychologists.

–Program director

because prior reimbursements had been late. Complicating matters, facilities reported that those specialists who were available often were not fluent in the languages spoken by the children or familiar with their cultural backgrounds. For example, one medical coordinator noted that the only bilingual psychologist in its network was in a neighboring State.

Children experienced treatment delays when they could not access external specialists. Mental health clinicians and program directors reported long waits for mental health evaluations and treatment from external specialists and other providers. Staff described making appointments with psychiatrists and psychologists for dates that were 2 or 3 months away. To help address the limited access to in-person specialists, some facilities reported using telemedicine to access psychiatrists remotely. For example, a facility in an underserved area reported using telehealth appointments to fill the gaps when they encountered difficulty finding local psychiatrists.

Care provider facilities reported challenges transferring and caring for children who needed specialized treatment

Care provider facilities reported challenges transferring children to RTCs

When mental health clinicians determined that children needed a higher level of care, facilities reported difficulties transferring those children to facilities in the ORR network that are licensed to provide specialized care.[34] At the time of our review, two RTCs, with a total capacity for 50 children, were available in ORR's network. Facilities reported that they were sometimes unable to transfer children with significant mental health needs to RTCs because the RTCs were at capacity or had waiting lists.

To supplement these two in-network RTCs, ORR sometimes refers children to out-of-network RTC providers with which ORR contracts. These are used in situations when the services provided by the two in-network RTCs are not appropriate to address a child's unique needs or because there is not ample bed space in network. As of September 1, 2018, at the time of our review, ORR reported that four children were in these placements.[35]

The facility tries to keep them safe, but there are many ways a child can harm themselves. The children need a secure residential treatment center for children that are high-risk and need intensive therapy.

–Lead mental health clinician

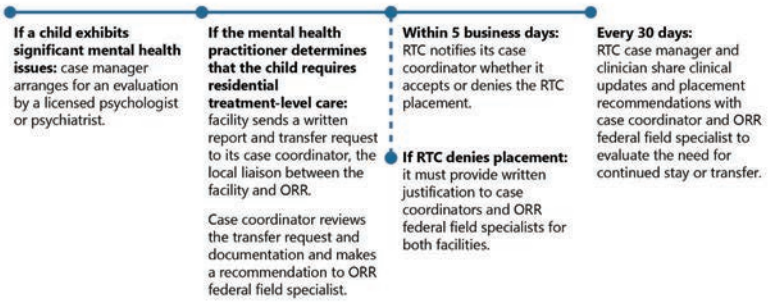
Program directors and mental health clinicians also expressed concerns about the lack of therapeutic placement options for children whom they diagnose as needing a higher level of mental health care, but who also have a history of behavior problems. Facilities reported that the RTCs in ORR's network of facilities do not accept aggressive children. According to mental health clinicians, this limited options for children who exhibited aggressive behaviors or were considered a runaway risk. For example, one mental health clinician noted challenges finding an appropriate placement for a child diagnosed with bipolar disorder, who was also physically aggressive. Facilities noted that sometimes a child's troublesome behavior resulted from underlying mental health issues that required more intensive treatment to resolve.

Although ORR's network includes one 16-bed therapeutic staff secure facility that provides intensive mental health services and a higher level of security,

this facility alone did not meet the demand. During an interview in March 2019, ORR officials described efforts to add new facilities that provide therapeutic care in more secure settings.

Facilities also mentioned difficulty obtaining the needed medical recommendation in a timely manner as another obstacle to transferring children to RTCs. As shown in Exhibit 4, to ensure that higher-level therapeutic care is warranted, ORR requires that a licensed psychologist or psychiatrist provides a recommendation for the transfer.[36] Facilities explained that they were not always able to get timely transfer recommendations, in part because of the difficulty scheduling appointments with external mental health specialists. One program director noted that an external psychiatrist often wanted several followup visits with a child before making a transfer recommendation.

Exhibit 4: Care provider facilities must receive a recommendation from a mental health specialist before transferring a child to an RTC



Source: OIG Analysis of *UAC Manual of Procedures*.

Facilities reported negative consequences of caring for children whom they judged should be transferred to another setting

Program directors and mental health clinicians reported safety concerns when children whom staff assessed as needing a higher level of mental health care were not transferred to RTCs. As a result, they reported that some children with more significant mental health needs—such as oppositional defiant disorder, dissociative symptoms, and suicidal ideation—remained in settings not well equipped to address their needs. Facilities noted that children who did not receive requested transfers to RTCs displayed behaviors that put themselves and others at risk. For example, one program director described caring for children who were

> The staff [in a shelter facility] end up brainstorming on how to provide mental health services to kids, but that's not what the facility is designed for. It is a temporary shelter, not a treatment facility. There is also an issue where residential treatment facilities won't take minors who are aggressive, even when those minors are aggressive because they have untreated mental trauma.
>
> –Program director

psychotic, self-harming, or actively attempting suicide. Another described a child whose self-harm and aggressive behavior continued while awaiting transfer to an RTC.

Facilities also reported that children who needed higher levels of mental health treatment consumed more attention, leaving less capacity to address the other children in the facility. One mental health clinician noted that a child who was denied admission to an RTC because of prior runaway attempts, "consumed most of my time from December to July." Another mental health clinician reported that managing a difficult case made it more challenging to fit in other children's scheduled counseling appointments because they were frequently called away to de-escalate situations.

CONCLUSION AND RECOMMENDATIONS

Facilities that care for children in ORR custody face the difficult task of addressing the mental health needs of all children in their care, including the needs of those who have experienced significant trauma. According to those who care for them, many children enter the facilities after fleeing violence or experiencing direct threats to their safety during their journey to this country. In 2018, some children also experienced the trauma of being unexpectedly separated from their parents as a result of U.S. immigration policies. Promptly addressing children's mental health needs is essential—not only to stabilize each child in crisis, but also to minimize the risk the child may negatively influence or harm others.

Facilities reported challenges addressing the individual mental health needs of children in ORR's custody. Facilities reported challenges employing in-house mental health clinicians and preparing them to treat children in crisis, accessing external providers to treat children who needed higher levels of mental health care, and transferring children to facilities that can provide needed specialized care. Exacerbating these concerns, policy changes in 2018 resulted in increases in the length of time that children stayed in ORR custody and a rapid increase in the number of children under the age of 12—many of whom had been separated from their parents after entering the United States.

This report provides ORR with information from the field, useful for directing attention toward the most significant mental health-related challenges facing facilities.

The following six recommendations represent practical steps ORR can take to assist facilities in addressing the mental health care of children in its custody. Across many of these recommendations, we encourage ORR to consult or partner with subject matter experts who can assist ORR in making improvements. Such experts may be available within HHS and have contacts with the broader mental health community.

We recommend that ORR:

Identify and disseminate evidence-based approaches to addressing trauma in short-term therapy

ORR should work with subject matter experts to identify and disseminate additional tools to help clinical staff address trauma in children. Mental health clinicians expressed concerns about feeling unprepared to handle the level of trauma that some children presented, despite their prior training and experience, especially in short-term therapy.

ORR should identify or create resources that can improve facilities' readiness to meet the mental health care needs of children of all ages, including very

young children and pre- or non-verbal children. ORR also could establish and make available a technical assistance group composed of subject matter experts, which could help to ensure that facilities' treatment reflects current best practices. This group could serve as a resource to facility mental health clinicians when they have questions or need help treating children in their care. ORR has already committed resources to addressing children's mental health by employing a clinical child and adolescent psychiatrist and a psychiatric nurse practitioner to support the UAC Program.

Develop and implement strategies to assist care provider facilities in overcoming obstacles to hiring and retaining qualified mental health clinicians

Facilities' challenges hiring and retaining mental health clinicians affect their ability to meet ORR's required staffing ratios, which are designed to ensure facilities can meet children's mental health needs. As one possible strategy, ORR could assist facilities with regional recruitment efforts, such as outreach to universities with clinical programs to raise awareness of the UAC Program and possible job opportunities.

ORR should also evaluate whether using telemedicine to access remote psychiatry and psychology services is an effective way to bridge the gap when facilities cannot access external providers in person. Facilities reported that, while not a perfect replacement for in-person care, access to these services allowed children to receive necessary treatment and helped to limit delays in care.

ORR also could consider entering agreements with governmental and non-governmental entities that could dispatch mental health clinicians to fill vacancies to address facilities' needs. These efforts could help release the time and workload pressures that contribute to mental health clinician staffing issues and could improve their ability to address children's needs.

Assess whether to establish maximum caseloads for individual mental health clinicians

Although ORR already requires facilities to maintain an overall facility-wide ratio of at least 1 mental health clinician employed for every 12 children in care, facilities sometimes assign large caseloads to individual clinicians. However, according to some mental health clinicians, such high caseloads limited their availability and effectiveness. ORR could consult with subject matter experts to determine an appropriate maximum caseload that would ensure mental health clinicians are able to meet the needs of children and adjust grant and contract requirements, as appropriate.

Help care provider facilities improve their access to mental health specialists

ORR should ensure that its national network of external healthcare providers includes the mental health specialists needed to address children's mental health needs. ORR should determine whether the provider networks maintained by ORR's insurance underwriter include providers operating in a full range of specialties and sub-specialties, with needed language skills, in locations where ORR-funded facilities operate. Facility staff reported that limited access to external providers resulted in delays in treatment and transfers. Ensuring access to necessary mental health care will help facilities meet children's mental health needs and limit the chance that they will become a risk to themselves or others.

For facilities in areas with a scarcity of mental health specialists, ORR could consider entering into agreements with Federal, State, or local health agencies or qualified specialists to provide necessary mental health treatment. ORR could work with HHS agencies and subject matter experts, such as the Administration for Community Living, to explore strategies and resources.

Increase therapeutic placement options for children who require more intensive mental health treatment

ORR should follow through with its plans to expand placements in its network for children with the most significant mental health needs. In particular, ORR should ensure that its network has sufficient options for children with both disruptive behavioral and significant mental health issues. During our site visits, program directors, mental health clinicians, and ORR federal field specialists highlighted the need for more therapeutic placements available in the ORR network for children who are identified as needing specialized treatment.

In addition, on an ongoing basis, ORR should assess its capacity to ensure that the availability of beds reflects the diversity of behavioral and mental health needs of children in its care. Moving forward, ORR should consult with subject matter experts about the types of therapeutic facilities that can meet children's needs in the least restrictive setting.

Take all reasonable steps to minimize the time that children remain in ORR custody

Mental health clinicians described that a child's mental health often deteriorates as the length of their stay in ORR custody increases. ORR should continue to make reasonable policy and practice decisions that can help to minimize the length of stay for children in ORR facilities. It is also essential that ORR appropriately assesses all sponsors before making a release determination, to ensure a child's safety after their release from ORR custody. OIG recognizes these constraints and does not suggest that ORR relax its sponsor screening requirements.

In addition, ORR should assess current policies and procedures to ensure that they do not present unnecessary barriers to children's release to appropriate sponsors and adjust, as appropriate. Lastly, ORR should establish procedures to ensure that future policy changes prioritize child welfare considerations and do not inadvertently increase the length of time a child remains in ORR custody.

AGENCY COMMENTS AND OIG RESPONSE

ACF concurred with all of our recommendations.

In concurring with the first, second, third, and sixth recommendations, ACF described its plans to address them, some of which are underway. ACF reported that ORR has hired a board-certified psychiatrist to serve as team leader working to improve ORR's mental health care services. ACF also reports engaging with experts in trauma-informed care to create a webinar to train facility staff in the unique mental health needs of children in HHS custody. ACF anticipates beginning the webinars in August 2019. ACF also committed to assisting facilities in hiring and retaining qualified mental health clinicians and assessing the size of clinician caseloads to ensure quality mental health care for children in ORR care. Additionally, ACF described policy changes that it has implemented to minimize the time that children remain in ORR custody and stated this it is required to submit a plan to Congress for improving the rate at which it discharges children.

Although ACF concurred with our fourth recommendation, it did not specify new actions it plans to take to improve access to external mental health specialists. We encourage ACF to expand its efforts to identify appropriate mental health specialists and look forward to learning more about ACF's efforts.

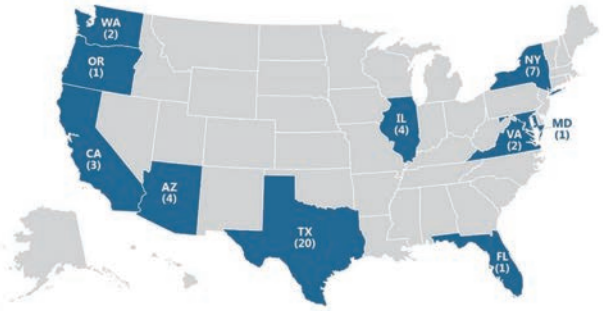
ACF concurred with our fifth recommendation and discussed the challenges it faces expanding the number of therapeutic placement options in ORR's network. We acknowledge these efforts and encourage ACF to continue its work to ensure that children who need higher levels of mental health care have access to the appropriate level of care.

One aspect of ACF's comments warrants correction. ACF stated that our qualitative analysis "corroborates that UAC generally received all legally-required mental health care." However, the report does not make such an assertion, because it was beyond the scope of our review to assess whether the mental health care provided in ORR-funded facilities met all legal requirements. Rather, the report identifies the most significant challenges that facilities faced in addressing the mental health needs of children in ORR custody.

For the full text of ACF's comments, see Appendix E.

APPENDIX A: Care Provider Facilities Visited by OIG

During August and September 2018, OIG staff conducted site visits to 45 facilities across 10 States.



Number and Type of Facilities Visited

28	**Shelter**	Most common type of residential care facility; provides housing, food, medical care, mental health and educational services, and recreational activities.
9	**Staff Secure**	Provides close supervision to children who exhibit disruptive behavior, are a flight risk, or display gang affiliation. This includes the only therapeutic staff secure facility that ORR funded at the time of our site visit, which provides a combination of close supervision and intensive support and clinical services (e.g., in-depth counseling).
2	**Secure**	Provides care for children who pose a danger to self or others, or who have been charged with a crime.
2	**Residential Treatment Center**	Provides children who need more intensive mental health treatment with sub-acute therapeutic care through a structured 24-hour-a-day program and services that are highly customized to individual needs.
2	**Influx**	Provides children with temporary emergency shelter and services; used when ORR experiences an influx of children.
2	**Transitional Foster Care**	Provides short-term foster care for children under age 13, siblings, pregnant and parenting teens, or those with special needs; services provided in the community.

Source: OIG analysis of ORR and facility data, 2019.

Facilities Visited

The table below lists and describes the 45 facilities that OIG visited.

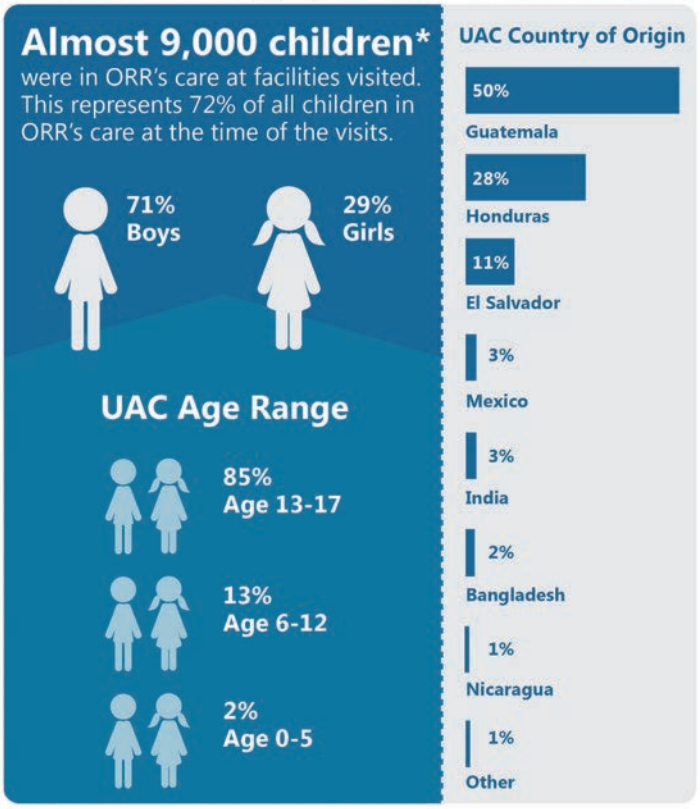
Facility Name	Facility Type	Number of Children in Care*	Licensed to Care for Younger Children**	Cared for Separated Children***
Arizona (4)				
SWK Campbell	Shelter	126	•	•
SWK Casa Phoenix	Shelter	385		•
SWK Estrella	Shelter	295	•	•
SWK Hacienda del Sol	Shelter	139	•	•
California (3)				
BCFS Fairfield	Staff Secure	11		
SWK Pleasant Hill	Shelter	26		•
Yolo County	Secure	19		
Florida (1)				
Homestead	Influx	1,347		•
Illinois (4)				
Heartland CRC IRC	Shelter	193	•	•
Heartland Casa Guadalupe	Shelter	47	•	•
Heartland IYC	Staff Secure	6		
Heartland SCIY	Shelter	5		•
Maryland (1)				
Board of Child Care	Shelter	42	•	•
New York (7)				
Abbott House	Shelter	51	•	•
Cayuga Centers	Transitional Foster Care	609	•	•
Children's Village	Shelter	167		•
Children's Village	Staff Secure	26		
MercyFirst	Residential Treatment Center	9		•
Leake and Watts/ Rising Ground	Shelter	47		•
Lincoln Hall	Shelter	184		•
Oregon (1)				
Morrison Paso	Staff Secure	11		

(Continued on next page)

Facility Name	Facility Type	Number of Children in Care*	Licensed to Care for Younger Children**	Cared for Separated Children***
Texas (20)				
BCFS Baytown	Shelter	216	•	•
BCFS Harlingen	Shelter	576	•	•
BCFS Raymondville	Shelter	50	•	•
BCFS San Antonio	Shelter	110	•	•
BCFS San Antonio	Staff Secure	26		
BCFS San Antonio	Transitional Foster Care	119	•	•
BCFS Tornillo	Influx	665		•
Shiloh Treatment Center	Residential Treatment Center	23		•
SWK Antigua	Shelter	276		•
SWK Casa Houston	Shelter	71		•
SWK Montezuma	Shelter	209		•
SWK Casa Padre	Shelter	1,398		•
SWK Casa Quetzal	Shelter	246		•
SWK Casita del Valle	Shelter	84	•	•
SWK Combes	Shelter	73	•	•
SWK Mesa	Staff Secure	7		
SWK El Presidente	Shelter	372	•	•
SWK Nueva Esperanza	Shelter	290		•
SWK Processing Center	Staff Secure	16		
SWK Rio Grande	Shelter	225		•
Virginia (2)				
Shenandoah Valley Juvenile Center	Secure	20		•
Youth for Tomorrow	Shelter	111		•
Washington (2)				
Friends of Youth	Staff Secure	11		•
Selma Carson	Staff Secure	14		•

Source: OIG analysis of ORR and HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) data, 2019.
*Data on the number of children in care was as of August 30, 2018.
**Younger children include those who were 9 years old and under.
*** We obtained from ORR and ASPR data on separated children that were part of the *Ms. L v. ICE* lawsuit. Our analysis identified that 37 of the 45 facilities had children covered by the lawsuit.

Children's Demographics at Facilities Visited



Source: OIG analysis of ORR and facility data, 2019.

*According to ORR data, on August 30, 2018, 12,409 children were in ORR care. Of those, 8,953 children were at the facilities that OIG visited; the percentages of boys and girls are based on this number. The percentages on age range and country of origin are based on data collected directly from the facilities that we visited. We reviewed age and country of origin data that facilities provided to OIG. Because some facilities provided data for a point-in-time (i.e., specific date) while other facilities provided data over a specific timeframe (i.e., 3-month period), the total number of children between these two data points differs. Age range is based on data from 5,835 children; country of origin is based on data from 7,081 children. Because of rounding, the total percentage for country of origin does not add up to 100 percent.

APPENDIX B: Job Descriptions of Key Personnel

Below are job descriptions of individuals involved in the care and placement of children in facilities.[37]

Program Directors. Program directors are senior facility staff who manage facility staff and oversee facility operations.

Medical Coordinators. Medical coordinators arrange care from external providers, coordinate other services related to children's medical and mental health care, and manage medication.

Mental Health Clinicians. Mental health clinicians are employed at every facility and are responsible for providing in-house mental health care for children in the facility. They conduct mental health assessments, provide counseling services, provide crisis intervention services, and recommend care from external providers. Lead mental health clinicians coordinate clinical services, train new mental health clinicians, and supervise staff.

Case Managers. Case managers coordinate assessments of children, individual service plans, and efforts to release children to sponsors. They also ensure that all services are documented in children's case files.

Youth Care Workers. Youth care workers provide around-the-clock monitoring of children. Youth care workers have direct and frequent contact with children and are the staff primarily responsible for their supervision.

ORR Federal Field Specialists. Federal field specialists are ORR employees who serve as local ORR liaisons to one or more facilities within a region. They are responsible for providing guidance and technical assistance to facilities and approving or denying children's transfer and release.

APPENDIX C: Related OIG Work

Information on OIG's work on this topic can be found on our Unaccompanied Children webpage. Below is a list of OIG reports on unaccompanied children.

Title	Report Number	Date Issued
Southwest Key Programs Did Not Always Comply With Health and Safety Requirements for The Unaccompanied Alien Children Program	A-06-17-07005	August 2019
Southwest Key Did Not Have Adequate Controls in Place To Secure Personally Identifiable Information Under the Unaccompanied Alien Children Program	A-18-18-06001	August 2019
The Children's Village, Inc., an Administration for Children and Families Grantee, Did Not Always Comply with Applicable Federal and State Policies and Requirements	A-02-16-02013	April 2019
Lincoln Hall Boys' Haven, an Administration for Children and Families Grantee, Did Not Always Comply with Applicable Federal and State Policies and Requirements	A-02-16-02007	February 2019
Separated Children Placed in Office of Refugee Resettlement Care	OEI-BL-18-00511	January 2019
BCFS Health and Human Services Did Not Always Comply With Federal and State Requirements Related to the Health and Safety of Unaccompanied Alien Children	A-06-17-07007	December 2018
The Tornillo Influx Care Facility: Concerns About Staff Background Checks and Number of Clinicians on Staff	A-12-19-20000	November 2018
Florence Crittenton Services of Orange County, Inc., Did Not Always Claim Expenditures in Accordance with Federal Requirements	A-09-17-01002	October 2018
Heartland Human Care Services, Inc., Generally Met Safety Standards, but Claimed Unallowable Rental Costs	A-05-16-00038	September 2018
Florence Crittenton Services of Orange County, Inc., Did Not Always Meet Applicable Safety Standards Related to Unaccompanied Alien Children	A-09-16-01005	June 2018
BCFS Health and Human Services Did Not Always Comply With Federal Requirements Related to Less-Than-Arm's-Length Leases	A-06-16-07007	February 2018
Office of Refugee Resettlement Unaccompanied Alien Children Grantee Review–His House	A-04-16-03566	December 2017
HHS's Office of Refugee Resettlement Improved Coordination and Outreach to Promote the Safety and Well-Being of Unaccompanied Alien Children	OEI-09-16-00260	July 2017
Division of Unaccompanied Children's Services: Efforts to Serve Children	OEI-07-06-00290	March 2008

APPENDIX D: Use of Psychotropic Medications by Children in Care Provider Facilities Visited by OIG

In the 4 months before our visit, legal actions and press accounts alleged forced and otherwise improper use of medication by facilities.[38] Given the disturbing nature of the allegations and the potential for harm to children, we wanted to learn about any concerns that staff had about their facilities' use of psychotropic medications and any related challenges they faced. Therefore, we specifically asked facility personnel a series of questions related to use of psychotropic medications in each of the facilities we visited.

We collected information about psychotropic medications administered to children in the facilities that we visited. From each facility, we requested the number of children who had been prescribed a psychotropic medication during the 3-month period between May 1, 2018, and July 31, 2018, along with the name of each medication and the child's associated diagnosis. During interviews, we inquired about any challenges or concerns that program directors, mental health clinicians, or medical directors had related to the use of these medications. We also asked ORR federal field specialists about concerns they had about the facility's ability to manage medications. We did not independently review medical records or assess the appropriateness of any treatment or prescriptions.

Because the concerns and challenges that we heard were not widespread and involved a form of treatment provided to a relatively small number of children, we chose to address them in this Appendix, rather than in the body of the report, and we are making no formal recommendations. This choice was not meant to minimize the importance of the concerns and challenges that we heard, but instead reflects our approach of including only the most commonly voiced challenges as findings in the report.

The first section of this Appendix outlines the issues identified by facility management and staff and ORR field specialists related to use of psychotropic medications. The second section lists the most prevalent psychotropic medications that facilities reported had been prescribed to children in their care, and the corresponding health diagnoses.

Interview responses about use of psychotropic medications

A relatively small number of children in ORR custody had been prescribed a psychotropic medication. Between May 1, 2018, and July 31, 2018, only about 300 children (roughly 1 in 30, overall, in the facilities that we visited) had been prescribed a psychotropic medication. Mental health clinicians in most facilities (38 of 45), however, reported that they had some direct experience managing these medications.[39]

The mental health clinicians, medical coordinators, program directors, and ORR federal field specialists whom we interviewed described the following issues concerning facilities' use of psychotropic medication.

Access to psychotropic medications. Facilities reported relatively few challenges accessing and administering psychotropic medications. Although program directors and health staff mentioned that they sometimes found it difficult to schedule appointments with external specialists who could prescribe and modify medications, children were able to receive needed medications. Some program directors noted that using telemedicine to access psychiatrists remotely helped bridge gaps in access.

Lack of clarity about authorization and consent for psychotropic medications to children. A few program directors, medical staff, and an ORR federal field specialist described uncertainty about the process for obtaining authorization to treat children using psychotropic medications. ORR policy requires that an ORR staff member authorize children's use of prescription drugs to treat mental health conditions. However, facility staff reported that they were not always sure who within ORR needed to approve psychotropic medications; specifically, whether they needed to seek approval from their ORR federal field specialist or another ORR representative and whether parents' consent was required.

Confusion about authorization and consent may have been attributable, at least in part, to rulings by the *Flores* court regarding informed consent and varying State laws.[40] As of May 2019, ORR reported that it is working through the Department of Justice to try to negotiate a national framework for treatment authorization and consent for psychotropic medications with class counsel in *Flores*. ORR told us that if a facility notifies it that State law requires informed consent from parents before children use psychotropic medications, then ORR directs the facility to seek such consent, recognizing that this may not be possible or timely due to their inability to locate or establish communications with parents. If it is not possible to obtain parental consent in a timely way, then ORR may, depending on State law, direct the facility to seek a court order authorizing the use of psychotropic medications.

Medication refusal. A more common issue reported by facilities was children's reluctance to take psychotropic medications. Medical and mental health staff noted that stigma and medication side effects led some children to refuse psychotropic medications that were recommended as a part of their mental health treatment. According to staff accounts, children and their families did not always support treatment involving psychotropic medications. In some cases, they expressed a cultural stigma against psychotropic medications and mental health treatment, more generally. Medical and mental health staff also reported that some children experienced side effects, such as weight gain, drowsiness, and disrupted sleep, which led them to discontinue medications or request treatment changes. Facilities reported working with external prescribing physicians to adjust dosages to help manage side effects, and counseling children about the medications' expected benefits and potential side effects.

Concerns about treatment involving psychotropic medications. Although not widespread, we heard concerns about the use of psychotropic medications in facilities. Facility staff and ORR federal field specialists reported concerns that the particular medications or dosages prescribed by external specialists may not have been right for the children. In one instance, a lead mental health clinician in a secure facility questioned why a child was receiving anti-psychotic medication for help sleeping before other treatment methods were tried. In other cases, program directors, mental health clinicians, and medical coordinators questioned the number or dosage levels of psychotropic medications

that had been prescribed to children who transferred from other facilities in ORR's network. Conversely, a lead mental health clinician at a facility expressed the concern that a nurse practitioner would not prescribe psychotropic medications in cases when he and a psychiatrist recommended them. Our oversight of the program is continuing, and this area may warrant further review.

List of common psychotropic medications used and corresponding diagnoses

We collected a list of psychotropic medications used between May 1, 2018, and July 31, 2018, by children in the facilities that we visited. Below are the 10 psychotropic medications that the facilities most commonly reported. Facilities also reported the diagnoses or symptoms of the children taking these medications. Because some children, however, had more than one diagnosis or symptom, those listed below do not always reflect the primary treatment focus of the medication.

Prescribed Psychotropic Medication	Mental Health Diagnoses or Symptoms of Children in ORR Care Provider Facilities Taking the Medication.*	
Fluoxetine Brand name: Prozac	• Acute stress, anxiety & impulsivity • Adjustment disorder • Borderline personality traits • Disorganized thinking • Major depressive disorder	• Mood disorder • Sleep disruption • Schizophrenia • Self-injurious behavior • Post-traumatic stress disorder (PTSD)
Hydroxyzine Brand name: Vistaril	• Adjustment disorder • Attention-deficit/hyperactivity disorder (ADHD) • Generalized anxiety disorder • Impulsive aggression	• Major depressive disorder • Insomnia • Oppositional defiant disorder • PTSD
Risperidone Brand name: Risperdal	• Adjustment disorder • Bipolar disorder • Chronic irritability • Disruptive mood dysregulation disorder	• Major depressive disorder • Schizophrenia • Sudden mood changes • Self-injurious behavior • Oppositional defiant disorder
Sertraline Brand name: Zoloft	• Generalized anxiety disorder • Major depressive disorder • Mood disorder • Panic disorder	• Self-mutilating behaviors • Substance abuse • Suicidal ideation

(Continued on next page)

Medication	Mental Health Diagnoses or Symptoms of Children in ORR Care	
Trazodone Brand name: Desryl	• Adjustment disorder • ADHD • Disruptive, impulse-control, and conduct disorders • Generalized anxiety disorder	• Major depressive disorder • Mood disorder • Panic attacks • Schizophrenia spectrum • Psychotic disorder
Escitalopram Brand name: Lexapro	• Anxiety disorder • Bipolar disorder • Major depressive disorder • Impulse-control disorder • Insomnia	• Mood disorder • Oppositional defiant disorder • Substance abuse • Suicidal ideation • PTSD
Prazosin Brand name: Minipress	• Adjustment disorder • Disorganized thinking • Flashbacks of abuse • Insomnia	• Major depressive disorder • Night terrors and nightmares • Panic attacks • PTSD
Mirtazapine Brand name: Remeron	• Adjustment disorder • Disruptive impulse-control and conduct disorder • Disruptive mood dysregulation disorder	• Generalized anxiety disorder • Insomnia • Major depressive disorder • PTSD • Substance abuse
Guanafacine Brand name: Intuniv	• Adjustment disorder • ADHD • Impulse control disorder • Insomnia • Intermittent explosive disorder	• Major depressive disorder • Mood disorder • Oppositional defiant disorder • Psychotic disorder • PTSD
Quetiapine Brand name: Seroquel	• Adjustment disorder • Bipolar disorder • Conduct disorder • Insomnia	• Major depressive disorder • Mood affective disorder • Oppositional defiant disorder • Panic disorder

* These diagnoses and symptoms do not always reflect the primary treatment focus of the medication.

Source: OIG analysis of facility data, 2019.

APPENDIX E: Agency Comments

ADMINISTRATION FOR CHILDREN & FAMILIES

Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

August 7, 2019

Joanne M. Chiedi
Acting Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Chiedi:

The Administration for Children and Families (ACF) appreciates the opportunity to respond to the Office of Inspector General (OIG) report entitled, *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody* (OEI-09-18-00431). ACF is committed to meeting the mental health needs of the unaccompanied alien children (UAC) in the care of the Office of Refugee Resettlement (ORR), and welcomes OIG's report as we work to continually improve ORR's delivery of mental health care to UAC.

ACF is equally committed to providing the public with a fair accounting of ORR program operations. To that end, we agree with OIG that significant factors beyond ACF's control contributed to the issues identified in the report. Those factors included: the surge of UAC that occurred during the period covered by the report; the unique mental health needs of UAC who experienced severe trauma prior to entering ORR's care; and the shortage of qualified, bilingual mental health clinicians, particularly in the rural areas where many ORR facilities are located.[1] Such context is critical to fairly assessing the mental health care delivered to UAC.

OIG was also correct to underscore the nature and scope of its methodology for the public. OIG performed a qualitative analysis of interviews with program directors, mental health clinicians, and medical coordinators. OIG also reviewed three selected case files from each of the 45 facilities visited, which it discussed with the assigned mental health clinician. We agree that this qualitative analysis provides the public and the program with helpful insights. Indeed, it corroborates that UAC generally receive all legally-required mental health care. It is not, however, a quantitative or clinical review that assesses the reasonableness of the mental health care delivered to UAC

[1] *See* OEI-09-18-00431, at 11 ("The number of young children, age 12 and younger, in ORR's care increased sharply in May 2018 when DHS formally adopted the zero-tolerance policy of criminally prosecuting all adults for illegal entry into the U.S."); *id.* at 9 ("Facility managers and mental health clinicians reported that many children who entered facilities in 2018 had experienced intense trauma from a variety of events before and upon their arrival in the U.S."); *id.* at 14 ("Program directors reported difficulties in finding qualified candidates, especially those who were fluent in the languages spoken by children in their care. Program directors explained that these challenges were heightened for facilities in remote or rural areas, reflecting a shortage of mental health professionals in certain geographic regions.").

against standards of ordinary care or best clinical practices. This distinction is important given the complex mental health presentations of this young and vulnerable population.

As discussed more fully below, ACF has already taken steps to address many of the concerns identified in the report, such as the impact of length of stay in ORR facilities on child welfare. The average, system-wide length of stay reached a "high of 93 days for children who were released from ORR custody in November 2018"; in fact, "[b]y April 2019, the average length of stay had declined to 48 days," which is significantly shorter than the 70-day concerns identified in the report. *See* OEI-09-18-00431, at 13 ("For example, one mental health clinician explained that even children who were outgoing and personable started getting more frustrated and concerned about their cases around the 70th day in care."). Today, the discharge rate of children to sponsors are at some of their highest levels ever, which has a positive impact on length of stay.

In April 2019, a board-certified child, adolescent, and adult psychiatrist was hired by ORR to serve as the Mental Health Team Lead for ORR's Division of Health for Unaccompanied Children (DHUC). Since the hiring, the psychiatrist is working to improve ORR's mental health care system for UAC.

The following are ACF's specific responses to OIG's recommendations:

Recommendation 1: Identify and disseminate evidence-based approaches to addressing trauma in short-term therapy (p.18)

Response: ACF concurs with this recommendation.

In general, ORR's goal for UAC is stabilization and fostering a sense of security. All UAC undergo a brief screening for trauma and its impact during intake. If a UAC displays trauma related symptoms or other mental health issues at any point in their care, they are assessed for specific psychiatric disorders by the appropriate medical or psychological providers and treated accordingly. ORR provides supportive therapy to facilitate UAC acclimation because the patient's psychiatric baseline is needed to assess for specific psychiatric disorders, and is best observed once a patient is acclimated to his or her surroundings.[2]

ORR continues to work to improve upon this framework for delivering mental health care. Notably, ORR has collaborated with the National Center for Traumatic Stress Network (NCTSN) to develop a 4-part webinar series on trauma in unaccompanied alien children, including an overview of treating the effects of traumatic separation in young children. The webinars will cover: (1) Trauma 101, including assessment, cultural humility and competence when working with immigrant youth and families, and an overview of the migration journey and exposure to potentially traumatizing events; (2) a review of the research on trauma and psychoeducation specific to traumatic

[2] *See* Prins, A., Bovin, M.J., Kimerling, R., Kaloupek, D.G., Marx, B.P., Pless Kaiser, A., & Schnurr, P.P. (2015). Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). *See also* Rousseau, C., Pottie, K., Thombs, B., et al. Post traumatic stress disorder: Evidence review for newly arriving immigrants and refugees. Can. Med. Assoc. J. 2011; Appendix 11.

separations, including how to recognize the effects of trauma/traumatic separation in youths seven and above; (3) recognizing Secondary Traumatic Stress (STS) in care providers, including recommendations for preventing and reducing STS at work; and (4) recognizing the effects of trauma/traumatic separation in youths ages six and under, working with children ages six and under, and an overview of the principles of attachment.

ORR anticipates launching the webinars in mid-August 2019. All UAC care providers will be required to participate in order to strengthen their understanding of how to effectively recognize and respond to children exhibiting signs of trauma. The webinars will be available through the NCTSN Learning Center. Upon successful completion of the series, participants will receive a certificate for the competency folder of their personnel file.

In addition, NCTSN has received supplemental appropriations UAC mental health services. ORR is working with NCTSN to identify training resources on evidence-based, brief therapeutic interventions for children affected by trauma and separation. ORR has proposed that NCTSN use its supplemental funding to strengthen the mental health services available to UAC after they are discharged from ORR custody. ORR has provided NCTSN with the list of post-release services (PRS) providers so that children who need ongoing mental health services after discharge can continue to receive these services.

ORR's continuing efforts to provide for the mental health needs of UAC even after they leave ORR's care is illustrated by the below statistics for home studies (HS) and PRS. PRS allow for UAC to be released to a sponsor and have their social integration, medical, and mental health needs attended to while under the supervision of their sponsor. Additionally, PRS case workers are able to meet with sponsors and released children on an ongoing basis to ensure the child's basic needs are met. If there are safety concerns the PRS case worker may notify ORR or local child protective services and law enforcement, as appropriate.

YEAR	HOME STUDIES	UAC SERVED BY PRS	NUMBER OF UAC RELEASED	RELEASE UAC WITH PRS
FY2018	3,641	14,088	35,249	40%
FY2017	3,173	13,381	42,729	31%
FY2016	3,540	10,546	52,661	20%
FY2015	1,895	8,618	28,289	22%

Post-release care helps address the inherent tension between ORR's goals of keeping children in ORR custody for the shortest period of time possible, and providing mental health treatment for

severe trauma, which can require more time than children will be in ORR care.[3] There are simply fewer therapeutic interventions available to use with children who are in care for a relatively short period of time. *Mental health experts have noted that, in certain circumstances, there may be no suitable evidence-based approaches to addressing trauma in short-term therapy.* ACF urges OIG and the public to consider this important clinical limitation—and the critical role played by post-release care—when evaluating ORR's delivery of mental health care to UAC.

Recommendation 2: Develop and implement strategies to assist care provider facilities in overcoming obstacles to hiring and retaining qualified mental health clinicians (p.19)

Response: ACF concurs with this recommendation.

As the report recognizes, there are significant external challenges to hiring and retaining qualified mental health clinicians. In addition to "demanding work schedules[] and competing job opportunities," "[p]rogram directors reported difficulties in finding qualified candidates, especially those who were fluent in the languages spoken by children in their care. Program directors explained that these challenges were heightened for facilities in remote or rural areas, reflecting a shortage of mental health professionals in certain geographic regions." OEI-09-18-00431, at 14. Public misinformation about ORR's UAC program has exacerbated the challenges to recruitment. Faced with these challenges, ORR is currently working on several strategies to improve the hiring and retention of qualified mental health clinicians.

First, ORR is working to develop an internship program that partners with colleges and universities in order to place interested students in ORR programs. ORR's goal is to create a standardized process with clearly defined requirements through which interested students can obtain a one-year internship at any ORR facility. Although some ORR grantees already have partnered with colleges and universities to provide internship opportunities, expanding and standardizing the internship program across the ORR network would create a direct pipeline between new professionals in the field and ORR.

Second, ORR has made additional funding for continuing education available to licensed clinicians as a retention strategy.

Third, ORR is working to expand its presence at job fairs in geographic regions where there is particular need to hire additional mental health clinicians.

Recommendation 3: Assess whether to establish maximum caseloads for individual mental health clinicians (p.19)

Response: ACF concurs with this recommendation.

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[3] As the report recognizes, "mental health clinicians did not know how long a child would be in their facility" and were "wary of having children revisit traumatic incidents that they might not be able to address adequately through continued therapy." OEI-09-18-00431, at 9–10.

ORR plans to evaluate the one to twelve ratio of mental health clinicians to children in consultation with internal HHS and external subject matter experts. ORR will review subject matter recommendations in concert with an evaluation of barriers to hiring and retaining staff identified in the response to recommendation 2. Additionally, ORR will consider varying clinical ratios dependent on facility type and whether a care provider serves a special population that may be in need of smaller clinical ratios. ORR's goal is to ensure children are provided quality mental health counseling and that care providers are given sufficient support to serve children in ORR care and custody.

Recommendation 4: Help care provider facilities improve their access to mental health specialists (p.20)

Response: ACF concurs with this recommendation.

Unfortunately, there is a national shortage of qualified mental health professionals—especially where the additional language requirement is concerned.[4] The effects of this national shortage are particularly acute for those "facilities . . . in underserved areas with relatively few practicing specialists." OEI-09-18-00431, at 14. Despite these challenges, ORR and its care provider facilities have achieved success relative to the national trend, in that the children in ORR custody have significantly greater access to mental health professionals than those in the United States but who are not in ORR custody, particularly in the states where the 45 grantee facilities are located.[5]

Since 2004, it has been standard practice for ORR to allow care providers to seek services from out-of-network providers in their community, if no ORR facility meets the needs of a child in ORR care. Both the previous agency that provided underwriting services to ORR (the Department of Veterans Affairs), and the current underwriter, Point Comfort Underwriters (PCU), have been very open to helping ORR meet any unmet mental health needs of UACs through out-of-network providers.

DHUC works with PCU to identify mental health providers in geographic locations with few resources, including hospitals, non-profit mental health clinics, and individual providers. DHUC also seeks behavioral telehealth providers, whose practices have a farther reach than traditional in-person treatment providers.

In addition to routine psychiatric and psychological evaluation and follow-ups, services include specialized treatment, such as trauma-focused cognitive behavioral therapy and dialectical behavior therapy. Specialized care is also being sought out for the ORR network, such as intensive outpatient programs (IOP) and partial hospitalization programs (PHP), both of which are intended to be utilized when routine outpatient services have been insufficient to meet the needs of UAC in ORR care. ORR hopes that greater access to specialized care will obviate the need for longer-term and more restrictive settings, such as residential treatment centers (RTC).

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[4] *See* https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[5] *Id.*

Recommendation 5: Increase therapeutic placement options for children who require more intensive mental health treatment (p.20)

Response: ACF concurs with this recommendation.

Prior to placing a child in a higher level of care, ORR recommends there be a discussion using the case consultation program in order to mitigate the use of intensive mental health treatment. ORR's case consultation program involves a multi-disciplinary team comprised of staff of varying expertise and programmatic experience who help analyze complex cases and make recommendations regarding care. The team includes senior ORR personnel, ORR medical professionals, senior Federal Field Specialists (FFS), and other subject matter experts.

In addition, ORR has hired a Field Supervisor for Special Populations to oversee care and treatment services for UAC in secure, staff secure, and RTC placements. This position's responsibilities have expanded to include seeking and coordinating increased mental health and treatment services for shelter cases needing specialized placement.

Due to the limited number of beds for children with greater mental health needs in the ORR network, coupled with the surge of UAC, ORR has experienced an increased need for additional therapeutic programs for the UAC population. ORR has engaged several out-of-network therapeutic facilities to aid in providing treatment for UAC, such as Acadia, Devereux, The Farm Trillium, Laurel Ridge, Indian Oaks, and NY Children's Hospital, as well as existing ORR grantees, KidsPeace and Youth for Tomorrow. Acadia has several RTC and sub-acute hospitals within the United States that have been utilized to help with ORR's population requiring unique care. Additionally, efforts have been made to engage new partners to further support this special population.

Unfortunately, adverse media coverage and negative public perception of the UAC program have hampered efforts to expand ORR's network of treatment providers. For instance, one of Acadia's programs, Detroit Behavioral Institute, opted out of becoming an in-network facility after beginning the process of joining the ORR care network due to concerns over negative media coverage and possible legal liability. Out-of-network providers also have cited language barriers and the requirements of *Flores* and the Trafficking Victims Protection Reauthorization Act as additional challenges they are not equipped to handle.

As discussed above, DHUC is working to expand access to higher levels of mental health care, such as IOP and PHP.

Lastly, DHUC has developed and delivered trainings for FFS on the appropriate use of RTC. It is emphasized that UAC should first be referred to appropriate outpatient services, and only when these services are exhausted or unavailable should referral to an RTC be considered, provided the referral criteria set forth in ORR Guide § 1.4.6 are met. DHUC also consults with shelter, staff secure, and secure facilities on these issues.

Recommendation 6: Take all reasonable steps to minimize the time that children remain in ORR custody (p.20)

Response: ACF concurs with this recommendation.

ACF has already taken reasonable steps to accelerate discharges to safe, suitable sponsors, which has helped to greatly reduce the average time that UAC stay in ORR's care and custody. The report recognizes that those efforts resulted in system-wide average lengths of stay in April 2019 that were more than 48 percent below the "high of 93 days for children who were released from ORR custody in November 2018." OEI-09-18-00431, at 13. The average time UAC now spend in ORR care has decreased from more than 93 days in November 2018, to 45 days in July 2019.

ORR continuously evaluates its policies, procedures, and operations to align with best practices in child welfare, and to achieve an optimal balance between safe and timely discharge of UAC to sponsors. In late 2018, ORR reviewed the effects of expanded biometric background checks, per the ORR-ICE-CBP Information Sharing Memorandum of Agreement (MOA) of April 2018. The purpose of this review was to assess whether or not the new biometric background check procedures under the MOA yielded new information that enabled ORR to identify child welfare risks that it would not have found under prior policy. ORR also examined whether a correlation existed between the expanded biometric background checks and UAC length of stay.

Following that assessment, between December 2018 and June 2019, ORR issued four operational directives that modified its sponsor suitability assessment process to optimize the balance between child safety and timely discharge to sponsors. Under the operational directives, ORR now completes individualized suitability assessments of sponsors without obtaining fingerprints from all household members, or all parents or legal guardians or certain close relatives in appropriate cases. ORR also permits, under certain circumstances, the release of children to other relatives who were their primary caregivers prior to receiving the results of a fingerprinting background check. Within 180 days of issuing the fourth operational directive, ORR will complete a full evaluation of its implementation, including any correlation with reduced length of stay.

Congress has prohibited HHS from using funds provided in the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019 (Pub. L. 116-26) or previously appropriated funding to reverse the procedures of the first three operational directives, unless the Secretary of Health and Human Services determines that a change is necessary to protect a child from being placed in danger. The HHS Secretary is required to submit the justification for the change in writing to the Office of Inspector General and to Congress prior to implementation of a proposed change.

The Act also requires HHS to submit a discharge rate improvement plan to Congress. That plan will set forth our future strategies for optimizing our discharge rate.

Again, thank you for the opportunity to review this report. As detailed above, ACF is already implementing many of the report's recommendations. ACF takes its responsibility to care for UAC very seriously, and looks forward to continuing to work to improve the mental health services

it provides. Please direct any follow-up inquiries on this response to Scott Logan, Office of Legislative Affairs and Budget, at (202) 401-4529.

Sincerely,

Lynn A. Johnson

Lynn A. Johnson,
Assistant Secretary
for Children and Families

ACKNOWLEDGMENTS

Camille Harper served as team leader for this study. Other Office of Inspector General staff who conducted the study and were primary contributors include Chelsea Samuel and Diana Merelman. Key advisors included Laura Canfield, Abigail Cummings, and Carla Lewis, with support from Lyndsay Patty and Seta Hovagimian.

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This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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ENDNOTES

[1] Charles D. R. Baily, et al. "The Psychosocial Context and Mental Health Needs of Unaccompanied Children in United States Immigration Proceedings," *Graduate Student Journal of Psychology*, Vol. 13, 2011, p. 4. Accessed at https://www.tc.columbia.edu/publications/gsjp/gsjp-volumes-archive/gsjp-volume-13-2011/19225_V13_1_Baily.pdf on July 17, 2019.
[2] 6 U.S.C. § 279(g)(2).
[3] *Flores v. Reno*, No. 85-4544 (C.D. Cal. Jan. 17, 1997). This Stipulated Settlement Agreement sets out an order of priority for sponsors with whom children should be placed. The first preference is for placement with a parent, followed by a child's legal guardian, then other adult relatives. In fiscal year 2018, 42 percent of children released to sponsors were released to a parent. *Ms. L v. ICE*, No. 18-0428. (S.D. Cal. Feb. 1, 2019) (Declaration of Jonathan White).
[4] 6 U.S.C. § 279(g)(2), in part, defines UAC as a child who "has not attained 18 years of age." *Also see*, Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied* (ORR Guide), Introduction. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-0 on July 17, 2019.
[5] HHS, ACF, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, pp. 6, 38. Accessed at https://www.acf.hhs.gov/sites/default/files/olab/acf_congressional_budget_justification_2020.pdf on July 17, 2019. DHS referred 49,100 children to ORR in 2018.
[6] Based on OIG analysis of ORR data, as of August 13, 2018.
[7] 8 U.S.C. § 1232(c)(2)(A).
[8] ORR Guide), § 1.4.6, Residential Treatment Center Placements. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1 on July 17, 2019.
[9] *Flores v. Reno*, No. 85-4544 (C.D. Cal. Jan. 17, 1997) (Stipulated Settlement Agreement).
[10] ORR Guide, § 3.2.1, Admissions for Unaccompanied Alien Children. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.2.1 on July 17, 2019.
[11] ORR Guide, § 3.3.1, UAC Assessment and Case Review. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.3.1 on July 17, 2019.
[12] ORR Guide, § 3.3: Care Provider Required Services. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.1 on July 17, 2019.
[13] ORR Guide, § 1.7.5, Medical Services. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1 on April 19, 2019. Also see, *The Tornillo Influx Care Facility: Concerns About Staff Background Checks and Number of Clinicians on Staff*, A-12-19-20000, Nov. 27, 2018, available at https://oig.hhs.gov/oas/reports/region12/121920000.pdf, which discusses the mental health staffing at Tornillo and Homestead, the two influx facilities in operation during the period of OIG's review.
[14] Cooperative Agreement Between HHS and [Grantee Facility] § IV.C.1. ORR may grant waivers to the 1:12 ratio.
[15] Cooperative Agreement Between HHS and [Grantee Facility] § IV.C.7.
[16] Cooperative Agreement Between HHS and [Grantee Facility] § IV.C.7. Lead Clinicians with a bachelor's degree (but not a master's degree) must have at least 5 years of clinical employment experience in the behavioral sciences.

[17] Ibid. If the size of the facility does not justify a full-time medical coordinator, those duties may be combined with another position.

[18] The zero-tolerance policy, signed by the Attorney General on April 6, 2018, directed prosecutors "in consultation with DHS—to adopt immediately a zero-tolerance policy" for all illegal entry. *Memorandum for Federal Prosecutors Along the Southwest Border: Zero-Tolerance for Offenses Under 8 U.S.C. § 1325(a).* Office of the Attorney General, April 6, 2018. Accessed at https://www.justice.gov/opa/press-release/file/1049751/download on July 17, 2019. DHS began implementing this policy with respect to family units in early May 2018.

[19] Exec. Order 13841, 83 Fed. Reg. 29435, dated June 20, 2018, and published on June 25, 2018; *Ms. L v. ICE*, No. 18-0428 (S.D. Cal. June 26, 2018) (Order Granting Plaintiffs' Motion for Classwide Preliminary Injunction).

[20] In January 2019, OIG found that the number of separated children placed in ORR care as a result of increased immigration enforcement by DHS was unknown. In addition to 2,737 separated children of *Ms. L v. ICE* class members who were in ORR care as of June 26, 2018, HHS officials estimated that thousands of additional children may have been separated by DHS, transferred to ORR care, and released through normal procedures during an increase in separations that began in 2017, before the accounting required by the Court and nearly a year before the zero-tolerance policy was announced. Additionally, some separations continued after the court order. HHS OIG Issue Brief, *Separated Children Placed in Office of Refugee Resettlement Care*, OEI-BL-18-00511, January 2019, available at https://oig.hhs.gov/oei/reports/oei-BL-18-00511.pdf.

[21] As of December 2018, ORR discontinued the requirement that non-sponsor adult household members undergo fingerprint background checks in every circumstance. In March 2019, ORR discontinued the FBI fingerprint requirement for parents and legal guardians in every circumstance.

[22] Memorandum of Agreement Among the Office of Refugee Resettlement of the U.S. Department of Health and Human Services and U.S. Immigration and Customs Enforcement and U.S. Customs and Border Protection of the U.S. Department of Homeland Security Regarding Consultation and Information Sharing in Unaccompanied Alien Children Matters, April 13, 2018.

[23] Section 224 of the Consolidated Appropriations Act, 2019 (P.L. 116-6), which was enacted into law on February 15, 2019, prohibits DHS from bringing enforcement actions against a sponsor, a potential sponsor or members of a household of a sponsor or potential sponsor based on data provided by HHS unless the background check reveals a felony conviction or pending felony charge, among other exceptions. Unless extended, this prohibition may expire on September 30, 2019. (See, e.g., *Williams v. United States*, 240 F.3d 1019,1063 (Fed. Cir. 2001); 65 Comp. Gen. 588; B-230110, Apr. 11, 1988; B-228838, Sept. 16, 1987; B-145492, Sept. 21, 1976.)

[24] *Unaccompanied Alien Children Care Provider Facilities Generally Conducted Background Checks but Faced Challenges in Hiring, Screening, and Retaining Employees*, A-12-19-20001.

[25] In addition to interviews with lead clinicians at each of the 45 facilities, we conducted 123 case study reviews with 96 clinicians (some of whom may have been lead clinicians).

[26] If the individual who held the position was not available, we interviewed the staff member acting in that capacity at the facility.

[27] Each ORR federal field specialist may oversee multiple facilities. As such, a federal field specialist may have been interviewed multiple times regarding different facilities.

[28] As detailed in *Unaccompanied Alien Children Care Provider Facilities Generally Conducted Background Checks but Faced Challenges in Hiring, Screening, and Retaining Employees*, A-12-19-20001, OIG reviewed 1,050 employee files from the 45 facilities we visited during August and September 2018. Only 5 of the 173 clinicians included in our review did not meet minimum educational requirements. Of these, three mental health clinicians had a bachelor's degree, but their employee file did not support the required 5 years of clinical experience. OIG found only one clinician with no relevant degree or experience and one

clinician whose employee file did not contain educational records or a diploma documenting a degree.

[29] *Duchitanga v. Hayes*, No. 1:18-cv-10332-PAC (S.D.N.Y. May 15, 2019) (Declaration of Jalynn Sualog).

[30] See Endnotes 22 and 23. Also see, 83 Fed. Reg. 20844 (May 8, 2018) (DHS' system of records notice for the collection and maintenance of records for background checks to inform an HHS determination regarding sponsorship of a UAC and to use this information for other purposes consistent with its statutory authorities).

[31] More than half of facilities (26 of 45) reported that their clinician positions were the most difficult positions to fill.

[32] H. Andrilla, MS et al., "Geographic Variation in the Supply of Selected Behavioral Health Providers," *American Journal of Preventive Medicine*, Vol 54(6), Pg. S199-S207.

[33] Four facilities reported in-house mental health specialists, including a psychologist (shelter), psychiatrist (RTC and secure facility), and psychiatric nurse practitioner (transitional foster care facility). Three additional facilities reported employing other medical practitioners.

[34] As noted earlier, ORR is legally required to house children in the least restrictive setting that is appropriate for the child among its continuum of care provider facility types. That determination may change over time, necessitating transfer of a child to a more or less restrictive setting. See ORR Guide, § 1.4, Transfers Within the ORR Care Provider Network. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.4.6 on July 17, 2019.

[35] On March 1, 2019, 15 children in ORR custody were in non-ORR placements.

[36] ORR Guide, § 1.4.6: Residential Treatment Center Placements. Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.4.6 on July 17, 2019.

[37] Position descriptions are summarized from the ORR Guide: Guide to Terms, Accessed at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms, on July 17, 2019; and the Cooperative Agreement between HHS and [Grantee Facility] § IV. C.7.

[38] *Jenny L. Flores, et al. v. Jefferson B. Sessions, III, et al.*, CV-85-4544 DMG (AGRx) (C.D. Cal. July 30,, 2018) (Order Re Plaintiffs' Motion to Enforce Class Action Settlement); *Lucas R., et al. v. Alex Azar and E. Scott Lloyd* (C.D. Cal. June 29, 2018) (Complaint for Injunctive Relief); "Forced Drugging: Migrant Children's Accounts" *Reveal*, June 22, 2018 accessed at https://www.revealnews.org/blog/forced-drugging-migrant-childrens-accounts/ on July 17, 2019; "Immigrant Shelters Drug Traumatized Teenagers Without Consent," *ProPublica*, July 20, 2018; accessed at https://www.propublica.org/article/immigrant-shelters-drug-traumatized-teenagers-without-consent on July 17, 2019.

[39] Of the 45 facilities we visited, 38 either reported during interviews that they cared for a child who was prescribed psychotropic medications or separately shared information about psychotropic medications that had been prescribed to children in their facilities between May 1, 2018, and July 31, 2018.

[40] A July 30, 2018 order from the *Flores* court addressed the consent requirements that Texas-based care provider facilities must follow when dispensing psychotropic medications to UAC. According to ORR, before the implementation of the July 30, 2018, order, ORR Federal staff provided informed consent as the Federal custodian of children in Texas facilities. After the order, ORR informed facilities in Texas that they must instead obtain consent from a parent, close relative, or other person authorized by court order to give consent. However, Texas licensing authorities have since indicated that ORR, as the Federal custodian, should continue to give informed consent. Other States vary in how they apply their licensing laws and regulations to the ORR grantees that provide care to children. For example, in Arizona, the medical authorization of the ORR Director, as well as the clinical judgment of treating clinicians, is considered sufficient documentation and protocol for prescribing medications.

Ms. SHALALA. What the report outlined was how this administration's child separation policy makes worse the trauma that immigrant children have already experienced on their journey to this country. The investigators found that separated children exhibited more heightened symptoms of anxiety, fear of abandonment, and post-traumatic stress disorder than children who had not been separated from their parents.

The report goes so far as to say, and I quote, "some separated children expressed acute grief that caused them to cry inconsolably." Many of these children will eventually attend our schools once released from custody. Some of them will stay in detention centers in which—for example, in the Homestead facility, which

had over a thousand children, the teachers had no training in trauma.

Could you tell us what the science says about the effects of separating young children from their parents and placing them in inadequate conditions.

Dr. BURKE HARRIS. The science on that is unequivocal, that this is a harmful practice and that it increases children's both physical health risks as well as their mental, psychological, and developmental risks.

Ms. SHALALA. Thank you.

Perhaps the executive director from Chicago could comment, because you have had a lot of immigrant children that have come through and who are in your school system on your own experience with these children that have been separated from their families for some period of time.

Ms. JACKSON. Yes. I would just extend some of the comments that Dr. Burke Harris made. In particular at the school system, CPS,—Chicago is a welcoming city, a sanctuary city, so we have a lot of students who emigrate to the United States and end up setting up a home in Chicago.

We do our best to support those students when they disclose their status. And with that comes additional resources and support, in particular around navigating the school process, making sure that they don't have any barriers to enrollment, but also working with our students to make sure that there is the stability in their home life and that they have access to resources or know how to access those resources should they need them.

I would count this as an area where we could definitely be doing more. Earlier there was a comment made just about our students and their families and how they feel or trust the school system or any type of government agency. I think the more we show an awareness around the need to support our students and families, they will disclose to us their status and ask for that support and thereby making it easier for us to identify students who may have experienced trauma. You know, they would disclose that so that we can support them.

But I do still see a huge disconnect, if you will, because many of our families, in particular our immigrant families or undocumented families, do not trust the government agencies enough to disclose their status.

Ms. SHALALA. Ms. Hofmeister, what advice—particularly in the large facilities that we now have that are holding children that have been separated from their parents, we have not thought about or at least invested in training the teachers that are working with those children. What advice would you give to us on insisting that if we are going to hold unaccompanied children that we ought to be training the teachers?

Ms. HOFMEISTER. Well, we definitely agree that our teachers need and actually want professional development support. Students of all kinds of trauma are arriving at our school doors and coming from the school bus. Teachers, though, are telling us that they want more specifics, more clinical and practical advice as well.

But it is something that we are addressing again with a State-level trauma summit that is coming up, because the demand has

been so great called Bridges to Hope, Teaching in the Shadow of Trauma.

You know, trauma is trauma. We open our arms wide in public school for any child who comes through that door. And our teachers deserve to have the training needed. And we are using our Title 2 dollars, our Title 4 dollars as well that are afforded to us under the flexibility of ESSA, and we are grateful for that.

Ms. SHALALA. Thank you.

I yield back.

Mr. SABLAN. Thank you very much, Dr. Shalala.

At this time, I am going to recognize Mr. Grothman for five minutes, please.

Mr. GROTHMAN. Thank you.

First of all, I want to respond a little bit to Congresswoman Shalala's comments. I have been down on the border three times. And I know in—or at least we were told, in May alone, 15,000 children came into this country unaccompanied by their parents. I think—we should all agree that it is better for children to be with their parents. And right now, apparently under American law, we have to accept most of these children, or do try to accept them or find foster care. I would be happy to work with her and, A, make sure that these children are not allowed in this country but sent back to their countries of origin where they can be reunited with their parents.

And, secondly, I know one the things that bothers the border guards is even when children come with a parent, frequently it is only one parent, and the other parent is back in Central America or, whatever. And I know this bothers some of the courts in Central America. I know in our courts, even if, you know, parents are separated, we try to keep them in the same area as the children. So I would be happy to also work with you. And if a parent shows up with children in this country but the other parent remains in another country to again send those people immediately back to their country of origin where the children could be with both parents.

Ms. SHALALA. Mr. Chairman, if I might respond. The point is, if they are here, if they are being incarcerated by us in a facility and we are offering educational services, whatever services we are offering—

Mr. GROTHMAN. Yeah. I think—right. Well, that is the problem. We have too many people around here who don't want to address the problem.

Mr. SABLAN. Do you yield?

Mr. GROTHMAN. Okay. Now, Ms. Hofmeister, just because some of these statistics they throw out, I almost question. You are telling us that 75 percent of the children in Oklahoma suffer moderate or serious depression? I mean, if I look out at a class of 28 kids, 21 are suffering from depression. Are you sure that is right or somebody isn't kind of exaggerating? 21 out of 28, if I look in a class in Oklahoma.

Ms. HOFMEISTER. That is what the data tells us. And that is based on the students' voice.

Again, we have surveyed 47,900—

Mr. GROTHMAN. That is okay. I just encourage you, because I just find that hard to believe.

I will ask Ms. Jackson. I wasn't aware you had so many immigrants in the Chicago schools. Of the immigrants that you invite into your sanctuary city, how many come with immigrant children? How many come with both parents? How many one parent and how many no parent?

Ms. JACKSON. I don't have that information. I don't want to make up any numbers.

Mr. GROTHMAN. Why don't you—that is very relevant. Why don't you—because you collect all sorts of other data. Why don't you—can you get that information for us? Because I kind of would like to know what we are getting here.

Ms. JACKSON. Just for the record, we do not collect that information as a school district. We have removed every barrier for students to enroll, so that is not information that we even collect.

Mr. GROTHMAN. You mean you don't know if, say, Johnny breaks his arm or something. You don't know whether no parents are at home, one parent is at home, or two parents at home? You don't even keep track?

Ms. JACKSON. Yes. We know, for every student, who is the parent or guardian of record. What I am saying is we don't know initially a student status, whether they—we don't ask them that information when they enroll in school in Chicago. It doesn't matter. Our door is open to all students.

Mr. GROTHMAN. That is not the point. I am just kind of stunned. That is not the purpose of this hearing, but it seems to me, if something horrible happens, say a health crisis, whatever crisis, I think the parent should know. You know, if both—if their mom and dad—both mom and dad should know. If just one parent is there, they should know. If there are no parents and we just deal with a guardian or a foster parent, we should know.

Ms. JACKSON. We do. We do have the information for the guardians and the parents of record.

Mr. GROTHMAN. Okay. So you cannot tell us the percentage of immigrants in Chicago who have a guardian and not a parent of the people who came here who are of a different citizenship?

Ms. JACKSON. No, sir. As I stated earlier, that is not information that we collect.

Mr. GROTHMAN. Okay.

Well, next question. And I am going to kind of follow up on Congresswoman Foxx's comments. You have all sorts of statistics that you break down by race as far as people getting in trouble at school or being removed.

Do you adjust that for, again, parents at home? I mean, we have had a dramatic change in the last 50 years in this country. Many, many less children raised with both parents at home, and I think that is a—some absolutely wonderful parents. Wonderful parents I know in that situation doing a great job. But I think overall it might be better sometimes both parents there.

Do you have on how well your children are doing? Could you adjust it for parental situation at home?

Ms. JACKSON. No. Typically when we disaggregate the data, we look at race, socioeconomic class, gender. I think those are the—

and then ability, whether or not the student is a special needs student or not. We do not disaggregate the data based on their family status.

Mr. GROTHMAN. That stuns me. I mean, if we are going to—I mean, that is something we can change people's behavior on, right, in the future? You are not going to change your race. You are not going to change any of these other things.

Mr. SABLAN. I hate to interrupt, but I said I was going to be stricter on time.

Mr. GROTHMAN. You have been very patient.

Thank you very much.

Mr. SABLAN. Thank you, Mr. Grothman.

And now Mr. Morelle, please, your five minutes.

Mr. MORELLE. Good morning. Thank you, Mr. Chairman. This is truly an important topic, and I appreciate each of the witnesses and their testimony. I think this is a really, really important topic. And I had some prepared remarks, which I am going to largely dispense with and just talk about my district for a moment, which is in Upstate New York, Rochester, New York.

Rochester has, over the last several years, been identified as either number two or three in terms of childhood poverty in the United States among cities. So it is something that is distressing, the impacts of poverty.

And I have been working on a number of initiatives that I am going to touch on briefly. But in the context of some of the work that I have been doing around poverty, several years ago I would admit to the fact that I thought, when people would talk about trauma, that it was generally regarded as physical kinds of trauma, domestic violence, gang-related violence, neighborhood violence. And it has really become clear to me over the years, I have become sensitized to the fact that it is housing and food insecurities and things that you don't necessarily see easily.

And so that has led me to lead an effort in Rochester over the last several years, with significant State and philanthropic support, to not only have trauma-informed care in our community but to do it in an interdisciplinary way. I think Dr. Schrier talked about how, in the medical community, pediatricians and nurse practitioners see trauma. Classroom teachers and educators see trauma.

In Rochester, we are trying to break down the silos between education, health, and human services so that those professionals can all speak to one another, identify trauma. So something I am very engaged in, very optimistic about.

But I wanted to just ask a couple questions. I think you have all done a great job of just sort of identifying the impacts of trauma on development and on future success in life for children. And I think you have talked a great deal about the types of things you are doing.

One of the things that I would like to ask you to talk a little more detail about, and perhaps let's start with Dr. Burke Harris, but any panelist who wants to comment, is—you talk about screening. I am just curious what the research tells you about how to identify trauma in children. I am sure there is screening questions you could ask. There is probably some obvious things about children who are withdrawn.

But I suspect that some children carry the impacts of trauma that are harder to see. And I am just curious as what research tells you and what you are doing to try to become more sensitive to or more aware of traumas that don't have sort of an easily outward identifiable manifestation, if that is a fair question. I would just be curious what the research tells you and what you are doing in sort innovation around that.

Dr. BURKE HARRIS. Absolutely. You are right that some children will demonstrate behavioral or learning difficulties, but many children will not. For many children, there are no outward signs. And that is why, number one, screening is so important, and that is why California has moved toward universal screening for adverse childhood experiences for children and adults.

Mr. MORELLE. May I ask you? Could you just; talk a little about what that screening consists of? I hated to be really granular, but just sort of trying to get at that.

Dr. BURKE HARRIS. Sure.

The screening actually consists of the ten criteria that were in the adverse childhood experiences questionnaire, which, for example, don't include poverty or community violence. Although the screening that we are using in California, the pediatric adverse and related life events screening the PERIL's tool does include other social determinants of health like food insecurity, housing insecurity, community violence, et cetera.

So that is what is being used for kids. And then the traditional adverse childhood experiences for adults.

Mr. MORELLE. Sure. And may I ask you—and I am sorry. These five minutes go by so quickly. So when you are looking at food insecurities, is it done through an interview with the child, or do you get data from other sources that you somehow integrate? How is that—how do you get to that?

Dr. BURKE HARRIS. The screening is done in the primary care home. It is a questionnaire that families fill out. And, actually, the way that we do it in California is we use a de-identified screen. So we actually say don't necessarily tell us which ones of these your child has experienced, only how many. So that allows the primary care clinician to rapidly, in that very short 15-minute pediatric visit, identify who needs additional services. And then they can receive those services from a social worker.

Mr. MORELLE. And do you find that there is—that people—the respondents still feel stigmatized in some way about being truthful about what the environment is that their child is living in? Is there sort of an embarrassment? Is it getting easier to get to that?

Dr. BURKE HARRIS. We find that the de-identified screen actually makes it more much easier. That is higher disclosure rates.

Mr. MORELLE. Well, I am sorry I have run out of time, Mr. Chair. But I appreciate it. And I will have to get further information from the panelists.

Thanks.

Mr. SABLAN. Thank you.

Now I recognize Mr. Taylor for five minutes.

Mr. TAYLOR. Thank you, Mr. Chairman.

I am going to yield 2 minutes to my colleague from Rochester to continue his line of questioning. I think he was asking some good questions.

Mr. SABLAN. Mr. Morelle, you have 2 minutes.

Mr. MORELLE. Mr. Taylor, thank you. You are quite a gentleman.

So I am troubled by—not troubled by it. I understand it. So the ability to sort of drill down and really identify is partly self-identification by a parent or guardian. Is there any verification you do? Or how do you sort of get to—I guess I am—I know this is really granular, but to really sort of identify things that are hard to identify.

Dr. BURKE HARRIS. So we have 88,000 providers, primary care providers in California who see Medicaid patients. And in order for those 88,000 to be able to identify ACEs rapidly in primary care, that is why we use the de-identified screen.

And then when that de-identified screen shows that a family needs more services for whatever reason, then they are referred to someone who can unpack that and do an identified screen. And that is the verification. So it is a two-step process, and that allows us to be able to more thoroughly identify.

Mr. MORELLE. And that is primarily done through the health side? That is a primary care provider or social worker?

Dr. BURKE HARRIS. Yes, on the health side through the primary care provider.

Mr. MORELLE. Do you match that data, then, with anything that you get out the classroom so that—so that in other words, if you had one or two risk factors on the social side, one or two factors on the health side, and one or two on the school, can you aggregate that data and get a profile and say, gee, we wouldn't have normally thought that child was suffering from trauma. And maybe by looking at one piece or one dimension we wouldn't have—but when we combine this, there is a troubling pattern here that tells us that we ought to do X.

Dr. BURKE HARRIS. Those are the systems that we are hoping to put in place. And I look forward to leading in my role as surgeon general of California.

Mr. MORELLE. Thank you, Mr. Taylor, for extending that courtesy to me. I don't know if anyone else had a comment about sort of that aggregating information. But if I might continue to borrow my time from Mr. Taylor? He has been very kind.

Mr. TAYLOR. I did have one question.

Mr. MORELLE. You said 2 minutes, so I probably used them both up.

So I will yield back. I appreciate both Mr. Taylor's indulgence and the panelists.

Mr. TAYLOR. Thank you, Congressman Morelle.

Ms. Hofmeister, this is a question for you. When we think about child trauma, where is that coming from? What are the—I mean, do we have statistical data on what the sources are? What are the sources?

Ms. HOFMEISTER. Yes. It is childhood abuse, neglect, and other forms of child malpractice. Those could be when we are thinking strictly about ACEs, or adverse childhood experiences, those are

different events that have occurred in the life. Divorce of a parent, an incarcerated parent.

Mr. TAYLOR. Do we have percentages for that? I mean those percentages?

Ms. HOFMEISTER. Yes.

So Oklahoma leads the Nation with ACE scores of two or higher. We know that this is also in our world in schools, we feel it is most important to be able to focus on learning. But we really can't learn until we have some of that connection and some of those other areas addressed.

But we also know that it is a heavy burden for teachers. And that is not something that we are asking burden teachers more and more with new mandates or additional programs, necessarily, that they must bear.

Instead, we would like to see an awareness created, practical applications of trauma-sensitive instruction that could be as simple as telling a child what to do instead of what not to do. A child that has cortisol washing over the brain that is in a constant fight-or-flight kind of mode is not going to know what to do when you say stop, quit, don't. But instead, a teacher can simply say it is time to open our book or it is time to walk in the hall. Those are practical examples of tools that teachers can use, and they don't have to know a child's history to be able to do that.

Mr. TAYLOR. And just speaking of history, what protections have you put in place in terms of privacy? I mean, clearly there are things we have to think about. Privacy is something important to all of us. How do you think about privacy? Knowing about the trauma, how far out do you go? Who do you tell? How do you keep privacy?

Ms. HOFMEISTER. I think privacy is very important. And thank you very much, Representative, for bringing that up. And that is, then, outside the scope of what we focus on in our public school right now.

Our teachers, with a new awareness, are able to make connections regardless of the details that might have occurred. And I think that is a very important first step.

There is a program that is being used right now between law enforcement and schools. It is called Handle With Care. And our law enforcement that are in the home and notice a child is there have connected with the school and let them know, handle this child with care.

Mr. SABLAN. I am sorry.

Mr. TAYLOR. Thank you.

I yield back, Mr. Chairman.

Mr. SABLAN. Thank you, Mr. Taylor.

So now I would like to recognize Mrs. Davis for five—Mrs. Davis for five minutes.

Mrs. DAVIS. All right. Thank you very much, Mr. Chairman. Thank you to all of you.

I think this is a politically well-informed and inspirational panel today. And I want to thank you for that.

We have just been talking about sources of trauma for students. Ms. Hofmeister, you mention abuse, neglect.

One of the issues that hasn't come up is actually gun violence and the impact that has on students, certainly not the only source of trauma as we said, but it is one of those sources.

And I know that we had a hearing here recently. And Mrs. Hayes, I believe, asked Secretary DeVos about the use of Federal money to arm teachers. And she stated that she lacks the authority—Secretary DeVos, that she lacks the authority to tell schools they cannot use Federal funding to arm teachers. But I am wondering where you all feel this comes in and whether you believe, maybe if you all want to have a show of hands, whether or not you think that arming teachers is part of the solution to addressing gun violence in schools.

Anybody feels that it is part of the solution to addressing gun violence in schools?

Okay.

Ms. HOFMEISTER. So I can only speak to Oklahoma. And that is not something we have had requested of the State Department of Education. Of course, this is a conversation for the Federal and the State level.

Mrs. DAVIS. Okay. Thank you.

Just so the record shows that nobody raised their hands.

But what I also wanted to know was if you feel that gun reform can be part of the solution to reducing trauma and how do you think that might be. We know that for many students, actually, even the act of lockdown drills can be traumatic for them. And, of course, we know that the homicide rate in our country for 15- to 24-year-olds is 49 times higher than in other high income countries.

How could we move some of those reforms into being something that is helpful in schools?

Ms. HOFMEISTER. You know, I think some of what we are talking about is also meeting the needs of students early. And how that is often—when that is unaddressed there are serious complications and issues that arise. So our focus in Oklahoma is on meeting our kids right where they are early. And we believe that is the best use of our funds and preparing teachers through training. That is the key.

Mrs. DAVIS. Yeah. Thank you. I don't know if anybody else wants to comment. I do have another question that really speaks to the need for us to be more responsive to teachers.

Dr. Jackson, did you want to—

Ms. JACKSON. Yes. I think commonsense gun reform is extremely important. Many times when we see these acts of violence in school it is a manifestation of, you know, things that have gone unnoticed or missed in a way that I think can be better addressed with the right policies and supports in place in our schools.

One other thing that I would like to add is that what we do in CPS is we take seriously any types of threats of violence and that we work directly with the families. And we have taken an approach where, even if it is something such as a student making a threat online, we address that, and we don't go in with a law enforcement mentality initially. I know that some other cities and schools have taken that approach. But instead to get to the real issue, why would a student post this information. And oftentimes what we

find, except in a few rare occasions when it is just a prank, is that there is something going on that needs to be addressed. And so we spend a lot of time connecting them with the resources but, more importantly, following that student and keeping track of, like, are they getting the resources that they need. Do they, you know, still have these ideas.

And I think that is one of the things that we have been pretty—proud isn't the right word, but we feel good that we have a good process in place to address these issues. But with that said, it is constantly on the back of everybody's mind that an event could happen.

Mrs. DAVIS. Thank you. Thank you, Dr. Jackson.

What I wanted to just mention really quickly—oh, so one of the issues is around Oklahoma on the teacher's can carry a weapon, and I just wanted to again, for the record, mention that.

Really quickly, because we talk about secondary trauma and compassion fatigue on the part of teachers. Having put in language in Title 2 for social and emotional learning and for being able to get grants to teach that, what would it look like if we really did support teachers in this effort and we acknowledge that it does make a difference for them. It is a reason that a number of teachers leave school. What would that look like for you? What is the most important thing that we could do that really addresses that?

Mr. SABLAN. I am going to interrupt, Dr. Jackson, and ask you to please respond to her in writing.

Mrs. DAVIS. Writing.

Ms. JACKSON. Oh, will do.

Mrs. DAVIS. Thank you.

Mr. SABLAN. Thank you.

I would like to now recognize the Ranking Member, Mr. Allen, for five minutes.

Mr. ALLEN. Thank you, Mr. Chairman. And we know that the family is one of the seven cultural pillars in our society. Statistically, we know that the family has been under severe attack in this Nation. In 1950, 93 percent of households, both parents were there for those children. And today it is less than 60 percent.

And, Ms. Hofmeister, I know we don't allow studying in trying to come to grips with what is the real problem here. Are we doing anything as far as reaching these young people to change this cycle? I mean, if this cycle continues, how does it get better?

Have you got anything to offer with regard to that, or are we just trying to fix what problem we have and we are ignoring the real cure here?

Ms. HOFMEISTER. Well, in a public school, again, we are there to serve children who come with a variety of backgrounds. And our educators are there to address their academic needs. And we recognize that we are not able to work on those without first building that connection and rapport and trust with the students.

So getting to know families and reaching out to families, all families, is important. And this is what builds a strong school and a strong community. So our approach is different now than it perhaps was years back. We are needing to be more creative in how we make those connections. And we also recognize that it is important to have school counselors in place as there are need for aca-

demic counseling as well as those who can provide crisis counseling or referring students and families to receive support that is needed through other community resources.

The most—

Mr. ALLEN. Do you have the flexibility? I know that, when I talk to teachers, they are pretty limited in some regards legally what they can do and what they can share with their students about their life experiences, which is one reason I think we are losing teachers, because they feel like they are just being observed and criticized every step. Yet it sounds like that they are actually becoming the family, the family unit.

Ms. HOFMEISTER. This is very true. We actually know that in Oklahoma we are looking to teachers often to be kinship placement family for those that are being put in foster care.

Mr. ALLEN. Are there limits to what a teacher can share with a student in Oklahoma?

Ms. HOFMEISTER. Certainly there would be some limits, I suppose, that would be—I am not sure exactly how to answer that except I would say this: We just want our teachers to feel supported so that they can support our students. And having more of our school counselors, it is beyond the service to students is also to coach teachers, to provide the kind of training that I think many of us at this table are talking about now, perhaps. But in the classroom setting. Classroom management is what we call this where you are building that kind of——

Mr. ALLEN. So, for example, are you able to talk about the family and the importance of the family unit and, you know, the design of the family and those kind of things? The teachers, are they allowed to do that?

Ms. HOFMEISTER. Well, in public school we support families.

Mr. ALLEN. Okay.

Ms. HOFMEISTER. And that is paramount in our agency at the State Department of Education in Oklahoma recognizing that family engagement is key to success for students, and we are making that a priority and a focus.

Mr. ALLEN. Okay. Now, when these students leave school, what is their feeling toward the family? Do they realize that, hey, to fix this, the cure here is for us to, you know, not have children before we get married. And then we get married, and we have children, and we raise those children with a set of values that will give them the freedom to do the things that I was able to do because I had an amazing family.

So, like, are they—do they understand how—you know, what really has to change there.

Dr. BURKE HARRIS. May I add something?

Mr. ALLEN. Yes.

Dr. BURKE HARRIS. I think that one of the pieces that is critical about this work is reducing stigma and reducing blame and shame. That is critical for healing and a recognition I think for families of understanding how the experience that parents had, perhaps their own adversity can be handed down and recognizing the key of safe and stable relationships.

Mr. SABLAN. Again, I am sorry.

Mr. ALLEN. I yield back, Chairman.

Thank you, panel.

Mr. SABLAN. Thank you, Dr. Harris.

So now I would like to recognize for five minutes Ms. Bonamici, please. Thank you.

Ms. BONAMICI. Thank you, Mr. Chairman.

I am going to start with a series of sort of big-picture questions about prevention. And these are issues that this committee works on. And I want to know if they should be part of the solution.

Ms. BONAMICI. School-based health clinics, just yes or no?

[ALL WITNESSES]: [Yes all around.]

Ms. BONAMICI. Paid family leave?

[ALL WITNESSES]: [Nod their heads "yes" in agreement.]

Ms. BONAMICI. So yes all around.

Ms. BONAMICI. Affordable childcare, a real challenge.

[ALL WITNESSES] [Witnesses said "yes" in agreement with Ms. Bonamici.]

Ms. BONAMICI.Thank you. I appreciate that. We need to look at prevention as well as how we address the serious issue. And thank you for your testimony. I thought it was all very, very enlightening. We know the growing awareness of the profound effects of ACEs, and some of them have been mentioned.

I want to follow up on a couple of them. Representative Shalala talked about children of immigrant parents. And I have to tell you that when I talk to kids, they are afraid to go to school because they don't know if their parents are going to be home when they get back. So that is a concern I have. I had a young woman who is a high school student say to me at a townhall meeting that the first thing she does when she walks into a classroom is to figure out where she can hide or how she can escape.

So you can understand why these kids are going through so much trauma with the threat of gun violence, with immigrant families. And, of course, thank you, Dr. Burke Harris for talking about trying to get rid of the stigma. We want to make sure that everyone gets the help they need.

And, Dr. Jackson, I think you mentioned the LGBTQ students who are already facing discrimination, oftentimes, and higher suicide rates and the inability to do well in school if they are feeling that pressure.

So we know that, you know, schools in Oregon and across the country are doing what they can to support these students, but they need extra resources. And I am glad several of you mentioned the student support and academic enrichment grant programs and Title 4A of the Every Student Succeeds Act. We need to make sure, and I have been a leader on getting that fully funded, make sure that the schools have the resources to support those students.

Dr. Burke Harris, a 2018 report by Child Trends, children of color are disproportionately represented among children who have experienced trauma, specifically 61 percent of African-American children, 51 percent of Latino children have experienced at least one adverse childhood experience. African-American children are also disproportionately subject to severe discipline. That is a GAO report.

So how does racial and historical trauma and early adversity affect these marginalized students, particularly African-American, Native American students?

Dr. BURKE HARRIS. Although discrimination is not one of the traditional adverse childhood experiences, what we understand now is that cumulative adversity is what leads to the toxic stress response which is what causes the harm.

Experiences of discrimination based on race, national origin, or other forms of discrimination add to the cumulative adversity and put those individuals at greater risk of health and—mental health and behavioral social risks.

Ms. BONAMICI. Thank you.

And, Dr. Jackson, evidence suggests that the opioid crisis is, you know, creating all these new challenges in protecting vulnerable children. In October of 2018, Congress passed the Support for Patients and Communities Act to address the opioid crisis. The bill included $50 million to support trauma-informed practices in schools. Unfortunately, that program has not yet been funded. But what would you do with funding to scale trauma-informed practices in your school district specifically with regard to the opioid crisis?

Ms. JACKSON. These resources would make a significant difference in Chicago. I know a lot of times, when we talk about the opioid addiction, you know, we focus on other areas. But this is something that we struggle with in the city as well. One thing that we would do is expand the work that we are doing in our parent universities. I know family has come up with a lot, and we do have engagement with many of our parents through a parent-university structure. And with additional support being able to help train them and, in some cases, help direct them to other resources again to break that cycle would be helpful to us.

So I would say more awareness and language to address those issues and reducing barriers to getting the support.

Ms. BONAMICI. Do you have any recovery high schools? Portland is getting ready to open a recovery high school to high school students who are in recovery so they don't have all the peer pressure of the students who aren't struggling with—

Ms. JACKSON. No, we don't. We have prioritized putting health clinics in some of our schools who do provide that support to both students and people in the community, but we don't yet have a recovery high school.

Ms. BONAMICI. Thank you.

And in my remaining few seconds, just one quick anecdote that was really meaningful to me. I was visiting a small school on the Oregon coast, and the principal told us an example of implementation of trauma-informed practices. There was a student who used to go to school with his hood up, on his hoodie. And the teachers would tell him to put his hood down and sit up. When they let him keep his hood over—

Mr. SABLAN. I am sorry, Ms. Bonamici.

Ms. BONAMICI.—he did well in school because he was protecting himself—

Ms. BONAMICI. Thank you, Mr. Chairman.

I yield back.

Mr. SABLAN. Thank you. You are welcome. Thank you.

I now recognize Ms. Wild for five minutes, please.

Ms. WILD. Thank you, Mr. Chairman.

It would be lovely if everyone had a perfect family. I don't think there is a definition of a perfect family. My own family of origin was flawed, and my current family that includes two children in their 20s who are doing fairly well was also flawed. So the—I am distressed by some of the comments we have heard today that seem to lay all of this at the feet of the family and the fact that there may be a number of children going to school without two-parent families.

I don't think that anybody disagrees about the effects of ACEs. That is what I am hearing at least from all of you. And it seems to me that two things are just so important.

First is awareness. And you are helping us with that. And I really appreciate it. I know we all do. We all need to understand this and know more about it.

But the second and the most obvious elephant in the room is the funding for these kinds of programs. That includes, I might add, supporting teachers who have been put in the very unfortunate position of having to become counselors and pastors in addition to what they went in to teaching for, which is educating students. And, of course, the issue of secondary trauma is so important.

So on that funding issue, it seems pretty clear to me that we still have a lot of work to do to convince our colleagues across the aisle that there is not only a place but a demand and a need for Federal funding to support these kinds of programs.

So with that in mind, I would like to ask you a couple questions about why everybody should care about providing some additional Federal funding for this issue.

We know that there are distressed school districts all over the country. In my district, which is the 7th District of Pennsylvania, we have one very severely distressed district. And, by the way, in that district, 3,000 Puerto Rican families came into the Allentown School District following Hurricane Maria. I might point out, they are citizens. They aren't immigrants. But it has very much contributed to the issues that are faced by that distressed school district that has trouble even affording textbooks and supplies.

So we need to—we obviously have to do a job of convincing. So what I would like to know, and let me address this first to you, Dr. Jackson, what Federal programs or Federal funding are most important to supporting schools in creating and sustaining trauma induced— trauma-informed care?

Dr. Jackson. Funding to support programs like I talked about earlier, the SPARCS program, which allows us to work directly with students and their families doing psychotherapy, these are very powerful and impactful programs. They are also very expensive, and many school districts just simply can't afford to do this at scale.

I would also say programming for trauma-informed practices to train all of the teachers as well as the other professionals in the district is something that is extremely helpful and can be impactful and, again, one of those things that we have trouble finding the necessary resources to support.

I could go down the list, but I am sure my colleagues on the panel would like to get theirs in as well.

Ms. WILD. Well, one of the things that I really wanted to ask you, Dr. Burke Harris, is about the issue of children in the United States currently getting the mental health and treatment services that they need. How can we in Congress and the Federal Government better support children who are experiencing ACEs?

Dr. BURKE HARRIS. I think that it is critical for us to certainly—I think the screening piece is absolutely critical, because early detection improves outcomes.

The second piece, obviously, is the support for the responses, including mental healthcare, trauma-informed educational systems. And another critical piece is a public education campaign to raise awareness among families and everyday Americans.

Ms. WILD. I am really struck by a quote that I read from Dr. Robert Block, former president of the American Academy of Pediatrics, who has been widely quoted as saying: Adverse childhood experiences are the single greatest unaddressed public health threat facing our Nation today. I think you made reference to that.

Dr. BURKE HARRIS. I want to also point out that ACEs don't just happen in low-income neighborhoods. The original study was done in a population 70 percent Caucasian, 70 percent college-educated, all middle class adults. And when we are looking at two-thirds of Americans have experienced ACEs, then we are really seeing that we cannot afford not to do early detection and early intervention.

Ms. WILD. You get no argument from me. Thank you.

Chairman SABLAN. Thank you, Ms. Wild.

And now I would like to recognize myself for five minutes. And I ask unanimous consent to insert into the record a letter from an eighth-grader whose school campus was destroyed by a super-typhoon, and it is entitled—and she shared her experience. It is entitled "From Hopwood to Tarpwood." And having seen no objection, I insert this letter to get it for the record.

Chairman SABLAN. I do have questions that I may not be able to ask of you and submit it for your answers.

But, Dr. Barker, how has McDowell County Schools changed its policies, procedures, and practices to align with being trauma-informed?

Ms. BARKER. We had to become more inclusive, and we had to create policies to work with our mental health providers and our school-based health clinics. As you know, you have FERPA and HIPAA regulations, and sometimes those don't communicate.

So we had to really change those policies so that our mental health clinicians would be able to get information from our teachers to help them in their therapy sessions and, again, consequently be able to be back with the teachers and tell them not the diagnosis, but how can they help in the classroom. Because if we do all this therapy and work with our kids and it never translates into the classroom practices, it just cannot, you know, cannot be productive. So we had to include that.

And we are also moving to restorative justices. Instead of just telling the kids, here, you go home for five days because you were fighting, what happened, you know, what happened at home the

night before that kind of got you a little, you know, upset that you decided to take matters into your own hands?

So we are working to be more open and change our privacy and confidentiality policies, just to make sure that we are communicating along the lines to help our kids.

Chairman SABLAN. So could I say then that teachers and staff have had to do things differently because of changes in policies, procedures, and practice?

Ms. BARKER. Yes. And we are using a lot of professional development. We have trained our service personnel and our professional personnel in Youth Mental Health First Aid, which is recognizing the signs and symptoms of certain behaviors and be able to refer and communicate with different therapists.

Also with trauma-informed, we are providing the training. Let's take a look at the kid, you know, and just giving them scenarios. Here is Johnny. He did not bring homework to you. Here are the two scenarios: Teacher yells at you because, you know, Johnny, you did not do your work and you explode, or teacher actually asks Johnny and talks to him individually, what happened to you before? And just kind of looking at different scenarios. How do you react? How should you be reacting?

So we are working with teachers to help them understand not everybody grew up with two parents and had, you know, place for homework at home. Kids are different and we should meet them as they are.

Chairman SABLAN. All right. And let me now turn to Dr. Burke Harris, if I may, because we have man-made climate change driving more severe weather, such as hurricanes, typhoons, fires that devastate entire communities, homes, and schools.

This committee has heard testimony that students are experiencing post-traumatic stress disorder. What recommendations do you have for schools post natural disasters in caring for their students? And you have a minute and a half.

Dr. BURKE HARRIS. Yes. I would say, again, this just reiterates how important it is for all individuals in the educational environment to receive professional education and professional training about how to respond to a traumatic situation, whether that trauma is the result of a natural disaster or whether it is the result of community violence or violence or trauma that is happening at home.

The responses, the fundamentals of the response and what the science shows us makes a difference in improving outcomes, are safe, stable, and nurturing relationships and environments, ensuring that all folks in the educational environment have that training; and more than just the knowledge, a set of tools and skills that they can apply in the educational environment to support children.

Chairman SABLAN. All right. Thank you. I am going to cut my 30 minutes. I will have records, I mean questions submitted of you and you will have time to respond.

I remind my colleagues that pursuant to committee practice, materials for submission for the hearing record must be submitted to the Committee Clerk within 14 days following the last day of the hearing, preferably in Microsoft Word format.

The material submitted must address the subject matter of the hearing. Only a Member of the committee or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the Committee Clerk within the required timeframe, but please do recognize that years from now that link may no longer work.

And now, without objection, I would like to enter into the record the 1998 Regional Adverse Childhood Study By the Centers for Disease Control and Prevention and Kaiser Permanente; a 2019 report from the U.S. GAO, Government Accountability Office, regarding the approaches and challenges to supporting children affected by trauma; a report by the National Child Traumatic Stress Network on creating, supporting, and sustaining trauma-informed schools; a scholarly article written by researchers at Washington State University on the connection between adverse childhood experience and elementary school children; article by Rand on evidence-based practices that are effective in schools to support children affected by trauma. I am going to go through the list.

An article by Everytown for Gun Safety on the impact of gun violence on children and teens; a fact sheet on ten things to know about trauma and learning by Alliance for Excellent Education; a policy statement by the American Academy of Pediatrics on the impact of racism on child and adolescents' health; a statement of Civil Rights Principles on Safe, Healthy, and Inclusive School Climates from the Leadership Conference; and five letters for the record from Alliance for Excellent Education, American Federation of Teachers, Binghamton University Community Schools, National Indian Education Association, National Association of School Psychologists, and National Education Association, in support of trauma-informed practices in schools.

[The information follows:]

Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

Background: The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described.

Methods: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Logistic regression was used to adjust for effects of demographic factors on the association between the cumulative number of categories of childhood exposures (range: 0–7) and risk factors for the leading causes of death in adult life.

Results: More than half of respondents reported at least one, and one-fourth reported ≥2 categories of childhood exposures. We found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied ($P < .001$). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Conclusions: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

Medical Subject Headings (MeSH): child abuse, sexual, domestic violence, spouse abuse, children of impaired parents, substance abuse, alcoholism, smoking, obesity, physical activity, depression, suicide, sexual behavior, sexually transmitted diseases, chronic obstructive pulmonary disease, ischemic heart disease. (Am J Prev Med 1998;14:245–258)

Department of Preventive Medicine, Southern California Permanente Medical Group (Kaiser Permanente), (Felitti) San Diego, California 92111. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, (Anda, Williamson, Spitz, Edwards, Marks) Atlanta, Georgia 30333. Department of Pediatrics, Emory University School Medicine, (Nordenberg) Atlanta, Georgia 30333. Department of Family and Community Medicine, University of Arizona Health Sciences Center, (Koss) Tucson, Arizona 85727.

Address correspondence to: Vincent J. Felitti, MD, Kaiser Permanente, Department of Preventive Medicine, 7060 Clairemont Mesa Boulevard, San Diego, California 92111.

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Introduction

Only recently have medical investigators in primary care settings begun to examine associations between childhood abuse and adult health risk behaviors and disease.[1–5] These associations are important because it is now clear that the leading causes of morbidity and mortality in the United States[6] are related to health behaviors and lifestyle factors; these factors have been called the "actual" causes of death.[7] Insofar as abuse and other potentially damaging childhood experiences contribute to the development of these risk factors, then these childhood exposures should be recognized as the basic causes of morbidity and mortality in adult life.

See related Commentary on pages 354, 356, 361.

Although sociologists and psychologists have published numerous articles about the frequency[8–12] and long-term consequences[13–15] of childhood abuse, understanding their relevance to adult medical problems is rudimentary. Furthermore, medical research in this field has limited relevance to most primary care physicians because it is focused on adolescent health,[16–20] mental health in adults,[20] or on symptoms among patients in specialty clinics.[22,23] Studies of the long-term effects of childhood abuse have usually examined single types of abuse, particularly sexual abuse, and few have assessed the impact of more than one type of abuse.[5,24–28] Conditions such as drug abuse, spousal violence, and criminal activity in the household may co-occur with specific forms of abuse that involve children. Without measuring these household factors as well, long-term influence might be wrongly attributed solely to single types of abuse and the cumulative influence of multiple categories of adverse childhood experiences would not be assessed. To our knowledge, the relationship of adult health risk behaviors, health status, and disease states to childhood abuse and household dysfunction[29–35] has not been described.

We undertook the Adverse Childhood Experiences (ACE) Study in a primary care setting to describe the long-term relationship of childhood experiences to important medical and public health problems. The ACE Study is assessing, retrospectively and prospectively, the long-term impact of abuse and household dysfunction during childhood on the following outcomes in adults: disease risk factors and incidence, quality of life, health care utilization, and mortality. In this initial paper we use baseline data from the study to provide an overview of the prevalence and interrelation of exposures to childhood abuse and household dysfunction. We then describe the relationship between the number of categories of these deleterious childhood exposures and risk factors and those diseases that underlie many of the leading causes of death in adults.[6,7,36,37]

Methods

Study Setting

The ACE Study is based at Kaiser Permanente's San Diego Health Appraisal Clinic. More than 45,000 adults undergo standardized examinations there each year, making this clinic one of the nation's largest free-standing medical evaluation centers. All enrollees in the Kaiser Health Plan in San Diego are advised through sales literature about the services (free for members) at the clinic; after enrollment, members are advised again of its availability through new-member literature. Most members obtain appointments by self-referral; 20% are referred by their health care provider. A recent review of membership and utilization records among Kaiser members in San Diego continuously enrolled between 1992 and 1995 showed that 81% of those 25 years and older had been evaluated in the Health Appraisal Clinic.

Health appraisals include completion of a standardized medical questionnaire that requests demographic and biopsychosocial information, review of organ systems, previous medical diagnoses, and family medical history. A health care provider completes the medical history, performs a physical examination, and reviews the results of laboratory tests with the patient.

Survey Methods

The ACE Study protocol was approved by the Institutional Review Boards of the Southern California Permanente Medical Group (Kaiser Permanente), the Emory University School of Medicine, and the Office of Protection from Research Risks, National Institutes of Health. All 13,494 Kaiser Health Plan members who completed standardized medical evaluations at the Health Appraisal Clinic between August–November of 1995 and January–March of 1996 were eligible to participate in the ACE Study. Those seen at the clinic during December were not included because survey response rates are known to be lower during the holiday period.[38]

In the week after visiting the clinic, and hence having their standardized medical history already completed, members were mailed the ACE Study questionnaire that included questions about childhood abuse and exposure to forms of household dysfunction while growing up. After second mailings of the questionnaire to persons who did not respond to the first mailing, the response rate for the survey was 70.5% (9,508/13,494).

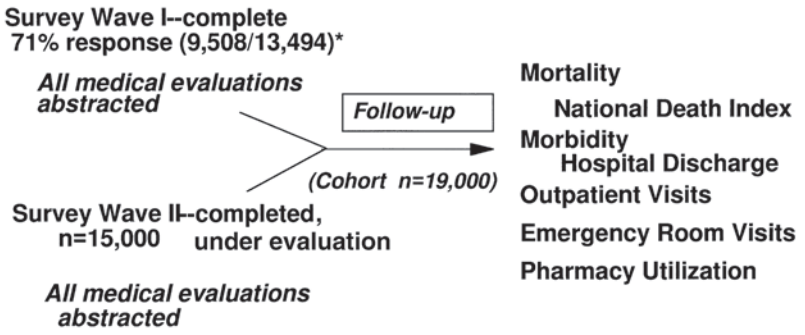

Figure 1. ACE Study design. *After exclusions, 59.7% of the original wave I sample (8,056/13,494) were included in this analysis.

A second survey wave of approximately the same number of patients as the first wave was conducted between June and October of 1997. The data for the second survey wave is currently being compiled for analysis. The methods for the second mail survey wave were identical to the first survey wave as described above. The second wave was done to enhance the precision of future detailed analyses on special topics and to reduce the time necessary to obtain precise statistics on follow-up health events. An overview of the total ACE Study design is provided in Figure 1.

Comparison of Respondents and Nonrespondents

We abstracted the completed medical evaluation for every person eligible for the study; this included their medical history, laboratory results, and physical findings. Respondent (n = 9,508) and nonrespondent (n = 3,986) groups were similar in their percentages of women (53.7% and 51.0%, respectively) and in their mean years of education (14.0 years and 13.6 years, respectively). Respondents were older than nonrespondents (means 56.1 years and 49.3 years) and more likely to be white (83.9% vs. 75.3%) although the actual magnitude of the differences was small.

Respondents and nonrespondents did not differ with regard to their self-rated health, smoking, other substance abuse, or the presence of common medical conditions such as a history of heart attack or stroke, chronic obstructive lung disease, hypertension, or diabetes, or with regard to marital status or current family, marital, or job-related problems (data not shown). The health appraisal questionnaire used in the clinic contains a single question about childhood sexual abuse that reads "As a child were you ever raped or sexually molested?" Respondents were slightly more likely to answer affirmatively than nonrespondents (6.1% vs. 5.4%, respectively).

Questionnaire Design

We used questions from published surveys to construct the ACE Study questionnaire. Questions from the Conflicts Tactics Scale[39] were used to define psychological and physical abuse during childhood and to define violence against the respondent's mother. We adapted four questions from Wyatt[40] to define contact sexual abuse during childhood. Questions about exposure to alcohol or drug abuse during childhood were adapted from the 1988 National Health Interview Survey.[41] All of the questions we used in this study to determine childhood experiences were introduced with the phrase "While you were growing up during your first 18 years of life . . ."

Questions about health-related behaviors and health problems were taken from health surveys such as the Behavioral Risk Factor Surveys[42] and the Third National Health and Nutrition Examination Survey,[43] both of which are directed by the Centers for Disease Control and Prevention. Questions about depression came from the Diagnostic Interview Schedule of the National Institute of Mental Health (NIMH).[44] Other information for this analysis such as disease history was obtained from the standardized questionnaire used in the Health Appraisal Clinic. (A copy of the questionnaires used in this study may be found at *www.elsevier.com/locate/amepre.)*

Table 1. Prevalence of childhood exposure to abuse and household dysfunction

Category of childhood exposure[a]	Prevalence (%)	Prevalence (%)
Abuse by category		
Psychological		**11.1**
(Did a parent or other adult in the household . . .)		
Often or very often swear at, insult, or put you down?	10.0	
Often or very often act in a way that made you afraid that you would be physically hurt?	4.8	
Physical		**10.8**
(Did a parent or other adult in the household . . .)		
Often or very often push, grab, shove, or slap you?	4.9	
Often or very often hit you so hard that you had marks or were injured?	9.6	
Sexual		**22.0**
(Did an adult or person at least 5 years older ever . . .)		
Touch or fondle you in a sexual way?	19.3	
Have you touch their body in a sexual way?	8.7	
Attempt oral, anal, or vaginal intercourse with you?	8.9	
Actually have oral, anal, or vaginal intercourse with you?	6.9	
Household dysfunction by category		
Substance abuse		**25.6**
Live with anyone who was a problem drinker or alcoholic?	23.5	
Live with anyone who used street drugs?	4.9	
Mental illness		**18.8**
Was a household member depressed or mentally ill?	17.5	
Did a household member attempt suicide?	4.0	
Mother treated violently		**12.5**
Was your mother (or stepmother)		
Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her?	11.9	
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?	6.3	
Ever repeatedly hit over at least a few minutes?	6.6	
Ever threatened with, or hurt by, a knife or gun?	3.0	
Criminal behavior in household		
Did a household member go to prison?	3.4	**3.4**
	Any category reported	**52.1%**

[a]An exposure to one or more items listed under the set of questions for each category.

Defining Childhood Exposures

We used three categories of childhood abuse: psychological abuse (2 questions), physical abuse (2 questions), or contact sexual abuse (4 questions). There were four categories of exposure to household dysfunction during childhood: exposure to substance abuse (defined by 2 questions), mental illness (2 questions), violent treatment of mother or stepmother (4 questions), and criminal behavior (1 question) in the household. Respondents were defined as exposed to a category if they responded "yes" to 1 or more of the questions in that category. The prevalence of positive responses to the individual questions and the category prevalences are shown in Table 1.

We used these 7 categories of childhood exposures to abuse and household dysfunction for our analysis. The measure of childhood exposure that we used was simply the sum of the categories with an exposure; thus the possible number of exposures ranged from 0 (unexposed) to 7 (exposed to all categories).

Risk Factors and Disease Conditions Assessed

Using information from both the study questionnaire and the Health Appraisal Clinic's questionnaire, we chose 10 risk factors that contribute to the leading causes of morbidity and mortality in the United States.[6,7,36,37] The risk factors included smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, any drug abuse, parenteral drug abuse, a high lifetime number of sexual partners (≥50), and a history of having a sexually transmitted disease.

We also assessed the relationship between childhood exposures and disease conditions that are among the leading causes of mortality in the United States.[6] The presence of these disease conditions was based upon medical histories that patients provided in response to the clinic questionnaire. We included a history of ischemic heart disease (including heart attack or use of nitroglycerin for exertional chest pain), any cancer, stroke, chronic bronchitis, or emphysema (COPD),

diabetes, hepatitis or jaundice, and any skeletal fractures (as a proxy for risk of unintentional injuries). We also included responses to the following question about self-rated health: "Do you consider your physical health to be excellent, very good, good, fair, or poor?" because it is strongly predictive of mortality.[45]

Definition of Risk Factors

We defined severe obesity as a body mass index (kg/meter^2) ≥35 based on measured height and weight; physical inactivity as no participation in recreational physical activity in the past month; and alcoholism as a "Yes" response to the question "Have you ever considered yourself to be an alcoholic?" The other risk factors that we assessed are self-explanatory.

Exclusions from Analysis

Of the 9,508 survey respondents, we excluded 51 (0.5%) whose race was unstated and 34 (0.4%) whose educational attainment was not reported. We also excluded persons who did not respond to certain questions about adverse childhood experiences. This involved the following exclusions: 125 (1.3%) for household substance abuse, 181 (1.9%) for mental illness in the home, 148 (1.6%) for violence against mother, 7 (0.1%) for imprisonment of a household member, 109 (1.1%) for childhood psychological abuse, 44 (0.5%) for childhood physical abuse, and 753 (7.9%) for childhood sexual abuse. After these exclusions, 8,056 of the original 9,508 survey respondents (59.7% of the original sample of 13,494) remained and were included in the analysis. Procedures for insuring that the findings based on complete data were generalizable to the entire sample are described below.

The mean age of the 8,506 persons included in this analysis was 56.1 years (range: 19–92 years); 52.1% were women; 79.4% were white. Forty-three percent had graduated from college; only 6.0% had not graduated from high school.

Statistical Analysis

We used the Statistical Analysis System (SAS)[46] for our analyses. We used the direct method to age-adjust the prevalence estimates. Logistic regression analysis was employed to adjust for the potential confounding effects of age, sex, race, and educational attainment on the relationship between the number of childhood exposures and health problems.

To test for a dose-response relationship to health problems, we entered the number of childhood exposures as a single ordinal variable (0, 1, 2, 3, 4, 5, 6, 7) into a separate logistic regression model for each risk factor or disease condition.

Assessing the Possible Influence of Exclusions

To determine whether our results were influenced by excluding persons with incomplete information on any of the categories of childhood exposure, we performed a separate sensitivity analysis in which we included all persons with complete demographic information but assumed that persons with missing information for a category of childhood exposure did not have an exposure in that category.

Results

Adverse Childhood Exposures

The level of positive responses for the 17 questions included in the seven categories of childhood exposure ranged from 3.0% for a respondent's mother (or stepmother) having been threatened with or hurt by a gun or knife to 23.5% for having lived with a problem drinker or alcoholic (Table 1). The most prevalent of the 7 categories of childhood exposure was substance abuse in the household (25.6%); the least prevalent exposure category was evidence of criminal behavior in the household (3.4%). More than half of respondents (52%) experienced ≥1 category of adverse childhood exposure; 6.2% reported ≥4 exposures.

Relationships between Categories of Childhood Exposure

The probability that persons who were exposed to any single category of exposure were also exposed to another category is shown in Table 2. The relationship between single categories of exposure was significant for all comparisons ($P < .001$; chi-square). For persons reporting any single category of exposure, the probability of exposure to any additional category ranged from 65%–93% (median: 80%); similarly, the probability of ≥2 additional exposures ranged from 40%–74% (median: 54.5%).

The number of categories of childhood exposures by demographic characteristics is shown in Table 3. Statistically, significantly fewer categories of exposure were found among older persons, white or Asian persons, and college graduates ($P < .001$). Because age is associated with both the childhood exposures as well as many of the health risk factors and disease outcomes, all prevalence estimates in the tables are adjusted for age.

Relationship between Childhood Exposures and Health Risk Factors

Both the prevalence and risk (adjusted odds ratio) increased for smoking, severe obesity, physical inactivity, depressed mood, and suicide attempts as the number of childhood exposures increased (Table 4). When

Table 2. Relationships between categories of adverse childhood exposure

First Category of Childhood Exposure	Sample Size*	Percent (%) Exposed to Another Category								
		Psychological Abuse	Physical Abuse	Sexual Abuse	Substance Abuse	Mental Illness	Treated Violently	Imprisoned Member	Any One Additional Category	Any Two Additional Categories
Childhood Abuse:										
Psychological	898	—	52*	47	51	50	39	9	93	74
Physical abuse	874	54	—	44	45	38	35	9	86	64
Sexual abuse	1770	24	22	—	39	31	23	6	65	41
Household dysfunction:										
Substance abuse	2064	22	19	34	—	34	29	8	69	40
Mental illness	1512	30	22	37	46	—	26	7	74	47
Mother treated violently	1010	34	31	41	59	38	—	10	86	62
Member imprisoned	271	29	29	40	62	42	37	—	86	64
	median	29.5	25.4	40.5	48.5	38	32	8.5	80	54.5
	range	(22–54)	(19–52)	(34–47)	(39–62)	(31–50)	(23–39)	(6–10)	(65–93)	(40–74)

*Number exposed to first category. For example, among persons who were psychologically abused, 52% were also physically abused. More persons were a second category than would be expected by chance ($P < .001$; chi-square).

persons with 4 categories of exposure were compared to those with none, the odds ratios ranged from 1.3 for physical inactivity to 12.2 for suicide attempts (Table 4).

Similarly, the prevalence and risk (adjusted odds ratio) of alcoholism, use of illicit drugs, injection of illicit drugs, ≥50 intercourse partners, and history of a sexually transmitted disease increased as the number of childhood exposures increased (Table 5). In comparing persons with ≥4 childhood exposures to those with none, odds ratios ranged from 2.5 for sexually transmitted diseases to 7.4 for alcoholism and 10.3 for injected drug use.

Childhood Exposures and Clustering of Health Risk Factors

We found a strong relationship between the number of childhood exposures and the number of health risk factors for leading causes of death in adults (Table 6). For example, among persons with no childhood exposures, 56% had none of the 10 risk factors whereas only 14% of persons with ≥4 categories of childhood exposure had no risk factors. By contrast, only 1% of persons with no childhood exposures had four or more risk factors, whereas 7% of persons with ≥4 childhood exposures had four or more risk factors (Table 6).

Relationship between Childhood Exposures and Disease Conditions

When persons with 4 or more categories of childhood exposure were compared to those with none, the odds ratios for the presence of studied disease conditions ranged from 1.6 for diabetes to 3.9 for chronic bronchitis or emphysema (Table 7). Similarly, the odds ratios for skeletal fractures, hepatitis or jaundice, and poor self-rated health were 1.6, 2.3, and 2.2, respectively (Table 8).

Significance of Dose-Response Relationships

In logistic regression models (which included age, gender, race, and educational attainment as covariates) we found a strong, dose-response relationship between the number of childhood exposures and each of the 10 risk factors for the leading causes of death that we studied ($P < .001$). We also found a significant ($P < .05$) dose-response relationship between the number of childhood exposures and the following disease conditions: ischemic heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis or jaundice, skeletal fractures, and poor self-rated health. There was no statistically significant dose-response relationship for a history of stroke or diabetes.

Table 3. Prevalence of categories of adverse childhood exposures by demographic characteristics

Characteristic	Sample size (*N*)	Number of categories (%)[a]				
		0	1	2	3	4
Age group (years)						
19–34	807	35.4	25.4	17.2	11.0	10.9
35–49	2,063	39.3	25.1	15.6	9.1	10.9
50–64	2,577	46.5	25.2	13.9	7.9	6.6
≥65	2,610	60.0	24.5	8.9	4.2	2.4
Gender[b]						
Women	4,197	45.4	24.0	13.4	8.7	8.5
Men	3,859	53.7	25.8	11.6	5.0	3.9
Race[b]						
White	6,432	49.7	25.3	12.4	6.7	6.0
Black	385	38.8	25.7	16.3	12.3	7.0
Hispanic	431	42.9	24.9	13.7	7.4	11.2
Asian	508	66.0	19.0	9.9	3.4	1.7
Other	300	41.0	23.5	13.9	9.5	12.1
Education[b]						
No HS diploma	480	56.5	21.5	8.4	6.5	7.2
HS graduate	1,536	51.6	24.5	11.3	7.4	5.2
Any college	2,541	44.1	25.5	14.8	7.8	7.8
College graduate	3,499	51.4	25.1	12.1	6.1	5.3
All participants	**8,056**	**49.5**	**24.9**	**12.5**	**6.9**	**6.2**

[a]The number of categories of exposure was simply the sum of each of the seven individual categories that were assessed (see Table 1).
[b]Prevalence estimates adjusted for age.

Assessment of the Influence of Exclusions

In the sensitivity analysis where missing information for a category of childhood exposure was considered as no exposure, the direction and strength of the associations between the number of childhood exposures and the risk factors and disease conditions were nearly identical (data not shown). Thus, the results we present appear to be unaffected by our decision to exclude persons for whom information on any category of childhood exposure was incomplete.

Discussion

We found a strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. Disease conditions including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, as well as poor self-rated health also showed a graded relationship to the breadth of childhood exposures. The findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative.

The clear majority of patients in our study who were exposed to one category of childhood abuse or household dysfunction were also exposed to at least one other. Therefore, researchers trying to understand the long-term health implications of childhood abuse may benefit from considering a wide range of related adverse childhood exposures. Certain adult health outcomes may be more strongly related to unique combinations or the intensity of adverse childhood exposures than to the total breadth of exposure that we used for our analysis. However, the analysis we present illustrates the need for an overview of the net effects of a *group* of complex interactions on a wide range of health risk behaviors and diseases.

Several potential limitations need to be considered when interpreting the results of this study. The data about adverse childhood experiences are based on self-report, retrospective, and can only demonstrate associations between childhood exposures and health risk behaviors, health status, and diseases in adulthood. Second, some persons with health risk behaviors or diseases may have been either more, or less, likely to report adverse childhood experiences. Each of these issues potentially limits inferences about causality. Furthermore, disease conditions could be either over- or under-reported by patients when they complete the medical questionnaire. In addition, there may be mediators of the relationship between childhood experiences and adult health status other than the risk factors we examined. For example, adverse childhood experiences may affect attitudes and behaviors toward health and health care, sensitivity to internal sensations, or physiologic functioning in brain centers and neurotransmitter systems. A more complete understanding of these issues is likely to lead to more effective ways to address the long-term health problems associated with childhood abuse and household dysfunction.

However, our estimates of the prevalence of child-

Table 4. Number of categories of adverse childhood exposure and the adjusted odds of risk factors including current smoking, severe obesity, physical inactivity, depressed mood, and suicide attempt

Health problem	Number of categories	Sample size (N)[a]	Prevalence (%)[b]	Adjusted odds ratio[c]	95% confidence interval
Current smoker[d]	0	3,836	6.8	1.0	Referent
	1	2,005	7.9	1.1	(0.9–1.4)
	2	1,046	10.3	1.5	(1.1–1.8)
	3	587	13.9	2.0	(1.5–2.6)
	4 or more	544	16.5	2.2	(1.7–2.9)
	Total	8,018	8.6	—	—
Severe obesity[d] (BMI ≥ 35)	0	3,850	5.4	1.0	Referent
	1	2,004	7.0	1.1	(0.9–1.4)
	2	1,041	9.5	1.4	(1.1–1.9)
	3	590	10.3	1.4	(1.0–1.9)
	4 or more	543	12.0	1.6	(1.2–2.1)
	Total	8,028	7.1	—	—
No leisure-time physical activity	0	3,634	18.4	1.0	Referent
	1	1,917	22.8	1.2	(1.1–1.4)
	2	1,006	22.0	1.2	(1.0–1.4)
	3	559	26.6	1.4	(1.1–1.7)
	4 or more	523	26.6	1.3	(1.1–1.6)
	Total	7,639	21.0	—	—
Two or more weeks of depressed mood in the past year	0	3,799	14.2	1.0	Referent
	1	1,984	21.4	1.5	(1.3–1.7)
	2	1,036	31.5	2.4	(2.0–2.8)
	3	584	36.2	2.6	(2.1–3.2)
	4 or more	542	50.7	4.6	(3.8–5.6)
	Total	7,945	22.0	—	—
Ever attempted suicide	0	3,852	1.2	1.0	Referent
	1	1,997	2.4	1.8	(1.2–2.6)
	2	1,048	4.3	3.0	(2.0–4.6)
	3	587	9.5	6.6	(4.5–9.8)
	4 or more	544	18.3	12.2	(8.5–17.5)
	Total	8,028	3.5	—	—

[a]Sample sizes will vary due to incomplete or missing information about health problems.
[b]Prevalence estimates are adjusted for age.
[c]Odds ratios adjusted for age, gender, race, and educational attainment.
[d]Indicates information recorded in the patient's chart before the study questionnaire was mailed.

hood exposures are similar to estimates from nationally representative surveys, indicating that the experiences of our study participants are comparable to the larger population of U.S. adults. In our study, 23.5% of participants reported having grown up with an alcohol abuser; the 1988 National Health Interview Survey estimated that 18.1% of adults had lived with an alcohol abuser during childhood.[41] Contact sexual abuse was reported by 22% of respondents (28% of women and 16% of men) in our study. A national telephone survey of adults in 1990 using similar criteria for sexual abuse estimated that 27% of women and 16% of men had been sexually abused.[12]

There are several reasons to believe that our estimates of the long-term relationship between adverse childhood experiences and adult health are conservative. Longitudinal follow-up of adults whose childhood abuse was well documented has shown that their retrospective reports of childhood abuse are likely to underestimate actual occurrence.[47,48] Underestimates of childhood exposures would result in downwardly biased estimates of the relationships between childhood exposures and adult health risk behaviors and diseases. Another potential source of underestimation of the strength of these relationships is the lower number of childhood exposures reported by older persons in our study. This may be an artifact caused by premature mortality in persons with multiple adverse childhood exposures; the clustering of multiple risk factors among persons with multiple childhood exposures is consistent with this hypothesis. Thus, the true relationships between adverse childhood exposures and adult health risk behaviors, health status, and diseases may be even stronger than those we report.

An essential question posed by our observations is, "Exactly how are adverse childhood experiences linked to health risk behaviors and adult diseases?" The link-

Table 5. Number of categories of adverse childhood exposure and the prevalence and risk (adjusted odds ratio) of health risk factors including alcohol or drug abuse, high lifetime number of sexual partners, or history of sexually transmitted disease

Health problem	Number of categories	Sample size (N)[a]	Prevalence (%)[b]	Adjusted odds ratio[c]	95% confidence interval
Considers self an alcoholic	0	3,841	2.9	1.0	Referent
	1	1,993	5.7	2.0	(1.6–2.7)
	2	1,042	10.3	4.0	(3.0–5.3)
	3	586	11.3	4.9	(3.5–6.8)
	4 or more	540	16.1	7.4	(5.4–10.2)
	Total	8,002	5.9	—	—
Ever used illicit drugs	0	3,856	6.4	1.0	Referent
	1	1,998	11.4	1.7	(1.4–2.0)
	2	1,045	19.2	2.9	(2.4–3.6)
	3	589	21.5	3.6	(2.8–4.6)
	4 or more	541	28.4	4.7	(3.7–6.0)
	Total	8,029	11.6	—	—
Ever injected drugs	0	3,855	0.3	1.0	Referent
	1	1,996	0.5	1.3	(0.6–3.1)
	2	1,044	1.4	3.8	(1.8–8.2)
	3	587	2.3	7.1	(3.3–15.5)
	4 or more	540	3.4	10.3	(4.9–21.4)
	Total	8,022	0.8	—	—
Had 50 or more intercourse partners	0	3,400	3.0	1.0	Referent
	1	1,812	5.1	1.7	(1.3–2.3)
	2	926	6.1	2.3	(1.6–3.2)
	3	526	6.3	3.1	(2.0–4.7)
	4 or more	474	6.8	3.2	(2.1–5.1)
	Total	7,138	4.4	—	—
Ever had a sexually transmitted disease[d]	0	3,848	5.6	1.0	Referent
	1	2,001	8.6	1.4	(1.1–1.7)
	2	1,044	10.4	1.5	(1.2–1.9)
	3	588	13.1	1.9	(1.4–2.5)
	4 or more	542	16.7	2.5	(1.9–3.2)
	Total	8023	8.2	—	—

[a]Sample sizes will vary due to incomplete or missing information about health problems.
[b]Prevalence estimates are adjusted for age.
[c]Odds ratios adjusted for age, gender, race, and educational attainment.
[d]Indicates information recorded in the patient's chart before the study questionnaire was mailed.

ing mechanisms appear to center on behaviors such as smoking, alcohol or drug abuse, overeating, or sexual behaviors that may be consciously or unconsciously used because they have immediate pharmacological or psychological benefit as coping devices in the face of the stress of abuse, domestic violence, or other forms of family and household dysfunction. High levels of exposure to adverse childhood experiences would expectedly produce anxiety, anger, and depression in children. To the degree that behaviors such as smoking, alcohol, or drug use are found to be effective as coping devices, they would tend to be used chronically. For

Table 6. Relationship between number of categories of childhood exposure and number of risk factors for the leading causes of death[a]

Number of categories	Sample size	% with number of risk factors				
		0	1	2	3	4
0	3,861	56	29	10	4	1
1	2,009	42	33	16	6	2
2	1,051	31	33	20	10	4
3	590	24	33	20	13	7
≥4	545	14	26	28	17	7
Total	8,056	44	31	15	7	3

[a]Risk factors include: smoking, severe obesity, physical inactivity, depressed mood, suicide attempt, alcoholism, any drug use, injected drug use, ≥50 lifetime sexual partners, and history of a sexually transmitted disease.

Table 7. Number of categories of adverse childhood exposure and the prevalence and risk (adjusted odds ratio) of heart attack, cancer, stroke, COPD, and diabetes

Disease condition[d]	Number of categories	Sample size (N)[a]	Prevalence (%)[b]	Adjusted odds ratio[c]	95% confidence interval
Ischemic heart disease	0	3,859	3.7	1.0	Referent
	1	2,009	3.5	0.9	(0.7–1.3)
	2	1,050	3.4	0.9	(0.6–1.4)
	3	590	4.6	1.4	(0.8–2.4)
	4 or more	545	5.6	2.2	(1.3–3.7)
	Total	8,022	3.8	—	—
Any cancer	0	3,842	1.9	1.0	Referent
	1	1,995	1.9	1.2	(1.0–1.5)
	2	1,043	1.9	1.2	(1.0–1.5)
	3	588	1.9	1.0	(0.7–1.5)
	4 or more	543	1.9	1.9	(1.3–2.7)
	Total	8,011	1.9	—	—
Stroke	0	3,832	2.6	1.0	Referent
	1	1,993	2.4	0.9	(0.7–1.3)
	2	1,042	2.0	0.7	(0.4–1.3)
	3	588	2.9	1.3	(0.7–2.4)
	4 or more	543	4.1	2.4	(1.3–4.3)
	Total	7,998	2.6	—	—
Chronic bronchitis or emphysema	0	3,758	2.8	1.0	Referent
	1	1,939	4.4	1.6	(1.2–2.1)
	2	1,009	4.4	1.6	(1.1–2.3)
	3	565	5.7	2.2	(1.4–3.3)
	4 or more	512	8.7	3.9	(2.6–5.8)
	Total	7,783	4.0	—	—
Diabetes	0	3,850	4.3	1.0	Referent
	1	2,002	4.1	1.0	(0.7–1.3)
	2	1,046	3.9	0.9	(0.6–1.3)
	3	587	5.0	1.2	(0.8–1.9)
	4 or more	542	5.8	1.6	(1.0–2.5)
	Total	8,027	4.3	—	—

[a]Sample sizes will vary due to incomplete or missing information about health problems.
[b]Prevalence estimates are adjusted for age.
[c]Odds ratios adjusted for age, gender, race, and educational attainment.
[d]Indicates information recorded in the patient's chart before the study questionnaire was mailed.

example, nicotine is recognized as having beneficial psychoactive effects in terms of regulating affect[49] and persons who are depressed are more likely to smoke.[50,51] Thus, persons exposed to adverse childhood experiences may benefit from using drugs such as nicotine to regulate their mood.[49,52]

Consideration of the positive neuroregulatory effects of health-risk behaviors such as smoking may provide biobehavioral explanations[53] for the link between adverse childhood experiences and health risk behaviors and diseases in adults. In fact, we found that exposure to higher numbers of categories of adverse childhood experiences increased the likelihood of smoking by the age of 14, chronic smoking as adults, and the presence of smoking-related diseases. Thus, smoking, which is medically and socially viewed as a "problem" may, from the perspective of the user, represent an effective immediate solution that leads to chronic use. Decades later, when this "solution" manifests as emphysema, cardiovascular disease, or malignancy, time and the tendency to ignore psychological issues in the management of organic disease make improbable any full understanding of the original causes of adult disease (Figure 2). Thus, incomplete understanding of the possible benefits of health risk behaviors leads them to be viewed as irrational and having solely negative consequences.

Because adverse childhood experiences are common and they have strong long-term associations with adult health risk behaviors, health status, and diseases, increased attention to primary, secondary, and tertiary prevention strategies is needed. These strategies include prevention of the occurrence of adverse childhood experiences, preventing the adoption of health risk behaviors as responses to adverse experiences during childhood and adolescence, and, finally, helping change the health risk behaviors and ameliorating the disease burden among adults whose health problems may represent a long-term consequence of adverse childhood experiences.

Table 8. Number of categories of adverse childhood exposure and the prevalence and risk (adjusted odds ratio) of skeletal fracture, hepatitis or jaundice, and poor self-rated health

Disease condition	Number of categories	Sample size (N)[a]	Prevalence (%)[b]	Adjusted odds ratio[c]	95% confidence interval
Ever had a skeletal fracture	0	3,843	3.6	1.0	Referent
	1	1,998	4.0	1.1	(1.0–1.2)
	2	1,048	4.5	1.4	(1.2–1.6)
	3	587	4.0	1.2	(1.0–1.4)
	4 or more	544	4.8	1.6	(1.3–2.0)
	Total	8,020	3.9	—	—
Ever had hepatitis or jaundice	0	3,846	5.3	1.0	Referent
	1	2,006	5.5	1.1	(0.9–1.4)
	2	1,045	7.7	1.8	(1.4–2.3)
	3	590	10.2	1.6	(1.2–2.3)
	4 or more	543	10.7	2.4	(1.8–3.3)
	Total	8,030	6.5	—	—
Fair or poor self-rated health	0	3,762	16.3	1.0	Referent
	1	1,957	17.8	1.2	(1.0–1.4)
	2	1,029	19.9	1.4	(1.2–1.7)
	3	584	20.3	1.4	(1.1–1.7)
	4 or more	527	28.7	2.2	(1.8–2.7)
	Total	7,859	18.2	—	—

[a]Sample sizes will vary due to incomplete or missing information about health problems.
[b]Prevalence estimates are adjusted for age and gender.
[c]Odds ratios adjusted for age, gender, race, and educational attainment.
[d]Indicates information recorded in the patient's chart before the study questionnaire was mailed.

Primary prevention of adverse childhood experiences has proven difficult[54,55] and will ultimately require societal changes that improve the quality of family and household environments during childhood. Recent research on the long-term benefit of early home visitation on reducing the prevalence of adverse childhood experiences is promising.[56] In fact, preliminary data from the ACE Study provided the impetus for the Kaiser Health Plan to provide funding to participate at 4 locations (including San Diego County, California) in the Commonwealth Fund's "Healthy Steps" program. This program extends the traditional practice of pediatrics by adding one or more specialists in the developmental and psychosocial dimensions of both childhood and parenthood. Through a series of office visits, home visits, and a telephone advice line for parents, these specialists develop close relationships between children and their families from birth to 3 years of age. This approach is consistent with the recommendation of the U.S. Advisory Board on Child Abuse and Neglect that a universal home visitation program for new parents be developed[57,58] and provides an example of a family-based primary prevention effort that is being explored in a managed care setting. If these types of approaches can be replicated and implemented on a large scale, the long-term benefits may include, somewhat unexpectedly, substantial improvements in overall adult health.

Secondary prevention of the effects of adverse childhood experiences will first require increased recognition of their occurrence and second, an effective understanding of the behavioral coping devices that commonly are adopted to reduce the emotional impact of these experiences. The improbability of giving up an immediate "solution" in return for a nebulous long-term health benefit has thwarted many well-intended preventive efforts. Although articles in the general medical literature are alerting the medical community to the fact that childhood abuse is common,[59] adolescent health care is often inadequate in terms of psychosocial assessment and anticipatory guidance.[60] Clearly, comprehensive strategies are needed to identify and intervene with children and families who are at risk for these adverse experiences and their related outcomes.[61] Such strategies should include increased communication between and among those involved in family practice, internal medicine, nursing, social work, pediatrics, emergency medicine, and preventive medicine and public health. Improved understanding is also needed of the effects of childhood exposure to domestic violence.[19,62] Additionally, increased physician training[63] is needed to recognize and coordinate the management of all persons affected by child abuse, domestic violence, and other forms of family adversity such as alcohol abuse or mental illness.

In the meantime, tertiary care of adults whose health problems are related to experiences such as childhood abuse[5] will continue to be a difficult challenge. The relationship between childhood experiences and adult health status is likely to be overlooked in medical practice because the time delay between exposure

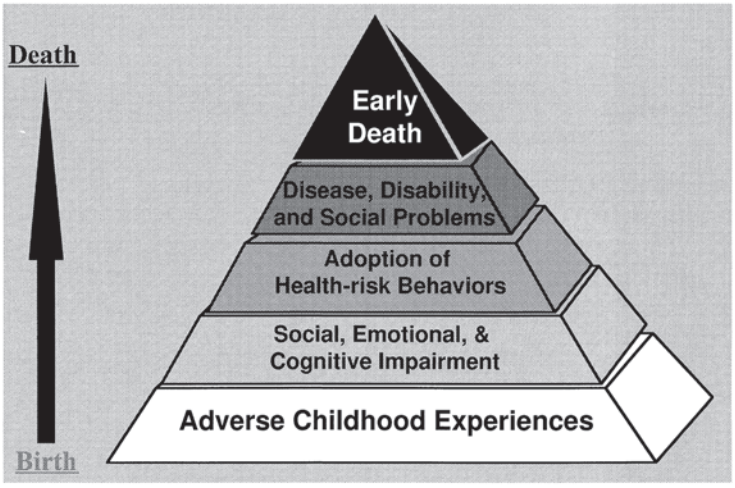

Figure 2. Potential influences throughout the lifespan of adverse childhood experiences.

during childhood and recognition of health problems in adult medical practice is lengthy. Moreover, these childhood exposures include emotionally sensitive topics such as family alcoholism[29,30] and sexual abuse.[64] Many physicians may fear that discussions of sexual violence and other sensitive issues are too personal even for the doctor-patient relationship.[65] For example, the American Medical Association recommends screening of women for exposure to violence at every entrance to the health system;[66] however, such screening appears to be rare.[67] By contrast, women who are asked about exposure to sexual violence say they consider such questions to be welcome and germane to routine medical care,[68] which suggests that physicians' fears about patient reactions are largely unfounded.

Clearly, further research and training are needed to help medical and public health practitioners understand how social, emotional, and medical problems are linked throughout the lifespan (Figure 2). Such research and training would provide physicians with the confidence and skills to inquire and respond to patients who acknowledge these types of childhood exposures. Increased awareness of the frequency and long-term consequences of adverse childhood experiences may also lead to improvements in health promotion and disease prevention programs. The magnitude of the difficulty of introducing the requisite changes into medical and public health research, education, and practice can be offset only by the magnitude of the implications that these changes have for improving the health of the nation.

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United States Government Accountability Office
Report to Congressional Requesters

April 2019

CHILDREN AFFECTED BY TRAUMA

Selected States Report Various Approaches and Challenges to Supporting Children

GAO-19-388

GAO Highlights

Highlights of GAO-19-388, a report to congressional requesters

April 2019

CHILDREN AFFECTED BY TRAUMA

Selected States Report Various Approaches and Challenges to Supporting Children

Why GAO Did This Study

Trauma is a widespread, harmful, and costly public health problem, and its effects are especially detrimental to children. Any frightening, dangerous, or violent event that threatens a child or their loved ones can potentially be traumatic. While not every child who experiences trauma will suffer lasting effects, trauma significantly increases the risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance. GAO was asked to review selected states' efforts to support children affected by trauma.

This report describes (1) the assistance that HHS and Education provide to help state and local agencies support children affected by trauma; (2) how child welfare and education agencies in selected states support these children; and (3) the challenges these agencies have faced in selected states in supporting these children.

GAO interviewed state and local officials in six states that were selected based on recommendations from subject-matter experts and federal officials, among other factors; administered a questionnaire to 16 state agencies in the selected states; interviewed federal officials from HHS and Education; and reviewed relevant federal, state, and local agency documents, such as reports and guidance. Although our findings cannot be generalized to all states, they provide insight into government support for children affected by trauma.

GAO is not making recommendations in this report.

View GAO-19-388. For more information, contact Kathryn A. Larin at (202) 512-7215 or larink@gao.gov.

What GAO Found

The Department of Health and Human Services (HHS) and the Department of Education (Education) provide grants, disseminate information, and fund training and technical assistance to help state and local agencies support children affected by trauma. HHS's Administration for Children and Families and Substance Abuse and Mental Health Services Administration (SAMHSA) have awarded discretionary grants specifically to address childhood trauma. In addition, state and local officials reported making use of other discretionary grants from HHS and Education—as well as formula funds meant for broad purposes like mental health, substance abuse, child welfare, and education—to support their work with children affected by trauma. In terms of non-financial support, state and local officials in six selected states all referred to the National Child Traumatic Stress Network, which is funded by SAMHSA, as an important resource for information, training, and technical assistance. Both HHS and Education have also made other guidance and informational resources available to states.

Officials in child welfare and education agencies in the six selected states reported using a range of approaches to help children affected by trauma, including training staff, screening children, and providing services and support systems. To train child welfare workers, educators, and birth and foster parents to understand trauma and its effects on children, agencies in the six selected states used various approaches, such as learning communities, which include in-person learning and coaching, and online courses. Several state child welfare agencies also used learning communities to train clinicians in trauma-focused therapies. In addition, child welfare and education agencies in five states used screening tools to identify children exposed to and exhibiting symptoms of trauma. Children identified as experiencing trauma are referred for a trauma-informed mental health assessment. Also, to help children affected by trauma, child welfare and education agencies in five of the six states provide support and services. For example, in one state, caseworkers provide specialized services, including weekly visits, to children and families.

Officials in the six selected states reported facing various challenges in their efforts to support children affected by trauma, and they emphasized the importance of engaged leadership in establishing and sustaining support for these children. In three states, officials said that a lack of such leadership hindered their efforts, and they described cases that included delayed, incomplete, or unsuccessful implementation of initiatives. Officials in all six states also talked about limitations on their agency's capacity to support children affected by trauma, including:

- high rates of staff turnover, especially in child welfare;
- limited staff time to dedicate to trauma initiatives;
- lack of clinicians trained in trauma-focused therapies; and
- insufficient funding to support trauma initiatives.

Officials in some states reported strategies they have used to help address these challenges, including providing additional support to employees and coordinating with partner agencies to jointly leverage resources, expertise, and data.

Contents

Abbreviations

ACF	Administration for Children and Families
CMS	Centers for Medicare and Medicaid Services
Education	U.S. Department of Education
HHS	U.S. Department of Health and Human Services
MCO	managed care organization
NCTSI	National Child Traumatic Stress Initiative
NCTSN	National Child Traumatic Stress Network
Project AWARE	Project Advancing Wellness and Resilience Education
SAMHSA	Substance Abuse and Mental Health Services Administration
STS	secondary traumatic stress
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

April 24, 2019

The Honorable Danny K. Davis
Chairman
Subcommittee on Worker and Family Support
Committee on Ways and Means
House of Representatives

The Honorable Richard J. Durbin
United States Senate

Trauma is a widespread, harmful, and costly public health problem, and its effects are particularly detrimental to children, according to the U.S. Department of Health and Human Services (HHS). Children can be exposed to various types of trauma. Any frightening, dangerous, or violent event that threatens the life or safety of a child or their loved ones can potentially be traumatic. For example, in fiscal year 2017, HHS reported that there were approximately 674,000 victims of child maltreatment, including neglect and physical and sexual abuse.[1] In addition, in 2016, students ages 12 through 18 experienced an estimated 749,400 victimizations (theft and nonfatal violent victimization) at school and 601,300 victimizations away from school.[2] While not every child who experiences trauma will suffer lasting effects, studies have shown that for many there are serious short- and long-term consequences. As GAO has previously reported, trauma significantly increases the risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance.[3]

[1]U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment 2017* (Washington, D.C.: Jan. 28, 2019).

[2]For the estimate of victimizations at school, the 95 percent confidence intervals range from 585,000 to 913,000; and for the estimate of victimizations away from school, the 95 percent confidence intervals range from 460,000 to 743,000 for students ages 12-18. See L. Musu-Gilette, A. Zhang, K. Wang, J. Zhang, J. Kemp., M. Diliberti, and B.A. Oudekerk, *Indicators of School Crime and Safety: 2017*, NCES 2018-036 / NCJ 251413 (Washington, D.C.: U.S. Department of Education, National Center for Education Statistics & U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, March 2018).

[3]GAO, *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, GAO-13-15 (Washington, D.C.: Dec. 10, 2012).

You asked us to review how selected states identify and treat children and families who have experienced or are at risk of experiencing trauma. This report examines:

1. the assistance HHS and the U.S. Department of Education (Education) provide to help state and local agencies support children affected by trauma;
2. how child welfare and education agencies in selected states are supporting children affected by trauma; and
3. the challenges child welfare and education agencies in selected states have faced in supporting children affected by trauma.

To address these objectives, we conducted in-person and telephone interviews with state and local officials in six states, and administered a questionnaire to 16 state agencies. The states we selected were Colorado, Massachusetts, North Carolina, Ohio, Washington, and Wisconsin. These states were selected based on four criteria: (1) recommendations from subject-matter experts and federal agency officials; (2) reviews of state child welfare and education agency websites to locate statewide initiatives to support children affected by trauma; (3) variation in state child welfare system administrative frameworks (two state-administered, three county-administered, and one hybrid partially administered by the state and partially administered by counties); and (4) geographic diversity.[4] We spoke with state child welfare officials in all six states and with state education and Medicaid[5]

[4]For purposes of this report, the term "education agency" includes state educational agencies and local educational agencies (specifically, school districts).

[5]Medicaid is a joint federal-state program that finances health coverage for low-income and medically needy individuals. See 42 U.S.C. § 1396 et seq. Certain children in foster care are categorically eligible for Medicaid, such as those receiving foster care maintenance payments under title IV-E of the Social Security Act. States are required to provide Medicaid coverage to such children. Children in foster care who are not eligible under this category may qualify for Medicaid under optional eligibility criteria established by a particular state. According to the Congressional Research Service, nearly all children who are in foster care are eligible for health care services funded via Medicaid. In addition, some children in foster care may be eligible for the State Children's Health Insurance Program, a federal-state program that provides health care coverage to children living in families whose incomes exceed the eligibility requirements for Medicaid. We spoke with Medicaid officials in Colorado, Massachusetts, North Carolina, and Ohio to obtain their perspective because child welfare officials in those states reported challenges in using Medicaid to support children affected by trauma. We did not conduct interviews with state Medicaid agencies in Washington or Wisconsin because child welfare officials in those states did not report facing challenges using Medicaid.

officials in four states.[6] Also, in each state we selected two localities and interviewed local officials from the respective child welfare and education agencies, where practicable. These localities were selected based on recommendations from state officials and geographic diversity (one urban and one rural). In addition, we interviewed officials from other selected state and local agencies and organizations, such as departments of health, interagency trauma groups, universities, and hospitals, as appropriate. We also reviewed relevant state and local child welfare and education agency documents, such as annual reports and policy guidance.

We supplemented and confirmed the information obtained during interviews with state officials through a questionnaire sent to 16 state agencies[7] across the six states from August to October 2018.[8] We pre-tested the questionnaire with three state agencies in Washington and updated the questions based on feedback from those agencies. All 16 agencies completed the questionnaire.

To obtain additional information about the assistance federal agencies provide to help child welfare and education agencies in selected states in their efforts to support children affected by trauma, we interviewed officials from HHS's Administration for Children and Families (ACF), Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS). We also interviewed officials from Education, including officials with the Office of Elementary and Secondary Education. We reviewed relevant agency documents, such as guidance provided to states, issue briefs, and budget documents. Our findings cannot be generalized to states or localities outside our selection sample.

We conducted this performance audit from January 2018 to April 2019 in accordance with generally accepted government auditing standards.

[6]State education officials in North Carolina and Ohio told us that they did not have statewide initiatives to support children affected by trauma, so we did not interview them.

[7]In one of the selected states, two state agencies collaborate on a statewide initiative. We sent the questionnaire to officials in both agencies, but one official was primarily responsible for completing it.

[8]The 16 agencies represent all state-level government agency officials we interviewed, except for state Medicaid agencies. Our interviews with state Medicaid officials were narrowly focused on challenges raised by child welfare officials, so we did not ask state Medicaid officials to complete the questionnaire.

Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Childhood Trauma

Trauma or adverse childhood experiences[9] may include physical and sexual abuse, neglect, bullying, community-based violence, extreme poverty, the loss of a parent or primary caretaker, or natural disasters, among other things. These experiences may overwhelm a child's natural ability to cope[10] and can cause stress reactions in children, including feelings of intense fear, terror, and helplessness.[11] When children are exposed to chronic stressful events, their neurodevelopment can be disrupted. As a result, a child's cognitive functioning or ability to cope with negative or disruptive emotions may be impaired, causing long-term harm to their physical, social, and emotional well-being.[12] These adverse effects may include changes in a child's emotional responses; ability to think, learn, and concentrate; impulse control; self-image; attachments to caregivers; and relationships with others. Traumatic experiences have been linked to a wide range of health-related conditions, including addiction, depression and anxiety, and risk-taking behavior, and may also

[9]Adverse childhood experiences are stressful or traumatic events, including abuse and neglect. In a landmark study, researchers from the Centers for Disease Control and Prevention and Kaiser Permanente found a "strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults." V. Felitti, MD, FACP; R. Anda, MD, MS; D. Nordenberg, MD; D. Williamson, MS, PhD; A. Spitz, MS, MPH; V. Edwards, BA, M. Koss, PhD; and J. Marks, MD, MPH, "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*, Volume 14, Number 4, (1998), p. 245.

[10]U.S. Department of Health and Human Services, Children's Bureau, Child Welfare Information Gateway, *Developing a trauma-informed child welfare system* (Washington, D.C.: 2015).

[11]Vanessa Sacks and David Murphey, Child Trends, *The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity* (Feb. 12, 2018), accessed March 13, 2018.

[12]Child Welfare Information Gateway, *Developing a trauma-informed child welfare system.*

increase the likelihood of chronic ill health conditions, such as obesity, diabetes, heart disease, cancer, and even early death. Not all children will experience all of these effects. Children's responses to traumatic events are unique and affected by many factors, including their age at the time of the event, the frequency and perceived severity of trauma, and the child's innate sensitivity, as well as protective factors such as the presence of positive relationships with healthy caregivers, physical health, and natural coping skills.[13]

While all children can be affected by trauma, trauma is common among children who enter the child welfare system.[14] Many of these children have been abused or neglected, and involvement in the child welfare system, primarily through placements into a foster care home, may cause additional trauma due to the separation from family; changes in school placement, neighborhood, and community; as well as fear and uncertainty about the future. Child welfare experts generally believe that child welfare systems that use trauma-informed approaches[15] are better able to

[13]Child Welfare Information Gateway, *Developing a trauma-informed child welfare system.*

[14]Other subpopulations may also be likely to experience trauma, such as homeless children, children who live in unsafe neighborhoods, and unaccompanied alien children—those under 18 years old with no lawful immigration status and no parent or legal guardian in the United States available to provide care and physical custody. During the 2015-16 school year, there were 1.3 million homeless students enrolled in the nation's public school districts. Also, in 2017, GAO reported that the safety of a child's environment, including their neighborhood, can affect a wide range of health, functioning, and quality-of-life outcomes and risks, including a child's sense of security and well-being. See National Center for Homeless Education, Federal Data Summary: School Years 2013-14 to 2015-16, Education for Homeless Children and Youth (Browns Summit, NC: Dec. 2017); GAO, *Child Well-Being: Key Considerations for Policymakers, Including the Need for a Federal Cross-Agency Policy Goal*, GAO-18-41SP (Washington, D.C.: Nov. 9, 2017); and Statement of Jack P. Shonkoff, M.D., Director, Center on the Developing Child at Harvard University, before the Energy and Commerce Committee, Subcommittee on Oversight and Investigations, United States House of Representatives, February 7, 2019.

[15]According to SAMHSA, a program, organization, or system that is trauma-informed: (1) realizes the widespread impact of trauma and understands potential paths for recovery; (2) recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; (3) responds by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) seeks to actively resist re-traumatization.

address children's safety, permanency, and well-being needs.[16] Although trauma-informed frameworks may vary, they generally include interventions as well as a change in culture; thus if an agency or organization is taking a trauma-informed approach, it is incorporating knowledge of trauma and its effects into its policies, procedures, and practices. A trauma-informed child welfare system may offer services to help identify and mitigate the effects of trauma, including screening and assessing children for trauma, and providing or referring children to services. These approaches may produce improved outcomes for children in the child welfare system, including fewer children requiring crisis services, such as residential treatment, and fewer foster home placements, placement disruptions, and reentries into foster care. Other trauma-informed approaches may result in reduced lengths of stay in foster care and improved child functioning and increased well-being.[17]

In addition to child welfare agencies, school staff and members of the school community can play a key part in recognizing and responding to children who have experienced trauma. In a 2017 report on child well-being, GAO reported that an expert noted that health and human service agencies are not the only entities needed to address child well-being and suggested that community stakeholders work together to determine what resources are needed for the children in their community.[18] A trauma-informed school, characterized by an understanding and a commitment of teachers and staff to an awareness of how trauma affects students, is an example of a coordinated approach to trauma. Trauma-informed teachers and staff are aware of trauma's impact on students' behavior, their relationships, their ability or inability to self-regulate behavior, and how it

[16]Federal funding is available to states to support their child welfare and foster care programs under Titles IV-B and IV-E of the Social Security Act. In 2018, the Act was amended to enable states to use federal funds provided under Title IV-B and Title IV-E to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services. The law requires that any such services provided under Title IV-E be trauma-informed. Bipartisan Budget Act of 2018, Pub. L. No. 115-123, §§ 50701-50734, 132 Stat. 64, 232-253. ACF published program instructions about the Title IV-E prevention and family services programs in November 2018. Department of Health and Human Services, Administration on Children, Youth and Families, Administration for Children and Families, Children's Bureau, *Program Instruction: State Requirements for Electing Title IV-E Prevention and Family Services Programs*, ACYF-CB-PI-18-09 (Washington, D.C: Nov. 30, 2018).

[17]Child Welfare Information Gateway. *Developing a trauma-informed child welfare system.*

[18]GAO-18-41SP.

contributes to their classroom behavior. Specific elements of a trauma-informed school may include addressing and treating traumatic stress, developing partnerships with students and families, evaluating and revising school discipline policies and practices, and creating a trauma-informed learning environment.[19]

Trauma Treatments and Approaches

Federal agencies, academic institutions, and community-based treatment centers have generated evidence-based trauma treatments that clinicians and therapists can use when working with children and their families.[20] See table 1 for examples of treatments.

Table 1: Selected Evidence-Based Treatments

Attachment, Self-Regulation, and Competency	Includes multiple modalities, such as individual, group and family treatment; parent workshops; and a home-based prevention program. The approach addresses how a child's entire system of care can become trauma-informed to better support trauma-focused therapy.
Child-Parent Psychotherapy	Focuses on the way the trauma has affected the parent-child relationship, and the family's connection to their culture and cultural beliefs, spirituality, immigration experiences, and parenting practices, among other things.
Early Pathways	Focuses on helping caregivers better understand and manage their child's behavior and emotional problems; strengthening the child's prosocial behaviors and setting limits on challenging behaviors; and learning trauma-informed strategies to include safety, calming techniques, and recovery, among other things.
Parent-Child Interaction Therapy	Treats young children exposed to interpersonal violence. It offers concrete, practical parenting skills. The emphasis is on changing negative parent/caregiver child patterns.
Structured Psychotherapy for Adolescents Responding to Chronic Stress	Designed as a group treatment to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault).
Trauma Focused-Cognitive Behavioral Therapy	Focuses on development of skills for regulating behavior; improving relationships; and enhancing safety, trust, parenting skills, and family communication

Source: GAO summaries from National Child Traumatic Stress Network fact sheets. | GAO-19-388

[19]Individuals with experiences of trauma are found in multiple service sectors. In addition to child welfare and education agencies, trauma-informed approaches can be adapted to other sectors, such as criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach,* 14-4884 (Rockville, MD: 2014).

[20]Evidence-based programs generally indicate those interventions and activities that evaluations have shown to be effective at addressing a particular outcome.

Recent studies have also found that trauma-informed approaches that are infused into the practices and work of child welfare and school staff can help children, their families, and others. While these studies are limited in terms of the number of participants, they indicate the positive effects of including trauma-informed approaches into the work of child welfare staff and educators. For example, one study that used child welfare administrative data for about 1,500 children from Kansas found that implementing a trauma-informed approach was associated with improved child well-being and placement stability for children in foster care.[21] Another study of two public child welfare agencies that involved 52 children, as well as child welfare staff, mental health providers, and foster parents and kinship caregivers, suggests, among other things, that fewer children exited foster homes for negative reasons, such as running away or moving to a group home, when families were trained in a trauma-informed approach.[22] In addition, a study of 126 female youths residing in two treatment centers in Massachusetts suggests that the youth at the center receiving the trauma-informed approach experienced a reduction in post-traumatic stress disorder symptoms compared with the youth in the residential center that did not offer this approach.[23] A study of five schools that adopted a trauma-sensitive approach also reported positive outcomes. For example, the study found a decrease in disciplinary actions, and staff at one school reported that the school felt safer and calmer. School staff also reported improved relations among colleagues

[21]Researchers studied the effectiveness of a research-informed therapeutic model, Trauma Systems Therapy, implemented across a child welfare system. K. Murphy, K. Anderson Moore, Z. Redd, K. Malm, "Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative," *Children and Youth Services Review*, 75 (2017): 23–34.

[22]This study examined how a trauma-informed care approach (Trauma Systems Therapy-Foster Care, an adapted version of Trauma Systems Therapy for foster care) was implemented in two child welfare agencies. Jessica Dym Bartlett, Berenice Rushovich, Martha Beltz, Esther Gross, and Ann Schindler, Child Trends, *Evaluation of the Implementation of Trauma Systems Therapy-Foster Care in a Public Child Welfare Setting* (Nov. 17, 2017), accessed March 28, 2018.

[23]The residential treatment centers used the evidenced-based, trauma-informed treatment Attachment, Regulation and Competency, an intervention for children with complex trauma. H. B. Hodgdon, K. Kinniburgh, D. Gabowitz, M. E. Blaustein, and J. Spinazzola, "Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework," *Journal of Family Violence*, vol. 28 (2013): 679–692.

and with students, as well as better relations between students and increased parent engagement.[24]

HHS and Education Provide Grants, Disseminate Information, and Fund Training and Technical Assistance to Help State and Local Agencies Support Children Affected by Trauma

HHS and Education Provide Multiple Sources of Funding That State and Local Agencies Can Use to Support Children Affected by Trauma

HHS's ACF and SAMHSA have awarded discretionary grants to states specifically to address childhood trauma. From 2011 to 2013, ACF awarded 20 state and local agencies and other organizations discretionary grants to address childhood trauma, according to ACF officials, totaling about $58 million.[25] Each grantee, including two state child welfare agencies and a county agency as well as two universities in five of the six states we selected to review, received up to 5 years of

[24]"The Trauma and Learning Policy Initiative, a joint program of Massachusetts Advocates for Children and Harvard Law School, developed an inquiry-based process for creating trauma-sensitive schools, which was implemented by educators in four elementary and one middle-high school over the course of two school years." Wehmah Jones, Juliette Berg, and David Osher, *Trauma and Learning Policy Initiative (TLPI): Trauma-Sensitive Schools Descriptive Study* (Washington, D.C.: American Institutes for Research, October 2018).

[25]These funding opportunities were referred to as: Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service Delivery; Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare; and, Promoting Well-Being and Adoption after Trauma. All three grants were administered under the authority of the Adoption Opportunities Program, see 42 U.S.C. § 5113. As part of its administration of these grants, ACF provided technical assistance to states and convened annual conferences so grantees could share information with each other. Several grantees collaborated to publish articles about their efforts to support children affected by trauma.

funding. The grants were used to screen and refer children to treatment, implement or expand trauma-focused, evidence-based treatments, and bridge the gap between child welfare and mental health. According to HHS officials, funding for the last of these grants will end in September 2019.

SAMHSA also awards discretionary grants specifically to address childhood trauma to state and local agencies, universities, and other organizations through an initiative to transform mental health care for children and adolescents affected by trauma. The National Child Traumatic Stress Network (NCTSN), a collaborative network of experts created through the National Child Traumatic Stress Initiative (NCTSI),[26] conducts research on trauma treatment approaches and provides services to children affected by trauma. In fiscal year 2017, SAMHSA received over $48 million for the NCTSN, and it awarded four new grants and supported 82 5-year grant continuations through NCTSI. Officials that we spoke with from one state child welfare agency, three universities, and two nonprofits in four of the selected states received grants through this initiative. Several of these entities used these funds to train clinicians and educate other child serving professionals about trauma and mental health conditions.

In addition to grants that were specifically meant to address childhood trauma, the selected states used other HHS discretionary grants to support children affected by trauma. For example, officials from five state education agencies in the selected states told us that they received SAMHSA's Project Advancing Wellness and Resilience Education (Project AWARE) grant.[27] Wisconsin officials also said they received

[26]NCTSI is authorized under the Children's Health Act of 2000, see 42 U.S.C. § 290hh-1. Established in 2000, the National Child Traumatic Stress Initiative (NCTSI) seeks to improve the quality of community-based trauma treatment and services and increase access to effective trauma-focused interventions.

[27]Through Project AWARE, education agencies may receive funds to increase awareness of mental health conditions among school-age youth, prepare educators and other adults to detect and respond to such conditions, and connect youth with appropriate services. These Project AWARE grants are authorized under the Public Health Service Act, as amended, see 42 U.S.C. § 290bb-32.

Education's School Climate Transformation Grant,[28] which was used to create the state's trauma-sensitive schools initiative. Washington officials credited SAMHSA's Mental Health Transformation Grant[29] with driving the state's initial trauma-informed work, including its guide about trauma in schools.[30]

State agency officials also reported using formula funds, meant for broad purposes like mental health, substance abuse, child welfare, and education, to support their work with children affected by trauma. Officials from five agencies in the selected states reported using formula funding from Title IV-E of the Social Security Act to help children affected by trauma.[31] According to Colorado officials, the state's Title IV-E waiver has allowed child welfare workers to screen, assess, and provide interventions that are trauma-informed.[32] Also, North Carolina officials told us that Title IV-E, combined with other funding sources, has helped pay for trauma-informed learning communities to help counties build trauma-informed programming. Two states reported using the Substance Abuse

[28]Education administers the School Climate Transformation Grant program, which provides competitive grants to state and local educational agencies to develop, enhance, or expand systems of support for schools implementing an evidence-based, multi-tiered behavioral framework for improving behavioral outcomes and learning conditions for all students. These grants are authorized under Title IV-F of the Elementary and Secondary Education Act of 1965, as amended, see 20 U.S.C. § 7281.

[29]The Mental Health Transformation Grant program was intended to support changes in the organization, management, and delivery of public mental health services. Grants were administered by SAMHSA and authorized under the Public Health Service Act, see 42 U.S.C. 290bb-32. The final 5-year grants were awarded in fiscal year 2010, according to HHS officials.

[30]Ray Wolpow, Mona M. Johnson, Ron Hertel, and Susan O. Kincaid, *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success* (WA: Washington State Office of Superintendent of Public Instruction, September 2009), accessed July 23, 2018.

[31]Title IV-E authorizes the large majority of federal funding dedicated to child welfare, with funds chiefly available for specific foster care and adoption expenses. Title IV-E is codified at 42 U.S.C. §§ 670-679c.

[32]HHS was authorized to waive certain Title IV-E requirements to enable states to carry out approved demonstration projects. HHS was authorized to approve new demonstration projects through FY 2014. Demonstration projects are generally limited to five years and may not continue after September 30, 2019. See 42 U.S.C. § 1320a-9.

and Mental Health Block Grants.[33] (See table 2 for additional grants states reported using to support children affected by trauma.)

Table 2: Selected Federal Funding Sources Used to Support Children Affected by Trauma as Cited by Selected State Officials

Federal funding sources	CO	MA	NC	OH	WA	WI
Department of Health and Human Services						
Discretionary grants						
Administration for Children and Families trauma grants[a]	-	✓	✓	-	✓	-
Mental Health Transformation Grants	-	-	-	✓	✓	-
National Child Traumatic Stress Initiative Grants	-	-	✓	-	-	✓
Project Advancing Wellness and Resilience Education (Project AWARE) Grants	✓	-	✓	✓	✓	✓
Safe Schools, Healthy Students Initiative Grants[b]	-	-	-	-	-	✓
System of Care Expansion Planning Grants[c]	✓	-	-	✓	-	-
Formula funds						
Medicaid[d]	✓	✓	✓	✓	✓	✓
State Opioid Response Grants[e]	-	-	-	✓	-	-
State Targeted Response to the Opioid Crisis Grants[f]	-	-	-	✓	-	-
Social Services Block Grants[g]	-	-	✓	-	✓	-
Substance Abuse and Mental Health Block Grants	-	-	-	✓	-	✓
Temporary Assistance for Needy Families[h]	-	-	✓	-	✓	-
Title IV-B of the Social Security Act[i]	-	-	✓	✓	✓	✓
Title IV-E of the Social Security Act	✓	-	✓	✓	✓	✓
Department of Education						
Discretionary grants						
State Personnel Development Grants[j]	✓	-	-	-	-	-
School Climate Transformation Grants	-	-	-	-	-	✓
Formula funds						
Title I-A of the Elementary and Secondary Education Act[k]	-	-	-	-	✓	-

[33]The Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (Substance Abuse and Mental Health Block Grants) provide funds and technical assistance for substance abuse and mental health services. These grants are administered by SAMHSA and authorized under the Public Health Service Act. See 42 U.S.C. § 300x *et seq*.

Federal funding sources	CO	MA	NC	OH	WA	WI
Title IV-A of the Elementary and Secondary Education Act[l]	-	-	-	-	✓	-

Legend: ✓ = Officials at one or more state agencies reported using funding source to support children affected by trauma.

Source: GAO analysis of questionnaire responses received August-November 2018. | GAO-19-388

Note: With two exceptions, officials are points of contact at the 16 state child welfare, education, and other agencies—such as departments of health—which completed our questionnaire across the six states. For Massachusetts and Wisconsin, statements about Medicaid from our interviews with state child welfare officials were used to supplement questionnaire responses. Additionally, North Carolina and Ohio education agencies were not asked to complete the questionnaire because officials in these states told us that they did not have statewide initiatives to support children affected by trauma, but a state education official in each state told us that they have received Project Advancing Wellness and Resilience Education grants.

[a]The ACF's Children's Bureau awarded trauma-focused discretionary grants across three cohorts from 2011 to 2013.

[b]Launched in 1999 as a joint program of the Departments of Education, Health and Human Services, and Justice, the Safe Students, Healthy Schools Initiative has awarded grants to school districts to prevent youth violence and promote healthy development of youth.

[c]System of Care Expansion Planning Grants are administered by SAMHSA and intended to facilitate adoption of a system of care approach for children and youth with serious emotional disturbances. SAMHSA has not awarded these grants since 2014, according to officials.

[d]Although the Massachusetts and Wisconsin officials who completed our questionnaire did not mention Medicaid as a source of funding to support children affected by trauma, under the Medicaid program, states are required to provide eligible children under age 21 with coverage for certain health services, which may include mental health services, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, state child welfare officials we interviewed in both of these states talked about using Medicaid to support children affected by trauma. For example, the Wisconsin Department of Health Services and the Department of Children and Families partnered to implement Care4Kids, a program designed to offer comprehensive and coordinated health services for children in foster care. The Care4Kids program creates a "medical home" team for children in foster care, assuring that children receive individualized treatment plans in order to address their specific health care needs, including trauma-related care.

[e]State Opioid Response Grants are administered by SAMHSA and aim to address the opioid crisis by increasing provision of prevention, treatment, and recovery activities for opioid use disorder.

[f]State Targeted Response to the Opioid Crisis Grants are administered by SAMHSA and aim to address the opioid crisis by increasing provision of prevention, treatment, and recovery activities for opioid use disorder.

[g]Social Services Block Grant goals include, among others, preventing or remedying child abuse and neglect, preventing or reducing inappropriate institutional care, and achieving or maintaining self-sufficiency.

[h]Temporary Assistance for Needy Families is a block grant that supports four overarching goals, including providing assistance to needy families so that children can live in their homes or the homes of relatives.

[i]Title IV-B of the Social Security Act authorizes federal funds to support state child welfare programs and services. In addition to formula grants under the Stephanie Tubbs Jones Child Welfare Services program and the Promoting Safe and Stable Families program, Title IV-B also authorizes some discretionary grants.

[j]The Individuals with Disabilities Education Act authorizes federal funds for the State Personnel Development Grants program. The program provides grants to help state educational agencies reform and improve their training and professional development systems for individuals who serve children with disabilities.

[k]Title I-A of the Elementary and Secondary Education Act of 1965, as amended, provides formula grants to states for their school districts to improve educational programs in schools with high concentrations of students from low-income families.

[l]Title IV-A of the Elementary and Secondary Education Act of 1965, as amended by the Every Student Succeeds Act, authorizes the Student Support and Academic Enrichment program, which is intended to increase the capacity of state and local education agencies, schools, and local communities to provide all students with a well-rounded education and to improve school conditions and the use of technology.

In addition to federal funding, officials in the six selected states reported receiving state funding to support children affected by trauma. For example, officials in North Carolina told us that, in 2013, the North Carolina General Assembly appropriated $1.8 million in annually recurring funds to train clinicians in evidence-based trauma treatments. Also, in Massachusetts, state funding may be used to create and support trauma-sensitive initiatives in schools, among other things. In addition to state funding, officials in three of the selected states reported using nonprofit funding to support their efforts.

HHS and Education Share Information and Fund Training and Technical Assistance to Help State and Local Agencies Support Children Affected by Trauma

HHS offers information and funds training and technical assistance to help state and local agencies support children affected by trauma.[34] For example, state and local child welfare officials in each of the six selected states cited the National Child Traumatic Stress Network (NCTSN) as an important resource for information, training, or technical assistance.[35] State and local officials in four of the selected states told us that they use the NCTSN's Child Welfare Trauma Training Toolkit curriculum to train their staff. The curriculum, designed to be completed in about 13 hours, covers topics such as the essential elements of a trauma-informed child welfare system, the impact of trauma on the brain and body, and the

[34]The Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which was enacted on October 24, 2018, directs federal agencies to take several actions related to trauma-informed care. Among other things, it authorizes HHS to collect and report data on adverse childhood experiences, and it requires HHS to disseminate information and resources to early childhood care and education providers on how to recognize children impacted by trauma and respond appropriately. The act also establishes an Interagency Task Force on Trauma-Informed Care, comprised of various components within HHS, Education, and the Departments of Veterans Affairs and Justice, among others, to identify, evaluate, and make recommendations regarding: (1) best practices with respect to children and youth who have experienced or are at risk of experiencing trauma, and (2) ways in which federal agencies can better coordinate to improve the federal response to families impacted by substance use disorders and other forms of trauma. In addition, the act authorizes HHS to award grants, contracts, or cooperative agreements to state and local education agencies for the purpose of increasing student access to evidence-based trauma support services and mental health care. See Pub. L. No. 115-271, §§ 7131-7135, 132 Stat. 3894, 4046-56 (2018). Given its recent enactment, we did not review the implementation of this law for this report.

[35]The NCTSN develops and disseminates interventions and resource materials, offers education and training programs, and engages in data collection and evaluation, among other activities, to help education and child welfare agencies and others support children affected by trauma. As noted earlier, NCTSN is part of SAMHSA's NCTSI and is comprised of its current and former grantees.

identification of trauma-related needs of children and families.[36] Also, two state child welfare agencies told us that they use the Resource Parent Curriculum to train foster parents and others about trauma, and another used the Think Trauma curriculum to prepare trainers of group home and residential center staff; both curricula are provided through the NCTSN.[37] In addition, the NCTSN makes other resources available to state and local communities on its website. For example, NCTSN offers fact sheets about various assessments and treatments, including those mentioned in table 1, as well as two evidence-based treatments for use in school settings.[38]

In addition to information and training provided through the NCTSN, in 2012, HHS's ACF issued guidance to encourage state child welfare directors to focus on improving behavioral and social-emotional outcomes for children who have experienced abuse or neglect. In 2013, SAMHSA, in collaboration with ACF and CMS, issued joint guidance to encourage the integrated use of trauma-focused screening, functional assessments, and evidence-based practices in child-serving settings.[39] Also, in 2014, SAMHSA, in an effort to help service sectors, such as child welfare, education, and juvenile justice, become more trauma-informed, released *Concept of Trauma and Guidance for a Trauma-Informed Approach*. This

[36]The NCTSN also offers a Child Trauma Toolkit for Educators.

[37]The Resource Parent Curriculum helps foster parents to understand how traumatic events may impact children and to recognize behaviors as symptoms of those experiences. Think Trauma provides an overview for juvenile justice staff of how to work towards creating a trauma-informed juvenile justice residential setting. According to a summary of the curriculum, creating a trauma-informed setting is a process that requires not only knowledge acquisition and behavioral modification, but also cultural and organizational paradigm shifts and policy and procedural change at every level of the facility.

[38]The two evidence-based treatments, Bounce Back and Support for Students Exposed to Trauma, are aimed at relieving symptoms of child traumatic stress, anxiety, depression, and functional impairment among children, ages 5-11 and 10-16, respectively. Bounce Back includes group sessions where children learn and practice feelings of relaxation, problem solving, and conflict resolution, among other activities. Support for Students Exposed to Trauma includes 10 lessons in which children learn about common reactions to trauma, practice relaxation, learn problem solving skills, build social support, and process the traumatic event. Between sessions, children practice the skills they have learned. For more information, see NCTSN fact sheets on Bounce Back and Support for Students Exposed to Trauma.

[39]As GAO noted in a previous report, enhancing the well-being of children requires a coordinated federal approach
that takes into account the interrelatedness of federal actions and policies that aim to improve the lives of children. See GAO-18-41SP.

document included a framework of key assumptions and principles of a trauma-informed approach. SAMHSA intended that the trauma framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families, and communities. (See table 3.)

Table 3: Summary of Substance Abuse and Mental Health Services Administration's Trauma-Informed Care Framework for State, Local, or Nonprofit Organizations

Key assumptions	
Realization	Staff realize and understand trauma's effects on individuals, families, groups, organizations, and communities.
Recognize	Staff recognize the signs of trauma.
Respond	Staff respond to people with the understanding that traumatic events affect all people involved.
Resist re-traumatization	Staff seek to not re-traumatize their clients.
Key principles	
Safety	Staff and clients should feel physically and psychologically safe.
Trustworthiness and transparency	Staff build and maintain trust with their clients and each other to ensure transparency.
Peer support	Children or family members who have also experienced trauma support each other to promote recovery.
Collaboration and mutuality	Staff and clients build and maintain relationships, recognizing that everyone can help people heal from trauma.
Empowerment, voice, and choice	Staff foster clients' empowerment and support clients' shared decision making.
Cultural, historical, and gender issues	Staff respond to the racial, ethnic, and cultural needs of their clients by overcoming stereotypes and biases.
Examples for implementing a trauma-informed care organization	
Organization's physical environment	Physical spaces feel safe, open, and transparent, and there are shared spaces for staff and clients.
Screening, assessment, and treatment services	Practitioners are trained in and use evidence-based therapies that reflect trauma-informed care principles.
Evaluation	Staff design trauma-informed care focused evaluations that measure service and program implementation.

Source: GAO summary of SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. | GAO-19-388

Note: Besides SAMHSA's framework, other organizations, such as nonprofits, have developed models to help organizations incorporate awareness of trauma into their work.

In addition to the information and training and technical assistance referenced above, HHS and Education fund technical assistance centers and make other resources available to states, including:

- SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint offers technical assistance to various publicly-funded systems and organizations on issues relating to trauma education, among other things.
- Education's Readiness and Emergency Management for Schools Technical Assistance Center helps local education agencies before, during, and after emergency situations. Among its various activities, this technical assistance center offers information and technical assistance to local education agencies and others on Psychological First Aid for Schools, which is an intervention model to assist students, staff, and families in the immediate aftermath of an emergency.
- Education's National Center on Safe Supportive Learning Environments as well as its Positive Behavioral Interventions and Supports Technical Assistance Center offer an array of materials about trauma and approaches to supporting children affected by it.
- ACF, through its Child Welfare Information Gateway website, provides information on building trauma-informed systems, assessing and treating trauma, and addressing secondary trauma in caseworkers. It also offers trauma resources for caseworkers, caregivers, and families, as well as information about trauma training. In some instances, the website directs users to SAMHSA or the NCTSN's website.

Selected States Use Various Approaches to Support Children Affected by Trauma

Officials we spoke with in the six selected states told us they used a variety of approaches to help staff understand trauma and its effects on children, identify children affected by trauma, and provide support to them. These approaches range from training child welfare workers, educators, and clinicians to screening children for symptoms caused by traumatic experiences. They also include developing support systems, including providing services, to children and their families who need more help. While we did not evaluate the effectiveness of the selected state and county initiatives, many of them incorporate key trauma principles and activities cited in the SAMHSA framework above.[40] For additional

[40]For this review, we did not evaluate the effectiveness of the selected states' or counties' initiatives. Also, we did not independently verify the information provided, but

information on examples of approaches taken in each selected state and in selected counties, see appendixes I and II.

Training

State and local child welfare and education agency officials in the six selected states use various approaches to train staff and birth and foster parents[41] about trauma and its effects on children and families. Child welfare officials in two states, Wisconsin and North Carolina, told us that they use learning communities to train staff, and in some instances, foster parents. For example, North Carolina's child welfare agency used a learning community approach—which included face-to-face training, as well as coaching and practice, over an extended period—to work with child welfare staff in 32 of the state's 100 counties, according to a state official. In a 2016 agency report, state officials reported that the 9- to 12-month learning community process was designed to allow staff the time required to become steeped in trauma knowledge, to learn how to spread that knowledge into skills and practices, and to develop a sustainable program. Conversely, state and local education and child welfare officials in three states told us that they use online learning or university coursework to train staff. For example, Wisconsin education agency officials told us that they developed a three-tiered training, including online modules for educators and school staff. The modules are designed for self-study and, among other things, include guidance on making policies and procedures more trauma-sensitive, as well as information about the characteristics of safe, supportive learning environments. Also, Massachusetts state child welfare officials told us that they partnered with three universities to provide trauma-focused courses to child welfare workers, and local school officials told us that a university offers a graduate certificate in trauma and learning to area educators.

In addition to training staff, state and local child welfare agency officials in four of six selected states told us they train clinicians in trauma-focused, evidence-based therapies. For example, Wisconsin child welfare officials told us that clinicians participate in learning communities where they receive training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based therapy. Clinicians participate in 5 days of in-person training, receive 16 consultation calls with a trainer, and complete

corroborated, when possible, the information we received during our state and county interviews with relevant state documents. We provided officials the opportunity to review the content for accuracy and provide revisions or corrections.

[41]These parents can also include kinship caregivers.

a 10-hour, self-paced webinar. According to Wisconsin's child welfare website, clinicians who complete the training are eligible for certification as TF-CBT therapists and can be listed on a national website of certified clinicians.[42] Similarly, North Carolina's state child welfare agency, in partnership with a nonprofit organization, trains clinicians in four trauma-focused, evidence-based therapies, including TF-CBT and Parent-Child Interaction Therapy. Similar to the Wisconsin effort, over the course of a year, clinicians learn about these therapies and practice them with children and families.

Screening

While training staff and parents is important to broaden understanding of trauma and its impact on affected children, identifying these children is also key to helping them receive needed support, including trauma-focused treatment. State and local child welfare and education officials in five of the six selected states told us that they screen certain children to determine whether they have experienced trauma, are exhibiting symptoms of trauma, or need to be referred for a trauma-informed mental health assessment. For example, North Carolina and Washington child welfare officials told us they screen children for trauma when they enter the child welfare system. North Carolina counties that participated in the state's training efforts, described above, use two screening tools: one for children under age 6 and the other for those ages 6 through 21. The social worker, with input from the caregiver, completes the screening tool for children under age 6. Older children are asked questions about their exposure to trauma, including physical abuse, domestic violence, sexual abuse, and other traumatic events. According to the North Carolina child welfare agency, the trauma screen has a number of benefits for child welfare practice, including informing placement decisions for the youth, prioritizing children who might need to receive treatment quickly, and providing the mental health professional with a better understanding of a child's issues. Child welfare officials in Washington also reported integrating trauma screening into the state's child screening program, using a 2012 ACF trauma grant.[43] Children and youth are screened within 30 days of placement in foster care if officials expect them to remain in

[42]When we spoke with Wisconsin officials in May 2018, they planned to expand their training program for clinicians to include Child-Parent Psychotherapy. The 18-month program would be coordinated by the University of Wisconsin-Madison.

[43]As described earlier in this report, ACF awarded trauma-related discretionary grants in 2011, 2012, and 2013. Among the recipients of these grants are university and state government entities in four of the six selected states—Colorado, Massachusetts, North Carolina, and Washington.

care 30 days or more. With these grant funds, officials reported that Washington's child welfare agency added a tool to screen for children's trauma symptoms and developed a protocol that rescreens these children every 6 months.[44] In addition, education agency officials from three states told us that schools have developed processes to identify students who may have experienced trauma. For example, one Wisconsin school district official told us that any staff member, family member, or student can refer a student for screening. This official explained that the school district formed school-based teams to review information, such as data on suspensions and class disruptions, to identify at-risk students. In addition to the screening process, the school district developed school-based and community mental health service partnerships at 23 schools where therapists provide mental health services, according to this official.

Support Systems

State and local child welfare and education agency officials in five of six selected states told us they have developed support systems, which can include providing services, to try to help children affected by trauma. For example, Colorado and Ohio child welfare agencies have spearheaded efforts to provide services and support to children who may have experienced trauma. The Colorado child welfare agency, as part of its system of care, uses an evidence- and team-based planning model, referred to as high-fidelity wraparound services, to manage care for children with or at risk of serious emotional disturbance and who are involved in multiple systems, such as the child welfare and juvenile justice systems.[45] As part of these wraparound services, county child welfare staff and local service providers and professionals work with the family to create a plan for them and their children. A coordinator sets up meetings, oversees the plan, and makes sure all team members participate in achieving the plan's goals. In addition to the coordinator, a family advocate provides peer support, via weekly visits, to parents and caregivers of youth receiving wraparound services. In addition, depending on the needs of the child, wraparound services may include participating

[44]Trauma screening tools include the Pediatric Symptom Checklist and Screen for Child Anxiety Related Emotional Disorders. A Washington child welfare official explained that they started using the Screen for Child Anxiety Related Emotional Disorders tool to screen for trauma because it is more sensitive than the Pediatric Symptom Checklist to identify symptoms of trauma, such as anxiety and Post-Traumatic Stress Disorder. In addition to these two screening tools, they reported piloting other trauma screening tools to use for children ages 3-7.

[45]The Colorado child welfare agency collaborates with the Office of Behavioral Health to implement Colorado's Trauma Informed System of Care, or COACT Colorado. As of February 2019, 17 counties participate in this effort.

in a support group or meeting with a therapist or grief counselor, among other things. In Ohio, child welfare officials in two counties told us about a partnership that provides services to children and their families who have experienced trauma because of parents' substance use disorder.[46] As part of the program, children and parents are screened for trauma and may get referred for treatment and services. Families receive wraparound services that are provided by a caseworker and family peer mentor; the family peer mentor has personal experiences with addiction and is in recovery.

In addition, state education agency officials in four selected states told us that they had at least one statewide effort administered by the state education agency to help support all children, including those affected by trauma.[47] Colorado, Washington, and Wisconsin encourage schools to implement tiered systems of behavioral support, according to state officials. Tiered systems of support generally consist of three tiers of support: (1) universal supports that apply to all children; (2) specialized supports for smaller groups of children; and (3) supports for individual children who need intensive interventions. To implement the first tier, school staff support students in various ways, such as interacting with students and setting up a dedicated space in a classroom for students to regulate their behavior. The second tier may include convening small groups to help children with similar behavioral issues learn how to regulate their emotions, and the last tier may include intensive support for students who need more help, such as developing and implementing wraparound services plans. School district officials that we spoke with in Massachusetts told us that although they do not use tiered systems of behavioral support, they help children affected by trauma by employing practices to create safe classroom environments for all students, such as developing and building upon relationships and engaging students in structured conversations.

[46]Ohio's Sobriety, Treatment, and Reducing Trauma is administered by the Public Children Services Association of Ohio, an organization representing Ohio's county child welfare agencies. The program is primarily funded by the Ohio Attorney General's Office through a Victims of Crime Act grant, according to a state official. Child welfare agencies participating in the program partner with local behavioral health providers and juvenile and family courts. As of March 2019, 32 counties participate in this effort.

[47]North Carolina and Ohio do not have statewide education initiatives that support children affected by trauma, according to state education agency officials.

Child Welfare and Education Agencies in Selected States Identified Leadership and Capacity Limitations as Challenges to Supporting Children Affected by Trauma

Officials in Selected States Reported That Leadership Is Important for Supporting Children Affected by Trauma

Officials in all six selected states spoke of the importance of having engaged leadership in establishing and sustaining support for children affected by trauma.[48] They cited a wide range of leaders, including state government officials; managers and supervisors; and those in partner agencies, such as schools or nonprofits, who supported these states' trauma efforts. In some cases, these leaders helped establish new trauma initiatives. For example, Wisconsin's former First Lady launched the work of a statewide, interagency trauma initiative. Additionally, Ohio county child welfare officials spoke about the value of obtaining management support for their plan to become a trauma-informed organization. In other cases, leaders were seen as important to sustaining trauma initiatives and ensuring their impact. In Massachusetts, university officials said that, to ensure the continued availability of evidence-based therapies, they train not only clinicians, but also the individuals who supervise them. Also, a county public health official in Washington, whose agency is implementing trauma initiatives in schools, told us that their efforts tend to be unsuccessful unless they first engage school leadership and align their health initiatives with the schools' existing efforts.

Federal officials and reports have also cited leadership as an important factor in the implementation of trauma initiatives, with some maintaining that leadership is necessary to support children affected by trauma

[48]Officials in this context include education and child welfare officials, as well as officials from other agencies and organizations we interviewed, including a university and other government bodies, such as interagency groups and departments of public health.

because of the need to change an organization's culture. In 2013, NCTSN reported on takeaways from a learning collaborative in which nine teams led by child welfare agencies developed, implemented, and tested trauma-informed child welfare practices.[49] Based on the experiences of the teams, the NCTSN report stated that strong and consistent leadership is necessary to implement trauma-informed practice because it requires a shift in organizational culture. SAMHSA's 2014 guidance for a trauma-informed approach similarly suggests that organizations consider the importance of leadership to initiate a systems-wide change.[50] In addition, HHS officials, who worked with states on a series of trauma-related grants awarded between 2011 and 2013, also told us that leadership commitment was important for their grantees in building organizational and worker resiliency, acting upon data and evaluation, and sustaining initiatives. These documents and statements echo previous GAO work on organizational transformation; for example, in 2003 we reported on key practices found at the center of successful transformation efforts, noting that leadership must set the direction, pace, and tone and provide a clear, consistent rationale that brings everyone together behind a single mission.[51]

In addition to discussing the important role that leadership plays in establishing and sustaining support for children affected by trauma, officials in three states highlighted instances in which a lack of leadership hindered their efforts to support these children. The cases they described included delayed, incomplete, or unsuccessful implementation of trauma initiatives.

- **Delayed implementation.** Officials in one school district said they had developed policies around multi-tiered system of supports in 2009 but did not receive support from political leaders or funding for the

[49]J. Agosti, L. Conradi, J. H. Goldman, and H. Langan, *Using Trauma-Informed Child Welfare Practice to Improve Placement Stability Breakthrough Series Collaborative: Promising Practices and Lessons Learned* (Los Angeles, CA & Durham, NC: NCTSN, June 2013).

[50]Substance Abuse and Mental Health Services Administration, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*.

[51]GAO, *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, GAO-03-669 (Washington, D.C.: July 2, 2003). For more recent work in this area, see GAO, *Government Reorganization: Key Questions to Assess Agency Reform Efforts*, GAO-18-427 (Washington, D.C.: June 13, 2018).

initiative until 2016. They told us that this hindered the initiative's implementation.

- **Incomplete implementation.** State education officials in that same state said that a lack of leadership hindered their ability to track school districts' implementation of the state's trauma initiatives. These officials said that a lack of requirements for districts to scale up trauma work was a barrier to collecting data on local activities. In another state, there was a county child welfare initiative to implement universal trauma screening which was conducted in partnership with a local university. The university reported that less than half of children with open cases were screened during the project period, which university officials attributed to some supervisors not supporting the screening initiative.
- **Unsuccessful implementation.** According to officials in a third state, turnover among high-level leaders contributed to difficulties integrating trauma-informed practices at the state's child welfare agency, and the agency was not successful at implementing a trauma screening process.

Child Welfare and Education Officials in Selected States Also Reported Capacity Limitations and Other Challenges to Supporting Children Affected by Trauma

Capacity Limitations

Officials in all six selected states talked about limitations on their agency's or organization's capacity to support children affected by trauma. Limitations included high rates of staff turnover, limited staff time to focus on trauma, insufficient numbers of clinicians trained in trauma-focused, evidence-based therapies, and insufficient funding for trauma initiatives. Some agencies and organizations had taken actions to address these challenges.

Staff Turnover

High rates of staff turnover were reported in all six selected states. This limitation was more commonly raised by child welfare agencies than by

Secondary Traumatic Stress

According to the National Child Traumatic Stress Network (NCTSN), Secondary Traumatic Stress (STS) is the emotional duress experienced when hearing about another person's traumatic experiences. Professionals working with children affected by trauma, such as child welfare workers, are commonly at risk of developing STS. STS can compromise these professionals' ability to do their jobs and may drive them to leave their job or their professional field.

NCTSN notes that several factors can increase the risk for developing STS, including heavy caseloads of children affected by trauma, social or organizational isolation, and feeling unprepared for the job due to lack of training. NCTSN suggests taking a multi-dimensional approach to STS, which includes both prevention and intervention. This could include strategies such as establishing self-care groups, helping workers maintain work-life balance, and training organizational leaders on STS.

Source: National Child Traumatic Stress Network | GAO-19-388

education agencies. Child welfare officials in all six states talked about high rates of staff turnover, while education officials did so in two states (Colorado and Wisconsin).[52] Staff turnover resulted in difficulties maintaining staff trained in trauma-informed approaches and sustaining institutional trauma knowledge and trauma-related activities, according to officials. Colorado university officials partnering with a county child welfare agency said that staff turnover forced them to invest additional time in training replacement staff and made it more difficult for child welfare officials to conduct regular follow-ups. Similarly, one education official in another part of Colorado said that high turnover at many agencies, including education and child welfare, hindered the county's efforts to maintain institutional knowledge about trauma-informed practices and sustain the services these agencies were providing to children affected by trauma. Some state and local officials in three states attributed high rates of staff turnover to fatigue and secondary traumatic stress, which is the emotional duress that staff may experience when they hear about children's traumatic experiences (see sidebar). Some agencies said that they sought to address staff turnover by supporting employees through training on secondary traumatic stress; at least one agency in each of the six states offered such training. Officials from Ohio and Wisconsin told us that another way they were addressing the issue was by participating in an HHS-funded project to improve child welfare workforce outcomes.[53]

[52]In four states, officials from other agencies and organizations partnering with child welfare agencies also commented on the high rates of staff turnover in that field. GAO has previously reported on the high rate of staff turnover in child welfare and its associated challenges. In 2003, we reported that child welfare staff turnover had been estimated at between 30 and 40 percent annually nationwide, with the average tenure of child welfare workers being less than 2 years. We found that turnover hampered agencies' attainment of some key federal safety and permanency outcomes by producing staffing shortages which increased the workloads of remaining staff. We further found that these increased workloads left less time for staff to establish relationships with children and families, to conduct frequent and meaningful home visits, and to make thoughtful and well-supported decisions regarding safe and stable placements. GAO, *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*, GAO-03-357 (Washington, D.C.: Mar. 31, 2003).

[53]The Quality Improvement Center for Workforce Development was established in 2016 under a 5-year cooperative agreement with HHS's Children's Bureau. This center is working with eight public and tribal child welfare agencies in different states to develop strategies for improving child welfare workforce outcomes. Quality Improvement Center for Workforce Development, *Building Knowledge to Strengthen the Child Welfare Workforce*, accessed Jan. 31, 2019, https://www.qic-wd.org/sites/default/files/about-qicwd.pdf.

Limited Staff Time

Many agencies also said they faced limitations on the time that staff could dedicate to trauma initiatives. This issue was more commonly raised by education agencies than by child welfare agencies. Education agency officials reported this limitation in three of four states that had education initiatives,[54] whereas child welfare officials reported it in two of the six selected states. Some of these officials explained that lack of staff time to focus on trauma may have limited the implementation of their trauma initiatives. State education officials in Washington and local education officials in Massachusetts told us that they have the expertise to provide trauma training to schools and community groups, but time limitations restrict their ability to do so. A Colorado county child welfare official told us that some caseworkers see trauma screening as an additional burden due to their already large workload, and a child welfare official in another Colorado county told us that many caseworkers forget to do trauma screening because they are busy. At least one agency we interviewed in each of the six states has or had a staff position dedicated to trauma work, which could help address this limitation.

Lack of Clinicians

Officials in all six selected states said that there were not enough clinicians trained in trauma-focused, evidence-based therapies to serve children affected by trauma.[55] GAO has previously reported on difficulties finding specialty care for children.[56] For example, in 2017 we found that limited access to mental health services was a challenge for several

[54]State education officials in two of our six selected states told us that they did not have statewide trauma initiatives.

[55]Though this issue was raised in all six states by child welfare or Medicaid officials, it was not reported by any education officials.

[56]In a 2010 national survey of physicians, in which GAO asked about difficulties referring children to specialty care and the particular specialties for which making a referral is difficult, one of the specialist types most frequently cited was mental health specialists, such as psychiatrists, psychologists, drug counselors, and other therapists. Physicians surveyed offered various explanations for why making referrals is difficult, including the short supply of specialists in their area and long waiting lists for specialists. GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624 (Washington, D.C.: June 30, 2011). GAO has also reported on behavioral health workforce shortages for low-income adults, see GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, GAO-15-449 (Washington, D.C.: June 19, 2015).

selected states due to a variety of factors, including insufficient numbers of providers in certain specialties, such as child psychiatrists.[57] Some officials indicated that a shortage of clinicians trained in trauma-focused, evidence-based therapies can limit the ability of child welfare agencies to address trauma. For example, state child welfare officials in Massachusetts specifically noted that identifying children affected by trauma is not helpful if there are not enough clinicians trained in these therapies to treat them. County child welfare officials in Massachusetts and local healthcare partners in Ohio said that providers sometimes rely on interns to address the shortage of clinicians, but Massachusetts officials viewed this as problematic because interns have short tenures that prevent them from establishing relationships with the children. Officials in five of the six selected states told us about initiatives to address the shortage by training clinicians in trauma-focused, evidence-based therapies, and university officials in Massachusetts described an initiative to make trained clinicians more accessible. (See text box.)

[57]This challenge was identified by state and county officials in four of the seven selected states and five of the nine national organizations that were interviewed for the report. GAO, *Foster Care: HHS Has Taken Steps to Support State' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration*, GAO-17-129 (Washington, D.C.: Jan. 5, 2017).

LINK-KID: A centralized trauma treatment referral service

The Child Trauma Training Center at the University of Massachusetts Medical School trains clinicians and operates a centralized referral service called LINK-KID. The goal of LINK-KID is to facilitate connections between children in need of trauma-focused, evidence-based therapies and clinicians who have been trained to provide such therapies. LINK-KID maintains an active database of trained clinicians throughout the state of Massachusetts.

University officials told us that anyone in Massachusetts with concerns about a child, including family, teachers, clinicians, and child welfare workers, may call the service. LINK-KID collects information about the child and family, works with them to decide which treatment is most appropriate, and ensures the child is referred for that treatment.

University officials said that using LINK-KID is easier for families and child welfare workers, who otherwise might have to call multiple service providers to determine who offers the needed treatment and accepts their insurance. These officials also said they have seen a reduction in the time children must wait for treatment when using LINK-KID. They said that prior to LINK-KID, they saw many children waiting 6 months to a year to receive treatment after having been identified as having experienced trauma, whereas wait times are generally between 25 and 40 business days with LINK-KID.

Source: GAO and Child Trauma Training Center. | GAO-19-388

Limited Funding

Finally, some agencies said they had difficulties getting or maintaining sufficient funding to support trauma initiatives. Officials in Washington, including, among others, state and local education officials and a local public health partner, reported this issue. In addition, local officials in four other states noted limited funding to support trauma initiatives. School district officials in Washington indicated that a lack of funding limited their implementation support for one major trauma initiative to approximately one-quarter of their schools. These schools were chosen based on need, as demonstrated by measures such as discipline and absenteeism rates. County child welfare officials in Ohio said they had to stop one of their trauma initiatives 3 years ago because the state funding supporting the initiative ran out. Those Ohio officials said they have relied on relationships and collaboration to address the issue of scarce funding. For example, they said that county organizations, including local government agencies, private healthcare providers, and nonprofits, share data

extensively and pool funding to support various initiatives. One initiative they pointed to is a local interagency council which provides services to children affected by trauma.

Other Challenges

Child welfare and other officials in the six selected states, including officials with nonprofit partners, a state department of health, and a state interagency collaborative, also raised at least one other challenge. Challenges included sharing data while remaining in compliance with state and federal privacy laws; sharing data across incompatible systems; limitations on services billable to Medicaid; and Medicaid reimbursement rates. Some agencies had taken actions to address or avoid data sharing challenges. In the states where child welfare officials identified Medicaid-related challenges, state Medicaid officials offered a different perspective on perceived Medicaid challenges and cited alternative ways to support children affected by trauma.[58]

Officials in all six states talked about sharing data with other agencies for various purposes; however, privacy laws and regulations were sometimes cited by these officials as a barrier to sharing data about children affected by trauma.[59] For example, officials in two Massachusetts school districts told us they are notified by police or child welfare workers when a child has been involved in an incident with those agencies. One official described the goal of this effort as making staff aware of incidents and events that may affect children's learning and behavior and ensuring that children feel supported. However, child welfare officials in four of the six selected states and other officials in two states said that it was difficult to share data while remaining in compliance with state and federal privacy

[58]Child welfare and Medicaid programs share responsibility for providing for the health care needs of children in foster care. In its June 2015 report to Congress, the Medicaid and CHIP Payment and Access Commission noted that collaboration among agencies responsible for the health care needs of such children is critical, but can be hampered by a lack of knowledge among staff regarding benefits, among other things. Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: June 2015).

[59]For various reasons, not all agencies we interviewed reported collecting or wanting to share data specific to children's traumatic experiences or their initiatives to support children affected by trauma. For example, Washington state education officials reported that they did not have the resources for formalized data collection on their trauma initiatives, while an official from an interagency collaborative in the same state said they lacked the administrative power or capacity to collect such data. Massachusetts state and Ohio county child welfare officials said they did not want to track traumatized children as a distinct population, as they assume every child entering the child welfare system has been exposed to trauma.

and confidentiality laws and regulations, though the reasons they cited for these difficulties varied.[60] State child welfare officials in Massachusetts told us that the state has strict privacy laws in addition to federal laws such as the Health Insurance Portability and Accountability Act of 1996.[61] These officials said that data sharing is possible but generally requires a specific memorandum of understanding because of privacy laws. In contrast, a state child welfare official in North Carolina said they had difficulties with counties not understanding what data they are allowed to share. That official told us that the state tries to mitigate this challenge by helping counties understand what they can share and encouraging them to share screening information with mental health and medical providers. Additionally, a North Carolina university has published state-specific guidance on sharing education, mental health, and other records.

Systems incompatibility and technology issues were also sometimes seen as barriers to sharing data about children affected by trauma. Child welfare officials in three of the six selected states, and state health

[60]Various GAO reports have outlined challenges states have faced in navigating federal privacy and security protections for health, child welfare, education, and other data. These challenges have included uncertainty over the types of data that states are able to share under these laws. See GAO, *Foster Care: HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration*, GAO-17-129 (Washington, D.C.: Jan. 5, 2017); *Human Services: Sustained and Coordinated Efforts Could Facilitate Data Sharing While Protecting Privacy*, GAO-13-106 (Washington, D.C.: Feb. 8, 2013); and *Postsecondary Education: Many States Collect Graduates' Employment Information, but Clearer Guidance on Student Privacy Requirements Is Needed*, GAO-10-927 (Washington, D.C.: Sept. 27, 2010). In response to a GAO recommendation from GAO-13-106, HHS published a "Confidentiality Toolkit" in August 2014 that aims to support state and county data sharing efforts by bringing greater clarity to the rules governing confidentiality in certain human services programs. In response to a GAO recommendation from GAO-10-927, the Department of Education revised its Family Educational Rights and Privacy Act regulations in December 2011 to, among other things, clarify the means by which states can collect and share graduates' employment information consistent with federal requirements. Additionally, the Department of Education published a data-sharing tool kit for civic and community leaders in March 2016.

[61]The Health Insurance Portability and Accountability Act of 1996 required HHS to promulgate regulations addressing the privacy and security of health information. Pub. L. No. 104-191, tit. II, subtit. F, 110 Stat. 1936, 2021-34 (codified at 42 U.S.C. §§ 1320d–1320d-8). HHS has published Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) and Security Standards for the Protection of Electronic Protected Health Information (the Security Rule). 45 C.F.R. pts. 160 and 164. The Privacy Rule establishes national standards for safeguarding individually identifiable health information that is transmitted or maintained in any form or medium (protected health information). The Security Rule establishes nationwide standards for safeguarding protected health information that is held or transferred electronically.

officials in a fourth state, said that incompatibility among various systems made data sharing very difficult or impossible.[62] For example, county officials in Wisconsin said that the state's child welfare and juvenile justice offices use one data reporting system while the state's mental and behavioral health offices use another, and these two statewide data systems are unable to communicate. While state child welfare officials in Colorado also reported systems incompatibility issues, county child welfare officials in that state talked about efforts to make data systems more accessible to relevant partners. Officials in one county said that they have a database which is accessible by all members of the county's multi-agency partnership, including child welfare, school districts, public health, and others. Those officials also said they use a universal release-of-information which includes all partner agencies, enabling them to share data at multi-agency meetings.[63]

Additionally, child welfare officials in Colorado, Ohio, and Massachusetts said that certain services for children affected by trauma or certain service providers were not billable to Medicaid, although Medicaid officials in these states offered a different perspective and cited alternative ways to support these children.[64] Depending on the state, child welfare officials said they could not bill wraparound services, trauma assessments, transportation, or non-traditional therapies, such as animal therapy or

[62]HHS officials also told us that data integration was a challenge for the recipients of the trauma-related grants ACF awarded from 2011 to 2013. They said that moving and integrating data between systems was a problem for grantees even though states were able to develop memoranda of understanding and data sharing agreements.

[63]This release-of-information is an authorization, signed by the individual receiving services or a parent or legal guardian, which allows specified county agencies to receive, use, and disclose certain types of confidential information for specified purposes.

[64]NCTSN has also reported on Medicaid challenges faced by those serving children and families affected by trauma. In 2016, they conducted a financing and sustainability survey of NCTSN members. Of 110 responders from 33 states and the District of Columbia, 52 percent reported difficulties with Medicaid reimbursements as a financing challenge. NCTSN, *NCTSN Financing and Sustainability Survey Report* (November 2016).

community and relationship building.[65] County child welfare officials in Ohio also mentioned restrictions on providers; they said that potential peer support specialists with a criminal background and interns could not bill Medicaid.[66] However, Medicaid officials in these states generally said that such services were billable to Medicaid, and Ohio Medicaid officials said that interns and those with a criminal background could bill Medicaid, under certain circumstances. For example, they said that while certain severe criminal offenses, such as homicide, could exclude someone from providing services, those with lesser offenses could become eligible after a waiting period. Colorado and Ohio Medicaid officials we spoke with offered some alternative ways to use Medicaid to support children affected by trauma in cases where services could not be billed to Medicaid. For example, a Colorado Medicaid official and a child welfare official both said that Medicaid does not pay providers for travel time or mileage and that this can be a problem in rural areas; however, the state Medicaid official said that telehealth is available to address this issue and that reimbursement rates for services in rural areas can be higher to reflect the additional cost of travel.[67]

Finally, child welfare and Medicaid officials in Colorado and North Carolina also had different perspectives regarding Medicaid reimbursement rates. Child welfare and other officials in these states said that certain services for children affected by trauma, such as trauma assessments and trauma-focused, evidence-based therapies, are expensive, and that Medicaid reimbursement rates are too low to incentivize providers to offer these services. However, Colorado and North Carolina Medicaid officials explained that most children in Medicaid in their states receive mental health care through managed care, where

[65]While the theme of certain services not being billable to Medicaid was reported by child welfare officials across these three states, the specific services the officials mentioned varied by state. The variance of reimbursable services across states is consistent with differences in state approaches to supporting children affected by trauma and with the state-by-state variance of Medicaid programs generally. Medicaid, by design, allows significant flexibility for states to design and implement their programs, which has resulted in over 50 distinct state-based programs. Federal law requires state Medicaid programs to cover a wide array of mandatory services, such as physician, laboratory, and preventive services, and permits states to cover additional services at their option. GAO, *Medicaid: Key Issues Facing the Program*, GAO-15-677 (Washington, D.C.: July 30, 2015).

[66]Officials noted that individuals who have gone through the criminal justice system may have life experiences that make them uniquely well-suited to be peer support specialists.

[67]The official said that Colorado Medicaid does pay for transportation for children to receive medically necessary services covered by Medicaid.

the state pays a set rate per child to managed care organizations (MCOs) to provide or arrange for any mental health services a child may need, including trauma-related care. MCOs, in turn, reimburse providers for the services they deliver, and MCOs set the rates they pay providers for those services rather than the state. Medicaid officials in Colorado and North Carolina noted that MCOs have flexibility to negotiate rates with providers and may choose to reimburse at a higher rate.[68] North Carolina Medicaid officials said that some MCOs in their state were reimbursing providers at a higher rate for comprehensive, trauma-informed mental health assessments, and a Colorado Medicaid official also noted that MCOs in their state may vary reimbursement rates based on provider availability, offering higher rates in areas where there are shortages.

Agency Comments

We provided a draft of this report to HHS and Education for review and comment. HHS did not provide written comments. Education provided technical comments, which were incorporated into the report as appropriate.

[68]Used effectively, Medicaid managed care may help states reduce Medicaid program costs and better manage utilization of health care services. However, GAO has also previously reported on problems associated with managed care. For example, in 2018 we reported that managed care payments have the potential to create program integrity risks and that there exist multiple challenges to program integrity oversight for managed care. GAO, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*, GAO-18-528 (Washington, D.C.: July 26, 2018). We also found that CMS has provided states with limited information on how to fulfill regulatory requirements related to oversight of MCO data, and we recommended that CMS provide states with additional information on this topic. GAO, *Medicaid Managed Care: Additional CMS Actions Needed to Help Ensure Data Reliability*, GAO-19-10 (Washington, D.C.: Oct. 19, 2018).

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretaries of HHS and Education, congressional committees, and other interested parties. In addition, this report will be available at no charge on the GAO website at https://www.gao.gov

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or larink@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Kathryn A. Larin
Director, Education, Workforce, and Income Security Issues

Appendix I: Selected State Information

Table 4: Examples of State Child Welfare Agencies' Initiatives to Support Children Affected by Trauma in the Six Selected States

State	Initiative	Description of the initiative that supports children affected by trauma
Colorado	Trauma Informed System of Care (known as COACT Colorado)	Uses an evidence-based and collaborative approach to help families of children and youth with complex needs involved in multiple systems in 17 counties throughout the state. Agencies involved with this initiative include child welfare, juvenile justice, and education. Dedicated staff exist to assist families and provide them with support as children receive services.
Massachusetts	Child Trauma Project[a]	Provided a series of training and activities organized throughout the state that expanded on inter-agency collaboration to support children affected by trauma. It also created leadership teams focused on trauma in all of Massachusetts' child welfare offices. In addition, it trained clinicians in three trauma-focused, evidence-based therapies, including Trauma-Focused Cognitive Behavioral Therapy.
North Carolina	Project Broadcast	Trains county child welfare workers over a 9-12 month period to incorporate an understanding of trauma and its effects into their every day practices. It also trains staff to use two screening tools—one for children 6 and under and one for children ages 6-21—to identify whether they have experienced trauma and refer them for an assessment if needed. Additionally, it trains clinicians on four trauma-focused, evidence-based therapies to treat children's trauma symptoms.
Ohio	Child Welfare Training Program	Provides training on core and specialized competencies for child welfare caseworkers, supervisors, and foster parents. The training program includes courses for the three groups that teach about the effects of trauma on children. For example, caseworkers can take trainings on the impact of emotional abuse and interventions for children who have suffered trauma while caregivers can take trainings on providing discipline that is trauma-informed and dealing with the effects of complex trauma.
Washington	Child Health and Education Tracking Program	Screens children in five areas, including physical and behavioral health, within the first 30 days of entering the child welfare system. In addition, dedicated staff are trained to use tools to identify children's trauma symptoms, including anxiety and attention problems. One tool includes questions about children's anxiety, such as whether they are scared to go to school. Children are rescreened every 6 months using these tools.
Wisconsin	Trauma Project	Consisting of three parts, this initiative trains clinicians who treat children affected by trauma in trauma-focused, evidence-based therapies; holds workshops for foster, birth, adoptive, and kinship parents attended by social workers and others to learn about trauma and its effects; and provides learning communities for state and county child welfare staff that infuse an understanding of trauma into staff's every day work.

Source: GAO analysis of state child welfare agency documents and Administration for Children and Families grant reports. | GAO-19-388

[a]A Massachusetts child welfare official told us that this initiative, funded by an Administration for Children and Families grant, ended in 2017. According to another Massachusetts state child welfare official, once the funding was eliminated for the full-time staff person who organized the Child Trauma Project, the agency could not sustain it throughout the state.

Table 5: Examples of State Education Agencies' Initiatives to Support Children Affected by Trauma in Selected States

State[a]	Initiative	Description of the initiative that supports children affected by trauma
Colorado	Positive Behavioral Interventions and Supports and Multi-Tiered System of Supports[b]	Encourages the use of Positive Behavioral Interventions and Supports and Multi-Tiered System of Supports as prevention frameworks for improving the outcomes of all students. This occurs through partnerships with families, schools, and communities. It also uses multiple evidence-based practices at the classroom, school, district, region, and state levels.
Massachusetts	The Safe and Supportive Schools Grant Program	Helps school districts ensure that a school creates a safe, positive, healthy and inclusive learning environment. This state-funded grant program also makes sure there is use of a system for integrating services and aligning initiatives that promote, among other things: • students' behavioral health, including social and emotional learning, and trauma sensitivity, • children's mental health, and • positive behavioral approaches that reduce suspensions and expulsions.
Washington	Compassionate Schools and Social and Emotional Learning	Provides universal supports to all students through these initiatives, which include creating a positive school climate and culture. • Compassionate Schools support all students and focus on helping teachers understand fundamental brain development, interpret and manage children's behaviors successfully, and engage students, families, and the community. • Social and emotional learning is the process through which children learn how to understand and manage emotions, set and achieve goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions.
Wisconsin	Trauma Sensitive Schools	Modeled after the Positive Behavioral Interventions and Supports school improvement process, this initiative focuses first on universal practices (Tier 1), followed by strategies for groups of students who need additional support (Tier 2), and intensive interventions for students who require ongoing support (Tier 3).

Source: GAO analysis of state agency documents and interviews with agency officials. | GAO-19-388

[a]Four of the six selected states had at least one statewide initiative administered by state education agencies to support children affected by trauma. North Carolina and Ohio do not have statewide education initiatives, according to state education agency officials.

[b]Positive Behavioral Interventions and Supports and Multi-Tiered System of Support utilize evidence-based, prevention-oriented practices and systems. Positive Behavioral Interventions and Supports' framework provides academic, social, emotional, and behavioral support to all students while Multi-Tiered System of Support focuses on addressing students' academic issues. Both models comprise three tiers—the first uses universal practices to support children, such as changing a classroom's environment; the second uses strategies, such as small group cognitive behavioral therapy, for students who need additional support; and the third provides intensive interventions for students who require ongoing support, such as developing and implementing wraparound services plans.

Appendix II: Selected County Information

Table 6: Examples of County and Local Agency Initiatives to Support Children Affected by Trauma in the Six Selected States

County, State	Initiative	Description of the initiative that supports children affected by trauma
Boulder County, CO	Integrated Managed Partnership for Adolescent and Child Community Treatment	Consisting of 11 public agencies and nonprofit organizations, including the Boulder Valley School District and a nonprofit organization that provides mental health services, this initiative is an interagency collaborative partnership. The group provides case coordination and ensures participating agencies and organizations have consistent practices and processes for children involved in multiple systems. Services, such as trauma-focused, evidence-based therapies and mentoring for youth in the juvenile justice system, are also available through this effort.
Plymouth County, MA	Brockton Public Schools	Creating trauma-sensitive schools has been Brockton Public Schools' focus, one official explained. Among other things, the schools create safe and supportive environments by enhancing relationships with students and ensuring educators are aware of students' behavior, according to this same official. In addition, Brockton Public Schools collaborates with the county district attorney's office on two trauma-focused initiatives—the Childhood Trauma Initiative and Handle With Care. The Childhood Trauma Initiative trains educators and law enforcement, among others, about trauma's effects on children's development. Handle With Care allows police officers or caregivers to notify a school that a child may have experienced a traumatic event.
Rowan County, NC	Partnering for Excellence	Consisting of the county department of social services, the county's mental health managed care organization, and private mental health providers, this initiative supports children ages 5-17 and families involved in the child welfare system. Key elements of Partnering for Excellence include screening children for trauma and, if needed, trauma-intensive comprehensive clinical assessments. The initiative also facilitates improved communication, coordination, and monitoring of child and family treatments by ensuring staff train together and participate in ongoing collaborative meetings.
Athens County, OH	School Outreach Caseworkers	Placing caseworkers in local elementary schools, the county child welfare agency's initiative supports students, families, and teachers by promoting positive school relationships to enhance student success and strengthen families. Among other responsibilities, caseworkers help coordinate services for individual students and bring outside resources into schools. They also support parents by providing home and school-based services and coordinating parenting classes to help strengthen skills.
King County, WA	King County Department of Public Health	Beginning in 2017, King County's Department of Public Health implemented changes to become a trauma-informed agency. One official explained that the agency has three areas of focus—creating a trauma-informed care training plan and standardized curriculum; awarding mini-grants to agency "champions" who create small projects connected to the agency's trauma-informed care principles, which includes fostering compassionate relationships; and making policy and human resources changes, including the investigation process for internal human resources complaints.

County, State	Initiative	Description of the initiative that supports children affected by trauma
Waupaca County, WI	Waupaca County Department of Health and Human Services	Beginning in 2012, the Department of Health and Human Services has worked to transition into a trauma-informed agency by incorporating trauma-informed care into its operations. The agency's operating principles include partnering with clients, promoting safety, and earning clients' trust. The agency has become more family-friendly and is more focused on preventing children from entering the child welfare system, according to an agency official. Since becoming trauma-informed, it was reported that staff have had less secondary stress and there has been a decrease in staff turnover.

Source: GAO analysis of county child welfare, local education, and other county agency official interviews and county agency documents. | GAO-19-388

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact	Kathryn Larin, (202) 512-7215 or larink@gao.gov
Staff Acknowledgments	In addition to the contact named above, Elizabeth Morrison (Assistant Director), Ramona L. Burton (Analyst-In-Charge), Isabella Guyott, and Robin Marion made significant contributions to this report. Also contributing to this report were Luqman Abdullah, Susan Aschoff, Sarah Cornetto, Kelsey Kreider, Hannah S. Locke, Jean McSween, Mimi Nguyen, Stacy Ouellette, Michelle Rosenberg, Almeta Spencer, Daren K. Sweeney, Shelia L. Thorpe, and Carolyn Yocom.

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Public Affairs	Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room 7149 Washington, DC 20548
Strategic Planning and External Liaison	James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707 U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548

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NCTSN The National Child Traumatic Stress Network

Creating, Supporting, and Sustaining Trauma-Informed Schools:

A System Framework

BACKGROUND AND OVERVIEW

This framework will help schools and sites who partner with schools have a better sense of the areas to address when working towards a more trauma-informed school.

The primary mission for schools is to support students in educational achievement. To reach this goal, we know that children must feel safe, supported, and ready to learn. As schools strive to accomplish this for all students—regardless of strengths, needs, and capacities—schools must recognize the influence of the students' personal experiences on their learning and achievement. Children are exposed to violence and trauma at an alarming rate in the United States. By age sixteen, two-thirds of children in the United States have experienced a potentially traumatic event such as physical or sexual abuse, natural disaster or terrorism, sudden or violent loss of a loved one, refugee and war experiences, serious accident or life-threatening illness, or military family-related stress. Many children, with support, are able to heal and overcome such traumatic experiences. However, a recent report examining the impact of adverse childhood experiences (ACEs) on academic outcomes found that communities with higher ACE scores had higher rates of suspension and unexcused absences and lower rates of graduation from high school and progression to post-secondary school than communities with relatively low prevalence of ACEs.[1] Not only are individual children affected by traumatic experiences, but other students, the adults on campus, and their communities can be impacted by interacting or working with a child who has experienced trauma. Thus, as schools maintain their critical focus on education and achievement, they must also acknowledge that mental health and wellness are integrally connected to students' success in the classroom and to a thriving school environment. This framework illustrates why becoming "trauma-informed" should be an essential component of the overall mission of our education system.

1 What Does It Mean to Be "Trauma-Informed?"

The National Child Traumatic Stress Network (NCTSN) defines all trauma-informed child- and family-service systems as

> "one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, staff, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery or adjustment of the child and family, and support their ability to thrive."

In order to create, support, and sustain these elements specifically in schools, a tiered approach is suggested to create an environment with clear expectations for everyone, open communication, and a collective commitment to a safe and nurturing school culture. The tiered approach describes how trauma-informed practices can be applied both universally as a preventative approach and to help those in need of more intensive support. The aim of a trauma-informed tiered approach is to create a school-wide environment that addresses the needs of all students, staff, administrators, and families who might be at risk for experiencing traumatic stress symptoms. There are many ways to weave trauma-informed approaches into the fabric of schools, including strategic planning by administrators, approving trauma-informed policies, staff training, direct intervention with traumatized students, and building knowledge and communication in a variety of domains, all with a focus on creating and supporting academic achievement, behavioral competence, and mental health of all students, families, and staff.

2 The Challenges

While healing from trauma and loss exposure is possible with the appropriate level of support, before these supports are present many students may experience a range of reactions including behavioral changes, emotional distress, grief, difficulties with attention, academic failure, nightmares, or illness. These reactions sometimes develop into psychiatric disorders, including posttraumatic stress disorder (PTSD), anxiety, and depression.[2] It is critical to highlight that even when a traumatic event does not result in clinical symptoms/behaviors consistent with traumatic stress, it can have a serious impact on the developmental trajectory of a youth across all major domains of functioning (e.g., physical/health, cognitive/learning, behavioral, social/emotional).

Trauma and traumatic stress reactions such as the symptoms and behaviors described above can disrupt the school routine and the processes related to teaching and learning not only for the child who experienced the event, but also for his or her peers, classroom environment, teachers, as well as staff. The ability to read, write, solve math problems, and engage in discussion requires attention, organization, comprehension, memory, the ability to produce work, engage in learning, and trust. These activities also require students to have the capability to regulate their own attention, emotions, and behavior.[3] Students traumatized by exposure to violence are at increased risk for displaying emotional dysregulation, disruptive behaviors, declines in attendance and grade point averages, and more negative remarks in their cumulative records than other students. They may have increased difficulties concentrating and learning and may engage in unusually reckless or aggressive behavior.[4] It is important to note that recent research highlights the unique impact of grief and loss when youth are exposed to traumatic events. Grief and loss reactions can heighten traumatic stress reactions and worsen symptoms such as feeling disconnected from others, strong negative reactions to relationships, and general disengagement from school.[5]

Repeated childhood exposure to traumatic events can affect the developing brain and nervous system, such that the brain is more easily triggered into survival mode even when there is no actual danger present. When areas of the brain associated with survival are triggered and highly activated, the thinking and learning areas of the brain are bypassed and largely "go offline." Further, exposure to chronic trauma is associated with an increase in health-risk behaviors such as smoking, eating disorders, substance use, and high-risk sexual behaviors leading to teen pregnancy and sexually transmitted infections.[5] In the classroom, behaviors resulting from exposure to trauma can lead to reduced instructional time, suspensions, and expulsions. Long-term results of exposure to violence include reduced graduation rates, along with increased incidences of teen pregnancy, joblessness, and poverty.[6]

School environments that do not recognize when externalizing behaviors and emotional dysregulation of a student are a result of trauma and loss may respond in a punitive and potentially harmful way. Students who have been exposed to trauma are at increased risk of receiving out-of-school discipline.[7] Historically, schools and districts have responded to a broad range of student behaviors by implementing zero tolerance policies, resulting in suspensions and expulsions for drug use and violence as well as minor infractions such as "willful defiance." Although zero tolerance policies are aimed at improving safety on school campuses, unintended consequences can result such as greater school dropout and justice system involvement of those who are suspended or expelled from school. Out-of-school discipline also disproportionately affects African American students, who are four times more likely than their White peers to be suspended, a trend that begins in preschool. Schools may also inappropriately respond to defiant behavior by relying on a show of force by police.[8] Collectively, these well-intentioned policies and practices can undermine feelings of safety for students impacted by trauma and inadvertently contribute to a school climate counter to many principles of a trauma-informed approach.

3 The Opportunities

Traumatic stress can arise from a variety of sources, both internal to the school environment and external, such as bullying, school shootings, dramatic weather events, community or domestic violence, grief due to loss of a loved one, and even the day-to-day exposure to events such as divorce, poverty, homelessness, abuse and/or neglect. Children and adults can be affected by traumatic stress. Having the tools and strategies to identify, address, and manage traumatic stress empowers all stakeholders involved with the school community, and supports their primary pursuit of educational achievement.[9]

School personnel are uniquely situated to identify, respond to, and be impacted by students' traumatic stress symptoms due to their central role in children's lives and their continued assessment of children's learning abilities and relationships with peers and school staff. The goals of schools that pertain to student learning, test scores, and successful outcomes are directly impacted by children's traumatic experiences, so addressing students' trauma and loss symptoms is essential for meeting those goals. School personnel have the ability to change the course of children's lives while meeting their own systems' goals through teaching children skills to regulate their emotions and behaviors, partnering with families to strengthen children's relationships with adults in and outside of the school, and allowing them to develop their academic potential.[1]

Trauma-informed schools build resilience by preparing schools to be responsive to the needs of their constituents with seamless, accessible social, behavioral, and emotional supports involving all school community members, as well as access to evidence-based, developmentally appropriate, child and family services. This requires the engagement of all administrators, educators, and staff, as they are each involved with the daily life of students who have experienced trauma and loss.

Strengthening systems is particularly important when working with diverse and vulnerable student populations including ethnically and culturally diverse youth, sexual minorities, developmentally-delayed students, and youth with linguistic diversity. Trauma-informed approaches are most effective when implemented during a student's initial encounter with early learning systems (e.g., pre-school, head-start) and are sustained throughout their educational experience.

4 What Does a Trauma-Informed School Look Like?

Trauma-informed approaches within any system aim to adhere to the "4 Rs":

- **R**ealizing the widespread impact of trauma and pathways to recovery
- **R**ecognizing traumas signs and symptoms
- **R**esponding by integrating knowledge about trauma into all facets of the system
- **R**esisting re-traumatization of trauma-impacted individuals by decreasing the occurrence of unnecessary triggers (i.e., trauma and loss reminders) and by implementing trauma-informed policies, procedures, and practices.[9]

More specifically, a trauma-informed school system (pre-school – 12th grade) is one in which all administrators, staff, students, families, and community members recognize and respond to the potentially negative behavioral, relational, and academic impact of traumatic stress on those within the school system including children, caregivers, teachers, other school staff, as well as on the system itself. Such a school system provides trauma awareness, knowledge, and skills as part of the fabric of the school culture, practices, and policies and acts in collaboration with those who are involved with the child, including students' families, community agencies, leaders, and law enforcement, using the best available science to facilitate and support the recovery and resiliency of the school community. Specifically, a trauma-informed school promotes a safe and welcoming climate; seeks to create a structured and predictable learning environment that minimizes unnecessary trauma and loss reminders; focuses on building positive and attuned relationships between teachers and students, and among school staff; has anti-bullying and suicide prevention programs; and uses a balanced restorative justice (a.k.a. restorative practices) approach to conflict and conflict mediation with appropriate disciplinary action.

In essence, a school that is trauma-informed recognizes the relationship between and alignment of trauma-informed core areas with social, emotional, and behavioral learning practices, disciplinary response, classroom management, and student and professional supports. It acknowledges the impact that mental health can have across all major developmental domains (physical/health, cognitive/learning, behavioral, social/emotional) both inside and outside of the classroom, as well as how the scholastic experience can influence mental health. Given that the relationship between mental health and academic achievement is bidirectional and highly correlated, a trauma-informed school nurtures this relationship while maintaining its primary focus on educational outcome.

5 The Role and Goal of this Framework

The NCTSN System Framework for Trauma-Informed Schools provides strategic guidance in order to achieve the vision of a trauma-informed school described above. It is not a prescriptive roadmap for a one-size-fits all approach. Instead, it includes core areas that will help to focus educational system improvements and organizational changes. These core areas can be applied to each of the three intervention tiers to create a trauma-informed environment within the school system while identifying those who are at risk or might need more intensive support to address their traumatic stress or loss symptoms.

6 System Framework

Although the framework attempts to break down the complexity of a school system and its environment into discrete components, no single core area should be viewed in isolation. Only in totality can the framework serve to help create, support, and sustain a trauma-informed school.[10] The framework for trauma-informed schools that follows applies to Pre/K-12. It is rooted in the Multi-Tiered Systems of Support (MTSS)[10] framework pyramid, which is a multi-tiered approach for the early identification and support of students with learning and emotional/behavior needs. The framework not only infuses all three tiers of the MTSS (see diagram below) with trauma-informed concepts and practices, but it also recognizes and addresses the broader contexts in which these tiers operate: school environment/culture, community, and family partnerships.

Within each of these tiers are strategies that are critical to creating a trauma-informed school. These include practices that influence the day-to-day interactions among educational staff, students and families, organizational policies and procedures, and community capacity-building strategies. All of these—inside the school and in the family and community contexts—are essential to support the overall culture, practice, and structures for a trauma-informed school. While it is noted that education and mental health perspectives for serving student social/emotional needs may differ, the following framework is intended to integrate these perspectives and highlight the core areas necessary to implement and sustain trauma-informed practices in a school.

Tier 1

Safe Environments and Universally Healthy Students / Creating and Supporting a Trauma-Informed School Community

Schools transform on a number of levels to create and support safe environments that promote healthy and successful students and staff. This foundational work is Tier I of the MTSS pyramid and necessary to support strategies across the entire pyramid.

Tier 2

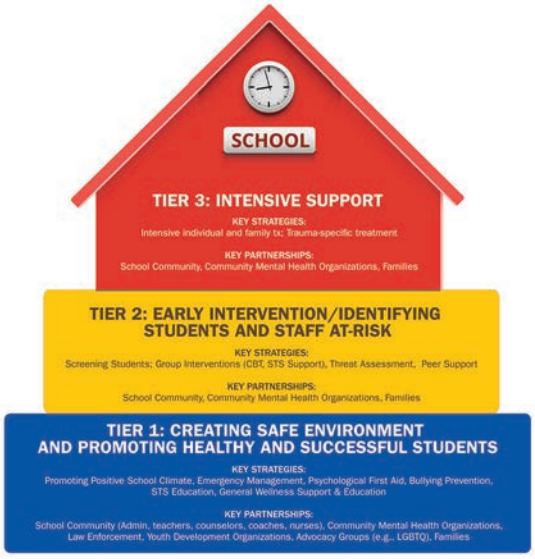
Early Intervention/Identifying Students and Staff At-Risk

Schools identify and respond to students and staff who are at-risk or have been exposed to trauma and/or loss in ways that meet their unique exposures, experiences, developmental, and personal needs.

Tier 3

Intensive Support

Schools provide support to those students whose behaviors and experiences necessitate intensive interventions and aim to meet their unique exposures, experiences, developmental, and personal needs.



7 CORE AREAS OF A TRAUMA-INFORMED SCHOOL

A trauma-informed school recognizes that trauma affects staff, students, families, communities, and systems. Thus organizational support, partnerships, and capacity-building are essential. The following represent 10 Core Areas for a trauma-informed school system and relevant tiered approaches within each area. Note: ▲1=Tier 1; ▲2=Tier 2; ▲3=Tier 3

I

Identifying and Assessing Traumatic Stress

The school recognizes and values identification of students that are vulnerable to traumatic events as an important prevention and intervention strategy with an intentional and transparent plan to use information to help a student attain educational goals. This requires implementing a tiered approach to identifying students for trauma-related mental health problems when indicated. Such factors include (but are not limited to) significant changes in key developmental domains (physical/health, cognitive, behavioral, social/emotional) as well as disruption in the student's academic performance, attendance, or pattern of school engagement. A tiered approach includes a diversity of strategies beginning with parent and family engagement and sustaining engagement throughout the process.

▲**1 Systematically Assessing School-Wide Trauma-Informed Practices.** The school employs an organizational assessment that requires identification of trauma-informed policies, practices, and/or procedures to support students and staff.

▲**1 Standard Protocols for Considering Trauma-Exposure.** School personnel are prompted routinely to consider the presence and/or impact of trauma exposure on student academic and behavioral performance. This includes observing signs, symptoms, and risk factors related to a potential traumatic event, and addressing barriers to support youth facing these challenges. Staff use trauma-related and/or routinely collected data to inform decisions about students in a systematic manner (e.g., attendance, grades, nursing visits, behavioral incidents). Staff meetings, student performance reviews, and other standard protocols for regularly assessing student performance while integrating trauma-informed considerations.

▲**2 Trauma Screening for Behavioral Referrals.** The school includes as a primary response to behavioral referrals a screening for traumatic experiences and traumatic/loss stress reactions using evidence-based screening tools. When traumatic exposure or traumatic/loss stress reactions are identified, a more comprehensive assessment is conducted to direct future interventions.

▲**3 Ongoing Monitoring of Traumatic Stress Responses.** The school makes available ongoing assessment that is aligned with ongoing intervention of traumatic stress reactions for students experiencing ongoing academic, behavioral, and mental health challenges.

II

Addressing and Treating Traumatic Stress

Adequate supports are available for all school stakeholders who have directly or indirectly experienced traumatic events or are at risk for exposure. Stakeholders include students, families, teachers, administration, and additional school personnel. Referral and access to evidence-based prevention and intervention resources are available and adapted to the needs of service recipients. Provision of services are systematically linked to protocols for identifying individuals exposed to trauma and loss. Routine reviews of service referral and provision are conducted to ensure effectiveness.

▲**1 De-stigmatized Self-Referral Options.** Students and school personnel are made aware of support services available. Schools provide options for self-referral that reduce stigma about mental health. Individuals are encouraged to connect with services when necessary. Service options are made available in the community to support privacy preferences.

▲ **2 Early Interventions.** Based on screening results, the school provides trauma-informed, evidence-based, resiliency-building early interventions. Interventions for schools may include cognitive-behavioral or mindfulness strategies, treatments for youth identified at risk for traumatic stress grief, or depression; or referrals to trauma-informed services that address behaviors such as substance abuse. Schools also provide opportunities for educators to employ in-class supports that address behavior in a trauma-informed manner.

▲ **2** ▲ **3 Trauma-Informed Behavior Support Plans.** The school's behavioral support planning team incorporates an understanding of trauma, trauma and loss reminders, trauma's impact on key developmental domains, and evidence-based practices for supporting children experiencing traumatic stress into its behavior support planning process.

▲ **2** ▲ **3 Trauma-Informed Special Education Services.** School-based Individualized Education Plan (IEP) team members incorporate an understanding of trauma, trauma and loss reminders, trauma's impact on key developmental domains, and evidence-based practices for supporting children experiencing traumatic stress into its IEP planning process.

▲ **3 Referring for Services.** Educators and school staff refer students to evidence-based trauma-informed treatments as needed when the school is unable to meet their trauma-based mental health needs. The school develops strong relationships with community providers of trauma-informed care.

III

Trauma Education and Awareness

Professional development for educators, administrators, and allied professionals and partners is routinely offered with the goal that the entire community will share the understanding of trauma's impact on learning and will build student coping and protective skills. This will be done by using a whole-school inquiry-based approach to creating trauma-sensitive schools. Schools and districts work to create local policies that support trauma-informed practices and have adequate staffing to perform screenings, provide services, and create an effective infrastructure to achieve the administrative functions necessary for effective implementation of trauma-informed policies, practices, and procedures.

▲ **1 School Mission and Vision.** The schools' academic mission recognizes (formally and in practice) that addressing trauma and behaviors associated with exposure to trauma and loss is key to improving academic outcomes.

▲ **1 Professional Development.** Trauma literacy is a key component of professional development for school administrators, teachers, and staff. Building on a strong foundation of therapeutic and crisis management practice in schools, trauma literacy helps staff recognize the continuum of trauma in children and its impact on academic achievement and development. Leadership and staff share an understanding of trauma's stress on the brain and body, student learning, their behavior, and the need for a school-wide approach to develop skills for coping with such stress.

▲ **1 Psychoeducation for Students on the Effects of Stress and Trauma.** The school provides health and psychoeducation to students about the effects of stress and trauma on the body; how to develop healthy coping skills for managing stress; promotes associations and activities that nurture healthy peer and family relationships and connections to community organizations; and incorporates practices to increase students' resilience and protective factors. For youth who have recently experienced a loss, the school provides grief-specific psychoeducation and supports. Psychoeducation empowers youth to seek services when necessary.

▲ **2 Developmentally Appropriate Trauma-Informed Responses.** The school recognizes that trauma can impact development. A child's developmental level should be considered when addressing their educational needs, including classroom structure and individualized supports. For younger students, the recognition that the adults in these children's lives may have to provide additional support to help them thrive. It also recognizes that certain students may have developmental delays or intellectual disabilities that require specialized trauma-responses.

IV

Partnerships with Students and Families

Trauma and loss involves experiences of powerlessness and isolation that can make students and families less likely to trust school institutions and authority figures or to fully participate in programs created to support their trauma recovery. It is therefore essential to empower students and family members as partners in the creation of a trauma-informed school as well as in the planning of trauma-informed practices. While limits exist for who the school can engage within the student's family directly, a trauma-informed lens recognizes the impact of caregiver, sibling, and other important family member's life experiences in an effort to enhance a school's ability to address adverse life experiences for the student and find practical opportunities to maximally address challenges facing students. Specifically, this supports student engagement academically and addresses potential trauma-related factors that are impacting students at home. Particular efforts should be made to build meaningful partnerships among students, families, caregivers, and school staff in order to better support students who have experienced trauma and loss; and to create, implement, and sustain trauma-informed programs and practices. Students and families are actively engaged in student-specific assessment of strengths and needs and the development of individualized education and treatment plans. Students and families are also actively engaged in school-wide planning and implementation efforts to address trauma, including the development of school-wide policy, protocol, and guidelines to create a trauma-informed school climate and to implement trauma-informed practices. Schools should embrace practices that incorporate peer and parent support and guidance.

▲**1 Education for Parents/Caregivers.** The school, together with community partners, teach parents about the effects of stress and trauma on children's brains and bodies, and instructs them in how to develop skills for coping with stress to bolster student's learning-readiness and a sense of psychological safety (feeling and believing one is safe).

▲**1 Education for Students.** The school provides education to students about the effects of stress on their brains and bodies, as well as stress management strategies such as slow breathing, mindfulness, effective problem-solving, and asking for help.

▲**1 Engagement in Program Planning and Implementation.** The school engages students and families/caregivers in the process of creating trauma-informed schools at all levels. School staff and administrators collaborate with students and families to develop practices that will best address their needs and implement those practices in ways that make them most useful, effective, and accessible. On an organizational level, schools partner with students, families, and caregivers when making decisions regarding the development and implementation of programs.

▲**2 Families are an important Source for Identifying Students In Need of More Support.** Parents and caregivers want their children to succeed in school and often need assistance themselves in learning ways to help their child. Therefore, they are a primary source for identifying students in need of more individualized planning and support.

▲**3 Engaging Families in Treatment.** The treatment process must engage both youth and families as actively as possible. Providers should partner with families to address safety issues and concerns, define their needs and hopes for treatment, explore their role in their child's treatment, and regularly provide input about how their child is doing. A general understanding about issues parents may face such as managing personal stresses, difficulties sleeping, or interpersonal challenges should inform interventions. Families should have an easy and accessible mechanism for providing frequent feedback to the school and to the treatment provider.

V

Creating a Trauma-Informed Learning Environment (Social/Emotional Skills and Wellness)

The school creates a safe environment by promoting healthy interactions among students and staff and teaching social/emotional skills and self-regulation skills. In a trauma-informed approach, the school promotes the wellness of all students, ensuring they feel safe and supported physically, socially, emotionally, and academically. School personnel model healthy social/emotional skills and integrate trauma-informed practices with other

school-wide behavioral programming. Protocols to address bullying, identify threats, harassment, bigotry, inequity, and other behaviors that compromise the safety of the learning environment are clearly outlined and employ a trauma-informed perspective.

▲**1 Promoting a Safe School Climate & Education about Trauma.** By promoting healthy activities and utilizing protective factors that include connections to community organizations and practices to increase students' resilience and coping skills, schools create an environment that leads to healthier student interactions with others and a school that feels physically and psychologically safer for all its members.

▲**1 Predictable and Supportive Learning Environments.** The school uses an understanding of trauma to deepen and augment school-wide practices to create a predictable and supportive learning environment that minimizes unnecessary trauma and loss reminders.

▲**1 Developing Sense of School Community.** The school explicitly connects students and teachers to each other, to the schools' programs, and to the rest of the school community—including the promotion of teacher peer consultation and support models.

▲**1** ▲**2 Teaching Social Skills.** The school provides training for staff and curriculum implementation for students on creating, sustaining, and promoting a positive and safe learning environment. Content includes conflict resolution, problem-solving skills, social communication, emotional/behavioral literacy, bullying prevention, and suicide prevention. The school recognizes that unhealthy social conflict between peers can have serious developmental consequences and negatively impact the mental health of all youth involved. Consequently, the school proactively addresses bullying/cyberbullying by educating staff, students, and families in bullying awareness, relevant social skills (empathy, friendship, assertiveness) and effective response and repair strategies. Providing targeted supports for youth at risk of displaying behaviors that adversely impact the psychological and physical safety of others is an important supplement to universal supports.

▲**3 Safe Spaces for Students.** The school develops and designates safe spaces inside and outside of the classroom for students to calm themselves after exposure to trauma and loss triggers. Safe spaces provide opportunities for students to self-regulate when experiencing behavioral and emotional challenges.

VI

Cultural Responsiveness

The school recognizes that there are cultural differences in experiences, interpretations, and responses to trauma. For students seeking help after a trauma, the school ensures that responses of school staff are culturally appropriate. The school also works to actively counteract the effects of historical trauma, societal oppression including implicit and explicit bias, and institutional oppression including eliminating disproportionality in punitive and exclusionary (out-of-school) discipline practices.

▲**1 Cultural-Responsive Approaches Integrated School-Wide.** Professional development and supervision of school personnel are infused with strategies for understanding cultural perspectives and traditions of students and their families, as well as strategies for actively counteracting the effects of implicit and explicit bias on an institutional level and in individual interactions. Connecting with community partners who can enhance cultural responsiveness and support cultural brokering (partnering with a community member to champion trauma-informed practices) is a priority.

▲**2 Address Systemic Practices Countering Cultural-Responsiveness.** The school reviews policies and procedures to identify and address standard practices that may adversely and disproportionately impact specific groups of students and exacerbate traumatic stress or loss reactions. The school also pays particular attention to cultural practices of families, such as disciplinary practices, in a manner that protects the student while respecting and understanding the cultural frame of the family.

▲**3 Adapting Interventions Using Cultural-Responsive Strategies.** Evidence-based practices are adapted to the students and their families in an attempt to reduce stigma and increase effectiveness of service utilization. Cul-

tural brokers (members of the student's community tasked with translating cultural practices for school) engage with the school to act as a bridge between school and community, especially when a family is reluctant to engage in health and trauma-informed services. Interventions recognize and address the impact of traumatic stress that can result from societal oppressions such as racism, xenophobia, homophobia, and sexism.

VII

Emergency Management/Crisis Response

The school has clear and well-communicated procedures to address emergencies before, during, and after an event. Trainings and drills that involve students and school staff must be delivered in a trauma-informed manner, which includes special attention to those who have been previously traumatized and adapting protocols to reduce the impact of these exercises. The school develops a comprehensive protocol for all hazards and trains staff, students, and partners in those procedures.

▲ **1 Comprehensive Emergency Operations Plan.** Schools consider all threats and hazards, provides for the access and functional needs of the whole school community, considers all settings and all times, and creates a collaborative process for regularly revising this plan. Schools Emergency Operations plans should be developed and maintained by various representatives from administration, staff, parents, and community representatives (e.g., law enforcement, fire officials, mental health practitioners).

▲ **1 Staff and Partners Informed of Emergency Procedures.** Staff and partners should be well informed about the Emergency Operations Plan, including the protocol for communications with individuals inside the school and their parents/caregivers. The whole community should regularly practice the plan using different drills and exercises. Staff should also be trained in appropriate early interventions for when an emergency takes place, such as Psychological First Aid.

▲ **2 Threat-Assessment.** The school should create and maintain a comprehensive threat assessment protocol which includes a multidisciplinary school threat assessment team for early identification and intervention of potential targeted acts of violence.

▲ **3 Recovery Services.** In the aftermath of a crisis, a team of trained professionals, which may include school staff, provides evidence-based and trauma-informed screenings and intervention following the crisis to ensure adequate support for individuals impacted by the crisis. To facilitate recovery, when necessary, the school provides both short-term supports to stabilize students affected by an immediate crisis and long-term supports in the aftermath to facilitate recovery and adjustment.

VIII

Staff Self-Care and Secondary Traumatic Stress

The school trains staff in social/emotional skills that promote the physical, social, emotional, and academic wellness of all teachers and staff, and support school climate of physical and psychological safety. Additionally, schools identify sources of secondary traumatic stress (STS) for teachers and staff and intervene to mitigate and/or manage stress.

▲ **1 Work Responsibilities Consider Self-Care Practices.** School administration and key decision-makers consider the impact of school staff assignments, general workload, and exposure to students displaying traumatic stress reactions on staff mental health. Plans for addressing barriers to a supportive professional environment and incorporating feedback from school staff should be implemented. Wellness practices are encouraged and offered regularly to reduce staff stress.

▲ **1 Prevention and Awareness of Secondary Traumatic Stress (STS) in Educators.** Schools provide training for staff to understand the signs of secondary traumatic stress and the ways to prevent STS and burnout. A support structure that promotes help seeking should be available to support the self-care of its staff, teachers, and administrators. Offerings of wellness activities and promoting routine health care is another critical component to supporting staff well-being.

▲ **2 In-School Supports for Educators.** Peer supports and stress-management are provided for educators displaying signs of burnout and/or STS. Schools integrate protocols for checking in with educators (in a non-punitive manner) to assess their level of need.

▲ **3 Support Services and Employee Assistance Programs Availability.** School staff have access to resources after experiencing potentially traumatic life events or exposure to substantial levels of stress in their professional or personal lives. Access and utilization of these resources are provided in non-stigmatizing ways. Ensure that Employee Assistance Programs (EAPs) and insurance companies offer trauma and loss-specific evidence-based practices.

IX

School Discipline Policies and Practices

The school includes a trauma-informed lens in the review and revision of discipline policies and practices. The impact of traumatic life experiences on students' behavior and home life is considered when administering discipline. Disciplinary actions should be aimed to address the safety of those in the school environment and to utilize available resources to help students learn skills that support reintegrating into the school.

▲ **1 Standard Discipline Procedures Are Trauma-Informed and Equitable.** Schools refrain from using zero tolerance policies and out-of-school discipline procedures as a primary disciplinary tool. Schools also refrain from unnecessarily calling on school resource officers (SRO) for punitive responses to student behaviors and integrates SROs into non-punitive school activities to increase trust. Schools should consider whether traumatic event exposure plays a role in student behavior and communicate behavioral expectations and disciplinary actions in a clear and consistent manner. Disciplinary procedures are implemented in an equitable way that eliminates disproportionality in disciplinary practices.

▲ **2 Disciplinary Actions Accompanied by Trauma-Informed Interventions.** Students requiring frequent disciplinary actions are assigned appropriate support services to address underlying causes of the behavior. The school coordinates support services with the student's family and gives appropriate referrals as available when required.

▲ **3 Restorative Practices Embedded in Disciplinary Protocols.** Best practices for engaging students in repairing situations and relationships harmed by their behavior are integrated into disciplinary procedures (i.e., restorative justice practices).

X

Cross System Collaboration and Community Partnerships

Trauma-informed approaches span all aspects of the school environment, including classrooms, health services, administration, school discipline and attendance, guidance, and extra-curricular programming. Staff collaborate to ensure continuity of trauma-informed practices across student services. The school routinely collaborates with family and community partners for trauma-informed approaches. Schools outreach to community partners, including community mental health organizations, community diversity and human rights organizations, youth-focused groups, law enforcement, child welfare, advocacy groups, military family organizations, and others to (1) increase their knowledge of the impact of trauma exposure on children and youth, (2) share strategies for supporting students impacted by traumatic stress, (3) increase their knowledge of secondary traumatic stress and the personal and professional impact of working with trauma-impacted children, youth, and families, and (4) share strategies for promoting health and wellness in educators and school staff. School leaders participating in community advisory boards or taskforces ensure that schools contribute to collective efforts toward building a trauma-informed community.

▲ **1 Developing and Sustaining Trauma-Informed Policies and Practices.** Laws, policies, and funding streams are cultivated and maintained to support schools in the development of an action plan to create whole-school trauma-informed approaches that are organized according to core school operations. The ultimate goal is to pro-

vide clear and consistent messages among partners—including all levels of school governance, federal agencies, state and local government—articulating a clear, strong, coordinated message that trauma-sensitive schools are a priority. Schools and districts build and maintain organizational infrastructure, including the support of local "champions," to sustain trauma-informed practices. These practices include ongoing assessment of the effectiveness of trauma-informed policies, practices, and procedures.

▲ **1 Resource Mapping and Service Access.** Schools, community agencies, and state and local governments collaborate to ensure support services are an integral part of trauma-sensitive whole-school environments and that they connect students to their school communities. Further, schools and partners should routinely generate a catalogue of services available at the school and in the community. These services should be based on screening and assessment outcomes and delivered to students with fidelity to evidence-based principles.

▲ **2 Multidisciplinary Team-Based Approaches.** The school uses team-based approaches for problem-solving, decision-making, and action planning to support students receiving Tier 2 level intervention efforts. Teams facilitate student eligibility and placement into Tier 2 group interventions, monitor progress and effectiveness of interventions, and collectively collaborate to make adjustments to the student's intervention plan.

▲ **3 Consultation and Partnership with School Staff and Community Members.** Intensive trauma-informed school-based individual and family interventions should include consultation with school staff and wrap-around services. Partnerships in the community that can maintain youth safety and where youth may utilize services should be established in child welfare and residential settings, justice settings, or law enforcement settings.

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The Association Between Adverse Childhood Experience (ACE) and School Success in Elementary School Children

Christopher Blodgett
Washington State University Spokane

Jane D. Lanigan
Washington State University Vancouver

We explored the feasibility of using school personnel as reporters to examine the relationship between the level of adverse childhood experiences (ACEs) exposure in a nonclinical sample of public elementary schoolchildren and academic risk. We selected a random sample of 2,101 children from kindergarten through 6th grade classroom rosters at 10 elementary schools. Students were 50% male, 78% White, and 55% free and reduced meal program participants. School personnel reported their factual knowledge of 10 ACEs and academic risk in a database controlled by the schools. Data were de-identified prior to analysis. A high prevalence of ACEs exposure was reported (44%), with 13% of students experiencing 3 or more ACEs. Binary logistic regression analyses revealed a dose–response effect between the number of ACEs and risk of poor school attendance, behavioral issues, and failure to meet grade-level standards in mathematics, reading, or writing. Using elementary school personnel reports of child ACE exposure minimized family burden and potential intrusion while producing prevalence estimates consistent with those of caregiver report from the National Survey of Children's Health. Results suggest that understanding and responding to a child's ACE profile might be an important strategy for improving the academic trajectory of at-risk children.

Impact and Implications

Although fewer than half of elementary school students had adverse childhood experiences (ACEs) exposure, 13% of students experienced 3 or more ACEs. As ACE exposure increased, students were more likely to have poor school attendance, behavioral issues, and failure to meet grade-level standards. Staff report of known ACE exposure in students is useful for describing the prevalence of ACEs in the school population and detecting academic and behavioral risk.

Keywords: adverse childhood experience, academic risk, school success, trauma-informed system

Supplemental materials: http://dx.doi.org/10.1037/spq0000256.supp

Adverse childhood experiences (ACEs) refer to the prolonged exposure of children to potentially traumatic events that may have immediate and lifelong impact (Felitti et al., 1998). ACEs can occur across the child, family, or community ecologies and may include child maltreatment (e.g., verbal, physical, or sexual abuse), family stress or dysfunction (e.g., a family member that is mentally or physically ill, incarcerated or substance abusing; the absence or loss of a parent because of death, divorce, or separation; domestic violence), community violence, and natural disasters (van der Kolk, 2005). The public health implications of ACE are supported by a substantial literature that documents the dose–response relationship between ACE exposure and a large variety of negative physical and mental health outcomes in adulthood (Centers for Disease Control and Prevention, 2010; Felitti & Anda, 2010). Those studies, however, rely on retrospective adult reports. The proximal effects of ACE exposure on childhood physical health, mental health, and academic outcomes have received limited research attention. The current study advances the ACE literature by using school personnel rather than parent or child report to examine the prevalence of ACE exposure in a nonclinical sample of kindergarten through sixth grade (K-6) public elementary schoolchildren and the association between student ACE profiles and the risk of academic, behavioral, and attendance problems.

ACE Prevalence

ACE exposure is widespread in the United States. Retrospective recall among a representative adult population using the ACE module of the Behavioral Risk Factor Surveillance System found that 59% reported having one or more ACE, with almost 9% reporting five or more ACEs (Bynum et al., 2010). The 2011–2012

Christopher Blodgett, Department of Human Development, Washington State University Spokane; Jane D. Lanigan, Department of Human Development, Washington State University Vancouver.

Blodgett directs the Child and Family Research Unit and has ongoing research programs at the national and state level addressing adverse childhood experiences and trauma response. Lanigan is an Associate Professor and Academic Director in the College of Agriculture, Human and Natural Resource Sciences.

Correspondence concerning this article should be addressed to Christopher Blodgett, Child and Family Research Unit/CLEAR Trauma Center, Washington State University, P.O. 1495, Spokane WA 99210. E-mail: blodgett@wsu.edu

National Survey of Children's Health (NSCH) added nine items to examine ACE exposure in children 0 to 17 years of age. NSCH, which uses parent report, found that 48% of children experienced one ACE and 22.6% experienced two or more ACEs (Bethell, Newacheck, Hawes, & Halfon, 2014). Economic hardship was the most frequently reported ACE, followed by divorce or separation of a parent and living with a parent who has a substance abuse issue (Sacks, Murphey, & Moore, 2014). No studies were identified that examined ACE prevalence in a representative sample using school personnel reporting.

ACE, Cumulative Risk, and Trauma

Predating the emergence of ACE as a framework for describing risk, the cumulative risk (CR) model suggests that increasing numbers of concurrent risk factors are predictive of a higher prevalence of negative developmental outcomes in children (Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). Risk factors are conceptualized as dichotomous variables, which are summed to create a CR metric. The model, which focuses on the cumulative number of risks experienced rather than the nature of the risk exposure, has received robust empirical support for its predictive ability, but has been criticized as being atheoretical—lacking the power to explain the observed effects (Evans, Li, & Whipple, 2013). In addition, the CR model permits identification of a variety of specific risks, which limits comparability across studies. By contrast, the original ACE questions represent a specific constellation of CR factors linked by their emergence specifically in childhood and their potential to induce a chronic stress response requiring frequent mobilization of physiological systems. This increased allostatic load can result in disruptions in typical neural development (McLaughlin, Sheridan, & Lambert, 2014).

It is important to note that ACE exposure does not inevitably result in an increased allostatic load, developmental problems, or trauma because protective factors such as individual characteristics, safe nurturing relationships, and family or community supports can mitigate ACE risk (Brown & Shillington, 2017; Hamby, Grych, & Banyard, 2018). The variable contribution of ACE to trauma risk is further complicated in childhood because of the emergent nature of adjustment problems. These problems may be precursors to mental health disorders from trauma, or they may never meet the diagnostic thresholds but still interfere with a child's academic success and social skill development.

In education, the discussion of ACE effects is often used interchangeably with discussions of trauma, even though the concepts of ACE exposure and childhood trauma disorders are distinct. When referring to trauma-related mental health problems, current *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) inclusion criteria align only with original ACE questions for direct or witnessed threat of death, severe physical injury, or sexual violence. Although not elements in a trauma-related diagnosis, ACE items like caregiver mental health, family member incarceration, and divorce are potential contributors to persistent and damaging stress and disrupted adjustment. The overlap in concepts is reinforced by shared concerns with the neurodevelopmental threats resulting from persisting stress and shared intervention targets to improve affect self-regulation, attachment quality, and resilience in affected individuals. Recognizing the distinct but complementary implications of ACE and trauma can support a continuum of comprehensive and conceptually aligned responses contributing to educational efforts to create multitiered systems of support (Freeman, Miller, & Newcomer, 2015), in which a common understanding of risk permits consistent responses adjusted to children's needs.

Effect of ACE Exposure on Children

Health, Behavior, and Quality of Life Outcomes

Although a multitude of studies have examined the effects of ACE exposure in adulthood, the literature regarding children remains limited. In a survey conducted by the National Child Traumatic Stress Network, 63 clinicians treating 1,699 children reported that patients had been exposed to a mean of 2.9 childhood traumas, with the most frequent types being child emotional abuse, loss, impaired caregiver, and domestic violence. Three quarters of the children experienced multiple events or continuing trauma exposure. The most frequent posttraumatic sequelae reported were affect dysregulation, attention/concentration, negative self-image, impulse control, and aggression/risk-taking (Spinazzola et al., 2002). Although this study did not use the ACE framework, several of the ACE indicators are embedded in the adversity exposures examined.

Two studies used adapted versions of the original ACE questionnaire to assess ACE exposure and the incidence of problematic behaviors during childhood. Both found a positive relationship between ACE exposure in children and developmental or health issues. Higher ACE exposure was positively associated with behavioral problems, a higher incidence of mental health disorders, special health care needs, and an increased risk of obesity (Bethell et al., 2014; Burke, Hellman, Scott, Weems, & Carrion, 2011).

Academic Risk and Demographic Characteristics

Student demographic differences are known contributors to academic risk and have complex associations with ACE exposure risk. Girls perform better than boys in school, with differences in self-regulation as a suggested mechanism contributing to these sex differences (Duckworth & Seligman, 2006). The evidence for sex differences in ACE exposure, however, is inconsistent depending on the specific ACE and type of outcome (Mersky, Topitzes, & Reynolds, 2013). Racial group membership has been associated with ACE risk as well as lower academic achievement, with non-Hispanic Black and Hispanic populations at greatest risk (Centers for Disease Control and Prevention, 2010; Duncan & Magnuson, 2005). Poverty increases the risk for lower academic achievement (Duncan & Magnuson, 2005) and was positively correlated with ACE exposure (Tomer, 2014).

Academic Outcomes

A higher incidence of ACE was associated with greater risk of repeating a grade, absenteeism, and lower school engagement (Bethell et al., 2014). Burke and colleagues (2011) found that as ACE exposure increased, learning and behavior problems in schools also increased. Single and co-occurring adversities have been shown to negatively affect reading ability (Delaney-Black et al., 2002; Duplechain, Reigner, & Packard, 2008). Multilevel risk factors can have a cumulative effect on school outcomes. In a study involving 10,639 urban third graders, researchers used multilevel modeling to examine

how school concentrations of early risk factors affected attendance and achievement in reading and mathematics (Fantuzzo, LeBoeuf, & Rouse, 2014). Although the study focused on school concentrations of risk factors rather than individual risk profiles, and the risk factors examined were not limited to those associated with ACE, results indicated that high concentrations of children who were experiencing four risks (displacement, homelessness, child maltreatment, or inadequate parental care) were associated with lower reading achievement and school attendance.

Current Study

This study contributes to the literature by examining the proximal effect of ACE exposure in a nonclinical, representative sample of K-6 public elementary schoolchildren and the risk of academic, behavioral, and attendance problems. This study explores the utility of using educators as reporters of ACE exposure in their students. The use of professionals reporting their knowledge of risk, referred to as *sentinel surveillance*, is an established practice in the National Incidence Study of Child Abuse and Neglect (Sedlak et al., 2010). We adopted this strategy to examine ACE exposure in schools because it is minimally invasive, relatively low cost, and a strategy that local schools could adopt to determine the impact of ACE exposure on their school success. Documenting the utility of professional report would provide an alternative to other assessment strategies, such as screening for trauma, that could minimize family burden and limit the level of sensitive information maintained in school records. Professional report compiles information that may suggest the need for additional inquiry about whether increasing adversity poses a barrier to individual student and overall school success.

The literature addressing scope of adversity exposure in the general population and the potential school effects is limited. This study provides an added estimation of adversity exposure and impact in elementary-aged children. The prevalence of ACE exposure has been estimated from the NSCH parent survey. Although parents are most likely to have knowledge of ACEs across contexts, a social desirability confound risks underestimating ACE prevalence. National data may have limited application in local school decision making, but school collection of local data from families is complicated by mandated reporting requirements and the need to protect sensitive information. School personnel report of factual knowledge of ACE exposure eliminates the possible parent social desirability confound while protecting children and families from intrusive data collection that risks disclosure to mandated reporters.

Two hypotheses guided the current study: (a) A dose effect should be found, in which the total number of ACEs should be positively associated with each of the following—school absence, behavior problems, and failure to achieve grade-level standards in mathematics, reading, or writing; and (b) The prevalence of ACE exposure determined by local school professional report should underestimate the prevalence of ACE exposure when compared with the NSCH survey.

Method

Sample

The sample consisted of 2,101 children randomly selected from de-identified K-6 classroom rosters provided by 10 elementary schools distributed across four school districts in a medium-sized Northwestern metropolitan area. Five Title I (an indicator of high poverty percentages) and five non-Title I schools participated. Fifty percent of children were male and 50% female, with 78% identifying as White, 6% more than one race, 4% Native American, 4% Hispanic, 3% African American, 2% Asian, 1% Pacific Islander, and 2% not reported or other. Free and reduced meal (FRM) program enrollment was used as a proxy measure for poverty. In the total sample, 55% of students were FRM enrolled. Thirteen percent of the students were classified as special education students. Demographic characteristics reflect the public school population of the region.

Measures

Student risk. We adapted the original ACE survey into a 10-item questionnaire (Felitti et al., 1998). The original ACE survey included 10 questions adapted from previously validated survey instruments (Felitti et al., 1998). With the permission of one of the original ACE study authors, we retained original wording on all questions except for those addressing neglect, physical abuse, emotional abuse, and sexual abuse. A positive answer to any of these four questions could require a mandated report to child welfare by the school, with resulting disclosure risk to families. These four questions were replaced with questions addressing any contact with child welfare services, homelessness, or homelessness risk, and significant concerns about basic needs related to food and clothing as proposed indicators of abuse and neglect risk. These items are consistent with the recommendation by Freisthler, Merritt, and LaScala (2006) that specific challenges to resources and supports can serve as indicators of child maltreatment risk. In addition, we added exposure to community violence, which was not part of the original ACE questions but was chosen to provide an additional indicator of violence exposure risk. The adapted ACE questions are included in the online supplemental appendix.

Prior to data collection, school professionals (teachers, school psychologists, and principals) received 1 hr of training regarding the survey and definition of factual knowledge, which included child or parental report of experiences disclosed directly to school personnel or notification by social service agencies such as Child Protective Services (CPS; the term in this community for the child maltreatment response system) to school personnel. The data collected consisted of existing knowledge of school personnel, not suspicions. No additional information was solicited from caregivers or children. The research team did not participate in the reviews of selected children and only received categorical information as de-identified data with a numeric code. School professionals recorded their factual knowledge of the following 10 experiences for two time periods, during the previous 12 months and since the child's birth: (a) Has this child ever been homeless or highly mobile (an education term indicating homelessness risk)?; (b) Has this child ever had a CPS referral or out-of-home placement?; (c) Has this child ever had unmet basic needs that interfere with school adjustment?; (d) Have this child's parents been divorced or separated?; (e) Has this child experienced the death of a primary caregiver?; (f) Has any member of this child's family ever been incarcerated?; (g) Has this child ever witnessed or been the victim of domestic violence?; (h) Has this child ever witnessed or been the victim of community violence?; (i) Has any member of this child's family been diagnosed with mental illness?; and (j) Has any

member of this child's family had a substance abuse problem? An affirmative response was scored as 1 and no known exposure was scored 0. The sum of scores across the 10 questions represented the child's ACE exposure score.

Academic status. School staff rated academic concerns as currently true or not true on three separate dimensions producing three ratings of each student reviewed: academic failure, significant attendance concerns, and significant school behavior problems. Academic concerns were based on school records and defined as not meeting grade-level standards in reading, writing, or math as reported on the most recent student report card. Attendance and school behavior concerns were based on school staff reporting these issues as existing areas of the school's concerns for the specific student. Attendance problems were defined as a pattern of absent days, late arrivals, or early dismissals that interfered with the student's learning. School behavior problems were defined as a pattern of behavior either in the classroom or the school that interfered with the student's learning or disrupted the classroom environment. School behavior problems were further distinguished as principally internalizing, externalizing, or having both internalizing and externalizing characteristics. Student academic, attendance, and behavior concerns were based on the categorical designation (concern or not a concern) by the educators that one or more of these three areas was a focus for needed additional supports based on the cumulative professional experience of the child.

Procedure

This study was approved by the Washington State University Institutional Review Board (IRB). Data collection involved de-identified categorical ratings of student status (e.g., known risk exposure, attendance concerns as yes–no responses) based on school records or professional knowledge. Data collected was considered as existing data. The IRB approved a waiver of informed consent from caregivers and children given there was no contact with either caregivers or children and the research team received de-identified data. Informed consent was required for school personnel participating in the data collection.

Schools were provisionally recruited through the building principal following professional development workshops for elementary schools about ACE. The school district superintendent's office provided final authorization for schools that volunteered to participate. School leadership, classroom teachers, and other educational specialists (counselor, learning support, literacy specialist, psychologist, and nonclassroom teachers such as physical education, music, or media) who volunteered to participate in the study provided informed consent. Greater than 95% of personnel in the 10 study schools agreed to participate, including 179 classroom teachers as well as an additional 100 school leaders and educational specialists.

Students were randomly selected from de-identified student rosters provided by the schools from consented teachers' classrooms. Half of the students in each classroom were selected based on alternating positions (first, third, etc.) of the students on the classroom roster and given a unique study identifier. The key list linking identifiable student information and the unique study identifier were generated by a Microsoft Excel program provided to the participating school. At no time did members of the research team have access to identifiable student information. The lists of selected students were then entered in a Microsoft Access database that allowed the schools to reidentify students for reporting while assuring that the research team did not have access to identifying student data. The staff then used the Access data collection tool on school computer systems to respond to the student risk and academic status questionnaire for each selected student. The resulting student data reports were exported from the Access database as individually de-identified data sets for analysis.

School professionals received a 1-hr training regarding the survey and definition of factual knowledge. In order to reduce the burden of data collection and maximize flexibility, schools determined how data would be collected. Some schools had the classroom teachers complete the reports individually, with supplemental information then added for each student by other personnel (principals, educational specialists). In other schools, data collection was integrated into student planning meetings in which several staff and building leadership completed the data reporting in small groups. Regardless of data reporting strategy, the classroom teacher first provided their responses, and school leadership and education specialists then added information but could not change the reports of the classroom teacher.

Statistical Analyses

Student demographic, academic success measures, and adversity exposure were analyzed using SPSS Version 22 to describe the nature of ACE exposure in the sample and explore the predictive utility of ACE exposure in understanding academic risk. The scope of risk exposure was assessed using descriptive and nonparametric statistical tests to examine the interaction of ACE and student demographic characteristics. The explanatory utility of ACE as a correlate of student concerns was tested separately for academic success, attendance, school behavior, and total concerns using binary logistic regression analyses, analysis of variance (ANOVA), and generalized estimating equations (GEE) analyses. Binary logistic regression permitted examining the unique predictive power of ACE after accounting for the risk contributions of school program enrollment and student demographics. GEE is a related regression strategy that is particularly useful for controlling group effects (school districts, schools, teachers) that are highly correlated with the variables we are interested in testing (Hanley, Negassa, Edwardes, & Forrester, 2003). For the GEE analyses, school district, school site, and teacher were entered as the fixed effects and the level of ACE exposure was compared in turn with student grade level, student gender, student race (White or other race), FRM enrollment status, and special education enrollment as other variables of interest. District, school, and reporting teacher were included as fixed factors in the GEE analyses, with the goal of controlling for possible policy and practice differences across the 10 schools and participating classroom teachers. Student demographic characteristics and educational program status are routinely collected data known to correlate with academic success or the incidence of behavior and attendance concerns.

For academic success, school attendance, and school behavior concerns, the predictive significance of each variable was represented as an odds ratio (*OR*) controlling for the other variables. *OR*s for ACE reflect the relative risk of academic, attendance, or school behavior concerns after controlling for the school program

enrollment and demographic variables. The odds tables represent the relative risk of the school concerns by comparing children with increasing known ACE to children for whom there were no known ACEs.

Results

Demographic Characteristics and ACE Exposure Prevalence

A frequency analysis was conducted to examine the prevalence of known exposure for each of the 10 types of adversity reported. Among children with reported ACE exposure, divorce was the most frequent ACE (36%) and loss of a primary caregiver (2%) was the rarest. Table 1 presents the ACE frequency percentages.

ANOVA analyses examined mean ACE exposure for five child demographic characteristics (race, grade level, gender, special education enrollment, and FRM enrollment). ACE exposure was coded as no known ACE (56%, $N = 1,170$), one ACE (22%, $N = 457$), two ACEs (10%, $N = 209$), three ACEs (5%, $N = 112$), and four or more ACEs (7%, $N = 153$). ACE exposure was not significantly related to grade level or student gender. However, ACE risk was significantly related to student's race (White or other racial groups), special education enrollment, and FRM enrollment. Table 2 presents the results of ANOVA comparisons of mean ACE scores for these variables.

School Performance Concerns and the Dose Effect of ACE Exposure

Fifty-one percent of the students had no reported school performance concerns (academic failure, attendance problems, school behavior problems), 27% had one of the three areas of concern, 17% had two areas of concern, and 5% had all three areas of concern identified. Table 3 summarizes the ANOVA comparisons for mean ACE score by level of school performance concern.

Thirty-four percent of students were failing to meet grade-level standard in one or more of the three learning areas. Students with two and three areas of school performance concerns were combined because of the comparatively small number of students ($N = 97$) with all three areas of concern.

Table 1
Percent of Children With Reported Lifetime Exposure to 10 Adverse Experiences

Type of adverse experience	*n*	%
Residential instability	182	9
CPS involvement	188	9
Basic needs	164	7
Parents divorced	762	36
Primary caregiver died	41	2
Family member mental health	100	5
Family member substance abuse	153	7
Domestic violence	180	9
Parent incarcerated	76	4
Community violence	54	3

Note. $N = 2,101$. CPS = Child Protective Services.

Thirteen percent of students had significant attendance problems. Students with identified attendance problems had a significantly higher ACE score ($M = 1.8$, $SD = 1.3$) compared with students without attendance concerns ($M = 0.8$, $SD = 1.9$). Twenty-eight percent of students had significant school behavior concerns; 16% of the overall sample were identified with externalizing behaviors, 6% with internalizing behaviors, and 6% with both internalizing and externalizing behaviors. The type of school behavior concern was significantly related to known ACE exposure. ACE exposure increased for all types of school behavior concerns but was greatest for the children identified with both internalizing and externalizing behavior concerns.

ACE as an Indicator of Academic Risk

Increasing ACE exposure was associated in a linear fashion with greater rates of academic failure, attendance problems, and school behavior problems after controlling for the school the student attended, grade level, gender, race, FRM enrollment, and special education enrollment. As ACE levels increased, the percent of children with two or more areas of school problems increased. Twelve percent of students with no known ACEs had two or more areas of school problems compared with 52% of students with three or more ACEs. Academic failure was meaningfully correlated with both attendance, $r(2101) = 0.24$, $p < .001$, and school behavior concerns, $r(2101) = 0.34$, $p < .001$. Attendance and school behavior concerns were weakly correlated, $r(2101) = 0.16$, $p < .001$. As the number of school performance concerns increased, the mean ACE scores of children also increased, $F(1, 2,098) = 169.9$, $p < .0001$. The mean scores by level of school problems were 0.47 ACEs with no reported school concerns, 1.04 ACEs with one area of school problem, and 1.75 ACEs with two or more areas of school problems.

Schools in the study differed significantly in terms of ACE exposure, with higher mean ACE scores in Title I schools, $F(1, 2,091) = 23.2$, $p < .0001$. The range in mean ACE scores by school was 0.17 to 1.5 ACEs. In the GEEs, the student's school was used as the grouping variable to control for potential differences across the 10 schools. Comparing students with four or more ACEs to students with no known ACEs, the observed *OR*s were as follows: academic failure ($OR = 3.4$, $p < .0001$), attendance problems ($OR = 4.9$, $p < .0001$), and school behavior problems ($OR = 6.9$, $p < .0001$). Table 4 presents the progressive ACE level's *OR*s for academic failure, attendance problems, and school behavior problems.

Discussion

Recent studies provide limited confirmation that children's ACE exposure is associated with academic success (Bethell et al., 2014; Fantuzzo et al., 2014). The present study results replicate this relationship and provide a more nuanced description of the relationship between ACE and academic failure in elementary school-children—as known ACEs increase, the risk of a broad range of school-related problems also increases. The results suggest that an understanding of ACE risk is not only useful for the most vulnerable children but may also be productively used to understand and respond to children who struggle with academic success as a critical developmental process but who may never be formally diagnosed or referred for services.

Table 2
ANOVA by Demographic Variables

Student demographics	*n*	Mean ACE score	*F*	*df*	*p*
Race					
White	1,647	.9	20.3	1,2099	.0001
Other racial groups	454	1.2			
Grade level					
K	298	.75	2.3	1,2094	.03[a]
1	335	.76			
2	298	.94			
3	299	1.00			
4	328	1.04			
5	326	.89			
6	217	.99			
Gender					
Male	1,055	1.41	2.60	1,2100	*ns*
Female	1,046	1.32			
Special education enrolled					
No	1,824	.9	41.8	1,2099	.0001
Yes	277	1.5			
Free and reduced meal enrollment					
No	938	.4	287.6	1,2099	.0001
Yes	1163	1.4			

Note. ACE = adverse childhood experience; *df* = degrees of freedom; K = kindergarten; *ns* = not significant.
[a] Because of the large sample size, statistical test results greater than $p < .01$ were considered nonsignificant.

The Utility of and Constraints on Educator Report of Adversity

The original ACE questions have demonstrated significant construct and predictive validity across multiple research studies. Although adult retrospective recall of childhood events has been criticized as an assessment method, the principal impact according to Hardt and Rutter (2004) is underreporting of experiences. Examining adversity exposure in children presents several complications because of mandated reporting laws regarding child maltreatment and the complexities of safely introducing the purpose of these questions in ongoing relationships between schools and parents.

The present strategy using educators as reporters is likely to underreport the scope of adversity in the lives of children, particularly those functioning well in the school environment. Parents and children may be careful about disclosure. Staff receptiveness to, and recall of, adverse disclosures may vary. Despite these constraints, the present study suggests that researchers can use professional reporting to identify relative risk in a manner that minimizes burden, potential intrusion, and unintended consequences in families. Because the reporting strategy employed in this study organized information already known to educators, school burden concerns were minimized and the ethical duty to protect participants when collecting new information was main-

Table 3
ANOVA of Mean ACE Scores by Level of School Performance Concerns

School performance concern	*n*	Mean ACE score	*F*	*df*	*p*
Total school performance concerns	1,078	.5	180.5	2,2098	<.00001
No reported concerns					
One concern	562	1.1			
Two or three concerns	461	1.9			
Academic failure					
Meeting grade level standards	1,375	.7	137.3	1,2099	<.0001
Not meeting grade level standards	726	1.4			
Attendance concerns					
None reported	1,831	.8	141.7	1,2099	<.00001
Attendance concerns	270	1.8			
Behavior concerns[a]					
None reported	1,546	.6	93.6	3,2097	<.00001
Externalizing only	325	1.7			
Internalizing only	115	1.6			
Externalizing and internalizing	115	1.9			

Note. ACE = adverse childhood experience; *df* = degrees of freedom.
[a] For behavior concerns, internalizing, externalizing, and both internalizing and externalizing behaviors were all significantly different from no reported concerns but were not different in ACE histories from each other.

Table 4
Odds Ratios for Child ACEs as a Predictor for Three Measures of Academic Risk

	Wald	*p*	Odds ratio	95% CI Lower	95% CI Upper
Academic failure					
ACEs total	63.4	.0001			
Four or more ACEs	30.8	.0001	3.4	2.2	5.2
Three ACEs	26.6	.0001	3.1	2.0	4.8
Two ACEs	24.9	.0001	2.5	1.8	3.7
One ACE	12.7	.001	1.6	1.2	2.0
Special education	172.0	.001	12.5	8.6	18.3
Gender	11.1	.001	1.4	1.2	1.7
Free and reduced meal enrollment	17.9	.0001	1.7	1.3	2.2
Attendance problems					
ACEs total	70.1	.0001			
Four or more ACEs	48.7	.0001	4.9	3.1	7.6
Three ACEs	40.6	.0001	4.5	2.9	7.2
Two ACEs	20.8	.0001	2.7	1.8	4.1
One ACE	15.8	.0001	2.0	1.4	2.8
Special education	8.9	.003	1.7	1.2	2.4
Race	10.9	.001	1.6	1.2	2.0
Free and reduced meal enrollment	9.8	.002	1.8	1.3	2.7
School behavior problems					
ACEs total	130.8	.0001			
Four or more ACEs	80.1	.0001	6.9	4.5	10.5
Three ACEs	44.3	.0001	4.8	3.0	7.7
Two ACEs	61.2	.0001	4.8	3.2	7.1
One ACE	44.0	.0001	2.4	1.9	3.2
Special education	49.7	.0001	3.4	2.4	4.8
Gender	83.2	.0001	2.8	2.3	3.6
Free and reduced meal enrollment	8.5	.004	1.5	1.2	2.1

Note. ACE = adverse childhood experience; CI = confidence interval.

tained. However, we strongly caution that schools should consider similar efforts to understand the impact of ACEs in their students only after careful planning to protect the resulting information and prepare educators to understand ACEs as a population description of risk. Particularly, educators need to understand that the evidence for population risk cannot be used to describe individual risk. Finally, we strongly endorse the principle that understanding adversity requires understanding the social and material resources that build resilience and mitigate the effects of adversity. A constraint of the present study is that we focused on establishing the value of ACE as a risk indicator but did not incorporate resilience measures in this initial study.

Known ACE did not differ meaningfully across grade levels. This appears to contradict the NSCH data finding that ACE exposure increased with child age (Sacks et al., 2014). The current study, however, included a more restricted age range that excluded adolescents. Another discrepancy with the NSCH data was that divorce rather than economic hardship was the most prevalent ACE. Instead of using generalized poverty, the current study used two specific indicators of economic hardship: homelessness and a failure to meet basic needs. This is not intended to negate the profound potential impact of poverty but rather to align with predominant practice in the ACE literature, in which poverty is considered an important environmental stressor but is not listed as an ACE. This treatment of poverty differs from the CR model and the NSCH survey. Given the high rate of FRM enrollment in our schools, it is likely that poverty would have been the most common risk if we had included it as an ACE. The consistent finding that just under half of elementary school students have experienced one or more ACEs is notable, as the studies used different data collection methods—NSCH relied on caregiver report and the current study used school personnel report of factual data.

A noteworthy result was that the association between ACE exposure and school success remained significant even after accounting for some of the most widely accepted threats to school success, including gender, variability across schools, race, and overall school poverty. Although these factors remain important considerations, accounting for ACE reduced their respective explanatory power in the current study. This finding at the individual level is similar to results of the school-level analysis conducted by Fantuzzo and colleagues (2014). Focusing on the individual students' ACE profile may provide an effective framework for practice and policy changes in education to potentially alter the academic and developmental trajectories associated with ACE exposure (Gutman, Sameroff, & Cole, 2003).

ACE risk and childhood trauma disorders are distinct but complementary concepts with the potential to inform a multilayered, continuum of response to student academic and social challenges. Schools respond to normal development variations, adaptive behaviors that are barriers to development but do not meet criteria for diagnosis, and severe disruptions for which formal diagnosis and mental health intervention are needed. Estimates of children who struggle with adjustment problems are twice as high, with an estimated 10% of children experiencing severe emotional disorders compared with an additional 20% of children with functional limitations that do not meet diagnostic standards (Committee on

Psychosocial Aspects of Child and Family Health and Task Force on Mental Health, 2009). From educators' perspectives, students' trauma disorder risk is a critical student outcome, but one considered in addition to concerns with academic achievement, attendance, and school behavior problems that are markers of both trauma and ACE effects. Because of the emergent nature of many children's mental health needs and because the effects of ACE are on a gradient, linking the ACE and trauma conversation may provide a coherent conceptual framework for risk mitigation and intervention targets that addresses the needs of the most affected children and the adaptive struggles of children with subclinical problems.

Implications

Given the prevalence of adversity in childhood, the present findings indicate that educators will benefit from broad literacy and skills in managing the developmental challenges that can result from ACE exposure. Our findings demonstrate a dose-related risk affecting over one fifth of the general school population. Many children who have significant ACEs are at risk for academic problems but likely will not meet the diagnostic and access-to-care standards that define most of our intervention systems. Although access to specialized services needs to be part of the continuum of response, adoption of trauma-informed responses and resilience-building experiences within natural systems supporting children is likely to be the most practical and effective way to respond to the scope of ACE exposure.

Exposure to adversity is a risk, not a guarantee, that problems will emerge. Educators need to be careful not to assume that school success challenges are inevitably related to ACE exposure. Rather, this study confirms the broader finding in the ACE literature that ACE exposure is an indicator of risk and may provide useful concepts about the needs of children that, in turn, may guide more effective school responses. Understanding the protective assets and resilience of the individual child and family are critical mediators of whether adversity results in significant barriers to school success.

The K-12 and early education systems are well positioned to meet the developmental needs of children whose ACE exposure has caused distress by implementing trauma-informed practices system-wide (Bilias-Lolis, Gelber, Rispoli, Bray, & Maykel, 2017). Well-established treatments for the developmental and behavioral effects of adversity are available (National Child Traumatic Stress Network, n.d.). The Trauma and Learning Policy Initiative (TLPI) identified four trauma-impacted domains that can interfere with school success: self-regulation, physical functioning, relationships, and academics (Tishelman, Haney, Greenwald O'Brien, & Blaustein, 2010). TLPI suggests adopting a "trauma lens" that uses the four domains as a framework for school-focused child assessments. Cognitive Behavioral Intervention for Trauma in Schools (Jaycox, 2004) and Support for Students Exposed to Trauma (Jaycox, Langley, & Dean, 2009) are examples of evidence-based intervention programs designed for school delivery (Jaycox, Langley, Stein, et al., 2009; Kataoka et al., 2011).

The prevalence of ACE exposure suggests prevention strategies aimed at the school level might yield even greater benefits and reach those children whose ACE exposure is undetermined. Such changes in practice are typically referred to as trauma-sensitive or trauma-informed school practices. Creating a responsive educational climate that understands the potential effects of adversity necessitates a paradigm shift based on a deeper consideration of how adversity may affect child development. Changing the complex school organizational culture will require commitment from leadership, educators, and other personnel who interact with children and their families, as well as intensive, ongoing training and technical support (Walkley & Cox, 2013). Studies suggest that teachers vary in their need for additional skills development to identify how ACE exposure and possible trauma-related symptoms may manifest in their classroom (O'Neill, Guenette, & Kitchenham, 2010) and are uncertain about how to assist children effectively (Alisic, Bus, Dulack, Pennings, & Splinter, 2012). The promise of a trauma-sensitive, whole-school approach is illustrated by Lincoln High School in Walla Walla, Washington. After a year of ongoing trauma-sensitive training, the alternative school saw school suspensions drop 85% (Stevens, 2014). It is important to note that the empirical foundation for a trauma-sensitive approach within the education system has yet to be established, as the literature contains very few controlled evaluation studies. This is a critical area for future research. In the context of public health, several states are implementing trauma-sensitive child and family systems (Kramer et al., 2015; Overstreet & Mathews, 2011; Walkley & Cox, 2013). Although the extant literature is sparse, these system-level approaches appear promising.

Limitations

There are limitations to the present study. Although using educator report of known ACE has several benefits with respect to minimizing risk, it is likely a conservative strategy, with a resulting underestimate of ACE prevalence, especially among students who are functioning well. Despite this constraint, the level of known exposure is consistent with other published results. Both the independent and dependent variables are based on educator report. To mitigate the possibility of introducing bias, educators were trained to report factual knowledge based either on objective reports (e.g., child welfare involvement, standardized performance measures, attendance records) or family self-report (e.g., disclosure of violence exposure). Although we employed six of the 10 questions from the original ACE study, four new questions were introduced, and the psychometric characteristics of the revised assessment were not tested. To increase consistency, common operational definitions were provided for the ACE items and school performance measures. Because multiple school personnel contributed to each child report, the study design did not allow computation of interrater reliability, as different informants contributed different information. When there was a discrepancy, school personnel met and reached consensus. In addition, it is likely that students who struggle in school are more likely to be students for whom risks are better understood, with the resulting risk that teachers may overreport for high-need students and underreport for students who are less challenging. Studies indicate that classroom teachers are more accurate reporters of student externalizing behaviors and that internalizing behavior often goes undetected (Bradshaw, Buckley, & Ialongo, 2008). This suggests that report of student internalizing behaviors is likely an underestimate (Bradshaw et al., 2008). The study and its reporting strategy are limited to elementary schools. It is likely that the structure and

level of teacher–student relationships in middle and high schools may limit the extension of this data collection strategy. Also, although the study includes a large randomly selected group of students, the community in which the study was conducted is not racially or ethnically diverse, and generalization of results to more diverse communities may be restricted. Finally, this study did not address resilience and protective factors in the lives of children, and the moderating effects of these personal resources were not addressed in the design.

Conclusion

The current study confirmed that the incidence of ACE exposure within the general elementary school population is relatively common, with nearly half of children experiencing one or more ACEs. Higher numbers of reported ACEs exponentially increased children's risk of poor school attendance, behavioral issues, and failure to meet grade-level standards in mathematics, reading, or writing. Results suggest that understanding a child's ACE profile and associated risk for the development of persisting trauma-related problems and the potential impact of adversity on school success may be important strategies for improving the academic trajectory of at risk children.

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Research Highlights

RAND HEALTH

Helping Children Cope with Violence and Trauma

A School-Based Program That Works

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Corporate headquarters
1776 Main Street
P.O. Box 2138
Santa Monica, California
90407-2138
TEL 310.393.0411
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Violence is one of our most significant public health issues. Between 20 percent and 50 percent of children in the United States are touched by violence, either as victims or, even more commonly, as witnesses. Even more are exposed to natural disasters, accidents, and traumatic losses. The emotional impact may be profound. Children exposed to violence frequently develop post-traumatic stress symptoms. They are more likely to have behavioral problems, poorer school performance, more days of school absence, and feelings of depression and anxiety. Violence affects all racial, ethnic, and economic groups, but its burden falls disproportionately on poor and minority children—the very children whose mental health needs are least likely to be met by the health care system. School officials are often willing to provide help at school. But these professionals face an important question: What works? Until recently, there was no evidence base for determining the effectiveness of interventions to address these problems.

To fill this gap, a team of clinician-researchers from several institutions collaborated to develop, implement, and evaluate an intervention designed to help children traumatized by violence. The team included professionals from the RAND Corporation, the University of California, Los Angeles (UCLA), and the Los Angeles Unified School District (LAUSD) and has expanded over time to include colleagues at the University of Southern California and many community partners.

The program works. Students who participated in the program had significantly fewer post-traumatic stress symptoms, less depression, and less psychosocial dysfunction. The program was implemented successfully by school-based mental health clinicians. The participating schools, located in economically disadvantaged neighborhoods, have a large percentage of Latino students, demonstrating the program's ability to reach poor and minority children. And the program was welcomed by students, teachers, school officials, and parents.

Key findings:

- cognitive-Behavioral Intervention for Trauma in schools (cBITs) significantly reduced symptoms of post-traumatic stress and depression in students exposed to violence.
- school mental health clinicians successfully delivered the program.
- The program produced consistent results and was well accepted by students, parents, and teachers.
- A version of the intervention has been adapted for delivery by regular school staff with no mental health training.
- A new website that provides online training and support for mental health professionals to deliver cBITs is now accessible, free of charge: http://cbitsprogram.org

The First Randomized Controlled Study of a School Program to Help Children Traumatized by Violence

RAND, UCLA, and LAUSD began to collaborate in 1998 to conduct studies to determine the magnitude of violence exposure and post-traumatic stress symptoms among LAUSD schoolchildren and to develop effective interventions. The team developed and implemented an earlier program designed specifically for immigrant children, many of whom are subjected to violence in their country of origin, during their immigration to the United States, and/or after their arrival (often to

a disadvantaged neighborhood). Building on the earlier work, the team designed and conducted a randomized controlled study in the 2000–2001 academic year. Students in the study attended one of two Los Angeles public middle schools in largely Latino neighborhoods. Psychiatric social workers from LAUSD administered a screening questionnaire to English-speaking sixth-grade students in the two schools. Students were eligible to participate in the program if they (1) had substantial direct exposure to violence, (2) had post-traumatic stress symptoms in the clinical range (a score of 14 or higher on the Child Post-Traumatic Stress Symptom Scale [CPSS]), and (3) were willing to discuss their symptoms in a group setting. Participants experienced a range of violence, from witnessing serious physical fights to being attacked with a knife or gun. A total of 159 students were eligible to participate; 126 actually participated (the parents of 28 children did not give consent, and five children elected not to participate). All 126 students completed the baseline assessments, 93 percent completed a three-month follow-up, and 90 percent completed both the three-month and the six-month follow-ups.

Students were randomly assigned to two groups. One group (the early-intervention group) started the program promptly; the other (the late-intervention group) was waitlisted for later in the school year. The intervention program, called the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), was developed at RAND in close collaboration with mental health clinicians at LAUSD. It consists of ten group sessions designed for inner-city schools with a multicultural population. Activities include training children in relaxation; dealing with negative thoughts; solving real-life problems; approaching anxiety-provoking situations; and coping with the violent event through talking, drawing pictures, and writing. The program is also designed to build both peer and parental support. In addition to the group sessions, the program included at least one individual session for each child, four group parenting meetings, and an educational presentation for teachers. The LAUSD school clinicians who delivered the program received two days of training and weekly supervision from the other members of the research team. To help ensure that the program was standardized, the clinicians followed the CBITS treatment manual (see the text box).

Participants Experienced Significant Mental Health Improvement

Data from students, parents, and teachers were collected at baseline, three months, and six months. These intervals enabled both early- and late-intervention groups to complete the program and to be tested in the same academic year.

Baseline: The 126 students enrolled in the program had substantial levels of exposure to violence. On average, students reported being a victim of 2.8 violent events and directly witnessing 5.9 violent events in the previous year. The mean CPSS score was 24, indicating moderate to severe post-traumatic stress symptoms. There were no significant differences between the early-intervention and late-intervention groups at the start of the program.

Three months: At three months, students in the early-intervention group had completed the program; students in the late-intervention group had not yet begun. Figure 1 compares the CPSS scores for the two groups. The early-intervention students showed substantial improvement. The magnitude of the difference between the two groups means that 86 percent of the early-intervention group reported less-severe post-traumatic stress symptoms than would have been expected without intervention. Figure 2 shows depressive symptom scores; the magnitude of the difference between the two groups means that 67 percent of the early-intervention group reported less-severe symptoms than would have been

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) Session Outline

Session 1: Introduction of group members, confidentiality, and group procedures; explanation of treatment using stories; discussion of reasons for participation (kinds of stress or trauma).

Session 2: Education about common reactions to stress or trauma, relaxation training to combat anxiety.

Individual Session: Between sessions 2 and 6.

Session 3: Thoughts and feelings (introduction to cognitive therapy), "fear thermometer," linkage between thoughts and feelings, combating negative thoughts.

Session 4: Combating negative thoughts.

Session 5: Avoidance and coping (introduction to real-life exposure), construction of fear hierarchy, alternative coping strategies.

Sessions 6 and 7: Exposure to stress or trauma memory through imagination, drawing, and writing.

Session 8: Introduction to social problem solving.

Session 9: Practice with social problem solving and hot seat.

Session 10: Relapse prevention and graduation ceremony.

SOURCE: Jaycox LH, *Cognitive-Behavioral Intervention for Trauma in Schools*, Longmont, Colo.: Sopris West Educational Services, 2003.

Figure 1
Post-Traumatic Stress Symptoms at Baseline, Three Months, and Six Months

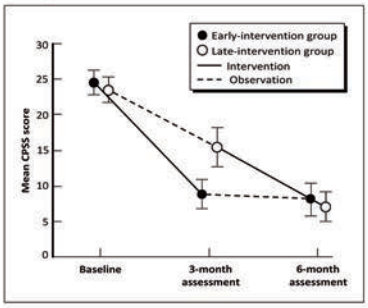
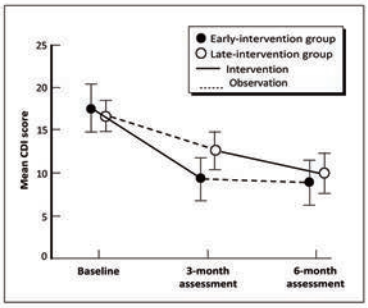


Figure 2
Depressive Symptoms at Baseline, Three Months, and Six Months



SOURCE: Stein BD, Jaycox LH, Kataoka SH, Wong M, Tu W, Elliott MN, and Fink A, "A Mental Health Intervention for School Children Exposed to Violence," *Journal of the American Medical Association*, Vol. 290, No. 6, August 6, 2003, pp. 603–611. Copyright © 2003, American Medical Association. All rights reserved.

NOTE: CDI = Children's Depression Inventory, an assessment tool and scale for measuring child depression.

expected without intervention. In addition, parents of students in the early-intervention group reported that their children were functioning significantly better.

Six months: At six months, both groups had completed the program. The group that received CBITS after the waiting period also showed substantial improvement in symptoms, and the group that had received CBITS earlier maintained their gains.

Classroom Behavior Stayed About the Same

Teachers assessed each student's shyness and anxiety, learning skills, and acting-out behavior in the classroom. Teachers observed only slight improvements throughout the study period. Possible explanations include the following: A student's classroom behavior is affected by many factors, not just the child's mental health; there may be a time lag before improved mental health translates into improved behavior; teachers may be more attuned to disruptive behavior than to anxiety or depression; or perhaps the program simply does not affect classroom behavior.

SSET: A Version of CBITS for Nonclinical School Personnel

As the CBITS program began to be disseminated nationally, the CBITS research team sought feedback from teachers, school counselors, clinicians, and national experts on how to make their program easier for schools to implement. The result was an adaptation of CBITS: Support for Students Exposed to Trauma (SSET). SSET keeps the same cognitive-behavioral approach and ten group-session structure as CBITS, but the clinical aspects of the original program have been modified to allow them to be used by teachers and other nonclinicians. Changes include the following:

- Instructors use the lesson-plan format familiar to teachers.
- Individual student sessions and optional parent sessions are eliminated.
- Students draw or write about their traumatic experiences rather than recounting them one-on-one with a counselor.

SSET Pilot Test. Beginning in 2005, SSET was pilot-tested for two years in two Los Angeles middle schools, one in the San Fernando Valley and the other in South Central Los Angeles. Most of the students were Latino and came from lower socioeconomic backgrounds, and more than half were English learners. Of the students screened for participation in SSET, 58 percent met the initial study criteria: They had experienced symptoms of post-traumatic stress disorder (PTSD). The final pilot test sample consisted of 76 students with appropriate parental and student consent to participate in the study. Three teachers and one school counselor

without any specific mental health clinical background were trained to deliver SSET. Each of the four instructors led four SSET groups; each group met once a week during the school day and received a total of ten lessons. Half of the students were given SSET immediately, while the start of the other half was delayed until the first intervention group had ended. The latter group of students served as controls.

Students were surveyed to measure their trauma symptoms at baseline, at three months after the first group had completed SSET, and at six months after the control group had completed the program. Additional assessments focused on the instructors' ability to faithfully deliver quality SSET lessons. Both students' parents and teachers were surveyed about the students' behavior at home and at school, and students were surveyed about their own symptoms and behaviors.

Promising Results. Even in this small pilot test, the results indicate that SSET can be implemented successfully by teachers and school counselors without mental health training to address violence-related PTSD and depression, especially in low-income, urban students. The pilot test results showed that, overall, students showed small reductions in trauma symptoms, with those having a high level of symptoms before taking SSET benefiting the most. In addition, both students and parents reported good-to-high satisfaction with the program. Teachers reported small improvements in student behavior, although parents did not.

A CBITS Dissemination Website: Making CBITS Training More Accessible

In March 2011, the CBITS team made CBITS training materials available online. Districts and schools now have the option of in-person or online training for mental health professionals who intend to deliver CBITS. The program's website (http://cbitsprogram.org/) allows mental health professionals to register free of charge for an online CBITS course to support training. The site also provides additional support resources, including a discussion board, an ask-the-expert feature, quick tips, and implementation materials.

Conclusions

Extensive research since 2000 has supported the team's initial study results: CBITS has significantly helped students cope with the devastating effects of violence. Students who participate in the program report fewer symptoms of post-traumatic stress, depression, and psychosocial dysfunction. CBITS is now recognized as a recommended practice by several national agencies that assess the quality of mental health interventions, including the Centers for Disease Control and Prevention's Prevention Research Center, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices, and the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention.

CBITS has been implemented widely across the United States and abroad and is also being actively disseminated through SAMHSA's National Child Traumatic Stress Network. Since 2001, the CBITS team has supported use in several states in the United States and in other countries, including

- California, Colorado, the District of Columbia, Illinois, Louisiana, Maryland, Mississippi, Missouri, Montana, New Jersey, New Mexico, Tennessee, Washington, and Wisconsin
- Australia, China, Guyana, and Japan.

The program is designed to build resilience and coping skills, so it is possible that the short-term effects identified by research will be lasting. The team hopes that the program will form the basis of continuing efforts to provide long-term help to victims of violence. ▪

CBITS Update

The new CBITS training website is available for mental health professionals interested in learning to deliver the CBITS intervention: http://cbitsprogram.org

The CBITS manual is available from Cambium Learning: http://store.cambiumlearning.com

CBITS was used successfully to help children who were affected by Hurricane Katrina with post-traumatic stress symptoms.

Adaptations and materials are available for special populations, including students in foster care and special education.

Work is ongoing to study different ways to disseminate programs like CBITS to schools.

CBITS resources are disseminated through the Trauma Services Adaptation Center for Schools and Communities, part of the National Child Traumatic Stress Network.

The RAND CBITS website includes a list of CBITS and SSET publications; information about user products, including program manuals; and related links: http://www.rand.org/health/projects/cbits.html

This research highlight summarizes RAND Health research reported in the following publications:

Stein BD, Kataoka S, Jaycox LH, Wong M, Fink A, Escudero P, and Zaragoza C, "Theoretical Basis and Program Design of a School-Based Mental Health Intervention for Traumatized Immigrant Children: A Collaborative Research Model," *Journal of Behavioral Health Services and Research*, Vol. 29, No. 3, August 2002, pp. 318–326.

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Jaycox LH, Cohen JA, Mannarino AP, Walker DW, Langley AK, Gegenheimer KL, Scott M, and Schonlau M, "Children's Mental Health Care Following Hurricane Katrina: A Field Trial of Trauma-Focused Psychotherapies," *Journal of Traumatic Stress*, Vol. 23, No. 2, April 2010, pp. 223–231.

Langley AK, Nadeem E, Kataoka SH, Stein BD, and Jaycox LH, "Evidence-Based Mental Health Programs in Schools: Barriers and Facilitators of Successful Implementation," *School Mental Health*, Vol. 2, No. 3, September 2010, pp. 105–113.

RB-4557-2 (2011)

HEALTH

THE IMPACT OF GUN VIOLENCE ON CHILDREN & TEENS

"I'M GLAD I MADE IT TO SEE 18."

When Davonte was asked what he wanted for his birthday, he didn't ask for a big celebration, he only said, "I'm glad I made it to see 18." He was shot and killed less than one week after turning 18. He had previously spoken before the Baltimore City Council on youth violence prevention.

Children and teens in the US experience staggeringly high rates of gun deaths and injuries. They are also harmed when a friend or family member is killed with a gun, when someone they know is shot, and when they witness and hear gunshots. Gun homicides, non-fatal shootings, and exposure to gun violence stunt lives and, because of their disproportionate impact, reflect and intensify this country's long-standing racial inequities.

WHEN NEIGHBORHOODS AND SCHOOLS ARE NOT SAFE FROM GUN VIOLENCE, ENTIRE GENERATIONS OF AMERICAN CHILDREN ARE AFFECTED.

Black and Hispanic children and teens are impacted by gun violence at higher rates than their white peers, in part because of deliberate policy decisions that created segregated neighborhoods and underinvestments in their communities.[1] Exposure to gun violence has an impact on children's and teens' psychological and mental well-being and affects their school performance, among other factors. When neighborhoods and schools are not safe from gun violence, entire generations of American children are affected.

KEY FINDINGS
THE DEADLY IMPACT OF GUNS ON AMERICAN CHILDREN AND TEENS

Annually, nearly 2,900 children and teens (ages 0 to 19) are shot and killed, and nearly 15,600 are shot and injured — that's an average of 51 American young people every day.[2] And the effects of gun violence extend far beyond those struck by a bullet: An estimated three million children witness a shooting each year.[3] Gun violence shapes the lives of the children who witness it, know someone who was shot, or live in fear of the next shooting.

Child and teen gun deaths per year, by intent[4]

Firearms are the second leading cause of death for children and teens.[5] This is a uniquely American problem. Compared to other high-income countries, American children aged 5 to 14 are 21 times more likely to be killed with guns, and American adolescents and young adults aged 15 to 24 are 23 times more likely to be killed with guns.[6]

When American children and teens are killed with guns, 58 percent are homicides—about 1,700 deaths per year.[7] Children are particularly impacted by the intersection of domestic violence and gun violence. For children under age 13 who are victims of gun homicides, 85 percent of those deaths occur in the home, and nearly a third of those deaths are connected to intimate partner or family violence.[8] Between 2009 and 2017, 86 percent of child victims (17 and under) of mass shootings died in incidents connected to domestic violence.[9] Data drawn from 16 states indicate that nearly two-thirds of child fatalities involving domestic violence were caused by guns.[10]

Another 36 percent of child and teen gun deaths are suicides—over 1,000 per year.[11] And firearm suicide has been rising dramatically: Over the past decade, the firearm suicide rate among children and teens has increased by 76 percent.[12] For people of all ages, having access to a gun increases the risk of death by suicide by three times.[13] Research shows that an estimated 4.6 million American children live in homes with at least one gun that is loaded and unlocked.[14] The combination of suicidal ideation and easy firearm access can be lethal. When children under the age of 18 die by gun suicide, they are likely to have used a gun they found at home: Over 80 percent of child gun suicides involved a gun belonging to a parent or relative.[15]

Gun violence manifests in a myriad of ways in American schools, and school shootings have created new anxieties for the younger generation of students. According to an Everytown analysis, there have been at least 405 incidents of gunfire on school grounds from 2013 to 2018.[16] Of these, 260 occurred on the grounds of an elementary, middle, or high school, resulting in 109 deaths and 219 injuries.[17] While mass shootings like the incident at Sandy Hook — and, more recently, Parkland and Santa Fe — are not commonplace, schools are more likely to experience homicides and assaults, unintentional shootings resulting in injury or death, and suicide and self-harm injuries. All incidents of gun violence in schools, regardless of their intent or victim count, compromise the safety of students and staff.

NINETY-TWO PERCENT OF ALL HOSPITALIZATIONS OF CHILDREN FOR FIREARM INJURIES OCCUR IN URBAN AREAS.

Children and teens who live in cities are at a significantly higher risk of gun homicides and assaults compared to their peers in rural areas. Ninety-two percent of all hospitalizations of children for firearm injuries occur in urban areas (counties with over 50,000 residents).[18] These injuries have lifelong consequences: Almost 50 percent of the wounded have a disability when they are discharged from the hospital.[19] Fifteen- to 19-year-olds in urban areas are hospitalized for firearm assaults at a rate eight times higher than 15- to 19-year-olds in rural areas.[20] Urban and low-income youth are much more likely to witness gun violence than suburban and higher-income youth.[21]

THE DISPROPORTIONATE IMPACT OF GUN VIOLENCE ON BLACK AND HISPANIC CHILDREN AND TEENS

As with gun violence generally, impact among children and teens is not equally shared across populations. **Firearms are the leading cause of death for Black children and teens in America,**[22] and they are 14 times more likely than their white counterparts to die by gun homicide.[23] Black children are 10 times more likely to be hospitalized for a firearm assault than white children.[24] Hispanic children and teens are three times more likely to die by firearm homicide than their white peers.[25]

White and Black children may live in the same city yet experience it differently. Due to policy decisions that result in racial segregation and disinvestment in certain communities, gun violence is concentrated in Black neighborhoods within cities, many of which are marked by high levels of poverty and joblessness and low levels of investment in education.[26] A high concentration of these factors in a neighborhood is referred to as "concentrated disadvantage" and is a strong predictor of violent crime. Youth in neighborhoods that experience concentrated disadvantage can be isolated from institutions such as schools and jobs, increasing the risk that they will engage in crime and violence, thus feeding into this vicious cycle.[27]

Black and Hispanic children in cities are exposed to violence at higher rates than white children. Exposure includes witnessing violence, hearing gunshots, and knowing individuals who have been shot. Black children in Columbus, OH, were exposed to 66 percent more violence, on average, than white children.[28] In Chicago, Hispanic children had 74 percent greater odds of exposure to violence, and Black children 112 percent greater odds, than white children.[29] When children in these cities are exposed to gun violence, their communities and schools often lack the resources to help them heal.[30]

The disproportionate impact of gun violence on Black and Hispanic children and teens extends to schools. Among the 253 incidents of gunfire at K-12 schools between 2013 and 2018, where the racial demographic information of the student body was known, 64 percent occurred in majority-minority schools.[31] **Although Black students represent approximately 15 percent of the total K-12 school population in America, they constitute 24 percent of the K-12 student victims of gunfire who were killed or injured on school grounds.[32]**

Black students represent

HARM TO CHILDREN FROM VIOLENCE

- drug and alcohol abuse
- depression and anxiety
- posttraumatic stress disorder
- aggressive and violent behavior
- criminal activity
- poor performance in school
- reduced physical activity

While the above discussion shows the disparate experiences of gun violence by race and ethnicity, the data further shows that **gun violence is concentrated in specific neighborhoods in cities, with some schools and certain communities experiencing gun violence with an alarming frequency.**

- Of the schools covered by gunshot detection technology in **Washington, DC,** just 9 percent experienced nearly half of all gunfire incidents. Four schools, including two middle schools and two high schools, had at least nine incidents of gunfire within just 500 feet of the school.[33]
- Similarly, in **Los Angeles,** 34 percent of middle school students in one neighborhood with high rates of violence reported exposure to firearm violence.[34]
- At certain urban middle schools in **Texas,** nearly 40 percent of boys and 30 percent of girls have witnessed a gun being pulled.[35]
- A study of 7-year-olds in an **urban neighborhood** found that 75 percent had heard gunshots, 18 percent had seen a dead body, and 61 percent worried some or a lot of the time that they might get killed or die.[36]

THE FAR-REACHING EFFECTS OF CHILDREN'S & TEENS' EXPOSURE TO GUN VIOLENCE

Children are harmed in numerous ways when they witness violence. Children exposed to violence, crime, and abuse are more likely to abuse drugs and alcohol; suffer from depression, anxiety, and posttraumatic stress disorder; resort to aggressive and violent behavior; and engage in criminal activity.[37] Exposure to community violence, including witnessing shootings and hearing gunshots, makes it harder for children to succeed in school.[38]

Exposure to gun violence can also erode physical health. When children live in neighborhoods where gun violence is common, they spend less time playing and being physically active, with one study finding that children said they would engage in an additional hour of physical activity every week if safety increased in their neighborhood.[39]

HIGH SCHOOL STUDENTS WHO HAVE BEEN EXPOSED TO VIOLENCE HAVE LOWER TEST SCORES AND LOWER RATES OF HIGH SCHOOL GRADUATION.

Stress related to gun violence affects student performance and well-being in schools. School-aged children have lower grades and more absences when they are exposed to violence.[40] High school students who have been exposed to violence have lower test scores and lower rates of high school graduation.[41] One study estimated that Black children in Chicago's most violent neighborhoods spend at least a week out of every month functioning at lower concentration levels due to local homicides.[42] In Syracuse, NY, elementary schools located in areas with high concentrations of gunshots had 50 percent lower test scores and higher rates of standardized test failure compared to elementary schools in areas with a low concentration of gunshots.[43]

Black high school students in the US are over twice as likely as white high school students to miss school due to safety concerns.[44] In Chicago, following spikes in neighborhood violence, students reported feeling less safe, experiencing more disciplinary problems, and having less trust in teachers.[45]

RECOMMENDATIONS

One essential way to protect American children and teens from gun violence in their communities and schools is to prevent people with dangerous histories from ever getting a gun. Recommendations for comprehensive gun safety laws include:

Background checks on all gun sales: The foundation of any comprehensive gun violence prevention strategy must be background checks for all gun sales. Under current federal law, criminal background checks are required only for sales conducted by licensed dealers. This loophole is easy to exploit and makes it easy for convicted felons or domestic abusers to acquire guns without a background check simply by finding an unlicensed seller online or at a gun show.

Extreme Risk laws: These laws, increasingly being adopted by states, empower family members and law enforcement to petition a judge to temporarily block a person from having guns if they pose a danger to themselves or others. Extreme Risk laws — also known as Red Flag laws — can help prevent suicide, too. That is meaningful because suicide accounts for nearly two-thirds of gun deaths in this country,[46] and the suicide rate among children and teens has been increasing exponentially in the past 10 years.

Responsible gun storage and child access prevention laws: Responsible storage laws require people to store firearms responsibly to prevent unsupervised access to firearms. A subset of these laws, known as child access prevention laws, specifically target unsupervised access by minors. Responsible firearm storage practices are associated with reductions in the risk of self-inflicted and unintentional firearm injuries among children and teens — up to 85 percent depending on the type of storage practice.[47]

Keeping guns out of the hands of domestic abusers: Children are frequent casualties of domestic violence homicides when a gun is involved. Research also shows that the presence of a gun in a domestic violence situation makes it five times more likely that a woman will be killed.[48] It is imperative to keep guns out of the hands of domestic abusers to keep women, children, and their families safe. When abusers are convicted of domestic violence or subject to final restraining orders, they should be blocked from purchasing guns and required to turn in those they already own. We also need to close the "boyfriend loophole" by making sure those laws apply to abusers regardless of whether the violence is directed towards a spouse or a dating partner.

In addition to evidence-based gun safety laws, there are a number of programs and strategies that communities and schools can adopt to keep children and teens safe from gun violence, some examples of which include:

Threat assessment programs: Threat assessment programs—like the Everytown and AFT-endorsed Virginia Student Threat Assessment Guidelines (VSTAG)[49]—help schools identify students who are at risk of committing violence and get them the help they need in order to resolve student threat incidents.[50] The programs generally consist of multi-disciplinary teams that are specifically trained to intervene at the earliest warning signs of potential violence and divert those who would do harm to themselves or others to appropriate treatment. Several studies have found that schools that use threat assessment programs see fewer students carry out threats of violence and experience fewer suspensions, expulsions, and arrests.[51] Importantly, studies have shown that VSTAG threat assessment programs generally do not have a disproportionate impact on students of color.[52]

Safe and equitable schools: School communities must look inside their schools to make sure they are encouraging effective partnerships between students and adults, while also looking externally to ensure that they are a key community resource. Schools should review discipline practices and ensure threat assessment programs are not adversely affecting school discipline. They should work to become "community schools" by building effective community partnerships that provide services that support students, families, and neighborhoods. If and when employing school resource officers (SROs), schools should take steps to build relationships between communities and law enforcement.

Youth-centric intervention programs: A variety of programs exist to help children cope with witnessing firearm violence. School-based programs, including social emotional learning, have been shown to reduce the negative effects of violence exposure. Mentoring programs are effective at improving academic performance and reducing youth violence. Chicago's Safe Passage program makes children feel safer on their way to and from school and may increase school attendance. To learn more about two specific organizations that help children succeed after witnessing violence, please explore these resources about the Hip Hop Heals and Becoming A Man programs.

If you or someone you know has been exposed to gun violence, there are resources that can help. Everytown's Children's Responses to Trauma provides information for parents and adults about how to support children and teens who have experienced a shooting or are upset by images of gun violence. Additional information to help with the emotional, medical, financial, and legal consequences of gun violence for individuals and communities is on our Resources page.

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Ten Things to Know About Trauma and Learning

Research from neuroscience highlights that adolescence represents a critical period for brain development—second in importance only to early childhood. This research shows that adolescence is a period when the human brain develops the capacity to engage in key elements of learning, such as critical thinking and problem solving. In fact, the degree to which adults can engage in analytic thinking depends largely upon the degree to which this capacity develops during adolescence. While it is well known that adolescence is a period of heightened risk for behaviors such as truancy and substance use, the "risk" of adolescence is not solely about problem behaviors. It also is about potentially limiting the ability to thrive as an adult.

Trauma[1] can impede this development by interfering with critical processes that comprise the neurological foundation for learning. The adolescent brain is malleable, which makes adolescents particularly vulnerable to the impact of trauma. Yet this malleability also presents an opportunity. Since the brain undergoes dramatic changes during adolescence, this period of development offers the chance to heal from trauma experienced early in life when young people receive targeted support and intervention.

Trauma and Victimization Are Prevalent Among the Nation's Children and Youth

1. The gun homicide rate for fifteen- to twenty-four-year-olds is forty-nine times higher in the United States than in other high-income countries.[2]
2. Among children aged one month to seventeen years, 60 percent have been exposed to violence, while more than one in ten children report five or more exposures to violence.[3]
3. Students aged twelve to eighteen years experienced 827,000 total victimizations, such as theft and nonfatal violent victimization, at school and 503,800 total victimizations away from school in 2017. Also in 2017, 20 percent of students aged twelve to eighteen years reported being bullied, which undermines their confidence and emotional well-being.[4]

Students of Color and Those from Low-Income Families Disproportionately Experience Trauma and Victimization

4. African American children aged two to seventeen years are nearly twice as likely as white children (12.8 percent versus 7.7 percent) to experience multiple types of victimization, such as sexual or physical abuse, bullying, or exposure to family violence. Children from low-income families are nearly twice as likely as more affluent children (7.3 percent versus 4.7 percent) to experience multiple types of victimization.[5] Just to be clear—no matter the group, such trauma is never acceptable.
5. Latino children between the ages of twelve and fourteen years are twice as likely as white children of the same ages to be victims of robbery (6.1 per 1,000 versus 2.9 per 1,000) or aggravated assault (7.3 per 1,000 versus 3.8 per 1,000).[6] Once again, these types of experiences must be addressed for all children as the impacts of trauma are too significant to ignore.

The Adolescent Brain Is Vulnerable to Trauma

6. Adolescence is a significant period for brain plasticity, or adaptability, during which a burst of neural connections develop that lay the foundation for students to engage in learning and complex mental tasks for the rest of their lives.[7]

ALLIANCE FOR EXCELLENT EDUCATION

7. During this period of brain growth, adolescents have a heightened vulnerability to stress because several parts of the brain are still developing, including the prefrontal cortex, which is responsible for attention, working memory, and the expression of emotions and appropriate social behavior.[8]

Trauma Impedes Learning

8. Brain scans show that trauma and stress impact regions of the adolescent brain engaged in learning. These effects include changing gray matter volume—which can inhibit working memory—and reducing the size of the anterior cingulate cortex—the portion of the brain that engages in memory formation and responds to anxiety and fear.[9]
9. Chronic stress can increase the size and sensitivity of the amygdala—the portion of the brain that stimulates the body's "fight-or-flight" response—and triggers the production of cortisol. Elevated levels of cortisol may impede learning because the parts of the brain engaged in learning (as described previously in bullets 7 and 8) are still developing and can be damaged by excessive cortisol.[10]
10. Neurological changes to the brain caused by stress affect students' abilities to learn by limiting their capacity to pay attention to things other than what is causing them stress. These changes also make it more difficult for students to remember concepts and impede students' abilities to respond appropriately to interactions in their surrounding environments and in key relationships.[11]

For additional information about the science behind adolescent learning and development, visit all4ed.org/SAL.

Endnotes

1 Trauma is any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. See R. Harper, et al., *Science of Adolescent Learning: Valuing Culture, Experiences, and Environments* (Washington, DC: Alliance for Excellent Education, 2018), https://all4ed.org/wp-content/uploads/2018/12/Science-of-Adolescent-Learning-Valuing-Culture-Experiences-and-Environments.pdf.

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Photos by Allison Shelley/The Verbatim Agency for American Education: Images of Teachers and Students in Action

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

The Impact of Racism on Child and Adolescent Health

Maria Trent, MD, MPH, FAAP, FSAHM,[a] Danielle G. Dooley, MD, MPhil, FAAP,[b] Jacqueline Dougé, MD, MPH, FAAP,[c] SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON ADOLESCENCE

The American Academy of Pediatrics is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. By acknowledging the role of racism in child and adolescent health, pediatricians and other pediatric health professionals will be able to proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health effects of structural, personally mediated, and internalized racism and improve the health and well-being of all children, adolescents, emerging adults, and their families.

STATEMENT OF THE PROBLEM

Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."[1] Racism is a social determinant of health[2] that has a profound impact on the health status of children, adolescents, emerging adults, and their families.[3–8] Although progress has been made toward racial equality and equity,[9] the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear.[10] Failure to address racism will

abstract

[a]Division of Adolescent and Young Adult Medicine, Department of Pediatrics, School of Medicine, Johns Hopkins University, Baltimore, Maryland; [b]Division of General Pediatrics and Community Health and Child Health Advocacy Institute, Children's National Health System, Washington, District of Columbia; and [c]Medical Director, Howard County Health Department, Columbia, Maryland

Drs Trent, Dooley, and Dougé worked together as a writing team to develop the manuscript outline, conduct the literature search, develop the stated policies, incorporate perspectives and feedback from American Academy of Pediatrics leadership, and draft the final version of the manuscript; and all authors approved the final manuscript as submitted.

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Address correspondence to Maria Trent, MD. E-mail: mtrent2@jhmi.edu

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continue to undermine health equity for all children, adolescents, emerging adults, and their families.

The social environment in which children are raised shapes child and adolescent development, and pediatricians are poised to prevent and respond to environmental circumstances that undermine child health. Pediatrics as a field has yet to systematically address the influence of racism on child health outcomes and to prepare pediatricians to identify, manage, mitigate, or prevent risks and harms. Recognizing that racism has significant adverse effects on the individual who receives, commits, and observes racism,[11,12] substantial investments in dismantling structural racism are required to facilitate the societal shifts necessary for optimal development of children in the United States. The American Academy of Pediatrics (AAP) is committed to reducing the ongoing costs and burden of racism to children, the health care system, and society.[13,14]

Today's children, adolescents, and emerging adults are increasingly diverse. Strategies to address health and developmental issues across the pediatric life span that incorporate ethnicity, culture, and circumstance are critical to achieving a reduction in health disparities. Accordingly, pediatrics should be at the forefront of addressing racism as a core social determinant. The inclusion of racism is in alignment with the health equity pillar of the AAP strategic plan.[15] In a series of workshops in 2016 during national meetings of pediatricians, 3 strategic actions were identified: (1) development of a task force within the AAP to address racism and other forms of discrimination that impact the health status and outcomes of minority youth, (2) development of a policy statement on racism, and (3) integration of evidence-based anticipatory guidance about racism into *Bright Futures*.[16]

The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. This policy statement will allow pediatricians to implement recommendations in practice that will better address the factors that make some children more vulnerable than others.[13] The statement also builds on existing AAP policy recommendations associated with other social determinants of health, such as poverty, housing insecurity, child health equity, immigration status, and early childhood adversity.[9,17–19]

RACISM AS A CORE DETERMINANT OF CHILD HEALTH

Racism is a core social determinant of health that is a driver of health inequities.[20–22] The World Health Organization defines social determinants of health as "the conditions in which people are born, grow, live, work, and age." These determinants are influenced by economic, political, and social factors linked to health inequities (avoidable inequalities in health between groups of people within populations and between countries). These health inequities are not the result of individual behavior choices or genetic predisposition but are caused by economic, political, and social conditions, including racism.[23]

The impact of racism has been linked to birth disparities and mental health problems in children and adolescents.[6,24–30] The biological mechanism that emerges from chronic stress leads to increased and prolonged levels of exposure to stress hormones and oxidative stress at the cellular level. Prolonged exposure to stress hormones, such as cortisol, leads to inflammatory reactions that predispose individuals to chronic disease.[31] As an example, racial disparities in the infant mortality rate remain,[32] and the complications of low birth weight have been associated with perceived racial discrimination and maternal stress.[25,33,34]

Investments in policies to address social determinants of health, such as poverty, have yielded improvements in the health of children. The Food Stamp Program, a War on Poverty initiative first developed in the 1930s during the Great Depression and later revived in the 1960s, is linked to improvements in birth outcomes.[35] Efforts in education, housing, and child health insurance have also led to improved health outcomes for issues such as lead poisoning, injuries, asthma, cancer, neurotoxicity, cardiovascular disease, and mental health problems.[20,36,37] Expansion of child health insurance has improved health care access for children, with significant gains for African American and Hispanic children in terms of access to well-child, doctor, and dental visits.[38] Despite these improvements, it is important to recognize that children raised in African American, Hispanic, and American Indian populations continue to face higher risks of parental unemployment and to reside in families with significantly lower household net wealth relative to white children in the United States, posing barriers to equal opportunities and services that optimize health and vocational outcomes.[39–45]

Juvenile justice involvement is also a critical social determinant of health. Because racial inequity continues to shape the juvenile justice system, this area is a modern example of race being an important determinant of short- and long-term outcomes. The AAP published a statement in 2011[46] focusing on key health issues of justice-involved youth, which was recently revised to include an in-depth discussion on racial and ethnic inequalities for this population.[47] Although the overall rates of youth incarceration have decreased, African American, Hispanic, and American

Indian youth continue to be disproportionately represented.[48] While incarcerated, youth experience additional adverse experiences, such as solitary confinement and abuse, that have the potential to undermine socioemotional development and general developmental outcomes.[49–51] Differential treatment of youth offenders on the basis of race shapes an individual's participation and ultimate function in society. This type of modern racism must be recognized and addressed if the United States seeks to attain health equity.[52]

THE DEVELOPMENT OF RACE AS A CONSTRUCT

Race as a social construct is rooted in history and remains a mechanism through which social class has been controlled over time. Flawed science was used to solidify the permanence of race, reinforce the notions of racial superiority, and justify differential treatment on the basis of phenotypic differences as people from different parts of the world came in contact with each other.[53] Race emerged as a social classification used to assign dominance of some social classes over others.[53] Scientific, anthropologic, and historical inquiry further solidified race as a social construct.[54] Modern science, however, has demonstrated that there is only 1 biological race and that the clines (phenotypic differences in skin and eye color, hair texture, and bone structure) at the core of early anthropologic research were insufficient to establish different races among human beings. Dr Francis Collins, former director of the National Human Genome Project and presently the director of the National Institutes of Health, has affirmed that humans are 99.9% the same at the level of their genome.[55] Despite this, efforts to collect, organize, and categorize individuals on the basis of the plausibility of the 0.01% human variation remain a force of scientific discovery, innovation, and medical-pharmaceutical collaborations.[56] Rather than focusing on preventing the social conditions that have led to racial disparities, science and society continue to focus on the disparate outcomes that have resulted from them, often reinforcing the posited biological underpinnings of flawed racial categories.[57] Although race used in these ways has been institutionalized, linked to health status, and impeded our ability to improve health and eliminate health disparities,[58,59] it remains a powerful measure that must be better measured, carefully used, and potentially replaced to mark progress in pediatric health disparities research.[60,61]

As such, it is important to examine the historical underpinnings of race used as a tool for subjugation. American racism was transported through European colonization. It began with the subjugation, displacement, and genocide of American Indian populations and was subsequently bolstered by the importation of African slaves to frame the economy of the United States. Although institutions such as slavery were abolished more than a century ago, discriminatory policies, such as Jim Crow laws, were developed to legalize subjugation. As the United States expanded west in North America and into Alaska and the Pacific Islands, the diversity of populations encompassing the United States also expanded. Native Hawaiian and Pacific Islander, Alaskan native, Asian American, and Latino American populations have experienced oppression and similar exclusions from society.[62–65] Although some racial and/or ethnic groups have received reparations[66] and fared better than others over time, remnants of these policies remain in place today and continue to oppress the advancement of people from historically aggrieved groups.[67–72]

Through these underpinnings, racism became a socially transmitted disease passed down through generations, leading to the inequities observed in our population today. Although the endemic nature of racism has powerful impacts on perceived and actual health outcomes, it is also important to note that other forms of discrimination (eg, sex, religion, sexual orientation, immigrant status, and disability status) are actively at play and have created a syndemic with the potential to undermine child and family health further. It is important to address racism's impact on the health and well-being of children, adolescents, and emerging adults to avoid perpetuating a health system that does not meet the needs of all patients.[52] Pediatricians are uniquely positioned to both prevent and mitigate the consequences of racism as a key and trusted source of support for pediatric patients and their families.

CHILDHOOD EXPERIENCES OF RACISM

Children can distinguish the phenotypic differences associated with race during infancy[73–75]; therefore, effective management of difference as normative is important in a diverse society. To identify, address, and manage the impacts of racism on child health, it is critical that pediatricians understand 3 key levels through which racism operates: (1) institutional, (2) personally mediated, and (3) internalized. The experience of race is also impacted by other identities that people have related to ethnicity, sex, religious affiliation, immigrant status, family composition, sexuality, disability, and others that must be navigated alongside race. Much of the discussion to date related to the historical underpinnings of race deals with institutionalized (or structural) racism, expressed through patterns of social institutions (eg, governmental organizations, schools, banks, and courts of law) that implicitly or

explicitly discriminate against individuals from historically marginalized groups.[22,52,76,77] Children experience the outputs of structural racism through place (where they live), education (where they learn), economic means (what they have), and legal means (how their rights are executed). Research has identified the role of implicit and explicit personally mediated racism (racism characterized by assumptions about the abilities, motives, or intents of others on the basis of race)[78] as a factor affecting health care delivery and general health outcomes.[79–86] The impacts of structural and personally mediated racism may result in internalized racism (internalizing racial stereotypes about one's racial group). A positive racial identity mediates experiences of discrimination and generates optimal youth development outcomes.[12,87,88] The importance of a prosocial identity is critical during adolescence, when young people must navigate the impacts of social status and awareness of personally mediated discrimination based on race.[89–91]

Although children and adolescents who are the targets of racism experience the most significant impact, bystanders are also adversely affected by racism. As an example, young adults who were bystanders to racism and other forms of victimization as youth experience profound physiologic and psychological effects when asked to recall the memory of a past anchoring event as a victim or bystander that are comparable to those experienced by first responders after a major disaster. Three core features that characterized the abusive event(s) were as follows: (1) an individual gets hurt psychologically or physically, (2) a power differential exists (eg, age, size and/or stature, or status) versus the target individual resulting in domination and erosion of the target's self-esteem, and (3) the abuse is repetitive, causing stress levels to increase because of anticipation of future events.[11] Internalized negative stereotypes related to race can unconsciously erode self-perception and capacity and may later play out in the form of stereotype threat or the fear of confirming a negative stereotype of one's race.[91] Stereotype threats can undermine academic and vocational attainment, key developmental milestones for the victim. Underachievement then reinforces the stereotype held by both the perpetrator and victim, further enhancing the vulnerability of the victim and the bystander to repeated acts of overt or covert victimization. These observations suggest that universal interventions to eliminate racism (experienced as a victim or bystander) from the lives of children and to engage in active societal antiracism bystander behavioral intervention may optimize well-being for all children and the adults who care for them. For individual intervention to occur, however, bystanders must identify critical situations, view them as an emergency, develop a sense of personal responsibility, have self-efficacy to succeed with the intervention, perceive the costs of nonintervention as high, and consciously decide to help.[11,92] Research has demonstrated that racism has an effect on health across racial groups in communities reporting high levels of racism[93] but that racially diverse environments, such as schools, can benefit all youth by improving cognitive skills such as critical thinking and problem-solving.[94]

RACISM AT THE INTERSECTION OF EDUCATION AND CHILD AND ADOLESCENT HEALTH

Educational and vocational attainment are key developmental outcomes that pediatricians monitor to assess for successful growth and development. After accounting for sleep and time spent at home, children spend a significant portion of their time in educational settings.[95–97] Educational achievement is an important predictor of long-term health and economic outcomes for children. Adults with a college degree live longer and have lower rates of chronic disease than those who did not graduate from college.[98] It is critical for pediatricians to recognize the institutional, personally mediated, and internalized levels of racism that occur in the educational setting because education is a critical social determinant of health for children.[99]

Disparities in educational access and attainment, along with racism experienced in the educational setting, affect the trajectory of academic achievement for children and adolescents and ultimately impact health. Chronic absenteeism, defined as missing ≥10% of school days in an academic year, is a strong predictor of educational achievement. Chronic absenteeism disproportionately affects children of color, children living in poverty, children with disabilities, and children with chronic diseases.[100] In high school, 21.2% of Hispanic, 23.4% of African American, and 27.5% of American Indian children were chronically absent in 2013–2014 compared with 17.3% of white children.[101] Immigration enforcement and the fear of apprehension by authorities can negatively affect school attendance for Hispanic and black immigrants, thereby perpetuating inequalities in attendance.[102] According to the National Center for Education Statistics, the graduation rate for white students nationally in 2015–2016 was 88% compared with 76% for African American students, 72% for American Indian students, and 79% for Hispanic students.[103] Disparities in chronic absenteeism and high school graduation rates prevent children from realizing the full benefits of educational attainment

and can increase the development of chronic disease and reduce overall life expectancy.[104]

Although the landmark US Supreme Court case *Brown v Board of Education* banned government-sponsored segregation and laid a foundation for equal access to a quality public education, the US Department of Education continues to report institutional or structural inequality in educational access and outcomes,[105] even in the most diverse and well-resourced communities in the United States. Students from historically aggrieved groups have less access to experienced teachers, advanced coursework, and resources and are also more harshly punished for minor behavioral infractions occurring in the school setting.[105] They are less likely to be identified for and receive special education services,[106] and in some states, school districts with more nonwhite children receive lower funding at any given poverty level than districts with more white children.[107]

Children may also experience personally mediated racism early in their schooling, which may be internalized and ultimately affect their interactions with others.[108] Early teacher-child interactions are important for long-term academic outcomes. The relationship of teacher to student across ages and grade levels influences school adjustment, literacy, math skills, grade point average, and scholastic aptitude test scores.[109–111] Given the critical nature of the student-teacher relationship, it is important to explore how racism and implicit bias affect this dynamic. Student-teacher racial mismatch can impact academic performance, with studies showing that African American children are more likely to receive a worse assessment of their behavior when they have a non-Hispanic white teacher than when they have an African American teacher.[112] This finding may result from racial bias in teachers' expectations of their students, with data demonstrating that white and other non–African American teachers are more likely than African American teachers to predict that African American students would not finish high school.[113] Similarly, data indicate that teachers may underestimate the ability of African American and Latino students, which can lead to lower grade point averages and fewer years of schooling.[114] African American students who have 1 African American teacher in elementary school are more likely to graduate from high school and enroll in college than their peers who do not have an African American teacher; the proposed mechanism for this improved long-term educational outcome is the exposure to a role model early in the educational experience.[115] These findings indicate the importance of ensuring a diverse teacher workforce, particularly as the population of students in US schools continues to diversify.[116] School racial climate, which refers to norms, curricula, and interactions around race and diversity within the school setting, also impacts educational outcomes for students.[117] Students who had a positive perception of school racial climate had higher academic achievement and fewer disciplinary issues.[118] Racial inequities in school discipline begin early, and school discipline has long-term consequences for children. Although federal civil rights laws prohibit discrimination in the administration of discipline in public schools, the US Government Accountability Office found that African American and American Indian students are overrepresented among students experiencing suspension.[119] Data from the US Department of Education confirm that a disproportionate number of African American children receive more than 1 out-of-school suspension in preschool and overall in kindergarten through grade 12 are suspended 3 times more and expelled 1.9 times more than white students.[120] To mediate the effects of institutional and personally mediated racism in the educational setting and prevent internalized racism, studies show that a positive, strong racial or ethnic identity and parental engagement in families is protective against the negative effects of racial discrimination on academic outcomes.[121–123]

HOW PEDIATRICIANS CAN ADDRESS AND AMELIORATE THE EFFECTS OF RACISM ON CHILDREN AND ADOLESCENTS

Pediatricians and other child health professionals must be prepared to discuss and counsel families of all races on the effects of exposure to racism as victims, bystanders, and perpetrators.[124–126] Pediatricians can implement systems in their practices that ensure that all patients and families know that they are welcome, that they will be treated with mutual respect, and that high-quality care will be delivered regardless of background using the tenets of family- and patient-centered care.[127] To do this, it is critical for pediatricians to examine their own biases.[128] Pediatricians can advocate for community initiatives and collaborate with government and community-based organizations to help redress biases and inequities in the health, justice, and educational systems. These strategies may optimize developmental outcomes and reduce exposure to adverse events that dramatically alter the lived experiences, health, and perceived self-value of youth.[48,129,130]

Optimizing Clinical Practice

In practice, pediatricians and other child health care providers encounter children every day who have experienced racism. There are interventions available for use in the medical home that can identify and potentially ameliorate inequities.

- Create a culturally safe medical home[131] where the providers acknowledge and are sensitive to the racism that children and families experience by integrating patient- and family-centered communication strategies and evidence-based screening tools that incorporate valid measures of perceived and experienced racism into clinical practice.[132–136]
- Use strategies such as the Raising Resisters approach during anticipatory guidance to provide support for youth and families to (1) recognize racism in all forms, from subversive to blatant displays of racism; (2) differentiate racism from other forms of unfair treatment and/or routine developmental stressors; (3) safely oppose the negative messages and/or behaviors of others; and (4) counter or replace those messages and experiences with something positive.[137,138]
- Train clinical and office staff in culturally competent care according to national standards for culturally and linguistically appropriate services.[139,140]
- Assess patients for stressors (eg, bullying and/or cyberbullying on the basis of race)[141] and social determinants of health often associated with racism (eg, neighborhood safety, poverty, housing inequity, and academic access) to connect families to resources.[9,142,143]
- Assess patients who report experiencing racism for mental health conditions, including signs of posttraumatic stress, anxiety, grief, and depressive symptoms, using validated screening tools and a trauma-informed approach to make referrals to mental health services as needed.[144]
- Integrate positive youth development approaches,[145] including racial socialization,[123,146] to identify strengths and assess youth and families for protective factors,[9] such as a supportive extended family network, that can help mitigate exposure to racist behaviors.[138]
- Infuse cultural diversity into AAP-recommended early literacy–promotion programs[147] to ensure that there is a representation of authors, images, and stories that reflect the cultural diversity of children served in pediatric practice.
- Encourage pediatric practices and local chapters to embrace the challenge of testing best practices using Community Access to Child Health grants and participation in national quality-improvement projects to examine the effectiveness of office-based interventions designed to address the impact of racism on patient outcomes.
- Encourage practices and chapters to develop resources for families with civil rights concerns, including medicolegal partnerships and referrals to agencies responsible for enforcing civil rights laws.
- Encourage pediatric-serving organizations within local communities, including pediatric practices, hospitals, and health maintenance organizations, to conduct internal quality-assurance assessments that include analyses of quality of care and patient satisfaction by race and to initiate improvement protocols as needed to improve health outcomes and community trust.

Optimizing Workforce Development and Professional Education

- Advocate for pediatric training programs that are girded by competencies and subcompetencies related to effective patient and family communication across differences in pediatric populations.[148,149]
- Encourage policies to foster interactive learning communities that promote cultural humility (eg, self-awareness, lifelong commitment to self-evaluation, and commitment to managing power imbalances)[150,151] and provide simulation opportunities to ensure new pediatricians are competent to deliver culturally appropriate and patient- and family-centered care.[152–155]
- Integrate active learning strategies, such as simulation[156] and language immersion,[157] to adequately prepare pediatric residents to serve the most diverse pediatric population to date to exist in the United States[158] and lead diverse and interdisciplinary pediatric care teams.[159]
- Advocate for policies and programs that diversify the pediatric workforce and provide ongoing professional education for pediatricians in practice as a strategy to reduce implicit biases and improve safety and quality in the health care delivery system.[160–162]

Optimizing Systems Through Community Engagement, Advocacy, and Public Policy

- Acknowledge that health equity is unachievable unless racism is addressed through interdisciplinary partnerships with other organizations that have developed campaigns against racism.[163,164]
- Engage community leaders to create safe playgrounds and healthy food markets to reduce disparities in obesity and undernutrition in neighborhoods affected by poverty.
- Advocate for improvements in the quality of education in segregated urban, suburban, and rural communities designed to better optimize vocational attainment and educational milestones for all students.

- Support local educational systems by connecting with and supporting school staff. The AAP Council on School Health provides resources to help physicians engage and interact with their school system and provides guidelines around the role of school physicians and school health personnel.[165,166]
- Advocate for federal and local policies that support implicit-bias training in schools and robust training of educators in culturally competent classroom management to improve disparities in academic outcomes and disproportionate rates of suspension and expulsion among students of color, reflecting a systemic bias in the educational system.[167]
- Advocate for increased access to support for mental health services in schools designed to help teachers better manage students with disruptive classroom behaviors and to reduce racial disparities in school expulsion.[144,168,169]
- Advocate for curricula that are multicultural, multilingual, and reflective of the communities in which children in their practices attend school.[170]
- Advocate for policies and programs that diversify the teacher workforce to mitigate the effects of the current demographic mismatch of teachers and students that affects academic attitudes and attainment for all students.[115,171]
- Advocate for evidence-based programs that combat racism in the education setting at a population level.[172–174]
- Encourage community-level advocacy with members of those communities disproportionately affected by racism to develop policies that advance social justice.[19,175]
- Advocate for alternative strategies to incarceration for management of nonviolent youth behavior.[50,176,177]
- Collaborate with first responders and community police to enhance positive youth engagement by sharing expertise on child and adolescent development and mental health, considering potential differences in culture, sex, and background.[178]
- Advocate for fair housing practices, including access to housing loans and rentals that prohibit the persistence of historic "redlining."[179]

Optimizing Research

- Advocate for funding and dissemination of rigorous research that examine the following:
  1. the impact of perceived and observed experiences of discrimination on child and family health outcomes[180];
  2. the role of self-identification versus perceived race on child health access, status, and outcomes[52];
  3. the impact of workforce development activities on patient satisfaction, trust, care use, and pediatric health outcomes[161];
  4. the impact of policy changes and community-level interventions on reducing the health effects of racism and other forms of discrimination on youth development; and
  5. integration of the human genome as a way to identify critical biomarkers that can be used to improve human health rather than continue to classify people on the basis of their minor genetic differences and countries of origin.[55]

CONCLUSIONS

Achieving decisive public policies, optimized clinical service delivery, and community change with an activated, engaged, and diverse pediatric workforce is critically important to begin untangling the thread of racism sewn through the fabric of society and affecting the health of pediatric populations. Pediatricians must examine and acknowledge their own biases and embrace and advocate for innovative policies and cross-sector partnerships designed to improve medical, economic, environmental, housing, judicial, and educational equity for optimal child, adolescent, and emerging adult developmental outcomes.

Makia E. Powers, MD, MPH, FAAP
Maria H. Rahmandar, MD, FAAP
Krishna K. Upadhya, MD, FAAP
Stephenie B. Wallace, MD, FAAP

LIAISONS

Liwei L. Hua, MD, PhD – *American Academy of Child and Adolescent Psychiatry*
Geri D. Hewitt, MD – *American College of Obstetricians and Gynecologists*
Seema Menon, MD – *North American Society of Pediatric and Adolescent Gynecology*
Ellie E. Vyver, MD, FRCPC, FAAP – *Canadian Pediatric Society*
Lauren B. Zapata, PhD, MSPH – *Centers for Disease Control and Prevention*

STAFF

Karen S. Smith

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ABBREVIATION

AAP: American Academy of Pediatrics

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The Impact of Racism on Child and Adolescent Health
Maria Trent, Danielle G. Dooley, Jacqueline Dougé, SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS and COMMITTEE ON ADOLESCENCE
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House Education & Labor Subcommittee on Early Childhood, Elementary, and Secondary Education

Hearing on "The Importance of Trauma-Informed Practices in Education to Assist Students Impacted by Gun Violence and Other Adversities"
September 11, 2019

Warman Hall, Principal
Aztec High School
Aztec, NM
Member, NASSP Principal Recovery Network

Congressman Sablan, Congressman Allen, and members of the subcommittee, thank you for the opportunity to submit the following testimony for the record on behalf of the National Association of Secondary School Principals (NASSP). My name is Warman Hall, and I am the principal of Aztec High School in Aztec, NM, where I have served as the principal for 10 years and before that as an assistant principal, athletic director, and dean of students. I am also a member of the NASSP Principal Recovery Network, a national network of current and former school leaders who have experienced gun violence tragedies in our buildings.

On December 7, 2017, a former student opened fire in two of our hallways and a classroom at Aztec High School just as school was getting started. The violence that day resulted in the gunman's suicide and murder of two precious student lives. As an active shooter situation, the entire event lasted roughly 15 minutes or less—but also caused a response that immediately put our school and district into lockdown and then generated a very swift response from law enforcement and emergency management. Our community is a relatively remote and rural community compared to a lot of places in the country, and shelter-in-place, if not lockdown, was issued in a number of schools around San Juan County that day.

Immediately after the event, my biggest recollection is how much of that day was swept up in the tidal flow of trying to work and coordinate with emergency responders as they came to our aid and conducted a room-by-room sweep. Then, at our site, the day culminated in an evacuation to the county fairgrounds—roughly 12 miles away—and a final reunification for families at the fairgrounds.

The shooting occurred at roughly 8:15 a.m., and I recall catching the last bus at 4:00 p.m. as we were evacuated. I also remember returning to the district office in Aztec by 7:00 p.m. after all the

kids had gotten picked up and after helping the ongoing effort to make contact with students marked absent on our evacuation roll.

As the kids had been evacuated from our gym, we had crossed names off and tried then to make contact with them that evening. The campus didn't get released back to us until two days afterward, on a Saturday, and we immediately began planning the process of opening school back up and supporting kids and staff as they returned.

The other district schools returned to classes the following Monday or Tuesday. We were not able to have kids back on campus at Aztec High for a number of days after that. The first thing that we had to do administratively was meet with school psychologists and counselors from all over the region. They encouraged us to not fully open back up for school right away. Instead, we first brought the staff in and brought them through a debriefing process.

One of the interesting tasks in the initial on-campus recovery effort was identifying backpacks and different belongings that the kids had to leave in the classrooms and hallways when they were evacuated. We brought the kids and their parents in for an afternoon and an evening where they could pick up their belongings and just reconnect with their teachers. That was literally the only goal those days: to have them reconnect with their teachers and reestablish those ties. After a couple of evenings of that, we did reinitiate our term and actually finished up the semester, telling families that we understood if kids couldn't physically or emotionally get back to campus. We felt it was important to reestablish and finish up our term. Students returned for three full school days before they were released again for Christmas break.

Although it's been almost two years since the tragedy at Aztec High School, our entire community is still recovering from the trauma of that day and trying to establish a new normal for our school. And unfortunately, I'm not the only principal in the country going through this experience. Earlier this year, I attended the first meeting of the NASSP Principal Recovery Network. Invitations were extended to school leaders who had been principals at the time of 87 school shootings that resulted in fatality or injury since 2013. Attendees included the principals of Columbine High School and Marjory Stoneman Douglas High School—but also the principal of a school near St. Louis where a student committed suicide on campus during school hours. While each of our tragedies was unique, we shared similar challenges of restoring a learning focus after a shooting, and we discussed the fine line of commemorations (not "anniversaries") that can either advance healing or reopen emotional wounds.

Conversations also revolved around the need for additional mental health services for schools, both to prevent violent incidents and to help schools recover from them. Our school counselors were amazing in the aftermath, but they weren't adequately trained to deal with trauma. Like the teachers and other adults in the building, they also felt traumatized by the shooting. My colleagues discussed the need for additional mental health services and the various strategies they used to access those resources. Our students and staff had different levels of need based on their proximity to the incident and their relationships with the shooter or the victims. And our need for mental health services didn't end once we got back to school. The annual

commemorations and recent school shoootings and other violent tragedies trigger an emotional response for our school communities, even for those principals whose incidents occurred years ago.

It was an emotional day of sharing, but it was also cathartic to talk about our incidents and recovery effort with colleagues who are also navigating the healing process. Our goal with the Principal Recovery Network is to assist principals in the immediate aftermath of a crisis and well beyond. Our members will reach out directly to our colleagues to provide much-needed support, share the combined wisdom of our experience with the larger principal community, assist schools during recovery, and advocate for national school safety enhancements and gun violence prevention policies.

Following the school shooting at Sandy Hook Elementary School, NASSP came together with five other national organizations to author A Framework for Safe and Successful Schools in 2013. The document outlines evidence-based policies and practices for improving school safety and increasing access to mental health supports for children and youth. Efforts to improve school climate, safety, and learning are not separate endeavors and must be designed, funded, and implemented as a comprehensive schoolwide approach. The document outlines specific policy recommendations on the integration of services and initiatives, implementation of integrated multitiered systems of support, access to school-based mental health supports, integration of school safety and crisis preparedness efforts, balance of physical and psychological safety, and use of effective discipline practices. I urge the subcommittee to support this guidance to shape meaningful policies that will genuinely equip America's schools to educate and safeguard our children over the long term.

This coming November, the NASSP Board of Directors will consider a new position statement on Trauma-Informed Schools. While the focus of this hearing is on children who are traumatized by gun violence, data from Child Trends indicate that 45 percent of children in the United States have experienced at least one adverse childhood experience (ACE) that could be trauma-inducing. These include abuse or neglect, violence, discrimination, bullying, natural disasters, or a death of a loved one, but the two most common ACEs are economic hardship and the separation or divorce of parent or guardian. Nationwide, 61 percent of black children and 51 percent of Hispanic children have experienced at least one ACE compared to only 40 percent of their white peers.

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. Researchers have also identified a "cycle of trauma" in schools when teachers' rules and consequences are viewed as punishment by children, increasing the likelihood of retraumatization and exclusionary discipline practices. Schools with higher incidents of ACEs also have higher rates of suspensions and unexcused absences, with lower graduation rates and postsecondary participation.

In the position statement, NASSP will offer guidance for school leaders and recommendations for state and local policymakers, but we do feel that the federal government has an important role in helping schools to be trauma-informed. First, we feel that the U.S. Department of Education should conduct

more research on how childhood trauma affects student learning and their behaviors in schools as well as provide technical assistance to help schools and educators address the educational needs of children. Congress should increase funding for Title II of the Every Student Succeeds Act (ESSA), which can be used for professional development for principals and school staff to better assist children affected by trauma. Congress should also assist schools in recruiting and retaining school counselors, social workers, and school psychologists to support school-based interventions and coordination of services. Finally, NASSP urges to Congress to adopt the Trauma-Informed Schools Act, introduced by Reps. Katherine Clark (D-MA) and Brian Fitzpatrick (R-PA). This bipartisan legislation would define "trauma-informed practices" and require state ESSA plans to address how states and districts will support efforts to increase the prevalence of trauma-informed practices in our schools.

By understanding and responding to trauma, principals, teachers, and staff can help reduce its negative impact, support critical learning, and create a more positive school environment. Trauma-informed schools can help students overcome trauma and build resilience by helping educators be responsive to the needs of their students and ensure that they can be successful in their learning.

Testimony Before the House Committee on Education and Labor

The Importance of Trauma-Informed Practices in Education to Assist Students Impacted by Gun Violence and Other Adversities

Phillip Lovell
Vice President of Policy Development and Government Relations
Alliance for Excellent Education

September 10, 2019

Chairman Scott, Ranking Member Foxx, and members of the Committee, the Alliance for Excellent Education (All4Ed) appreciates your convening a hearing about the impact of trauma on learning. In light of the numerous shootings taking place across the country that receive attention in the press, and the innumerable instances of child victimization that do not, it is critical for policymakers to understand the impact of trauma on our children and equip educators to address it.

The nation's economy, and our democracy, depend upon our ability to educate the next generation of workers, citizens, and leaders. While our nation has achieved its highest high school graduation rate on record—84.6 percent[1]—only 37 percent of twelfth graders are actually prepared for postsecondary-level reading and math.[2] Students who come from privilege—those in the top socioeconomic quintile—enroll in college at a rate that is 50 percentage points higher than their peers in the lowest quintile.[3] Among students who do enroll in higher education, persistent inequities in outcomes exist. Only 60 percent of first-time college freshmen graduate within six years.[4] Moreover, major gaps exist between college graduation rates for white students (64 percent) and students who historically have been underserved (e.g., 21 percent for African American students and 32 percent for Latino students).[5]

Despite innumerable reforms and billions of dollars in investment, our nation's education outcomes have yet to see the dramatic improvement at scale necessary to ensure that all students are prepared for postsecondary education and the workforce. One reason for this is that most of our efforts to close achievement and opportunity gaps have lacked a comprehensive approach, one that acknowledges students have significant social, emotional, and physical needs in addition to academic ones.

The activities and experiences students encounter in school are not the only factors that influence their learning and well-being. Students also are affected by their families, communities, and their own biological and social development. Typically, though, education policy efforts focus on students' academic needs in isolation and fail to consider these additional—and critical—influences. Yet this focus on instruction and academic achievement must be reinforced by comprehensive support that addresses what science now tells us about learning and development, particularly for adolescents, according to analyses recently released by the National Academies of Science[6] and All4Ed.[7]

One area that is vital to address is the impact of trauma[8] on learning. Neuroscience finds that trauma can have a detrimental impact on the ability to learn. However, this impact can be mitigated through effective support, which presents an opportunity for policymakers and practitioners to intervene, especially during the middle and high school years.

The Prevalence of Trauma and Victimization

Addressing the effects of trauma on learning requires a systemic approach because trauma and victimization affect a large portion of our nation's children and youth. Among children aged one month to seventeen years, 60 percent have been exposed to violence, while more than one in ten children report five or more exposures to violence.[9]

Students of color and those from low-income families disproportionately experience trauma and victimization. For example, African American children aged two to seventeen years are nearly twice as

likely as white children (12.8 percent versus 7.7 percent) to experience multiple types of victimization, such as sexual or physical abuse, bullying, or exposure to family violence. In addition, children from low-income families are nearly twice as likely as more affluent children (7.3 percent versus 4.7 percent) to experience multiple types of victimization.[10] Moreover, Latino children between the ages of twelve and fourteen years are twice as likely as white children of the same ages to be victims of robbery (6.1 per 1,000 versus 2.9 per 1,000) or aggravated assault (7.3 per 1,000 versus 3.8 per 1,000).[11]

The Adolescent Brain Is Vulnerable to Trauma

Children are especially vulnerable to the effects of trauma during adolescence since parts of the brain involved in learning still are developing. Adolescence is a significant period for brain plasticity, or adaptability, during which the human brain develops the capacity to engage in key elements of learning, such as critical thinking and problem solving. In fact, the degree to which adults can engage in analytic thinking depends largely upon the degree to which this capacity develops during adolescence. While it is well known that adolescence is a period of heightened risk for behaviors such as truancy and substance use, the "risk" of adolescence is not solely about problem behaviors. It also is about potentially limiting the ability to thrive as an adult.

Trauma can impede this development by interfering with critical processes that comprise the neurological foundation for learning. Brain scans show that trauma and stress impact the adolescent brain in several ways, including changing gray matter volume—which can inhibit working memory—and reducing the size of the anterior cingulate cortex—the portion of the brain that engages in memory formation and responds to anxiety and fear.[12] Moreover, chronic stress can increase the size and sensitivity of the amygdala—the portion of the brain that stimulates the body's "fight-or-flight" response—and triggers the production of cortisol. Excessive levels of cortisol can damage the parts of the brain involved in learning that still are developing.[13] Neurological changes to the brain caused by stress limit students' capacity to pay attention to things other than what is causing them stress. These changes also make it more difficult for students to remember concepts and impede students' abilities to respond appropriately to interactions in their surrounding environments and in key relationships.[14]

Although an increase in brain malleability makes adolescents particularly vulnerable to the impact of trauma, this malleability also presents an opportunity. Since the brain undergoes dramatic changes during adolescence, this period of development offers the chance to heal from trauma experienced early in life when young people receive targeted support and intervention. Therefore, it is critical for policymakers and practitioners to attend to the neurological and developmental needs of adolescents in addition to the needs of younger children.

Trauma-Informed Practices

A growing body of research is developing under the heading of "trauma-informed practices" in response to the prevalence of trauma and its potential impact on learning. "To be trauma-informed means to know the history of past and current abuse in the life of the person one is serving, no matter the service setting,"[15] according to *The Promise of Adolescence: Realizing Opportunity for All Youth,* the seminal study on adolescent development by the National Academies of Sciences. The study describes the

importance of informing teachers and school support staff about accurately identifying and effectively supporting victims of trauma since many students "are frequently misidentified as presenting with attention deficit disorder, oppositional-defiant disorder, or conduct disorder."[16] The study also notes the importance of schools becoming trauma-informed to prevent retraumatizing students.

There are many strategies and frameworks for implementing trauma-informed practices in schools. The Trauma and Learning Policy Initiative (TLPI), a joint program of Massachusetts Advocates for Children and Harvard Law School, is one such framework that has been studied independently by the American Institutes for Research. According to TLPI, there are six elements of a trauma-sensitive school:

1. Leadership and staff share an understanding of trauma's impacts on learning and the need for a schoolwide approach.
2. The school supports all students to feel safe physically, socially, emotionally, and academically.
3. The school addresses student needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional well-being.
4. The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills.
5. The school embraces teamwork and staff share responsibility for all students.
6. Leadership and staff anticipate and adapt to the ever-changing needs of students.[17]

Recommendations

While the delivery of trauma-informed education takes place at the local level, federal officials can take a number of actions to support these efforts:

1. Student Support and Academic Enrichment Grants: Congress should fully fund the Student Support and Academic Enrichment Grants program at the level authorized under the Every Student Succeeds Act (ESSA)—$1.6 billion. This program provides flexible funding that school districts can use to support key elements of trauma-informed schools, ranging from professional development to school-based mental health services. Congress also should expand funding for programs that support students' comprehensive needs, such as Promise Neighborhoods and Full-Service Community Schools.

2. Mental Health in Schools Pilot Program: Congress should fully fund the Mental Health in Schools Pilot Program authorized under section 7134 of the SUPPORT for Patients and Communities Act. Funding would support collaborative efforts between school-based service systems and trauma-informed support and mental health service systems, professional development, and Full-Service Community Schools.

3. Higher Education Act (HEA): Students are more likely to learn if they are taught in ways that respond to their developmental needs. As Congress works to reauthorize HEA, it should provide

opportunities for prospective educators to learn about the science of learning, child and youth development, and trauma-informed instructional practices.

4. Education Sciences Reform Act: The authorization of the Education Sciences Reform Act expired in 2008. When Congress reauthorizes this law, it should include research on trauma-informed education.

5. Trauma-Informed Schools Act (H.R. 4146): Congress should include the Trauma-Informed Schools Act in the eventual reauthorization of ESSA. H.R. 4146 defines trauma-informed practices and calls upon states and districts to implement efforts to increase the prevalence of trauma-informed practices.

6. Federal Guidance: The U.S. Departments of Education and Health and Human Services should issue guidance to states and school districts about ways in which schools and communities can use federal resources to expand trauma-informed education and other services, building upon the guidance released by the Substance Abuse and Mental Health Services Administration, the Center for Medicaid, and CHIP Services regarding mental health and substance use in schools.[18]

Conclusion

Federal attention and support are warranted to address the impact of trauma on learning due to the prevalence of trauma and victimization nationwide and its impact on students' abilities to learn. Neuroscience demonstrates that trauma can physically impact brain development and impede a student's capacity for learning. Because the brain undergoes substantial development during adolescence, the adolescent brain is particularly vulnerable to trauma and stress. However, the malleability of the adolescent brain presents the opportunity for intervention and support to effectively help young people heal from trauma and fully engage in learning. Therefore, Congress has the ability, and responsibility, to support trauma-informed approaches to education that will allow students to thrive. Our children—our future leaders—deserve no less.

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[1] Information on the national high school graduation rate obtained from the U.S. Department of Education's National Center for Education Statistics Common Core of Data, https://nces.ed.gov/ccd/tables/ACGR_RE_and_characteristics_2016-17.asp (accessed September 5, 2019).
[2] U.S. Department of Education, National Center for Education Statistics, "The Nation's Report Card 2015: Mathematics & Reading at Grade 12," https://www.nationsreportcard.gov/reading_math_g12_2015/# (accessed September 4, 2019).
[3] ———, *The Condition of Education 2019* (NCES 2019–144) (Washington, DC: U.S. Government Printing Office, 2019), https://nces.ed.gov/programs/coe/indicator_tbe.asp.
[4] Ibid.
[5] Ibid.
[6] R. J. Bonnie and E. P. Backes, eds., *The Promise of Adolescence: Realizing Opportunity for All Youth* (Washington, DC: National Academies of Sciences, Engineering, and Medicine, 2019).
[7] R. Harper et al., *Science of Adolescent Learning: How Body and Brain Development Affect Student Learning* (Washington, DC: Alliance for Excellent Education, 2018), https://all4ed.org/wp-content/uploads/2018/08/Science-of-Adolescent-Learning-How-Body-and-Brain-Development-Affect-Student-Learning.pdf; ———, *Science of Adolescent Learning: Risk Taking, Rewards, and Relationships* (Washington, DC: Alliance for Excellent Education, 2018), https://all4ed.org/wp-content/uploads/2018/09/Science-of-Adolescent-Learning-Risk-Taking-Rewards-and-Relationships.pdf; ———, *Science of Adolescent Learning: Valuing Culture, Experiences, and Environments* (Washington, DC: Alliance for Excellent Education, 2018),

https://all4ed.org/wp-content/uploads/2018/12/Science-of-Adolescent-Learning-Valuing-Culture-Experiences-and-Environments.pdf; H. Hermann, et al., *Science of Adolescent Learning: How Identity and Empowerment Influence Student Learning* (Washington, DC: Alliance for Excellent Education, 2019), https://all4ed.org/wp-content/uploads/2019/08/04-Identity-and-Empowerment_FINAL.pdf.

[8] Trauma is any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. See Harper, et al., *Science of Adolescent Learning: Valuing Culture, Experiences, and Environments*.

[9] D. Finkelhor et al., "Children's Exposure to Violence, Crime, and Abuse: An Update" (Laurel, MD: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2015), https://www.ojjdp.gov/pubs/248547.pdf.

[10] D. Finkelhor et al., "Polyvictimization: Children's Exposure to Multiple Types of Violence, Crime, and Abuse" (Laurel, MD: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2011), https://www.ncjrs.gov/pdffiles1/ojjdp/235504.pdf.

[11] Child Trends, "Violent Crime Victimization," https://www.childtrends.org/indicators/violent-crime-victimization (accessed August 28, 2019).

[12] Ibid.

[13] Ibid.

[14] Ibid.

[15] Bonnie and Backes, *The Promise of Adolescence*.

[16] Ibid.

[17] W. Jones, J. Berg, and D. Osher, *Trauma and Learning Policy Initiative (TLPI): Trauma-Sensitive Schools Descriptive Study* (Washington, DC: American Institutes for Research, 2018), https://traumasensitiveschools.org/wp-content/uploads/2019/02/TLPI-Final-Report_Full-Report-002-2-1.pdf.

[18] E. Katz and C. Lynch, "Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools" (Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2019), https://store.samhsa.gov/system/files/joint_info_bulletin_school_based_services_final_508_6.28.19.pdf.

American Federation
of Teachers, AFL-CIO

AFT Teachers
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Professionals

555 New Jersey Ave. N.W.
Washington, DC 20001
202-879-4400
www.aft.org

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September 10, 2019

The Honorable Gregorio Kilili Camacho Sablan
Chairman
Early Childhood, Elementary and Secondary Education Subcommittee
Committee on Education and Labor
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Sablan:

On behalf of the 1.7 million members of the American Federation of Teachers, we are grateful that your subcommittee is initiating a conversation around addressing trauma in educational settings, specifically trauma caused by gun violence.

Tragically, too many of our nation's schools and communities are being terrorized by the effects of gun violence. Gun violence, including in school, is the biggest fear faced by young people ages 13-24. The depth of trauma and anxiety that gun violence has wrought upon a generation will not go away, and schools are struggling to provide mental health supports to children and their communities.

AFT members have witnessed and experienced the results of gun violence at Marjory Stoneman Douglas High School in Florida, Sandy Hook Elementary School in Connecticut, and countless other schools where the violence does not make the nightly news. Our nurses and healthcare professional members work to heal both bullet wounds and psychological wounds. Our social workers comfort children and families torn apart by loss. Our kids see their friends, parents, siblings, cousins and neighbors shot, but they do not experience the love and outpouring of support from a nation sharing their suffering.

Congress can help, or it can continue to do nothing and allow children across this country to live in fear of, and even die from, gun violence. We must work to pursue and implement commonsense solutions to reduce violence and provide students with support after traumatic experiences.

The AFT calls on Congress to provide the resources needed to fully staff every school in America with qualified mental health professionals who can support students affected by violence. Congress must also invest in community schools, after-school activities, programs like peer counseling and wellness programs, and other social supports such

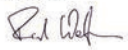
as schoolwide practices to reduce bullying behavior, which are all crucial initiatives needed to decrease the impact of violence in and around schools.

We have a collective responsibility to ensure that our schools are safe and welcoming places for teaching and learning—not armed fortresses. While the precautions many are taking to protect children from gun violence can be helpful, when we harden schools, conduct active shooter drills, buy kids bulletproof backpacks and raise the idea of arming educators, we are potentially causing them even more trauma and anxiety.

As we work to address existing trauma, we must also focus on the underlying causes of gun violence. The AFT supports expanding the background check system, banning both assault weapons and high-capacity ammunition magazines, establishing extreme risk protection order systems and rescinding the gun industry's immunity.

We look forward to continued discussions and will support you in developing legislation to support our nation's children.

Sincerely,



Randi Weingarten
President

RW : emc opeiu#2 afl-cio

Written Testimony of

Luann Kida MA, LMSW

Director, Regional Network

Binghamton University Community Schools (BUCS)

Submitted to the

Committee on Education and Labor

September 9, 2019

Thank for the opportunity to provide written testimony on the importance of trauma-informed practices in schools as a way to support students and families for optimal educational outcomes. In line with the research literature, in our experiences, the need for trauma-informed practices is crucial to providing true access for all children. Failure to address trauma perpetuates predictable patterns making academic success more difficult impacting educational outcomes that affect not only individual students but the whole of society. When children do not succeed in school, they do not graduate. When they do not graduate, they do not have the same opportunities for income as adults. As adults they begin their own families and an intergenerational cycle of failure and, often, poverty continues.

Our trauma-informed work with schools in Broome County, New York began in 2010 when we embarked on a partnership with a rural school district encompassing 144 square miles serving approximately 1400 students. Administrators of this school recognized the many challenges their students and families faced due to the rural location and lack of community resources. There was a realization that the district must find a way to better serve the students and families in need. The partnership began with bully prevention work in school, as many of the students in poverty were victims of bullying, and family outreach outside of school to bridge the gap between home and school.

In 2013, the district worked with BUCS to become a community school. Lead by a Community School Coordinator, master level social work interns began knocking on doors within this rural community to talk to families about the needs they faced at home and what they needed from their school system. The stories we heard were heart wrenching and full of sorrow with repeated trauma and social injustice families faced daily. Through it all, and despite the fact that none of these parents were high school graduates themselves, the number one dream each parent shared was to have their child graduate high school and succeed as an adult. These were the same parents that did not answer the telephone when the school attempted contact and did not return paperwork needed to obtain services. The actions did not match the words they were saying.

Continued outreach and intentionality generated by school administrators began to build trust. Families began to share why they were not engaging with the school. They spoke of their own childhood abuse and neglect, living with parents who struggled with alcoholism and mental health challenges, food insecurity, homelessness, and domestic violence. The world was not a safe place as a child and that did not change now that they were adults raising children. In fact, it often intensified as families shared their fears that they would fail their own children.

What looked like a parent who did not care about education because they did not send their child to school was really a mother with no means of transportation terrified because her child was being bullied at the bus stop by other adults who had criminal records. An angry father, banned from school grounds

because of this threats to the school, was a man confused and angry about his son's recent suspension exacerbating the fear that his son would end up just like him. The childhood trauma had not healed with old wounds kept fresh by sending their children to a system that brought angst and failure to them as a child. What started out as a way to engage families, revealed a need to understand trauma and the impact this has on involvement with the educational process.

By hosting "family cafés" where families were invited to gather at a location that was easily accessible and comfortable, professionals, graduate students and families began to talk together about barriers to engagement in the school system. Using trauma-informed practices and understanding that the family members truly loved their children and wanted them to be successful was the foundation for the work. Families began to share their fears and worries. The school began to ask how they could help and bring information to the families to help build trust and partnerships. Slowly the adults began to work together for the success of the children.

This same school district, now well into the development of their community school, used this same approach when looking at student needs and behaviors. Understanding the impact that trauma had on families, they began to develop strategies to address trauma within school to create an environment that did not reopen the wounds for families and created an environment of acceptance and trust for their students. Intentionality around social and emotional needs of students and staff became the norm and continues to this day. Not only has this lead to an examination of policies and procedures, it has created strategic supports for both families and students, leading to improved attendance, grades and graduation rates.

"Family cafés" and outreach continue with a focus on connecting caregivers to the educational process of their children. This effort has expanded to include strategic outreach to grandparents who are raising their grandchildren, always because of some sort of trauma. Grandparents find support among their peers and undergraduate students provide academic support that both directly impacts the young students and simultaneously increased their grandparents' feelings of competence. A network and system of support is expanded for the adults; educational opportunities are expanded for the children.

As relationships grew among, families, school administrators and students, high school students in this district approached their school administrators asking for more social-emotional support during the schoolday. Students who lived with struggling families, in violent neighborhoods, and experienced a lack of resources were searching for support. A drop-in center was created within the high school that is now open for all students who want to attend. Staffed by the Community School Coordinator and master level social work interns, this space uses trauma-informed practices to provide academic and emotional support. School attendance has improved as well as access to academic support. What looked like bad behavior is now identified with the appropriate emotion helping students to share their barriers to academic success. Instead of foul language because this subject is "stupid", young people trust and open up about experiences and fear they have from home and how that impacts their ability to concentrate on the subject at hand. This leads to their ability to concentrate better and to increased academic success.

An additional trauma-informed practice of peer and community mentoring occurs after school, connecting high school students to middle school students under the supervision of community volunteers. The time after school is used to build connections to each other and the community in which they live. Community members see young people for who they are rather than what they hear on the news and young people see caring adults that want them to succeed – everyone wins! This same approach is implemented during the summer with one of our favorite community mentors being the town's mayor who the students are thrilled to see as a "real person" that cares about them, as opposed to solely a figure head.

School social workers, school counselors, and the Community School Coordinator work closely to ensure that students receive referrals needed for more formal supports when students' traumas need greater attention to reduce their impact on academic success. Additional professionals have been co-located at the school to reduce barriers to access to services. When appointments cannot occur at school, transportation and finances are addressed to ensure students get what they need to succeed. This collaborative approach creates a safety net for students and families and has provided a quick intervention for students before a crisis occurs.

The trauma-informed approaches outlined in this one rural school district are not unique to our county. Many of our schools are searching for creative ways to support students, families, and their staff around trauma. Capacity is always limited because of funding. Attaching Federal funding specific to trauma would help to strengthen the work and help address educational equity, addressing the predictable patterns we see occurring for some of our most marginalized and vulnerable students while also supporting the teachers and school staff that pour their hearts into educating the faces of our future!

Approaching trauma in the schools not only makes sense for the well-being of our children, it makes fiscal sense as well. When students succeed, they have more opportunities. Opportunities for higher education, apprenticeships, and careers provide financial stability. Financial stability creates more housing options allowing families to live in safer neighborhoods where trauma does not become a routine occurrence. Being proactive with support in the school means fewer crisis referrals to hospitals and mental health centers, which reduces health care costs. When we support our schools with the work they must do to keep their students safe and successful, we support our local, state, and federal communities by providing better outcomes for all.

NATIONAL INDIAN EDUCATION ASSOCIATION

National Indian Education Association

House Committee on Education and Labor
Statement for the Record
In Support of Trauma-Informed Education Practices in Native Communities

On behalf of the National Indian Education Association (NIEA), the most inclusive national organization advocating for culturally relevant educational opportunities for American Indians, Alaska Natives, and Native Hawaiians, we write today to highlight the importance of implementing trauma-informed practices throughout our education systems.

Native students serve as the foundation of NIEA's work, from early childhood to postsecondary education. Despite the vibrant cultures, traditions, and languages of Native communities, our students continue to bear the burden of historical events that began centuries ago. Federal policies developed an education system that removed Native children from their homes and communities to boarding schools that prohibited the practice of traditional lifestyles and mandated the acceptance of mainstream Christian and English ways. In the words of Carlisle Boarding School founder Robert Pratt, these schools endeavored to "kill the Indian and save the man." Such practices persisted until the 1970s, creating generations of Native families traumatized by the very education systems that promised opportunity to their peers. Today, Native youth continue to experience the impacts of these policies through historical and childhood trauma. Our students still attend classrooms where, a generation ago, their parents were punished for their languages, traditions, and cultures.

Historical trauma now manifests through nationwide performance metrics. For example, Native students are disciplined and held back more frequently than their peers. Native youth also make up a disproportionate amount of those in juvenile facilities. These trends continue through graduation, as only 72 percent of Native students graduate from high school compared to the national average of 85 percent. These barriers have led to the lowest college participation rates in the nation, at 19 percent. From there, approximately 39 percent of Native students who enroll in a four-year, post-secondary institution actually graduate, the lowest rate of any group in the United States.

Congressional action and support for trauma-informed education practices in schools that serve Native students is critical to reversing centuries of federal policies that resulted in the genocide of Native cultures, traditions, and languages. Native students must have access to educators that have the professional training and experience to create safe classrooms where our youth can thrive. In addition, funding and programs that support Native language instruction, assessments, and preservation are critical ensuring that Native students are able to learn and speak their languages for generations to come. Curriculum and education practices

1514 P St NW, Suite B, Washington DC, US 20005
www.niea.org (202) 544-7290

should value and encourage the expression of Native languages and cultures in the classroom. Finally, tribes, policymakers, and schools must have access to data that accurately measures student progress to ensure that programs fully serve the unique needs of Native students.

NIEA looks forward to working with legislators to address educational disparities through trauma-informed education practices for the only students that the federal government has a direct responsibility to educate— Native students. If you have any questions, please contact NIEA Legislative Analyst Adrianne Elliott at aelliott@niea.org.

1514 P St NW Suite B Washington DC US 20005
www.niea.org (202) 544-7290

NASP
NATIONAL ASSOCIATION OF
School Psychologists

4340 East West Highway, Suite 402, Bethesda, MD 20814
PHONE: 301-657-0270
FAX: 301-657-0275

The Honorable Gregorio Kilili Sablan
Chairman
U.S. House Subcommittee on Early Childhood,
Elementary and Secondary Education
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Rick Allen
Ranking Member
U.S. House Subcommittee on Early Childhood,
Elementary and Secondary Education
2176 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman and Ranking Member,

Thank you for holding this critical hearing to discuss the importance of trauma-informed practices to assist and support students who are affected by adverse events. On behalf of the more than 24,000 members of the National Association of School Psychologists (NASP), we know firsthand that schools play a critical and irreplaceable role supporting students' mental health. Our members regularly work with students and families who have experienced adversity, stress, and trauma, and we understand the impacts of those experiences on their daily lives and learning. Gun violence in communities represents a particularly potent stressor, among many potential adversities that pose a serious threat to the well-being of America's children and youth. Children and youth do not leave the resulting issues at the classroom door, so our schools must respond with sensitivity, compassion, and understanding of the trauma that may come from adverse life events.

Adverse childhood experiences and trauma negatively affect a significant proportion of the school-age population. Nearly 61% of youth younger than age 17 report exposure to violence in the past year alone (Finkelhor, Turner, Ormrod, & Hamby, 2009; Sickmund & Puzzanchera, 2014). Students ages 12–18 were victims of 749,200 serious violent crimes and simple assaults in 2012, and 7% of students in grades 9–12 reported being threatened or injured with a weapon, such as a gun, knife, or club, on school property in 2011 (Robers, Kemp, Rathbun, & Morgan, 2014). Events such as these, in addition to trauma resulting from child abuse, bullying, natural disasters, homelessness, poverty, gun violence, food insecurity, immigration, and/or parental issues undermine students' ability to learn, form relationships, and manage their feelings and behavior, and place them at increased risk for trauma and a range of negative academic, social, emotional, and occupational outcomes (Rossen & Hull, 2013).

Although research shows that a significant number of school-age children have experienced a violent or traumatic event, many educators and other professionals remain unaware and/or are unable to meet the complex needs of these students. There is, however, an increasing recognition that stress, adversity, and trauma can have a detrimental impact on learning—which is why adopting a trauma-informed approach is so critical to student success.

Trauma-informed schools are generally comprised of four components: (a) a school-wide focus, (b) a commitment to building a physically and *psychologically* safe school environment, (c) an intentional focus on building student capacities, and (d) an intention to focus on building staff capacities. A trauma-informed approach benefits all students, staff, families, and the community, whether or not they have been directly impacted by traumatic events themselves. This approach reduces burnout of administrators and staff, and it provides for an environment that leads to increased family engagement and community involvement. Even children without a significant history of trauma benefit from this approach, as they contribute to building more connected, safe school environments that enable teachers to teach and students to learn.

Trauma-informed schools also recognize observable behaviors of our students as developmental and even adaptive responses to their experiences. In a trauma-informed school, adults in the building have a shared awareness and sensitivity to the potential impact of trauma and adverse experiences on students' lives. In this sense, a trauma-

informed school approach does not represent a new program; rather, in its simplest form, it represents a framework or an approach to how we interact with our students, families, and each other.

Involvement of specialized instructional support personnel—such as school psychologists, school counselors, and school social workers—is critical in these efforts, especially given that few preservice teacher preparation programs include components to help educators develop the skills and coping strategies needed to detect and teach traumatized students.

Several states, including Wisconsin, Washington, and Massachusetts, have successfully made statewide commitments to helping integrate a trauma-informed approach into everything from instruction to disciplinary policies to crisis response and intervention procedures. Several districts in these states report improved academic and behavioral outcomes, reduced disciplinary problems, and better attendance among both staff and students. Other states have passed resolutions or legislation dedicating funding or resources to integrating trauma-informed approaches within schools, amidst little to no controversy.

The trauma-informed approach fits well into other mental health initiatives, including positive behavior interventions and supports and multitiered systems of support. Schools that have already implemented comprehensive school safety policies and practices are already naturally trauma-informed, to some degree. Multitiered systems of supports, positive school climates, and well-trained staff contribute to positive outcomes for students while fostering trauma-informed school environments. Just as important: Fair, consistent, and culturally competent discipline policies that promote positive student behaviors, while avoiding overly punitive responses, remain central to implementing a trauma-informed approach in schools.

Importantly, when a single potentially traumatic event, such as mass violence or a natural disaster, affects multiple members of a school community, schools will need more intensive acute crisis mental health response capabilities. This includes a trained crisis response team that involves school-employed mental health professionals, who can help assess and triage trauma and other mental health needs among students and staff. School-employed mental health professionals can also provide guidance to school administrators on best practice response interventions and supports for the school community, provide guidance (psychoeducation) for teachers and other staff on how to support students with mental health concerns, and facilitate collaboration with any needed additional community mental health supports. Three things are critical to keep in mind: (a) being prepared and properly trained ahead of time is vital to effectively meeting mental health needs in the short- and long-term; (b) the mental health consequences of a traumatic event can last a long time and ripple out across a community; and (c) using a trauma-informed approach on an ongoing basis greatly improves the ability of a school to meet acute and more long-term needs.

A trauma-informed approach requires a *sustained commitment*. It requires an intentional focus to ensure access to qualified teachers and school-employed mental health professionals, such as school psychologists. And it requires sustained funding and ongoing evaluation as part of a scaled implementation.

In order to make our schools sensitive and responsive to traumatic experiences of students and families, we must provide the resources, high-quality training, and school-employed mental and behavioral health personnel, such as school psychologists, to create a safe and supportive environment. As Congress proposes strategies to work with students and families who have experienced trauma, we urge any legislation to be grounded in research and best practice. If you have any questions or would like to follow up, please contact me at kminke@naspweb.org.

Sincerely,

Kathleen Minke

Kathleen Minke, PhD, NCSP
Executive Director
National Association of School Psychologists

NASP NATIONAL ASSOCIATION OF School Psychologists

Research Summaries

Creating Trauma-Sensitive Schools: Supportive Policies and Practices for Learning

Children and adolescents in the U.S. experience high rates of stress and adversity from a wide variety of sources. These include physical, emotional, and sexual abuse; neglect; exposure to community violence; bullying; natural disasters; poverty; homelessness; immigration; and parental issues such as domestic violence, incarceration, death, mental illness, involvement in substance abuse, and military deployments. Such experiences undermine students' ability to learn, form relationships, and manage their feelings and behavior and place them at increased risk for trauma and a range of negative academic, social, emotional, and occupational outcomes (Rossen & Hull, 2013). Thus, there is increasing awareness of the need to create *trauma-sensitive schools*.

Trauma-sensitive schools have the potential to increase positive outcomes among *all* students, regardless of trauma history. This is important given that not all students who experience adverse childhood experiences will go on to suffer symptoms of trauma. Designed to be safe and attuned to the needs of students, families, the community, and school staff, trauma-sensitive schools support the academic competence of students, provide tools to support students and staff in managing emotional and behavioral challenges, and support teachers and other staff in negotiating difficult situations (Blaustein, 2013).

Adverse childhood experiences and trauma negatively impact a significant proportion of the school-aged population. Yet many educators and other professionals are still unaware of these children's complex needs and how to meet them during the school day (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008; Rossen & Hull, 2013). Although some argue that such efforts are secondary to the goal of educating children, the increasing recognition of the impact of stress, adversity, and trauma on learning has brought a sense of urgency to the creation of trauma-sensitive schools (Cole, Eisner, Gregory, & Ristuccia, 2013).

SCOPE OF THE PROBLEM

The list of potentially trauma-inducing issues that impact children and adolescents is very long, precluding a full presentation of prevalence rates in this document.

- *Child abuse and neglect*: There are more than 3 million referrals involving 6 million children each year for child abuse and neglect in the U.S. (Institute of Medicine and the National Research Council, 2014). An estimated 679,000 children were victims of abuse and neglect in fiscal year 2013 (U.S. Department of Health and Human Services, 2015).
- *Exposure to violence*: Nearly 61% of youth younger than age 17 report having been exposed to violence in the past year (Finkelhor, Turner, Ormrod, & Hamby, 2009; Sickmund, & Puzzanchera, 2014). Students ages 12–18 were victims of 749,200 serious violent crimes and simple assaults in 2012, and

7% of students in grades 9–12 reported being threatened or injured with a weapon, such as a gun, knife, or club, on school property in 2011 (Robers, Kemp, Rathbun, & Morgan, 2014).

- *Bullying*: During the 2009–10 school year, 23% of public schools reported that bullying occurred among students on a daily or weekly basis (Robers et al., 2014).
- *Natural disasters*: Nearly 14% of U.S. children aged 2–17 report having been exposed to a disaster in their lifetime, and more than 4% report having experienced a disaster in the past year (Becker-Blease, Turner, & Finkelhor, 2010).
- *Homelessness, poverty, and food insecurity*: More than 1.6 million American children, one in 45, are homeless during the course of each year (National Center on Family Homelessness, 2011). During the 2008-09 academic year, schools across the U.S. identified 956,914 students who were homeless, a 41% increase over two years (National Center for Homeless Education, 2010). In 2013, 21% of school-age children were living in poverty (Kena et al., 2015). More than one in five U.S. children is food insecure (ETS Center for Research on Human Capital and Education, 2013).
- *Immigration*: In 2013, there were 7,255,000 U.S. children under age 18 who are foreign-born or who have at least one foreign-born parent, in which neither resident parent is a U.S. citizen (Kids Count Data Center, 2015). The number of unaccompanied children entering the U.S. grew dramatically from 6,000 in 2011 to an estimated 60,000 in 2014 (U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement, n.d.).
- *Parental issues*: Approximately 8.3 million children in the U.S. have parents under correctional supervision (prison, jail, parole, or probation), and nearly half of those children are in or approaching adolescence (Correctional Association of New York, 2009). There were 700,000 children with at least one military parent deployed to a war zone in 2007 (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families, and Service Members, 2007).

CONSEQUENCES

An abundance of empirical evidence reveals that childhood traumatic experiences can chronically and extensively alter social, psychological, cognitive, and biological development (Cook et al., 2005). Here are a few of the many empirical findings:

- Childhood traumatic experiences can produce negative changes in the structure and function of the brain that are pervasive and lasting (Anda et al., 2006; Lupien, McEwen, Gunnar, & Heim, 2009; Teicher et al., 2003).
- Childhood traumatic experiences have the power to undermine child and adolescent development in myriad areas that threaten academic success: communication skills, coherent sense of self, coping skills, peer and adult relationships, the ability to attend to classroom tasks and instructions, organizing and remembering information, and grasping cause-and-effect relationships (Briggs-Gowan, Carter, & Ford, 2011; Cole et al., 2005; De Bellis, Woolley, & Hooper, 2013; Goodman, Miller, & West-Olatunji, 2012; Madrid, Grant, Reilly, & Redlener, 2006; Williams, 2007).
- Adverse childhood experiences increase a child's risk for a range of health problems as an adolescent and adult, including alcohol and substance abuse, depression, intimate partner violence, multiple sexual partners, suicidality, unintended pregnancy, and adolescent pregnancy (Centers for Disease Control and Prevention, 2014).

- Negative health outcomes for children and adolescents are a function of the amount and degree of exposure to stress and adversity, with the risk for negative outcomes increasing with each cumulative adverse experience (Felitti et al., 1998).

ASSESSMENT

Although adversity and trauma are pervasive among students, service providers regularly attempt to address the symptoms rather than the source of distress (Cooper et al., 2007). Several screening measures have become available to examine exposure to adverse childhood experiences, and the National Child Traumatic Stress Network (n.d.) has compiled a compendium of standardized measures for use in assessing complex trauma. However, it is important to note that not all individuals experiencing adversity or stress develop trauma, and assessing the development of trauma symptoms poses several challenges.

- A single psychiatric diagnosis does not exist that can account for the cluster of symptoms that research has shown occurs frequently in children exposed to trauma (D'Andrea, Ford, Stobach, Spinazolla, & van der Kolk, 2012).
- There are few psychometrically sound diagnostic instruments for directly assessing trauma in children, and those that are available do not appropriately consider children's developmental levels (Hawkins & Radcliffe, 2006; Strand, Pasquale, & Sarmiento, 2011).
- Assessment is often accomplished using parent questionnaires, and research indicates that parents may be less aware of their child's symptoms of internalizing disorders, such as anxiety and depression (Teagle, 2002), and those of their older children, since their symptoms may become less overt and occur in settings outside of the home (Achenbach, Dumenci, & Rescoria, 2002).
- Only 16% of adolescents develop PTSD after exposure to adverse experiences. Rates also ranged from 8% among boys experiencing non-interpersonal adversity to 33% of girls experiencing interpersonal adversity (Alisic et al., 2014).

INTERVENTIONS

Trauma-informed care is based on these core principles: creating a sense of safety; practicing trustworthiness and transparency; employing collaboration and mutuality; practicing empowerment; fostering voice and choice; and recognizing cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration, 2014). School-based programs and approaches have been developed to address the impact of childhood traumatic experiences by reducing emotional and behavioral problems and fostering resilience. For programs that involve screening for trauma, students are selected for participation via four major avenues: referrals from school-employed mental health professionals or teachers, nomination by parents, targeted screening at school, and general screening at school (Jaycox, Morse, Tanielian, & Stein, 2006). Given the complex and varied presentation of trauma symptoms, however, no single intervention is appropriate for all children and adolescents. Although many have not yet been evaluated, some have demonstrated positive results and many are based on evidence-based techniques (Jaycox et al., 2006).

- Empirical studies have demonstrated the positive impact of trauma-focused cognitive behavioral therapy (TF-CBT) to help children, adolescents, and their caregivers overcome trauma-related difficulties. Findings consistently demonstrate its effectiveness in reducing symptoms of posttraumatic

stress disorder, symptoms of depression, and behavioral difficulties (Child Welfare Information Gateway, 2012).

- An evaluation of trauma-sensitive practices in high school yielded evidence that it significantly increases student resilience overall and on each of its component dimensions: supportive relations, problem solving, and optimism. Grades were uniformly higher among 70% of students whose resilience scores had increased, irrespective of initial trauma levels (Longhi, 2015).
- The Attachment, Self-Regulation, and Competency (ARC) model for addressing the impact of trauma experiences is grounded in child development theory and empirical knowledge about the effects of trauma. It emphasizes intervening with the child-in-context and the creation of effective and sustainable outcomes through systemic change (Blaustein & Kinniburgh, 2010; Kinniburgh, Blaustein, & Spinazzola, 2005).
- The Head Start Trauma Smart program is used in Head Start classrooms to decrease the stress of chronic trauma, foster social and cognitive development, and create a trauma-informed culture for young children, parents, and staff. An evaluation revealed statistically significant improvements in the ability to pay attention, externalizing behaviors, internalizing behavior, and oppositional defiance (Holmes et al., 2014).

SCHOOL-BASED MENTAL HEALTH SUPPORTS

Research has shown that social support, resilience, and hope are important in helping children successfully cope with the mental and behavioral challenges that often accompany exposure to trauma (Hines, 2015). To ensure the academic success of these students, it is necessary for schools to address their health and emotional well-being. Specific school-based interventions are most effective when they are implemented within the context of integrated and coordinated mental and behavioral health services for all students (Adelman & Taylor, 2013; Huang et al., 2005). Involvement of specialized instructional support personnel, such as school psychologists, school counselors, and school social workers, is critical given that few pre-service teacher preparation programs include components to help educators develop the skills and coping strategies needed to detect and teach traumatized students (Wong, 2008). School-based mental health supports take a variety of forms:

- Interventions using positive behavior supports have been shown to improve academic performance and decrease behavior problems (Caldarella, Shatzer, Gray, Young, & Young, 2011; Luiselli, Putnam, Handler, & Feinberg, 2005; Waasdorp, Bradshaw, & Leaf, 2012).
- Students who participate in school-based social and emotional learning programs show significant improvement in grades and standardized test scores, social and emotional skills, caring attitudes, and positive social behaviors, and a decline in disruptive behavior and emotional distress (Bierman et al., 2010; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).
- Interventions that foster students' engagement in school have been shown to reduce high school dropout (Reschly & Christenson, 2006) and improve academic performance (Battistich, Schaps, & Wilson, 2004; Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004).
- Interventions that foster strong and supportive relationships with teachers help students to feel more safe and secure in school, feel more competent, make more positive connections with peers, and achieve greater academic success (Hamre & Pianta, 2006).

SCHOOL POLICIES

Policies to support trauma-informed care are relatively new, but emerging rapidly within some organizations. Several areas are ripe for policy development, including the need to develop practice standards and collect evidence of the impact of interventions (Yatchmenoff, 2015). Yet, schools that have already implemented comprehensive school safetly policies and practices are already naturally trauma sensitive to some degree. Multitiered systems of supports, positive school climates, and well-trained staff contribute to positive outcomes for students while fostering trauma-sensitive environments. For some schools, even small steps can produce significant progress toward the creation of trauma-sensitive learning environments. Broad consensus is emerging regarding which policies support the creation of trauma-sensitive schools, such as the following:

- The ecologies of trauma-sensitive schools have these interrelated characteristics: 1) Staff understand trauma's impact on learning and the need for a school-wide approach; 2) the school helps students feel safe (physically, socially, emotionally, and academically); 3) the school addresses students' needs in holistic ways that take into account their relationships, self-regulation, academic competence, and physical and emotional well-being; 4) the school connects students to the school community and provides them with multiple opportunities to practice newly developing skills; 5) staff work as a team and share responsibility for all students; and 6) staff anticipate and adapt to students' ever-changing needs (Cole et al., 2013).
- Effective discipline policies can be especially important in counteracting the effects of trauma (Ristuccia, 2013). Zero tolerance policies, in particular, have been shown to be ineffective and even counter-productive in terms of supporting appropriate behavior and increasing student engagement in school (American Psychological Association Zero Tolerance Task Force, 2008). Supportive approaches to discipline involving fair and consistent enforcement efforts and the availability of caring adults are more effective, while avoiding the negative consequences of punitive approaches (Gregory et al., 2010).
- Interventions based on positive behavior supports have been shown to decrease behavior problems and improve academic performance (Caldarella et al., 2011; Waasdorp, Bradshaw, & Leaf, 2012).
- School codes of conduct should promote positive student behaviors and include graduated systems of developmentally appropriate responses to student misconduct that hold students responsible for their actions. Examples include making sure interventions are culturally appropriate, engaging students in efforts to improve the code of conduct, making use of restitution, employing cooling off periods, and ensuring that students continue to receive quality instruction when they are removed from the classroom for disciplinary reasons (Morgan, Salomon, Plotkin, & Cohen, 2014).

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Kim A. Anderson
Executive Director

September 10, 2019

Chairman Gregorio Sablan
Early Childhood, Elementary and Secondary Education Subcommittee
Education and Labor Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Sablan:

On behalf of the 3 million members of the National Education Association and the 50 million students they serve, we thank you for recognizing that violent events—like school shootings and everyday community violence—can leave lasting scars on our students' minds, as well as their bodies. It is important to discuss ways to help them. We would like to submit for the record timely materials from our flagship publication, NEA Today, in connection with the September 11 hearing, "The Importance of Trauma-Informed Practices in Education to Assist Students Impacted by Gun Violence and Other Adversities."

A workshop developed by teacher Melodie Henderson—potentially a model that could be used nationwide—provides basic information, tips, and strategies on ways to improve learning atmospheres for students with mental illnesses. For more information, please see the attached excerpt from "Are Schools Ready to Tackle the Mental Health Crisis?" The full article is available at http://neatoday.org/2018/09/13/mental-health-in-schools/

Professor Janet Shapiro, dean of the Graduate School of Social Work and Social Research and director of the Center for Child and Family Wellbeing at Bryn Mawr College, discusses the challenges facing both students and educators in the attached article, "Helping Students Cope with Active Shooter Drills," also available at http://neatoday.org/2019/08/29/helping-students-cope-with-active-shooter-drills

We thank you for the opportunity to submit these materials and stand ready to help address these vitally important issues.

Sincerely,

Marc Egan
Director of Government Relations
National Education Association

Chairman SABLAN. Again, I want to thank the witnesses for their participation today. What we have heard is very valuable. Members of the committee may have some additional questions for you, like I said, and we ask the witnesses to please respond to those questions in writing. The hearing record will be held open for 14 days in order to receive those responses.

I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the Majority Committee Staff or Committee Clerk within 7 days. The questions submitted must address the subject matter of the hearing.

I now recognize the Ranking Member for his closing statement.

Mr. ALLEN. Thank you, Mr. Chairman.

I want to thank the witnesses for coming today. And I do want to clarify that, first, I am not talking about stigma or shaming. I am talking about the importance of faith and family in this culture. As we said in the beginning of the hearing, the testimony today makes it clear that trauma has a detrimental impact on student lives.

We heard a lot of statistics about children suffering as a result of trauma. In fact, I am amazed at the numbers we are talking about here. But the bottom line is that each one of those numbers is a child, a child that needs to be helped and given the attention they need to succeed in life. I think Ms. Hofmeister shared some interesting information about projects she has undertaken in her State to help these students.

One of the reasons I ran for Congress is an experience I had in my district. I supported a school there. I actually built the school. It is a great example of what it takes in children who have experienced trauma to transform their lives.

I was proud to be a part of a local movement in Augusta, Georgia, which created the Heritage Academy. The Heritage Academy is a mission-based school that serves inner city school kids who have been labeled losers in the public school system. Their moms have no choice but to send these children to Heritage School. And they have been given up on by everybody but their mom.

One of the key elements of this school is that kids are given a faith-based education. These children come from broken homes and through their education they learn their value and worth, taught by loving teachers, who are free to share their values so these students can learn the truth about what is right and what is wrong.

These kids grow up to go to the best schools in Georgia and this Nation. I have never seen anything like it. It is a complete miracle. Heritage Academy is one of the many reasons that I believe families need options in education, options that help them connect with individuals who will care about them and help trauma not be a life sentence. It is not for everybody, but there are young people that need this. Considering what we have learned today about trauma, I believe this even more so.

I did share earlier about this book, Death on Hold. This gentleman experienced everything that you described out there today. In fact, his life would be the capital T trauma. He was on death row. This man made a covenant with God, if God would let him live that he would make a difference. I ask you to read this book. It will tell you a lot about what is going on in this culture and what he says needs to be done to turn it around, because, like I said, he made a covenant to do that. And I encourage you to do that. In fact, he is now on life without parole, and I am going to do everything I can to get him pardoned, to get him out there talking to young people about his experiences and the consequences of those experiences. He is an amazing, amazing individual.

Thank you again for being here today and helping us to learn more about this issue.

And, with that, Mr. Chairman, I yield back.

Chairman SABLAN. Thank you very much, Mr. Allen.

I now recognize myself for the purpose of making my closing statement.

Again, thank you again to our distinguished witnesses for being with us. The insights and expertise you shared today make clear that childhood trauma is a pervasive public health crisis that demands our attention.

Far too many children suffer from trauma that prevents them from healthy growth and success in school. Without adequate care, these child victims of trauma can become life-long victims. Yet, when a child struggling with toxic stress acts out in class, many of our schools resort to harsh discipline that not only fails to address the student's trauma but can even elevate it. Even schools that understand the care needed for traumatized children lack the resources and assistance to offer adequate student services. That is why Congress must invest in trauma-informed school practices that ensure children coping with trauma can look to their schools for support, not further harm.

Before I close, let me reiterate again that our children's trauma can be prevented if we are able to recognize and address the root causes. If we can come together to stop the school shootings, end the separation of families at the border, and address widespread poverty, we can not only care for victims of trauma, but prevent children from becoming trauma victims in the first place. Only then can we truly ensure that all children have a chance at reaching their full potential.

Thank you very much, again, to all of you. Thank you, Mr. Allen, for being with us today. And if there is no further business, without objection, the committee stands adjourned. Thank you.

[Questions submitted for the record and their responses follow:]

September 19, 2019

Ms. Ingrida Barker, Ed.D.
Associate Superintendent
McDowell County Schools
30 Central Avenue
Welch, WV 24801

Dear Dr. Barker:

I would like to thank you for testifying at the September 11, 2019 Early Childhood, Elementary, and Secondary Education hearing *"The Importance of Trauma-Informed Practices in Education to Assist Students Impacted by Gun Violence and Other Adversities."*

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, September 27, 2019, for inclusion in the official hearing record. Your responses should be sent to Lakeisha Steele of the Committee staff. She can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Early Childhood, Elementary, and Secondary Education Subcommittee Hearing
"The Importance of Trauma-Informed Practices in Education to Assist Students Impacted by Gun Violence and Other Adversities"
Wednesday, September 11, 2019
10:15 a.m.

Chairman Scott (D-VA)

- You mentioned in your testimony the significant challenges West Virginia is facing with poverty and parental substance use. According to the 2019 Kids Count "The State of Our Children" data book, McDowell County has the highest rates of children living in poverty (54.3%), low-birth weight babies (12.9%), and children in kinship care/living with grandparents (13.3%) in the country. Additionally, a statewide trauma study by the Adverse Childhood Experiences Coalition in West Virginia shows 52 percent of children in West Virginia have at least one adverse childhood experience (ACE). The study also found that 62 percent of children from low-income families in West Virginia have at least one ACE. What is the effect of these traumatic experiences on children, especially for low-income children who lack access to the most basic resources?

- How does trauma hinder student behavior, attendance, and academic success?

- What is the role of community partnerships and the community school's strategy in supporting trauma-informed practices in McDowell County Schools?

- What is the role of teachers, school leaders, and school personnel in understanding and delivering trauma-informed care in schools?

- How has the science of trauma changed the way you support the academic, mental, and behavioral health needs of students?

- What are some examples of school or district-wide outcomes from trauma-informed practices?

- What are some of the challenges McDowell County Schools is facing as a rural school district in supporting students affected by trauma?

- Last year, Congress passed the *SUPPORT for Patients and Communities Act* (H.R. 6) to combat the opioid crisis. The legislation created a pilot program to support collaborative efforts between schools and mental health service systems. Funds could be used for a variety of activities, including professional development and integrating support services into schools through community schools. Unfortunately, this pilot program hasn't been funded. Would this funding be useful to you and, if so, how would you use it?

Representative Morelle (D-NY)

- How has trauma-informed care in McDowell County Schools improved student academic, social, emotional, and behavioral outcomes?

Representative Omar (D-MN)

- Dr. Barker, you mentioned that McDowell County Schools has only received one federal grant, the Project Aware Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), to support mental health in schools. Given that McDowell is largely relying on state funding, how will the loss of this funding impact the sustainability of your trauma-informed care practices?

- You stated in your written testimony that the McDowell County Schools shouldn't have to choose between funding academics or social and emotional learning supports. Can you explain what happens when schools are put in this position?

- How will you continue to support students exposed to trauma?

Early Childhood, Elementary, and Secondary Education Subcommittee Hearing
"The Importance of Trauma-Informed Practices in Education to Assist Students Impacted by Gun Violence and Other Adversities"
Wednesday, September 11, 2019
10:15 a.m.

Response to Committee questions from Dr. Ingrida Barker, Associate Superintendent, McDowell County Schools, West Virginia

Chairman Scott (D-VA)

- Children experiencing traumatic experiences tend to experience a variety of behaviors and health issues that might severely impact their academic achievement. Individuals living in chronic stress devote all their mental and emotional resources to just survive. Therefore, hunger, depression, anger, fear, or lack of sleep result in the student inability to focus on instruction. These issues, if not mitigated, result in behavior issues, classroom disruptions, increased absences, which altogether lead to decrease in student achievement. We all know that in order for our children to thrive in our schools, we need to be able to meet the basic needs of our students before we can help them be attentive and responsive to the classroom instruction.
- Trauma is exhibited in multitude of behaviors and health conditions. Exposure to ACES can lead to behaviors that mimic hyperactivity and attention-deficit disorders, which, if compounded with neo-natal abstinence syndrome, can add to very complex issues that result in student disruptive behaviors, chronic absenteeism, and challenges in academics.
- Community partnerships and community schools strategy play an immense role in helping build wraparound services in our schools. Since schools are dealing with multi-faceted issues connected to trauma, it makes perfect sense to institute a multi-faceted approach to helping students meet their needs. Helping the development of the whole child requires a village, and creating partnerships with various partners who specialize in addressing mental, physical, dental, and other needs can help the schools concentrate on meeting the students' educational needs.
- Educator understanding of trauma-informed practices in schools is vital to helping build relationships with students and being able to recognize issues from the very onset and addressing these issues through caring and understanding approach and the referral to the appropriate professional through community partnership framework. Trauma-informed practices help educators meet the students where they are and see the world through their frame of reference and make accommodations to help students reach their potential instead of adhering to their own rigid expectations for student work in the classroom that might not be appropriate for the students they are teaching.
- Being cognizant of research on trauma and information on the importance of trauma-informed practices has definitely changed the way the district and schools support academic, mental, and behavioral health needs of students. The district places an emphasis on positive behavior supports and explicit teaching of behavior expectations to all students in addition to working with community partners to place mental health

therapists in each school. The school district has created multiple partnerships to bring not only mental, but also physical and dental services to students in addition to providing food backpacks for the weekends to the neediest ones and securing clothing through care closets in schools. These services were not in place 5 years ago, but the need to meet the students where they are in order to help them achieve made the district reconsider the nature of the services provided to students, moving us from instruction-only approach to wraparound services supports for students.

- In terms of outcomes of trauma-informed practices, the schools are seeing less instances of severe behavior and more cohesive staff with less turnover at the school that has been implementing community schools strategy. Our therapy, medical visit, and dental checks data is supporting the growing need for the wraparound supports and meeting the needs of students dealing with trauma. Our climate survey data shows that increasing numbers of students state that they have a positive connection to schools and know they can talk to an adult in school about their issues and form positive relationships. Research consistently shows that a positive relationship with one significant adult can be a game changer for a child.
- McDowell County schools is located in a very remote district, which poses great challenges in terms of securing partnerships with community organizations to help provide students with comprehensive supports. Human resource is one of the greatest hurdles the district faces, starting with teachers. District is able to partner with various mental health organizations, but those too struggle to adequately staff their organizations and meet the ever growing need for services. The remote location and the high levels of childhood poverty exacerbate the issue, as our students already face a multitude of challenges before they even start school. The lack of human resources and the traumatic experiences students face on a frequent basis create a perfect storm of various challenges in the district schools.
- The funding through the SUPPORT for Patients and Communities Act (H.R.6) would have been very useful, as it would help the district solidify structures to integrate wraparound supports into the school system and make communication channels between all the stakeholders more fluid and smooth. The professional development especially considering the numbers of inexperienced teachers in the district, would have been a great help in supporting the professionals in engaging in trauma-informed practices with their students and therefore alleviating some of the secondhand trauma that teaching professionals frequently experience when dealing with the issues that are out of their control.

Representative Morelle (D-NY)

- At this point, the school district is seeing improvements in severe behavior instances, which also indicates improvement in social-emotional health of our students. Southside, our community school, has met state targets for progress in language arts and mathematics, which shows the staff's commitment and focus on instruction, which would

not have been possible if children's basic needs were not addressed before the instructional needs could be focused on.

Representative Omar (D-MN)

- With the loss of Project Aware funding, the county will either have to find an alternative stream of funds to support the coordinator of services position or put this responsibility on already stretched central office staff who usually do not possess enough knowledge about specific processes that should be taking place in terms of therapy, treatment, and communication between various organizations with respect to FERPA and HIPAA regulations. Of course, building and sustaining the knowledge base about best practices and trauma-informed care requires additional partnerships with professionals in the field as well as focused, comprehensive professional development plan for the school staff. Having a funding stream to support social- emotional health of students would help alleviate the strain on the funding used for content and instructional supports for teachers and students.
- When schools are put in a position of choosing between funding academics and social emotional supports, the focus will remain on academics, because accountability measures focus on the metrics of achievement for the most part. Social emotional learning is not highly visible component in these metrics, but it undergirds all of the components for accountability purposes. Without specific focus on social emotional learning, the schools won't be able to implement and promote structures and professional learning with an understanding that these supports will have with achievement.
- Our district has made a commitment to support our students regardless of funding. We will continue our partnerships with the mental health providers and will work with those organizations to help providing some training to our teachers. We will also work with the West Virginia State Department to procure technical assistance and professional development supports through their ReClaim WV initiative. Throughout the years of Project AWARE funding, we have been able to impact the mindset of our school staff in terms of the importance of trauma-informed care in our schools and we will continue our focus on helping the schools become more focused on meeting the needs of every child, every day.

[Whereupon, at 12:33 p.m., the subcommittee was adjourned.]