Policy Analysis and Trauma Informed Care

Darlene Mack, *Bowling Green State University*
Trauma Informed Care Policy

Darlene J. Mack

Bowling Green State University
When following the policy process, the ensuing steps will be discussed: agenda setting, policy analysis/policy formation, policy legitimation, policy implementation, policy and program evaluation, policy change and recycle the process. The purpose of this policy analysis is to explore a segment of educational policy, Trauma Informed Care (TIC) in K-12 Education. Kraft and Furlong (2013) discussed education policy and ways to improve the quality of education in the nation’s schools. Historically, policy has focused on “improving standards for students and or teachers, improving teacher pay, providing alternate education routes for parents to address the on-going proposed issues of inadequate academic achievement” (p. 394). The TIC policy is of focus of the policy process paper at the national, state and local level and filling the possible existing gap in the strategies for improving academic achievement. As a solution to the academic achievement problem, serious consideration needs to be given to adding to the solutions to the realm of the social-emotional behavior of students, families and staff.

Agenda setting

Salasin (2012) founder of National Center for Traumas Informed Care, which is funded by Substance Abuse Mental Health Services Administration (SAMHSA)/The Center for Mental Health Services (CMHS), discussed the current interest in TIC approaches developed from a plethora of sources which include “stories and voices of survivors, research on trauma and violence, the emergence of trauma treatment models and social and political action to prevent and respond more efficiently to violence” (p. 2). In the past, the concept of trauma was of interest to the areas of behavioral and health; however, it is evolving to a social movement. A social movement is a collective, sustained effort in support of a change in societal structures or
values. It is fueled by the hope that “things could be different” (p. 2), that there is a better way to manage societies and severe social issues.

Salasin (2012) discussed the Trauma Informed Services Movement and its development from the 1960s to 2010s. In the 1960s and 1970s, there was early research on people who survived captivity, war, the feminist and domestic violence movements. In the 1980s, the diagnosis and treatment of Post Traumatic Stress Disorder began a mental health consumer/survivor/ex-patient movement and it gained popularity stressing restraint and seclusion be stopped. Also in the 80s, Congress passed The Victims of Crime Act and the International Society for the Study of Traumatic Stress Disorders was founded. The 1990s included the first national trauma conference, Women, Co-Occurring Disorders and Violence Study funded by Substance Abuse Mental Health Services Administration (SAMHSA), multiple models for trauma services were developed, Violence against Women Act passed Congress, and the Adverse Childhood Experiences (ACE) study suggested the prevalence and impact of childhood trauma on adult health and well-being. In the 2000s, SAMHSA organized centers for child trauma, disaster, seclusion and restraint and trauma informed care. Neurological research suggests trauma impacts the brain and SAMHSA makes trauma and justice a priority. In 2010, a Federal Partner Workgroup on trauma included 35 agencies and departments, national professional associations and media increased the focus on trauma.

The Senate Health, Education, Labor and Pensions (HELP) Committee passed the Mental Health and Awareness and Improvement Act of 2013 (S. 689) on April 10, 2013 (http://www.nasmhpd.org/legislation). The focus of the bill was on children and young adults, and reauthorizing and improving existing programs administered by the Departments of Education and Human Services. The first section focused on educational programs, which
promote awareness, prevention and early identification of mental health conditions. In the bill, The Elementary and Secondary Education Act of 1965 redistributed the allocation of funds to encompass the promotion of school-based mental health programs and other behavioral interventions to improve the learning environment of schools. The second section of the legislation covers health programs and was designed like the Mental Health First Aid Act (S. 153, HR 274) to include training of school staff and others to recognize signs and symptoms of mental illness, connecting services and resources for community members with a mental health condition safely de-escalate a crisis situation with someone with a mental illness. Among other provisions, the bill focused on Children’s Recovery from Trauma and reauthorizes the National Child Traumatic Stress Initiative (NCTSI) and stresses work between the NCTSI and Health and Human Services to distribute evidenced-based and trauma informed interventions, treatments and resources (http://www.nasmhpd.org/legislation). Encourages states to provide technical assistance to Local Educational Agencies and school personnel on the implementation of school-based mental health programs and other approaches designed to improve learning environments in schools.

(http://www.nasmhpd.org/sites/default/files/SenateHELPCommitteeUnanimouslyApprovesMeasuretoPromoteMHAwareness042013.pdf)

Policy Analysis Formation

Staten (2013) discussed Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards,…Marks 1998 published landmark study on the relationship of adverse childhood experiences (ACE) and adult health and well-being. Staten (2013) reported later studies had shown a relationship between ACE scores (ACES) including 10 events: “verbal abuse, physical abuse or threatening,
sexual abuse, feeling unloved or not supported, not having enough basic care or a parent who was too high or drunk to provide basic care, parents separated or divorced, physically threatened or mistreated by a mother or stepmother, living with someone with an alcohol problem or used street drugs or who was depressed or mentally ill or attempted suicide, or was in prison” (p. 160). When individuals experience one or more ACEs the research suggests there is a correlation between the experience(s) and a negative effect on adult health and well-being.

From the ACES landmark study in 1998, Bethell, Newacheck, Hawes & Halfon (2014) explored data from a 2011-12 National Survey of Children’s Health for the incidence of adverse childhood experiences to the connections and factors affecting children’s development and lifetime health. The outcome of the analysis suggests children experience higher rates of disease and lower rates of school engagement for children who experience ACE. ACE are common in children: 48% of children ages 0-17 years in the United States experience at least one ACE and 23% experience two or more (Bethell et. al., 2014). The opportune time to intervene when children experience adverse experiences is during childhood and adolescence and this may prevent long-term adult health consequences and healthcare utilization. Walker & Walsh (2014) suggests providing resources and programs to assist children and families when ACE occurs. Schools are ideally positioned to identify children and families at risk, to intervene, and to link families to community resources.

Bethell et al., (2014) discussed the role of building resilience with children. Their research suggests building resilience can improve the destructive consequences of adverse life experiences in children 6-17. In building resilience with the children, the researchers found higher rates of school engagement. Staten (2013) discussed how the ACES research has caused
those who work with children to look at children differently from “what is wrong with you” to “what has happened to you” (p. 160). Children who experience two or more ACES are less likely to demonstrate resilience, live in a protective environment or a safe and supportive neighborhood. The National Council on Behavioral Health reported that the ACE study revealed that the economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at $161 billion in 2000 with the human costs being too great to measure.

From a local perspective, Findlay City Schools (FCS) trained over 800 classified and certified staff on September 3 and 4, 2015 on Trauma Informed Care (TIC). This was driven by data compiled by the Hancock County Alcohol Drug Addiction Mental Health Board (ADAMHS) where a Health Assessment of adult residents in 2013 and found that 44% had an ACE score of 1 or more and 24% had a ACE score four or more. From this information the ADAMHS Board obtained a grant from the Ohio Department of Mental Health to train various agencies and organizations in Hancock County in Trauma Informed Care (A. Wolf from, personal communication, October 8, 2015). Given the research on the prevalence of Adverse Childhood Experiences and the connection to academic achievement and adult health and well being, TIC may be an instrumental piece in filling the achievement gap even though it is a monumental task. Implementing TIC as a local initiative with the goal to create physically and psychologically safe environments for students, families and staff, to build resilience and connect students and families to appropriate treatment to heal, recover and become productive members of society.

Utilizing authority and inducements to gain buy in from the Hancock County organizations, the ADAMHS Board director, met with the various leaders and agreements were made to participate in the initiative. In return for the participation, the ADAMHS Board offered training, coaching and monetary funds. The trainings, coaching and on-going meetings built
capacity and the established learning community reinforced on-going learning and accountability. In the case of TIC, the main instrument from the local perspective was providing education.

Nationally, The Mental Health First Aid Act of 2015 (S. 711/H.R. 1877) provided $20 million in grants to fund Mental Health First Aid training programs. The grant would train stakeholders to be aware of symptoms of common mental illnesses and substance use disorders, safely de-escalating crisis circumstances, connecting those in need to community mental health and substance abuse resources. A major focus of the grant was to improve the nation’s mental health, reduce the stigma of mental illness and getting people who at risk for self-harm or suicide to appropriate services. Teachers and school administrators were part of the targeted population for training. Research has reported that Mental Health First Aid positively shows an increase in connecting and guiding people appropriate services and agreement with the health professionals about treatment. The Mental Health First Aid Act (S. 711/H.R. 1877) was introduced in the House by Congresswomen Lynn Jenkins (R-KS) and Doris Matsui (D-CA) and in the Senate by Senators Richard Blumenthal (D-CT) and Kelly Ayotte (R-NH). For the FY 2016 an additional 15 million dollars was allocated to support Mental Health Trainings nationwide.

From the state of Ohio perspective, The Mental Health and Addiction Services department has developed a strategic framework to implement TIC that includes and advisory committee, TIC project coordinator and collaborative relationships with other departments and organizations to become competent TIC practices. (http://mha.ohio.gov/Default.aspx?tabid=104 Nov. 24, 2015).

Findlay City Schools is ahead of the curve of TIC for the state of Ohio (E. Kurt, personal communication, December 5, 2015). Findlay City Schools is working to create a transformative
culture change where everyone who interacts with students or family members view situations with a TIC Lens, which means instead of thinking what is wrong with you?, the thought process what has happened to you and how can I help you? Ideally this change would entail training everyone who has interaction and would it be plausible to train future educators in the mindset of creating safe and caring environments for all. Would it be viable to have a shift in our cultural on how to discipline children from a punishment mentality to a discipline mentality?

To continue to support the work of TIC form a time, energy and resources perspective, collecting data to study the effect of student achievement would be beneficial which may include attendance rates, discipline reports (numbers of in school suspensions, out of school suspensions, grade point average and test scores. In addition, collecting survey data on student perception of adult caring as well as providing care and support for the classified and certified staff who work to create TIC environments.

The TIC initiative is a universal approach to how adults interact with students, family members and co-workers and thus makes it efficient. In understanding the idea of universal approach, consider the use of ramps in sidewalks at intersections. Originally, the ramps in sidewalks were mandated to make accessibility for handicapped persons on public walkways. Overtime, many, from the elderly to parents with strollers, use the ramps in sidewalks and are universally accepted. So, the implementation of TIC is for the greater good. Trauma is a universal human experience and developing TIC organizations is an ethical and equitable process.

Policy Legitimation

The National Center for Trauma Informed Care (2012) discussed TIC as a social movement in that it makes sense for everyone. With the movement of TIC sweeping across the
nation in organization and now schools the evidence suggests that TIC is compatible with political, social and cultural values of the nation. In addition, locally in Findlay City Schools there has been an outpouring of support for the TIC training. The TIC principles are being written into the district strategic plan and TIC has been aligned to the district Ohio Improvement Plan which is being developed by district leaders, in addition to business and community members. While it is early in the process, on going data is being collected on student perception of adult caring and adult growth and development of TIC knowledge. The data cannot be released at this time due to the use in dissertation development.

Policy Implementation

The administration of TIC from a local perspective included numerous steps and processes. In August of 2014, three school counselors and a mental health counselor/Board of Education member attending training with other Hancock County Organizations. The team completed an Organizational Self Assessment and determined FCS would grow from the implementation of TIC. There are seven domains to TIC and it is a 5 to 7 year process to fully implement TIC. According to Coach Karen (C. Karen, personnel communication September 15, 2014) domain have specifically designed for schools. The domains are: Student Assessment, Safe, Secure Environments, Trauma Informed and Educated Workforce, Evidence Based Interventions and Practices, Community Partnerships, Collect Data and Data Driven Decisions. Insert Domains. It was determined the first domain to implement was to create a trauma informed organization. Surveys were sent to principals and counselors to obtain baseline data if there was a need, from their perspective to train. The data obtained suggested classified and certified staff would benefit from training. A larger TIC team was developed that included
various stakeholders from the district. In working with the inducements from the ADAMHS Board, funding was offered to bring a national speaker to train the certified staff and training was developed to train the classified staff. Past practice of the district was not to train the classified staff; however, the ADAMHS Board provided funding to pay wages for additional hours. The trainings were successfully implemented and there are on-going meetings with classified staff leaders to sustain growth and development of TIC. To sustain the TIC culture being built, the district will train new employees in TIC using Safe Schools and on-line training tool. This will insure the common language of TIC is being developed and used through educational meetings such as Response to Intervention, behavioral issues and the lens in which adults see students, parents and one and other.

The district has the remaining six domains to implement and the original team continues to meet with the superintendent to drive the program forward. The larger team will reconvene in January 2016 to focus on the next domain. Again, a pre-survey will be developed to determine if there is need in the district. While the original grant from the ADAMHS Board is exhausted, the ADAMHS Board will be invited to the larger team to participate and collaborate.

Policy and Program Evaluation

To evaluate the TIC Policy and Program Evaluation, the TIC initiative was discussed from a national, state and local level. While emphasis has been on a local level, the policy at the national and state is an instrumental piece of the work being done at the local level. As the author of this paper is the lead person on the TIC program, from the perspective of Findlay City Schools, the program is meeting the stated goals and objectives at this time. All the classified and certified employees of the district have been trained on what trauma informed care means, the neurobiology of the brain and discussion is occurring on implementing the next domain. As
the social-economic status is changing in the Hancock County and the heroin problem exists and is growing, and academic achievement is not being met, the TIC is needed and it legitimate as it is an universal approach to interacting with everyone in the organization. Positive consequences from the TIC program include local media coverage, opportunities to present at a national conference, opportunities to present at other school districts and acknowledgement of TIC implementation from the Ohio State Department of Education and additional funding being offered to the district, better student/teacher relationships, a decrease in negative consequences at Findlay High School (E. Kurt, personal communication, Nov. 15, 2015) and disciplining students from the vantage point of teaching new behavior and not punishing (K. Glick, personal communication, Dec. 11, 2015). Negative consequences include certain classified and certified not realizing or implementing the program and thus certain student teacher relationships not developing, strains on resources due to demands of TIC awareness referrals.

Policy Change

The policy goals at the local level will evolve as the district is being offered additional funding for TIC. With the additional funding, the school superintendent is asking for ideas from principals and counselors as ways to develop and expand programming around TIC for the district. As the transformative organization change occurs the demands and needs of social and emotional needs of students, parents, families and staff will present new levels action to occur which will stress the resources of time, energy and money. With the demands, it could be expected the federal and state funding will need to occur or local monies earmarked to support the universal TIC program. At the local level, the author of this paper will be asking the superintendent to add to the Board of Education policy to further insure adherence to the program.
References


