ACE INTERVENTION LEARNING COLLABORATIVE

INTERVIEW PROJECT REPORT

September 2016

Withycombe Scotten & Associates
Portland, Oregon

ACE Intervention Learning Collaborative

The ACE Intervention Learning Collaborative began with informal conversations initiated by Bob Stewart, superintendent of the Gladstone School District, with colleagues in six other Oregon districts. In August 2015, these seven superintendents met to affirm their commitment to participate in a year-long learning collaborative focused on the impacts of adverse childhood experiences (ACEs).

In addition to the commitment of their leaders, these seven districts were chosen to represent a diverse subset of Oregon school districts, in an effort to develop a broader understanding of how schools and communities experience and address issues related to childhood trauma. The collaborative's membership includes districts of varying sizes, located across western and northern Oregon.

- Bethel School District (5,671 students, Lane County)
- Gladstone School District (2,173 students, Clackamas County)
- North Wasco School District (3,108 students, Wasco County)
- Phoenix-Talent Schools (2,675 students, Jackson County)
- Portland Public Schools (48,383 students, Multnomah County)
- Tillamook School District (2,069 students, Tillamook County)
- Umatilla School District (1,372 students, Umatilla County)

Each district sent a diverse team of staff members (and in one case, community partners), numbering from seven to 14, always led by the district superintendent.

- Bethel School District: superintendent, deputy superintendent, special services director, assistant special services director, equity coordinator, elementary school principal, middle school principal, high school principal, district PBIS coordinator, health center director
- Gladstone School District: superintendent, director of student and family supports, elementary school principal, middle school principal, elementary school counselor, middle school counselor, elementary school teachers (2), middle school teachers (2), director of special education, Gladstone Center for Children and Families principal, kindergarten teacher, Culture of Care coach
- North Wasco School District: superintendent, middle school principal, elementary school principal, elementary school counselor, middle school counselor, elementary school ESL/ELL teacher, elementary school special education teacher
- Phoenix-Talent Schools: superintendent, elementary principals (3), middle school principal, director of special programs, TOSAs (teachers on special assignment) (2)
- Portland Public Schools: superintendent, assistant superintendent for school performance, assistant superintendent for school supports, assistant superintendent for the office of teaching and learning, senior director of the Madison cluster, Creative

Science School principal, elementary school principals (2), director of student services, assistant director for academic progress, director of special education, restorative justice coordinator

- Tillamook School District: superintendent, grants/foundations director, elementary principals (3), middle school principal, curriculum director/Title I director, English language learners director
- Umatilla School District: superintendent, high school vice principal, middle school dean of students, elementary school vice principal, elementary school counselor, middle school/high school counselors (2), director of special education, instructional coach, DHS family stability manager, Lifeway school-based services (2)

These diverse district teams took part in seven, five-hour sessions in Oregon City, planned collaboratively by the superintendents with the assistance of Gladstone administrative and support staff and of facilitator Richard Withycombe, of Withycombe Scotten & Associates.

- The November 2 session featured Dr. Chris Blodgett, director of the CLEAR Trauma Center in the Child and Family Research Unit at Washington State University.
- The centerpiece of the November 30 session was a presentation by Dr. Vincent Felitti, one of the lead investigators in The ACEs Study, a large, longitudinal study conducted by Kaiser Permanente and the Centers for Disease Control.
- The group spent a portion of the next session, on January 12, reflecting upon what they had learned; and they began a series of "expertise in the room" presentations, in which member districts shared local efforts related to the implementation of ACE intervention strategies and trauma-informed practices.
- On February 22, the collaborative viewed *Paper Tigers,* a documentary about Lincoln Alternative High School in Walla Walla, Washington, and had an opportunity to ask questions of the principal at that time, Jim Sporleder. They also learned about CareOregon's Health Resilience Program.
- March 29 saw the resumption of the "expertise in the room" presentations, as well as reports from collaborative participants who took part in visitations to Lincoln Alternative High School or to Cherokee Point Elementary School in San Diego.
- The following session featured presentations by Chris Bouneff, executive director of the Oregon chapter of the National Alliance on Mental Health, and Tony Biglan, senior scientist at the Oregon Research Institute and author of *The Nurture Effect: How the Science of Human Behavior Can Improve Our Lives and Our World.*
- Dr. Jody McVittie, cofounder of Sound Discipline, joined the group on May 23, ending the discovery year with a focus on building resiliency in children and working effectively with students who have been exposed to trauma.

These activities were made possible by financial support provided by healthcare provider organizations CareOregon and Moda Health, as well as by the commitments of participant school districts.

Outcomes of the First Year

The findings that follow are drawn from onsite, group interviews conducted by Withycombe Scotten & Associates at each of the seven school districts in August 2016. These conversations involved as many district team members as possible, given the many demands on administrators' time as the opening of school neared.

The quotes aligned with these outcome findings are meant to be illustrative, to expand upon the nature of the finding rather than to profile any individual district or indicate the relative frequency of any particular idea. Comments have been lightly edited for brevity and clarity.

1.0 Participants described the collaborative experience as engaging and rewarding, valuable both for their own professional development and for their districts' abilities to respond to student needs. The diversity among participating school districts was a significant factor in achieving a valued and dynamic "learning community."

- The stars are beginning to align. Things are beginning to deepen. This was really needed this year. I just don't know how we could have coordinated and pulled this off without our participation in the collaborative. (North Wasco)

- At that time, my study was really surface-level. It was more like "admiring the problem" than finding real solutions. Before this past year, I knew what ACEs stood for, but the collaborative really opened my eyes toward why it's so important and how big a problem it really is. (Umatilla)

- For us, as a team, the meetings were very valuable. The speakers were excellent. Beyond this, however, the meetings gave us an opportunity to hear what other districts were thinking and doing. (Tillamook)

- The connections with other district leaders, the emails and phone calls, and learning about the experiences of others were so important. (North Wasco)

- We're the largest district, but we didn't come into this thinking that. We're all learners — we're all learning. The fact that there was no obligation to produce a particular product by a certain date enabled us to learn and listen carefully to others without feeling anxious — to just be genuine, responsive learners. Our size is something that is not always helpful. (Portland)

- What made this experience so rich for me and made me prioritize participation in these meetings, which was tough because it was a lot of time, is that you had great speakers. I always walked away knowing something I didn't before. I really valued the people you brought into that room. (Portland)

- To be in the same room with like-minded people was invigorating. (North Wasco)

- I measure success in terms of the parking lot conversations after something has ended. It gives you a glimpse of what people are going to do. (Portland)

- At every meeting, we were just learning so much. It was difficult at times to travel so far, but everyone wanted to go. It was never a waste of time. (Phoenix-Talent)

- We couldn't wait to get to the ACEs meeting. We wanted to learn more. We wanted to do more. We had great conversations regarding how we were going to change things in our schools and in our community. (Umatilla)

- What do restorative practices mean? That was something our district leadership was grappling with, particularly for discipline. There was no clear understanding of what it looked like, what it sounded like, why it was so important. The collaborative really helped with that lens. (Bethel)

- All of the sessions were very valuable. For our entire team, it was just a great learning experience. A lot of information was available that we could bring to our own situation here. (North Wasco)

- The collaborative meetings weren't just something we did occasionally. It became part of our life last year. It was very powerful to have that experience every month. (Umatilla)

- The San Diego trip was a real eye-opener for us. We realized we could achieve this type of environment too. It's all about connections. We started to look at how we could build those connections with our students. (North Wasco)

- Our district's benefit from participation included the visitations, with a recognition of the importance of the sanctuary approach to caring — that everyone's safe throughout the expanded school community. (Gladstone)

- With every training session, we walked away with a different lens. I would approach students differently, especially those struggling behaviorally. (Bethel)

- Our participation answered a need we already saw. We were seeking to identify what we could do to best support our students — socially and not just academically. We wanted to provide some hope and engagement for kids and their families. We know it's not just our instructional practices that we must continuously improve. We were experiencing very young children with behavior that we more and more didn't understand. (Phoenix-Talent)

2.0 The ongoing involvement of all seven superintendents served to establish the collaborative's importance and, together with diverse and strategic team memberships, contributed to the ability of all seven districts to immediately apply new knowledge and understandings.

- We wanted someone from each level of district leadership — as many as we could take. The superintendent reached out to each of us, and we extended our membership to the secondary-school level. High school representation was very important. (Bethel)

- Our elementary school had established the membership of its Professional Learning Community, and those people were embedded in our ACEs collaborative team, along with representatives of our middle school. (Gladstone)

- Any one individual trying to undertake this change is going to be met with significant resistance. That is the value of introducing this at the district level. It's not just my school; it's every school doing this in a similar way. That's what I'm banking on to facilitate systemic change. (Phoenix-Talent)

- Our team was influenced by a very powerful commitment on the part of our superintendent. She attended pretty much every meeting, along with the assistant superintendent staff. (Portland)

- Our team's construction was really quite easy. We had the ability to bring most of our district's leadership team — the high school joined us at the end — and we brought together all of the right people. The evolution from elementary to K-12 was an important and natural extension of our experience. (Tillamook)

- I was impressed by the diversity of our group and its representation of our district. (Portland)

- Our team's construction was pretty obvious. We took everyone in a leadership position who could help our kids and said, "Let's go." And we did. That was our team. (Umatilla)

- Our superintendent's hope was to bring this to other areas of the district, and we'd love to honor that. We know this is tender work. There's something really precious about this work because the care and communication is much stronger than in any other area of my district work and with other community partners. (Portland)

- It was never a group that we said, "Be here at 6:00 a.m., we're going to this meeting, and you have to do it." Never. We had more people asking to go than we ever expected to take. (Tillamook)

3.0 Each participating school district identified significant organizational changes, activities, and plans resulting from the collaborative experience. Two common themes were the way it helped them to align existing programs and services and to craft strategic approaches based on local needs and resources.

- The ACEs work does move across all our systems. The timing of this opportunity was perfect. The collaborative experience added a missing link, a missing background piece. (Bethel)

- We'll do anything if it will really help a kid. However, some kids just need more. We looked to ACEs to see if we could figure out how to deliver that "more" in a systemic and impactful way. (Umatilla)

- At the start of the year, we had never had a conversation about ACEs. Not once. As the collaborative meetings began, and we heard about things others were doing to address trauma, we would say, "We're doing that! We're doing that too!" It was a recognition that some of what our district already does to help kids corresponds to ACEs. This process led us to understand we had a lot of good pieces in place already. (Tillamook)

- This last year, we did trauma-informed training with all district TOSAs, and we're integrating our trauma-informed lens into all of our school-climate work. We held a one-day ACEs conference for eight schools, which covered a large part of northeast Portland and involved more than 100 teachers. The idea came from the principals, who want to do this work in their schools. Teachers entered with very different levels of knowledge, but they all stayed engaged the entire time. Their responses were very touching. I was deeply moved and inspired by our teachers. (Portland)

- Because of our experience with the collaborative, rather than just jumping on board with a single model, we're doing pretty much an organic model, taking differing approaches to best match with differing needs. (Phoenix-Talent)

- People here are really accepting of each other. As a result, we have been able to undertake an implementation path that may have been difficult in another community. We did things designed to start a conversation in our community. We've received no pushback from our board, staff, or community. (Umatilla)

- We took nine staff members to Seattle for an intensive, two-day training. All of our staff wanted to go, but we couldn't afford that. (North Wasco)

- We focused on staff taking care of themselves, which was a key to acceptance of the training. (North Wasco)

- Our decision to focus on ACEs for our staff is like a breath of fresh air. People come into education because of the relationships they hope to form with kids. "This is why I teach." There's no resistance to this focus. It's natural fit for why teachers got into education. (Tillamook)

- In 2016-2017, our focus is going to be on ACEs and how to implement trauma-informed care. Every in-service is going to focus on that. We've never done anything like this before. (Tillamook)

- Our entire year coming up is built on training for this topic, staff-wide. We're working to create a trauma-informed community. One Monday each month, we are introducing a modularized training program. We've identified what we believe the modules are. Our whole staff will receive the same message that Monday. We will all team up to help each other on those Mondays. (Phoenix-Talent)

- There's a new vocabulary. People know what trauma-informed practices are. We're creating a shift. We're seeing a bigger picture. This is not a trendy buzzword. (Bethel)

- Our participation has fundamentally altered our approach to our discipline system. We realized we were causing trauma. What we want to see is a system that actually reduces the effects of trauma, for all our kids, at all levels. (Phoenix-Talent)

- We've moved to more in-school suspensions, as opposed to students just being gone. We still have some exclusionary practices we are working to remove. PBIS has some practices that are exclusionary. It's just due to a lack of knowledge. We're working to align all our practices. (Bethel)

- We are currently working to more effectively engage our family members in a way to calm, settle, and nurture their children. That would be a great benefit. (Gladstone)

- This is where we are today. We just want to make life more normal. ACEs lead to ACEs, lead to ACEs. We're not saying it's someone's' fault. We're just trying to get a child and family to a better place. (Umatilla)

- We're working hard on customer relationships. Coming into a school can be difficult for people who have had bad prior school experiences. Our workshop and training for front-office secretarial staff is an effort to improve customer service. (North Wasco)

- This year, we're working on a school improvement plan that adds a third component: the social and emotional development of our students, moving beyond academic improvement and instructional growth. Focusing on social and emotional development will take us time. It's a difficult, but critical, commitment, a significant initiative. Our objectives are: a common vocabulary, a shared understanding that all behavior comes from a need to feel connected and accepted, and the implementation of community class meetings in which students are able to function, create an agenda, and learn to solve problems on their own. (North Wasco)

- We want to dig deeper and deeper into our implementation strategies and work to preserve what we've got going. The collaborative then becomes a vehicle to share with others and to gain knowledge from their efforts. (Gladstone)

- Based on what we're doing in our district, we're being approached to share and to help others. We're being identified as a showcase district, with people coming down to see what we're doing. (Phoenix-Talent)

- This will impact how our children's services department builds its organization. A lot of our department is being organized with the idea that resilient schools, resilient teachers, resilient students, and resilient families are the collective work of the whole organization. (Portland)

- I want to say by the end of the 2016-2017 school year that we have become a trauma-informed school district. (Phoenix-Talent)

- Our belief here is that we can change the culture of this community, not just the culture of our schools and kids. Some families in our community are living in a recurring nightmare of a lifestyle. We're going have to figure out a way to break those physical, mental, and emotional patterns of abuse. We're the one thing that even the lowest-functioning families in our community connect with — they get their kids to school. (Tillamook)

- I think we're primed for Phase II in another year. Perhaps one element of this would be employee wellbeing, helping people to better manage themselves in a more in-tune and subtle way. (Gladstone)

Thoughts about the Collaborative's Second Year

Representatives of all seven district teams said they could see potential benefits in another year of participation, if it were offered and if it were feasible for their district; and they suggested alternative ways of structuring a follow-up year.

- Additional expert presentations and visitations that focus on K-12 implementation of trauma-informed practices.
- Convening representatives of the seven districts for conversations that focus on sharing implementation efforts, particularly lessons learned. Areas of interest appear to include effective data collection and use, professional development strategies, working with diverse families and communities, avoiding stigma, developing family support, building community partnerships, and developing new resources.

Interview participants also talked about the possibility of adding a second cohort of school districts next year.

- One alternative would be to encourage current districts to expand team memberships to widen their internal bases of understanding and commitment.
- Another would be to identify additional school districts for an experience like the one these seven districts experienced in 2015-2016, perhaps allowing each current member to recruit a neighboring district in order to begin to develop regional capacity and establish mutual support relationships.

I. Welcome and Introductions

Convener Bob Stewart, superintendent of the Gladstone School District, welcomed participants from the seven Oregon school districts that have formed the ACE Interventions Learning Collaborative. In addition to Gladstone, they are Bethel, North Wasco, Phoenix-Talent, Portland, Tillamook, and Umatilla. He asked the superintendents to introduce their teams. Team memberships vary, but the collaborative as a whole engages central office administrators, school administrators, counselors, and teachers.

Bob introduced Dick Withycombe, who will facilitate the study process; Gladstone staff members who will provide logistical and technical support; Dave Ford, former president and CEO of CareOregon; and (later in the meeting) Martin Taylor, current CareOregon president and CEO. CareOregon has provided funding support for the collaborative's activities through December.

II. Overview of ACE Interventions Learning Collaborative

Bob talked about the formation and purpose of the ACE Interventions Learning Collaborative. For Gladstone, an opportunity provided by CareOregon to attend an August 2012 symposium was the catalyst. "Walking out, we said: we knew this stuff, but we didn't really know this stuff." It has been an 18-month journey, but the district is now implementing strategies to address the needs of students who have experienced multiple adverse childhood experiences (ACEs), with the expectation that these will evolve as they learn more.

The collaborative grew out of conversations with fellow superintendents who have similar interests: "As we talked, it seemed time to bring people together and identify, collectively, our best thinking." The purpose is, first, to identify and share effective intervention strategies within the collaborative, and then, if possible, to conduct broader research into proven practices in schools.

To illustrate the need for this work, Bob shared information from Gladstone's 2014 Oregon Healthy Teen Survey. The survey of eleventh-grade students found that:

- 44.3 percent reported that their parents were divorced or separated,
- 39.1 percent that they lived with a problem drinker,
- 25.7 percent that they lived with a street drug user,
- 35.7 percent that they had a family member suffering from depression,
- 23.7 percent that they did not always have enough to eat,
- 14.9 percent that they sometimes had to wear dirty clothes, and
- 14.9 percent that they had no one to protect them.

III. From ACEs to Action: How Schools Can Move to Sustainable Trauma-informed Practice

Bob introduced Chris Blodgett, director of the CLEAR Trauma Center, in the Child and Family Research Unit at Washington State University. A clinical psychologist by training, Chris and his staff have conducted research in the Spokane School District and worked with schools to help them develop sustained trauma-informed practices.

Participants received copies of his PowerPoint presentation, "From ACEs to Action." These edited excerpts from the additional information he provided are keyed to slide numbers.

PART 1: How trauma from childhood adversity is different

- Everyone in this room is a trauma survivor, has been through a transformational experience that changed them and maybe made them stronger. But what if the trauma were not an event, but a process? And what if it happened at a young age? Early childhood trauma is qualitatively different. (3)
- ACEs are becoming a national conversation, but that doesn't tell us what we should be doing in schools. In a survey of households with children aged five to 15 years, criminal justice researcher David Finkelhor found that six of 10 children had been victims of violent action within the last year. Approximately half of those victimizations were known to authorities, and nearly 75 percent of the time those were school personnel. Not just teachers and principals, but also bus drivers and cafeteria workers; so this needs to be an all-staff issue. (4)
- [The format of slide 5, when printed, obscures these additional risks: sexual abuse, physical abuse, neglect, emotional abuse, caregiver substance abuse, caregiver mental health, caregiver incarceration, and domestic violence. An example of people who suffer from historical trauma: immigrants who have fled war zones.]
- More than 25 years later, the Kaiser Permanente ACEs study is still active, following more than 17,000 adult patients. There is a "dose effect": the more ACEs before age 18, the greater the long-term health impact. There has to be a continuum of responses, because the level of need would overwhelm the mental health care system. We should avoid an "error of reasoning" that could lead to bias: these risk factors apply to groups, not individuals. Some people have the resources to overcome risks, to be resilient. [BRFSS: the Centers for Disease Control Behavioral Risk Factor Surveillance System.] (6)
- "Population attributable risk" is a public health concept: If you know this one thing, how much variability across groups can you predict? (7)
- These charts illustrate the stepwise impact of the ACEs dose effect. (8)
- You can assume that approximately 25 percent of your workforce have four or more ACEs, maybe more among those who choose education or health and social services careers. You need to be sensitive to that when you ask your staff to take this on, because some of them may have unresolved issues. We don't recommend screening for this. Instead, ask yourself: What would I do if I assumed trauma? (9)

- CLEAR is working with the Spokane Head Start grantee to help them develop their trauma-informed practice. They are part of a national "prison pipeline" study funded by the US Department of Justice, so they need to screen for early childhood trauma. They excluded some families because the screening might jeopardize their relationship with them or because they knew they couldn't provide the indicated services (e.g., because of language barriers). Participation was voluntary, but nearly 90 percent of the parents who were asked granted permission to screen; and the survey involved approximately 600 families. You have to be so careful, so thoughtful about how you approach screening. For example, we replaced four questions about abuse with one question: Have you had any contact with Child Protective Services? (10)
- The Spokane Head Start survey found that one in four of the children had experienced four or more ACEs. [The lines on this graph represent, from the top: 0-1 ACE, 2-3 ACEs, and 4+ ACEs.] All three lines trend upward because this was a developmental assessment; the issue is the gap in gains. (10)
- The 2010 Spokane ACEs study involved 2,100 randomly selected BRFSS students in Title I schools and focused on what school staff members knew about the children (aged 6-12). In this chart, students with no known ACEs are the comparison group; for example, children with three or more ACEs were five times more likely to have severe attendance problems than students with no known ACEs. The analysis controlled for special education (generally, not by program), race, and free/reduced lunch. The only factor that was more predictive than ACEs was special education. CLEAR will share the methodology for this study in return for access to data, because we want to try to replicate our findings. (11)
- [These CLEAR Trauma Center studies can be found at http://ext100.wsu.edu/cafru/research/.]
- [RTL refers to Readiness to Learn, a Washington state program in which school districts partner with community-based organizations to help students at significant risk of not being successful in school.] After two years of needs assessment related to non-academic reasons for academic failure, we realized we could apply the idea of ACEs. You may not need to screen for ACEs. You may already have a significant amount of data that just needs additional analysis. (12)
- This is a cross-generational problem that requires a community solution. A study using existing data sets to evaluate the impact of 120 community characteristics (risk and asset indicators) on academic success (measured by standardized tests) identified two major themes: the level of poverty and the percentage of adults with three or more ACEs. (13)
- Note that the range on the vertical axis in this chart is 50 percent to 75 percent, rather than 0 percent to 100 percent. Poverty is a major driver, but we can't demonstrate the relationship between poverty and ACEs. Which is the cause, which is the symptom? (15)
- The data in this chart are taken from Washington's Healthy Youth Survey; they reflect students' self-report responses. (16)

Part 2: Moving from the "what" to "how" as the framework for action

- Complex trauma is what makes childhood trauma unique. The term refers to multiple adversities experienced early in life, before age five and typically before age three. Children that age have no control over their environment; they cannot manage or escape it, they can only survive. It happens before they have the language make it understandable, so it becomes physical trauma. Their ways of coping become hardwired. You can't assume intention — because the child is not activating the brain. This has implications for how we deal with the child and for how we approach discipline. (17)
- According to an American Academy of Pediatrics position paper, toxic stress is the physiological process of inescapable and unremitting stress. Heightened levels of stress hormones that act as neurotoxins in the developing brain lead to structural dysfunctions. (17)
- The trauma of ACEs is that it steals safety: you may not be able to count on the people you love. These children believe they are not safe, and that is the major driver of their behavior. This is a uniquely family issue, but be careful about moving to blaming the parents. They are often survivors of the same kind of childhood and trying to do their best for the children they love. This is the best place to start. Not believing that is a dead-end engagement strategy. (17)
- Trauma creates a fundamental shift in how we understand the world. It's about how we respond in the absence of safety. There's a relationship between poverty and disruption. That's important for policy because it allows us to concentrate resources in some schools. Poverty is not the fire; it's the gasoline poured on the fire. (18)
- One of our basic biological functions is sensing the world for safety. Trauma makes the brain's medulla hypersensitive, triggering fright/flight/freeze responses. The regulatory mechanism that allows us to read safety and respond appropriately is knocked off kilter. The kids who act out draw our attention, but we need to be aware of the quiet kids in the back of the room too. Some children disconnect from their own experiences, their own feelings. They can't read emotional language, their own or that of others. (19)
- Regarding principle 1: We organize ourselves in relationship to others. Principle 2: We need to create space between feeling and acting, to help children make better decisions. Principle 3: If a child is constantly dealing with issues of safety, that part of the brain becomes overdeveloped. (20)
- We ask teachers to think about the number of transitions they require during the day. Every transition is an opportunity for a traumatized child to feel threatened by change. Do an audit of the transitions in your classroom. Are they all necessary? Can you reduce the number of opportunities for kids to dysregulate around behavior issues? (20)
- These PET scans compare activity in the brains of a healthy four-year-old and a four-year-old Romanian orphan. The most striking differences are in the temporal lobes, which are related to language acquisition and decoding, as well as transfers from short-term to medium-term and long-term memory. (21)
- You can hold kids accountable, but you don't need to put topspin on it. Guilt is about the incident; shame is about *me.* I did something to deserve this. I wasn't lovable enough.

This happens when adults believe behavior is directed at them and come back at the child. We need to shift the conversation in schools away from punishment. Our culture believes that punishment works. But it is a scientific law: punishment teaches nothing. It will suppress behavior if you frighten the child enough, but that's corrosive to the relationship. Trauma steals safety, deep in our bones. That idea is important to understanding where behavior comes from. (22)

- Children have an inherent drive to master, to be good. Give them opportunities to do positive things, to assume responsibility. (23)
- ADHD is a real condition, but often it is actually trauma-induced behavior. (24)
- The goal is kids with learning-ready brains. That means addressing the problem of the highly sensitized medulla. Put self-regulation at the center of classroom management. Shift the problem from the child to your relationship with the child. (25)
- Transitions and punishment can be traumatizing for children with ACEs. It's possible to reduce and replace traumatic responses, and resilience can be learned. (26)
- Building resilience is slow, bricklaying work. Resilience is the ability to continue to prosper in the face of adversity. It's like a bank account; you build it up and draw it down. Wherever you start, it's possible to build resiliency. (28)
- Unremitting praise may seem like a good idea, but for some trauma-exposed kids attention and touching may be triggers. It's important to understand how trauma affects interaction. (32)
- Washington is big on Positive Behavior Interventions and Supports (PBIS). Schools send teams for training and they all come back energized — for about three months. To qualify for mental health funding, Montana schools must be at a high level of PBIS practice; so they fund coaches to help schools develop sustained practice. That's smart policy. What we know about innovation is that it can't be done in less than three years, whatever it is. There's not much evidence that a one-day training works without the opportunity for supervised practice of new skills. Our training combines exposure to new ideas and opportunities to practice new skills. We meet an hour per month for more than two years for 20 minutes of didactic training and 40 minutes of conversation. I find that educators are desperate to talk with each other; they get very few opportunities to do so. (32)
- High standards for all means from where kids are now; individual education forward is the goal. Social and emotional learning practices is the best training investment, along with trauma-informed practices. (32)
- For trauma-exposed children, triggers evoke the behaviors that meet the need of the moment, and at that point the child needs to survive, not to learn. Aware teachers can intervene, deescalate the situation and help the child return to a steady state (until the next trigger). Trauma-informed practice is about helping kids get back to a regulated state and break out of a disengagement cycle. (33)
- [This video of Dr. Daniel Siegel presenting a hand model of the brain can be an effective parenting tool and can be used with children as young as five years of age: https://www.youtube.com/watch?v=gm9CIJ74Oxw.]

IV. Team Conversations

Dick asked participants to meet in their district teams to discuss the above presentation, suggesting they address the following questions — "or other topics that will make this time valuable to you."

- What for you are the three or four critical discoveries or lessons learned?
- What are the implications for moving forward as a school, a school district, a community?
- What are you currently doing that you could share with others?

After about 45 minutes, he asked each team to share briefly the nature of their conversation. Those reports included language that reflects some of the things these districts hope to gain from their participation in the ACE Interventions Learning Collaborative this year.

- Systematizing this knowledge and using it to empower staff and parents
- Implementing strategies to build relationships with parents — early
- Sharing information and strategies across schools within our district
- Expanding high-leverage strategies that are working well in our district
- Identifying our next steps
- Finding a way to deepen this work, to engage all staff
- Focusing on how to have relationships with students
- Sharing the strategies we do have
- Finding the time for sharing and for coaching
- Looking at our system to discover what we do to trigger trauma responses
- Engaging people and organizations in what is necessarily a community effort
- Not overloading a school system that is already stressed
- Inventorying the projects we already have
- Ensuring equitable services across our system, for all students
- Finding the decision-making tools to make sure this is the direction we want to take as a school district

V. Next Meeting November 30

Bob said the purpose of these first two meetings is to build common knowledge and vocabulary. Toward that end, the next speaker will be Dr. Vincent Felitti, an originator of the Centers for Disease Control and Prevention study at Kaiser Permanente.

I. Welcome, Introductions, and Reflections

Bob Stewart, superintendent of the Gladstone School District, welcomed participants from the seven school districts that have formed the ACE Interventions Learning Collaborative and asked people attending for the first time to introduce themselves.

He introduced Dick Withycombe, who is facilitating this discovery phase. Dick added his welcome and asked the district teams to share their reflections on the November 2 session, which featured Chris Blodgett, director of the CLEAR Trauma Center, in the Child and Family Research Unit at Washington State University.

- North Wasco School District *There are people present who haven't been part of our district before, who are now more engaged in the work that's going on. Our work in trauma-based care has been community-based, and it's interesting to see how that's starting to weave together. Trauma-informed practice is starting to infiltrate the district, but more slowly; so we're interested in how other districts are implementing school-based practices.*[*]
- Tillamook School District *For us, this has been very community-oriented. One thing we're interested in, is how to gather community resources to help address this issue. What we talked about was that it's nice to hear specific descriptions of the effects of trauma on students. What will be nice about this is helping staff to understand these specific descriptions and to develop ways of seeing and helping students and of partnering with parents to address issues. We've all had students about whom we've said things like "if only they would make better choices." What's good about this is that we will be able to see specific ways of dealing with that. Staff will have specific tools. We talk about building relationships with students. This can help us form deeper, better-understood relationships.*
- Bethel School District *This gives us a lens through which we view everything anymore. An example is our Positive Behavioral Interventions and Supports (PBIS) practices. As we start to move our work forward, this becomes part of the training and of how we view the practices we've put in place. We've begun meeting with a group called Trauma Informed Communities in Eugene; we had someone come down from The Dalles, and we have another meeting in January. We continue to inform school groups, such as our cabinet and administrator group, of what we've learned. In terms of pushing this work out to a larger audience, we haven't moved in that direction yet.*
- Gladstone School District *We have both a district team and an elementary team. The elementary team invited the kindergarten and middle school to a meeting to talk about Chris Blodgett's presentation, and we're interested in knowing more about what's*

[*] The comments of participants appear in italic print, those of the facilitator and presenter in regular print. Comments not enclosed in quotation marks have been edited for brevity and clarity.

going on in Spokane. At the elementary, our focus is what we call a Culture of Care: the whole school environment. We truly believe that all of this stuff is good for all kids. As a team, we recognize that, unless we really address these issues, we won't be able to educate kids. The Culture of Care model is based on the Attachment, Self-regulation, and Competency (ARC) framework. The bottom rung is about effective routines and transitions, teachers who are attuned, and consistency. We're also looking at PBIS through the lens of trauma. That's where we are now: trying to prepare ourselves to better meet the needs of the kids we call our outliers. We hope we can get ourselves up to speed so we can teach the rest of the elementary staff, so we're all on board.

- Phoenix-Talent Schools *We have more and more children who have more and more extreme behaviors, so this is not a matter of whether we want to do this. It's a matter of discovering what we can do to help, because a lot of the traditional means are not effective at all. There was so much information last time. We soaked it in and took it back; and we discovered some of the newer things we're working on are really pieces of a puzzle. So right now, our team has lots of puzzle pieces all over the place, and our work is to see how those fit together in a way that's caring and also conducive to the academics of our students. We've branched off a little bit, but these are pieces of the puzzle too: collaborative problem-solving, restorative justice. We discovered the HEARTS Program and Susan Cole, author of "Caring and Advocating for Trauma-sensitive Schools." So we're learning about others across the country, examining our own practices, and discovering what we're already doing that may contribute to greater success, such as "Music in the Morning," playing classical music to help elementary students settle in.*
- Portland Public Schools *We talked about programs we currently have in place — such as restorative practices, early kindergarten transition, collaborative problem-solving — and how to bring it all together. Also, how to involve more parents and community in this work. We spoke a lot about the notion that we have educators who were traumatized in their youth and about putting in place universal supports for staff as well as students. Universal supports so that all staff know when to intervene and how to help kids who are escalated. We talked too about possibly applying this work to the way we staff buildings, maybe providing extra resources to schools with high ACE Scores.*
- Umatilla School District *This gave us an opportunity to look more cohesively at what we're doing. We have community resources and DHS support coming into our schools, but we don't have coordination between all those school counselors and community resources. This can guide our collective practices.*

II. Adverse Childhood Experiences and Their Relationship to Adult Well-being and Disease: Turning Gold into Lead

Bob introduced Dr. Vincent Felitti, one of the lead investigators in the large, longitudinal ACEs study conducted by Kaiser Permanente and the Centers for Disease Control. He said hearing Dr. Felitti speak made him realize that educators, in addition to seeing students through to high school graduation, have "a different level responsibility too, because while they're in their childhood we can perhaps prepare them for a life of wellbeing." Edited excerpts from Dr. Felitti's presentation appear below.

- This study, the largest of its kind, involved 17,000 adults and focused on what happens to people over their lifetimes.
- Adverse Childhood Experiences (ACEs) are:
  - common, but largely unrecognized;
  - the reason for a significant portion of adult medical care need and for common public health and social problems;
  - strong predictors of adult social functioning, wellbeing, health risks, disease, and death; and
  - interrelated, not solitary.
- This combination makes ACEs the leading determinant of the health, social, and economic wellbeing of our nation.
- The ACE Study design involved two waves of 13,000 individuals each. A 71% participation rate yielded a study group of 17,337 patients. Their average age was 57 years; about half were women; 80% were white (including Hispanic), 10% African American, and 10% Asian American. It was a largely middle class population; 74% had attended college. They completed a questionnaire about their experiences prior to age 18; and their health outcomes were followed for 20 years. Measured outcomes included deaths, hospitalizations, doctor office visits, emergency room visits, and pharmacy utilization.
- The 10 ACE categories were based on their totally unexpected presence in a Kaiser obese population. The ACE Study was devised to determine their prevalence and long-term implications in a *general* population. Those categories are:
  - psychological abuse by parents (11%),
  - physical abuse by parents (28%),
  - sexual abuse by anyone (22%),
  - emotional neglect (15%),
  - physical neglect (10%),
  - alcoholism or drug use in the home (27%),
  - loss of a biological parent from the home before age 18 (23%),
  - depression, mental illness, or suicide in the home (13%),
  - mother treated violently (13%), and
  - household member incarcerated (5%).
- ACEs rarely occurred alone. For example, in the case of a battered mother, there was a 95% chance of an additional ACE and a 52% chance of five or more additional ACEs.
- Two of three patients reported at least one ACE category. Women were 50% more likely than men to have more than five ACEs. If any ACE category is present, there is an 87% chance that at least one other is also present and a 50% chance of three.
- The traditional understanding of addiction is that it's due to characteristics intrinsic in the molecular structure of the substance. The common belief is: take heroin enough times and you won't be able stop. But a study of soldiers returning from Viet Nam found that eight months later 94% percent of those who had reported daily cocaine use were no longer using. Another study found that rats moved from the lab to a large, park-like enclosure gave up heroin-laced water for plain water.

- The ACEs study has shown that addiction correlates highly with characteristics intrinsic to the individual's childhood experiences.
- It also found correlations between ACE Score (number of ACEs reported) and severe obesity, smoking, heart disease, liver disease, alcoholism, and intravenous drug use in adulthood.
- We realized we had discovered a paradox: many of the most common and intractable public health problems were patients' unconscious efforts to deal with childhood experiences that lead to shame, secrecy, and pain.
- The common views of depression are that it's a disease, genetic, or a matter of chemical imbalance. What if depression is a normal response to abnormal circumstances?
- There is a clear relationship between the number of reported ACEs and self-reported chronic depression. More than 50% of the women who reported four or more ACEs also reported chronic depression.
- There is also a relationship between ACE Scores and suicide attempts; almost 20% of those with four or more ACEs also reported suicide attempts, compared to less than 2% for patients who reported no ACEs.
- There's a clear relationship between ACE Score and being raped in later life. People who reported four or more ACEs were more likely to report rape. How does this work? It's an important question whose answers may have a broader reach.
- There is a relationship between ACE Score and promiscuity and sexually transmitted disease. Patients who reported four or more ACEs were much more likely to also report having had more than 50 sexual partners.
- For women, ACE Scores correlate with rates of unintended pregnancy and elective abortion. Also miscarriage. How does that work? How does what happens to a little kid affect pregnancy decades later?
- Compared to those reporting no ACEs, patients who reported five or more ACEs were 5.8 times more likely to report more than 50 sexual partners, 3.8 times more likely to report three or more marriages, and 2.9 times more likely to have an unwanted pregnancy or elective abortion.
- Higher ACE Scores are associated with a higher risk of perpetrating domestic violence. Both women and men commit violence, but we hear less about women because their victims are usually children.
- Keep in mind that, if there is one ACE category, there are likely to be others. There is a clear relationship between the number of alcoholics in a household and all forms of child abuse (psychological, physical, and sexual). There is also the risk of intergenerational transfer of both alcohol and child abuse.
- Childhood experiences can set one up to be the victim of violence. For women, the population attributable risk (portion attributable to specific risk factors) of ACEs is 62% for sexual assault and 52% for domestic violence.

- It isn't uncommon for a doctor to hear, "I don't remember anything from about age 10 to 13." Amnesia is a form of disassociation, which is a high-grade marker for traumatic life experience. More than one-third of the patients who reported five or more ACEs had impaired memory of childhood.
- Higher ACE Scores correlate with the rate of self-reported hallucination. The relationship is stronger when drugs or alcohol are involved, but still present when those factors are corrected for.
- There are clear relationships between ACE Scores and prescription rates for both antipsychotic medications and anti-anxiety medications, half a century later on average.
- ACEs determine the likelihood of the 10 most common causes of death in the US. The top 10 risk factors are smoking, severe obesity, physical inactivity, depression, suicide, alcoholism, illicit drug use, injected drug use, more than 50 sexual partners, and sexually transmitted diseases. An ACE Score of six or more is associated with shortening life span by almost 20 years.
- These risk factors for serious, chronic illnesses are often short-term coping mechanisms, which are reliable markers for earlier problems. The Framingham Study identified many underlying risk factors (e.g., smoking and lung cancer). What we're learning is the origins of those risk factors, the predictors that offer an opportunity to start thinking about prevention.
- Dismissing these health risks as "bad choices" or "self-destructive behavior" allows us to avoid thinking about their causality.
- ACE Scores correlate with three measures of impaired worker performance: chronic absenteeism, serious financial problems, and serious job problems. It would be possible to discover the relationship between ACEs and school performance. It is also interesting to consider the possibility that poverty is an outcome, rather than a basic cause.
- How and why do ACEs exert their influence throughout life? Why is treatment so difficult? Where is the resilience?
- Compare the brains of two three-year-old boys, one of them from a Romanian orphanage noted for extraordinary levels of neglect. The PET scans depict biochemical activity overlaying the anatomical structure. In the neglected child's brain, there are large areas without measurable activity, including the temporal lobes. Different biochemical activity will affect the kind of brain that's formed. Life experiences may be hardwired. Maybe that's why they are so hard to undo.
- We can summarize our observations this way. Visualize a pyramid representing a lifespan, from conception to death. ACEs are the base. From there up: disrupted neurodevelopment; social, emotional, cognitive impairment; adoption of high-risk behaviors; disease, disability, social problems; early death.
- How might we use this information? I believe public health has an opportunity to study this and develop preventative treatments. Improving the futures of patients who

have experienced childhood trauma will require us to acknowledge that these problems exist and to recognize these cases in clinical practice.

- What can we do today? We can use questionnaires to seek information about ACEs from every patient, acknowledge the patient's reality by asking them how that has affected them, provide help with current issues and problems they're facing, and develop systems for primary prevention.
- We have 30 examiners in our department who talk to patients about their questionnaires before they see the doctor. In the exam room, the doctor follows up — and listens. We gave 130,000 patients new questionnaires with trauma-oriented questions; and we saw a 35% reduction in outpatient visits and an 11% reduction in emergency room visits. If these results are replicable, the economic implications are huge.
- Asking, listening, and accepting — that was an important part of how we did that. Just acknowledging a person's experience has a positive effect, without providing direct treatment. Timewise, it's a negligible intervention that has a remarkable impact. Even so, resistance is likely to be significant, unless education is different from medical practice. The point is that a simple maneuver costing essentially nothing had profound implications.
- People will say, "You can't ask these questions, they will cause patients to decompensate." But patients were rarely upset by identifying and discussing these issues. Many of them expressed relief at finally being able to talk about them openly.
- Certainly providing help with current problems is important, but that leaves the bulk of the issue untouched. We need to discover how to prevent these problems, rather than treat them after the fact.
- Future interventions should include: primary prevention (e.g., parenting programs, home visitations, and therapeutic use of TV and theatre); secondary prevention (e.g., programs for high-risk or imprisoned parents); and tertiary strategies (e.g., improved physician training and the development of an internet-based medical history).
- The goal would be an individual, population-based health appraisal system: a biopsychosocial concept. We've seen that the introduction of trauma-related questions into a comprehensive medical evaluation has a profound impact on the number of clinic and emergency room visits in the subsequent year.
- What would happen if you did something like that in schools? How might that affect things like attendance, behavior problems, and visits to the school nurse? You have reliable systems to track those outcomes right now.
- Childhood traumas lead to disruptive neurodevelopment, anger-control issues, depression, suicide, hallucinations, anxiety, disrupted sleep, multiple somatic symptoms, memory impairment, flashbacks, dissociation, and disease.
- Behaviors for coping with traumas include overeating, smoking, inactivity, withdrawal, promiscuity, teen pregnancy, suicide, alcoholism, drug use, repetition of trauma, and self-injury.

- Biomedical consequences of trauma can include diseases of the heart, liver, and lungs; bone fractures; miscarriage; sexually transmitted disease; and early death.
- Serious social consequences include homelessness, addiction, prostitution, violence, unemployment, domestic violence, rape, and an inability to parent.
- The insights from the ACE Study can be summarized as follows.
  - ACEs are common, but typically unrecognized.
  - Their link to major problems later in life is strong, graded, and logical.
  - They are the nation's *most basic* public health and social problem.
  - It is comforting to mistake intermediary mechanism for basic cause.
  - What presents as the problem may in fact be an attempted solution.
  - Treating the solution may be threatening and cause flight from treatment.
  - Primary prevention is presently the only feasible population approach.
  - The resistance to introducing these changes can be major.
- Your work matters. What you do in your schools matters enormously — now, and for decades to come.
- Further information can be found at www.acesconnection.com, www.avahealth.org, and www.humaneexposures.com or by emailing vjfmdsdca@mac.com or info@cavalcadeproductions.com (DVDs).

Questions and Discussion

- *Where do we start with taking this work forward? With teachers or with students?* I would do it on a small scale both ways and see which works better. You video what you do, to help you evaluate it later; video is a powerful tool.
- *When I think about it, it seems possible that a significant percentage of special education students have multiple ACEs. I wonder if any of this information has been given to either the US Department of Education or to state education departments, so they can consider that in the eligibility process.* I don't know, it's not my field; but I think that's an important question. Don't be disturbed by not having the answers; the goal is to have the right questions.
- *My concern is, how to present these questions to children.* You can pool the responses and present them as "a population" for the purpose of discussion. If you want to galvanize community interest, get the local newspaper to run the questionnaire and report the pooled data; this has been done in some small cities. I've seen effective use of theater in medical settings; and no doubt that's possible in schools. The Oakland educational theater program, available to all California districts, has plays ranging from "Walking Down Safety Street" for kindergartners to "Secrets," a play about AIDS for high school students. Maybe Kaiser Permanente would fund something like that in Oregon.
- *You were also going to talk about hypnotherapy.* We have spoken about general approaches to affected populations, but what about specific individuals? Psychotherapy is an important, beneficial treatment, but it is inefficient and very costly. Medical hypnosis has a cost advantage over psychotherapy. If you can find a

capable hypnotist, remarkable things can be accomplished in one or two visits. If you want to know more, go to the American Society of Clinical Hypnoses website, created by psychiatrist Milton Erickson.

- The other thing I mentioned was Eye Movement Desensitization and Reprocessing (EMDR) therapy. It's about 25 years old and highly accepted by experienced people in the field. Its advantage is that it often accomplishes significant changes in a few visits, so it's affordable for people who couldn't engage in traditional therapy.
- *Do people ever refuse to respond when asked how their childhood experience affected their lives?* Occasionally, but we don't push it. We see it as a seed planted; they may feel differently in a couple of months.
- *I've been thinking about the culture of shame and silence surrounding ACEs and how to help students help themselves and each other. Is it developmentally appropriate to start educating students that these experience do exist in their lives? I'm thinking about creating talk time for students in the classroom, when they could listen to each other. What kinds of issues might there be?* This is a good role for theater; it helps people speak about these things without taking personal responsibility for it. I once heard someone say that, since the ancient Greeks, theater has helped people speak about the unspeakable. The other thing is to do this in groups, not one-on-one. Groups provide support for those who lack a meaningful support system, and people learn more quickly from each other. We do very little telling; we ask questions and listen.
- *I'm hearing that, when dealing with an adult population, your approach is about acceptance, creating a caring environment that isn't intrusive. Creating a safe space so things are not so personally identifiable may be the way to work with children, rather than a direct encounter.* I agree. Something that's been written about extensively is the use of autobiographical writing. I ask patients to write autobiographies in five-year segments. It's very useful, but I don't see it in a school setting because parents would object. That's the value of theater: it isn't about yourself, it's make-believe.
- *What's your thinking about working with parents?* I don't have any experience doing your work, but I think I would ask people with similar problems to meet in small groups. I think that would be a very effective approach; parents would be relieved to find they aren't the only ones, and they would learn from each other.
- *The parenting programs we see are typically about telling parents, even if they're research-based. Are you aware of others that are more about sharing than telling?* The essence of my point is to not spend much time telling people what to do, to spend more time asking them what they do and why. Asking how old they were when they started their high-risk behavior can help identify when the cause occurred. You can ask: why then? You may get a good answer or cause someone to think about it and arrive at an answer. I've found asking questions in small groups very productive.
- *We have certain areas in which we are mandatory reporters, so if kids are talking about certain things — suddenly I'm the enforcer in the room, and that changes the dynamic. Education and medicine come at the problem from such different angles. There are significant differences in how we support our clients.*

- *The Department of Human Services is doing quite a lot of work with trauma-informed practice. It's rolling out slowly; like us, they have more questions than answers at this point.*
- *One lens we can place on this is to assume that all kids have ACEs. We know 40% have three or more, and it's higher in some communities. Let's talk about what we would do if we put that lens on. Think about PBIS or Response to Intervention (RTI): the big green zone, the smaller yellow zone, the even smaller red zone. Kids in foster care are probably in the red zone, because that's about systems. Yellow is about schools and their community partners. Green is us: just schools.*

III. Small Group Discussions

The small groups were made up of people with similar roles, from different districts. Dick provided a four-question discussion guide.

- Thinking about the presentations both by Dr. Vincent Felitti and by Dr. Chris Blodgett, what are the most significant implications
  - from the perspective of your professional responsibilities?
  - from the perspective of your school or school district?
  - from the perspective of your community?
- What questions or concerns have these presentations raised for you?
- Looking ahead over the next six months, what topics would you like to see the collaborative explore?
- Are there particular speakers you would like to hear?

At the end of the afternoon, he asked each group to share highlights from their discussion.

- *We talked about ways to implement trauma-informed care without traumatizing kids, families, or teachers. Specifically: questionnaires at parents' night, parent/teacher conferences, and other ways to get information about children's home lives. We discussed the negative impacts on children with ACEs of public or exclusionary discipline. We felt that there are some lenses missing from the conversation, such as race, immigration, gender identity, sexual orientation, and poverty. How can we customize the ACEs process to meet the needs of a diverse community and to be inclusive? We recommend the work of Portland's Teatro Milagro.*
- *We had a great conversation. We talked about young teachers who have had training in holistic teaching, but are told once they get on the job that they must teach the core curriculum. We discussed the role of mindfulness and of MindUp™ training; there's a speaker from Portland State University* who may be a good person to hear.
- *We talked about what teachers need and the things the Gladstone School district is doing, which we would like them to share. We were thinking about the commonalities among the seven districts in the collaborative and how we can go forward in a meaningful way.*

- *We focused on what we'd like to do in the next six months, how to move our institutions — especially how to engage teachers who are dealing with fatigue and leery of "just another program," because people from schools that have successfully implemented trauma-informed practices talk about the importance of a shift in thinking. We talked about frameworks for making these changes, including the ARC model, and the value of working with other agencies in a more coordinated way.*
- *We want more information, more knowledge, people who can talk to us about successful ideas and experiences so there can be cross-pollination. We'd like to hear from thinkers like Dave Pelzer, the author of A Child Called "It." What do we do next? How can we get this going? This really is a return to things we knew were good things. How free are people to return to what worked well, things like building relationships, kindergarten sharing, advisory, and homeroom? We also talked about better outreach to parents and community.*
- *Sharing what we're doing and how, we learned there's a lot we can learn from each other, even though we have different resources and different communities. This won't get done with just one school district. We talked about what moving forward looks like, about what we believe we need to move forward to — and our real hope that we can make a difference.*
- *We talked about starting with families: training families first before working with students. Also: how unmet needs and coping behaviors cause students with ACEs to be identified for special education. We talked about using current resources more efficiently, rather than looking for outside resources; about action plans, how nice it would be to see community action plans and school action plans; and streamlining systems, to make sure we all know who's serving students and families. As for resources, examples would be helpful; and we would like to see the movie Paper Tigers.*
- *One theme in our conversation was: what's our role as educators in supporting individual students, families, and staff members? We realized we can't do everything; and that got us to the question of partners, and then to a discussion about action plans. We would also like to view Paper Tigers; and we talked about visiting Spokane or getting some speakers from there.*

IV. Next Steps

The next two meeting dates are January 12 and February 22.[†] Dick said the purpose of these meetings will be to develop common understandings about a focused centerpiece for collaboration, a common core with flexibility for individual districts. These meetings are still part of the discovery phase, a focused exploration that may involve visitations or additional speakers. By March, the collaborative should be in a position to describe what it collectively seeks to accomplish and have some idea of the resources that will be required to support district and collaboration needs.

[†] A meeting will be canceled if Portland Public Schools are closed because of weather, and other districts will receive notice.

ACE Interventions Learning Collaborative
Discovery Phase
Meeting Date: January 12, 2016

I. Welcome, Introductions, and Overview

Bob Stewart, superintendent of the Gladstone School District, welcomed representatives of the seven school districts that make up the ACE Interventions Learning Collaborative. He introduced two visitors and asked district teams to introduce members attending for the first time.

He said that, as the superintendents talked, the collaborative's work seemed to fall into four sectors: parenting and family supports, what we can do in our schools, professional development, and partnering and collaboration. Today's session was intended to bring the expertise in the room to bear on these topics.

II. Reflections on Previous Sessions

Facilitator Dick Withycombe said that, as superintendents and other planners discussed how to engage seven districts in this effort, "We came to really understand that we won't get where we want to be unless we're certain what we're trying to do. The last two meetings have been opportunities for discovery. This is the discovery phase." He asked the district teams to spend 15 minutes talking about the sessions featuring Dr. Chris Blodgett and Dr. Vincent Felitti. Based on your district's experience, interests, and needs, what have you discovered? What are the apparent implications of what you've learned? Are there gaps we need to fill?

- Gladstone School District *We discussed how we could bring community-building back into the classroom, given the focus on the common core. Personally, I have been looking at my kids through a different lens, trying to bring more social-emotional teaching into my every-day practice. How do we do that across the school — provide the academics and also meet students' emotional needs?*

- Portland Public Schools *We started by talking about what's going well. The Pioneer Special School Program has had no suspensions this school year, which they attribute to staff training. The ACE research helps us put a name to behaviors and outcomes we've seen but couldn't articulate. Some schools have partnered with Multnomah County to provide training; and four departments, including special education, are hosting training for school counselors and psychologists, which is important because these specialists are in every school every day. We are hoping to provide other job-alike training opportunities. We talked about showing "Paper Tigers" and a TED Talk about ACE research to various district audiences; we all agreed the first two presenters were awesome and talked about bringing them to our district. We talked about starting small and scaling up. Head Start has been a frontrunner in dealing with child trauma. If something works in Head Start or pre-kindergarten, let's put resources into kindergarten, first grade, second grade, third grade. Older students also have needs, but we may benefit if we scale it up. As a district, we're talking about discipline policies; we talked about bringing ACEs into those conversations with our union and with other stakeholder groups. As for additional topics we'd like to see this collaborative address:*

How can we leverage partnerships across the seven districts beyond these meetings, to benefit from all the great things people are doing? And how can we help the adults to whom we've entrusted our children recognize and resolve their own childhood trauma?

- Umatilla School District *We also talked about the fact that we put resources in place before we knew about ACEs. We knew it was there, and this puts a name on it. We talked about the importance of educating staff because it would change the way they work with children, and also about the need to educate parents. We recognize that we can't do anything about what happened to these kids, so we need to shift our resources to helping them develop resiliency skills. If we can do that, we can make a big difference to their lives.*

- Bethel School District *Our conversation was partly about how we're beginning to infuse this into our other practices. The learnings from these sessions are informing our work with Positive Behavior Interventions and Supports (PBIS) and restorative justice. We've also talked about the use of our equity decision-making tool, that students with high ACE scores should be one of the populations we consider. These were the big take-aways. We talked about students who have historical traumas, as well as the traumas they've experienced in their own short lives, and how that impacts families and their interactions with the district. One challenge we see is how to recognize these things, to be empathetic toward students and families, and also to maintain high expectations — how to change the practices we use to help kids get there, but keep our expectations as high as they would be for other students. We don't want to be so empathetic we reduce our expectations for these children.*

- Tillamook School District *We talked about some of the same things. The awareness level we've gained has changed conversations in our district — what we talk about and how we talk about it. ACEs comes up. It has changed our awareness level, and that's good. It has helped with some of our frustration over student behavior. We have a different level of compassion toward parents, because we understand that many times they were also traumatized as children and that this is cyclical. One of the most powerful take-aways from the last session was that what we see as their problem, in many cases is their solution. As long as we've been in education, it's great to come across something that makes you think differently. This discussion has caused us to think differently about our kids. We need to think about the early intervention piece for children and for families (earlier than us), about the need to support staff, and about the need for community partners. The bottom line is, once we have this knowledge, we have a moral responsibility to do something with it. Now that we know, what do we do?*

- North Wasco School District *Most of our team is fairly new to the district, so I just listened. We started out working with a systems approach with community partners, both in the school and outside school. One of the perspectives I heard today was: I don't understand, I come to these meetings and then talk to teachers about it, and they just don't seem to get it. Someone else talked about mindset. It's so true that, when you have this knowledge there is a moral imperative — but when you don't have the resources to do anything differently, it's stressful and counterproductive. In the elementary schools for example, people may know what's going on and want to get help, but there's no help until the situation goes from zero to 80 and ends up with the principal. It's nice to have people who have had experience in other district settings. One of our new people is from*

a district where the state funds mental health services on campus, and she talked about how that worked and what a difference it makes. She talked about the value of working with students early; teachers may be resistant at first, but it makes a big difference down the road. As we continue to move forward, I'm grateful for the opportunity to be here and to listen to other school districts and also internally.

- Phoenix-Talent Schools *We agree with many of the comments already made. Coming back from these meetings, I feel like a first-grader who's learned new things and wants to shout them from the rooftops. We are taking it all back, and everything we do, we do under this lens. This has created new opportunities for us, including grants from healthcare organizations. Our responsibility is to carry this forth into the broader Grants Pass/Rogue Valley area, in addition to working to change things in our schools. The challenge for us is how to bring the whole community together, and that means bringing people together.*

Dick said, "These extraordinary reports should make us feel that our time together has been worthwhile." He said this kind of sharing is critical because, at the end of the discovery phase, the group will identify district-level and collaborative initiatives and determine how to help secure the resources to support both. "It's important to articulate where we are now and where we want to be so we can move forward with strategic intent, because this must be about more than discovery. It has been put very well this morning: once we have this knowledge, we have a moral responsibility."

III. The Expertise in the Room

Bill Stewart, the retired Gladstone administrator who is coordinating the collaborative's activities, introduced the centerpiece of today's meeting, which he described as an opportunity to benefit from the expertise of our colleagues, to see how things might fit together in the bigger picture, and to begin to identify "a tapestry of options."

Umatilla School District

Superintendent Heidi Sipe's PowerPoint presentation was supported by three handouts, which are available in the ACE Interventions Learning Collaborative archives: "Take the ACE Quiz — and Learn What It Does and Doesn't Mean" (National Public Radio); an all-staff email and preliminary summary of staff quiz responses; and an optional enrollment form with a cover letter to parents.

Heidi said attending these collaborative meetings has increased their awareness and understanding — and left them feeling that it's critical they do something. They started with educating their staff. She sent the NPR ACE quiz to all staff, attached to an email cautioning them not to read it with students present and asking them to share their ACE scores and resiliency factors. Of the first 20 responses, 47.4% reported four or more ACEs, and 21.1% reported none. That told them they had two very different training audiences: staff members who understand ACEs from personal experience and may still be dealing with their own traumas and staff members who can't relate on a personal level.

Beginning second semester, Umatilla's standard enrollment process will include an "Adverse Childhood Experience Quiz." They took care to make it nonjudgmental and worked with DHS to make sure it doesn't gather information that must be reported. The "Optional Enrollment Form" asks only for the final score. It also asks parents to consider consent for counseling if the score is 3 or more; offers information about building resiliency; and offers information about food, housing, cash, and daycare assistance. The form comes with an envelope addressed to the school counselor, and parents are assured that it does not go into the student's permanent file.

The district is also launching a social media campaign. Heidi created parenting tips related to the resiliency factors from www.acestoohigh.com that will be posted on Facebook, Twitter, and the district app. They hope showing parents that small changes can make a big difference will make ACEs less overwhelming for them.

Umatilla is exploring the provision of Eye Movement Desensitization and Reprocessing (EMDR) therapy through private providers. The ESD will help with billing for students whose families have medical insurance, and the district would cover their out-of-pocket costs; the district would pay for services to children whose families don't have insurance.

North Wasco School District

Superintendent Candy Armstrong began by saying they believe trauma also happens within organizations and communities and affects their ability to respond to the needs of students and families. The 2004 district consolidation was a traumatic event for the school district and its community. Her handout is included in the collaborative archive.

A group of community partners in the Columbia Gorge agreed to learn together about trauma and its impact on the families they serve. The first training introduced them to ACEs and to the Sanctuary Model. From there, they established a collective vision to "rescript the future of our communities through the science of trauma and resilience." Between 2011 and 2015, they hosted five Sanctuary Model training events; organizations signed on to implement the model internally and implemented a collective-impact approach to transforming their systems and communities to be trauma-informed and trauma-responsive.

With funding from the Health Federation of Philadelphia Mobilizing Action for Resilient Communities (MARC), they are hiring a full-time coordinator to help them formalize a community consortium and implement universal trauma-screening tools. (Google "creating sanctuary in the gorge.")

Implementation faces many challenges: staff changes, staff resistance, limited time, limited money, changing political winds — and the need to transition from the originators to a second generation of leadership. They realized they cannot do this work alone. The last line of the district vision is, "North Wasco is fully embraced by the community, reflecting its health and wellbeing." Candy said their team hopes that, through the ACE Interventions Learning Collaborative, they can broaden and enhance collective-impact efforts that lead to outcomes of resilient schools and communities.

Portland Public Schools

Assistant Superintendent for Early Learners and Prekindergarten-12 School Support Harriet Adair briefly summarized the evolution of some Portland programs related to what is now called ACEs, starting 50 years ago with Head Start, followed by the emergence of full-day kindergarten and prekindergarten programs during desegregation and now the district's Racial Equity Lens. She introduced the colleagues who presented information about the programs they oversee: Deborah Berry, director of Head Start; Nancy Hauth, Early Kindergarten Transition Program administrator; and Kate Silver, administrator of Pioneer Special School Program. Their combined PowerPoint presentation is included in the collaborative archive, as are two handouts ("Racial Equity Lens" and "Program at a Glance: Early Kindergarten Transition").

After an overview of Head Start and its child and family supports, Deborah talked about the 2014 implementation of a trauma-informed culture to support children and families at Clarendon Early Learners Academy. The focus was to align multi-tiered PBIS and transition strategies, starting with Head Start and prekindergarten teachers and transitioning to elementary schools in the Roosevelt cluster. Parents as well as staff have received training and support in trauma-informed practices, multi-tiered strategies, PBIS, CLASS, Mindfulness, and stress-reduction tools. The staffs of Clarendon and two kindergarten pilot schools received training in Mind Up. This is the first year of data collection; the data will be analyzed through equity and trauma-informed lenses. Among the early lessons learned are the importance of scheduling and funding professional development up front and the need for additional trained staff in classrooms with a number of students experiencing trauma or toxic stress.

Nancy told the group the Early Kindergarten Transition (EKT) program is a free kindergarten practice program for newcomer and high-poverty families whose children did not attend preschool or struggled in Head Start. Located where the child will attend in the fall, it's staffed by teachers and bilingual aides from that school. Children attend five mornings a week for three weeks in August, and adults meet with a school facilitator twice a week. The goals are to increase parental involvement in their child's learning, reduce chronic absenteeism, promote success in school, and reduce family stress around school. EKT students have been found to have better attendance through second grade and lower rates of identification for intensive support based on literacy skills (DIBELS). EKT shifts the family/school dynamic. Children become classroom helpers, and parents become classroom or school leaders, helping parents who didn't go through EKT to navigate the school.

Nancy also described two other early childhood programs. With county support, the district offers home visit training to teachers at self-identified Title I schools. All kindergarten families receive short, no-paper, "hopes and dreams" assessments between August and October. Teachers report positive interactions and find that their instruction and interactions become more differentiated. An Oregon Community Foundation P-3 grant has allowed the district to establish a resource room for informal care providers in North Portland that provides free and accessible training as well as preschool activities for the children in their care.

The Pioneer Special School Program serves students kindergarten-grade 12 who have been determined to be a danger to themselves or to others. Kate works most directly with the 50 high school students, all of whom have IEPs. This year, they are moving to a more inclusive model,

with the support of general-education colleagues. They are also applying a trauma lens. There are two preconditions to working on academics: the student's basic needs must be met and the community must be safe. They use two models consistently: collaborative problem-solving (CPS) and restorative justice. The CPS model assumes students will do well if they can. They have opening and closing circles every day and a restorative circle if harm has been done in the community; giving students the opportunity to repair their relationship with the community is powerful. Students receive daily social skills instruction and weekly counseling. Families receive home visits, parent conferences have been revised to a positive "hopes and dreams" approach, and the school communicates with parents in multiple ways. Data comparing this year to last indicate these changes are effective. Last year 25% of the students were included in the general education program; this year, 75% are. There were 198 incident reports last year; this year to date, there have been 37. Last year, 20 suspensions; this year, none. (Rather than suspensions, students are given "in school support days.") Last year, no students transitioned to the least restrictive environment; this year to date, eight students have done so. Traditionally, the program has been "a lot of black and brown boys." This year, Kate has worked with the high schools to keep those kids there, and Pioneer's equity profile looks more like that of the rest of the district.

Harriet closed with a quote from a TED Talk by pediatrician Nadine Burke Harris (https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en). She noted that these issues are particularly important in her African American culture and that she finds Dr. Harris' words reassuring: "This is treatable. This is beatable." She ended with Marvin Gaye, "Talk to me/so you can see/what's goin' on."

Gladstone School District

Wendy Wilson, principal, and Rick Robinson, care coach, provided a PowerPoint overview of the John Wetten Elementary School Culture of Care Model. This presentation can be found in the collaborative's archive, along with a handout labeled "7 Basic Assumptions," which also includes "5 Operating Principles," "Implementation Events," and "Implementation Materials Provided."

Gladstone is unique because it has one kindergarten center, one elementary school, one middle school, and one high school. The elementary school is large (approximately 800 students). Three years ago, several staff members heard Dr. Blodgett speak at a conference and came away with a sense of urgency. They found a lot of research, but not much in the way of structured school programs; so they realized they needed to create something that would work for Gladstone. Their initial plan was to start with the first grade and move up a grade each year; providing an overview for all teachers, but intensive attention to one grade at a time.

This year, they revised their approach to create something similar to what's already going on in the school: the Professional Learning Community (PLC) Model. Each grade now has a PLC Care Leader, and Rick meets with them monthly. This year's Tier 1 focus is routines/rituals, regulation, consistent response, affect, and attachment. The Tier 2 focus is social/emotional learning activities and zones of regulation. The emphasis is on "working the green zone," which affects all students and all teachers all day. It's a matter of shifting the culture to see through the trauma lens, because you can't focus on learning until kids are in a place to learn.

Integration with tiered-intervention systems is one of their roadmaps. The other is the Attachment, Self-regulation, and Competency (ARC) framework. The first goal is to provide a secure base for all students, on which they can build other skills. The goal is a safe, predictable environment. The key ingredients are classroom structure and routine and facilitative student/teacher relationships.

Four months into the year, there are already positive outcomes. Staff are beginning to feel empowered to do these things or to feel comfortable asking questions in the PLC environment. They avoid mental health language. They have it down to a few mantras. When the principal says she wants them to regulate, relate, and reason with kids — they know what she's talking about. They have developed a common language. There is a shared understanding that behavior problems represent skill deficits and that teachers can intervene, just as they do when they identify gaps between academic skills and expectations. Finally, the nature of informal conversations in the school indicate a growing investment among teachers.

The revised approach seems to offer a more hopeful, helpful framework. The lessons learned are: the priority of the green zone (what you do for the entire culture, because it's proactive); balance between thinking templates and tool boxes (teachers need to know what they can do today); reflecting on practice and conducting a fearless self-inventory (routines are easy, attunement is more challenging). Where are they going? The questions they're working to resolve now relate to the pacing of implementation, sustainability, and developing data-based evaluation strategies.

IV. Reflections on District Presentations

Bob asked each district team to share their reflections on these district presentations.

- Phoenix-Talent Schools *We talked about the ACEs lens and how to enfold that in our own district. We liked the kindergarten readiness ideas from Portland; we will implement some of those. The real question is how best to roll this out for staff — but the good news is, that they're ready to hear the message.*
- North Wasco School District *We heard some great ideas and talked about the different opportunities and challenges we have in our district. We problem-solved some of the disconnects we have with partner organizations, Head Start, early intervention, mental health, our own troops. Leadership is on the same page, but it's difficult to translate that down, in the face of a dominant culture that's been in place for a long time.*
- Bethel School District *We talked about where to begin training so we can ensure that everyone gets to the same level of understanding. Do we start with administrators? With our equity committee? We talked about identifying our community partners: who can do this work alongside us? As we listened to these presentations, we realized we have pieces of many of these programs in place already. How can we look at them differently and shift resources to potentially make this work?*
- Tillamook School District *We also discussed staff development — how to roll this out for staff. We really appreciated the presentations today. They gave us a good understanding of what districts that are a little ahead of us in this are doing. A lot of*

good ideas. There's so much good information, it's basically a matter of finding the right starting point so it makes sense to our staff and to our community.

- Umatilla School District *We brainstormed all that we heard and how to apply what we learned — meeting kids' basic needs and the supports we need to add to classrooms. We have early kindergarten transition, but we heard some ideas we want to consider. They have so many community partners, it reminded us that there are people we haven't yet engaged with and that it will slow us down if we don't.*
- Gladstone School District *Such an explosion of ideas in this room! Around our table it took on a personal tone. This is what I want to try, this is what I'm anxious about. It's really exciting as leaders of teams to talk about how to work on ourselves to move forward, to talk about intellectual and emotional limitations. The resource limitations will always be there, so let's talk about what's true among ourselves and go from there. Our middle school staff is very excited about collaborating with the elementary school. No one knows what the outcome will be, but we're in education so we're good with that. But we know we need to engage in order to move forward.*
- Portland public Schools *It was nice to hear the presentations and to have time to reflect together on their implications. We talked about the need to really focus on what we're doing so we know where to go next. To look at where our students are successful and to learn from programs like prekindergarten and Pioneer. We learned from Gladstone about creating a foundation in which every student gets something and then you do what you can for the outliers and about starting that focus with the first grade. We talked about how to use the media and social media to help get the word out to our communities and about the idea of a "student support day" instead of suspension. We want to get together regularly so we can draft action steps to bring back to the larger group.*

V. Next Steps

Bob reviewed some of the suggestions received for future meetings: a screening of the film *Paper Tigers;* school visitations (e.g., Cherokee Point Elementary School in San Diego, Lincoln High School in Walla Walla; and additional speakers (e.g., Jody McVittie M.D.).

I. Welcome and Introductions

Facilitator Dick Withycombe welcomed members of the learning collaborative and asked people attending for the first time to introduce themselves. In addition to guests and additional staff members from the seven member districts, they included representatives of Northwest Family Services, the Grant's Pass School District/Josephine County Community Network, the Ocean Beach School District (Washington), the Confederation of Oregon School Administrators, and the Masonic Model Student Program (see endnote).

Bob Stewart, superintendent of the Gladstone School District, introduced today's speakers, Jim Sporleder, former principal of Walla Walla's Lincoln Alternative High School, and Rebecca Ramsay, director of Population Health Partnerships for CareOregon, a Medicaid managed-care organization and a sponsor of the ACE Interventions Learning Collaborative.

II. *Paper Tigers:* Lincoln High School's Trauma-sensitive Approach

Jim Sporleder said he appreciated the opportunity to share his experiences at Lincoln Alternative

High School, subject of the award-winning movie *Paper Tigers.* Filmed over the 2012-2013 school year by Director James Redford, it documents the school's then relatively new trauma-sensitive approach through the stories and experiences of several individual students.

Jim said he was pleased to see school and district teams in the room because it requires a team to implement and sustain a trauma-informed school. It also requires a community that understands the effects of trauma and stress on children and families, so the needed wraparound services come together. "ACEs are more predictable than poverty," he said, "so public education has to consider this."

After the film showing, Jim answered questions.

- *What kind of professional development did you provide when you implemented your trauma-sensitive program?*[1] Natalie Turner [2] came in the first two years, and Laura Porter[3] helped us in year three as we further defined our purpose. Natalie taught us there are three things we needed to understand.
    - Dropping your personal mirror: being aware of your own triggers and being able to keep yourself regulated. (A calming adult represents safety for these kids; when we're calm, we have a better opportunity to find and seize a teachable moment. Deregulated adults and deregulated kids are not a good combination.)

[1] The comments of participants appear in italic print, those of the facilitator and presenters in regular print. Unless enclosed in quotation marks, comments have been edited for brevity and clarity.
[2] Natalie Turner is the assistant director of the Child and Family Research Unit at Washington State University.
[3] Laura Porter is the senior director of the ACEs Learning Institute at the Foundation for Healthy Generations in Seattle.

- The lizard brain: a highly escalated brain is flooded with cortisol; it's all about flee or freeze. (The body can handle this for about 10 minutes; these kids experience this 24/7. They are basically functioning from the stem of the brain; helping them deescalate helps them activate the thinking part of their brains.)
- It's not just about sympathy: you hold kids to a high level of accountability. (But you understand that discipline isn't teaching, and you keep discipline inside the school. The traditional model labels and punishes — and escalates behavior.)

- *What did you do in terms of caring for staff, supporting the people who worked with these kids?* We did bring a therapist into our staff meetings, but we weren't as tuned into self-care as we were into student care; and it's absolutely critical.
- *Was the school's health clinic an integral part of the program's success?* The health center was started without district support. Doctor Kirby did that on her own, but it was part of all focus-of-concern meetings and of many action plans.
- *Did you get the families involved, to help improve these kids' home environments?* Brooke knew how to build relationships on front porches. She knew where to call to get the electricity turned back on, and she would show up with bags of food. So we had that kind of partnership going on. Some parents, when there was a crisis, they would come to the school. Others, when she showed up, would just disappear, usually because drugs were involved. With those families, our focus was on student safety.
- *How did students react when you talked to them about ACEs?* Did you see the poster in the background, with the ACEs in a deck of cards? That was a powerful learning tool. The 10 ACEs along the bottom, and all the red resiliency cards above. I always let kids initiate the talk about ACEs. I didn't need to bring it up; they were curious, and they would ask about the poster. I would say, go over there and read the poster and come back and tell me how many — not which ones, just how many. They would come back and say: six, eight. It took me a while to develop the ability to talk to them about the prediction if there isn't intervention, but then I realized that stopping there left them without hope. I started saying: we can trump those ACEs, we can give you hope.
- *How did you overcome resistance from staff?* We weren't at 100 percent at full implementation. A couple, I counseled out. Others, we talked about the research, looked for common ground. The ones who couldn't put their mirrors down, who hurt kids — those were one-on-one conversations.
- *How often did you have focus-of-concern meetings?* We started doing them once a month, but they were so effective we went to twice a month because that's when we did the action plans. Action plans were living documents, and we got right on them. When teachers saw that things happened right away, when they saw they'd been heard, that brought us together. We kept the action plans very simple: Jim will schedule a parent conference, Brooke will follow-up on attendance. Fortunately, Washington has a very strong attendance law, and we used it. That was part of our accountability approach. The message was: we care about you so much that we'll take you to court if we have to, because we want you here. We rarely had to follow-up on threats of official action.

- *As students tell staff members these stories, what about child protective services?* We are mandatory reporters, of course, and we do report; but a good reporting relationship is important.
- *Where did the movie's title come from?* Someone said, kids who have experienced this much toxic stress are in so much fear, they can't tell the difference between a paper tiger and a real tiger.

III. CareOregon Health Resilience Program

Rebecca Ramsay briefed the group about CareOregon's Health Resilience Program. Her PowerPoint presentation is available in the ACE library maintained by the Gladstone School District for the ACE Interventions Learning Collaborative. The edited excerpts below are keyed to that presentation.

- The work of the Health Resilience Program is to support a small number of high-cost adults in their community, in their homes. In many cases, a primary objective is to secure stable housing. (slide 4)
- The program is intentional about supporting the Health Resilience Specialists. The team comes together every week to discuss difficult cases in a multidisciplinary setting that fosters collaborative problem-solving, program learning, and — most importantly — a culture of support and self-care for the difficult work they do. (slide 6)
- These are the qualities we look for when we hire Health Resilience Specialists (compassionate, trauma-informed, etc.). Another important one is having appropriate boundaries. (slide 7)
- Their role is a nontraditional one because they bring healthcare to the client. Clients sometimes come into the clinic, but the Health Resilience Specialists go where they can best engage clients. One of their goals is to humanize healthcare. (slide 8)
- Jeremy was one of our first clients. He was living in his car, and he suffered from multiple, serious, chronic conditions (heart disease, diabetes, end-stage renal disease). He had a history of frequent emergency room visits and hospital stays. He suffered childhood traumas that led to healthcare problems in his twenties. These three slides show his improved health; he is still alive today, three years longer than expected. His story is representative of the clients we serve. Their struggles often begin at age four or five, and they may not encounter a caring adult until they are 45 years old. This is why the work schools are doing is so important. (slides 10-12)
- CareOregon began this journey because it was facing significant rate cuts during the recession. Then-CEO David Ford initiated a national search for healthcare-delivery models; and staff visited two programs, the Commonwealth Care Alliance in Boston and the Camden Healthcare Coalition in Camden, New Jersey. (Slides 13-14)
- There were so many lessons learned, but we still had to apply them to our unique population, within this regional healthcare context. We did this by mining claims data, talking with healthcare providers, and interviewing a sample of high cost/high risk patients. (slide 15)

- What we learned was that the four most prevalent conditions among Oregon high cost/high risk Medicaid members were mental illness, chemical dependency, attention deficit disorder, and post-traumatic stress disorder. So we knew that more traditional healthcare wasn't what these people needed. (slide 16)
- We found that, among CareOregon adult Medicaid members, the majority who had diabetes also had substance use issues and the majority with chronic heart failure also had complex mental health issues. (slide 17)
- When we asked primary care providers what was driving patients' non-primary care healthcare utilization, they often talked about mental health needs and social determinants of health. The patients said: we need more help, not more medical treatment. (slides 18-19)
- Thirty-year-old Jake is another client whose history and circumstances are representative of many of the clients the Health Resilience Program serves. (slides 20-22)
- When they got to know Jake and Jeremy and other clients, the staff saw:
    - the prevalence of substance-abuse, mental health conditions, and mild-to-moderate cognitive deficits;
    - poor health literacy;
    - homelessness and food insecurity;
    - chaotic lives burdened with cumbersome social-service eligibility requirements;
    - lack of timely access to psychiatric assessment and mental health respite services;
    - extensive care-coordination needs, particularly between care sites; and
    - the inability to afford or access goods and services that are critical to optimal health and self-management, such as transportation, healthy food, medications, and a place to exercise. (slide 23)
- Health Resilience Program clients are more likely to experience high disease burden and psycho-social challenges. (slide 24)
- But the real common denominator is adverse childhood events and trauma: physical, emotional, or sexual abuse; physical or emotional neglect; domestic violence; divorce or separation; parental use of drugs or alcohol; parental incarceration; or parental mental illness. (slide 26)
- The conclusions of the Health Resilience Program experience are that:
    - as a population defined by poverty, Medicaid members are much more likely to represent a racial minority and to have lived with social inequity;
    - the highest cost/highest acuity Medicaid members have multiple medical, social, and behavioral co-morbidities; and
    - the vast majority of the highest cost/highest acuity clients have experienced a lifetime of trauma, with resulting health effects. (slide 27)
- It's clear that usual medical care, even *very good* usual medical care, will not be enough. These Medicaid clients need access to mental health and addictions resources, attention to socially determined risks traditionally considered to be outside

healthcare, trauma-informed care, and case management. Healthcare providers must find new, less costly approaches to meeting their needs. (slide 27)

After her presentation, Rebecca answered questions.

- *How did you learn about the importance of supporting each other? Did you know that at the beginning or realize it later?* The staff told us. It helped that our program manager had a background in mental health and had worked with "trauma stewardship." Laura van Dernoot Lipsky[4] came to Portland, and we took the team to listen to her talk. That opened our eyes to the importance of self-care and helping each other, but mostly it was organic. The staff recognized they would burn out if they didn't do something and developed a variety of self-care and mutual-support solutions. It helps that CareOregon has flexible human resources policies and that the supervisors watch what's going on with people. If someone has lost a client, for example, they may suggest some time off.
- *Given that our brains develop over more than 20 years, is there research about when toxic stress is most dangerous?* I am not an expert, but my understanding is that the amount of trauma, not just the kind of trauma, is important, that there is a cumulative effect. Also that the phase of brain development when the trauma first occurs is important. So you may see a different manifestation in someone who had a stable childhood, and then went to war. In some of the stories we hear from our clients, the trauma starts at birth and continues into the forties and fifties. One of the results of the Health Resilience Program is that the Center for Outcomes Research and Evaluation at Providence is doing a deep exploration of the lives of some of our clients in an effort to answer those kinds of questions. They're also fielding a survey, which contains some ACEs elements, of all adult Medicaid members in the tri-county area. It will be a really important study when it's done.

IV. Next Steps

Dicked thanked people for attending and thanked the speakers for sharing their experiences. Bill Stewart, the retired Gladstone administrator who is coordinating the collaborative's activities, talked about next steps. The site visits to Lincoln Alternative High School in Walla Walla and Cherokee Point Elementary School in San Diego will take place in March; and those collaborative members will share their observations at the March 29 meeting. The next meeting will also feature three district presentations, similar to those made at the January meeting.

Endnote

"Established in 1986, the Masonic Model Student Assistance Program (MMSAP) is a research-based and effective response to the negative behaviors that interfere with the success of children and their school communities. Our FREE, 3-day intensive workshops help educators identify, intervene with, and create appropriate referrals for students that may be at risk for substance abuse, depression, suicide, or violence. Visit www.masonic-oregon.com/mmsap/ for more information."

[4] Laura van Dernoot Lipsky is the founder and director of The Trauma Stewardship Institute and author of *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others.*

I. Welcome and Introductions

Facilitator Dick Withycombe welcomed people, saying every meeting reinforces for him that this is critically important work. He thanked Bill Stewart, Lennie Bjornsen, and Natalie Weninger for the behind-the-scenes efforts that make these meetings possible.

School district teams introduced people who were attending for the first time, and the collaborative welcomed new representatives of the Portland Public Schools, North Wasco School District, and Tillamook School District. Gladstone Superintendent Bob Stewart introduced special guests associated with Providence Health and Services: board member Byron Grant and his wife, Cynthia; and three fellows in the Innovation Fellows Program.

II. The Expertise in the Room

Bethel School District

Superintendent Colt Gill said Bethel's current approach includes many pieces of the puzzle and they will use their participation in the collaborative to help them pull these elements together around ACEs. Several Bethel team members narrated a PowerPoint presentation highlighting current programs.

- Kindergarten Smart Start This year, the district implemented a new approach to transitioning families to kindergarten. In the first week of school, teachers met with parents for strengths-based conversations about their children. Rather than telling parents about their children, teachers asked parents about their children. These meetings replaced deficit-based forms asking what the school "should be aware of." The conversations focused on resiliency factors and were so well received the district will continue them next year.
- Cross-agency Family Support Teams The Family Support Team came together in 2010 with the goal of preventing child abuse and neglect by providing wrap-around services to children and families in distress. Since then, it has worked with more than 50 families, helping to ensure that students are safe and that families have access to community resources. Team members include counselors, administrators, the homeless liaison, and staff from the Department of Human Services (Self Sufficiency, Child Welfare, and Youth Services). They meet monthly to staff families identified by school staff, and the working relationships they've established enable them to respond immediately and effectively to crises.
- Kids in Transition Bethel developed the KITS program with scientists from the Oregon Social Learning Center. It's based on positive peer relationships and positive psychological outcomes, all related to ACEs and trauma-informed practices. It focuses on the development of pro-social and self-regulatory skills.

The parenting component focuses on positive, effective, and consistent parenting. The program starts in the summer before kindergarten and goes through the school year, with twice as many sessions for students as for parents. Outcome data have shown significant impacts on early literacy skills and self-regulatory skills, and impacts on self-esteem and attitude toward school have been sustained through fourth grade. Parenting outcomes have also been documented. Next year, this program will be available throughout Lane County. Bethel has been working with Anthony Biglan, author of *The Nurture Effect: How the Science of Human Behavior Can Improve Our Lives and Our World.* This work involved the implementation of the Good Behavior Game, a primary-grades intervention program that has demonstrated lasting health-related benefits as well as improved academic achievement. They are currently working together on an app for parents.

- Counselor Supports The district has prioritized counseling FTE over the years and is now providing them training related to ACEs and trauma-related practices, focusing on resiliency factors. The counselors' involvement with the Family Support Team provided a foundation for training designed to ensure a common background.
- Special Education The special education program is working to embed trauma-informed practices. They have always taught social behaviors in special education classrooms, but the shift in thinking to trauma-informed practice is helping them to look beyond the *what* to the *why*. What happened to this student? Thinking of a student's behavior as an iceberg, they are helping teachers avoid being triggered by the behavior above the water so they can get to the cause below the surface. They are also helping them understand resiliency factors and the biology of trauma.
- Culturally Responsive PBIS Bethel implemented PBIS in the early 1990s and has both school and district teams. This year, they provided three half-day training programs. About half the time focused on deconstructing discipline and punishment and on restorative practices, the remainder on teaching students new skills to replace their hardwired coping skills. Bethel is also applying the draft of a culturally responsive companion to the TFI, an assessment tool that guides PBIS implementation.
- Restorative Justice Practices Bethel has implemented a restorative justice program, which, though more difficult than the traditional discipline matrix, is much more meaningful. Previous approaches had the effect of marginalizing students and families, but this approach, which focuses on consequences and resolution, helps to connect students and families to school.

Phoenix-Talent School District

Orchard Hill Elementary School Principal Brent Barry said it's amazing how much they have learned since the collaborative first convened — and amazing how much there still is to learn. Several members of the Phoenix-Talent team shared a PowerPoint presentation about the district's current programs.

- About three years ago, the district shifted its framework to setting goals related to hope, engagement, and well-being. They chose to participate in the free Gallup Student Poll, and those results helped them understand the *why*. There were some immediate results from this change in perspective. There have been no expulsions since the 2012-2013 school year, and the number of suspensions dropped from 216 to 165 in the first year. Their focus this year is to bring programs that have proven effective into alignment.
- Restorative Justice Practices The high school has implemented a restorative justice program with weekly circles, with the help of a local organization that has provided staff training. Now in its second year, this program has had a significant impact on school culture.
- Good Behavior Game With a grant from AllCare Health, the district has implemented the PAX Good Behavior Game in first-grade classrooms. A video interview with a first-grade teacher showed how it works in the classroom and identified positive impacts on individual behavior and classroom community.
- Music in the Morning Elementary schools start the day with classical music and class discussions of designated character topics.
- No Excuses University This program also has a character-teaching aspect. The goal is to increase the number of students who attend college. Teachers and their students adopt a college or university, and students set and track their own goals.
- Book Study This program stated with the book *Lost at School: Why Our Kids with Behavioral Challenges are Falling Through the Cracks and How We Can Help Them,* by Ross W. Greene. The focus is collaborative problem solving; the essence is forming relationships with students and listening to them.
- Community Partnerships The district partners with many community organizations and agencies and is now orienting those partnerships around ACEs and trauma-informed practices. Part of that is education. The Jefferson Funders, a regional organization of foundations, brought in Laura Porter from ACE Interface in Seattle, and that meeting generated a lot of excitement.
- These changes bring challenges. The outcomes of trauma-informed practices for students are great, but it can be hard to work through the impacts on teachers. When you shift from a discipline matrix that says "if you do A, B happens" to "how can we help you solve this problem," it puts more pressure on teachers than you would expect. Also parents. In part, because it's not familiar. Changes like this reveal the pressure points in the system — for students, teachers, and parents. Every pressure point is an indicator of where education needs to take place. It's important to recognize that this is difficult.
- Looking to the future, the district has identified four goal areas: minimize toxic stress events; teach, support, and richly promote pro-social behaviors; promote practices that reframe problematic behaviors; and foster psychological flexibility. At their retreat this year, they will develop action steps with community partners in these areas.

Tillamook School District

Superintendent Randy Schild said Tillamook has focused on relationships for 15 years, knowing they are key to whether students succeed, but it wasn't until they began learning about ACEs that they understood why. Several staff members and two students provided a PowerPoint presentation about trauma-related programs in their district. This PowerPoint is available in the collaborative's ACE Library.

- Wilson River School Wilson River School represents a new alternative education paradigm. Its mission statement is the evaluation framework for all program decisions: Wilson River School builds bridges to academic and career opportunities through positive relationships, discovery skills, and quality work. Staff members see themselves in partnership with students for their education. A February 2016 survey found that 72% of its 50 students had ACE scores of four or greater; 37% reported seven to 10 ACEs. Discovery is the first phase of the school's social-emotional program, followed by the Eagle Program. Each focuses on helping students to develop specific skills through a set of specific activities.
- In-service Opportunities The district is planning three in-service sessions for all staff next year — anyone who impacts or builds relationships with students. The first, full-day session will include Dr. Vincent Felitti, the Brain Architecture Game, and trauma-informed care and self-care. Session 2 will be a half-day session designed to help staff develop skills related to trauma-informed care and self-care. The spring session will feature the film *Paper Tigers*.
- Tools and Resources The district is developing a digital toolbox for school administrators, to help them reinforce the training. They are planning weekly emails to provide teachers with practical ideas; and youth advocate Jerry Fest has been invited to speak to staff.
- Integrating ACEs into Existing Programs In addition to linking trauma-informed practices with related programs such as RTI, PBIS, and discipline, the district is trying to embed these understandings and practices into less obvious programs such as literacy and natural resources education.
- Community Partners A variety of community partners can be engaged in this work, and community partners will be invited to participate in next year's in-service sessions. The district is working with teacher-preparation programs to help them better prepare future teachers for trauma-informed approaches.
- Funding Opportunities The district seeks additional funding to support programs related to ACEs and trauma-informed practices from healthcare providers and foundations that have priorities in this area (e.g., Oregon Community Foundation, Meyer Memorial Trust, and Spirit Mountain Community Fund.)
- The district continues to look for ways to foster connections. This year, they did away with pay-to-play sports. There was a cost, about $40,000. But two-thirds through the school year, 7% of the freshman involved in those activities are failing one or more classes, compared to 34% of the freshmen who aren't involved. It's

about relationships. That's why the Wilson River School devotes the first six weeks to discovery, because it builds relationships.

III. Visitation Reports

Walla Walla

Team members from Portland, The Dalles, Umatilla, and Gladstone visited Lincoln High School, the subject of the film *Paper Tigers,* with stops on the way to visit schools in The Dalles and Umatilla. Four of the people who made that trip shared photos and reflections.

- From a principal's perspective, what struck me was the commitment of the teachers at Lincoln — their passion makes the difference. Their belief in their kids and in the work. When we asked what administrators could do to support them, they said they wanted peers who share their commitment.
- I've never been in a high school where students were so welcoming and confident, initiating conversations with adult visitors. When asked to describe the culture of the school, one student said, "We're like a family." They are protective of each other, because of what they've been through. The prohibition against bullying is enforced by the students.
- We ended the day with a panel of former students, which was very powerful. One of them talked about how much more homework there is in college. As we work with these students and trauma-informed practices, we need also to prepare them for post-secondary education and training. Another talked about wanting to come back to Lincoln as a teacher, and there is no greater testimony to the value he placed on his experience there.
- When new students arrive at Lincoln, every teacher sits down with them for a conversation that communicates a genuine caring and an interest in learning who they are.
- How do your students value you? You might be able to demand respect, but you can't demand being valued. How do you build relationships that will cause them to say they value you? It's something to strive for, as a teacher.
- We asked one of the students on the panel what he wished had been different about his middle school experience. He talked about sitting with his head down every day because he couldn't do the work. He didn't feel the teachers knew what was going on or cared about him. That's so different from the conversations that start a student's experience at Lincoln. We talked a lot about how we can build those kinds of relationships in our own school settings. The relationships have to be there before teaching can happen.
- We also learned a lot at The Dalles and Umatilla schools, where they're putting relationships first in a lot of different ways. The take-away for me was: how can we know our kids individually, what they're bringing with them, what they're dealing with. And how can we connect with that?

- It's about making a flip in your thinking. At Lincoln, they still hold kids accountable, but the conversation is different. Instead of "go to the office, I'm done with you," it's "I'd rather you were in the classroom, I look forward to seeing you tomorrow."
- The Lincoln teachers love their kids and make them part of every day. They leave their doors open, and kids come in to eat their lunches there. I heard piano music and looked around the corner, expecting to see a student; but it was a teacher.

San Diego

Twelve people took a one-day trip to San Diego to visit Cherokee Point Elementary School. They shared photos, as well as their observations and reflections.

- The principal of the school, Godwin Higa, sees the school as a sanctuary in a community of violence and poverty.
- We were touched by the evident and genuine relationships of mutual admiration and respect we observed.
- The school has been able to give parents the language of trauma so they understand that what happened to them when they were young wasn't their fault and they can help their children and other members of the school community.
- It takes a village to raise a child, and this school and community truly recognize that by making the school a central place for families. Organizations, pastors, college students, all help to create a village for raising the children.
- I learned that this isn't about creating a trauma-informed school or system. It's about trauma-informed practice, and it's all about respect. Respect for kids and families. It's a practice of loving your kids and taking care of them and together creating a culture of respect.
- We observed several classrooms, in different grades; I saw only one child who had to be redirected, and that was by a hug. We saw kids walking quietly down the hallways. Maybe not even with their own teachers. And we talked to teachers. It all seemed seamless. It's a beautiful community. My big take-away was that they are reaching this sense of community by going to the parents. And that's something we need to think about doing in our district.
- They are leading with compassion and love. How you do it is to model it in your leadership.
- It was a profound experience. It's a framework for how you work with families dealing with heavy trauma. They have a lot of community support, a lot of resources, but the most important thing was how they built a sense of community in the classrooms. Every student felt safe, felt respect, felt a sense of belonging. It starts with the principal. Mr. Higa has two non-negotiables: treating students with the utmost respect, not just respect but the utmost respect; and leading with compassion.

IV. Small Group Conversations

Dick invited today's guests to join district teams to talk about the additional information they would like to receive at the two collaborative meetings remaining before the end of the school year. The superintendents collected this information for a planning meeting later in the afternoon.

Bob asked the guests who had participated in the discussions to introduce themselves to the whole group.

- Robin Henderson is the chief executive for Behavioral Health at Providence Health and Services. She said Providence has recommitted itself to be part of the community, to take its services out into the committee. They recognize that means partnerships, and also that changing the health of the community starts with kids. And that means doing things differently about ACEs. She told the collaborative members that, if they're willing to take the leap, the people at Providence want to help them do that. She encouraged them to think about how Providence and other healthcare providers in their communities could be of service to them.
- Chris Bouneff is the executive director of the Oregon chapter of the National Alliance on Mental Health (NAMI), a grassroots nonprofit organization with 7,700 members and 15 chapters in our state. NAMI offers educational and support programs for people affected by mental illness, including family members. It also offers a free educational program for professional educators (Parents and Teachers as Allies). He told the group that one in five people suffer from a serious mental illness and that half of them experience their first symptoms before the age of 14 years. "We now know that if we can catch this in the early years and intervene aggressively, we can prevent someone from having to deal with that mental illness for the rest of their life." Saying NAMI is active in their communities, he encouraged schools to contact him for additional information.
- Heather Jorna is the vice president for Heath Care Innovation for the American Hospital Association. Her team is working on a two-year grant from the Robert Woods Johnson Foundation, studying the unique partnerships hospitals in 10 communities across the country have developed to establish a culture of health in their communities. She said they want to understand how effective partnerships work as a way to help other hospitals work more effectively with their communities. Providence in Portland is one of those 10 communities.

I. Welcome and Introductions

Facilitator Dick Withycombe welcomed collaborative members and guests and asked people who were attending for the first time to introduce themselves. In addition to a new community member of the Umatilla School District team, there were two people from the Chief Education Office, Research Analyst Cheng-Fei Lai and Research and Policy Director Peter Tromba.

The Portland Public Schools team shared its thinking about race as an ACE and the over-identification of students for special education, sometimes just for support because the system doesn't have appropriate services for them. They look to the collaborative for help in reducing inappropriate special education referrals, and thus the number of students at risk of entering the school-to-prison pipeline. They have an interdepartmental rapid-response team that goes to schools when a student is in crisis, to help meet the student's needs and also to assess systemic issues at the building level.

II. Gladstone Community of Care

Lennie Bjornsen reviewed John Wetten Elementary School's tiered approach to supporting all students and meeting specific needs. He and Principal Wendy Wilson worked on its development for more than a year, and then revised it based on what they've learned about ACEs and trauma-informed practice.

The base of the pyramid is the "green zone:" a safe, empathetic, and predictable Community of Care for all. The "yellow zone supports" are aimed at building resiliency. At the top is the "red zone," intensive wraparound supports for students and families. Each tier comprises alternative practices and services, "a menu from which to choose the best strategies." Lennie suggested that these could be amended to reflect the specific needs and resources of a school or school district. In terms of funding, the green zone is funded by schools; the intermediate, yellow zone by schools and other sources (government, foundations, health insurers); and the red zone by government and insurers.

Lennie also reviewed the ARC Model for promoting student regulation, which the elementary school also uses. In this approach too, the base of the pyramid applies to all students (routines and rituals, consistent response, caregiver affect management, and attunement). The three levels of intervention align with the three levels of the social-emotional development curriculum. Both of these models have been posted to the ACEs collaborative archive.

Wendy said she sees her job as principal as being in the classrooms to support teachers. "It's hard work, a lot of work for teachers." They have a coach in the building, but it takes time for teachers to feel comfortable with being vulnerable. It's critical to provide adults with a safe environment and the resources they need — and the understanding that they won't always be successful. She

said it's about keeping the focus on the building because "once I decide it's the parent or mental health, I've lost it because it's outside my control."

III. Mental Illness in Our Communities

Chris Bouneff, executive director of the Oregon chapter of the National Alliance on Mental Health (NAMI), provided a PowerPoint presentation, which has also been posted to the archives.

- Mental illness is not a scandal, it's an illness. We still don't know a lot about it, but we do know that, with intervention, a person whose onset is before age 17 can avoid a life-long disability and live a life as any other person would do. (slide 3)
- NAMI Oregon is a statewide, grassroots organization dedicated to improving the quality of life for individuals living with mental illness, and for their families and loved ones. They see mental health as affecting whole structures, so they work with whole structures. (slide 4)
- Forty years ago, professionals believed schizophrenia was caused by "cold mothers." They were performing lobotomies and putting children in state hospitals. It was then that a group of mothers (the NAMI Mommies) formed the advocacy group that became NAMI. (slide 5)
- NAMI offers programs designed to fill the information gaps in the mental health treatment and support system. All programs are peer-led and free; all curriculum is nationally certified and evaluated. (slides 7-8)
- The incidence of mental illness is the same across all social, economic, ethnic, and racial groups — and all of these families need help. One in 10 children has a mental condition that causes significant impairment. Half of all lifetime cases of mental illness begin by age 14 and 75 percent by age 24. About half of students 14 years and older who have mental illness drop out of high school. (slides 9-11)
- For people living with serious mental illness, life expectancy is 25 years less than that of the average American. This isn't just the result of the mental illness itself, but also of related health risks and even of some medications prescribed to treat mental illness. (slide 12-13)
- Sixty percent of the people who need treatment receive no services; only five percent receive full benefit of treatment. The reasons are that we are not that far removed from blaming the patient and that the system is overwhelmed by the level of need. What we see on the streets, in jails, and in emergency rooms is the failure of the system. (slides 14-15)
- What would you do if suddenly you couldn't do what you used to do? If you started hearing voices? On average, there is an eight-year delay before from onset of symptoms to effective treatment. There is a stigma, and it's hard to navigate the system. (slide 16)
- There are many unknowns. We don't know why some people with the same risk factors transition (i.e., develop mental illness) while others don't. Some treatments and medications can be effective, but we don't know why. We do know that

medications alone aren't enough; people also need supports and attention to health (diet and exercise). (slide 17)

- The medical model works for physical health, but not for mental health. There are no standards of care. For example, the Cognitive Behavior Model has been proven to be effective, but it's still left to individual practitioners to use their own approaches. (slide 20)
- Insurance benefits are limited, and there are no standards of care or metrics for measuring quality. There was a class action suit in Oregon in which the issue was Applied Behavioral Analysis, a highly effective treatment for autism, should be a medical or education responsibility. The Oregon Health Plan (OHP) is adding this, but other insurance carriers are not. (slide 21)
- OHP has been cited as a model early-intervention program. (slide 22)
- How does a family navigate the "alphabet soup" of our mental health system? There are barriers to access to treatment. We talk about "navigation overload." NAMI gets about 2,000 calls a year asking for help finding resources. Some services are considered educational services, so insurance won't cover them. Services are not available in every community, and where they are available it can be difficult to find a provider who's taking new patients and is on your insurance plan — and people often wait three or four months for an appointment. (slides 23-24)
- There are hopeful signs on the horizon. As bad as things are, this is the best time for people with mental health afflictions. Twelve years ago, schools were not talking about this, and now we have this collaborative. We have restructured our public healthcare systems, and we have a health insurance exchange that works. Oregon's 2005 mental health parity legislation affected OHP; and federal law took on private insurance carriers. Housing is a critical need, and NAMI has launched an initiative to help provide housing. We know more than ever, with brain-imaging technology; but we have a long way to go. I heard a speaker at a conference say, "We can see the brain talking, but we don't know what language it's speaking." (slide 25)
- NAMI offers a variety of education programs, including an in-service training for teachers and school counselors. All are nationally developed, vetted, and updated. (slides 26-27)
- NAMI also offers support services for individuals living with mental illness and their families. Peer support teams of adults aged 18 to 25 have worked effectively with high school audiences. (slide 28)
- Schools and school districts can partner with NAMI to provide services that benefit students and their families. Most of NAMI's funding comes from charitable giving, but a small contribution is always welcome. NAMI has affiliates in 11 Oregon counties and is developing them in five others. More information can be found at www.namior.org. (slides 29-31)

IV. Thoughts About ACEs and What Can Be Done About Them

Tony Biglan is a senior scientist at the Oregon Research Institute and author of *The Nurture Effect: How the Science of Human Behavior Can Improve Our Lives and Our World.* His PowerPoint presentation has also been posted to the collaborative's archives.

- Our society has changed massively because of science… That includes the science of human behavior. If what we've learned in the last 40 years can be put into place, we can create a society in which young people arrive at adulthood with the skills, interests, assets, and health habits to live happy, healthy, and productive lives in caring relationships with others. (slides 1-5)
- Nurturing environments have generic features. Of these, minimizing toxic social and biological conditions is the most important. Others are fostering prosocial behavior, limiting opportunities for problem behavior, and promoting psychological flexibility. (slide 6)
- Threat rewires the brain for evolutionary reasons. Genetic, epigenetic, neuroscience, and behavior analysis are converging to show that stressful and threatening environments result in impaired self-regulation, hyper vigilance, mistrust of others, poor social relationships, deviant peer group formation, early childbearing, depression, obesity, and cardiovascular disease. (slide 8)
- Coercion is the fundamental process underpinning human conflict. Observational studies of families with aggressive behavior have shown children learn that aversive behavior works; similar studies of marital discord found both parties adept at using aversive behavior with the other. Depressed people use their affliction to bring respite from the averse behavior of those around them. (slide 9)
- Adults who experience poverty in childhood have a 20 to 40 percent greater risk of all-cause mortality. Cardiovascular disease is an inflammatory reaction to a threatening environment. People who escape poverty still have higher rates of cardiovascular disease, the exception being people who had nurturing mothers. Poverty is a risk factor because it stresses families and undermines their ability to care for kids. (slide 10)
- Robert Sapolsky has written a book called *Why Zebras Don't Get Ulcers,* about the psychology of the stress response. For zebras, when an event is over, it's over. Humans have many more stress episodes because we mull over past events and worry about what might happen. (slide 11)
- Nurturing environments and non-nurturing environments create two different developmental pathways for children. The latter can end in early childbearing, drug abuse, depression, and antisocial behavior. These kids have always been in your schools. It is probably detrimental to identify individual children because it's stigmatizing; making schools as nurturing as possible will benefit all students. (slides 15-16)
- The "Interventions by Developmental Phase" diagram was developed for a specific purpose, but it helps with others caused by the same environment issues. Some interventions, such as home visiting for infants, have lasting effects. Schools will reap

some of the benefit, but other organizations, such as the criminal justice system, will reap the most benefit. (slide 17)

- There are evidence-based interventions. The Nurse Family Partnership, which serves poor, single, teen mothers, has demonstrated significant impacts on abuse and neglect, child behavior development, mother economic wellbeing, time to next baby, and child adolescent arrests. Imagine the stress of a 16-year old whose parents have thrown her out; the nurse helps to create supportive social connections (e.g., an aunt or family friend). The Parent Management Training Oregon Model (PMTO) reliably reduces coercive processes in families and aggressive social behavior in children. The Positive Parent Program—Triple P is a community-wide system of parenting supports; it takes a public health approach and is, by intent, a minimally effective intervention (which can lead to more intensive intervention if needed). The Family Check-Up provides parenting support to families with young children through assessment, observation, and feedback. (slides 19-25)
- Schools and healthcare systems have the best chance to reach families. Between schools, Early Learning Hubs, and Coordinated Care Organizations, we have an opportunity to be more powerful around the values we have for the wellbeing of human beings, to create a high-level coalition around shared values. (slides 31-32)
- Acceptance and Commitment Therapy (ACT), developed by Steven C. Hayes, has shown positive impacts on numerous problems, including depression, drug abuse, pain, and stress. The idea is to be open and accepting of symptoms and attend to what people want their lives to be about. The perspective is that this is the human condition — not that these people are crazy and we're not. So it focuses on humility, compassion, and acceptance. (slides 34-36)
- The elementary-school Good Behavior Game has demonstrated benefits that last though high school. (slides 39-51)
- We are experiencing higher rates of child poverty and income inequality, and health and social problems are closely related to inequality in rich countries. In his book *Our Kids,* Robert Putnam found that America has become far less nurturing of the poor and that the chance of a poor child moving out of poverty has virtually disappeared. (slides 52-54)
- Many more families, schools, and neighborhoods lack the basic conditions that nurture the development of children and youth. It has created a vicious cycle and the erosion of communitarian values — and that engenders an environment of threat. (slides 55-56)
- Whatever you do, I suggest that you:
    - bet on evidence-based programs, policies, and practices (but understand they may not work);
    - measure fidelity of implementation carefully;

- implement initially in a limited number of places and only roll it out to other places when there is evidence that you have the system working; and
- involve the Hubs and CCOs. (slides 57-58)

V. District Team Work

District teams worked to consider the information they have acquired in the ACE Interventions Learning Collaborative discovery phase and to identify a focus they want to pursue in the next school year. At the conclusion of the May 25 meeting, two or three representatives of each team will spend time doing some strategic planning for both district and collaborative initiatives.

I. Opening Remarks

Facilitator Dick Withycombe welcomed representatives of the seven Oregon school districts that make up the ACE Interventions Learning Collaborative, noting that this was the fifth and last meeting in the 2015-2016 Discovery Phase. He and the group acknowledged Bethel Superintendent Colt Gill, whom Governor Kate Brown recently appointed to be the state's first education innovation officer.

Dick asked collaborative members who visited San Diego's Cherokee Point Elementary School on May 20 to share briefly their experiences. People from The Dalles, Umatilla, and Portland described an "inspiring and informative" visit, an "amazing parent group," a "transformative leader," "no tolerance for mean-spiritedness," a shared understanding of the brain science of ACEs, intentionality in working with kids, and strategies that "sound simple but are hard to put into practice."

At Dick's request, guests representing Trauma Informed Oregon, CareOregon, Columbia Pacific Coordinated Care Organization (CCO), Education Northwest, and the National Alliance on Mental Illness introduced themselves.

II. Building Resiliency: Working with Students Exposed to Trauma

Lennie Bjornsen, Gladstone's director of student and family support, introduced Dr. Jody McVittie, cofounder of Sound Discipline. She said their mission is working to make school a more welcoming place for all students, a place where all students have an opportunity to be academically successful. They began with Positive Discipline, which "works with 90 percent of students," but they realized that the remaining 10 percent of students presented 90 percent of the problems — and that all of those students had been exposed to trauma. She described it as a multigenerational problem, which isn't about assigning blame but about trying to make things easier for the next generation. "Everybody's doing the best they can in the moment."

- Dr. McVittie began her PowerPoint presentation by briefly reviewing:
    - Dr. Vincent Felitti's findings, noting that since the ACE Study began in the 1990s other categories of adverse experience have been identified (e.g., post-traumatic stress disorder) and that the key to resiliency appears to be believing you matter to another human being, more often than not an educator;
    - critical factors in the emotional development of infants, including the characteristics of parental behaviors that foster attachment (attuned, responsive, coherent, and consistent); and
    - the lasting impact on brain development of severe parental inattentiveness, which disrupts the arousal/relaxation cycle, leaving babies in a sustained state of emotional distress.

- Babies who suffer neglect adapt to their environment; they develop "a different lens" because their brains are wired differently.
    - Their causal thinking is diminished — and our whole discipline system is based on causal thinking. The idea is that if we punish children for doing something, they won't do it again. And then we say they can't learn because they don't connect the misbehavior and its consequences, and we hurt them (shaming, isolation, deprivation of recess, etc.).
    - Their ability to delay gratification is decreased. They live in an environment of lack, so they have less self-control.
    - The development of conscience is delayed.
    - Their ability to handle stress is decreased, and their baseline stress is elevated. These kids don't go from zero to 100 — they go from 90 to 100. (We should check their heartrates when these kids are sent to the office and not send them back to the classroom until they're back to their baseline normal.)
    - Their relationship skills are decreased, not only their ability to form relationships with others but also their inner sense of connection to others.
    - Their socialization is impaired.
    - Identity formation is impaired, especially in children of color.
    - Their ability to concentrate is diminished.
- The combination of insecure attachment and adverse childhood experiences leads to significant problems.
- When you're stressed and your body goes into survival mode, the prefrontal cortex turns off and you lose critical functions. The kids who give teachers and principals the most grief spend a lot of time that way. In general, boys spend more time in flight or fight, girls in freeze. You see more boys in the principal's office, but the girls go silent and you may not hear about their trauma until they self-expose in grade 10 or 11. However, they begin to fail academically in about the third grade because when you are in freeze, you're in and out; and when instructions get more complex, they fall behind.
- There are lots of ways to teach self-regulation. It involves building new neurons, so it isn't something you do once; you need to do it over and over. A new, free website, piloted by the Committee for Children, offers short modules, which kids love: http://www.mindyeti.com/in-the-classroom.
- The chime activity illustrates how exercises can help children integrate their right and left brains. When the chime is first struck, we're focused on our auditory system, using the right brain. Then we engage our left brain, asking ourselves: can I still hear it? This activity brings into play two elements critical to self-regulation: the ability to focus and the ability to connect the right and left brains.
- Left and right brain exercises are essential for children who have experienced trauma. Some of them, especially young ones, have such poor self-regulatory skills they have difficulty standing on one foot. Schools we work with have had success with Bal-A-

Vis-X exercises, amazing, integrative activities that help children to calm themselves and focus.

- Another strategy for fostering self-regulation is helping students name their emotions. We use an activity called SAD, MAD, SCARED, GLAD to help kids name their feelings by placing them in one of these categories. The data show that increasing a child's emotional vocabulary helps with self-regulation.
- As human beings, we are all connected by mirror neurons. When a child comes in from recess in an agitated state, the other children and the adults in the classroom will react with mirror neurons. When the teacher comes into the classroom evidently stressed, the children will respond. Children regulate off adults, and our ability to self-regulate makes a huge difference.
- Children who live in these difficult environments don't understand the difference between "I made a mistake" and "I am a mistake." They don't say "I made a mistake," they say "I'm stupid" because that's what they hear around them. They are sensitive to criticism or correction because they hear "you're defective." It's important to stress that mistakes are learning opportunities and to teach repair.
- We use a trauma-informed approach to working with children who are in distress, developed by Dr. Bruce Perry and based on brain research. There are three steps: regulate, relate, and reason. Too often we jump to reason, which isn't helpful if we haven't first helped the child regulate and haven't established a relationship with him.
- The human brain has three parts, which in a healthy brain are all connected. The brain stem is about survival and safety; related tools are freeze, fight, and flight. The mid-brain is looking for connection (love); the tools are freeze, fight, and flight — and drama. The prefrontal cortex is where thinking and learning take place, where all options are available.
- You need to keep kids connected to their brains. It's important to "connect before you correct," to acknowledge the student's feelings and to guide her to repair (e.g., an appropriate apology). Ask the student what made him behave that way because it's not his usual behavior (even if it is). Middle school and high school students will most often say that they've been sent to the office because the teacher was disrespectful to them — and that's usually true.
- The "resiliency window" is the space between the "lose it line" and the baseline stress level. The actions of teachers and other students can either open or close that window. Being invited to join other children or having your teacher greet you at the door: openers. A chaotic recess experience or having your seat taken on the bus: closers. Sometimes it's surprising what closes that window. For tier 3 kids, rewards for behavior or achievement are closers because they see other students getting them, when they don't. This is an example of the way trauma-informed practice calls into question lots of the things we do in our classrooms.
- Consider praise and encouragement. Child 1 receives all kinds of nonspecific praise, which encourages her to seek the approval of others. Child 2 receives acknowledgment of effort and of abilities specific to him, which he finds reinforcing.

Child 3 receives neither reinforcement nor praise; the teacher does nothing to her, but the teacher's treatment of other students affects her negatively.

- "Thank you" is an example of appreciative encouragement. Avoid the words good, better, and best. Empowering encouragement may say "I have faith that…" or "I trust that..." But it must be preceded by evidence for that faith or trust (e.g., I've seen you do something like this before) because students who live with trauma have well-tuned BS detectors. Empowering encouragement is thoughtful; it's not about consistency, but the ability to summon a capability. You have to know a student well to do it effectively; it assumes an established relationship. Teachers who have committed to making two encouraging statements a day for 10 days have transformed their relationships with students, one student at a time.

Dr. McVittie's handout (attached), "Building Resiliency: Working with Students Exposed to Trauma," includes the following elements.

- An overview of data related to ACEs and attachment (pages 1-2)
- Understanding Attachment and the Development of Beliefs (page 3)
- Steps for Growth: Tools for Supporting Children with Insecure Attachments (page 4)
- The Brain in the Palm of Your Hand (page 5)
- De-escalation tips: For when the mid brain takes over… (page 6)
- A Brief Introduction to the Thought of Alfred Adler (page 7)
- Developing Relationships with Children According to the Dimensions of Kindness and Firmness (page 8)
- Assessment of Lagging Skills and Unsolved Problems (page 9)
- Working with Students Exposed to Trauma (page 10-14)
- Encouragement or Praise? (pages 15-17)

She also provided a one-page overview of Trauma-informed Practices and a copy of the Student Intervention Team form, which Sound Discipline developed with the Annie E. Casey Foundation. They have found better results with intensive attention (spending an hour discussing one child, rather than six; meeting over time); with making small modifications over time; and with a solution-focused approach (creating a sense of belonging without changing expectations). Team membership includes the teacher, counselor, administrator, and other staff involved with the child (e.g., special education staff); it does not usually include the parents.

III. Panel of Healthcare Partners

Gladstone Superintendent Bob Stewart introduced the panel of healthcare partners: Martin Taylor and Shawn deCarlo of CareOregon and Nancy Knopf of Columbia Pacific CCO.

- Martin said childhood trauma is an important issue for CareOregon, a Medicaid HMO. Half of Oregon kids are born into families that qualify for Medicaid, and about

half of CareOregon's clients are kids. CareOregon intends to be involved in the transformation of the healthcare system, which means better connections between physical and mental health, with agencies that work on the social determinants of health (e.g., food insecurity, housing), and with schools. "We share a population: Oregon Health Program kids. Those are your students, and we want to be as connected to them as you are." He said the purpose of this panel was to inform people about what these healthcare partners are doing and to ask how they can help schools with their work.

- Nancy said about one-fourth of the population of the three counties served by Columbia Pacific CCO (Clatsop, Columbia, and Tillamook) are enrolled in Medicaid. A nonprofit line of business of CareOregon, Columbia Pacific CCO is the result of a community health assessment and a community health plan. The community identified three priorities: improving mental health and emotional wellbeing, reducing the rate of substance abuse, and reducing the rate of obesity. They believe trauma-informed care will help them address these priorities, and they are interested in working with community and clinical partners to move trauma-informed care forward. They're interested in creating a learning collaborative like this one to consider what that system of care would look like — and how they could work with schools to improve outcomes for high-risk children and families. Columbia Pacific CCO is hoping to engage people outside the healthcare system through a Community Wellness Investment Fund that supports community projects that address the three priorities identified in their community health improvement plan.
- Shawn said CareOregon's Community Benefits Grant Program supports projects undertaken by mission-aligned organizations to help address the community health priorities identified by CCOs. They are currently making grants in the three-county Portland Metro area; in Clatsop, Columbia, and Tillamook counties; in Jackson County; and in parts of Yamhill County. Their goal is to identify programs that are likely to have the most impact on at-risk children and families and to improve their health and wellbeing. The current funding cycle focuses on housing. The next one, which begins in the fall, will focus on ACEs.
- Martin talked about another point of connection between healthcare and schools: policy.
    - "We have had success in the 'thought leadership space,' informing legislators where the next important work is coming from. "Awareness of ACEs has increased significant among legislators," who recently passed HB 4002, which allocated $.5 million to fund three school-based demonstration projects to address absenteeism through ACEs and trauma-informed care. Another recent milestone was the federal Every Student Succeeds Act which provides funding for schools doing ACEs work.
    - He expects expansion of school-based health centers, perhaps through future legislation. He is a member of the national board of the School-based Health Alliance, which is looking into forging connections between healthcare payers and schools to work on ACEs.

- The Oregon legislature is likely to press both CCOs and school districts to work with the Early Learning Hubs to help meet the needs of preschool children. Oregon has enormous problems that affect young children and their families. Our childcare costs (in relationship to income) are the second-highest in the nation. That's a significant barrier to employment and one reason so many children are born into Medicaid. It's understandable, because people are making rational decisions for their families; but it perpetuates poverty, which impacts children in multiple ways. However it's a correctable problem, if we invest in childcare for the lowest-income families, especially if childcare providers adopt the kind of trauma-informed practices schools are implementing.
- Finally, we have predictive analytics. Increasingly, we have data that helps us identify the families who are likely to have problems. It helps us to be proactive and to identify early the kids who need healthcare services, even if their parents don't bring them in to be seen. This may be something healthcare does more than schools do, but it's applicable to education.

- Martin concluded by asking collaborative members what healthcare providers could do to be helpful to school districts.
  - *Lobby the legislature for adequate school funding.*[*]
  - *Come into schools to provide needed medical services, including well-child services.*
  - *Try to eliminate cost-shifting so kids can get services in schools.*
  - *Correct the intermittent coverage problem so kids have consistent access to medical services.*
  - *Create opportunities to talk about the intersection between healthcare and schools.*
  - *Provide introductions that help schools get in the door at other healthcare insurers across the state, help us tell a compelling story.*
  - *Help shift the conversation from doctors and clinics to wellbeing — child, family, and community wellbeing.*

IV. Closing Remarks

Dick asked each team to talk briefly about what these sessions have meant to them and how they have affected their school district. Representatives of each district had an opportunity to talk about these topics at greater length after lunch in a planning session that has been summarized separately. He thanked everyone for their contribution to an endeavor that has the potential to make an enormous difference to the state, as well as to these seven communities.

[*] The comments of collaborative members appear in italic print, those of presenters in regular print.