TRAUMA INFORMED PRACTICES AND EDUCATION

By

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Abstract

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The rural frontier community of Mountainville, along with the surrounding area, are usually last to grasp new technology, ideas or practices. Some large cities in California have begun to implement trauma informed practices in schools but if history is any indicator of when Mountainville will begin to implement, it will be waiting for many years. Mountainville, the home of Summit School has been recognized as having a large population of students who have experienced childhood trauma. The purpose of this project is to determine the most effective interventions in reducing barriers to education caused by childhood trauma for Summit School students. A literature review was conducted about childhood trauma, impact of trauma on youth, effects of trauma on the developing brain, and how this applies to student’s academics and social/emotional development. A review of trauma informed interventions being implemented at other schools was conducted to explore what has or has not worked thus far. Additionally, Summit School staff were given a presentation about the necessity of trauma informed practices in education, along with a pre/post survey. The survey supported the research of the project and determined knowledge of the subject, readiness of staff to implement trauma informed practices, and provided evaluation of the presentation. Based on the
literature review and survey findings, recommendations are made to assist school professionals in selecting and implementing the best trauma informed practices for the Summit School setting.
Acknowledgements

I would like to acknowledge all who made this project possible most importantly, my family, specifically my two daughters who inspire me every day to be a better me. I also thank those who directly impacted my project: Yatiel Owens, Analuisa Orozco, Terri Daniels, Rebecca Oset, and Jenn Rader. Their wealth of experience and knowledge helped shape and guide this project. Lastly, for all my instructors and supporting staff at HSU, as well as the staff at Summit School who shares their students with me and allows me to be a part of their world.
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Introduction

Working as a Behavioral Counselor for the Office of Education I have recognized a need in our community. Many of our students struggle every day because of trauma exposure. I want to start a movement in our area, transitioning schools to the use of trauma informed practices. The long term hope for my project is to implement trauma informed practices in all of our county schools to assist in reducing barriers to education and assisting in student success. My project will be the first step in working towards that goal. The purpose of this research project is assess the current knowledge of Summit School staff on trauma and determine readiness of implementation. The first portion of my project is the literature review. The Adverse Childhood Experiences (ACE) study (Fellitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Dross, & Marks, 1999) along with other research from Perry (2014 & 2015), Chasnoff (2015), and Powell (2014) found that childhood trauma leads to toxic stress levels causing social, emotional, and cognitive impairment in students. This impairment then leads to the adoption of risky health behaviors leading to disease, disability, and social problems (Fellitti et al., 1998). High ACE scores can correlate to early death (Fellitte et al., 1998). It would be impossible to ensure that no person ever experiences trauma as a child, but if our schools were able to recognize a trauma exposed child then trauma informed interventions could be used and may assist in building resilience for better lifelong outcomes.

Project Aims:
Aim 1: For Summit School staff to recognize trauma impacted youth in order to reduce the barriers to education.

Aim 2: Describe Summit School staff’s current knowledge of trauma as well as their openness to implementation. Develop and deliver a presentation to introduce school staff to trauma informed practices.

The idea for my project, to bring research around Trauma Informed Care into our community, was formulated based on the strengths and needs I’ve witness in the community. The youth and families I work with every day are resilient and strong. The teachers and administrators work hard to support the futures of their students. What I saw was that if we enhanced our tools and understanding of current research, our hard work would go so much further. I was fortunate to be invited to work with Summit School.

Summit School is located in the small town of Mountainville in north-eastern California along the Nevada border. It is a rural frontier community. Individuals living in this area work on farms, ranches, local jails/prisons, an army depot, or do not work. Families who are not gainfully employed live in poverty. There are no gangs and very little community violence. However, domestic violence is an issue. Many court cases concerning marijuana, methamphetamine and alcohol abuse originate from this area. Child Protective Services (CPS) is involved with a few families. Homes commonly consist of grandparents raising grand-children or single parent homes due to incarceration
or separation. A portion of the people who live in this rural area do so in an attempt to
avoid harassment by law enforcement due to use of drugs or the manufacturing thereof.
Another reason people end up here is because of inexpensive housing. Some of these
individuals live in a large trailer park centrally located in Mountainville. Moutainville is
a very closely knit quiet community.

The community with a population of approximately 200 people is made up of
mostly Caucasian and some Hispanic families. The town consists of a small general
store, a post office and Summit School. The majority of Mountainville, as well as the
entire county consists of conservative republicans. There appears to be somewhat of a
divide between the Caucasian ranchers/farmers, the Hispanic ranchers/farmers, those who
live in the trailer park, and families living in poverty, or having a history of drug use.

There are no community events outside of what the school sponsors. Such
events as fundraising dinners, small carnivals, and dances are backed by Summit School.
Summit School is the only school located in the area and is made up of 200 students
ranging from Transitional Kindergarten through 8th grade. Students live in Mountainville
and surrounding small communities. There is one teacher per grade and the nearest high
school is approximately 23 miles away located in the county seat. The superintendent of
Summit School, who is also the principal, visited every student’s home at the beginning
of last school year. While the school is small, this was an impressive accomplishment
and shows her dedication to the community. There is a strong representation of the
Hispanic population on the school campus. A valuable English Language learner’s program is in place at Summit school to assist the Hispanic population who come from Spanish speaking homes.

Summit School recently implemented the PBIS (Positive Behavior Interventions & Supports) model. PBIS is a model for creating school environments that are more predictable and effective for achieving academic and social goals (U.S. Office of Special Education Programs, 2016). The use of PBIS has been helpful and effective but according to the principal, several staff and many students are still struggling. Summit School has few resources and staff. Its rural location further hinders progress. As a Behavioral Counselor at Summit School I have encountered many students who have been the victim of childhood trauma. The majority of staff and parents are unaware of what affects this has on children concerning their learning, behavior, and long term outcomes. While PBIS addresses behavior, it does not attend to underlying trauma. Only a few therapists in the area do work from a trauma informed perspective, which is performed in the next closest town. Most families do not recognize the impact of trauma as well as exposure to ongoing trauma. Historically there has not been use of any type of trauma informed practice at Summit School or in any school in the county.

Summit is a school with an unbelievably dedicated staff who all go over and beyond in the work they do. They treat the school as a family and were therefore, welcoming in their attitude and busy schedule to learn about trauma informed practices and the possible implementation at their school. Implementing trauma informed practices
is a whole school approach, like PBIS. This means instead of a program that targets specific issues such as bullying or truancy it addresses many issues that affect everyone. At a school with a small amount of resources, this type of program would benefit Summit School’s students and staff.

To this project I bring my background of working for this same county’s mental health clinic as well as on-call crisis. Along with being at the end of my master’s program, I have an undergraduate degree in psychology. I work closely with this school under the auspices of the Office of Education, counseling some of the students who attend Summit. Therefore, I have direct knowledge of the impact trauma is having on students and feel a strong commitment to them. I lived near Summit for several years and have family that still does. I come from a family of farmers and ranchers so I feel very close personally to this population. I have existing solid working relationships at this school that have been developed over the past two years and plan to continue my work at Summit School for many years to come. Therefore, this project and the outcomes it has on Summit School are extremely important to me personally and professionally.
LifeVIEW

Literature Review

Trauma occurs when a psychologically distressing event is outside the range of usual human experience, often involving a sense of intense fear, terror, and helplessness (Perry, 2014). This event overwhelms a person’s ability to cope with the situation. Such traumatic events may include: getting into a car accident, being attacked by a dog, witnessing domestic violence, having a parent with addiction, mental illness, or some form of abuse. Childhood trauma is more damaging due to a child’s lack of development and coping skills with the potential of altering their physical, emotional, cognitive, and social development (Perry, 2014). Short term exposure to trauma would be an event such as a car accident. Examples of long term or ongoing trauma would be a parent’s continual neglect or abuse of a child (Perry, et al., 1995).

The most prominent work guiding this research is that from the Center for Disease Control and Kaiser Permanente that started in 1995 when they took 17,000 patients and gathered information on their exposure to childhood trauma and health outcomes, known as the ACE (Adverse Childhood Experience) study (Fellitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Dross, & Marks, 1998). The specific childhood traumas recorded were emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, domestic violence, substance abuse in the home, mental illness in the home, an incarcerated parent, and divorce (Fellitti, et al., 1998). For each form of trauma, the participant was assigned a point. This study, which is still ongoing, found the higher a person’s ACE score, the more social, emotional and behavior
impairments the person experienced; the more risky behaviors they participated in such as alcohol and drug use throughout with more disease experienced resulting in earlier death than those with low ACE scores. Therefore, high amounts of exposure to trauma when young equals early death (Fellitti, et al., 1998). The majority of participants in this study were white college graduates.

Powell (2014) states that the trauma a fetus experiences inside the mother’s body from substance exposure can have many of the same outcomes and affects as a child who has experienced trauma after birth (Powell, 2014). Just as a developing fetus’ brain is damaged from in utero substance exposure, traumatic events during childhood can also be damaging to the brain. Additionally, Powell has made a connection between the substance exposed fetus and the trauma exposed child to future educational implications (Powell, 2014).

The hindbrain or lower brain is in charge of the body’s survival. This is developed at birth and regulates breathing, digestion, heart rate, and instinctual behaviors such as the fight, flight or freeze response (Perry, et al., 1995). The midbrain is the emotional center and is developed between ages 0-4. It processes memory, emotions, response to stress, nurturing, caring, separation anxiety, fear, social bonding, and hormone control (Perry, et al., 1995). Lastly, the higher brain which is responsible for executive functioning develops between ages 5-6, then again at 11-12. The higher brain experiences development at age 15 and then continues all the way into the late 20’s. The high brain is responsible for: logic, empathy, compassion, creativity, self-regulation, self-
awareness, planning, problem-solving, and attention (Perry, et al., 1995). Children that have been exposed to cigarettes, drugs, or alcohol while in utero as well as children who have been exposed to trauma at a young age have difficulty with mid and high brain function. They often spend a significant amount of time in their lower brain in the fight, flight or freeze zone. These children: have difficulty focusing and learning, have poor skill development, display excessive anger or aggression, demand either positive or negative attention, have feelings of anxiety, fear or avoidance; are easily irritated, anxious or saddened (Perry, 2014). They lack self-confidence and can also have a poor appetite, low weight and/or digestive problems.

In school these children: have difficulties controlling their impulsivity, have poor attention, have distractibility, are overly active, have poor regulation of affect, and experience poor executive functioning (Powell, 2014). Furthermore, they have difficulty with memory, slow processing speed, and impaired judgement (Powell, 2014). These students become a problem for school personnel. Teachers want to work mostly in the high brain of their students, teaching about logic, problem solving, planning and creativity. This becomes a significant issue for students who spend the majority of their days in their lower brain.

In the classroom poor verbal working memory is shown by: poor recall, place keeping errors, difficulty following directions, and understanding cause/effect. A student’s difficulty with visual-spatial working memory is shown through: problem-solving, math problems, word problems, following directions, and reading facial
expressions (Powell, 2014). Difficulty with problem solving can be exhibited through lack of organization, and poor time management/planning. This behavior is often viewed as lack of attention, poor motivation, or flexibility. Attention problems in the classroom are evidenced by: struggling with visual sustained attention, reaction time, information processing, self-regulation, and control of arousal. Concept formation and set shifting is visible when a student struggles with abstract concepts, following rules consistently and shifting strategies in response to feedback (Powell, 2014). Inhibitory control is often seen with poor self-regulation, lack of empathy, jumping to conclusions, and difficulty with social cues. Furthermore, trauma impacted youth struggle with: managing emotions, chronic anxiety that interferes with problem solving, lack of empathy, difficulty expressing what they need in words, inability to appreciate how their behavior impacts others, difficulty working in groups, or connecting with others.

Trauma exposed children, whether pre or post utero, have difficulty regulating themselves. They have a lack of empathy and a hard time reading social cues (I. Chasnoff & R. Powell “personal communication”, May 27, 2015). They may often “blow out of class”. When a student’s behavior becomes so extreme they are removed or remove themselves from the classroom is commonly known as “blowing out of class”. They have difficulty making friends and getting along with their peers. Not only do they struggle academically, but they struggle with relationships and their own self-regulation (Powell, 2014). This makes being in a regular classroom all day difficult, not only for the student but for the teacher also.
The top research proven strategies for working with trauma exposed youth are: early intervention, formative evaluation, positive teacher-student relationships, direct instruction, behavior modification, reading composition instruction, and mnemonic training, mnemonic training being number one (I. Chasnoff & R. Powell “personal communication”, May 27, 2015). While early intervention is effective, it is required before age three. Children aren’t entering schools until ages 3-5. Formative evaluation, where the teacher is continually assessing and then re-teaching is number six in effectiveness. Number five is positive teacher-student relationships. A healthy relationship between teacher and student is so important because it has nothing to do with some kind of teaching strategy. It’s all about a bond between the teacher and student. It is also important to note that the most effective therapists are successful not because of any type of specific therapy or their ability in that type of therapy, but in the quality of the relationship they have with their client. The rapport a teacher and student have or a therapist and client have can be more effective than any specific strategy.

Next in research proven strategies is direct instruction: I do it, we do it, you do. Number three is behavior modification. While behavior modification is very effective it is important to understand that the behavior will get much worse before it gets better. Many people do not understand this and will write off the strategy as ineffective too soon. Behavior modification includes things like positive reinforcement, prompting, fading or extinction. The most effective teaching strategy is mnemonic training. Mnemonic training includes things like: acronyms, acrostics, peg words, or keywords. An example
is PEMDAS “please excuse my dear aunt sally” to remember the order of operations in algebra (I. Chasnoff & R. Powell “personal communication”, May 27, 2015).

Understanding the impact trauma has on our youth brings us to the importance of trauma informed practices. Working from a trauma informed practice or trauma informed perspective means that we are always looking through this lens that factors in the knowledge of trauma. When working with students, we are continually taking into account that a person may be trauma effected during all interactions. Perry explains the perspective very well. Instead of seeing a student who is acting out and thinking “what is wrong with this kid”, we stop and think “what has happened to this kid” (Perry, 2014). When we view things through a trauma informed lens we do not take things personally.

Dr. Bruce Perry also stresses the importance of educators working from a trauma informed lens. They must be regulated themselves or it will be impossible for them to assist a student with trauma (Perry, 2014). Regulation for educator’s means being aware of: stress, anxiety, frustration, anger, and our own personal trauma. If we are not truly in touch with and able to reflect upon ourselves, we cannot help others with the process. Self-care is the secret of self-regulation (Perry, 2014). If we don’t take the time to insure we are taking care of ourselves, whether that is our nutrition, exercise, or just doing what we need to do to de-stress or reduce anxiety, we will be ineffective in assisting students with trauma.

Massachusetts is leading the way in implementing trauma informed practices in schools. They signed into law the “Safe and Supportive Schools” provision, which has
boosted the trauma-informed movement (TLPI, 2015). This movement is assisted by the Trauma and Learning Policy Initiative (TLPI) which is made up of the Massachusetts Advocates for Children and Harvard Law School. In Massachusetts instead of focusing on something specific such as an anti-bullying or truancy programs, this is a whole school approach movement (TLPI, 2015). Most Massachusetts schools work from two books: Helping Traumatized Children Learn and Helping Traumatized Children Learn-Creating and Advocating for Trauma Sensitive Schools (Cole, O’Brien, Gadd, Ristuccia, Wallace, & Gregory, 2005) written in collaboration with Harvard Law School and the Task Force on Children Affected by Domestic Violence have paved the way for all schools in Massachusetts.
Methodology

The purpose of this project is to bring awareness, educate, stimulate conversation, and a desire to include trauma informed practices at Summit School. The long term plan will be implementation of trauma informed practices in all school districts inside the county.

The project consisted of inviting the teachers and staff of Summit School to an informational presentation on trauma informed practices in education developed from a literature review, trainings attended, and personal experience working in social work and education. Before the presentation, participants were given a pre-test to assess their current knowledge and understanding of trauma informed practices. After the presentation the participants were provided a post-test to gauge the school staff’s gained knowledge, effectiveness of presentation, and school readiness for implementation of trauma informed practices in their school from the presentation.

After completion of the presentation I analyzed Summit School’s readiness of implementation. I gauged this on how they answered questions in the survey. Depending on those answers I determined if more education and training is needed. The purpose of participants completing a pre and post survey will show if my presentation increased their knowledge on trauma informed practices. This will indicate the effectiveness of the presentation and possible future use of it at other school sites.
Recruitment and Selection

Summit School practices a monthly 'late start' once a month, starting school two hours late to provide information and training to staff. The Superintendent/Principal of Summit School provided me with permission to utilize one of their late start days for the presentation. All of Summit School staff were invited to the presentation. The attached flyer was emailed, as well as placed in each of the staff’s mail boxes at the school. Fifteen people were present for the presentation, 11 (n=11) of which participated in the survey. All 11 participants who completed pre-surveys also completed post-surveys. All participants were either teachers or teacher aids. Nine participants were female and two were male. The presentation was held at Summit School in the special education classroom. This presentation was created keeping in mind it would be given to a room of teachers and teacher aids. To assist in insuring it was appropriate for this audience feedback was obtained on the presentation prior to giving it from the school principal, an LCSW (Licensed Clinical Social Worker) who provides me supervision, my Second Reader, and my Community Partner who is also the School Psychologist for Summit School.
Results

The presentation was prepared and given to Summit School on February 3, 2016. The audience consisted of 15 people, 11 of which participated in the survey. Participants completed a consent form, along with the pre- and post-survey. The presentation took a little over an hour and covered: childhood trauma, symptoms of trauma, the neurobiology of toxic stress, behavioral and educational implications of trauma, information on the work of the Relationship of Childhood Abuse & Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study (Felitti, et al., 1998), The Child Trauma Academy (Perry, 2014), The Center for Youth Wellness (Harris, 2016), Supporting Educators Professional Responsibility for Intervention in Family Health Issues (Powell, 2014), information obtained from seminars by Ira Chasnoff, Ron Powell (I. Chasnoff & R. Powell “personal communication”, May 27, 2015), and Bruce Perry (B. Perry, “personal communication”, June 24, 2015). The presentation also provided information on the implementation that has already occurred in Massachusetts, resources being used in Massachusetts as well as classroom interventions and strategies.

- In the pre-survey only two out of the 11 participants knew what an ACE score was. In the post-survey all participants were able to correctly answer what an ACE score is.
• In the pre-survey most participants had a general idea of the definition of trauma. In the post-survey all participants were able to answer clearly and correctly what trauma is.

• In the pre-survey 10/11 consider their school to be trauma sensitive, while in the post-survey only 8 felt their school is trauma sensitive.

• In the pre-survey 10/11 feel trauma can prevent a student from learning, while in post-survey everyone felt trauma is a barrier to obtaining an education.

• In pre-survey there was little knowledge on what short term effects of trauma are. The post-survey showed all participants could answer what short term effects of trauma are.

• The participants showed extremely limited knowledge on long term effects of trauma in pre-survey while post-survey showed 10/11 could answer what long term effects of trauma are.

• The pre-survey showed 6/11 participants feel positively about mandating trauma informed practices in their school. The post-survey showed 9/11 in favor of implementation.

• Pre-survey showed 10/11 think trauma directly effects attendance, while post-survey showed 11/11 think trauma affects attendance.

• 10/11 think there is treatment for trauma and post-survey showed everyone feels there is treatment for trauma.
• 3/11 gave an in depth answer for what symptoms of trauma are and in the post-survey 9/11 answered correctly to symptoms of trauma.

• 1/11 was able to answer what resiliency is in relation to trauma. 7/11 answered correctly what resiliency is in relation to trauma in post-survey.

• Pre-survey showed 7/11 participants think trauma is a significant health concern while one feels it is only a mental health issue. Post-survey showed 8/11 think trauma is a significant health concern.

• Pre-survey showed 7/11 think their school would benefit from implementation of trauma informed practices while post-survey showed 9/11 participants think their school would be benefit from implementation of trauma informed practices.

• In the pre-survey only 6/11 think trauma affects a developing brain, while the post-survey showed 9/11 think trauma affects the developing brain.

• In the pre-survey 3/11 gave some, but minimal, suggestions of what they feel would be needed to implement trauma informed practices in their school and classroom. In the post-survey 7/11 gave ideas of what they would need for implementing trauma informed practices in their school and classroom.

Summary of Survey Results

After the presentation there was a large increase in knowledge of ACE scores. There was a slight drop in those who felt Summit School is trauma sensitive after the presentation. Post presentation showed a large increase in knowledge of short and long
term effects of trauma, as well as knowledge of trauma symptoms. There was a slight increase in those who felt positively about implementation of trauma informed practices. There was a big increase in knowledge of what resiliency is in relation to trauma and a slight increase in those who think trauma affects the developing brain. A significant increase was shown for staff reporting what they would need to be able to implement trauma informed practices in the school and classroom.

The results of the survey also showed that the presentation increased knowledge surrounding childhood trauma. There was a small increase in those who would be ‘on board’ with implementing or mandating trauma informed practices. After the presentation, seven of eleven participants gave ideas of what they felt would be helpful for them to be able to implement. Those ideas included: more information, school discussions, more examples, books, training, support groups to discuss, reassurance, talking with peers, and a request for more presentations such as this one.
Discussion and Conclusion

The results from my presentation and survey shows that educators possess very little knowledge of ACE’s, childhood trauma, as well as short and long term effects of trauma. After the presentation, the survey showed significant increase in knowledge of the symptoms of trauma, resiliency, and also increased the number of people in favor of implementing trauma informed practices at Summit School. The results also showed that more education, training, and discussions are desired before any kind of implementation efforts begin. Finally, results show that more education is needed throughout our community about the impact of trauma on our youth.

Many participants were engaged and clearly interested in implementing trauma informed practices at Summit School. I have been approached by the majority of participants either during the presentation or in the weeks after to discuss the topic further. I had hoped to spread this work to other schools and I am happy to report that it has really taken on a life of its own. Many people have suggested or requested I give the presentation at other school sites.

An unexpected issue arose on my surveys. The surveys I created were front and back. It was not until weeks after the presentation when I was reviewing the results that it became clear that some participants did not know there was a back-side to the survey and therefore left blank. Questions 1-9 were on the front and 10-15 were on the reverse. This negatively impacted the results for questions 10-15 since some participants did not
answer them. Even with this issue, I was able to gather rich information on the thoughts and knowledge of Summit staff.

Implementation of trauma informed practices in our schools is important to reduce this barrier to students obtaining an education. It can assist staff in working more effectively with children who struggle with learning and social/emotional issues. Understanding trauma can help staff keep students in the classroom and increase resiliency. Implementation can also bring awareness to teachers to not take behaviors personally and instead access more effective methods to working with behavior problems.

While survey results and presentation feedback show that Summit School is not ready to implement trauma informed practices, they are, however, very willing to gain continued education and experience on the topic. Considering the large amount of feedback I am continuing to receive, I strongly feel there that the eventual implementation of trauma informed practices at Summit School will have sustainability in the future. I hope that this will be true at my other school sites as well. Following the lead of Massachusetts schools and the success they have experienced with the Safe and Supportive Schools provision, my recommendation for Summit School is continued discussions and education working from the *Helping Traumatized Children Learn* and *Helping Traumatized Children Learn-Creating and Advocating for Trauma Sensitive Schools* texts. This will be followed by creating a trauma informed practices team and implementation plan. Implementing trauma informed practices throughout our education
system means reducing barriers to education, increasing resiliency, and better lifelong outcomes for students.


Appendices

Appendix A

SCHOOL PRESENTS
TRAUMA INFORMED PRACTICES

FEBRUARY 3, 2016
TIME: 8:15 A.M.

Please join us on our next staff late start school day to hear about Trauma Informed Practices in Education. Presented by Humboldt State University MSW student Seaira Olson.

FOR MORE INFORMATION CONTACT: SEAIRA OLSON @ (530) 906-0744
Appendix B

Consent Statement

You have been invited to participate in a presentation and study on implementing trauma informed practices in schools. The information provided from your survey will be used to assist in further research and implementation strategies in Lassen County schools.

If you agree to participate, you will be asked to listen to a presentation as well as take a written survey before and after the presentation that should take no longer than 20 minutes to complete.

Participation in the study is voluntary. There are no known risks to participants. Responses are confidential. The only identifying information will be that participants are Shaffer School staff. Information collected from the survey will be kept in a locked file cabinet and will be shredded after three years. No compensation is offered for participation.

For more information you may contact Seaira Olson at sao165@humboldt.edu or (530) 906-0744 as well as her instructor, Jennifer Maguire at jennifer.majuire@humboldt.edu or (707) 826-4565.

I understand that the Investigator will answer any questions I have about this study. I also understand that my participation is voluntary and I may stop at any time.

If you have any concerns with this study, contact the Chair of the Institutional Review Board for the Protection of Human Subjects, Dr. Ethan Gaitan, at eg51@humboldt.edu or (707) 826-4545.

If you have questions about your rights as a participant, report them to the Humboldt State University Dean of Research, Dr. Rhea Williamson, at Rhea.Williamson@humboldt.edu or (707) 825-5169.

I have read and understand the information above and I agree to participate.

Print Name __________________ Signature __________________ Date __________________

(A copy of this form can be provided to you upon request)

Trauma Informed Practices and Education
Appendix C

Survey

1. What is an ACE score?

2. What is "trauma"?

3. Would you consider your school "trauma sensitive"?

4. Is trauma a barrier to obtaining an education?

5. What are the short term effects of trauma on a child?

6. What are the long term effects of trauma on an individual?

7. How do you feel about schools being mandated to use trauma informed practices?

8. Do you think trauma directly affects a child’s attendance rate?

9. Is there treatment for trauma?

Trauma Informed Practices and Education
10. What are symptoms of trauma in a child?

11. What is resiliency in relation to trauma?

12. Is trauma a significant health concern?

13. Do you think it would be beneficial to implement trauma informed practices in your school?

14. Does experiencing a traumatic event effect a developing brain?

15. What type of training and/or support would you need to implement trauma informed practices in your school? Your classroom?