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Trauma-Informed Practices from Prenatal to Young Adulthood

Voices from the Field

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Contents

Introduction 1

The Purpose of this Brief 2

Current Practices 3

Noticing Trauma 3

Responding with Trauma-Informed Practice 4

Examples from the Field 6

Conditions for Success 8

Health and Mental Health Efforts Should Take a Two-Generation Approach 8

Innovative Ways to Provide Support for Professionals Should Be Developed 8

Families and Community Partners Can Share the Work and Amplify the Effects 9

School, District, and Early Childhood Leaders Must Be Committed Champions 10

Child-Serving Professionals Must Be Open to New Practice 11

Work Should Be Conducted at the Systems Level, to Protect Against Funding Turbulence 12

Training Should Be Ongoing 12

The Needs of the Field 13

Improved Cross-Sector Collaboration 13

Change in Organizational Culture 14

Support for Adults Experiencing Trauma or Burnout 15

Improved Integration Between Early Childhood and School-Aged Childhood Programs and Systems 16

More Widespread Awareness of Trauma 16

High-Quality Practices, Including Validated Measures and Effective Programs 17

In Conclusion 19

Appendix — Interview Participants 20

LIST OF TABLES

Table 1. Examples of Trauma-Informed Practices by Intended Impact 5

Table A1. List of Interview Participants 20

Introduction

For over 50 years, WestEd has brought our expertise in research, policy, and practice to the fight for excellence and equity in education. Our work to help child-serving organizations develop and sustain trauma-informed practices is a fundamental part of our vision of whole-child outcomes.

When asked what we most want for our children, most people think beyond just academic outcomes. We want them to be mentally and physically safe and healthy, socially and emotionally connected, and economically independent. We want them to be inspired and challenged to make the world a better place. But regardless of how we might describe a vision of success that encompasses the "whole child," the work to achieve that vision is complex and multifaceted.

At WestEd, we work with our clients to achieve this whole-child vision. Our projects span all developmental stages, from prenatal through young adulthood, and consider all developmental domains, including behavioral, cognitive, emotional, social, and physical. Further, research and experience show that children's outcomes are impacted by their family and community context, as well as other factors that exist outside of the control of any one social sector. Therefore, we believe that a cross-sector approach is essential to achieving excellent and equitable whole-child outcomes for every child. When all of our social sectors — including early childhood and K–12 education, health and mental health, child welfare, justice, and other child- and family-serving systems — work in aligned collaboration with families and communities, then children can thrive at every developmental stage and along every developmental domain.

This sort of cross-sector approach is particularly important when supporting children whose lives have been impacted by trauma. Toxic stress and trauma have an enormous impact on child development.[1] We now know that childhood trauma — often stemming from adverse experiences such as abuse, neglect, and household and community dysfunction — impacts just about every domain in which

[1] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults (The adverse childhood experiences study). *American Journal of Preventative Medicine, 14*, 245–258.

children function and inhibits their ability to learn and develop.[2] We also know that the adversity that can lead to trauma is widely experienced,[3, 4] trauma is often misunderstood,[5] and trauma is treatable.[6] Further, the high correlation between children's experience with adversity, their educational attainment, and their involvement in the justice system is well-documented.[7] The growing body of knowledge on early childhood adversity, toxic stress, and trauma, along with research on protective factors, resilience, and healthy human development, has enormous implications for how we do our work as educators.

The Purpose of this Brief

In early 2018, WestEd convened an internal, cross-program, multidisciplinary team to determine how best to grow our body of work in trauma-informed practices. To inform our planning and better understand how experts in the field are translating the research of stress and trauma into practice and policy, our team held a series of interviews with dozens of researchers and practitioners in the fields of early childhood and K–12 education, health, mental health, and social services. (The interviewees are listed in the appendix at the end of this document.) While this sample may not be completely reflective of the broader fields of education, health, and human services, we believe these interview participants provide important insights into how child-serving practitioners are envisioning and approaching trauma-informed practice.

Our goal with this brief is not to provide an extensive literature review or to delve deeply into the science of toxic stress, as that information is already well-documented and widely available. Rather, our hope with this document is to share the key themes we heard in our interviews about how trauma-informed practices inform the work of experts and practitioners in the field and about the supports needed to improve trauma-informed practice.

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[2] Center for Youth Wellness. (2013). *An unhealthy dose of stress: The impact of adverse childhood experiences and toxic stress on childhood health and development*. Retrieved from https://drive.google.com/file/d/1RD50llP2dimEdV3zn0eGrgtCi2TWfakH/view

[3] Felitti et al. (1998), pp. 249–254.

[4] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2014). *Child maltreatment report, 2014*. Retrieved from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment

[5] Confusion with attention deficit/hyperactivity disorder (ADHD) is common. Resources are now being offered to help child-serving professionals make the distinction. For example: National Child Traumatic Stress Network. (2016, August). *Is it ADHD or child traumatic stress? A guide for clinicians*. Retrieved from https://www.nctsn.org/resources/it-adhd-or-child-traumatic-stress-guide-clinicians

[6] Ludy-Dobson, C. R., & Perry, B. D. (2010). The role of healthy relational interactions in buffering the impact of childhood trauma (chapter 3). In E. Gil (Ed.), *Working with children to heal interpersonal trauma: The power of play*. New York: The Guilford Press.

[7] See, for example: Giovanelli, A., Reynolds, A. J., Mondi, C. F., & Ou, S. R. (2016, March). Adverse childhood experiences and adult well-being in a low-income, urban cohort. *Pediatrics, 137*(4).

Current Practices

Our interview participants use many approaches to notice and attend to the effects of trauma — both in the children they serve and in their colleagues. This section outlines some of the key trauma-informed practices that interview participants shared with us.

Noticing Trauma

The impacts of stress and trauma are observable to adults caring for babies, children, and adolescents.[8] However, the challenge with identifying and responding to trauma is that it presents itself in many different ways — from social withdrawal, passivity, or avoidance to aggression or impulsive behaviors — and can impact multiple domains of development, including physical, cognitive, behavioral, mental, social, and emotional. Further, symptoms of trauma can be easily confused with separate issues that are not trauma-related, such as attention-deficit/hyperactivity disorder (ADHD).

> *When I first started in this field, I was doing a fellowship at Stanford. Teachers would send me notes saying, "This child has ADHD. Please prescribe Ritalin." And I thought, "How fascinating. There's already a diagnosis and a treatment plan. What am I needed for?" But I realized that I was seeing a child who was hyper-aroused, versus hyperactive. And dissociated, versus inattentive. This research, and the identification of the biosocial markers, allows us to distinguish trauma from other diagnoses.*
>
> — Dr. Victor Carrion, Program Director and John A. Turner Endowed Professor for Child and Adolescent Psychiatry, Stanford University

Similarly, some mental or behavioral health symptoms of trauma are not necessarily exclusive to trauma. For example, in early childhood, delays in language acquisition or regressive behaviors such as a return to bedwetting may or may not be trauma-related. Similarly, in later stages of childhood and adolescence, diagnoses of anxiety, depression, or eating disorders may not necessarily stem from trauma.

[8] The internal symptoms and external behaviors related to childhood trauma are well documented. A variety of illustrations can be found from the websites of both researchers and practitioners. In particular, National Child Traumatic Stress Network offers several clear depictions of trauma on its website.

Regardless of their age, children with trauma live in a near-constant state of heightened alert. It is therefore essential that practitioners work with children in a way that does not reaffirm their assumption that they are in danger. Experiences that might seem neutral or mildly stressful to some children — like the cheerful noise of friends playing; switching to a new, challenging lesson; or being publicly corrected — can trigger a stress response in babies or children with trauma. Their response, which is a coping mechanism to perceived threat, is often viewed as an unacceptable reaction for the situation, resulting in even greater conflict with their peers and the adults around them. This may become a cycle of conflict, and the negative impact on their relationships may reinforce the impact of trauma.

Understanding how trauma and toxic stress impact a child's cognitive, social, and emotional development should inform both teaching practice and the way our early childhood and K–12 education systems work in partnership with other social sectors serving children, families, and communities. In our view, when child-serving professionals are able to use trauma-informed practices to notice and attend to toxic stress and trauma in children and families, their ability to serve them is greatly improved.

Responding with Trauma-Informed Practice

The phrase "trauma-informed practices" refers to the ways in which child-serving systems and professionals buffer the effects of adversity on children with trauma and help them to heal and thrive. While the importance of trauma-informed practices is widely recognized, we know that implementing and integrating these practices can be challenging.

Our interview participants use many trauma-informed approaches, both for the children they serve and to support their colleagues. In many cases, they integrate their trauma-informed practices into other essential aspects of their missions, blurring the boundaries of the work. For example, their trauma-informed practices show up in their instructional approaches, discipline policies, approaches to fostering positive school climate and culture, social-emotional development initiatives, professional learning and collaboration, and even family and community engagement efforts. Rather than listing and evaluating all of the strategies that interview participants shared, we organize what we heard by their intended impact:

- **Targeted:** Approaches designed to attend to the specific and unique needs of babies, children, and adolescents with trauma.
- **Universal:** Approaches that benefit the social and emotional development and mental and behavioral health of *all* babies, children, and adolescents.
- **Workforce development:** Approaches that develop the skills and competencies in educators and professionals, so that they can attend to the needs of the babies, children, and adolescents in their care.
- **Systems change:** Approaches that embed trauma-informed practices in the policies and practices of child-serving organizations and the broader sectors in which they work.

Table 1. Examples of Trauma-Informed Practices by Intended Impact

Intended impact	Trauma-informed practice
Targeted	• Trauma-specific or mental health screening protocols. • Evidence-based tools and instructional approaches to serve children with trauma (can be provided across settings, including clinics, childcare settings, school, and home). • Specialists trained to provide supports to students with trauma and help them deescalate when triggered. • Systems and processes to bring multidisciplinary and cross-sector teams to serve the needs of individual children with trauma and their families. • Attachment-driven, relationship-based work, especially in the infant/early childhood mental health world, such as Circles of Security and Child Parent Psychotherapy, a treatment model for trauma-exposed children, aged 0–5.
Universal	• Trauma-sensitive culture and climate strategies, including restorative justice approaches and mindfulness-based practices. • Trauma-sensitive policies and procedures, such as giving school health centers the explicit mission of providing confidential behavioral, mental, and physical health services onsite and providing supports at the school and district level for providing nurturing and responsive solutions to challenging behavior. • Instructional strategies that promote social-emotional learning and are also trauma-sensitive and relationship-based, such as arranging a child's environment to promote engagement and routines to promote self-regulation. • Strategies and programs for developing and sustaining authentic, protective relationships between children and the adults in their lives.
Workforce development	• Professional learning for providers and leaders, including cross-sector professional learning communities. • Reflective practice/supervision and other coaching strategies to support teachers and providers. • Supportive policies for those working with children and families to promote self-care and prevent vicarious trauma, secondary trauma, and compassion fatigue. • Training on instructional strategies, to help caregivers notice when student/child behavior is an indicator of trauma, and respond with trauma-sensitive approaches. • Training on cultural responsiveness.
Systems change	• Professional learning for policymakers and funders about the impact of trauma and toxic stress. • Creation of policies, funding, and technical assistance opportunities that encourage the sustainable adoption of trauma-informed practices, facilitate cross-sector collaboration, and embrace equity as a core value. Examples include: – Facilitated data sharing – Creation of strong referral networks – Coordination of services across sectors – Innovative financing models

Source: WestEd.

Examples from the Field

To illustrate how some of these trauma-informed practices are playing out in the field, we share examples of two organizations' coherent approaches to trauma-informed education and care. The first, the Lourie Center for Children's Social and Emotional Wellness in Maryland, primarily serves young children and their families. The second, the University of California, San Francisco (UCSF) HEARTS program, primarily serves the K–12 education sector.

The Lourie Center

The Lourie Center for Children's Social and Emotional Wellness, located in Maryland, provides a variety of services to family and children in the community. Their services include:

- **Early Head Start Program:** Provides comprehensive, year-round, child and family development services to low-income families with children, prenatal to three years old.
- **Therapeutic Nursery Program:** Two specialized preschools that address the needs of young children three and four years of age with emotional and behavioral problems that may interfere with success in a regular setting.
- **Parent-Child Clinical Services:** Outpatient clinic offering a comprehensive approach to the early identification, treatment, and prevention of emotional, behavioral, and developmental problems.
- **The Lourie Center School:** Serves children four to 12 years of age (including grades N4, kindergarten, and 1 to 5) with emotional disabilities and/or multiple disabilities that interfere with learning, functioning, and availability for learning in a typical classroom setting.

The UCSF HEARTS Program

The HEARTS program at UCSF, led by Dr. Joyce Dorado, recognizes that every school has different needs as it adopts trauma-informed approaches. The mission of UCSF HEARTS is to promote school success for trauma-impacted students by collaborating with school systems to create more trauma-informed, safe, supportive, and equitable school climates that foster resilience and wellness for everyone in the school community. The program helps schools become trauma-informed by *realizing* the widespread prevalence of trauma, *recognizing* how trauma's effect shows up in schools, *responding* by shifting practices to account for and address these effects, and *resisting re-traumatizing* the community. HEARTS tailors the work for each school, but adheres to the following six key principles:

1. Understand Trauma and Stress
2. Cultural Humility and Responsiveness
3. Safety and Predictability
4. Compassionate and Dependable Relationships
5. Resilience and Social Emotional Learning
6. Empowerment and Collaboration

The HEARTS program applies a public health approach in a Multi-Tiered System of Support (MTSS) framework, and serves students, families, staff, and school leaders. Through training and consultation, HEARTS uses trauma-informed approaches to augment universal (Tier 1) supports, including schoolwide Positive Behavioral Intervention and Support, health education, safe and supportive school climate work, social and emotional learning curricula, and restorative justice practices. HEARTS also builds capacity in school staff to notice and respond more effectively to trauma, and promotes staff wellness in order to mitigate the effects of vicarious trauma. In addition, when resources are available, HEARTS provides Tier 2 early intervention supports (such as providing a trauma-informed lens to coordinated care teams supporting students of concern and offering wellness groups for staff) and Tier 3 supports (such as providing on-site psychotherapy for trauma-impacted students).

Conditions for Success

In our interviews, participants shared several "conditions" that should be in place for trauma-informed practices to be implemented effectively and sustainably. The following ideas emerged consistently during these conversations:

- Health and mental health efforts should take a two-generation approach.
- Innovative ways to provide support for professionals should be developed.
- Families and community partners can share the work and amplify the effects.
- School, district, and early childhood leaders must be committed champions.
- Child-serving professionals must be open to new practices.
- Work should be conducted at the systems level, to protect against funding turbulence.
- Training should be ongoing.

Health and Mental Health Efforts Should Take a Two-Generation Approach

Both the Center for Youth Wellness and the Seneca Family of Schools use therapeutic family work as part of their treatment protocol for youth impacted by trauma. Anecdotally, both organizations note that when parents attend to their own mental health and well-being, their ability to have a healthy relationship and provide a protective buffer for their child improves, resulting in reduced symptoms associated with toxic stress in their children.

> *We are doing a big push to engage families. We can't force them to go to therapy, but anecdotally, it seems that children whose parents engage in therapeutic family work have better outcomes.*
>
> — Sama Hromnik, Principal, James Baldwin Academy, Seneca Family of Schools

Innovative Ways to Provide Support for Professionals Should Be Developed

Many of our interview participants shared that self-care is fundamental to their own sustainability in their practice. For example, many individuals who work with children have experienced trauma of their own and need regular access to a safe space in which to attend to their own experiences. However, budgets are seldom structured to include resources for reflective supervision or reflective practice

facilitation. (Reflective practice is a coaching model that involves reflecting on your own lived experiences to inform the way you serve others.) This coaching approach builds educators' capacity to support children and families. Because of budget limitations, program directors shared that they often had to find creative ways to protect the supports they provide to their staff:

> *We really can't cover the cost of supervision, but we find a way to make it happen.*
>
> — Jimmy Venza, Director, Lourie Center for Children's Social and Emotional Wellness

One interviewee described how her First 5 program found an ongoing way to learn from the diversity of the staff by having them share their unique experiences:

> *At First 5 Alameda, we had a range of multicultural staff, from no degrees to doctoral degrees. We embedded a "diversity share" each month where a staff member had an opportunity to share their experiences and perception of differences — racial, economic, cultural — growing up and how they felt it impacted their current work. People learned to understand each other in a different way and why their colleague may do something a certain way. We saw staff attrition go down significantly.*
>
> — Deborrah Bremond, Infant Early Childhood Mental Health Specialist Consultant

Families and Community Partners Can Share the Work and Amplify the Effects

Several schools and childcare settings take a place-based, cross-sector approach to trauma-informed practices by engaging community-based organizations to help them serve children. Through these collaborations, schools and childcare settings can broaden the services they provide to children without having to bring on additional staff. For example, Norwalk-La Mirada school district has created a Community Resource Collaborative so that students can receive mental health services regardless of their insurance status. Several interview participants are hungering for more and greater cross-sector collaboration on trauma-informed practices, especially between mental health services, social services, and education.

> *Ultimately, what we want is for every trauma-impacted child, regardless of age (0–25) to be served by one case manager with all the data. We want to break down all the bureaucratic and other barriers that are hurting kids. The field is slowly moving toward this.*
>
> — Ted Lempert, President, Children Now

Interestingly, the City of Camden in New Jersey is working to address trauma at the community level. It has developed a project called The Healing 10, in which the justice, education, and health sectors, along with community-based organizations, have formed a community of practice to adopt a trauma-informed approach to serving the city. The anchor organizations in this community of practice use the same professional learning curriculum and take the same training on trauma-informed practices, and also have access to curriculum specific to their sectors. For example, members of the network serving young children may take a course on trauma-informed consequences, as opposed to traditional punishment. As another example, members in the health care sector may take a course on how to ensure that a 15-minute health appointment is trauma-informed. This cross-sector, community-based approach seeks to impact the individual, organizational, and community levels, and hopes to spread to other communities in New Jersey.

Related to this community-based approach, one interview participant described the need for greater family voice to inform trauma-based supports, as an important equity issue:

> *We think about how active families are in determining the work, and how to include community and family voice in trauma-informed practices. If we really believe in the assets of our communities, then their voices must be front and center. This is at the heart of being trauma-informed.*
>
> — Melanie Wartenberg, Senior Director of School Based Behavioral Health, East Bay Agency for Children

School, District, and Early Childhood Leaders Must Be Committed Champions

The work of adopting trauma-informed practices is very difficult. Interview participants in the K–12 education system shared that if school and district leaders do not demonstrate their full commitment to the work, then it becomes easy for the staff to dismiss its value. Similarly, if leaders leave the school or district before the work has taken hold or before another champion emerges, trauma-informed practices may fall by the wayside.

Additionally, there is no research indicating a clear correlation between healing trauma and improving academic outcomes, nor is there clarity about milestones along the path to healing. Because of this, schools can find themselves under pressure to give up trauma-informed work when budgets get tight or when there is no immediate and substantial change in test scores.

> *Gaining district support to maintain the mental health service system that has been built through grant funds is a crucial task. For the districts to invest in it, they need to*

see the mental health services as essential to student success at school. I believe we are gathering that support in our district.

— Cara Lee, District Student & Family Services Specialist, Norwalk-La Mirada School District

Child-Serving Professionals Must Be Open to New Practice

Because trauma-informed practices center around healthy relationships, educators and child-serving professionals often begin to rethink their approach to culture and discipline as part of this work. Further, interview participants shared that some educators — especially veteran educators — may resist letting go of punitive discipline approaches that they have used throughout their career. They shared:

[Trauma-informed practice] is not an alien concept. It's just that change is hard, especially for people who are familiar with the old system.

— Cliff Curry, Superintendent, Red Bluff Union Elementary School District

The hardest thing about this work is changing adult behavior.

— Alicia Rozum, Coordinator of Prevention Supports and Services, Placer County Office of Education

Additionally, educators may resist asking about the trauma histories of their students. The idea of screening for trauma is also deeply uncomfortable for some:

Families don't like risk questionnaires. It feels like you're telling them they are a bad parent. In many places, those collecting such data or asking these questions don't give any explanation of why they are asking these [hard and exposing] questions. And educators often don't have the relationship with families to ask those questions, and get valid answers [because] families often tell you what they think you want to hear if they don't trust you. We need to relieve the fear that families and educators have of having these conversations. And we need to build the buffering capacity of communities to support families.

— Karen Finello, Project Director, Center for Prevention and Early Intervention at WestEd

Work Should Be Conducted at the Systems Level, to Protect Against Funding Turbulence

A significant roadblock to implementing trauma-informed practices is that available funding is often insufficient for the work at hand. Specifically, local agencies providing direct services to children and families often only receive a portion of the total grant funding for trauma work. Several interview participants described having to be creative in the way they manage their expenses in order to provide the best possible service for their staff and for the families and children they serve.

Additionally, several people that we spoke to shared that time-bound funding is often in conflict with creating permanent change. For example, when grants end, practitioners often struggle to replace the funding to keep a program:

> *San Mateo County had an excellent wrap-around school program, with cross-sector support for kids, including screenings. But when the funding went away, the program went away.*
>
> — Ted Lempert, President, Children Now

Similarly, sometimes when foundation-funded programs demonstrate that they are effective, the funder may feel that their goals have been accomplished and may decide not to renew funding. As a result, several interview participants talked about using funding to permanently change *the way* systems operate, so that even if budgets or staffing levels need to change, the culture, values, and processes around trauma-informed practices can remain.

Training Should Be Ongoing

Interview participants shared that a single training on trauma-informed practices is not enough to improve practice. Resources are needed for intentional, comprehensive trauma training that happens over time, as well as other ongoing support for trauma-informed practices. Additionally, training should be connected to opportunities for reflection. Finally, training should not happen in a reactive way, when teachers and early childhood educators are in the midst of a challenging situation with a child. They need to be given time and space to learn, process, and reflect.

> *We need time — time to reflect, time to meet, time to train, time for coaching, time for mental health consultants, time to talk as a team, and time to just pause. This is something so needed.*
>
> — Rebecca Borland, Early Childhood Education Mental Health Consultant

The Needs of the Field

In our interviews, we asked participants about the obstacles they commonly see in their adoption of trauma-informed practices and the supports they most need to overcome those obstacles.

Interview participants consistently shared six big needs in order to improve their trauma-informed practices:

- Improved cross-sector collaboration
- Change in organizational culture
- Support for adults experiencing trauma or burnout
- Improved integration between early childhood and school-aged childhood programs and systems
- More widespread awareness of trauma
- High-quality practices, including validated measures and effective programs

Improved Cross-Sector Collaboration

Effective adoption of trauma-informed practices invites cross-sector collaboration. Ideally, professionals from a range of disciplines and social sectors — such as health, mental and behavioral health, human services, child welfare, juvenile services, early childhood and K–12 education, and community organizations — work together to provide a holistic, coherent approach to addressing trauma in children and families. Interview participants shared that the structural gaps and frictions that often exist between education and other social sectors obstruct their ability to serve children and families well. To illustrate, one participant described the importance of improving communication among the key figures in a child's life:

> *Once a child's trauma reminders are identified, it is critical to make sure everyone in the child's life knows about them. Not everyone needs the same level of detail, but if a child faced starvation and being hungry is a trigger — everyone needs to know. The preschool teacher needs to know to never withhold food, the foster parents need to know, the after-school program needs to know, and when the child goes to kindergarten, the school needs to know. We need systems in place to create a web of*

understanding around this child. Just as we communicate a peanut allergy to everyone in a child's life, trauma reminders need to be shared the same way.

— Chandra Ghosh Ippen, Dissemination Director, UCSF Child Trauma Research Program

There are challenges to cross-sector collaboration at every level of the system, including — but not limited to — the following issues:

- Federal privacy laws limit the way information can be shared between the education, early education, and health systems.
- Funding streams and finance parameters limit what can be paid for, who can be paid, and how much can be paid.
- There is no shared language to describe how children and families are served or shared definitions of effective or successful service.

While there are a few places that have successfully surmounted these challenges, many child-serving organizations struggle to collaborate across sectors to provide a full range of integrated supports to children and families.

We need more integration across systems. There is no shared language. For example, when it comes to developmental disabilities, the medical field speaks of "diagnoses," and the education field uses eligibility determinations. Even this [terminology] changes between children 0–3 and 3–22 years. This can be very confusing to families.

— Dana Cox, Research Associate, Center for Child and Family Studies at WestEd

Change in Organizational Culture

Many people shared that the hardest part of this work is in changing the mindsets of educators and child-serving professionals who resist change. Without commitment to transforming systems — including policies, roles, responsibilities, and teaching practice — trauma-informed practices may be less effective.

I would change teacher beliefs. We have heard, "I have been teaching for 25 years. I know what to do." [To that] I say, "I value that you are a veteran teacher. But you have also said that the kids today are different from previous generations. We can both see we have different students with different needs. We can't do the same thing and expect to meet the students' needs."

— Cara Lee, District Student & Family Services Specialist, Norwalk-La Mirada School District

Interview participants also described the importance of integrating trauma sensitivity into every aspect of their organizations' policies, systems, and practices. When an organization is truly trauma-informed, it is evident in the interactions among colleagues, in the decision making from organizational leaders, and in the systems and processes of the work. For example, one participant noted that trauma training should not be reserved for just a subset of the staff. Another shared a desire for a framework or set of guidelines that could help organizations better support trauma healing for staff.

Interview participants also noted that the transition phase to trauma-informed practice can be especially challenging when educators have given up old teaching practices, but have not yet mastered new ways of responding to maladaptive behaviors.

Support for Adults Experiencing Trauma or Burnout

One important challenge of providing effective trauma-informed support is that so many of the adults caring for children with trauma — their parents and caregivers — have their own histories of adversity and trauma. We know that children experience their environment through the filter of the adults around them and when a parent or caregiver is struggling with their own untreated trauma, their ability to protect the children in their care from adversity is hindered.

We spend a lot of time talking about points of interventions for trauma-impacted children, and not an equivalent emphasis on the adults serving them, who are often also trauma-impacted. They are the success stories of trauma-impacted children.

— Chris Blodgett, Director of the Child and Family Research Unit, Washington State University

The people working at these agencies have their own trauma that they come with. Organizations need help to build their capacity to provide reflective practice facilitation so they can help staff untangle their personal issues and trauma from the children and family issues that they encounter in their work. It needs to be an ongoing process.

— Deborrah Bremond, Infant Early Childhood Mental Health Specialist Consultant

Additionally, some educators have a strong empathic reaction to the trauma of the children they serve (commonly called “vicarious trauma”).

> *One of the most challenging things at schools impacted by trauma is regular staff turnover. Teachers and support staff leave because of burnout, which can be made worse by the impact of vicarious trauma. Predictability and consistency is so important for students, especially our trauma-impacted students. Needing to train new staff every year also makes it challenging for schools to push their trauma-informed systems and structures to the next level.*
>
> — Jen Caldwell, School Social Worker, San Francisco Unified School District

Improved Integration Between Early Childhood and School-Aged Childhood Programs and Systems

In one interview, our conversation about trauma risk factors quickly moved to a more general observation that there is also a gap in knowledge and collaboration between the early childhood systems and the K–12 system. The interview participant observed that inadequate information sharing may mean that kindergarten teachers do not start the school year with everything they need to know to meet the needs of their incoming students:

> *There is no agreed upon way to know about school readiness. There are a number of tools, but I’m not sure how good they are. We need a readiness assessment that the preschools, daycares, and independent private schools use and provide to the elementary schools.*
>
> — Cliff Curry, Superintendent, Red Bluff Union Elementary School District

More Widespread Awareness of Trauma

One theme that emerged in several of our interviews was a desire for greater awareness about trauma and trauma-informed practices for all stakeholders, including families and communities, educators, and funders.

Early childhood interview participants described a desire for more population-level methods to raise the awareness of the general public about childhood trauma and its impact. Some referred to Sesame Street and children’s books as examples of ways to send targeted, critical messages to a broader population.

> *Trauma theory shapes the way you intervene, yet it hasn’t been disseminated broadly. It needs to be disseminated in an easy to understand, non-academic way so*

that everyone in the world understands the basics. Everyone should know what a trauma reminder is.

— Chandra Ghosh Ippen, Dissemination Director, UCSF Child Trauma Research Program

Participants also share a desire for preservice training of educators and child-serving professionals to include more trauma-informed approaches.

This needs to filter up to colleges so they have knowledge [of trauma-informed practices] from the beginning. The word trauma never came up in college. We need this as a course in college and community college level.

— Mitchell Ha, Assistant Director of Child Development Programs, Hayward Unified School District — Child Development Division

We also heard a desire for supporting the funding community's knowledge of trauma-informed practices, at every level.

Highlight all of the organizations doing this work — incorporating the neurology into practice. It could be a funder convening over a two-hour lunch. Frame it as a professional development opportunity for funders. I would also love to have more tools to talk to my board about this information.

— Christy Walther Tripp, Executive Director, Walther Family Foundation

High-Quality Practices, Including Validated Measures and Effective Programs

Interview participants shared that as the field of trauma-informed support becomes more and more crowded, it becomes increasingly difficult to distinguish the quality and effectiveness of the various programs and assessment tools. Assessment tools, in particular, are often imperfect for the needs of practitioners.

We are also trying to improve the way we assess kids. Our therapists do their own mental health assessments, and we get the paperwork from the kids' schools, but we need a specific trauma assessment. We need to know the children — discern their triggers, understand the details, fill in the gaps in our knowledge.

— Julia Bantimba, Occupational Therapist, James Baldwin Academy, Seneca Family of Schools

Some interview participants indicated that with screening and assessment comes the moral responsibility to provide services.

> *I wonder whether there will be a backlash if we keep screening and do not have the follow-up services available. Changes need to be made systemically so that the service system is bolstered at the same time to receive the increased referrals.*
>
> — Chandra Ghosh Ippen, Dissemination Director, UCSF Child Trauma Research Program

In Conclusion

As WestEd grows and evolves our body of work in trauma-informed practice, we will continue to be guided by evidence-based practices and by the first-hand experience and input of researchers and practitioners like those featured throughout this brief. Moving forward, we continue to think about how best to serve our clients: the educators, schools, early learning programs, child-serving agencies, entrepreneurs, districts, and state education agencies across the nation who recognize that noticing and attending to trauma in children and families is fundamental to their missions. While our planning is ongoing, we know that our work must be informed by the following five values:

- **Equity:** In everything we do — from the language we use, to our methods, to the partners we work with — we will seek to strengthen children, families, and communities, especially those that have been historically underserved.
- **Courage:** We will continue to be data-driven in our work, but we will not be afraid to think creatively and expansively and try new approaches. We will also share important evidence-based findings and truths, even when they may be unpopular or uncomfortable.
- **Innovative collaboration:** We will collaborate across sectors and disciplines. We will work to surmount the barriers and obstacles between us.
- **Asset-based:** We will value the individuals, families, and communities we serve and the gifts they bring to this work.
- **Capacity-creating:** To promote equity and sustainability, we will support the capacity of individuals, organizations, and communities to lead and sustain their own work.

A popular proverb says, "If you want to go fast, go alone. If you want to go far, go together." Even with the depth and breadth of WestEd's experience and expertise, we know that whole-child, trauma-informed practice is not something that any one person or organization can carry out alone. Our success will rely on the wisdom, skill, commitment, and resilience of our organizational partners, and the families and communities with whom we work.

For further information on WestEd's work related to trauma-informed practice, please contact Natalie Walrond at 415.615.3296 or nwalron@wested.org.

Appendix — Interview Participants

The interview participants included in this brief are expert researchers and practitioners in trauma and trauma-informed practices, representing multiple social sectors. Interviews were conducted between January and March 2018. Conversations were allowed to evolve organically, but the interviews generally focused on the following five guiding questions:

1. To what extent does your child-serving setting think about trauma-informed practices? Is this issue relevant/urgent/timely?
2. What are the goals, scope, and approach of your trauma-informed practices?
3. What systems, tools, and resources do you use, really like, or think are particularly effective?
4. What are the obstacles to your work? What supports do you wish you had?
5. What other insights or advice for WestEd would you like to share?

We want to express our enormous gratitude to our colleagues for sharing their work with us. WestEd benefits from their candor and wisdom. Participants are listed below, and are organized alphabetically by organization, categorized by their role in the ecosystem.

Table A1. List of Interview Participants

Organization	Participant
Practitioners & Service Providers	
Infant Early Childhood Mental Health Specialist Consultant	Deborrah Bremond, Consultant
Family Connections	Sarah Poulain, Executive Director
Hayward Unified School District – Child Development Division	Mitchell Ha, Assistant Director of Child Development Programs
James Baldwin Academy, Seneca Family of Schools	Sama Hromnik, Principal Joshua Heideman, Assistant Principal Julia Bantimba, Occupational Therapist, leading the school's trauma-informed practices work
KIPP Bay Area	Ric Zappa, Senior Advisor
Los Medanos College Child Study Center	Angela Fantuzzi, Child Development Specialist

Organization	Participant
Lourie Center for Children's Social and Emotional Wellness	Jimmy Venza, Director
Norwalk-La Mirada Unified School District	Cara Lee, District Student & Family Services Specialist
Placer County Office of Education	Alicia Rozum, Coordinator of Prevention Supports and Services
PlayWorks	Jill Vialet, Founder
Power of Two	Anne Heller, Chief Executive Officer
Red Bluff Union Elementary School District	Cliff Curry, Superintendent
San Francisco Unified School District	Jen Caldwell, School Social Worker
TALK Line, a Program of Safe & Sound	Daphne Tang, TALK Line Supervisor
Researchers	
Stanford University, Early Life Stress and Pediatric Anxiety Program	Victor Carrion, Program Director and John A. Turner Endowed Professor for Child and Adolescent Psychiatry Travis Bradley, Director of Social and Emotional Learning
Washington State University	Chris Blodgett, Director of the Child and Family Research Unit
University of California San Francisco Child Trauma Research Program	Chandra Ghosh Ippen, Dissemination Director
Policy & Advocacy	
Children Now	Ted Lempert, President Kelly Hardy, Senior Director, Health Policy
Center for Youth Wellness	Sara Marques, Director of Strategic Initiatives
Programs	
Edgewood/ Wu Yee SF	Rebecca Borland, Early Childhood Education Mental Health Consultant
Healthy Environments and Response to Trauma in Schools (HEARTS), a program of UCSF	Joyce Dorado, Director and Co-Founder

Organization	Participant
Turnaround for Children	Pamela Cantor, President & Chief Executive Officer Gabe Friedman, Director of Policy and Business Development Folusho Holloway, Manager, Digital Marketing
Agencies	
California Department of Health Care Services	Karen Baylor, Independent Consultant and former Deputy Director of the California Department of Health Care Services
East Bay Agency for Children	Melanie Wartenberg, Senior Director, School Based Behavioral Health
Funders	
Chan Zuckerberg Foundation	April Chou, VP of Education Brooke Stafford-Brizard, Director of Education
Walther Foundation	Christy Walther Tripp, Executive Director
WestEd	
Center for Child & Family Studies	Dana Cox, Research Associate
Center for Prevention & Early Intervention	Karen Finello, Project Director