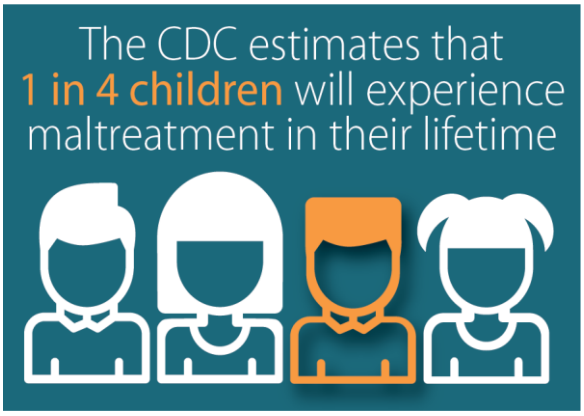
Mental Health America

Addressing Trauma in Youth

Not every child is afforded security or safety during their most formative years. The Centers for Disease Control and Prevention (CDC) estimates that 1 in 4 children will experience maltreatment in their lifetime, while 1 in 7 will experience it in the past year. The Children's Bureau of the United States Department of Health and Human Service reported that, between the years 2011-2015, there was an 3.8% increase in reported childhood abuse cases.[1] Many cases of child mistreatment will go unreported. This can happen for many reasons. Children cannot always advocate for themselves and rely on adults to act on their behalf; often abuse is taking place within their communities or in private settings. Inaction can result from those witnessing the abuse not wanting to get involved with matters that are perceived as private or being fearful of the consequences that community members may face (e.g. incarceration or removal of child from household). Abuse in the form of neglect is not always perceived as abuse, and/or those that engage in the abuse lack awareness of how environmental factors (e.g. incarceration of family member or parent separation) contribute to trauma. We can therefore assume that the percentage of children who experience trauma is higher.

The effects of trauma have been well documented. Trauma can cause permanent changes in the structure and chemical activity in the human brain. These changes are more significant in children's brains because they are still maturing. The main areas affected by trauma are those associated with learning and problem-solving, emotional regulation, and assessing and responding to environmental threats.[2] Disruptions in the maturation of these regions also place children at risk for developing mood, anxiety, psychotic and substance abuse disorders, throughout their lifetime. In 2012, the Proceedings of the National Sciences of the United States of America published the results of study that identified child maltreatment or abuse as a major risk factor for the development of mood and anxiety disorders. More than half of participants who had experienced three or more forms of trauma developed MDD and almost a quarter met the criteria for PTSD. Regardless of whether participants met the criteria for a mental health condition, the damage created by traumatic stress remained.[3]



[1] https://www.medicalnewstthday.com/articles/319566.php
[2] https://www.childwelfare.gov/pubPDFs/brain_development.pdf
[3] Teicher MH, Anderson CM, Polcari A: Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus, and subiculum. Proc Natl Acad Sci USA 2012; 109

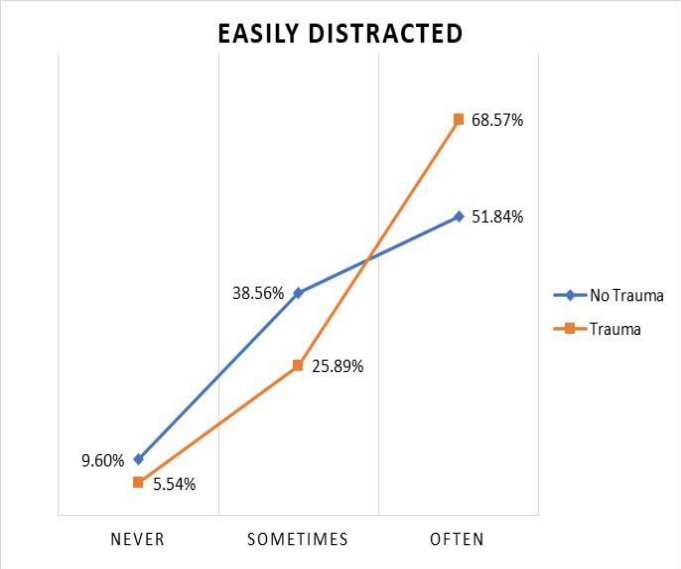
Youth Trauma Survivors and Schools

The cognitive, emotional, and behavioral effects of trauma are often heightened as a child enters the school system and becomes integrated in a classroom setting. This change in their environment and routine can cause emotional, psychological or physical distress, and often leads to issues related to attention, mood, and conduct. These emotional and behavioral irregularities are not often viewed as symptoms of trauma but mistaken for, and treated as, defiant behavior or emotional disorders.

In 2015, MHA offered the Pediatric Symptoms Checklist (PSC) for young screeners online. The PSC has been used to evaluate children for psychosocial problems. The youth form is 35 questions long and questions measure on a scale of Often, Sometimes, and Never, and focus on one of three buckets of symptoms:

- Attention Problems
- Mood Problems
- Conduct Problems

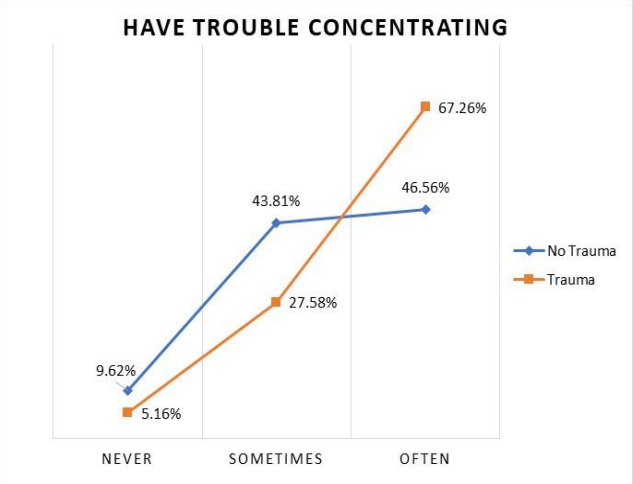
Since the Youth Screening launched, 116,683 youths have been screened. In February 2018, the option "trauma survivor" was added to the demographic question "Which of the following populations do you belong to?" The following data was collected from 569 youth trauma survivors who took the PSC. It should be noted that youth visiting MHA's screening page are a help-seeking population looking to address mental health concerns and in need of support. Although significant differences in percentages may exist between trauma-impacted youth and non-trauma youth, data from the Youth Screen demonstrates that overall a large percentage of youth are at-risk of developing a mental health condition and adopting unhealthy behavioral coping mechanisms. As a result, they are facing social and academic challenges.



Attention

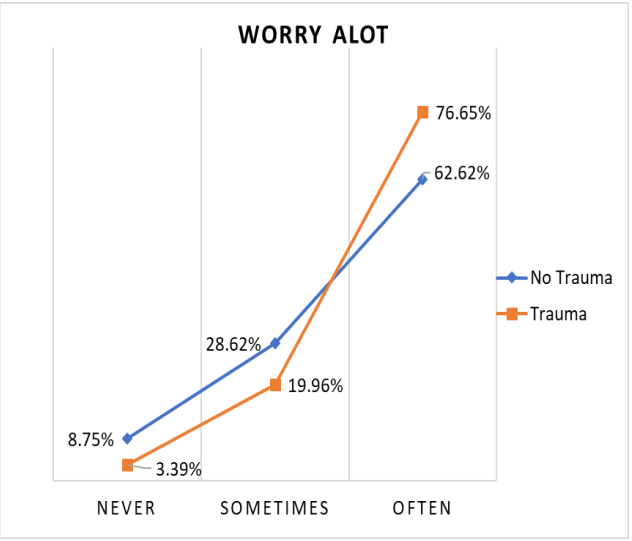
Research shows that early life trauma impacts a child's ability to pay attention as well as process and attain new information. Children impacted by trauma often become hypervigilant or hypersensitive to changes in environments, more specifically changes in the behaviors of the adults around them.[1] In the classroom, a trauma-impacted youth may become overly concerned about environmental threats, which may result in the youth being unable to focus or easily distracted. Sixty-seven percent of screeners stated that they *often* had trouble concentrating, compared to 47% of non-trauma survivors. Additionally, 51% *often* found it difficult to remain still and 69% percent stated that they *often* were easily distracted in the classroom; this was the case for 37% and 52% of non -trauma youth, respectively.

For youth to learn, they must be able to listen, memorize, and apply new information. This can be difficult if they are unable to focus. The inability to focus leads to higher levels of frustration and anxiety in the classroom, which has shown to result in lower self-esteem and learned helplessness. [4] Although a larger percentage of trauma-impacted youth reported having trouble paying attention in the classroom, data shows that a significant percentage of non-trauma youth also face the same challenges.



Mood

A child that is exposed to chronic trauma, such as abuse in their household, will often experience intense emotions, such as sadness, fear or anger. Without the skills to identify, control or protect themselves from these emotions, they learn that this state of being is natural. Additionally, they begin to associate difficult and/or negative emotions with escalated emotions. Negative emotions, such as sadness, fear, or anger become ruling emotions. Without the presence of positive emotions to counteract the negative ones, trauma-impacted youth give negative emotions greater meaning than positive ones. These emotions are often accompanied with negative core beliefs about self.

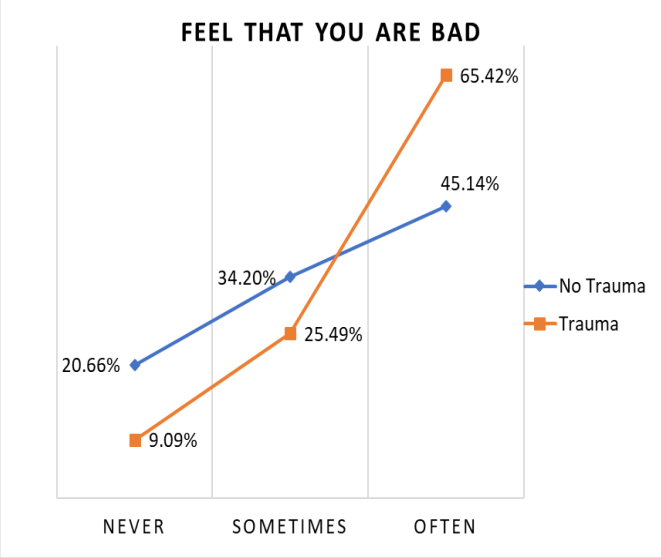


[4] Bussing, Regina et al. (2010) Self-Esteem in Special Education Children With ADHD: Relationship to Disorder Characteristics and Medication Use. Journal of the American Academy of Child & Adolescent Psychiatry , Volume 39 , Issue 10 , 1260 - 1269

These lingering emotions and thoughts will often lead to the development of mood or anxiety disorders.[5] Seventy-three percent of youth trauma survivors reported that they *often* felt sad or unhappy and 64% reported *often* feeling hopeless. Seventy-seven percent of youth trauma survivors also reported that they *often* worried a lot. Across all three measures, trauma-impacted youth were more likely to be experiencing symptoms of a mood disorder or anxiety. Overall, a significant percentage of youth were at-risk of developing a mental health condition.

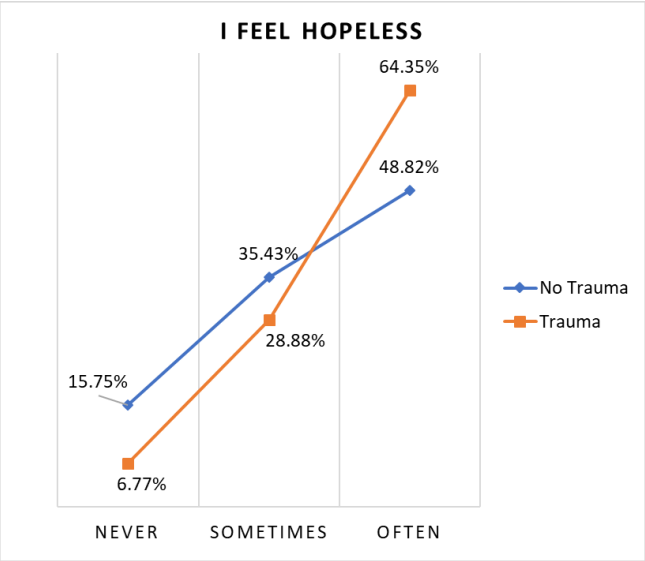
Conduct

Trauma-impacted youth often live in a state of "flight or fight (or freeze)," experiencing higher levels of arousal and hypersensitivity to environmental stimuli. Whether at home or in the classroom, they hold the same view: the world is an unpredictable and unsafe place. Research shows that intense, negative emotions lead to either internalizing or externalizing behavioral problems in children. Trauma-impacted children who internalize the effects of their trauma are likely to place a greater blame on themselves under the assumption that they are flawed.



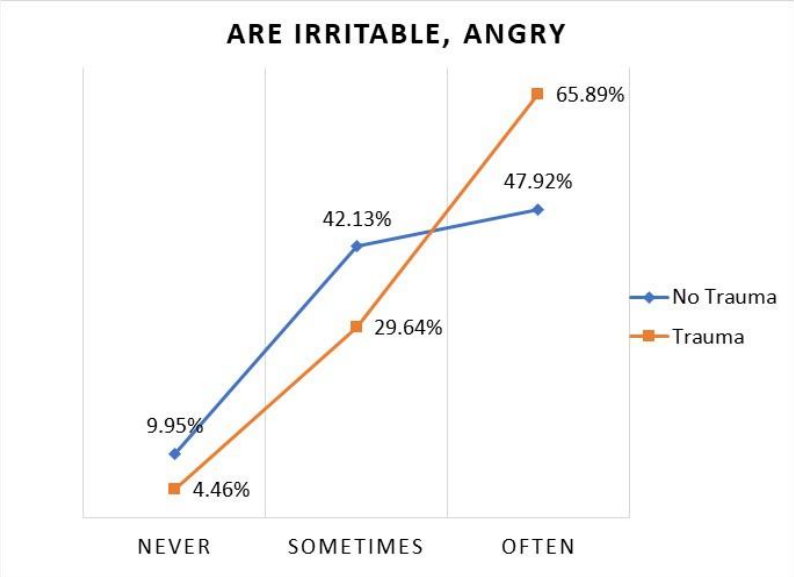
Sixty-five percent of youth trauma survivors reported that they *often* felt as if they were bad, 20% higher than non-trauma youth. Youth who externalize the effects of their trauma assign blame outwardly and tend to adopt a more *fight* response to perceived environmental threats.

Fifty-eight percent of trauma-impacted youth that took the MHA Youth Screen stated that they had experienced trouble with their teachers. The same percentage reported that they had engaged in fights with other children. Internalization is associated with underactive behaviors, due to child's tendency to overemphasize and ruminate over negative emotions and associated negative beliefs. It is the fear of failure or punishment that deters youth from trying new things, asserting themselves or engaging socially.



[5] Stefan G. Hofmann, Alice T. Sawyer, Angela Fang, Anu Asnaani. (2012). Emotion dysregulation model of mood and anxiety disorders. Depressed Anxiety. May; 29(5): 409–416. Published online 2012 Mar 16. doi: 10.1002/da.21888

Externalization has been associated with child's inability to control impulse, think things through (memory and learning) or remain present (attention span). Their reaction to a perceived threat is instinctual and defensive. Youth that have adopted this behavioral coping skill tend to more confrontational, displaying higher degrees of anger or aggression.[6] Sixty-six percent of youth trauma survivors reported they *often* felt irritable or angry. A third stated that they took unnecessary risks, which is nearly twice the figure of non-trauma youth who reported taking unnecessary risks. Studies have shown that externalizing behaviors are associated with individuals who are experiencing PTSD.[7]



Although trauma-impacted youth were more likely to struggle with both internalizing and externalizing behaviors, non-trauma youth appear to also have a need for support in learning to regulate their emotions and behaviors. In the classroom, this behavior can look like social withdrawal, fear of taking risks or fear of new situations. Seventy percent of youth trauma survivors reported that they often spend more time alone, and 58% stated they *often* felt fearful of new situations. Children who adopt this behavioral coping mechanism, in response to negative emotions or situations, are more likely to experience depression or anxiety and complain of psychosomatic symptoms.

Children will develop these behavioral coping mechanisms because they are feeling unsafe, unloved, or lacking control. Unfortunately, school teachers and administrators often view behavioral issues in trauma-impacted youth as an isolated issue or personality trait, not as symptom of trauma. In overlooking or misinterpreting these outward expressions of trauma, they are overlooking this populations' emotional, social, and educational needs, and in many instances exposing them to more trauma.

[6] Nancy Eisenberg, Amanda Cumberland, Tracy L. Spinrad, Richard A. Fabes,Stephanie A. Shepard, Mark Reiser, Bridget C. Murphy, Sandra H. Losoya and Ivanna K.Guthrie. (2001). The Relations of Regulation and Emotionality to Children's Externalizing and Internalizing Problem Behavior. Child Development, Vol. 72, No. 4 (Jul. - Aug., 2001), pp. 1112-1134

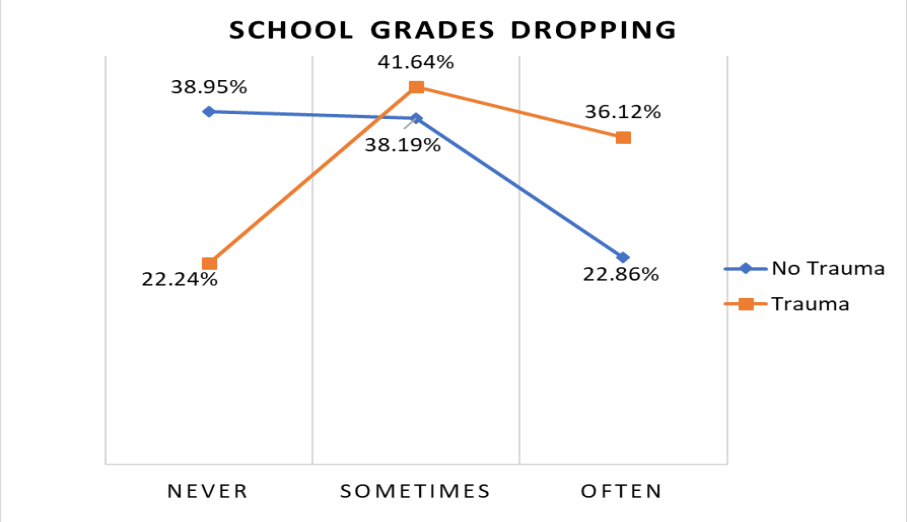
[7] Carliner, Hannah et al. (2017). Trauma Exposure and Externalizing Disorders in Adolescents: Results From the National Comorbidity Survey Adolescent Supplement. journal of the American Academy of Child & Adolescent Psychiatry , Volume 56 , Issue 9 , 755 - 764.e3

School Practices and Policies and Trauma

It is not uncommon for teachers to use behavioral management charts in the classroom to encourage and reward good behavior. For a child finding it too difficult to understand or regulate both emotion and behavior, these charts become are a form of public shaming. For some children, they can become daily reminders of their inability to integrate or succeed in the classroom, affirming their negative core beliefs. If this weren't distressing enough, there is the added element of shame.

These classroom practices reinforce negative emotions and defiant behavior, impeding academic achievement. Teachers who seek to improve behavior and performance in the classroom must recognize the importance of fostering positive relationships and adopting practices that nurture individual talents and skills.[8]

Many schools continue to adhere to archaic suspension and expulsion practices to deal with behavioral issues. These practices are more commonly adopted in middle school and high school. Regardless of age, expulsion or suspension from a classroom/school has been shown to be more detrimental than beneficial to a child's cognitive, behavioral, and emotional development.



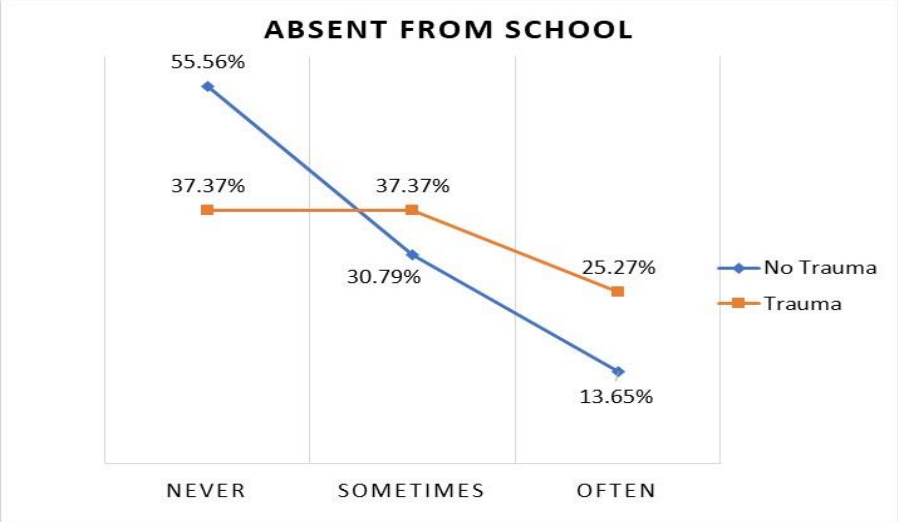
In a recent report, the US Department of Health and Human Services and Department of Education argued that early child suspension or expulsion was likely to lead to expulsion and suspension in later school grades. Additionally, youth that were expelled or suspended were more likely to drop out of high school, fall behind in school, and end up in the juvenile system.[9] This is commonly known as the school-to-prison pipeline, which disproportionally affects people of color from low-income households, those that identify as LGBTQ, and those with disabilities. These are individuals who are also more likely to be victims of chronic trauma.

[8] https://www.washingtonpost.com/news/parenting/wp/2016/09/29/the-darkside-of-classroom-behavior-management-charts/?noredirect=on&utm_term=.560658260404
[9] https://www2.ed.gov/policy/gen/guid/school-discipline/policy-statement-ece-expulsions-suspensions.pdf

Punitive in-classroom and school policies and practices ignore the primary reason why many children are unable to develop behavioral mechanisms that are conducive to learning or forming healthy relationships. Aggression, anxiety, irritability, depression, and social withdrawal are common ways in which trauma-impacted youth express psychological or emotional distress. It is also the way in which they communicate a need for adult support. Schools practices that adhere to punitive practices are placing the burden on children to make the appropriate changes, even though they lack the capacity and skills to do so.

Reversing School-to-Pipeline Practices

Schools are well positioned to provide trauma-impacted youth with a safe and supportive learning environment that builds resilience and enhances academic performance. Through the implementation of programs centered on positive-behavioral strategies, school staff can help trauma-impacted youth strengthen their social-emotional skills, particularly those that allow them to self-soothe and control their impulses in difficult situations. Without these skills, this population is more likely to engage in defiant and disruptive behavior, which often results in disciplinary action. Disciplinary measures often affirm core beliefs that something is inherently wrong and foster feelings of mistrust and being unsafe. Positive behavioral strategy programs encourage teachers to work with students to set clear expectations, acknowledge emotions and concerns, strengthen coping skills, and decide on personal rewards. Studies have shown that these programs reinforce good behaviors, enhance classroom performance, and decrease disciplinary referrals.[10]



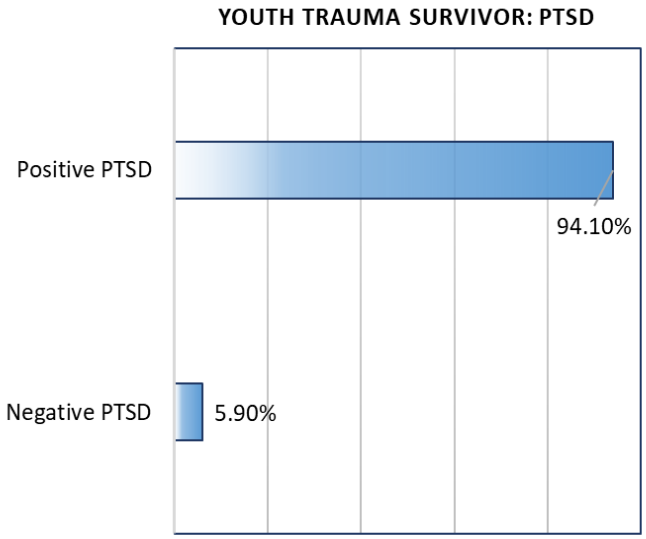
[10] https://jjie.org/2017/09/07/alternative-discipline-strategies-for-dismantling-the-school-to-prison-pipeline/

Trauma is one of the greatest barriers to academic achievement. Trauma-impacted youth are more likely to be absent from schools, find themselves removed from their classrooms, or display sub-optimal academic performance. A quarter of trauma-impacted youth reported that they were often absent from school, compared to 14% of non-trauma youth. Forty-one percent trauma-impacted youth reported that their school grades had dropped. In moving away from practices that criminalize youth experiencing emotional and behavioral difficulties, school staff can spend less time managing behavior and more time fostering engagement and reducing loss of opportunity to learn.

Mental Health Needs

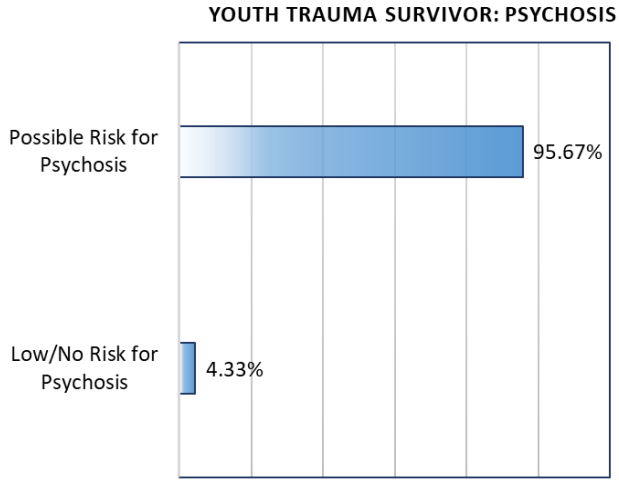
Among our Pediatric Symptoms Checklist (PSC) screeners, youth are more likely to self-identify as having emotional difficulties than conduct problems. More likely than not, this means that by the time teachers are noticing a disruption in the classroom, there have been ongoing mood problems or an existing mental health condition.

Youth who identify as trauma survivors also took the following mental health screens: PTSD, Depression, Psychosis and Bipolar screens. Ninety-four percent of youth scored positive for PTSD, and 68% screened for Severe Depression. Additionally, 96% of youth trauma survivors screened at risk for Psychosis, and 63% screened positive for Bipolar.



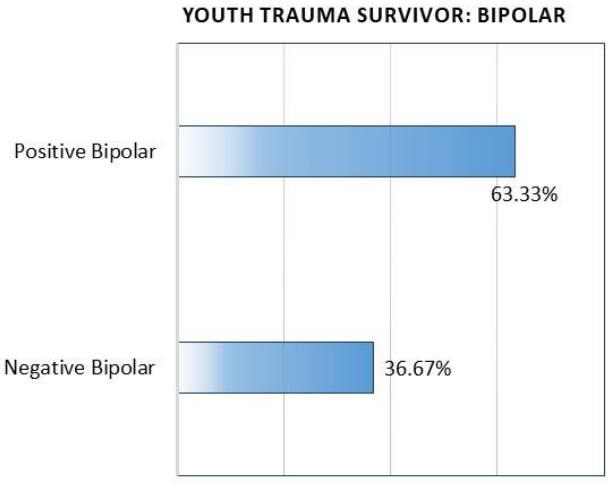
A lack of knowledge of the effects of trauma can lead to the misdiagnosis or underdiagnosis of youth. Symptoms can stem from a variety of conditions and can often overlap. For example, trauma symptoms or PTSD can look similar like those of ADHD. Symptoms can also be mistaken for personality traits, such as social withdrawal and difficulty making decisions, while others can be labeled as defiant.

With the proper training, school staff can play a key role in ensuring that children are receiving the proper in-classroom resources and support, as well as any mental health services that they may need. Their constant contact with children allows them to note any academic challenges that youth may be facing, as well as any changes in their mood or behaviors. They should not be expected to take on a diagnostic role in the classroom, but rather serve as advocates for youth facing emotional or behavioral issues. Doing so can reduce the risk of youth falling behind in school, engaging in self-destructive behavior, and not receiving the appropriate support or treatment.

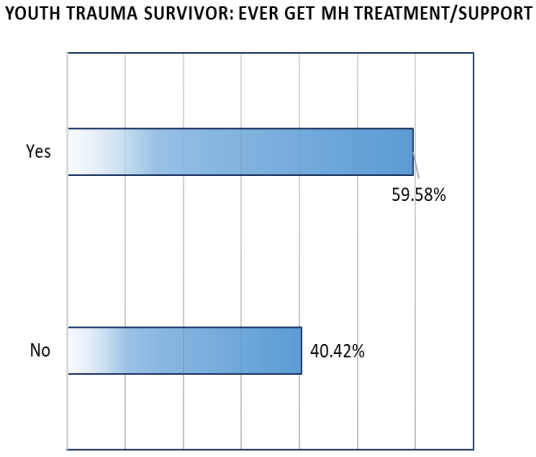


Increasing Access to Mental Health Services

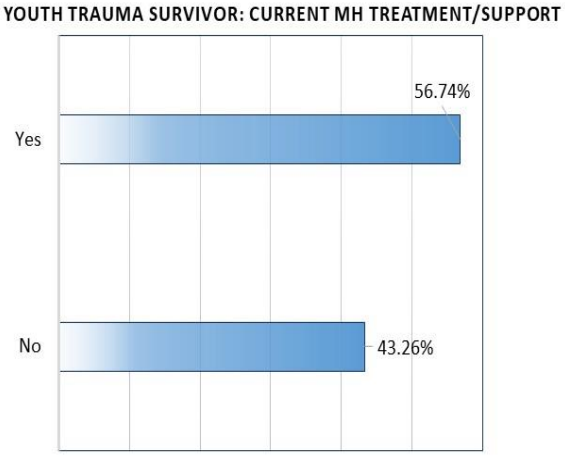
Given the increase in the number of children who are impacted by trauma, there is growing demand for mental health support services. Forty-three percent of youth who identified as trauma survivors were not receiving mental health treatment or support. Forty percent had never received any mental health treatment or support. In addition to equalizing access to education, schools are well positioned to equalize access to mental health services.



Children who experience trauma often struggle with mental health conditions that prevent them from becoming fully engaged in the classroom. Schools can increase engagement by offering mental health services and mitigate symptoms associated with mood disorders and anxiety. Mental health interventions have shown to shorten episodes of mental health conditions and prevent the development of more severe conditions in adulthood.



Integrating mental health services into the education system has many challenges, including student and caretaker understanding of mental health needs and the willingness to make use of mental health services when available; poor engagement of school staff; and poor coordination of services. Many of these challenges can be overcome by developing and adopting practices and policies that create a more trauma-sensitive climate through increased staff training, greater involvement of school community members, and the establishment of a mental health referral system that integrates school-based services and community-based mental health services.[11]



[11] Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools 1: Mental health interventions in schools in high-income countries. The Lancet. Psychiatry, 1(5), 377–387. http://doi.org/10.1016/S2215-0366(14)70312-8

Social Emotional Learning in Schools

Social Emotional Learning (SEL) refers to a child's ability to process, express, and manage their emotions, as well as foster relationships that are both positive and rewarding. Because they often experience a disruption in their social emotional development, trauma-impacted youth find it hard to tap into positive emotions that can counteract negative ones. As they progress through the education system, emotional and behavioral issues associated with social emotional impairment worsen over time.

In recent years, SEL programs have developed in response to research findings that show emotional and social development are just as critical as cognitive development. In fact, strong emotional and social skills can help improve cognitive function. SEL programs focus on the development of "self-awareness, self-management, social awareness, relationship skills and responsible decision making" skills. Children who are given the skills to strengthen positive behaviors have an easier time adjusting to their environment, forming healthy relationships, and creating positive experiences. Most importantly, they become more reliant on positive beliefs and values, which increase feelings of self-worth and confidence.[12] School-based interventions that prioritized SEL are beneficial for all youth, but of greater service to those youth impacted by trauma. SEL can both mitigate and reverse the effects or impact of traumatic stress.

Trauma-Informed Schools

Despite research confirming the link between trauma, emotional and behavioral issues, and low academic performance, trauma-impacted youth often do not receive the services they need to achieve academic success or respond to their mental health needs. Schools practices and policies continue to cultivate school climates that reinforce negative beliefs and behaviors, widening the achievement gap and increasing mental health disparities. Addressing the needs of children with trauma in schools requires active participation by school staff in adopting trauma-informed practices that promote resilience and enhance academic performance.

The Trauma and Learning Policy Initiative's Flexible Framework, developed by Massachusetts Advocates for Children (MAC) and an interdisciplinary of psychologist, educators, and lawyers, is a leading guide to implementing trauma-informed practices and fostering a trauma-sensitive culture in schools. It is structured according to what they identify as the 6 operational functions of schools.

[12] Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D. & Schellinger, K. B. (2011), The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development, 82: 405–432.

- **School Culture and Infrastructure:** Schools must assess the needs of their student population to ensure that their practices and policies foster a trauma-sensitive culture. Staff training needs must also be determined, as staff play an active role in classroom implementation. Moreover, the role of the community cannot be overlooked. Schools must establish community partnerships and identify available community resources.
- **Staff Training:** For staff to be equipped to address the needs of this population and foster a trauma-informed culture, staff training must focus on building teacher-student-caregiver rapport, expanding knowledge of outside support services, and helping students develop emotional and behavioral regulation skills.
- **Links to Mental Health Professionals:** Students who have experienced trauma may require outside services provided by a mental health professional. Developing and implementing a referral system ensures that students and their families are connected to the resources they need in a timely manner. Relationships with community-based organizations should be established during the strategic planning process to facilitate the referral process.
- **Academic Instruction for Students who have Experienced Trauma**: Schools must ensure that teachers are incorporating teaching practices that address youths' learning needs. Teachers should be trained on how to create a classroom routine, communicate expectations, and provide positive reinforcement. For example, adopting a language-based approach allows for the use of multiple ways of communicating information. For trauma-impacted children who have experienced this is critical because they often are more receptive to non-verbal cues and require support in verbally expressing their needs. Conducting school evaluations are key in determining the learning needs of students affected by trauma.
- **Nonacademic Strategies:** Children can learn so much outside of classroom curriculum, including how to build relationships, recognize hobbies and nonacademic interests and talents. Schools should offer and encourage participation in extracurricular activities and peer relationships.
- **School Policies, Procedures, and Protocols:** School policies, procedures and protocols can become barriers to creating a trauma-sensitive school climate. Administrators should review and amend practices to ensure that they promote accountability but do not reinforce traumatic behavior. Schools must create a culture that is nonviolent and safe for children who often see the world as threatening and associate punishment with being inherently flawed.[13]

In 2008, the San Francisco Unified School District (SFUSD) developed a multi-tiered strategic plan that resulted in the development of the Healthy Environments Response to Trauma in Schools (HEARTS) program. HEARTS was first implemented in four schools that largely served students of color who lived in low-income, trauma-impacted communities. Exposure to chronic trauma had resulted in several behavioral and emotional issues affecting academic performance.

[13] https://www.elc-pa.org/wp-content/uploads/2015/06/Trauma-Informed-in-Schools-Classrooms-FINAL-December2014-2.pdf

HEARTS aimed to increase staff education on the effects of trauma and end the overuse of disciplinary measures in responding to defiant behaviors. Staff members were trained on how to create a safe and supportive environment, implement practices that addressed students' learning needs, and assist trauma-impacted students in strengthening emotional and behavioral regulation skills. Mental health services were also embedded within the school system and behavior plans and procedures were amended to align with trauma-informed practices. An evaluation of the program showed an increase in staff knowledge on the effects of trauma and the use of trauma-informed practices, an increase in student engagement, and a decrease in problematic behaviors. Most notably students experienced a reduction in trauma-related symptoms.

An evaluation of a trauma-informed intervention within a youth residential facility schools in 2012, showed similar promise. The Heart of Teaching and Learning: Compassion, Resiliency, and Academic Success (HTL) curriculum was piloted in a public charter school that exclusively served court-involved children receiving residential treatment. Most of these children had a history of abuse or neglect and showed high rates of complex trauma or post-traumatic stress, making them vulnerable to "self-harm behavior…delinquency and perpetuation of violence…and low educational attainment." The HTL was an intervention designed to guide the development and implementation of trauma-informed practices in education settings. It provided staff training in defining trauma and understanding its effects, creating safe and secure environments, self-care, collaborative problem-solving techniques and teaching tools to increase learning and engagement. To determine effectiveness, students were asked to complete the following before and after the implementation of the curriculum: The Student Needs Survey (SNS), The Child Report of Post-traumatic Symptoms (CROPS), and The Rosenberg Self-Esteem Scale (RSE). These instruments were used to measure students' perception of whether their needs were being made, trauma symptoms, and self-esteem, respectively. Similarly, students saw a reduction of PTSD symptoms with the implementation of the HTL curriculum.

Findings from the HEARTS and Youth Facilities Intervention studies show that trauma-informed practices allow for a better learning environment and lead to more positive life outcomes, increasing student engagement and enhancing academic success. Staff members are trained to understand how learning and behavior are affected by trauma and are encouraged to use this information to guide their teaching practices and classroom management strategies. A trauma-informed culture also fosters positive relationships between students and teachers, which has been shown to improve student conduct and classroom performance, while nurturing positive emotions.[14] Finally, trauma-informed schools become gateways to mental health services for children impacted by trauma. They promote the early identification of symptoms, such as social withdrawal and aggression or hostility towards others, and timely intervention. In supporting services that address mental health concerns, trauma-informed schools are increasing the

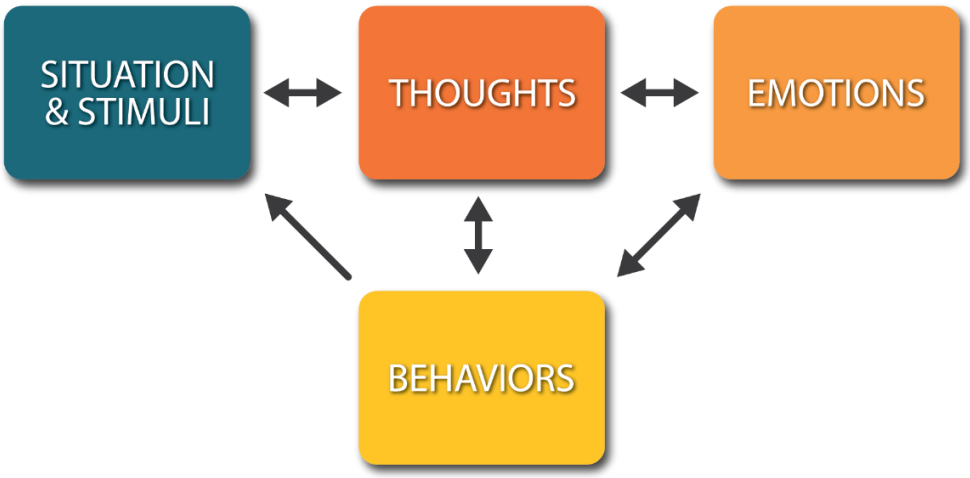
[14] Angelique G. Day, Cheryl L. Somers, Beverly A. Baroni, Shantel D. West, Laura Sanders & Cynthia D. Peterson (2015) Evaluation of a Trauma-Informed School Intervention with Girls in a Residential Facility School: Student Perceptions of School Environment, Journal of Aggression, Maltreatment & Trauma, 24:10, 1086-1105, DOI: 10.1080/10926771.2015.1079279

number of children who can access the resources and treatment that they need. Addressing trauma and its symptoms at an earlier stage can reduce children's risk of developing more severe mental health conditions.

Conclusion

One in four children will experience maltreatment in their lifetime, with 1 in 7 experiencing trauma it in the past year. Trauma can lead to a permanent restructuring of a child's brain, affecting the way in which they process and retain information, regulate negative emotions, and behave. The effects of trauma become more prominent when a child enters the education system. In addition to being placed in an environment that is unknown, they are expected to adhere to practices and policies that conflict with their emotional and behavioral functionalities.

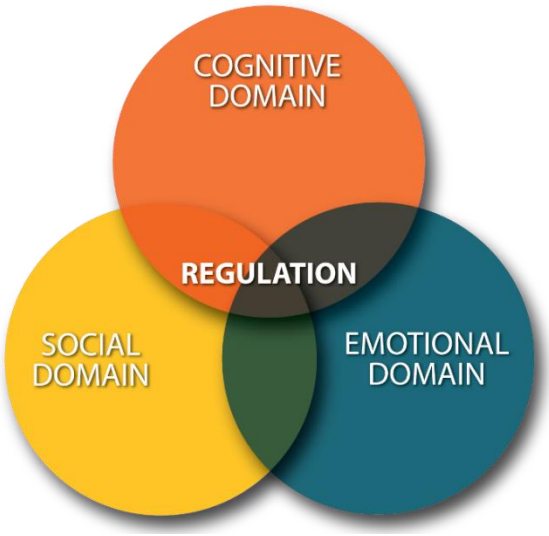
A large percentage of trauma-impacted youth are experiencing symptoms of mood disorder or anxiety before entering the classroom. MHA's youth screening data (n=561) showed that, in addition to struggling with concentration, youth trauma survivors showed signs of depression and anxiety. Most youth screeners reported feeling hopeless, believed that they were inherently bad, and worried a lot. Moreover, data collected from MHA's Post Trauma Stress Disorder, Bipolar, and Depression screens showed that a large percentage of youth trauma survivors were at high risk for developing all three conditions. A deeper analysis of this data showed that mood disorders often precede behavioral issues.



How the effects of trauma manifest themselves differs from youth to youth. Some will adopt externalizing behaviors while others will adopt internalizing behaviors. Commonly, those who adopt externalizing behavior appear to be more aggressive or hostile, while those who adopt internalizing behavior often withdraw socially or are fearful of new experiences. In the classroom, the latter regularly are overlooked while the former are repeatedly punished. Traditional school practices that aim to address defiant behavior through disciplinary measures reinforce the negative beliefs that trauma impacted youth often hold. This leads to further defiant behavior and fosters an unsafe environment exposing youth to additional trauma.

Schools can play a critical role in early identification and intervention. If unaddressed, short-term symptoms of trauma in youth are likely to become more severe in adulthood. In helping to mitigate the effects of trauma, schools can offer trauma-impacted youth the opportunity to build resilience and improve life outcomes. This can be done through the implementation of trauma-informed practices and policies that create trauma-sensitive climates. Evaluations of school-based, trauma-informed programs have shown that trauma-sensitive climates foster positive relationships between staff and students, leading to an improvement in conduct. More notably, trauma-sensitive climates have been shown to reduce symptoms of trauma in youth by increasing feelings of safety and support.

A lack of knowledge concerning the effects of trauma has allowed many trauma-impacted youths to fall through the cracks of the education system. This is primarily due to the criminalize of defiant behavior that is often indicative of trauma. Expulsion, suspensions, or classroom removals contributes to huge losses in learning and higher levels of disengagement or detachment. These are hostile and damaging practices that result in the re-traumatization of youth, the exacerbation of emotional and behavioral issues, and lower academic performance. Staff should be trained on how to respond to children experiencing emotional, behavioral and academic difficulties. Effective strategies include supporting youth in the development of emotional regulation and coping skills.



In most cases mood disorders precede behavioral issues. School-based mental health services programs can meet a growing demand for resources among trauma-impacted youth. School-employed mental health professionals are trained to provide mental health services in a learning environment, addressing mental health issues before they become chronic. Some youth require services outside of the scope of school-based mental health professionals. Schools can increase access to care by establishing relationships with community-based mental health services. Additionally, schools can ensure that trauma-impacted youth can access services by developing a referral system that connects youth to mental health services in their community. A critical component of a referral system is the creation of referral staff that receive continual training and updates on procedures and protocol.

Schools can also play an active role in helping *all* youth build resilience and improve academic performance by fostering social emotional development. MHA's youth screening data shows that a large majority of non-trauma youth were also experiencing issues with attention, mood, and conduct. Fifty-two percent of non-trauma youth stated that they *often* found themselves easily distracted, 47% stated that they *often* found it difficult to concentrate, and 37% *often* found it difficult to sit still. A large percentage of non-trauma youth also experienced symptoms of a mental health condition. Forty-nine percent reported *often* feeling hopeless, 63% stated that they *often* worry a lot, and 48% *often* felt angry or irritable. Emotional difficulties were accompanied by behavioral ones, including defiant behavior or social withdrawal. Both non-traumatized and trauma-impacted youth reported that they *often* saw their grades dropping or were absent from school, indicating a lack of effective support services in schools.

Regardless of exposure to trauma, Social Emotional Learning (SEL) programs have shown to cultivate a learning experience that promotes positive behavior, academic success, and emotional well-being in youth. Although trauma-informed care and SEL are often viewed as separate, they have many interrelated components. In most cases the emotional and behavioral symptoms of trauma worsen because trauma-impacted youth do not possess the necessary restorative skills. With a focus on self-awareness, self-management, social awareness, relationships skills, and responsible decision making, SEL programs complement trauma-informed practices in mitigating the effects of trauma and its behavioral manifestations. Schools interested in creating trauma-sensitive climates should not only focus on treating the trauma itself but also creating an environment that allows for it. Combining SEL and trauma-informed practices allows for just that.