

Early Lessons in Building Trauma-Sensitive Schools

Creating School-Health-Community Partnerships to Improve the Lives of Children

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Contents

Early Lessons in Building Trauma-Sensitive Schools

FOREWORD 2

INTRODUCTION..... 3

Graphic: Early Results of the Work..... 3

CREATING SCHOOL-HEALTH-COMMUNITY PARTNERSHIPS 5

SUPPORTING THE WHOLE STUDENT: HEALTHY AND READY TO LEARN 8

Graphic: Healthcare Impacts 8

Graphic: Developing a Universal Consent Form 11

BUILDING TRAUMA-SENSITIVE SYSTEMS WITHIN SCHOOLS 13

Graphic: Calumet Public School District 132 Results 13

LOOKING AHEAD 18

ACKNOWLEDGEMENTS..... 19

ENDNOTES 20



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Foreword

My brother and I began our conversation about resilience not in a conference room or in an office somewhere but at a family barbeque. It was over hotdogs and hamburgers that I, a lifelong educator, first heard about adverse childhood experiences (ACEs) and toxic stress from my brother, David, a pediatrician who had recently come across the literature. As David was describing the ACEs research and the impact of toxic stress on childhood and adult health, I quickly saw how its implications for education would resonate with teachers. It provided powerful science-based explanations for why no matter how hard an individual classroom teacher worked some children had trouble learning.



At that initial conversation in the spring of 2014, we already knew in order to do this work effectively we needed to invite other partners to the table. We set up a breakfast meeting with the Illinois Chapter of the American Academy of Pediatrics, the Illinois Education Association, the Consortium for Educational Change, and a community organizer—Tom Lenz. More partners were added as we explored ways to impact the problem. It was clear that the idea not only resonated with us but with other educators and physicians. We all believed that supporting children, their families, and their communities could not be accomplished by either sector alone. Working in silos would no longer suffice. The stubborn and lasting effects of toxic stress are formidable and could not be toppled without a persistent focus and cooperative effort.

So with our smart, capable, caring partners, we created the Partnership for Resilience. This report tells our story, and we are deeply grateful to the school districts, the educators, the physicians, and the community partners who are making such a huge difference in the lives of children and their families.

We often wonder why it took us so long to recognize that pediatricians and educators together are powerful advocates for students; it seems so clear in hindsight. We know that working together is powerful and how vitally important the impact of toxic stress is to the educational and health outcomes of children. Today, we continue to push ahead so we can bring positive change to every student in every community. We leave you with this thought as you learn more about the Partnership for Resilience; it's a quote from Dr. Bruce Perry, a foremost expert on ACEs and toxic stress: "Relationships are the agents of change and the most powerful therapy is human love." For us this has been a journey of love.

Audrey Soglin, Executive Director, Illinois Education Association

Introduction

The Partnership for Resilience (the Partnership) is a new effort to reorganize schools and communities to foster and build resilience to childhood trauma.

Audrey Soglin’s foreword describes how it began with recognition among educators and physicians that they might work together, and with others, to address trauma’s impacts.

Committed to exploring ideas through actions not words, in 2015 the team of colleagues launched a pilot initiative in three school districts in the southern suburbs of Chicago: Calumet Park District 132, Dolton Riverdale District 148, and Ford Heights District 169. These districts were chosen based on their need as well as contacts and networks previously built by some Partnership members.

That initial pilot has now expanded to include seven school districts in the southern suburbs of Chicago, serving roughly 14,000 students. Replication is underway in the state’s second largest school district, U-46, and in the central Illinois city of Decatur. Additionally, local leaders have engaged the Partnership to launch an effort in 15 counties in the rural southern tip of Illinois.

The Partnership’s work is a response both to the changing demographics of many public schools and to advances in our understanding of the science behind childhood trauma and resilience. Consider the huge changes in the demographics of American public schools:

Growing numbers of American children face adversity, trauma, and poverty. Today, nearly one-third of American youth have experienced two or more types of adversity likely to affect their health as adults. Nearly half of American children have experienced at least one type of serious childhood trauma. For the first time in two generations, the majority of public school students live below the poverty line.¹

The suburbanization of poverty presents suburban school districts with particular challenges. In Chicago’s southern suburbs (the Southland), where the Partnership began its work, the number of residents in poverty jumped by 99% in one decade.² The proportion of low-income or English language learner students is high, even compared to nearby Chicago public schools, yet resources are scarcer.

As these demographic changes have occurred, the focus within mainstream school reform circles has remained overwhelmingly on academic achievement and remediation. School leaders and educators have felt, and continue to feel, immense pressure to deliver higher test scores. Yet even districts that have embraced these reforms have struggled with insufficient progress on test results. As one Southland superintendent observed: “The needs in our community had changed. We were doing so much. Yet for some of our kids, the numbers were going down. We started to ask: what are we missing?”

One answer to the superintendent’s question: ACEs. The science of Adverse Childhood Experiences is the science of how experience changes the brain and body in enduring ways. Twenty years ago, in a seminal study, Kaiser Permanente and the Centers for Disease Control demonstrated a profound, proportionate relationship between childhood adversity and adult health, social

Early Results of the Work

- **Improvement on lead indicators for long-term academic outcomes.** In one participating school district, referrals decreased by 72%, detentions by 87%, suspensions by 79% and expulsions by 100% over two years. Students made statistically significant gains in English and math across all grades (K-8) during this period, correlated with the Partnership’s work.
- **Primary health challenges addressed.** Students obtaining mobile asthma services did not have a single return ER visit in year one in one participating school district; in year two another participating school district achieved nearly a 100% immunization rate.
- **Stronger schools.** Participating school districts report greater cohesion between administrators, unions, staff, and support services and growing job satisfaction among teachers.

problems, disability, and death.³ In the years since the ACEs study, research has explored cause and effect.

The converging findings in neuroscience, genomics, and molecular biology are compelling, shedding light not only on the long-term disruption caused by adverse experiences, but on opportunities to heal. Coachable skills, in areas such as executive function and social-emotional development, can make a difference. Environments that build safety, connection, and habits of self-regulation—powerfully and repeatably—can help students facing adversity thrive.

The science of ACEs and resilience has inspired programs in an array of settings from talent development to violence prevention. It holds particular promise if applied consistently and broadly for children growing up in poverty. Yet this knowledge has changed little in many school districts. Unlike delivering a student intervention or a lesson plan, bringing ACEs and resilience research into practice requires changing school environments. It means changing habits and patterns—forces beneath the surface. It requires broad awareness of trauma’s impacts, prioritizing action, and sticking with it.

The Partnership’s Underlying Principles

This report describes one ongoing attempt to integrate the science of ACEs and resilience into high-need/low-resource public schools. In particular, it focuses on how to create the kinds of partnerships needed to launch the work, how to bring needed health services into schools, and how to adapt school practices to promote healing and student growth. The following themes or principles, derived from experience and research, undergird all of the Partnership’s work:

- **Build strong relationships of trust at the outset.** In each stage of the work, the initial focus was on getting to know the school, health, and community leaders and understanding their unique stories and hopes. The Partnership did not arrive on the scene with the answers but with curiosity about and respect for teachers, administrators, and health providers; this took time but was essential for success.
- **Recognize that each school has distinct assets and challenges—“one size fits all” approaches miss the specific capacities and interests of school leaders.** For example, the work of linking schools and

health care providers unfolded in a variety of ways in the Southland. There was no single template or blueprint other than careful listening and patiently building teams of school and health leaders who could work together. With this as the starting point, local capacity to act and respond to new needs could grow.

- **Provide school leaders with a broad array of best practice ideas and let them determine where and how to start.** The Partnership’s professional development efforts draw on a wide array of sources including brain science, social-emotional learning, various models of trauma-sensitive and trauma-informed schools, community schools, and family and community engagement approaches. No single model was promoted; school leaders were encouraged instead to look at their own circumstances and choose knowledge and practices that would best address their most pressing concerns.
- **Acknowledge that progress takes time, but quick “wins” can build momentum for future work.** School leaders and teachers are incredibly busy and are subjected to constant demands to adopt this or that program. Many approach new “whole child” efforts with understandable skepticism and fatigue. The Partnership made intentional quick progress in a limited set of areas to gain buy-in for the work and build excitement needed to persevere over the long haul. This included asthma care and dental care provided by mobile vans at the schools.
- **ACEs awareness is action.** Finally, building a broad base of awareness is a critical action in itself. Building ACEs awareness takes time—and differs from implementing a new strategy as step one—but is critical to achieving the long-term changes necessary to make the school environment trauma-sensitive.

It is hard to overstate how powerful and hopeful the core science of childhood trauma and resilience is. The Illinois Education Association sensed this when it organized a campaign to show the movie *Paper Tigers*. Time and again the Partnership has heard stories of teachers who intuitively knew how to begin to adapt their practices once they had a basic understanding of ACEs and resilience.

Creating School-Health-Community Partnerships: A Community Organizing Approach



As the public school reform debate swings toward “whole child” approaches, there is growing interest in linking schools with an array of community supports. In many ways, this is not new: public schools have long partnered with their communities to offer a range of after-school programs and enrichment activities. For decades, “community schools” have offered a model that provides structure and rigor for this idea.⁴

More recently, the Harvard Education Redesign Lab’s *By All Means* initiative has used “children’s cabinets” that bring mayors and schools together as a strategy for expanding the services and supports available to local students.⁵ However, with some exceptions, the above initiatives have been in urban school districts. Step outside city schools into working class or poor suburbs and the availability of services and partnerships tends to drop dramatically. Head into small towns and rural areas and resources tend to be fewer still.

As the Partnership considered how to bring its vision for trauma-sensitive schools to the Southland, it did not have a specific model in mind for doing this work.

What it did have was a set of social change approaches derived from broad-based community organizing. The Partnership adapted these approaches, which effective public leaders have used in different contexts for years, to the needs and realities of high-need/low-resourced areas. These are described in the following sections: Creating a Steering Team to Oversee the Effort, Building Around Leaders and Their Interests, Initiating Quick and Meaningful Action, and Adding Structure with a Light Touch.

Creating a Steering Team to Oversee the Effort

The impetus to create what became the Partnership for Resilience came from the sibling leaders in the Illinois Education Association (IEA) and the Illinois Chapter of the American Academy of Pediatrics (see Foreword for details). They sensed the potential of a multidisciplinary effort to help schools address Adverse Childhood Experiences and toxic stress in a systemic way. They knew that taking on this challenge would

require a team of like-minded leaders who could bring the power of their institutions to the table.

Seeking a set of partners who trusted each other and could think and act together, they reached out to leaders in the Consortium for Educational Change, Cook County Health and Hospitals System, Harvard’s Education Redesign Lab, and Governors State University—all of whom had an interest in bringing trauma-sensitive practices to schools and medical settings in the Southland. This became the core of the Steering Team. The Partnership had no formal, legal standing (incorporation, bylaws, etc.) for its first two years.

The Steering Team pooled their own funds to hire an experienced community organizer. This is a key point: from the very beginning the partners had financial “skin in the game” and did not have to rely on philanthropic support.⁶ The partners also drew on their considerable set of contacts in the region and state to advance the effort.

In community organizing terms, these founders acted as the “sponsoring committee” of the fledgling effort. They were “all in” in terms of their own money, relationships, and time to address an issue that mattered to them personally and professionally. Importantly, their assets included deep local relationships. For example, an experienced educator on the Steering Team brought a career’s worth of strong relationships in the Southland, having run teacher quality and teacher mentoring programs there for decades.

Most new organizations and collaborations have a similar founding story. It takes a set of “sponsors” or “godparents” to call a new initiative into being. In Decatur, Illinois, the IEA’s staff organizer and the Regional Office of Education were the instigators of a local trauma-informed partnership. In Elgin, Illinois, the IEA partnered with a collective impact effort already in place—Alignment Collaborative for Education—to initiate resilience work in schools. In each case, the founders drew on their existing institutional connections to build the strongest possible partnership.

Building Around Leaders and Their Interests

The Southland has dozens of small, under-resourced school districts. Where and how might the Partnership get started? It might have looked to those districts with the highest poverty levels or lowest test scores. Instead, the Steering Team leaders drew on their decades of familiarity with the histories and leadership of the unions and administrators in the region to approach three school districts they thought had the leadership capacity and interest to tackle this challenge. The offer to these districts was to jointly explore if and how a

partnership could address trauma and poverty in their schools.

It is worth emphasizing what the initial approach was not: it was not an existing program or framework and it was not a six-step plan to become trauma informed. Instead, the work began with a set of conversations with key leaders in each of the districts—what organizers call one-on-ones or individual relational meetings.⁷

Individual relational meetings are the organizer’s stock-in-trade. They are short (usually 30–40 minutes), focused conversations with leaders and potential leaders to uncover what each person cares deeply about and what they might be willing to do about it. In the Southland, these meetings were set up by the superintendent and union leadership and were with a cross-section of teachers, administrators, school support staff, and others familiar with the schools. The organizer conducted a total of 45 such meetings over a three-week period.

The individual meetings in the Southland uncovered three areas of strong concern that crossed district boundaries: the behavioral health challenges of many of the students, the poor health of and lack of primary care for many students, and the difficulty of involving parents in their children’s education. These three priorities—and the stories behind them—became the focus of the Partnership’s work.



The idea that improved schools operating in isolation can compensate for gross and pervasive inequality in our society is naïve in the extreme. If we mean ‘all’ when we say ‘all’, it will take entire communities pooling strategies and assets to build systems of opportunity and support. It is just such systems of opportunity and support that the Partnership for Resilience builds.

— Paul Reville

Founding Director, Education Redesign Lab,
Harvard Graduate School of Education



To underscore the reason for this approach—teachers are busy and often under tremendous stress. If the Partnership’s work was going to have any chance of success, it needed to operate around the interests of the teachers and school leaders. The process of doing individual meetings also began to build the relationships and trust needed for effective action.

Initiating Quick and Meaningful Action

With an initial set of priorities, the Partnership moved quickly to convene the 50-plus school, union, and health care leaders who had been identified through the individual meetings. A set of ad hoc task forces were created in the three focus areas and given the charge to get up to speed on best practices in each. Speakers were brought in for dinnertime sessions at Governors State University—a total of four sessions over four months. These meetings built relationships and forward momentum as the participants began to imagine what work in their individual schools could look like.

Governors State University had seed funding available for some pilot projects. This relatively modest pool of money yielded some big results. Each district had \$27,000 to try out some ideas in one or more of the priority areas. Task forces had \$10,000 each to work on cross-district efforts such as a one-time parent university, a school health needs assessment, and a regional Adverse Childhood Experiences conference.

The availability of funding at the outset was a big help in getting things started, and the school health needs assessment (described in the following section) enabled the first, visible “win” of the Southland work: implementing comprehensive dental care in a number of the districts.

But even without funding for pilot projects, schools and communities can act to increase awareness of ACEs and resilience research. The IEA showed the trauma-themed film *Paper Tigers* at over 100 locations across the state, often paired with panel discussions with local educators, doctors, and mental health specialists. The union followed up with trauma-informed education trainings that reached over 2,000 people over the course of 12 months.

In Decatur, funding from the state board of education was tapped to train school teams in restorative practices and trauma-informed care. The Decatur effort also

initiated their own school health needs assessment with the Southern Illinois University School of Medicine’s Office of Population Science and Policy.

The key point is that the planning phase should not drag out indefinitely. Time is a precious commodity and unless people sense their efforts are leading to action on what they care about, they will tend to drift off. Finding quick and meaningful opportunities for action is a key challenge in the early phase of these partnerships.

Adding Structure with a Light Touch

“Low Overhead = High Independence” is the mantra of many community organizations. It means that by operating with minimal structure and bureaucracy the funding needed can be kept low, and if the operating costs are low there is less reliance on outside funders and their priorities.

The Partnership’s operating budget for its first two years was under \$100,000 and almost entirely raised from four sponsors: the IEA, the Consortium for Educational Change, Governors State University, and the Harvard Education Redesign Lab. However, the in-kind contributions of the members—web design and hosting, creation of videos and training materials, bookkeeping, sponsorship of conferences, and events—were at least that large. A lot can be accomplished if the partners are committed.

Nonetheless, growth does require the introduction of some structure; how this evolved at the school level is described later in this report. After 18 months of operation, the Steering Team decided to incorporate the Partnership for Resilience as an Illinois non-profit. Three years in, a federal tax exemption was obtained. However, even as the budget has grown, the ethos of operating with minimal bureaucracy and maximum buy-in and participation by the partners has been maintained.

Many, if not most, school-community partnerships can continue without formal incorporation if a lead sponsor takes on the legal and financial side of the work. This is the case in Decatur, Elgin, and the emerging partnership effort in southern Illinois. Strong leaders working around an agenda they build and care about can make significant progress in addressing trauma and adversity.

Supporting the Whole Student: Healthy and Ready to Learn

At the start of the Partnership for Resilience's work, access to care and meeting primary health care needs were identified as key areas of concern for the three inaugural school districts. The Partnership worked closely with the districts to find solutions to their concerns. In some cases, it leveraged resources that already existed in the community and in others it developed new partnerships.

The Partnership has begun to develop the capacity of schools and health providers to work together as a team that supports the health of the whole child. In the Southland, participating school districts are serving as hubs that weave health care services into the environment, while still promoting connections to medical homes.⁸ The Partnership's experience demonstrates how primary health care can generate early wins as school districts begin to address trauma and adversity. The following are core elements of the Partnership's health work: Assessing Each Community's Health Assets, Needs, Opportunities and Barriers; No Two Look the Same: Directing Initial Implementation with Intention; Once You Know Where You Plan to Start, Assemble a Health Team; Guideposts to Success as the Team Starts Work; The Power of Partnership; and Using Data and Learning Across Districts.

Assessing Each Community's Health Assets, Needs, Opportunities, and Barriers

Every community differs in its distribution of health problems, local leadership, existing resources, political realities, and historical efforts to address health. This local context determines which health issues to act on and through which approaches. The first step of the Partnership's health work was to conduct a community assessment, exploring the health assets, needs, opportunities, and barriers facing each of the school districts. Over 50 one-on-one conversations informed an assessment report and accompanying recommendations for action steps. This assessment process collected information and community voice, developed buy-in from stakeholders, and identified high-potential leaders.

Health Care Impacts

Asthma

Of the 37 students accessing asthma van services, 97% have not had an ER visit and 83% have <5 days of school absences which represents a significant reduction (Calumet Park District 132).



Dental

Of the initial 212 students screened, 111 needed restorative dental, including 356 cavities, 41 extractions, and other procedures. An impressive 86% of students screened followed their restorative care through to completion (Calumet Park District 132).



Immunizations & Physicals

By the 2017 state-mandated deadline, one district achieved 100% compliance on physicals and immunizations (Ford Heights District 169).



Access to Care

1500 students have received some level of school-based medical care over 18 months, largely supported by Medicaid (Calumet Park District 132).



In the Southland, the initial conversations surfaced overlapping challenges: behavioral health, oral health, asthma, vision, physicals and immunizations, and health education for students and families, with priorities varying by community. The conversations also surfaced assets in the community, including a Cook County Health and Hospitals System clinic that was physically next door to—but did not have a formalized partnership with—one district, a mobile care provider interested in expanding services in the Southland, and others.

No Two Look the Same: Directing Initial Implementation with Intention

No two implementations look the same. Participating school districts independently prioritized which challenges they would act on first and decided how quickly they would proceed. Despite the fact that these districts are close geographically, they differ widely in school culture and community resources; these differences meant that implementation differed according to local context. For example, the focus of the health work in Ford Heights District 169 was on formally connecting the district to a Cook County Health and Hospitals System clinic that is in walking distance of the school. Other districts without local assets pursued partnerships with mobile health care providers. The Partnership's role has been to make connections and foster relationships between the districts and the providers.

The cadence of listening first, prioritizing, and working collaboratively to piece together leadership and assets in response undergirds the Partnership's approach to implementation. In contrast to approaching school districts with a suite of services and seeking adoption, the Partnership supports locally guided and differentiated action over time—even as capacities and priorities evolve.

Once You Know Where You Plan to Start, Assemble a Health Team

Once participating school districts were clear on which need was their priority and which approach they would take to address it, it was time to assemble the right team.

Because the long-term objective is to build integrated partnerships for the health of the whole child, the ideal Health Team has school staff and community and



During their initial visit to Burr Oak Elementary, optometrists found that 60% of the students they screened needed vision correction. Above, students celebrate after receiving their first pairs of eyeglasses.

health partners that connect regularly and collectively take responsibility for health outcomes. Health Teams are an effective mechanism for planning, incubating ideas, addressing barriers, and sustaining and scaling what is working. Health Teams are ideally organized by school district—or, in a large school district, school by school—and are made up of key stakeholders (such as district or school administration, school nurses and other relevant school personnel, and external health providers) with early actions developing the capacity and cohesion of the team.

In the Southland, Health Teams were initially organized in two participating school districts and met every four to six weeks. Humor and food went a long way. The teams set targets, celebrated when those targets were met, and discussed tactics when results fell short. Regular, face-to-face meetings supported accountability, with participants within and outside the school feeling pressed to complete the tasks they had taken on before the team convened again. The Health Team structure provided a forum for new staff to learn and for processes that worked to be codified, supporting continuity in a high-turnover environment. The two Health Teams served as incubators for the other districts.

In practice, the priority is to find the least-intrusive method for launching the work in a given context. In many cases, this may not be a Health Team at the start. Some locations may have structures already in place that may be sufficient to begin the work (for example, a district where school nurses have a history of working across the district and partnering). Other locations may find the logistics of regular Health Team meetings

challenging, particularly in districts that are large and diffuse.

Guideposts to Success as the Team Starts Work

Include Decision-Makers

Where it is possible to build a Health Team, including both executive decision-makers and direct service providers is important for effective action. This usually means administrators who can make decisions, school nurses and counselors, health care providers, and other support staff who participate in relevant core processes.

Involve a Third Party or Neutral Facilitator, If Possible

School and medical cultures can be quite different, and relationships are critical to addressing barriers as they arise. A third party or neutral facilitator—one who is neither from a school nor a health care provider—can help facilitate progress and nurture relationships between the fields. This intentional broker can coordinate, troubleshoot, and translate between sectors to ultimately nurture a culture of collaboration and success among Health Team members.

Find the “Right” Provider Partners

Based on experiences in the Southland, assets to look for in a health care partner include:

- **Commitment to the particular community.** Partners built relationships with participating school districts with a long-term view, rather than framing it as a short-term transaction.
- **A track record of partnership.**
- **Shared interest or mutual benefit.** For example, Cook County Health and Hospitals System’s Cottage Grove Community Health Center was looking for new pediatric and adult patients, which a partnership with Ford Heights District 169 could help achieve.
- **An understanding of how school districts work—and that “how things work” can be frustrating.**
- **Flexibility.** For example, one asthma care provider modified their requirement of parent attendance to include grandparents and designated family members, allowing more students to be seen.

Generate Early Wins

During the Partnership’s planning stage, a common theme expressed across all districts was the need for dental care. In response to this need, a Partnership staff member contacted a mobile dental care provider with a long history of serving Chicago students. Interestingly, this provider—Mobile Care Chicago—had wanted to expand its service area into the Southland and had previously attempted to reach out to several districts with little success. The relationships that the Partnership had developed with the Southland districts through the planning phase helped open the door for a partnership with Mobile Care. The big reveal of this potential partnership happened at one of the first formal Partnership meetings: the Mobile Care dental van was parked outside of the meeting site and excited administrators and teachers were invited for a tour and discussion of how their districts could participate. Three years later, Mobile Care is successfully collaborating with six of the Partnership’s seven Southland districts.

Articulate Expectations Clearly

The Partnership supported the signing of Memorandums of Agreement between health providers and participating school districts setting out clear expectations and roles.

Invest in Understanding Medicaid Reimbursement

In the Southland, working with partners experienced in understanding and billing Medicaid was an important early step. Early data revealed that substantial numbers of students being served were eligible for insurance yet were uninsured, notwithstanding Illinois’ universal child health insurance policy. Ensuring that all eligible families are aware of and enrolled for benefits is critical, not only for students to have access to care but also to maximize Medicaid reimbursement for providers. An enrollment specialist has been engaged to work with one of the Partnership Health Teams to pilot strategies aimed to increase enrollment.

The Collective Power of Partnership

The Health Team structure supports school districts and health providers in collectively finding solutions to barriers that might have confounded each one working alone. Partnerships have strengthened as both providers and school staff have witnessed the others’ commitment

Highlighting Success: Developing a Universal Consent Form

The Health Team at Calumet Park District 132 identified the parent/guardian consent process as a significant challenge and barrier to reaching children in need of services. Passing out and collecting consent forms from several outside providers was burdensome for school staff and confusing for parents.

Members of the team, which included health care providers, decided to work on creating an innovative *universal* consent form that would include the critical language required by each provider, be easy to read for parents, and include a way to easily opt out of unwanted services.

After nearly a year of regular meetings and emails between the Health Team, partner health care providers, and their respective legal teams, a universal consent was successfully completed by the start of the 2017-2018 school year. The simple forms were distributed during registration, and **resulted in more signed consents in a single day than the district had collected in the entire previous year.**

To see a copy of the universal consent form, please contact the Partnership for Resilience.

to shared goals. Health providers have shared with the Partnership their greater willingness to “stick with it” and work through problems in one participating school district because they have witnessed the power of partnership in another.

A team taking accountability for health as a whole, rather than individual health care transactions, makes priorities and barriers to tackle clearer. Districts where Health Teams meet monthly serve as laboratories for innovation, as the team structure provides a natural venue for trying new things and continuous improvement. For example, one Health Team has developed and is implementing a universal consent form (see above) as well as a data-sharing tool.

Matt Seimer, Executive Director of Mobile Care Chicago, has been particularly impressed with the way partnership has significantly boosted outcomes for kids. As he shared, “[One Partnership district] is doing unprecedented work in dental that speaks to their level of commitment and engagement with parents. Chicago Public Schools have the same proportion of need, and typically get 10% of consents signed for restorative care. Here, they literally got 100%.”

Using Data and Learning Across Districts

The practice of looking at data to set goals and reflect on progress has helped the Partnership’s Health Teams focus their efforts, understand student needs, take effective action, and communicate the work’s impact. The comprehensiveness with which data are used has evolved with time.

A data dashboard was developed by one district’s Health Team to enable them to more effectively set goals and reflect on progress. The dashboard tracks a range of indicators including infrastructure (health teams, memoranda of understanding, and provider partnerships), health insurance enrollment, consents obtained and services delivered, impact on student health (such as reduced emergency department visits), impact on student attendance, and impact to the health care providers (such as numbers of new patients). Obtaining data can be slow and tricky, and the Health Team structure has allowed the district and providers to address collection challenges collectively.

Data from the dashboard has proven extremely useful for the Calumet Park Health Team, allowing them to celebrate the fact that their students who had received school-based dental services over a two year period had significantly less (33%) need for repeat restorative care. This finding has encouraged them to explore answers to the high number of eligible but uninsured students providers were seeing.

Calumet Park data also illustrates the incredible need of students in the Southland. At their first visit, three optometrists screened 77 students at Calumet Park. Out of these students, 60% needed glasses and 19% were referred for follow-up care with a vision specialist. Ageless Eye Care has scheduled additional appointments to provide service to another 143 students. All the students who needed glasses were able to choose their glasses the day of the screening and have them delivered within the month.

The Partnership also networks participating school districts and shares learnings where there is capacity to adapt it to the local context. Experience in one district fosters action in others. For example, one district set plans to migrate its dental services to mobile vans after seeing another district's data on restorative dental care and its impact. Similarly, multiple participating districts are exploring the use of the universal consent form.



It is easy to see why the Partnership gets results that others don't. What they're able to do is infrastructure building: creating plans busy people can follow, building accountability mechanisms so people feel they need to get their work done, connecting to issues that come up every day like suspensions and attendance.

— *Matt Seimer*
Executive Director
Mobile Care Chicago



Health Successes and the Classroom Experience

Partnership districts have realized many successes for their students, including:

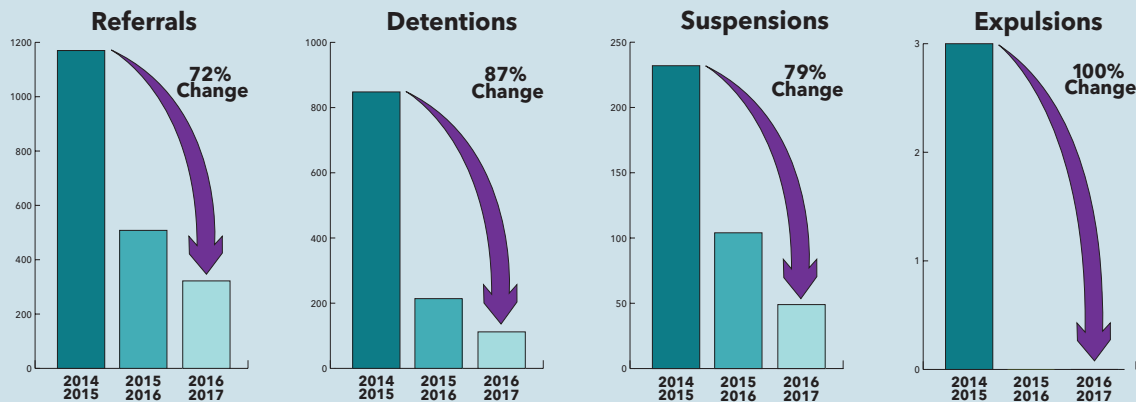
1. The development of an innovative universal consent form that dramatically increased student access to medical services.
2. School-based access to vision care for students, 60% of whom needed and received eyeglasses as a result of their school-based screenings.
3. School-based access to comprehensive dental services, with 85% completion rates for students who were identified as needing restorative care.
4. Achieving a 100% physical and immunization rate by the state-mandated deadline in 2018, ensuring that no students in that district would miss learning time due to unmet medical requirements.
5. A reduction in school absenteeism due to asthma thanks to school-based services provided by an asthma van.

As the work of the Partnership grows, districts will have more data from which to draw when iterating and improving their health practices. In these early years, teachers have shared anecdotal evidence about the changes they have seen in their students receiving health care services: students who have had their vision, dental, and/or other needs met seem to be more alert in class and are in class more often. These developments fuel teachers' growing excitement for and trust in the work.

Building Trauma-Sensitive Systems Within Schools

Calumet Park School District 132 Results

Discipline



Academic Outcomes

Students made statistically significant gains in English and math across all grades K-8 in years one and two, correlated with the Partnership's work.

Resilience brain research is applicable everywhere but holds particular promise if applied consistently and broadly for children growing up in poverty. This means changing school environments because, as trauma-sensitive schools expert Susan Cole notes, “schools are children’s communities.”

Adapting or redesigning schools, however, can be a long and very challenging process. Public schools in high-poverty districts are often hectic environments—struggling to keep up with day-to-day operations, budget constraints, changing regulations and mandates, and high turnover in leadership and personnel. School staff often experience secondary trauma or are surviving their own trauma and need care themselves.

The Partnership has engaged in a process that meets districts and schools where they are, working collectively with school and community partners to create trauma-sensitive and resilient communities of care for students, parents, and staff. The process is predicated on systems change and takes a patient, capacity-building approach to changing school and classroom culture.

The core elements of the Partnership’s approach to capacity-building are covered in the following sections: Assessing Readiness, Identifying a Cadre of Leaders, Organizing Structures That Can Drive Change and Learning, Using the Structure for Power and Action, Overcoming Real-World Resistance, and Using Data and Learning.

Assessing Readiness

Readiness is an important element to consider when selecting school or district partners for a resilience initiative. A school or district’s readiness will play a big role in its level of success. When choosing its initial districts, the Partnership considered need along with the following readiness factors:

- **Collaborative relationships** between what the Consortium for Educational Change (a partner in the work) terms the “three anchors”: the board of education; administration, including the superintendent; and teachers, particularly the union representative or a representative group.⁹

- **A culture** that values social-emotional learning. In the Southland, several participating districts worked on building a community of care for students, faculty, and staff through a grant-funded program with Vanderbilt University's Dr. Joseph Murphy in years prior to the launch of the Partnership.
- **Strong staff leaders** and several staff members who demonstrate a sense of mission about addressing trauma and adversity.
- **Proximity** of the school district—or in the case of larger districts, proximity of individual schools—to other participating districts to enable networking among participants.

Identifying a Cadre of Leaders

When beginning resilience work with a district, it is important to identify a cadre of existing and potential leaders and to build trust with that group. The goal is to work with a group rather than one or two leaders, particularly in high-poverty school districts that often have high attrition rates. Finding a group of the right leaders from the start may not be realistic, but even finding one is a good start. According to Dr. Karen Peterson, a member of the Steering Team and a guiding force for the Partnership, “Once you have some believers—even one person with a vision—you have the hook to begin.”

Early trainings, including active reflection on brain research, school culture, and organizational change theory, are a way to cast a wide net to find high-potential leaders. Those who buy in at trainings can be engaged to help find other leaders. At the beginning, the Partnership experimented with trainings of varying length. It was found that three days of training early on was enough time for participants to grasp the material, grapple with what changing the system could mean, network with one another, and reflect on how to apply the learnings and develop action plans.

In the early trainings, it is important that the school or district groups include a cross-section of roles (see the upcoming description of Resilience Teams for recommended roles to include). The group should include individuals with both an evidenced commitment to trauma-informed work and an awareness of district-level dynamics.

Trainings also offer a forum to begin to build relationships and trust. In the Southland, as small teams



After the Partnership's training, Thornton Township District 205's Resilience Team organized and delivered their own orientation to staff.

of leaders emerged, coaching and investing in their growth became possible. Creating a trauma-sensitive school environment is an opportunity for professional growth for participants, but it is also an opportunity for personal growth. During Partnership training sessions, participants reflected not only on the next steps they would take in their official roles but also on what they, personally, wanted to learn more about.

Organizing Structures That Can Drive Change and Learning: Teams and Networks

In creating trauma-sensitive schools, new structures are needed to promote change and learning. Over time, the Partnership developed the following four organizing structures to foster action and accountability and to enable “support and challenge”—a model for coaching and adult learning that allows a small team to effect action in a large group.

Resilience Teams

Resilience Teams represent a cross-section of the school district and are the Partnership's core structure to build capacity for ongoing work. A Resilience Team usually starts with a staff of 5–10 who are committed to being vision keepers and drivers of change to make their school trauma sensitive. They include a minimum of one administrator, one teacher leader representing the union or association, and one professional support person who might be a social worker, nurse, or counselor. All team members participate in a three-day Resilience Team training to become familiar with



Lincoln School (Dolton Riverdale School District 148) parents participate in a Restorative Justice Peace Circle during a Parent Advisory Committee Meeting.

childhood trauma and practical ways schools can address it.

Resilience Teams hold regular in-district meetings and create an action plan for the district using the Flexible Framework (from the Trauma and Learning Policy Initiative, in collaboration with Harvard Law School).¹¹ Though plans are differentiated by district, they usually define the structure for the work and include building awareness and knowledge for all staff through professional development, establishing external partnerships, data collection and continuous improvement, and coordination with other district initiatives. Some of the Partnership's school districts have adapted the Resilience Team structure to building-level teams or ensure that every building is represented in their Resilience Team.

Through ongoing in-district meetings, each Resilience Team drives action for its district to achieve the goals in its action plan. Over time, integrating trauma work into district initiatives—rather than viewing it as an add-on—is crucial to changing the culture. For example, Ridgeland School District 122 leaders are facilitating the integration of trauma-sensitive practices into their existing committee structure across the district.

Resilience Teams also meet collectively across districts three times a year in a Professional Learning Community (PLC) format and for a one-day end-of-the-year debrief and planning session focused on analyzing the year's work and planning for the

upcoming year. At each PLC, Resilience Team members across districts share their experience and lessons with one another to network and learn, and they report out in a standard format fostering accountability.

District Liaison Teams

District Liaison Teams are small groups—usually two people—from the district with passion to build a trauma-sensitive system and the capacity to lead others. This team meets monthly across districts and is a regular, systematic structure to lead the work. District Liaisons surface challenges and opportunities and reflect on progress against annual goals for the district. These inform the content of Resilience Team PLCs. One new resource is presented at each Liaison Team meeting, such as mobile financial literacy assistance. The District Liaisons bring information and resources back to the district's Resilience Team to determine what to implement and how to move forward.

Cross-District Subcommittees

Cross-District Subcommittees are based on the priorities set by each Resilience Team. In the Southland, some participating school districts chose to act rapidly on primary care, whereas others began quickly with teacher self-care and moved more slowly in other areas. Instructional leaders and teachers may participate in classroom strategies subcommittees while nurses, counselors, social workers, and administrators

may participate in primary and behavioral health subcommittees. Subcommittees include representatives from the Resilience Team with particular interest and leadership in the topic. Subcommittees tackle both content and process, and they define, lead, reflect on, evaluate, and continuously improve action on defined topics that emerge from Resilience Team goals.

Sessions with Top Administrators

A year into the work, the Partnership realized that promoting true culture change should involve district administrators more directly in the work being done by their Resilience Teams. Since all districts hold monthly administrative team meetings, the Partnership arranged to attend and present at an existing administrative team meeting at each school district at least once per school year. During these sessions, Partnership staff present an overview of the Partnership and the work in the Southland, share research, and discuss the importance of the administrator's role in developing trauma-sensitive schools. Representatives from the district's Resilience Team then present the district action plan and discuss the administrator role in achieving the goals.

Tips for Increasing Attendance and Engagement

From experience, the Partnership has identified some tips to increasing attendance and engagement: host meetings at school districts whenever possible; conduct collective calendar reviews to ensure meetings do not conflict with testing schedules, school board meetings, and other events; collect and review feedback regularly to sustain improvement; and ensure that meetings have an appropriate frequency so that time together is valued and put to good use.

Using the Structures for Power and Action

The structures the Partnership has put in place in participating districts have proven effective in fostering action. They help build broad awareness of childhood trauma, enable coaching to support the differentiated actions of individual schools, and network the districts in a way that fortifies the work.

Awareness

In their action plans, Resilience Teams have chosen varying approaches to building awareness. The most successful teams have used structured, ongoing



Teacher self-care workshops have been conducted in many participating districts.

professional development rather than ad hoc trainings. Some districts have regularly trained whole buildings, including custodial and cafeteria staff, to ensure broad, foundational knowledge in spite of staff turnover.

For example, after two years of broad-based trainings, the Resilience Team in one participating district launched book discussions on Susan Craig's book *Trauma-Sensitive Schools*: "Our entire staff is reading the book and presenting it. For staff new to the school, participating in a two-day foundational training and then joining the book group allows them to join those who have been working at this for three years, but with everyone still learning."

The investment in broad-based awareness through training and active reflection contrasts with change efforts that implement a new strategy as the first step. In the experience of the Partnership, this patient investment in awareness has been critical for schools to successfully change the environment and integrate new knowledge into how they operate.

Coaching

Research demonstrates the power of in-the-moment coaching to change behavior. The structures described above, and the Subcommittee structure in particular, enable Partnership staff to coach schools through the uncertainty of how to start and how to achieve consistency in practice. Resilience Team members—administrators, teachers, support staff—regularly call on Partnership staff as they try out new actions and approaches within their schools.

Networking

Resilience Team PLCs and District Liaison meetings have proved powerful forums to network school districts. Through these forums, successful ideas spread, energy and enthusiasm build, and progress from one school district spurs action in others.

When participating school districts convene, time is set aside for networking and problem solving; meaningful relationships build and leaders serve as guest speakers at other districts' professional development days. Partnership staff actively connect leaders across districts tackling similar strategies or challenges.

Overcoming Real-World Resistance

The Partnership's approach draws on best practices in building broad coalitions for change. In participating school districts, professional development includes organizational change theory and action planning covers process and content together. The approach is patient. Progress is, in the words of one Partnership member, "two steps forward, one step back, but an upwards spiral."

The Partnership pays keen attention to signals of engagement, including meeting attendance and completion of paperwork, when Resilience Teams attend and respond to feedback forms with detailed descriptions, or when participants put up their hands to host the next District Liaison meeting or present at the next Resilience Team PLC.

The Partnership pays equally close attention to signals of disengagement: if leaders or teams miss a networking meeting, follow-up is immediate. The administrators, teacher/union leaders, and staff participating in the work have a lot on their plates. The relationships that have been built over time help the Partnership identify the reasons behind disengagement, and then build on strengths. The support and challenge approach means

making ongoing contact, planting seeds, and making suggestions in a positive context.

In light of turnover, the Partnership invests regularly in emerging leaders, identifies needs not being met, and encourages new leaders to join the work. When a district experiences turnover at multiple levels at once, for example school board and administration, conducting individual meetings to identify new leaders and interests becomes central once again. Partnership staff regularly review district-by-district progress, looking at the core group's likelihood to succeed in the context of changes in the school board, administrative staff, and other factors.

Using Data and Learning

The sophistication with which data are used can evolve over time. Early on, developing feedback loops that were quick and easy helped school districts improve and generated energy by making successes more tangible.

As the PLC forum was launched, Resilience Teams used it to report their annual goals and how they would measure them. In the Southland, this was locally guided

with each district articulating their priorities and measures, aligning to data already collected where possible. One district decided to analyze its School-Wide Information System (SWIS) data trends on behavior and attendance and conduct a district-wide survey to measure educator quality of work life and stress management. Another focused on an American Federation of Teachers union survey on job satisfaction, local assessment

data on student growth, teacher and student attendance, and incidence of parent participation.

Three years into the work, the Partnership has engaged an external evaluator to analyze cross-district measures. In addition, the Partnership has provided small stipends to designated Data Coordinators within each district to better support their growing data efforts.



This was the answer to why our students' behavior had become so volatile and unpredictable over the past several years. The introduction to ACEs and the training was my "aha" moment. It transformed my approach to working with students.

— Sherri Sera

Teacher and Association President,
Blue Island District 130



Looking Ahead



Parents and teaching staff at Harnew Elementary (Ridgeland School District 122) discuss how they can increase parent engagement and deepen relationships.

Since its beginnings in 2015, the Partnership has expanded from three to seven school districts in the southern suburbs of Chicago and is initiating a new Resilient Southern Illinois effort in the Illinois Delta region. In addition to expanding the number of schools and students it reaches, the Partnership is deepening and embedding its work in a number of ways:

- While good progress has been made in **family and community engagement** (FACE), this aspect of the work must be improved and accelerated. Research-tested programs, such as the Parent Mentor Program and the Triple P—Positive Parenting Program, are being introduced in a number of school districts and FACE teams are being started in others.
- Research by the University of Illinois at Chicago School of Public Health has documented the paucity of mental health resources in the Southland, including in its schools. The Lurie Children’s Hospital Center for Childhood Resilience and Governors State University College of Education are partnering with the Partnership to **expand the behavioral health supports** available to Southland students.
- The Partnership is working with school leaders and teachers to help them **integrate trauma-sensitive practices** more consistently into classroom practice. This is slow but essential work after decades of focus on “academic press” alone.¹⁰

- Finally, to be sustainable, the Partnership is exploring how school districts might hire Resilience Coordinators to facilitate the expanding work within their schools and with community partners. The long-range goal is for resilience work to become part of a district’s structure and culture rather than dependent on specific individuals.

As Laura Porter, Co-Founder of ACE Interface, has said, we are only now beginning to understand “the magnitude of the solution” that is at hand. That sense of possibility and hopefulness continues to inspire and animate the work of the Partnership for Resilience.



Over the last two years, thanks to the Partnership for Resilience, Illinois teachers and support staff understand what Adverse Childhood Experiences mean for students’ ability to learn in school and achieve their true potential. We’ve learned when those needs are addressed, our students can flourish, their grades improve, their self-confidence increases and their outlook on life—as well as the quality of their life—improves.

— Kathi Griffin
IEA President



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*Nine times out of ten the story behind
the misbehavior won't make you
angry. It will break your heart.*
— Annette Breaux



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Endnotes

1. 2011/12 National Survey of Children's Health at <http://www.childhealthdata.org/browse/survey/results?q=2614&r=1&g=448> and <http://www.childhealthdata.org/browse/survey/results?q=2614&r=1>.
2. <https://www.the74million.org/article/the-shrinking-of-the-grand-old-school-districts-and-the-new-geography-of-suburban-poverty/>, figures courtesy of Elizabeth Kneebone and Alan Berube, The Brookings Institute.
3. Vincent J. Felitti et al., (May 1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245–258.
4. For background on the Community Schools model, see http://www.communityschools.org/aboutschools/what_is_a_community_school.aspx.
5. See <http://edredesign.org/by-all-means>.
6. In the Southland, startup funds came from the Steering Team. In southern Illinois, funding comes from sponsors and a large philanthropy.
7. For more on relational meetings, see <http://www.industrialareasfoundation.org/sites/default/files/individual%20meetings.pdf>.
8. A medical home is an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. A medical home extends beyond the four walls of a clinical practice. It includes specialty care, educational services, family support and more. <https://medicalhomeinfo.aap.org/Pages/default.aspx>.
9. Consortium for Educational Change: An Explanation of CEC's Theory of Action. (June 2015). See <https://www.cecweb.org/wp-content/uploads/2016/12/CEC-Theory-of-Action-Formatted.pdf>.
10. Helping Traumatized Children Learn: A Report and Policy Agenda. (2005). See Chapter 3 on the Flexible Framework.
11. Joseph Murphy & Daniela Torre (2014). *Creating Productive Cultures in Schools: For Students, Teachers, and Parents*.



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