

TESTIMONY

Human Services Committee

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Chairman Hogan and members of the Human Services Interim Committee – My name is Heather Simonich, PATH Operations Director for Eastern North Dakota. On behalf of the Department of Public Instruction (DPI), I am here to provide information regarding the impact of child traumatic stress on mental health and consequently children’s ability to learn. Additionally, I will provide a brief overview of the professional development curriculum that was recently developed to improve our educators understanding of traumatic stress and how it manifests in the classroom.

One out of four school children has experienced a traumatic event (NCTSN School Committee 2008). A traumatic event is different from run-of-the-mill stressful or upsetting events in several important ways. First, it poses a real or perceived threat to the life or well-being of the child or someone close to the child (such as a parent, grandparent, or sibling). Second, it causes an overwhelming sense of terror, helplessness, and horror. And finally, the body generally reacts to this threat automatically with an increased heart rate, shaking, dizziness, and rapid breathing due to the release of stress hormones like adrenaline and cortisol. This stress response is often referred to as our “fight, flight or freeze” response. Traumatic events may include child maltreatment experiences (e.g., sexual abuse, physical abuse, neglect) and/or other types of traumatic events (e.g., life-threatening car accident, witnessing domestic violence, a natural disaster, or exposure to community violence).

Child traumatic stress refers to the physical and emotional responses of a child to these life threatening situations. Traumatic stress reactions may become problematic when they begin to interfere with normal functioning and development. Although most children are extremely resilient, some children (about 1/3) may have traumatic stress reactions that significantly interfere with everyday functioning at both home and school. For many children the effects of early trauma exposure are compounded by additional stressors (e.g., discrimination or poverty) or household dysfunction (e.g., living with a caregiver with significant mental illness and/or addiction problems, having an incarcerated family member). Children exposed to trauma before the age of five and at the hands of their caregivers (i.e., complex trauma) are at greatest risk for negative outcomes.

The evidence regarding the impact of early childhood trauma and school functioning is clear. Research demonstrates that children who experience trauma are more likely to have:

- A lower GPA (Hurt et al., 2001; Beers & DeBellis, 2002)
- Higher rate of school absences (Beers & DeBellis, 2002)
- Higher likelihood of drop-out (Grogger, 1997)
- More suspensions and expulsions (Eckenrode et al., 1993)
- Decreased IQ and reading ability (Delaney-Black et al., 2003)
- Significant deficits in attention, abstract reasoning, long-term memory for verbal information (Beers & DeBellis, 2002)
- Special education services (Shonk & Cicchetti, 2001)

Unfortunately, less than 10% of the children that could benefit from mental health services ever make it to the door of a mental health facility. Many children who are suffering from child traumatic stress never receive a diagnosis of Posttraumatic Stress Disorder (PTSD), but rather an

extensive list of diagnoses such as: Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder, Bipolar Disorder, and/or Reactive Attachment Disorder (RAD) just to name a few. These diagnoses generally do not capture the full impact of trauma and often lead to ineffective treatment and educational planning because they never get us focused on the root of the problem – traumatic stress.

Exposure to chronic trauma causes the body's alarm system to be easily triggered, releasing stress hormones that interfere with the ability to reason and activate that flight, fight, or freeze response. Children cannot learn when living in a constant state of fight, flight or freeze – our brains are simply not wired to take in new information when this stress response is activated. Rather, the goal is to survive. Recent neurobiology studies strongly suggest this overactive stress response in children exposed to chronic trauma has the potential to derail healthy brain development and ultimately lead to numerous negative mental and physical health outcomes.

The Adverse Childhood Experiences Study (ACE; Felitti et al., 1998) asked a large sample of middle-class adults from San Diego, CA that belonged to the Kaiser Permanente Health Care plan about 10 categories of stressful childhood experiences. They found the number of adverse childhood experiences (ACEs) a person reported showed a graded or dose-response relationship to the presence of many adult diseases including heart disease, cancer, chronic lung disease, obesity and liver disease. In other words, the higher a person's ACE score, the higher the risk of several of the leading causes of death in the United States. Interestingly, one study demonstrated that people with six or more ACEs died an average of 20 years earlier than those without ACEs (Brown et al., 2009). The ACE study demonstrated early childhood trauma and adversity is not just a mental health problem but a physical health problem as well.

These children are in our classrooms. Every year. In every city. Big or small. Yes, even in North Dakota. They come to school every day looking for someone who will acknowledge what they are going through and offer to help them out. They need schools to be on their side and help them *feel* safe. They need teachers and administrators to understand that their challenging behavior is a cry for help, even when it seems to be a personal attack or an act of defiance. They need educators that know enough about trauma to accommodate their needs and partner with them to acquire the coping skills they need to be successful at school. They need administrators and legislators that recognize the need for consistent social emotional curriculum and value it as much as any other academic curriculum. They need teachers who feel supported and have access to “behavioral interventionists” or “coaches” to help them manage student behaviors that challenge our most experienced and knowledgeable teachers. They need school systems that are committed to engaging families because we know our best chance of helping these students involves helping their families. They need special education departments that are empowered to screen for traumatic stress as a possible explanation for learning difficulties because we will never know if we don’t ask. They need educators that have the courage and knowledge to make a strong referral for mental health care if they believe it is interfering with the child’s ability to be successful in school. Finally, they need communities that encourage collaboration and facilitate creative conversations about addressing the complex mental health needs of our most vulnerable children. These needs are critical for ALL students – not just students coping with the effects of traumatic stress.

Recently, The ND Department of Public Instruction in collaboration with Mid-Dakota Education Cooperative in Minot, made a significant commitment to creating schools that understand the impact of traumatic stress by funding the development of a 6-hour professional

development curriculum for elementary educators and a mechanism to train qualified trainers to deliver the training to local school districts. The broad goals of the curriculum are to 1) describe the effects of childhood trauma and its impact on student behavior and learning, 2) review trauma-sensitive strategies for educators, 3) discuss the impact of trauma on staff, and 4) describe a framework for creating a “trauma-informed” school culture.

In December, ten trainers from across the state participated in a 3-day intensive train-the-trainer workshop in Fargo. This group of trainers will continue to meet monthly over the course of the next year to continue their learning, share training experiences, and refine the curriculum. Preliminary feedback from educators and administrators has been overwhelmingly positive and there appears to be a high demand for such training. Ultimately, we will need more trainers as the goal is to deliver this trauma-informed curriculum to all elementary educators in the state of North Dakota. This type of professional development for educators is the first step in moving towards more trauma-sensitive schools which will improve our effectiveness in supporting and educating children with mental health needs.

Thank you for your time today and continued support for children’s mental health. I am incredibly grateful and humbled for the opportunity to speak with you today. I would be happy to answer any questions.
