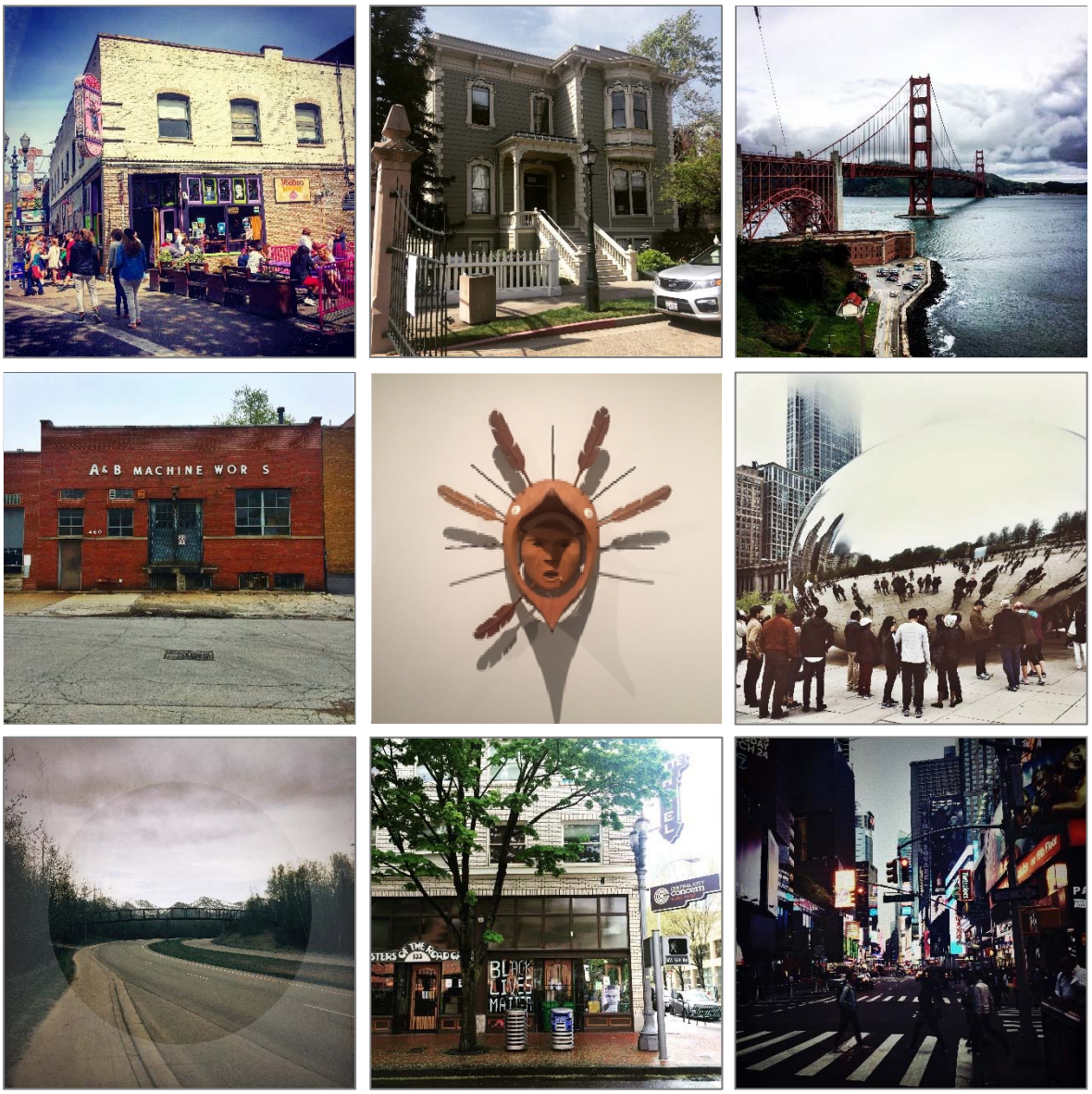


WINSTON CHURCHILL MEMORIAL TRUST

FELLOWSHIP REPORT 2016

Phil Light

Contents

Acknowledgements

Thanks to the Winston Churchill Memorial Trust for supporting the travel associated with this work. The opportunity to learn from others was hugely valuable and continues to be so as I integrate my learnings into the work we are doing.

Thanks to all of those people I met on my travels who were so generous of their time and knowledge.

Thank you to Dr David Jansen, Tereki Stewart, Carmel Ellis, and Dr Pip Anderson for their support at various stages of this work.

And last but not least, thanks to my family for their love and support.

Introduction

The main aim of this work was to increase my knowledge and understanding of different ways of delivering quality health and social services to children and young people.

This Fellowship was an opportunity to step back from my day to day work and reflect on what we are doing here in Auckland to deliver better services to children and their whānau. This report is a summary of what I learnt from the places I visited and from the things I read along the way.

As a manager within a health-focused NGO, I see tremendous potential both within our own organisation and across the sector to change the way health and social services are delivered. I work for an organisation that is innovative, highly skilled and passionate about delivering better services for vulnerable populations. We have the opportunity to develop and implement programmes and services which can make a difference for vulnerable children across New Zealand. Currently, I oversee an established school-based health programme (Mana Kidz) and a developing initiative addressing health and social issues for children and whanau in Papakura (Papakura Kotuitui). In addition, I have a leadership role as a part of a group leading the implementation of a Youth Health Model of Care in low decile secondary schools.

The intention of this work is to increase my knowledge and understanding of different ways of delivering quality health and social services to children and young people. I was particularly interested in exploring the following;

- Ways of developing strong partnerships within communities and between providers of health and social services
- Exploring alternative and innovative service models, particularly those that service high needs communities
- Understand how other organisations have engaged indigenous and/or migrant communities in the development and implementation of services
- Explore how organisations approach outcomes measurement in health and social services and how they evidence change/success
- Developing team-based care and data-driven management tools
- Supporting the ongoing development of people-centred primary care to deliver better services

On embarking on this project, I intend to broaden my own knowledge and experience, as well as tap into the knowledge and experience of others delivering effective programmes in other countries. Innovation 'flourishes at the intersection of diverse experience, whether it be others' or our own' (Dyer, Gregersen, Christensen, 2011).

This knowledge and experience will be directly applied to ongoing initiatives which I manage, specifically;

- Mana Kidz: a school-based health programme delivering free, comprehensive, nurse-led primary care services to more than 34,000 children across 88 schools in South Auckland
- Papakura Kotuitui: a new and innovative initiative incorporating school-based health services and social services to address social determinants of health and well-being in high needs children and their whanau.

A recent evaluation of Mana Kidz has shown that it is an important and effective programme that is making a substantial contribution to healthcare for vulnerable children. However, we know there are areas we can do better; deliver better services and deliver better outcomes. These kids deserve

nothing less than the best we can do. The opportunities to improve and build upon this strong platform is very exciting; we could make a huge difference in the health, social and education outcomes for thousands of young New Zealanders from communities with considerable disadvantages.

This project will develop new ways of working that will have wider application in the NZ health sector. Both Mana Kidz and Papakura Kotuitui are innovative programmes with considerable interest from other DHBs, Ministry of Health and the wider health sector. Learnings from overseas that can be successfully implemented within these initiatives will be shared across other projects and programmes.

I am hopeful of developing ongoing relationships with other experts and organisations to develop a mechanism for sharing information and knowledge on an ongoing basis. The opportunity to build international collaborations is exciting and would build a reciprocal sharing of information and success supporting long-term success.

Itinerary

Australia
Sydney – **Malpa project**
Canberra – **School Youth Health Nurse (SYHN) Program**

United States of America
San Francisco and Oakland –**REACH Ashland Youth Centre, Alameda County Center for Healthy Schools and Communities, California School-Based Alliance, Frontiers of Social Innovation**
Portland, Oregon – **School-based health centres, Milwaukie High School**
Anchorage – Southcentral Foundation re **Nuka System of Care**
Chicago –**Elev8 Chicago, Marquette Elementary**

Canada
Saskatoon –**In-school health clinics programme**
Toronto –**Model Schools Paediatric Health Initiative**

Importance of vision and outcomes

Measuring outcomes is critical as it enables us to provide evidence of what works and what doesn't, and why and how to improve effectiveness and efficiency.

One of the key takeaways from the Alameda County experience was the emphasis on vision and a broader concept of school health. Rather than simply focusing on service provision, the SBHC organisers provided clear outcomes goals with focus on results. A focus on service provision narrows the scope and loses partnership, veering from a holistic approach.

They ensure that providers are aligned with mission and vision; the alignment with the kaupapa is crucial element and leads to tough/honest conversations about what motivates the provider to deliver SBHC services.

Generally speaking though, most SBHC organisers were unclear on specific outcomes achieved by school-based health centres (SBHC). The key measurement tended to be in terms of number of people accessing services and wider service provision. Much of the focus in the US is on access to care and this is often a key measure of success in reporting.

However, as Marmot points out, equating health and health care access is not useful as the service accessed may be ineffective in improving health[1]. The key development is to have an outcomes framework with a set of indicators that clearly measure whether a service/s is having the desired impact.

In selecting measures, an indicator should[2];

- Be a good conceptual fit: there is evidence that the indicator specifically relates to a particular theme/outcome area/goal
- Be from a quality data source: the indicator comes from a reliable source with a valid methodology
- Capture the essentials: measure who, what, how much, how many and/or when
- Be achievable and measureable
- Be able to be tracked over time: if the indicator is used at different time points, it will indicate if change has or has not occurred. Benchmarks can also be established and compared to.

Some SBHC organisers used Results Based Accountability to evaluate the results of programmes.

Funding

SBHCs utilise similar funding approaches to sustain the clinics. This usually involves a base allocation from the regional health authority that is supplemented by grants and local funding. In the US, third party billing (insurance claims) can make up a significant component with anywhere from 5% to 55% of the funding required to maintain a clinic. Generally speaking, in the US context, Medicaid is the largest payer of third party payments.

In the New Zealand context, a number of people have questioned the current funding of primary care clinics if access (and health outcomes) is so poor. It is worth exploring a mechanism whereby

[1] Marmot, Michael (2015). The Health Gap: The Challenge of an Unequal World. Bloomsbury. pp72-73.
[2] From Muir, K & Bennet, S. (2014). The Compass: Your guide to social impact measurement. Sydney, Australia: The Centre for Social Impact.

school health services might be funded (to some degree) by the capitation payments that currently support primary care for the same population.

With more schools and communities requiring these services than we currently fund, exploration of alternate methods is a no brainer. It may be possible for a district health board (DHB) to provide seed funding (with the ability to meet certified standards) and then school communities themselves fund the rest of the services through other means (e.g. philanthropy etc).

If we can agree that SBHS are a key component of the primary healthcare system, we may need to look at the way providers are able to access funds to support the provision of these services.

Quality improvement metrics

Providers are contracted for three quality improvement projects specific to particular school communities. The provider defines these themselves. These incorporate specific metrics and clearly define what they intend to improve.

Examples are as follows;

Activity	Timeline	Measurable Outcomes
• Hold regular clinical health education appointments for students to receive nutrition education. • Ensure that all medical providers (including subs) know to refer students with elevated A1c blood test results to onsite health educator. • Continue with practice of warm hand offs and documented referrals to onsite health educator by medical providers. • Every quarter, monitor % of students meeting this goal and review during case conference or improvement team meetings.	• September 2015 – June 2016	Enhance and standardize clinical health education services for students who are at risk of obesity related chronic conditions, as indicated by BMI % (>95%) and A1c (>5.7). • Patients with BMI >95% and/or A1c >5.7 will meet with an onsite clinical health educator at least once for nutrition related counseling and goal setting (and/or be enrolled into an onsite nutrition education group). 50% of students with A1c >5.7 will reduce their A1c by 6/1/2016

Certification

A number of SBHC organisers use certification standards. Certification is useful in a number of ways including standardising the SBHC model by increasing emphasis on best practices, reducing site-to-site variability, increasing the ability to study clinical outcomes and increasing the potential for insurance reimbursement (which increases sustainability and service provision).

Examples include the *Oregon School-Based Health Centers: Standards for Certification*[3] which require providers to meet key minimum standards pertaining to operations/staffing, laboratory/diagnostic services, delivery of comprehensive services, data collection/reporting and billing.

Developing clear certification also provides a clear development pathway for SBHC providers to improve their service offering. It is particularly useful in instances where a range of providers are delivering SBHC services.

[3] This document can be accessed here: https://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Pages/certification.aspx

Some SBHC organisers have implemented certification that apply to the wider primary care sector. For example, in Portland, Oregon patient-centred certification is utilised. This certification comes from a Patient-Centered Primary Care Home Program worked which is used across the state to set the standards that determine what a recognized primary care home looks like. Core attributes of the certification include;

- **Access to care:** Patients get the care they need, when they need it.
- **Accountability:** Recognized clinics are responsible for making sure patients receive the best possible care.
- **Comprehensive:** Clinics provide patients all the care, information and services they need.
- **Continuity:** Clinics work with patients and their community to improve patient and population health over time.
- **Coordination and integration:** Clinics help patients navigate the system to meet their needs in a safe and timely way.
- **Patient and family-centered:** Clinics recognize that patients are the most important members of the health care team and that they are ultimately responsible for their overall health and wellness.

Further information can be found at http://www.oregon.gov/oha/pcpch/pages/index.aspx

REACH Ashland Youth Centre: Oakland, California

The Reach Ashland Youth Centre in San Leandro in Oakland, California is a community driven project that has seen the development of a purpose-built youth centre which delivers a range of programmes and services for local youth aged 11-14 years. All housed in the one place, young people have access to recreation (basketball, gym, boxing, dance), education support (including study support, credit recovery, college information/advice), arts and design (including purpose built studios for Visual Arts Classes and Digital Arts Classes), the county sheriff department, an onsite childcare centre and a café.

In addition, the wellness centre hosts a collaborative multi-agency Wellness team that supports the integration of health & wellness, social justice, and youth leadership into a range of programmes.

REACH Youth Centre provides a safe, supportive environment for young people to thrive.

The Centre's website is here http://reachashland.org/

This online video online gives a good summary of the centre:
https://www.youtube.com/watch?v=Nd8oISMqa5Y&feature=youtu.be

Portland, Oregon

Integration and relationships

Centrality of relational service provision was a common thread throughout the organisations. Providers of services noted strongly that developing relationships with the school community and the individuals within the school population is a fundamental factor to having positive health impact.

> *"Strong relationships are not a nice to have – they are a need to have"* David Ehrlichman

All people emphasised the importance of developing relationships with communities (including children and their families) as well as other service providers. It was notable that this was still an important development point for all service providers. It is clear that this is an ongoing process and requires intentional focus and resourcing to accomplish and do well.

The ability of children and young people to seek help with issues that are important to them in a setting in which they are comfortable and familiar is crucial. A number of people noted that in instances with a high turnover of clinicians, the service was considered to be less effective. Strategies need to be implemented to ensure that children and young people continue to feel connected.

> *"The single most important factor behind all successful collaborations is trust-based relationships among participants. Many collaborative efforts ultimately fail to reach their full potential because they lack a strong relational foundation" Jane Wei-Skillern*

COST: a strategy for integrating multiple resources within a school setting

The Center for Healthy Schools and Communities had developed a comprehensive toolkit to support integrating multiple resources within a school setting. It is a common theme both in the NZ and overseas that there is often a bewildering range of services available for children and whānau with a schools setting. Even within a defined population in the school setting, coordination of services is challenging.

A Coordination of Services Team (COST) is a strategy for managing and integrating various learning supports and resources for students. COST teams identify and address student needs holistically and ensure that the overall system of supports works together effectively.

A COST is a multidisciplinary team of school staff and providers who:

- create a regular forum for reviewing the needs of individual students and schools overall;
- collaborate on linking referred students to resources and interventions; and
- support students' academic success and healthy development.

What do COST teams do?	What is the COST make-up?
COST teams perform four major tasks: 1. Identify students through a school-wide referral system. 2. Assess referred students and explore strengths and supports needed. 3. Coordinate efforts to link students to appropriate supports, track progress, and tailor interventions over time. 4. Expand the learning supports at the school, make recommendations about resource allocation, and recruit new resources.	COST make-up varies by school. Possible members include: • Designated COST Coordinator • School administrators • School counselors • School nurse • School psychologist • Special education staff member • Teacher representatives for SST, IEP, 504 • Afterschool providers • Parent liaison • School Health Center staff • Social workers or clinical case managers • Other student or family support providers

From: Coordination of Services Team (COST) Overview

The toolkit would be worth both schools and service providers exploring. The COST toolkit is available from the School Health Works website:
http://www.achealthyschools.org/schoolhealthworks/tools---resources.html

It is important to measure the collaborative development also. This should sit alongside the outcomes framework and be part of any evaluator framework. Network efficacy measures can include communication, formal agreements (e.g. memorandum of understanding or letters of agreement and network participation.

Formal agreements with schools was considered to be fundamental for all SBHCs. This often extended to formalised relationships with district and/or regional education funders (the equivalent of NZs Ministry of Education).

In Toronto's Model Schools Paediatric Health Initiative, the schools are an integral part of a three way partnership with the funder, the provider and the school. The relationship is made simpler by the designation of the school as a 'model school' with a range of resources (health and educational) to support the school to address inequities.

In Counties Manukau, it has been apparent for some time that the existing informal relationships with schools are not ideal. Part of the challenge has been the inability to provide a long-term commitment to the school (due to funding constraints). Utilising a formalised agreement between the health service provider and the school will support the development of a strengthened partnership approach. This is likely to have positive effects on the integration of the service within the school ensuring improved access and facilitating better outcomes for children.

This is not a new idea; we have discussed this with providers over the past few years. The challenge has been priorities, workload and the uncertainty regarding sustained funding.

Policy and advocacy

Advocacy and policy work forms a significant part of the role of organisers (and funders) of SBHCs in the United States. This is largely the product of the unique funding environment in the US. However, there is an opportunity in NZ to influence policy and legislation to support the expansion of school health services and seek more funding to support more effective programmes. This may be linked to funding and developing a stronger, shared voice for school-based health services. In part, to ensure that funders see value.

A good service needs appropriate resourcing

A quality, patient-centred service requires an appropriate level of resourcing; both clinical and non-clinical. A quality service listens to the patient, the clinician and the manager.

You need to invest in capacity and capability for;

- Service brokering
- Engaging the customer (internal/external)
- Quality improvement
- Process improvement
- Information and knowledge management

Behavioural and mental health

One of the strong themes across the trip was a significant emphasis on behavioural (mental) health with some reporting that over a quarter of the presenting issues were related to students' mental health issues – including developmental and behavioural issues, learning difficulties, and emotional well-being. There simply isn't this level of activity in the school clinics we work with in New Zealand which means we are missing a key opportunity to meet an important health need for children and young people. Further, the work is highly integrated with other health activity (and with school communities) which is more effective in achieving outcomes for children and young people.

There is a growing understanding that childhood trauma impacts the academic, mental health and general well-being of children and young people, and school-based health initiatives are important

vehicles for improving the well-being of our children. School-based health providers offer a safe space for children to access mental health care services.

The ongoing longitudinal Adverse Childhood Experiences Study of adults has found significant associations between chronic conditions; quality of life and life expectancy in adulthood; and the trauma and stress associated with adverse childhood experiences, including physical or emotional abuse or neglect, deprivation, or exposure to violence.

The ACEs study looked at the association between self-reported adverse experiences (abuse, neglect, exposure to violence, etc.) and current health status. It found that the more such experiences a child had, the greater their chances of having health problems such as heart disease, diabetes, COPD or cancer during their adult years.

Recent research assessed the prevalence of adverse childhood experiences and associations between them and factors affecting children's development and lifelong health. Studies have found lower rates of school engagement and higher rates of chronic disease among children with adverse childhood experiences[4].

Bethell et al (2014) note that 'paying special attention to children at risk of adverse childhood experiences may yield both immediate and long-term benefits'.

Menschner and Maul (2016) outline why trauma-informed approaches to care as valued; *"Trauma-informed care acknowledges the need to understand a patient's life experiences in order to deliver effective care and has the potential to improve patient engagement, treatment adherence, health outcomes, and provider and staff wellness. A set of organizational competencies and core clinical guidelines is emerging to inform effective treatment for patients with trauma histories, but more needs to be done to develop an integrated, comprehensive approach that ranges from screening patients for trauma to measuring quality outcomes."*[5]

Organisational	Clinical
• Leading and communicating about the transformation • process • Engaging patients in organizational planning • Training clinical as well as non-clinical staff members • Creating a safe environment • Preventing secondary traumatic stress in staff • Hiring a trauma-informed workforce	• Involving patients in the treatment process • Screening for trauma • Training staff in trauma-specific treatment approaches • Engaging referral sources and partnering organizations

Adapted from Bethell (2016): Key Ingredients for Creating a Trauma-Informed Approach to Care

Trauma-informed approaches to care shift the focus from "What's wrong with you?" to "What happened to you?" by:

- Realising the widespread impact of trauma and understanding potential paths for recovery;
- Recognising the signs and symptoms of trauma in individual clients, families, and staff;

[4] Bethell et al (2014). Adverse Childhood Experiences: Assessing the Impact on Health and School Engagement and the Mitigating Role of Resilience. Health Affairs 33, NO. 12: 2106–2115

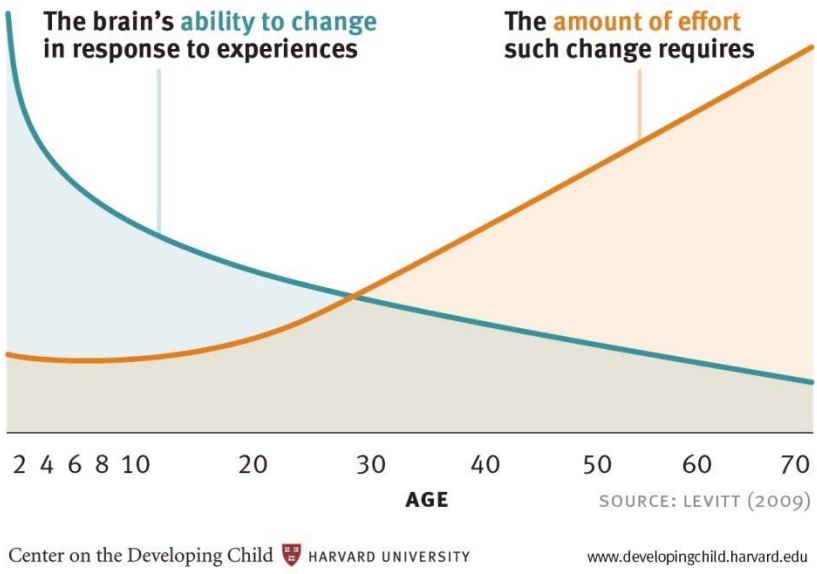
[5] Menschner and Maul (2016). Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Care Strategies.

- Integrating knowledge about trauma into policies, procedures, and practices; and
- Seeking to actively resist re-traumatisation (i.e., avoid creating an environment that inadvertently reminds patients of their traumatic experiences and causes them to experience emotional and biological stress).

Screening for adverse childhood experiences might be most useful in identifying the subset of the children with social determinants of poor health who may most need attention, as well as the subsets of children with special health care needs and children with physical and mental or behavioural health diagnoses who may benefit most from integrated health care approaches requiring medical, social, mental, and emotional attention.

Dr Stephanie Guinosso (Project Director, California School-Based Health Alliance) recommended a screener been developed by the Center for Youth Wellness in San Francisco (website here: http://www.centerforyouthwellness.org) which includes a child version that they use in their paediatric clinic. This tool can be access for free via the Center for Youth Wellness website. The California School-Based Health Alliance have had mixed success with this tool in middle and high school settings. They have found that some youth are reluctant to share their exposures until a really good relationship/trust is built with the provider. Dr. Nadine Burke-Harris (Center for Youth Wellness) uses the screen with a younger population.

There is significant opportunity within the NZ context for the application of emerging knowledge in the identification and mitigation of these early life experiences. Early identification of children exposed to adverse childhood experiences (ACEs) provides an opportunity to treat and support families to help mitigate the effects on children and reduce their long-term risk of poor health and mental health outcomes. SBHCs may prove an important platform.



Customer and satisfaction surveys

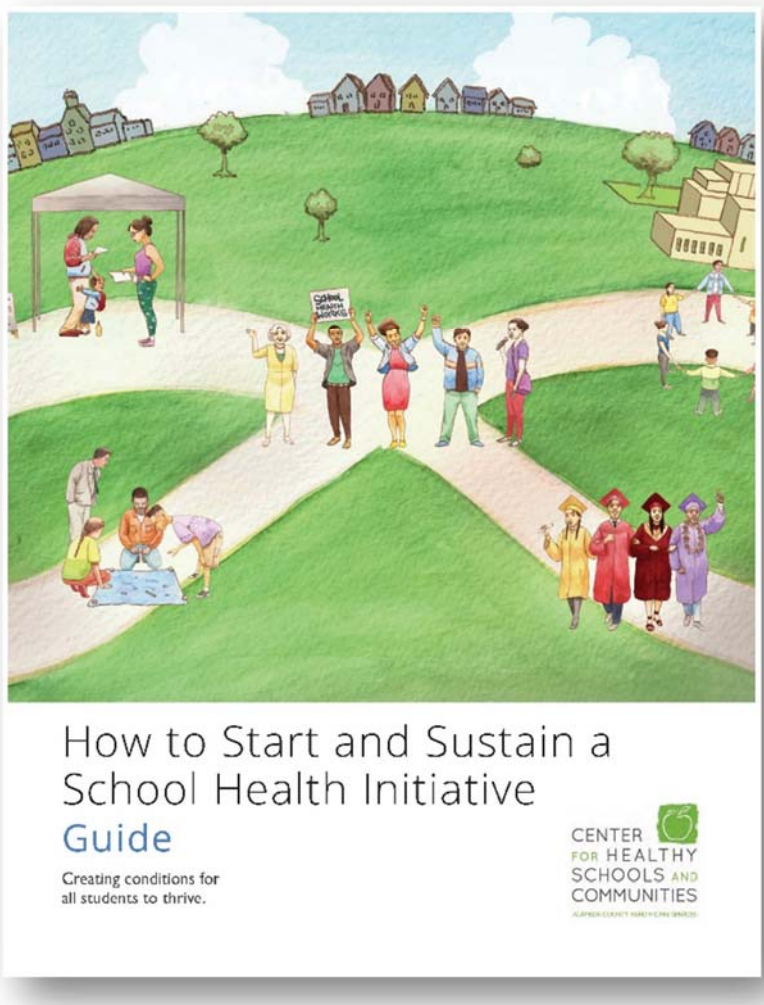
There's growing evidence that working with service users and whānau improves experience and outcomes. Many organisations ensure they are customer focused with regular surveying of parents and children to understand needs and assess how their service is responding to those needs.

Many SBHC organisers survey school staff, parents and children to better understand what the health need is and adjust their service offering accordingly.

There is also an opportunity to provide more information to communities (with a strong data focus) that supports a better the connection with community. There is evidence that this connection and information sharing means communities are more supportive leading to better integration of health teams, better relationships and improved health outcomes.

A guide for school health initiatives

The Center for Healthy Schools and Communities has published a very useful guide called 'How to Start and Sustain a School Health Initiative'. It contains a range of useful pointers, tools and guides for funders and organisers of school health initiatives. It can be accessed, along with a range of other tools and guides, from http://www.achealthyschools.org/schoolhealthworks/how-to-start-and-sustain-a-shi.html. Other useful resources are referenced on page 26.



Different models for service delivery

This research found that there are varied models of service delivery but a number of shared elements. All utilised multi-disciplinary teams with senior nurses in key positions and often the key component of the clinic operation.

Interesting elements are as follows;

- Many utilised community health worker type positions as a resource to undertake basic health assessments and connect children and young people with services. Often the relationship these particular people have with children (and to a lesser extent their families) were considered to be critical.
- Nurse Practitioners (NPs) are extensively used in school-based health services overseas[6]. This role is usually the senior clinician in a multi-disciplinary team. Supporting the development of NPs in the NZ system is important, as is extending the scope of registered nurses more generally.
- GPs are used sparingly and have a limited role in SBHCs.
- The wider team may include an operations supervisor role who often works across multiple schools and whose primary role is to support the running of the clinic and provide capacity to instigate health-related projects and to connect/collaborate with various partners within the school setting. This includes working with school staff (including employee wellness initiatives) to build relationships and educate.
- External organisations are used to run the SBHCs. These organisations are mainly non-profit, primary care experts who run a range of programmes in the region. The health teams are employed by these organisations.
- All teams put significant time/energy into building and maintaining relationships with the school. Integration is seen as an important success factor though of course the progress along that road varied from school to school.
- Use of specialists and escalation pathways (e.g. developmental paediatrician in response to high volumes of developmental issues)
- Funders and providers were pragmatic about the type of service delivery model with some variation within communities based on avaialble funding, staff availability, population needs. It was generally agreed that standardisation was important.
- Ensuring that SBHCs are connected to primary and secondary care is important.
- Providers are outcomes-oriented and not looking to make money. Most funders were clear about the type of organisation that should be involved; a strong alignment with their kaupapa is essential, non-profit and with a clear intention to improve outcomes for their clients.

Comprehensive vision services

In Toronto, schools are visited regularly by an optometry service funded by the regional health authority. Community health workers based at the schools regularly screen children for vision issues. Those children failing the test are identified and scheduled for an appointment with the optometrist who visits the school (or a nearby school) on a regular basis. It is estimated that around 30% of children screened fail the vision test and of those, around 70% require corrective glasses. The service is provide free for all children at schools with SBHCs, this includes glasses (via agreements with

[6] 'Nurse practitioner is a legal title for a nurse who has completed advanced education and training in a specific area. Nurse practitioners are highly educated and experienced health professionals working to improve health and to reduce inequalities in health'. Ministry of Health

glasses suppliers). Children choose glasses at the time of their optometry appointment and the glasses are sent to the school for children to wear. This is an effective way of maximising uptake for the children who need corrective vision. This model could be utilised effectively in South Auckland.

School-based clinics providing access/services to the wider community

Marquette Elementary in Chicago have a comprehensive primary care at the school which provides services to the school population and the wider community. The clinic is based in a part of the school which allows non-school patients to attend. The school and the health team work closely together to ensure that the needs of the school population are being met. Up to 70% of patients accessing the clinic may come from the community.

The clinic, called Esperanza Marquette, is run by local primary care organisation (Esperanza) and the team is made of a medical assistant, nurse practitioner (NP), psychiatric NP, provider (GP), counsellor, receptionist and social worker. An oversight organisation (LISC Chicago[7]) provides a health resource coordinator, programme director and programme coordinator who are responsible for ensuring integration within the school and connecting with other organisations.

This type of model may be a viable model for expanding school-based health services in the NZ context. Schools have existing private-public arrangements with providers such as swimming schools so there is precedent for community access to school-based facilities run by external providers. Clinics may be run as a satellite of existing primary care clinics or clinics in and of themselves.

Marquette Elementary, Chicago

After school programmes

The provision of after school programmes connected to the overall health and wellbeing approach was an unexpected finding. This was particularly evident in Chicago and Toronto[8] where the programmes were much more than simply child care services and were integrated with other health services in the school.

[7] LISC helps both community-based and for-profit development organizations transform distressed neighbourhoods into healthy ones – where people choose to live, do business, work and raise families. For more information visit www.lisc-chicago.org

[8] The Toronto programme has been formally evaluated.

Key features include;

- After school programmes offer a safe, constructive environment
- Provided free across school week (five days, Mon-Fri)
- Provide range of activities including nutrition programmes, recreation/exercise, homework support, enrichment programmes (e.g. art, sport)
- Operate in a structured way
- Connected to the curriculum to support better learning outcomes (may include tutoring)
- Feed children healthy meals
- Generally provided by external organisations and strongly integrated into the school
- Role modelling important for young people

Scoping of how the implementation of these programmes could support the wider health and wellbeing aims of both schools and health providers would be worthwhile.

Peer learning communities

A peer learning community is a group of organisations or individuals that operate as a collaborative network. This has been an effective way of supporting the ongoing development of the providers delivering services in schools in Alameda County, Oakland where the Center for Healthy Schools and Communities supports its provider network. The network meets regularly, shares expertise, and works collaboratively to improve the way they deliver services across the district.

The peer learning community operates in the following way, supported by a coordinator who has been trained in organisational and relationships systems coaching. Regular reports ask providers to identify any technical issues that they need support with and any training required by staff. Note that providers are contractually obligate to attend the forum. The group develops an annual schedule of meetings with topics relevant to the work they are doing; the collated topics come from both provider and funder. The topics are grouped and prioritised, and an expert who can lead a session/workshop identified (possibly from within the provider group).

The agendas for the meeting follow a similar structure;

1. Introductions
2. Icebreaker (often relating to the topic)
3. “Data minute” (brief, relevant statistic from programme/district/national source relevant to the meeting’s key theme
4. An interactive workshop session.
5. Announcements (e.g. opportunity, new schools, recruitment)
6. Requests from providers

Note that the meetings are not decision making forums; there are no minutes etc. The aim of the meeting is to grow knowledge, share expertise and develop collaboration.

Screening tools

The team at Milwaukie High School utilise screening tools within their clinic. These are simple tools designed to give students the opportunity to raise specific issues. All students are given the tool when they arrive at the clinic. The student can choose to complete and hand it to whomever they feel like within the clinic or they may choose to simply leave it with the NP during the consult. Support is provided to those that require it. This has been successful in ensuring that students are

able to raise issues that they may not be comfortable raising. Food insecurity is a significant issue for adolescents and their families in the area and so this tool is currently in use (see below).

This type of tool is used across a number of places I visited for a range of health issues (e.g. dental) and social determinants (violence). Such a tool could be implemented in our school programme for various issues.

Screen for Food Insecurity

Many adolescents and their families experience hunger because they cannot afford enough food. Please answer these questions as truthfully as possible so we can see if you need support.

1. Within the past 12 months we worried whether our food would run out before we got money to buy more.

☐ often true ☐ sometimes true ☐ never true ☐ don't know, or refused

2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

☐ often true ☐ sometimes true ☐ never true ☐ don't know, or refused

Case study: Nuka System of Care

Southcentral Foundation is an Alaska Native-owned, non-profit health care organization serving nearly 65,000 Alaska Native and American Indian people living in Anchorage, Matanuska-Susitna Valley and 55 rural villages in the Anchorage Service Unit. Southcentral Foundation is a large nonprofits, employing more than 2,000 people in more than 80 programmes.

Southcentral Foundation's Nuka System of Care (Nuka) is a relationship-based, customer-owned approach to transforming health care, improving outcomes and reducing costs.

Recognized as one of the world's leading examples of healthcare redesign and a recipient of the Malcolm Baldrige Quality Award, SCF offers health care organisations value-based solutions for data and information management, integrated care, behavioural health, workforce development, and quality improvement.

The following is a brief synopsis of some of the key learnings from a three day workshop.

Culture and values

The constant reinforcement of values and culture by staff and management was striking. The NUKA system of care is based on a number of key operational principles that underpin all activities;

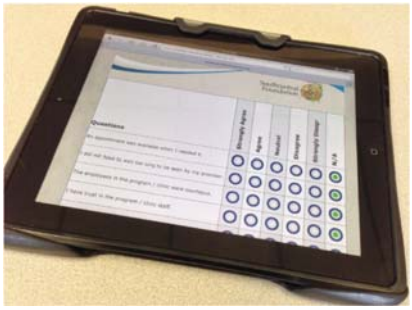
- **Relationships** between customer-owner, family and provider must be fostered and supported
- **Emphasis** on wellness of the whole person, family and community (physical, mental, emotional and spiritual wellness)
- **Locations** convenient for customer-owners with minimal stops to get all their needs addressed
- **Access** optimized and waiting times limited
- **Together** with the customer-owner as an active partner
- **Intentional** whole-system design to maximize coordination and minimize duplication
- **Outcome** and process measures continuously evaluated and improved
- **Not** complicated but simple and easy to use
- **Services** financially sustainable and viable
- **Hub** of the system is the family
- **Interests** of customer-owners drive the system to determine what we do and how we do it
- **Population-based** systems and services
- **Services** and systems build on the strengths of Alaska Native cultures

All staff and management constantly referenced these principles and often provided examples of how their work aligns to these operational principles.

Customer-owners

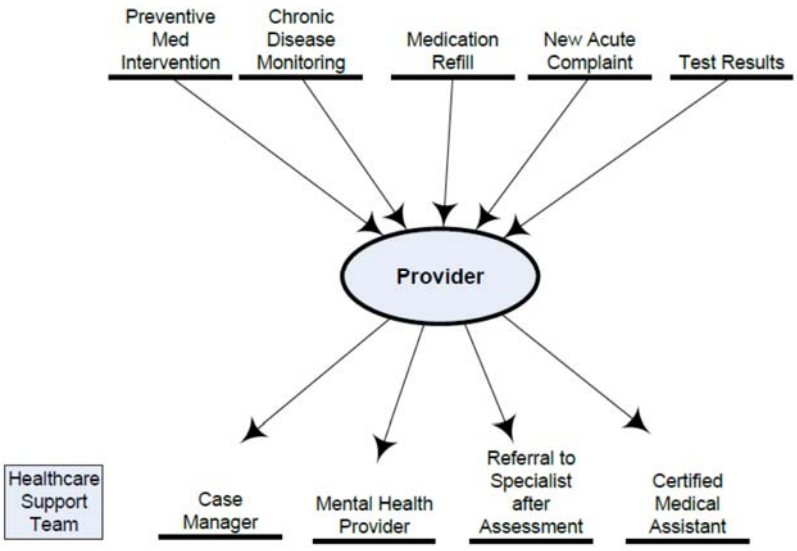
Southcentral Foundation refers to their patients as customer-owners which emphasises the importance of the individual at the centre of care. In order to ensure that the organisation is continually responsive to the needs of their customer-owners, Southcentral Foundation views the voice of the customer is important as a critical source of data. They gather data from customers regularly and in a range of ways (see word cloud below).

Customer feedback is constantly analysed and monitored and informs quality improvement projects. In addition, it feeds into the organisation's strategic planning process.

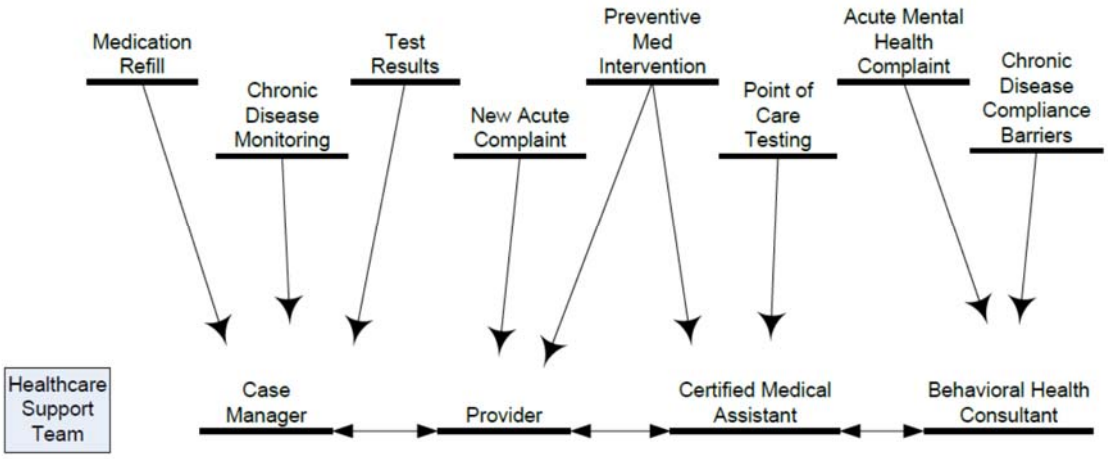


Integrated care teams

Traditional healthcare delivery in primary care has the GP (provider) as the focal point for the client-professional interaction (as per the schematic below);



The NUKA system of care changes this to integrated care teams which have a panel of approximately 1000-1500 clients/patients. The team includes registered nurses (case manager), general practitioner (provider), certified medical assistant, case management support (scheduler), behavioural health experts, dietician and pharmacist. The team works together to provide client centred care. The client can access care at any point they choose.



In addition, the Southcentral Foundation coordinates traditional healing practices with Western medicine to incorporate Alaska Native values, beliefs and practices for the benefit of customer-owners, families and the community

Quality improvement

The Southcentral Foundation (SCF) deploys a considerable quality improvement infrastructure that supports the wider organisation in improving quality. Functionally, this includes;

- Job Descriptions
- Recruitment Process
- New Hire Orientation
- Quality Management Courses and Improvement tools
- Functional Committee Structure including Process Improvement Committees
- Annual Re-Orientation
- Integration with other processes

SCF utilise two key roles in the deployment of this activity;

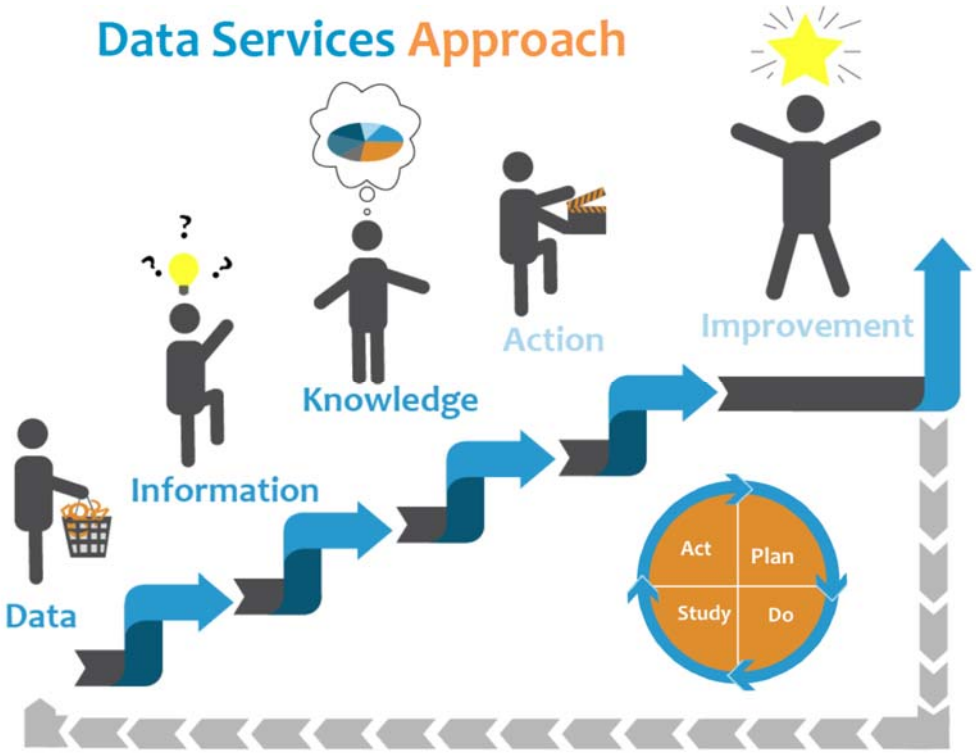
- **Improvement specialists** who have knowledge of improvement tools & methods and lead improvement teams.
- **Improvement advisors** who are proficient in tools & methods and advise and consult on improvement efforts.

SCF have identified some key learnings in the implementation of their quality improvement activity;

- Leadership commitment to improvement efforts & resources
- "Improvement" is a formal expectation of all employees
- Communication across the organisation
- Apply and teach-back tools
- Celebrate (big and small)

Data services

SCF have put considerable resource into developing a comprehensive data management approach which informs all aspects of their business. The data services approach includes;



Understanding needs and drivers:

- Strategic/operational objectives of the organization
- Regulatory/grant requirements

Relationship building:

- Stakeholders/Data stewards/Subject matter experts

Learn where the data is and how to get it:

- Transactional systems, historical, others
- Healthcare coding nomenclatures

Standardize and automate processes:

- Methods, reports, scorecards

> *"Not everything that can be counted counts and not everything that counts can be counted"*

Conclusion

The way that health care is funded and delivered across New Zealand, Australia, United States of America and Canada is varied and often complex, but the identified barriers to accessing health care are broadly similar. Barriers such as financial, geographic, availability of parents to take time off work, inability to get appointments within a reasonable period were commonly discussed in relation to higher needs populations. Less tangible barriers such as language, health literacy, cultural milieu, fear/intimidation, previous negative healthcare experiences and confidentiality were all noted. These are broadly similar to the NZ context while some of the specifics may vary.

The primary motivation for the establishment of school-based health services across Australia, United States of America and Canada, were to address barriers to accessing healthcare and to reduce health inequities. School health services provide an access point for children facing health care barriers to receive needed services in the most direct and efficient way, including assessment, diagnosis, management, and follow-up of multiple health and developmental concerns.

The experience left me with an increased belief that school health services are a critical tool in reducing health inequities and improving health and wellbeing outcomes for children. It is clear that school-based health services are an important component of the wider health system and there is much to learn from the way others deliver services.

The challenge is to continue to develop and improve services to ensure that we are meeting the needs of children and their whānau and to continue to strive to achieve outcomes and equity of health and wellbeing.

Further resources and reading

Alameda County Healthy Schools and Communities

School Health Works shares resources from the Alameda County Center for Healthy Schools and Communities and their partners. A range of very useful resources that are well worth checking out.

http://www.achealthyschools.org/schoolhealthworks/tools---resources.html

Frontiers of Social Innovation

On May 3-5, 2016, Stanford Social Innovation Review hosted the inaugural Frontiers of Social Innovation forum to discuss the best ways to build a more inclusive society. The event discussed the most recent research and thinking on the causes of social inequities, and, importantly, the approaches and programs that are proving to be most effective at creating a more economically just world.

More information (including slide sets from speakers): www.ssirfrontiers.org/

California School-Based Alliance

The website of the California School-Based Health Alliance has a range of…

More information: http://www.schoolhealthcenters.org/

Mental health and behavioural health

The California School-Based Health Alliance has some useful resources for improving school mental health policies and programs, as well as information and tools for specific topics: crisis response, minor consent, suicide prevention, school discipline, trauma, school climate, and social-emotional learning.

http://www.schoolhealthcenters.org/healthlearning/mentalhealth/mentalhealthresources/#trauma

Appendix 1: School health integration rubric

This rubric is used to assess how well health services and programs are integrated at a particular school.

HOW WELL ARE SCHOOL HEALTH SERVICES, PROGRAMS & PROVIDERS INTEGRATED INTO YOUR COMMUNITY SCHOOL?

Overview: A thriving full service community school effectively leverages health services and programs to meet the needs of students and families. This self-assessment tool is meant for you to quickly assess how well health services and programs are integrated at the school site. The rating scale is defined below:

1 Emerging	We have not yet begun to address this issue.
	We are talking about this, and developing plans, but have taken no significant action to make it a reality.
3 Developing	We have begun to do this, and support is growing, but changes remain fragile; some staff approach the task with a sense of compliance.
5 Thriving	We are consistently doing this; most staff are committed and feel it is an important factor in our collective efforts to improve the school.
	This practice is deeply embedded in our culture; we regularly review, adjust, and realign this work.

Integration Principles **School and Health Partners…**	**1 = Emerging**	**3 = Developing**	**5 = Thriving**
1. Implement mutually supportive **policies and procedures** that support student health and academic achievement	- Site-based health and education policies and procedures are developed and enforced separately. - School administrators and staff have little knowledge of the policies that govern the work of health providers, and health partners have little knowledge of school or education policies.	- School administrators and health partners are beginning to have conversations and co-develop mutually supportive policies and procedures at the school site. - School administrators and staff make an attempt to inform health partners about school policies and procedures, and health providers notify school administrators and staff as needed about program policies and procedures developed to support student health.	- School administrators and health partners routinely co-develop mutually supportive policies to support student health and academics. - School administrators and health partners are in close communication about policies and procedures that support health and academics, and regularly provide each other with updates about the policies and procedures that govern health and academic programs.

2. Implement **school wide strategies and frameworks** that support health and academics and help at-risk students	- Health partners are not typically involved in the development of school wide strategies developed to support at-risk students. - School administrators and staff are not typically involved in the development of school wide strategies to support student health and wellness.	- School and health partners are beginning to understand the importance of jointly implementing school wide strategies and frameworks that support health, behavior and academics. Most often, implementation teams have at least some representation of school and health programs.	- When new strategies and frameworks are considered and developed, school and health partners are always at the table together. - Strategies to support health, behavior and academics for at-risk students are most often considered one and the same.
3. Implement **collaborative systems and structures** to plan programs and direct resources to at-risk students and their families	- School systems and structures to support health and academics are typically thought of as separate. - School administrators and health partners rarely convene and participate in collaborative systems and structures that support student health and academic achievement.	- School administrators, school staff, and health partners sometimes participate together in developing and implementing collaborative systems and structures, though it is not always clear when and how this should happen.	- School administrators, school staff, and health partners jointly develop and participate together in a variety of collaborative systems and structures aimed at supporting student health and academic achievement.
4. Implement integrated school-health **programs and services** that support school goals and target student populations of concern	- In general, health partners develop health programs and the school administration and staff develops academic programs. - Health partners do not have a good understanding of school priorities and school administrators and staff do not always understand the goals of health partners.	- There are some programs that are developed jointly by the school and health partners, but for the most part these programs are developed and considered separate. - School and health partners have some sense of the programming that is happening on site in	- School and health partners have jointly developed thoughtful programming aimed at improving academic success and health outcomes, in direct response to jointly conducted needs assessment. - School and health partners have either developed or collected evaluations for all on-site

	- Target populations are identified separately by the school and health partners.	both the health and academic realms. - School staff and health partners have a basic understanding of each other's goals, priorities and target populations.	programs and have a real-time sense of how well these programs are meeting the identified goals and serving students and families. - Health programming and interventions are well-integrated into the classroom and school events/programs, and academic messaging and programming are integrated and reinforced through health programs and events.
5. Participate in collaborative school and health **leadership, decision making, and advocacy**	- School and health program leadership structures are mostly separate. Health partners do not typically participate in school leadership, decision-making, and advocacy. School administrators and staff are not often directly involved in leadership, advocacy, and decision-making around health programs.	- Though this does not happen routinely, school administrators and staff are sometimes invited to participate in leadership, decision making, and advocacy for health services and programs. Similarly, health providers are sometimes included in school leadership, decision making and advocacy. This happens more frequently when there is a specific task at hand or urgent decision to be made and not usually because this is viewed as the way of doing business.	- School administrators, school staff, and health partners are well represented on their respective leadership bodies and make decisions about health and academic programming jointly, as appropriate. - School administrators and staff view it as their role to advocate for health providers and programs, and health partners' advocate on behalf of the school and programs not traditionally viewed as health-related.
6. Utilize **education and health data** to drive	- School and health provides do not routinely exchange and	- School administrators and staff sometimes provide school data to	- Needs assessment is conducted at least annually in

policy and program development	jointly review health and academic data, and school staff and health partners do not always have access or are not aware of available data sources. - This data is rarely used to drive programming and evaluate program quality and effectiveness in meeting the needs of students.	health partners, and health providers sometimes provide health data to school administrators and staff. - Though school and health partners see the value in using data to think collectively about program quality, this is only done sometimes and is used even more rarely to think about gaps and how best to fill them.	collaboration with school administrators, staff, and health partners. - Existing data and data gathered through the needs assessment process is used regularly to develop programming and evaluate program quality and effectiveness in meeting identified needs.
7. Engage in **joint resource development** to support priority programs and services	- Budgets are kept separate and there is little conversation about how health partners can develop resources to support school goals and vice versa. - School administrators do not have a clear understanding of how health programs are funded and sustained and health partners have little knowledge about the school budget and finance.	- There are some examples of grants that have been developed collaboratively, but it is not common practice yet for school and health partners to consider the other as a key partner in fund and resource development. - School and health partners have begun to share more information about funding and sustainability.	- Health partners and school administrators/staff have a clear understanding of both school and health finance and how academic and health programs are funded and sustained. - Health partners and school administrators/school staff often collaborate on grants or have conversations about how to leverage funding and resources to support jointly developed priorities. School and health partners view each other as key resource development partners, especially in tough economic times.

How well are your school health services integrated into the school community?

Integration Principles School and Health Partners…	Strength	OK for Now	Could be Better	Urgent Gap	Not Sure	Implication(s) for Action
1. Implement mutually supportive policies and procedures that support student health and academic achievement						
2. Implement school wide strategies and frameworks that support health and academics and help at-risk students						
3. Implement collaborative systems and structures to plan programs and direct resources to at-risk students and their families						
4. Implement integrated school-health programs and services that support school goals and target student populations of concern						
5. Participates in collaborative school and health leadership, decision making, and advocacy						
6. Utilize education and health data to drive policy and program development						
7. Engage in joint resource development to support priority programs and services						

Appendix 2: Strategies and Resources to Create a Trauma-Sensitive School

Strategies and Resources to Create a Trauma-Sensitive School
Wisconsin Department of Public Instruction

Key Areas	What does this look like in a trauma-sensitive school?	Strategies	Resources
Academics	Classroom instruction is differentiated to allow students impacted by trauma to achieve academically consistent with their age and grade. Additional support is provided for students who are not successful.	• Balance expectations for students with flexibility. • Address skill deficits with interventions. • Provide instruction using a variety of methods. Present and process information in a variety of ways. • Use varied cueing methods to allow students to learn and recall material more easily. • Provide students with choices in instructional activities. • Provide frequent opportunities for students to demonstrate success. • Provide and repeat instructions in short, clear sequences.	• *The Heart of Teaching & Learning: Compassion, Resiliency & Academic Success* (Chapter 3), http://www.k12.wa.us/CompassionateSchools/HeartofLearning.aspx • *Calmer Classrooms: A Guide to Working with Traumatized Children* (Section 2), http://www.ccyp.vic.gov.au/childsafetycommissioner/downloads/calmer_classrooms.pdf • *Helping Traumatized Children Learn: Supportive School Environments for Children Traumatized by Family Violence* (Chapter 1), http://www.massadvocates.org/download-book.php • *Supporting & Educating Traumatized Students: A Guide for School-Based Professionals* (Section 2), Oxford University Press (2013) • *Reaching & Teaching Children Who Hurt*, Paul H. Brookes Publishing (2008) • *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives* (Chapters 4 & 5), Teachers College Press (2016)
Assessment & Screening	Assessment and screening is focused on understanding, teaching, and supporting students' behavior, both proactively and reactively.	• Use a variety of academic assessment methods to allow students to demonstrate knowledge. • Implement screenings in a professional and safe manner. • Recognize that any assessment that triggers a student will not yield valid results. • Create parameters and procedures for implementing screenings and sharing information. • Formally evaluate students who continue to struggle, despite interventions. Utilize IEP and 504 teams, as indicated. • With parent consent, refer students for community-based assessments, when students' needs are beyond what the school can meet.	• Measures Review Database, National Child Traumatic Stress Network http://www.nctsnet.org/resources/online-research/measures-review • Functional Behavioral Assessment *http://dpi.wi.gov/sped/topics/functional-behavioral-assessment* • *New Mexico Public Education Department Technical Assistance Manual: Addressing Student Behavior Functional Behavioral* http://www.minisink.com/fileadmin/user_upload/es/Addressing%20Student%20Behavior.pdf • *Identifying, Assessing, & Treating PTSD at School*, Springer Publishers (2009)

Behavioral Supports	Behavior is taught and supported to ensure students impacted by trauma are not triggered by situations or consequences that are perceived as aversive. Positive behavioral supports are provided to students in ways that nurture relationships.	• Build on students' strengths and interests to teach better behavior. • Create opportunities for students to make choices during the school day. • Establish and maintain predictable routines and transitions in the classroom and school. • Display and review schedules consistently. • Foreshadow changes, including new people and places, so students can predict what will happen next. • Establish and maintain consistent expectations for students. • Teach the reasoning behind the expectations and rules. • Remove stimuli in the environment that lead to inappropriate behavior. • Help students to understand how their behavior affects other people. • Utilize natural consequences that are logically related to the misbehavior. • Balance accountability with an understanding of behavior prompted by trauma. • Anticipate challenging times for students and provide additional support. For instance, create supplemental plans for new experiences (e.g., field trip). • Learn student triggers and how avoid them. Recognize verbal and nonverbal early warning signs of students. • Minimize triggers for students when setting limits. • Avoid engaging in a power struggle with students when they act out. • Address behavior issues as learning opportunities and teachable moments. Utilize "Time In" rather than "Time Out." • Provide positive behavioral supports for students who act out. Avoid use of exclusionary discipline (e.g., detention, suspension, expulsion). • Create behavioral plans that 1) are based upon an understanding of the meaning and function of a student's behavior and 2) clearly articulate accommodations, behavioral supports and other services, and actions to take (and not take) if a trauma reaction is triggered.	• School & Classroom Strategies http://studentsfirstproject.org/wp-content/uploads/QuickFactSheetTraumaStrategiesforteachers.pdf • *Making Space for Learning* (Section 2), http://www.childhood.org.au/ • *Supporting & Educating Traumatized Students: A Guide for School-Based Professionals* (Section 2), Oxford University Press (2013) • *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives* (Chapters 5 & 6), Teachers College Press (2016) • *Reaching & Teaching Children Who Hurt*, Paul H. Brookes Publishing (2008) • UW-Milwaukee Creating a Trauma-Sensitive School 2: Classroom Strategies http://www4.uwm.edu/sce/course.cfm?id=21723 • Youth Wrap Plan http://www.mentalhealthrecovery.com/store/product45.html • School Intervention Project Curriculum http://homepages.wmich.edu/~atchison/School%20Intervention%20Project%20CD%20Revised%20(SIP).pdf • Wisconsin PBIS Network http://www.wisconsinpbisnetwork.org/ • PBIS World http://www.pbisworld.com/ • Brain Gym http://www.braingym.org/index

Cognitive Skills	Cognitive skills are taught so students impacted by trauma are able to think about (rather than emotionally respond to) triggers and challenging situations. Staff understand the impact of trauma on the uneven acquisition, retention, and performance of cognitive skills.	• Teach problem-solving skills, social skills, relaxation techniques, and emotional literacy. • Teach cause and effect relationships. • Emphasize sequences of events. • Prepare students to begin cognitive and academic tasks. See section on Emotional and Physiological Regulation.	• *The Heart of Teaching & Learning: Compassion, Resiliency & Academic Success* (Chapter 3, Domain 3) http://www.k12.wa.us/CompassionateSchools/HeartofLearning.aspx • *Supporting & Educating Traumatized Students: A Guide for School-Based Professionals* (Section 2), Oxford University Press (2013) • *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives* (Chapter 6), Teachers College Press (2016) • Cognitive Behavioral Intervention for Schools (CBITS) http://cbitsprogram.org/ • The Amazing Teen Brain http://www.multiplyingconnections.org/become-trauma-informed/amazing-teen-brain

Community Partnerships	Partnerships exist between the school and community services to ensure students impacted by trauma access needed supports.
	
	Services to students in the child welfare and juvenile justice systems are coordinated.
		• Develop reciprocal partnerships with community partners. Value the roles and perspectives of all engaged to promote synergy vs. prescription.
		• Identify community service providers with strong backgrounds working with children and adolescents impacted by trauma.
		• Actively recruit community partners to participate in trainings and special events.
		• With parent consent, communicate with community partners to coordinate school and community plans for specific students. Utilize Coordinated Service Planning to bring all involved parties to the table for needs assessment, asset mapping, and strategic planning for both individual students and programs.
		• Develop common understandings between school and community partners:
		  ○ Shared language for student challenges,
		  ○ Focus on wellness rather than pathology,
		  ○ Collaborative asset mapping and needs assessment,
		  ○ Synergistic services that reduce duplication and facilitate compatibility,
		  ○ Value of diversity in problem-solving,
		  ○ Shared sense of ownership of needs and assets, and
		  ○ Clear goals, assigned leadership, and a strategic plan designed to meet the needs of children and families to eliminate barriers to learning.
			• *The Heart of Teaching & Learning: Compassion, Resiliency & Academic Success* (Chapter 4) http://www.k12.wa.us/CompassionateSchools/HeartofLearning.aspx.
			• *Helping Traumatized Children Learn: Supportive School Environments for Children Traumatized by Family Violence* http://www.massadvocates.org/
			• *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services*, Jossey-Bass, A Publishing Unit of John Wiley & Sons (2001)

Crisis Prevention & Response	Staff are trained in and utilize skills to prevent and address crisis. Responses avoid creating further trauma for students. Staff understand their responsibility to interact with students in ways that reduce the likelihood of triggering a trauma response.	• Develop a crisis plan that includes strategies to address behavioral incidents. A team meets regularly to review crisis responses and make adjustments, if necessary. • Plan ahead for how challenging behavior will be addressed. • See sections on Behavioral Supports and Emotional and Physiological Regulation for strategies to avoid triggering a trauma response by a student.	• Tips for Helping Students Recover from Traumatic Events http://www2.ed.gov/parents/academic/help/recovering/index.html • Responding to a School Crisis http://www.nctsn.org/resources/audiences/school-personnel/crisis-situation • Service Intervention Programs http://www.nctsn.org/resources/audiences/school-personnel/service-interventions • Psychological First Aid for Schools, National Child Traumatic Stress Network http://www.nctsn.org/content/psychological-first-aid-schoolspfa • Helping Children Cope with Violence & Trauma: A School-Based Program That Works www.rand.org • Making It Easier for School Staff to Help Traumatized Students www.rand.org • Support for Students Exposed to Trauma: The SSET Program www.rand.org
Educator Capacity	School staff receive training and support to: • Understand how trauma impacts students and their learning, • Learn and apply classroom and school-wide practices that support student success, • Understand how their own experiences and students' trauma impacts them, and • Learn about self-care to address those needs.	• Model emotional control for and respectful relationships with students. • Educate staff about how trauma impacts children and learning, including new staff at the beginning of each school year. • Educate staff about vicarious trauma, including how to recognize and manage it. • Encourage staff to participate in self-care activities in their work and personal lives. • Sponsor staff wellness activities.	• Professional Quality of Life http://proqol.org/ • *Mindfulness for Teachers: A Pilot Study to Assess Effects on Stress, Burnout, & Teaching Efficacy* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3855679/ • *Reaching & Teaching Children Who Hurt*. Paul H. Brookes Publishing (2008) www.brookespublishing.com • *The Heart of Teaching & Learning: Compassion, Resiliency & Academic Success* (Chapter 2), http://www.k12.wa.us/CompassionateSchools/HeartofLearning.aspx • *Calmer Classrooms: A Guide to Working with Traumatized Children* (Section 3) http://www.ccyp.vic.gov.au/childsafetycommissioner/downloads/calmer_classrooms.pdf • *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives* (Chapters 5 and 7), Teachers College Press (2016)

Emotional & Physiological Regulation	School staff model emotional regulation by interacting with adults and students in a respectful manner. Staff teach strategies to help students identify and name feelings, modulate responses, and behave in a manner appropriate to the classroom.	• Coach students to identify triggers that set off their "fight or flight" response. • Teach conflict management skills. • Teach grounding and focusing skills, including movement, stretching, relaxation techniques and activities. Provide opportunities at scheduled times each day. • Create a "calm box" with small items that students may choose to hold or keep close to help them to feel more comfortable. • Provide "calm zones" or safe places for students to seek out by choice to help regulate their emotions. • Help students understand how to identify and process feelings (allow students to calm down before doing this). • Use analogies to describe emotions and triggers. • Use journals, art, and poetry to allow students to express feelings. • Prepare students before doing something that might cause a reaction (e.g., turning out the lights, making a loud noise).	• *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives* (Chapter 6), Teachers College Press (2016) • Self-Regulation: The Second Core Strength http://teacher.scholastic.com/professional/bruceperry/self_regulation.htm • *Trauma-Proofing Your Kids,* Random House Publishers (2008) • Five Point Scale http://www.5pointscale.com/ • *Reaching & Teaching Children Who Hurt*. Paul H. Brookes Publishing (2008) • *The Zones of Regulation: A Curriculum Designed to Foster Self-Regulation and Emotional Control,* Think Social Publishing (2011) • Me Moves: Mind, Body, Connect www.thinkingmoves.com. • Yoga 4 Classrooms *http://www.yoga4classrooms.com/* • Classroom Yoga Project *http://www.classroomyogaproject.org/cyp_currently_online/home.html* • Classroom sensory kit *http://www.therapyshoppe.com/category/P2287-classroom-sensory-kit-Cot-sensory-school-tools* • FAQs for Teachers: Childhood Trauma & Dissociation http://www.isst-d.org/default.asp?contentID=101 • Teaching Children How to Calm Down *http://www.thepositiveclassroom.org/2011/06/teaching-children-how-to-calm-down.html* • Sensory Integration in the Classroom *http://www.superduperinc.com/handouts/pdf/155_SI.pdf*

Environment, Culture and Climate	People in the school community share beliefs and priorities that recognize the prevalence and impact of trauma in students' lives and create a flexible framework to respond to student needs.	• Create and provide a welcoming and physically and emotionally safe environment. • Train staff in culturally responsive practices. • Learn and value the cultural history of students and their families. • Learn and honor the historical trauma of students and their families. • Utilize equitable classroom practices. • Consider the sensory impact of the physical environment. Remove stimuli that may lead to inappropriate behavior. • Use and model non-violent communication. • Implement bullying prevention activities. Respond promptly and effectively to bullying incidents.	• *Helping Traumatized Children Learn: Supportive School Environments for Children Traumatized by Family Violence* (Chapter 2) http://www.massadvocates.org/download-book.php • Making Space for Learning (Section 2) http://www.childhood.org.au/ • Child Trauma Toolkit for Educators http://www.nctsn.org/resources/audiences/school-personnel/trauma-toolkit • *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives* (Chapters 1 and 5), Teachers College Press (2016) • *Supporting & Educating Traumatized Students: A Guide for School-Based Professionals* (Chapter 17), Oxford University Press (2013) • Wisconsin RtI Center http://www.wisconsinrticenter.org/home.html • Center for Non-Violent Communication https://www.cnvc.org/
Leadership	School leaders support a compassionate school structure and provide access to professional development for all staff on various subjects (i.e., trauma, adversity, brain research, self-care, community partnerships). Community partners are encouraged to participate in professional development opportunities.	• Provide opportunities for all staff (including school administrators) to learn about how trauma can affect students and their ability to learn, as well as strategies to support these students' learning. • Build efforts to incorporate trauma-sensitive practices into the school's improvement plan. • Model trauma-sensitive interactions with staff. • Provide program support for teachers to develop and refine specific strategies for students. • Assist teachers and families to develop shared relationships.	• Organizational Stress http://www.sanctuaryweb.com/PDFs_new/Bloom%20Organizational%20Stress%20NASMHPD.pdf • *Helping Traumatized Children Learn: Supportive School Environments for Children Traumatized by Family Violence* (Chapter 2) http://www.massadvocates.org/download-book.php • What Does It Take for Traumatized Kids to Thrive? http://www.psmag.com/health/what-does-it-take-for-traumatized-kids-to-thrive-56488/ • Lincoln High School Principal on Compassion and Punishment http://acestoohigh.com/2012/06/19/lincoln-high-school-principal-on-compassion-and-punishment-a-bigger-bat-may-hurt-a-student-but-hurts-a-community-more/ • There's No Such Thing as a Bad Kid in these Spokane WA Elementary Schools, http://acestoohigh.com/2013/08/20/spokaneschools/

Parent & Caregiver Involvement	Parents and caregivers are a respected and respectful part of the school community. The school respects the family dynamics, experiences, and culture and honors parents and caregivers as experts on their children. Parents and caregivers help create educational plans for their children and are an integral part of the decision-making process.	• Seek to develop trauma-informed partnerships with the home by helping parents and caregivers become an integral part of the school community**.** • Engage parents and caregivers through brochures, websites, email, phone calls, postcards, etc. throughout the school year. • Encourage families to take on leadership and outreach roles with other parents. • Respect the privacy and confidentiality of families with students who have been affected by trauma. • Build trusting relationships with families. Be friendly, reliable, consistently caring, and predictable. • Designate a pupil services professional or other staff member to be a liaison to families. • Include adult family members in the development of school plans for their children, including identifying behavior patterns, triggers, and effective strategies. • Collaborate to repair broken caregiver and school relationships.	• *For Parents: Childhood Traumatic Grief Educational Materials* http://rems.ed.gov/docs/SAMHSA_ChildhoodTraumaticGriefForParents.pdf • How the Brain is Built http://www.albertafamilywellness.org/resources/video/how-brains-are-built-core-story-brain-development • Wisconsin Statewide Parent Educator Initiative (WSPEI) http://wspei.org/ • Wisconsin Special Education Mediation Support System http://dpi.wi.gov/sped/dispute-resolution/wsems
Policies	District and school policies and procedures reflect an understanding of trauma and adversity as it relates to student behavior and learning.	• Review policies and procedures with the *Review Tool for School Policies, Protocols, Procedures & Documents.* Modify any that include practices or protocols that are not trauma-sensitive. • Develop strategies other than suspension and expulsion to hold students responsible for their behavior. Consequences should be formative and logical, not punitive. • Work to eliminate the need for exclusionary discipline and “Zero Tolerance” and “Three Strike” policies. • Educate the school board about how trauma impacts children and learning. Work with the school board to modify policies, as needed.	• *Helping Traumatized Children Learn: Supportive School Environments for Children Traumatized by Family Violence* http://www.massadvocates.org/download-book.php • Making Space for Learning (Section 2) http://www.childhood.org.au/ • *Trauma-Sensitive Schools: Learning Communities Transforming Children’s Lives* (Chapter 8), Teachers College Press (2016) • *Supporting & Educating Traumatized Students: A Guide for School-Based Professionals* (Chapters 17-19), Oxford University Press (2013) • Lives in the Balance http://www.livesinthebalance.org/

Relationships	The connection between staff and students and families is recognized as an essential component for learning**.** Behavioral supports are provided to students in ways that nurture relationships.	• Create safe, supportive and affirming relationships with students and families. • Become attuned to students by being an observer of their non-verbal cues. Consistently provide a caring and supportive response to cues. Be sensitive to changes in students and remain flexible. • Provide praise that is concrete and specific in a neutral tone. Acknowledge good decisions and choices but avoid general compliments (e.g., "You are a nice boy"). • Help students take responsibility for misbehavior in ways that will repair and maintain relationships. • Provide opportunities for and encourage students to participate in extracurricular activities related to their interests and strengths. • Build relationships with students that are not based upon academics. • Help students identify supports within the school. Help students understand that pupil services professionals are accessible and approachable. • Provide in-school mentors. • Use a daily check-in with students (e.g., *Check In – Check Out*). • Encourage friendships in each classroom, especially for students who are isolated or struggling.	• Attunement: Reading the Rhythms of the Child http://www.scholastic.com/teachers/article/attunement-reading-rhythms-child • This Emotional Life http://www.pbs.org/thisemotionallife/blogs/10-tips-connect-your-child • Attunement in the Classroom http://www.teachers.ab.ca/Publications/ATA%20Magazine/Volume%2081/Number%203/Articles/Pages/Attunement%20in%20the%20Classroom.aspx • *The Heart of Teaching & Learning: Compassion, Resiliency & Academic Success* (Chapter 3, Domain 1) http://www.k12.wa.us/CompassionateSchools/HeartofLearning.aspx • *Calmer Classrooms: A Guide to Working with Traumatized Children* (Section 3) http://www.ccyp.vic.gov.au/childsafetycommissioner/downloads/calmer_classrooms.pdf • *CAPPD: Practical Interventions to Help Children Affected by Trauma* http://www.multiplyingconnections.org/become-trauma-informed/cappd-interventions-guide • Making Space for Learning (Section 2) http://www.childhood.org.au/ • *Supporting & Educating Traumatized Students: A Guide for School-Based Professionals* (Section 2), Oxford University Press (2013) • *Attachment in the Classroom*, Worth Publishing (2006) • *Why is Johnny So Detached: A School Professional's Guide to Understanding & Helping Students with Attachment Issues,* Youth Light Publishing

Social-emotional learning	Schools embed social and emotional skill building in all learning activities. Students impacted by trauma learn skills to manage their social and emotional challenges.	• Classroom instruction is provided to help students develop social-emotional skills, including stress and conflict management, problem solving, and decision making. • Social-academic instructional groups (SAIGs) focused on social-emotional skills are provided to students who need additional time to learn these skills.	• Collaborative for Academic, Social, & Emotional Learning, http://casel.org/ • *The Heart of Teaching & Learning: Compassion, Resiliency & Academic Success,* Chapter 3: Domain Two http://www.k12.wa.us/CompassionateSchools/HeartofLearning.aspx • *Supporting & Educating Traumatized Students: A Guide for School-Based Professionals* (Chapters 17-19), Oxford University Press (2013) • Cognitive Behavioral Interventions for Trauma in School (CBITS) www.rand.org