Comprehensive Trauma-Informed Care for the Whole Community: The Whole Child Initiative Model

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Introduction

The Whole Child Initiative (WCI) is a decade-long blueprint for sustainable and comprehensive community-wide change. To be successful, community-wide sustainable change must embrace a common vision, language, and common experiences to address common conditions that give rise to mental, emotional, behavioral, and health difficulties. Common solutions to address common conditions include shared goals, strategies, and aligned supports ensure that every youth is safe, supported, engaged, healthy, and challenged in the community-at-large. In this article, we discuss the following aspects of the WCI: 1) The need for a population health or public health approach to sustainable change; 2) elements of the WCI model; and 3) outcomes of the WCI model.

Population Health/Public Health Approach

Mental, emotional, behavioral, and health problems are interrelated and stem from a set of common conditions (National Research Council & Institute of Medicine, 2009). However, approaches used to address these conditions treat these problems as if they are unrelated and as if they arise from different conditions (Biglan et al., 2012). So, what are the common conditions for mental, emotional, behavioral, and health problems? Adverse Childhood Experiences (ACEs) is the term given to describe common conditions for mental, emotional, and behavioral disorders. ACEs include all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18 (more info here: https://www.acesconnection.com/). The landmark Kaiser ACE Study examined the relationships between childhood ACEs and health, mental, emotional, and behavioral outcomes in adulthood (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998). Between 1995 and 1997, over 17,000 people receiving physical exams completed confidential surveys containing information about their childhood experiences and current health status and behaviors. The ACE study looked at three categories of adverse experience: childhood abuse (i.e., emotional, physical, and sexual abuse); neglect (i.e., including both physical and emotional neglect); and household challenges (i.e., growing up in a household were there was substance abuse, mental illness, violent treatment of a mother or stepmother, parental separation/divorce, or had a member of the household go to prison). Respondents were given an ACE score between 0 and 10 based on how many of the 10 types of adverse experiences they have experienced (Center for Disease Control and Prevention, 2018). Here are data to consider:

- People with six or more ACEs died nearly 20 years earlier on average than those without ACEs (Center for Disease Control and Prevention, 2018).

- The Centers for Disease Control and Prevention (CDC) estimates that the yearly lifetime costs associated with child maltreatment at $124 billion (Centers for Disease Control and Prevention, 2018).
- Chronic school absenteeism (missing 15 or more days during a single school year) is common among school-age children who witness neighborhood violence, live with family members using substances, or have multiple ACEs (Stempel, Cox-Martin, Bronsert, Dickinson, & Allison, 2017).

ACEs lie at the root of educational and health challenges. ACEs are the top basic public health issue of this generation (Center for Youth Wellness, 2016; Felitti, 2018). Moreover, consider the following impacts of emotional and behavioral disorders (EBD). Data on youth with EBD from the National Longitudinal Transition Study (NLTS) and the National Longitudinal Transition Study-2 (NLTS2) reveal the percentage of youth with EBD out of high school up to 4 years in 1990 who had ever been arrested—36 percent—had jumped to over 60% by 2005. More than one-third had already been arrested at least once when they were still in high school (Marder, Wagner, & Sumi, 2003). Data from 2009 indicate nearly 2 out of 3 youth with EBD ages 18-21 had been arrested (Wagner & Newman, 2012). Social and emotional difficulties in these students play a significant role in their bleak outcomes (e.g., Nelson et al., 2004; Nelson, Stage, Trout, Duppong-Hurley, & Epstein, 2008; Wagner et al., 2005).

To address ACES and the bleak outcomes associated with EBD noted above, WCI provides common solutions to common problems by simultaneously implementing systemic change across community, school, and family contexts. We now discuss the notion of preventive behavioral health as a common solution to common conditions that give rise to mental, emotional, behavioral, and health challenges.

Preventive Behavioral Health. We drew upon the literature to understand the "active ingredients" that comprised effective substance abuse, mental health, social and emotional learning, and youth violence prevention programs. A common solution is not found in a single packaged prevention program. Embry (2004) notes that there is considerable overlap in lists of presumptive best practices, published by the U.S. Department of Education, the Substance Abuse and Mental Health Administration, the Centers for Disease Control and Prevention, and the Office of Juvenile Justice and Prevention, among others. These agencies provide excellent lists of packaged evidence-based prevention and intervention programs, but not the specific, active ingredients of evidence-based interventions. By coming to understand the active ingredients in prevention programs, one can begin to create a community-based culture of effective practices that might be more sustainable, especially when state and local government resources are stretched to the limit (Embry, 2004).

Researchers have coined the term 'Behavioral vaccines' to describe community-wide preventive behavioral health efforts. A 'behavioral vaccine' shares the following characteristics: 1) any intervention that <u>inoculates recipients</u> against morbidity or mortality, in this case, problematic, aggressive, or potentially dangerous or lethal behavior, hospitalization, incarceration, suicide, or murder; 2) be of <u>low cost</u>, as exemplified by hand washing to prevent infections and diet and exercise to prevent high blood pressure and diabetes; 3) be <u>easily administered</u> to insure minimum costs and maximum benefits with daily routines, assuring every-day practice with a

minimum of training; 4) be amenable to <u>mass administration</u>. Behavioral vaccines are not the same as conventional "universal" prevention programs, as is commonly articulated by federal or state agencies (Embry, 2004; 2009; 2011). Preventive behavioral health makes it possible to directly reach as many people as is humanly possible with a minimum of costs without trained, technical, or professional personnel present. In our WCI work, we have described preventive behavioral health as fluoride in the water. All in the community benefit. In our WCI model, these preventive behavioral health practices are low or no cost, produce immediate benefit, easily explained, easily and widely socially marketed, and impact identified and targeted risk factors (Embry, 2004). Next we describe the specific components of preventive behavioral health in the WCI model.

The active ingredients for community and school prevention efforts have been identified; kernels are "fundamental units" or specific activities of effective prevention programs that have been shown through experimental studies to effect specific behavior changes (Jones, 2017; Embry, 2002; 2004; 2009). Kernels relevant to the work of the WCI include deep nasal breathing for calming down, using hand signals in the classroom to indicate a change in activities or to send a message to the group, and specific and concrete use of positive praise (Embry & Biglan, 2008). Kernels are effective for a wide-range of academic achievement and social adjustment outcomes including classroom behavior, discipline, self-control, and managing emotions effectively. Kernels are compelling because they do not necessarily have to be tied to a specific comprehensive curriculum (in fact they appear in many evidence-based curricula) and because they are typically low cost and relatively simple to use. Community members can choose kernels or sets of kernels based on individual needs and abilities. Thus, kernels are specific activities or strategies embedded within effective prevention programs. By design, kernels target a specific behavior and can be taught quickly. As a complement to universal approaches, kernels add a flexible and personalized approach that enables educators to select strategies or activities that best fit the needs and goals of their specific students, thereby increasing potency, efficacy, and buy-in while promoting sustainability (Jones & Bouffard, 2012).

Elements of WCI

In this context, the WCI model often starts with integration and infusion of social and emotional learning (SEL) across all environments in the community. This approach serves as preventive behavioral health, or vaccine, by employing high-yield evidence-based kernels of behavioral influence across all environments in a community. We begin with a brief explanation of SEL. SEL is foundational to comprehensive and sustainable change. The lives of youth are transformed when they move through and live in safe, equitable, welcoming and effective school, home, and community environments. The lives of educators, caregivers, and families are transformed when they work and live in these environments. Stated differently, SEL competencies include: self-awareness, self-management, social awareness, relationship skills, and responsible decision making (refer to [www.casel.org/ for definitions, examples, and resources](www.casel.org/)). SEL is the youth version of emotional intelligence in adults. Indeed, SEL is the foundation of sustainable comprehensive culture transformation in the WCI model. As one would expect, it is not easy to integrate and infuse high-yield evidence-based kernels across a community.

Infusion and integration of SEL across community contexts is a behavioral vaccine that leads to healthy changes in environments that people live in and move through. Indeed, the Center for Disease Control and Prevention (2014) indicated that safe, stable, nurturing relationships, and environments are essential for preventing child maltreatment (e.g., ACEs). Environments that foster successful development and prevent the development of psychological and behavioral problems are usefully characterized as nurturing environments. First, these environments minimize biologically and psychologically toxic events. Second, they teach, promote, and richly reinforce prosocial behavior, including self-regulatory behaviors and all of the skills needed to become productive adult members of society. Third, they monitor and limit opportunities for problem behavior. Fourth, they foster psychological flexibility—the ability to be mindful of one's thoughts and feelings and act in the service of one's values, even when one's thoughts and feelings discourage taking valued action (Biglan, 2012). Without a drastic shift away from a focus on individual problems to a focus on the prevalence of nurturing environments, progress in reducing mental, emotional, and behavioral disorders will continue at a glacial pace. Moreover, the lives of educators, caregivers, and families are transformed when they work and live in these environments.

What does the high-yield preventive behavioral health using SEL look like? WCI community-wide prevention begins with grassroots, authentic discussions with the people in the community. We asked the following questions:
1) What are the hopes and dreams for our youth?
2) What is success for our youth?
3) What do you believe in?
4) How do you teach what you believe in to the youth you care about?

Responses to the questions above provide the content for the vision for the WCI. Note that understanding the culture of the community, hopes and dreams for youth, beliefs, and what success should be for the specific community is a necessary starting point for a behavioral vaccine that is culturally responsive. Stated differently, answers to those four key questions provides a starting point for a community to move toward behavioral vaccines that are low or no cost, produce immediate benefit, are easy to explain and implement, meet or solve other competing demands, easily socially marketed, and impact community risk factors. We then moved toward consensus on the top 2-3 beliefs from the perspective of a set of diverse and randomly selected community members. For example, when this WCI process began in Scottsbluff, Nebraska in 2015, the community identified the three beliefs, or pillars, as Safe, Respectful, and Responsible. All community agencies were invited to first take the pledge to declare support of the WCI and willingness to post in the organization what being safe, respectful and responsible meant to them along with a plaque with the community pillars prominently displayed in a high-traffic area (for more details about this process in action please see http://www.3escottsbluff.com/). When we applied this procedure with the people of Tacoma, we reached consensus on the beliefs of Respect and Responsible. Similarly, using the same process with youth, community members, and tribal leadership associated with Chief Leschi Schools, the indigenous community of Tacoma, we arrived at the beliefs of Leadership, Respect, and Safe. Rooting preventive behavioral health in authentic beliefs of indigenous people is central to native education. The authentic beliefs and culture of indigenous peoples is woven through all environments and interactions. Positive identity of native belonging is promoted

community-wide (Martinez 2014; CHiXapkaid et al., 2008; Demmert 1994). Whether the community is primarily rural, urban, or indigenous, these beliefs form the basis of preventive behavioral health across all environments and interactions in the community.

In each school, the whole staff comes together to articulate what it looks and sounds like to treat youth safely, respectfully, and responsibly in each environment of and major activity of the school day —every classroom, hallways, lunchroom, extracurricular activities, arrival, and dismissal from school. Youth and staff in the school then co-create social and emotional norms for showing safe, respectful, and responsible behaviors in each environment in the school—every classroom, hallways, lunchroom, extracurricular activities, arrival, and dismissal from school. Thus, the transformation process begins with changing the culture to focus on aspirational pillars that are deeply important beliefs to the people of the community. Youth and adults practice how to show safe, respectful, and responsible social and emotional pillars in every interaction, every context, in time, every thought that an individual may think (e.g., "I keep thinking that I'm terrible at math—how can I show more respect for myself and think more positively?") and feeling that a person may feel (e.g., "I'm angry at my friend—how can I handle my emotions responsibly?"). Clear, visual, culturally-responsive expectations aligned to each pillar are posted and reinforced across all contexts in the schools, community settings, and homes. These pillars are taught, practiced, and reinforced from cradle to career across all community contexts, allowing for safe, nurturing, and caring environments in every school, community setting, and home across the community.

To many reading this article, implementation of a simple behavioral vaccine as described above may appear to not be feasible given realities of schools, communities, and families in most communities. We now move to the "How" of the WCI model so that community-wide transformative change can occur within even under the most challenging circumstances.

Fragmented and disorganized youth supports. Like fashion trends, initiatives often come and go in schools and community agencies. In fact, the average lifespan of an initiative is about 7 months (Lathum, 1988). Adelman and Taylor (2015) note that when one takes stock of these initiatives, it yields a consistent picture of many practices and fragmented, piecemeal, and usually disorganized activities. Examination of the range of such initiatives often appear to be "an inch deep and mile wide" or stated differently, extensive and expensive while Vollmer (2010) describes the amount of initiatives growing each year. Many educators express concern that there is no room on their plate of current responsibilities for another initiative. Vollmer has documented that year after year and decade after decade, the amount of federal and state initiatives continued to grow. Educators report "initiative fatigue" typified by burnout, exhaustion, ambivalence, and demoralization. Perhaps this path is unsustainable. Ponder for a moment the fiscal and human costs of initiatives that come and go or those that remain and pile up over time. What is needed is sustainable transformative change to systems to allow for continuous improvement and organizational health.

WCI applies implementation science and leadership development principles to prioritize implementation of robust behavioral vaccines and kernels. It requires the skillful gathering and analyses of data to inform decision making and adjustments to strategy implementation (Karachi, Abbott, Catalano, Haggerty, & Fleming, 1999). It is grounded in a number of evidence-based

practices that measure beliefs and attitudes, how well the capacity for change is developing, and multi-tiered system of supports (MTSS) frameworks. We believe the high-level commitment to these key elements of fostering sustainable change, including using evidence-based practices, tools, and strategies in a community-wide setting, is essential.

The National Implementation Research Network (NIRN) reviewed more than 2,000 articles on the implementation of change programs in schools and communities and identified five main stages of successful implementation, including: (1) exploration (i.e., selecting evidence-based programs); (2) installation (i.e., making the structural and instrumental changes necessary to implement the program within an organization); (3) initial implementation (i.e., putting into practice what has been planned for during exploration and installation); (4) full implementation (i.e., integrating the program into the service, organization, and system settings); and (5) program sustainability (i.e., institutionalizing a quality assurance mechanism to evaluate use of data and nurture organizational culture, leadership, and staff) (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). These phases parallel long-standing models in management literature, such as the mobilization, movement, and sustain phases of organizational change (Amenakas & Bedian, 1999; Lewin, 1951) and the eight-step process to create lasting transformations: (1) establishing a sense of urgency; (2) creating the guiding coalition; (3) developing a vision and strategy; (4) communicating the change vision; (5) empowering broad-based action; (6) generating short-term wins; (7) consolidating gains and producing more change; and (8) anchoring new approaches in the culture (Kotter, 1996). The WCI implementation plan was developed based upon best evidence from such implementation science, organizational change, and sustainable change literature.

The cornerstone of success in this effort is an effective leadership structure and functionality at the community, district/community, school building, and family levels. At the district level, the district leadership team (DLT) is charged with building capacity for sustainable systemic change; designing, implementing, and sustaining changes in professional practice; and overall management of the organizational change process to ensure sustainability. The DLT consists of the deputy superintendent, assistant superintendent of K–12 support, and the directors of student life, community partnerships, K–12 support, student services, safety, curriculum and instruction, student information systems, counseling, and human resources. The DLT utilizes the District Capacity Assessment (DCA) for scaling up of evidence-based practices as developed by the State Implementation and Scaling Up of Evidence-Based Practices, a technical assistance center funded by the U.S. Department of Education's Office of Special Education Programs (Duda et al., 2012). The DCA is administered every summer following the training of community and district leadership. The tool includes scoring definitions and parameters; a fidelity protocol for administering the tool; and sections covering commitment and leadership, system alignment, district-level, and school-level leadership (Fullan, 2005; Kronley & Handley, 2003).

The multiyear WCI plan includes the evolution of (a) developing and assessment of readiness for change (Rami Shani, Woodman, Pasmore, & Fredberg, 2011; Reeve, Ryan, Deci, & Jang, 2007); (b) establishing cohorts of schools to implement changes together (Wandersman, Chien, & Katz, 2012); (c) continuing to braid other viable strategies and initiatives with this work; and (d) building the capacity of professional learning communities to share insights and learning for

continuous improvements in student outcomes (DuFour, DuFour, Eaker, & Many, 2006; Feger & Arruda, 2008).

At the classroom level, WCI applies a job-embedded professional development approach that makes a direct connection between learning and application in teachers' daily practice (Darling-Hammond & McLaughlin, 1995; "Every Student Succeeds Act," 2015). Educators are equipped with knowledge and skills to deliver high-quality instruction and maintain an engaging, safe, and positive classroom climate (Benner, Nelson, Ralston, & Mooney, 2010; Carey, 2004; Center on Instruction, 2006; Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, DHHS, 2001; National Institute of Child Health and Human Development, 2000). We employ an evidence-based, collaborative, and job-embedded professional development model called Teacher Study Group (TSG) (Gersten, Dimino, Jayanthi, Kim, & Santoro, 2010) to build the capacity of educators over time. PLCs apply these TSG practices to implement and sustain evidence-based classroom practices. Without such an approach, evidence-based classroom practices are very unlikely to be implemented with fidelity or sustained in the classroom over time (Joyce & Showers, 2002). Stated simply, TSG is the process that will be used to learn and practice evidence-based approaches within existing building-level PLC structures. It is the process that will be used to build teacher fluency and skill with evidence-based practices over time.

The WCI classroom implementation plan follows recommended practices for skills development and successful sustainable change in classrooms (Durlak, 2016; Durlak & DuPre, 2008; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Fixsen, Blase, Naoom, & Wallace, 2009). Teachers are provided flexibility, space, and structure to collaborate and receive feedback from their peers about their implementation of classroom WCI, two essential elements of high-quality professional development (Abbott et al., 1999; DeMonte, 2013; Gersten & Dimino, 2001). The web-based materials will guide teachers to consistently reinforce the core skills and apply evidence-based kernels appropriately with their students.

Staff leadership teams at all levels of the district are trained in team-initiated problem solving (TIPS) (Newton, Todd, Algozzine, Algozzine, Horner, & Cusumano, 2014; Newton, Horner, Algozzine, Todd, & Algozzine, 2012; Todd, Horner, Newton, Algozzine, Algozzine, & Frank, 2011). TIPS is an evidence-based set of deceptively simple meeting disciplines that emphasize using data to pinpoint and precisely define problems, identify the goals for change, generate possible solutions that are relevant to the context, implement the solution with high integrity, and monitor the impact of solutions. TIPS tools help teams stay focused on improving student academic and life success. Effective use of data and business intelligence is a key part of the WCI process.

As part of the planning and development stage of WCI, we take inventory of strategic initiatives. In 2012, we began the Tacoma Whole Child Initiative (TWCI) by inventorying more than 250 different programs in operation and found significant confusion regarding priorities. Part of readying district and community leadership for embracing TWCI as a systemic approach to climate transformation in community organizations, schools, and homes was to both eliminate redundant and irrelevant initiatives and to integrate others through a braiding process. Now, TWCI has one key overarching vision which is: Whole Child. This is the purpose, cause, or

belief that inspires individuals at all levels in the community (Sinek, 2018). Underneath the overarching vision are no more than 8 key activities that move the community toward the shared vision.

Using community feedback on hopes and dreams, success, and beliefs, there are several key readiness approaches. First, the school board in the community should adopt a long-term strategic plan based upon community the community definition of youth success. In the TCWI, the community defined success as academic excellence, early learning, safety, and community partnerships. Next, a Multiple Measure Accountability System was developed. In Tacoma, 34 'success' indicators were measured by the Whole Child Benchmarks (for an example, please refer to https://www.tacomaschools.org/strategic-plan/Pages/default.aspx).

Outcomes

Outcome data on WCI indicates that social and emotional health of youth significantly improves (Benner, Allen, Greenaway, & Garcia, 2017; Zeng, Benner, & Silva, 2016). Student, parent, and staff perceptions of school climate and safety significantly rising. Attendance significantly improves and the percentage of students with chronic absences and chronic tardiness continues declines. Students want to come to healthy, safe, supportive, engaging and challenging school environments. Moreover, the hearts of educators continue to change as evidenced by dramatic changes in educator beliefs about student behavior, trauma, and social emotional wellbeing (Benner et al., 2017). Educators will not change their practices to support the whole child unless their hearts are changed first. Educators understand the "why" for sustained implementation of whole child practices and push to continually improve.

Discussion

In this context, WCI equips educators with knowledge and skills to deliver high-quality instruction and maintain an engaging, safe, healthy and challenging learning environment (Benner, Nelson, Ralston, & Mooney, 2010; Carey, 2004; Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, DHHS, 2001; National Institute of Child Health and Human Development, 2000) while strengthening the community and homes. WCI is backed by actionable implementation science findings and strategies, change management strategies, and concrete tools to support effective implementation (Blase, Kiser, & Van Dyke, 2013; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Odom, 2009; Penuel, Fishman, Cheng, & Sabelli, 2011; Wandersman, Chien, & Katz, 2012). Together with the schools and the community, WCI creates unprecedented support for the **whole child** by addressing, connecting and harmonizing academic, social and emotional stability. Long after the 10-year WCI plan has concluded, communities will be able to maintain focus on building resilience and developing the whole child.

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