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COLORADO ASSOCIATION OF SCHOOL BOARDS

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# **Adverse Childhood Experiences: The School Board's Role in Building Connections and Support for Students**

# NSBA's Vision for Equity in Public Education

The promise of public education is for every child to succeed in school and in life. To realize this promise, every child must be given resources, supports, and interventions based on their needs. The nation's school boards are uniquely positioned to and ethically responsible for fulfilling this promise to all students, which is why NSBA is committed to educational equity for all children in public schools.

For the benefit of each student in the United States, NSBA, its Board of Directors and staff embarked on a journey to define the concept of educational equity. Here is the product of this journey:

*“We affirm in our actions that each student can, will, and shall learn. We recognize that based on factors including but not limited to disability, race, ethnicity, and socio-economic status, students are deprived of equitable educational opportunities. Educational equity is the intentional allocation of resources, instruction, and opportunities according to need, requiring that discriminatory practices, prejudices, and beliefs be identified and eradicated.”*

This report was commissioned by the NSBA Equity and Member Services Department.

A special thank you to Joy Schaefer, Vice President of the Frederick County Board of Education (MD), for her authorship of this publication.





# **Adverse Childhood Experiences:**

## The School Board's Role in Building Connections and Support for Students

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## EXECUTIVE SUMMARY

According to research, childhood trauma is among the most relevant and significant psychosocial factors affecting education today.<sup>1</sup> The landmark ACE (Adverse Childhood Experiences) Study, conducted between 1995 and 1997, uncovered the correlation between trauma and toxic stress experienced in childhood to long-term physical and mental well-being in adulthood and into an individual's senior years. Further study and research began to find that certain levels and intensities of Adverse Childhood Experiences (ACEs) cause changes to the development of children's brains, and create challenges to growth and learning.

The scientific data allows educators to shift our approach to meeting students' needs, leading us from traditional questions based on identifying what is "wrong" with a student to uncovering what "has happened" to a student. It also has provided the education community with a set of common terms and specific definitions, such as toxic stress and childhood trauma, by which we can collectively better understand students and effectively address the barriers ACEs present to their well-being and education.

Further, the recognition of the prevalence and consequences of experiencing ACEs indicates the need for a strong commitment to cultural proficiency and equity in our K-12 public education system. The results of the research and the approaches required to respond underscore the need to focus attention to building and maintaining real and meaningful relationships across school communities. Moving districts towards becoming culturally proficient and providing equity for all students begins with the belief in our core responsibility to each and every student, the commitment to developing a deep understanding of each student as an individual, and an examination as adults of our own trauma triggers as well as our biases in attempting to serve students.

School boards have a unique role in the prevention of ACEs and in the direct response to children who are experiencing trauma, toxic stress and prolonged exposure to multiple ACEs. There are specific resources and policies they can put into place, as well as measures they can track in order to ensure their strategies are meeting students' needs and having a positive impact on their academic trajectory.

However, while schools and school districts play a critical role, meaningful prevention and treatment involves multiple agencies and organizations across all sectors—governmental, business and non profit. Effective responses to ACEs requires a complex, integrated and comprehensive effort. School boards must frame ACEs not only as an issue for their school system but for their community. Local boards have the opportunity to affect generational change via this community-wide and ageless issue. Leadership now will benefit current students, building their capacity as adults and as parents of our next generation of children.







## INTRODUCTION

Educators are well aware that their ability to teach their students is greatly affected by the degree to which they arrive at school “ready to learn.” But traditionally, “ready to learn” has, for the most part, focused on early childhood education. And the attention that has been paid to children’s caregiving centered mainly on the development of literacy and communication skills, or exposure to a wide variety of experiences. Far less attention was given to other foundational experiences, negative or positive, or to the home environment. Additionally, while there have been numerous studies on the immediate and long-term effects of issues like child abuse and neglect, they usually have focused on a single type of abuse and have not considered negative household conditions that might co-occur and involve children, such as parental drug use, criminal activity or spousal violence.<sup>2</sup>

Over the last two decades, a great deal of research has been conducted examining a child’s negative experiences, exposure to toxic stress, and the lifelong consequences of childhood trauma. Groundbreaking research, led by the 1998 study conducted by Kaiser Permanente in partnership with the Centers for Disease Control and Prevention (CDC), began to uncover the connection between Adverse Childhood Experiences (ACEs) and negative effects of prolonged and frequent trauma on children, their development and their physical and mental health outcomes as adults. While initial studies examined the correlation between toxic stress, complex childhood trauma, and outcomes on mental and physical health in adulthood, the subsequent studies inform the more immediate concerns for schools and school systems in terms of the learning and the emotional and behavioral needs of students who have had or who are currently experiencing ACEs.

There is currently substantial research connecting ACEs to academic outcomes and examining the intersection of ACEs with other factors such as socioeconomic status and race. Data all indicate that a direct response is required by schools and districts to support children, and support should include prevention as well as mitigation and treatment of toxic stress and trauma. Further, the complexity of the issues around trauma and ACEs requires schools and districts to reach beyond the classroom and the school building, and into the families and communities they serve.

This position paper provides an overview of ACEs, what it means for readiness to learn, and the role of school boards in providing leadership and capacity that will result in meaningful support for students and systemic change for school communities.





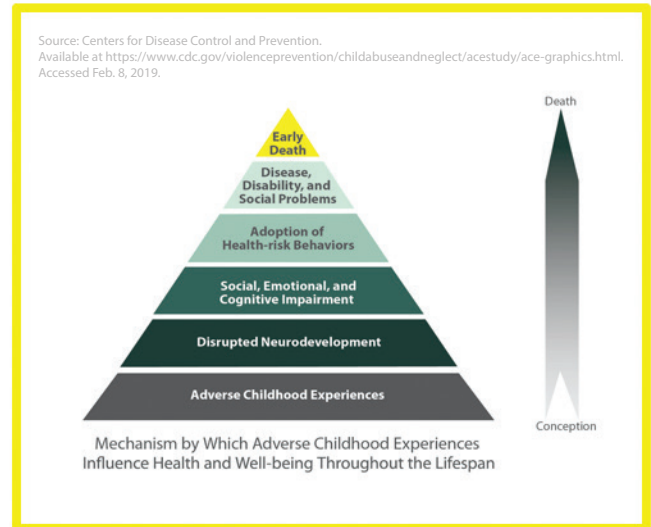


# UNDERSTANDING ACES

The concept of Adverse Childhood Experiences (ACEs) rests on the foundational belief that all childhood experiences, positive or negative, have a substantive impact on an individual during childhood and as an adult. Our knowledge on this issue is based on the 1998 CDC Kaiser Permanente Adverse Childhood Experiences Study (ACE Study), one of the largest investigations of the connection between childhood abuse, neglect and household dysfunction to later-life health and well-being.

Collecting data in two waves, Kaiser surveyed over 17,000 of its Health Maintenance Organization members in Southern California who received physical exams in 1995 and 1997. Members were asked questions related to their childhood experiences and to current health status and behaviors.

ACE questions referred to the respondent’s first 18 years of life, categorized into three groups: abuse, neglect and family or household challenges. Respondents answering these questions received a point for each “yes.” The measures of childhood exposure to abuse and household dysfunction are a sum of the categories.



## Abuse

- **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.

## Household Challenges

- **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother’s boyfriend.
- **Household substance abuse:** A household member was a problem drinker or alcoholic or a household member used street drugs.
- **Mental illness in household:** A household member was depressed or mentally ill or a household member attempted suicide.
- **Parental separation or divorce:** Your parents were ever separated or divorced.
- **Criminal household member:** A household member went to prison.

## Neglect\*

- **Emotional neglect:** Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and felt close to each other, and your family was a source of strength and support.\*\*
- **Physical neglect:** There was someone to take care of you, protect you, and take you to the doctor if you needed it\*, you didn’t have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

\* Collected during Wave 2 only.  
 \*\* Items were reverse-scored to reflect the framing of the question.

Source: Centers for Disease Control and Prevention. Available at <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html>. Accessed Feb. 8, 2019.

# Prevalence of ACEs

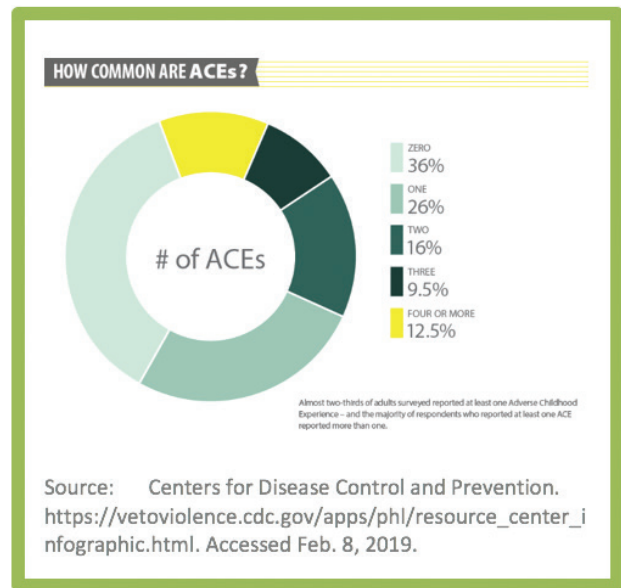
The study surveys revealed that ACEs are common. Almost two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs. In fact, the majority of respondents who reported at least one ACE reported more than one.

The ACE score, a total sum of the different categories of ACEs reported by participants, is used to assess cumulative childhood stress. Study findings repeatedly revealed a “graded dose-response” relationship between ACEs and negative health and well-being outcomes across the life course.<sup>3</sup>

Further there existed “a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.”<sup>4</sup>

In other words, as the level of exposure to an ACE increased, the intensity of the outcome for the individual also increased, and having one or more ACE can have lasting effects on an individual’s health, behavior and life potential.<sup>5</sup>

As the number of ACEs increases, so does the risk for specific physical and mental health outcomes in adulthood. Those risks can include alcoholism, alcohol abuse, chronic obstructive pulmonary disease, depression, illicit drug use, ischemic heart disease, liver disease, poor work performance, financial stress, risk for intimate partner violence, sexually transmitted diseases, smoking and risk for sexual violence.<sup>6</sup>



## ACEs can have lasting effects on...



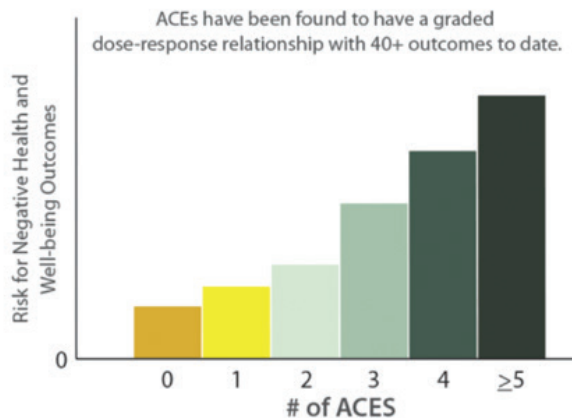
Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)



Behaviors (smoking, alcoholism, drug use)



Life Potential (graduation rates, academic achievement, lost time from work)



Source: Centers for Disease Control and Prevention. Available at <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html>. Accessed Feb 8, 2019.



# ACEs and Education

Building on the ACE Study, there is now substantial research into the correlation between ACEs and their effect on the developing brains of children, their social and emotional development, and the relationship to their ability to be effective learners.

Findings reveal that understanding and responding to students' ACE profile may be critical in setting a child's academic path. The research reveals that in order to ensure students' success and achieve equity across schools, school boards must respond directly to the challenges of ACEs through their allocation of resources, development of policies and approaches, and progress monitoring.

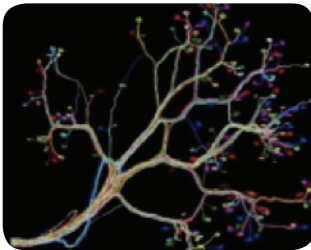
## Brain Development of Children and Exposure to ACEs

There are immediate effects of ACEs on a child's developing brain that manifest themselves in the classroom as behavioral issues, delays in language processing and communication, and trouble with or inability to self-regulate behavior and cope with challenges or adversity. In adolescence and early adulthood, the effect might be to engage in risky behavior beyond the typical extent.

Recently, there has been a tremendous amount of research and data that connect toxic stress, such as that caused by ACEs, and the changes it causes in the way that the developing brain works and grows. This is even more impactful when we consider that the brain is growing and changing, on average, through the age of 22 for girls, and 25 for boys.<sup>7</sup>

Traumatic stress causes danger-producing emotions (fear, anger, anxiety), which trigger stress hormones (adrenaline and cortisol), that, in turn, stimulate our natural "flight or fight stress response (FFSR).<sup>8</sup> Chronic activation of FFSR causes physical and mental health consequences. Young brains begin to "map" the FFSR response to *anything* that might trigger danger-producing emotions. And because they are young, age-appropriate coping skills and reactions are activated—crying, yelling or physically lashing out.<sup>9</sup> They also might shut down emotionally, or work hard to smooth things over for others, or lash out with anger, blame, or become manipulative. As children age and continue to have no protective factors in place to guide their brains to develop more appropriate coping skills and resiliency, they will continue to rely on these "reactionary" skills versus their "thinking" skills.<sup>10</sup>

### Global Impact of Trauma on a Child's Brain



Toxic stress that is **strong, prolonged and frequent** elicits a frequent fear response.

Source: Martin Teicher, 25th Annual International Trauma Conference, Boston MA, 2014

### Students with... 3 or more ACEs

- 2.5 times more likely to fail a grade \*
- more likely to be unable to perform at grade level \*\*

### 4 or more ACEs

- 32 times more likely to have a behavioral problem in school \*\*\*

Sources: \* Anda, Robert (2015)  
\*\* Balfanz, Vaughan, Fox (2012)  
\*\*\* Carrion, Victor (2014)







# What Can Districts Do?

The good news is that research also has shown that people are resilient and that ACEs can be prevented—and that their impacts can be mitigated, treated, and possibly reversed, in adulthood. The National Center for Injury Prevention and Control has identified eight effective responses to ACEs (see sidebar “What can be done about ACEs?”).

From the list, we can see that the strategies address needs of both children and their families. Some are outside the purview of traditional public schools but are functions of or services provided by non-school-based entities and/or through the wraparound services that can be provided by Community Schools. However, ACEs occur within an individual’s first 18 years of life, and there are immediate effects that manifest themselves as barriers to student learning. Coupled with the fact that school engagement and success are among the most predictive variables of adult healthy outcomes,<sup>11</sup> school districts play an important role with regard to ACEs.

The CDC-Kaiser study noted the positive impact that safe, stable and nurturing relationships and environments (SSNREs) have on a variety of health problems and on the development of skills that allow children to reach their full potential.<sup>12</sup> School districts already work hard to create environments that are safe and stable. Boards of education already understand that the key to student well-being and learning is based on strong, nurturing relationships in addition to high-quality, culturally responsive and trauma-informed instruction in a well-rounded curriculum.

## Prevention




Prevention is the most effective response to ACEs, and while school staff cannot provide services directly to families or to children before they reach school age, there are still many things districts can put into place at the preventative level.

**Early childhood centers and Head Start programs** already provide the opportunity for parents and families to learn with their children and gain parenting skills. They also provide social supports for families as they come together and work with educators and service providers to give children a strong educational foundation.

**Community Schools and School-Based Health Centers** can be leveraged to provide parenting programs and networks of support for families, as can partnerships between agencies to leverage resources and expertise. Families also can receive needed assistance and resources, which can alleviate household stress and instability.

### What can be done about ACEs?

Prevention is key!

-  Home visits to pregnant women and families with newborns
-  Parenting training programs
-  Intimate partner violence prevention
-  Social support for parents
-  Parent support & teens, teen pregnancy prevention programs
-  Mental illness, substance abuse treatment
-  High quality childcare
-  Sufficient income support for lower income families

Source: National Center for Injury Prevention & Control, Division of Violence & Prevention, 2016.

# School-Level Response

Ultimately, the most important thing that schools can put into place is a caring, safe environment that is supportive of and sensitive to students, allowing them to develop resiliency, self-confidence and trust. There are a variety of tools that respond directly to ACEs and build and strengthen positive school culture and environment.

## School-Based Mental Health Supports

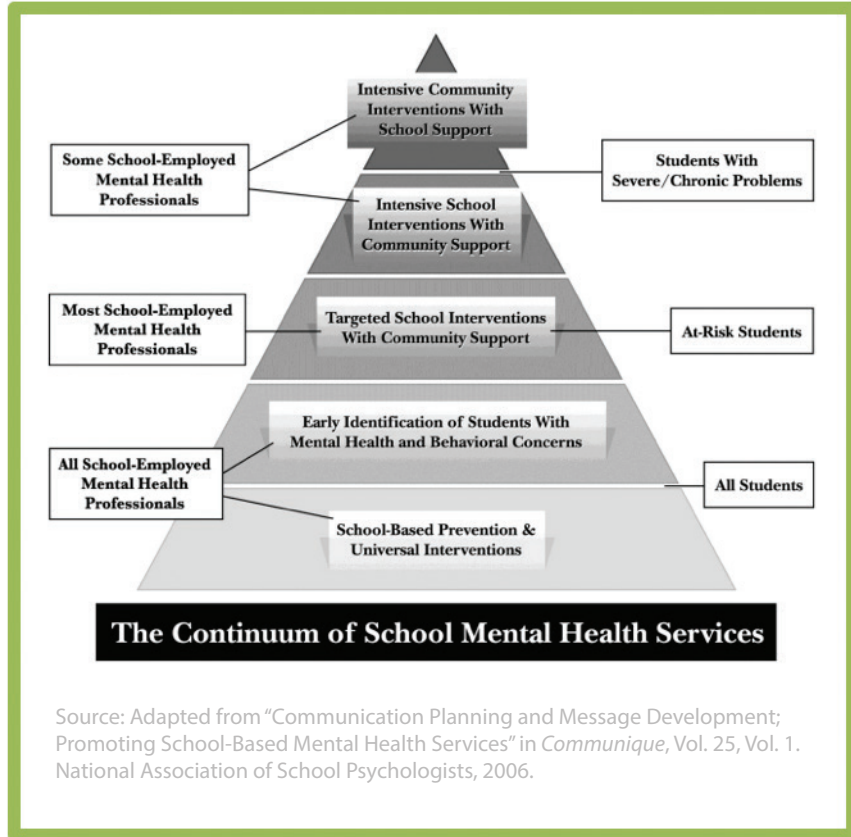
The National Association of School Psychologists articulates what we instinctively know: Mentally healthy children are more successful in school and life. We also know that the need for mental, behavioral and emotional health services is growing.

It's important for school boards to keep in mind that mental health goes beyond the absence of mental illness. School-based mental health supports include social, emotional and behavioral health and the development of coping skills and resiliency. They play a key role in establishing individual relationships with students, thereby building and strengthening a positive, caring and safe school environment. And providing mental health services to students at schools allows for alignment to and support of the education program, providing additional support for academic teaching and learning.

A continuum of school-based mental health supports that is comprehensive and, like all good intervention, is multitiered, is needed in order to effectively address the wide range and varying intensities of student needs. This enables a focus on prevention as well as on intervention.

Consideration must be given to enlisting appropriate professionals and staff for the delivery of specific services, inclusive of prevention, intervention, education and crisis response.

School districts also must attend to the accessibility and availability of services to students, families and staff.





## Trauma-Informed Approach and Practice (Trauma Responsive Schools)

There are many schools and districts embracing aspects of trauma-informed practice. Several states have passed legislation requiring the use of a trauma-informed approach or practice. But it is important to note that trauma-informed practice is not a stand-alone program. Rather, it provides the framework and philosophy to guide systems in implementing various programs, interventions and supports that are culturally aware and developmentally appropriate in the prevention and treatment of trauma.

The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Association (SAMHSA) published a paper that outlines principles around the concept of trauma, trauma-informed approach, a shared understanding of these concepts, and a framework that could be appropriate for a variety of stakeholders and service providers. SAMHSA convened experts in the field, trauma survivors who had experienced treatment and care, researchers, and behavioral health policymakers.<sup>13</sup>

### SAMHSA's Six Key Principles of Trauma-Informed Approach

1. Creation of sense of safety
2. Environment of trust and transparency
3. Support for those with live experiences of trauma
4. Collaboration, sharing of decision-making and power
5. Empowerment and encouraging voice and choice
6. Recognition and respect of cultural, historical or gender experiences and perspectives

Source: SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884 (2014).

SAMHSA has developed specific definitions for key terms, including:

**Trauma:** Experiences or set of experiences or circumstances that cause intense physical and psychological stress reactions and are experienced by an individual as harmful or life-threatening and that result in lasting adverse effects on the individual's physical, social, emotional or spiritual well-being.

**Trauma-informed:** A program, organization, or system that realizes and understands the impact of trauma and potential paths for recovery, recognizes the signs and symptoms of trauma, and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

It should be noted that trauma is complex and presents itself in a myriad of ways, through multiple symptoms. There is no one intervention that is appropriate for all children or that can be used by all ages. And many programs have not yet been or are just beginning to be evaluated. However, there are some that have yielded positive results and/or are founded in evidence-based methodology. The National Association of School Psychologists (NASP) cites several, including trauma-focused cognitive behavioral therapy (TF-CBT) that helps children as well as their caregivers deal with trauma-related difficulties; the Attachment, Self-Regulation and Competency (ARC) model based in child development theory and observed and verifiable research; and the Head Start Trauma program, used in Head Start classrooms to create a trauma-informed culture for our youngest students, their parents, teachers and staff.<sup>14</sup>

## **Restorative Practice/Restorative Justice**

As is trauma-informed approach, restorative practice, also referred to as restorative justice, is not a program. Rather they are practices that work together to build healthy relationships and a strong sense of community that allow individuals to build a safe and positive culture and address conflict or wrongdoing.<sup>15</sup>

Data from school systems is promising, with districts and schools reporting reductions in suspension rates and chronic absenteeism and increases in student academic performance and graduation rates. A response to counter zero-tolerance discipline policies, restorative practices also have been effective in reducing the disproportionality of discipline that often affect students with disabilities, low-income students, and students of color.

In 2014, the National Education Association, the American Federation of Teachers, the National Opportunity to Learn Campaign, and the Advancement Project published a toolkit that provides information on restorative practices and implementation. It notes that districts do not have to adopt new programs. In fact, established, evidence-based programs like Positive Behavioral Interventions and Supports (PBIS) are well-aligned to support restorative practices. An important first step is to reflect current school practice to create a welcoming environment for students, teachers and families.<sup>16</sup>

Several public school districts that employ restorative practice and are noted in the toolkit include Boston, Chicago, Denver, Madison, Minneapolis, New Orleans, New York City, Oakland (CA) and Peoria (IL).

## **Cultural Proficiency/Fluency**

The American Academy of Family Physicians has a simple but straightforward definition of cultural proficiency: the knowledge, skills, attitudes, and beliefs that enable people to work well with, respond effectively to, and be supportive of people in cross-cultural settings. Cultural proficiency, or fluency, requires policies and practices that support individuals in engaging and working with people and groups who are different from them.<sup>17</sup> It is rooted in the concept of self-examination to gain an awareness of one's own cultural beliefs, values, and biases, while working to understand and value the cultures of others around you.

Again, as with the practices previously identified, becoming culturally proficient is a process that involves a continuum of change and growth in perceptions, thinking and behavior that transforms culture and climate. It is a continuum of change that moves individuals, or groups, and institutions from ignoring differences between people to awareness, appreciation and support of and sensitivity to differences. The result is an organization or group of individuals who respect and learn from each other, interact in positive ways, and help, support and advocate for one another.

This kind of transformation requires that people see each other as individuals, a key ingredient of working towards equity throughout the district. It supports a climate that values people and gives them voice. It requires intentional and sustained effort with attention to policies, education and training, resources and operational practices.



## Climate and Connections

The effect of school climate and culture cannot be understated when considering the needs of students with a history of trauma. First and foremost, schools must provide a safe place for students, intentionally focused on not re-traumatizing children who have lived or are living through trauma. All children benefit from a clean, well-maintained physical environment in which there is structure and order that provides a strong sense of stability. This is even more critical for children who have experienced toxic stress. Districts also should be mindful of honoring and encouraging student voice and agency as an important part of building a supportive climate and strong connections.

## What Should School Boards Consider?

At the macro level, school boards are responsible for creating a district culture that values students and therefore supports responses to ACEs that result in meaningful changes in operation and practice. This will require the purposeful allocation of resources, evaluation of policies, and the identification of the right metrics to track efficacy.

### Investing in What Works: Budget Considerations

**Targeted education and on-going training and development** is a must. Meaningful and effective response to ACEs requires district teachers and staff to have a deep understanding of what they are and how to transform their practice. Staff will need this understanding in order to make real connections with students that allow them to trust and be trusted and to feel safe, accepted and valued. Teachers must be able to help students connect their learning with real opportunities, giving them hope for their future. This is much different from the professional development to which staff is accustomed or that districts traditionally provide. Further, continued education will require some staff to have more intensive training as organizational shifts change practice and specific approaches or programs are implemented.

**Expanded or specialized staff** may be needed, depending on the level of trauma and toxic stress of a student body at a particular school. Needs may include the provision of interventions directly to students or support and guidance to teachers and staff.

**Additional time** in the school day may be required, particularly for some of the practices related to restorative approaches. Additional time also can be used to add greater calm and deliberation to the school day, which might serve to alleviate pressure and stress or provide the necessary space to adequately deliver instruction as well as interventions. Changes to the structure of the day or lengthening school hours may require districts to consider additional staffing costs, and therefore additional expenditures.

**Direct services and interventions** to students need to be integrated into the teaching and learning program. This can be provided primarily by school-based staff, but districts should identify and collaborate with external entities as appropriate.

**Partnerships** with outside entities that fill gaps in services, resources and expertise are necessary to leverage all community resources for what is a community issue.

**Curriculum and instruction** that ensures each student has access to courses that directly address avoiding or coping with ACEs, as well as instructional strategies that promote student voice, is a critical factor.







# Board Policies

Broadly speaking, school boards should evaluate their existing policy as to whether they are aligned to support the school-level responses needed and the practices desired. Key policies to evaluate would be those related to discipline and codes of conduct. The foundation of board policies always should be grounded in the core value that all children can learn and in a commitment to meeting all students' needs equitably.

**Effective discipline policies** provide supportive approaches to discipline involving fair and consistent enforcement, accessibility of caring adults, and the avoidance of punitive approaches.<sup>18</sup> Appropriate, evidence-based, and tiered interventions, such as those based on positive behavior supports, have been shown to result in decreased behavior problems and improved academic performance.

**School codes of conduct** should encourage positive student behavior and, for student misconduct, provide a tiered system of graduated responses that are appropriate to the student developmentally while holding them accountable for their actions.

**Policies that institute caring and supportive environments** should be considered apart from discipline and any code of conduct. Policies relating to wellness and civility are effective vehicles for addressing school climate issues. Positive behavioral practices, such as mindfulness or other self-regulatory practices, can be covered in these policies as well. As with the discipline policy, districts also can call for a tiered, age-appropriate approach to emotional, social and behavioral supports for students, aligned to and integrated with the curriculum.

**Mandated training for staff and teachers** is key to awareness, understanding and effective response to ACEs. Educating staff in ACEs and trauma as well as providing ongoing professional development is needed to ensure their capacity to provide support and interventions. And districts should be sensitive to the health and well-being needs of their own staff, perhaps institutionalizing mindfulness activities during the day for them as well as for students.

**Curricular requirements** also can support ACEs awareness and response, as they do physical and mental health awareness and well-being. Examine the health curricula and the physical education requirements across elementary, middle and high school levels. Mindfulness training can be added in a variety of age-appropriate ways—PE units at the elementary or middle school and a PE credit for a yoga class in high school are some examples. A culturally relevant social studies/history curriculum helps young people situate themselves among innovators, inventors, creators, problem-solvers and heroes. In addition, CTE programs give those who may not be interested or immediately able to pursue post-secondary school hope for a future.

## Measuring What Matters

Unfortunately, because individual schools and districts have used varying approaches and practices in responding to ACEs, there is not a rich field of research to point school boards towards the target metrics that ensure progress or success. However, in this area both quantitative as well as qualitative measures are important to capture, especially when success requires not just changes to how districts and schools operate, but also to culture and climate. Additionally, some metrics will be appropriate to measure the efficacy of specific programs, for specific students. Others are appropriate for evaluating the district's approach across the system and the progress towards identified goals.

Some measures to consider:

- Discipline rates, inclusive of suspensions, expulsions, alternative placements, and disproportionality of rates (of all student groups)
- Tracking infractions and discipline response (violent behavior versus dress code violations)
- Time spent on discipline matters; days spent suspended (out of the classroom)
- Attendance and absenteeism
- Student performance in key areas and at critical junctures
- Graduation and drop-out rates
- Teacher satisfaction
- School climate surveys (students, teachers, families)

School boards also must ask themselves some critical questions in three key areas:

- What resources have we allocated (staff, dollars, materials, programs and curricula), and to what end and how have we distributed them?
- Do our policies support practice at the school and classroom levels that will result in the desired outcomes for students, families and staff?
- What data or metrics are we or should we be using to accurately track our progress towards our desired outcomes?

## **Approaching ACEs Essential to Providing Equity**

At the core of the commitment to equity is the belief that all students receive the specific resources that they need in order to be successful. Attending to a student's ACE score provides important information that enables the caring professionals in schools to identify supports necessary to help an individual student succeed.

At the district level, attention to ACEs and the deep understanding of students required can guide resource allocation, policy and accountability towards the support of the unique needs of each and every student. In responding to students in this area, districts are compelled to develop and exercise cultural literacy and make meaningful connections with students. ACEs require school systems to provide students different resources, different supports, at different levels of magnitude.

## **Leading the Community Conversation: The School Board's Unique Role**

School board members have a singular responsibility in their communities, and therefore, a unique and powerful leadership role. With their discussions and deliberations at the board table, school board members set goals and priorities, not just for the school system, but for the larger community.



The commitment to preventing and responding to the issues of ACEs will require focused resources and intentional operational changes, not just on the part of the school system, but on the part of the larger community. ACEs is a community issue, requiring a community response.

By framing the issue effectively at the board table, local school boards can serve as a fulcrum for the district's and community's understanding of and response to ACEs. Boards of education can leverage the resources, expertise and energies of a variety of partners. This convening is a crucial component to responding to ACEs. One evaluation found that, while there were promising outcomes in some communities, all community networks struggled to achieve communitywide change, and no single model worked best in terms of developing either capacity to address ACEs or build resilience.<sup>19</sup>

Knowing the depth and complexity ACEs present, any response must be comprehensive, inclusive of prevention, mitigation and treatment, with a role across all sectors. Partners must understand their unique role in addressing the identification and reduction of toxic stress among their clients. This is not just a preK-12 public school or student issue, but an intergenerational issue across service areas.

The FrameWorks Institute has done extensive work on effective framing of these complex subjects in ways that make them more easily understood, relevant and actionable. ACEs and its effects on brain development may not be as accessible when communicated with research terms, or from a health and mental wellness perspective. FrameWorks suggests using metaphors. Children's brain architecture is built from infancy on, in a process similar to that of building a house. Just as in building a house, the brain's process can run into difficulties along the way—perhaps the foundation is shaky or there is unexpected or undue stress to the structure.

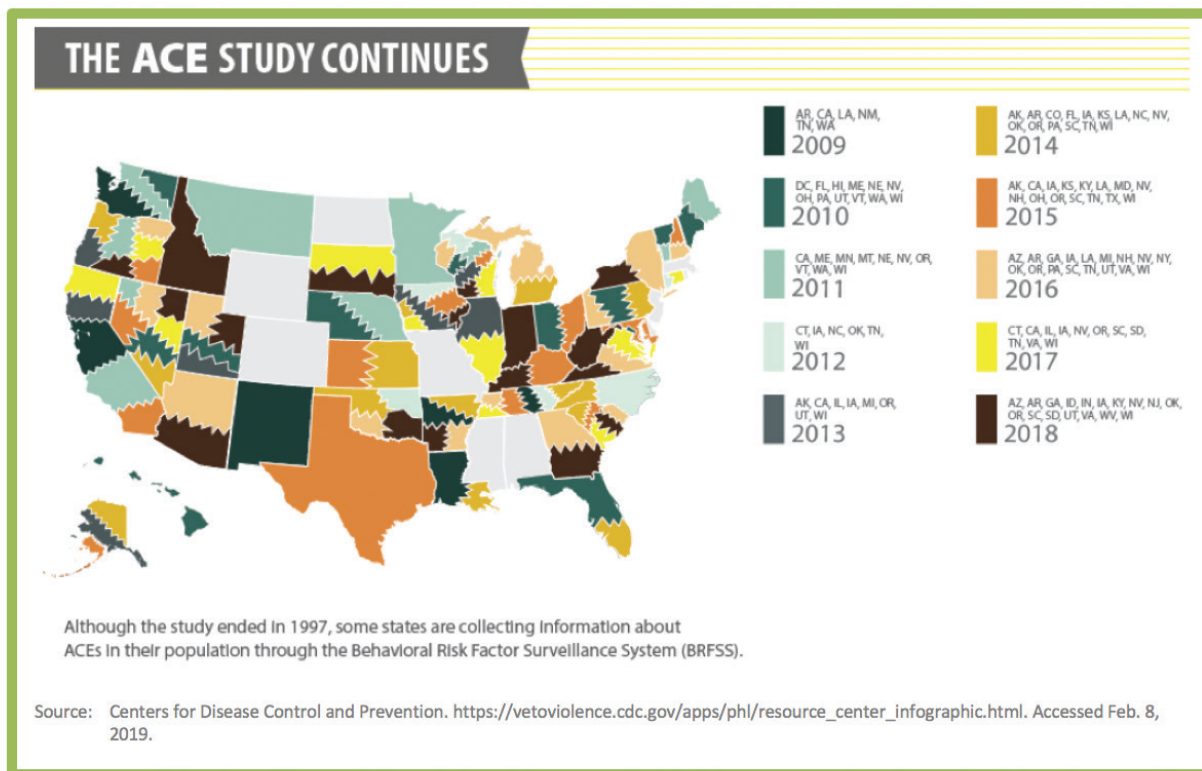
How do school boards handle the discussion around the resources needed to respond to ACEs? Why can't districts respond with the staffing and resources they currently have? FrameWorks suggests school boards talk about the fact that sometimes children need specialized services from specific professionals—behavioral specialists, counselors, school psychologists and specially trained teachers, and school staff.

Additionally, FrameWorks provides guidance in identifying some common thinking that might encourage barriers to mobilizing action. A possible barrier might be the perception that children are shaped by biology or genetics, and therefore nothing can be done. Or, a community might choose to focus on a specific ACE, such as sexual abuse, bogging down the necessary discussion with ineffective responses like enhanced background checks for employees.

## Resources

The studies, research reports and websites cited in this white paper offer a wealth of information and resources. In addition, more research is being done that will assist school boards in keeping abreast of new developments regarding ACEs, and in identifying and evaluating the most effective approaches, strategies, programs and curricula.

Many states are continuing to collect information in their communities about ACEs through their Behavioral Risk Factor Surveillance System (BRFSS), which will further inform the research and produce new data.



NSBA and your state associations have a variety of resources from conferences, symposia, and professional development and learning opportunities to reports, research and publications.

## Call to Action

School board members have long understood that student performance is not just reliant on the teaching and learning that goes on in the school building, between the arrival and dismissal bells. And that “ready to learn,” goes beyond knowing the alphabet or the ability to count to 10. The research of the ACEs Study and the subsequent research in the 20 years that have followed have given boards actionable hard data. Boards of education now have the research, the quantitative and qualitative data, to lead the charge, not only for their school system, but for their community.

School board members also have long understood that outcomes for students are related not only to each of their unique strengths, circumstances and challenges, but to their future path in life and to their ultimate well-being and success as adults. In making the commitment to providing equity and educational excellence to all students, public schools transform the lives of the students they serve. We must make use of the hard data we now have to marshal our collective efforts and fully bring to bear the resources, expertise and energies of our communities to fulfill their critical roles alongside public schools so that we guarantee the full civic participation, financial stability, long-term health, and well-being of our students, their children, and their children’s children.



# END NOTES

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- <sup>6</sup> Centers for Disease Control and Prevention, (2016, June 14) *About the CDC-Kaiser ACE Study*, Retrieved from <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html>.
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## NSBA's Equity Councils

NSBA has four councils that represent school board members in districts with underserved students. The councils—the National American Indian/Alaska Native Council of School Board Members (AIAN), the National Black Council of School Board Members (NBC), the Council of Urban Boards of Education (CUBE) and the National Hispanic Council of School Board Members (NHC)—have been working for years to ensure that school board members both understand and are equipped to support the unique needs of historically disadvantaged children.

The councils promote the goals and vision of the National School Boards Association. The councils' leadership and members contribute through active engagement with school board members and educators by sharing the importance of policies that address the unique cultural and historical perspective of their represented groups. They address the educational challenges of all students attending the nation's public schools.

For more information regarding the councils and NSBA's equity programming, visit [www.nsba.org/equity](http://www.nsba.org/equity), view our "Equity Matters" [video](https://vimeo.com/263029277) at <https://vimeo.com/263029277>, or email [equity@nsba.org](mailto:equity@nsba.org).





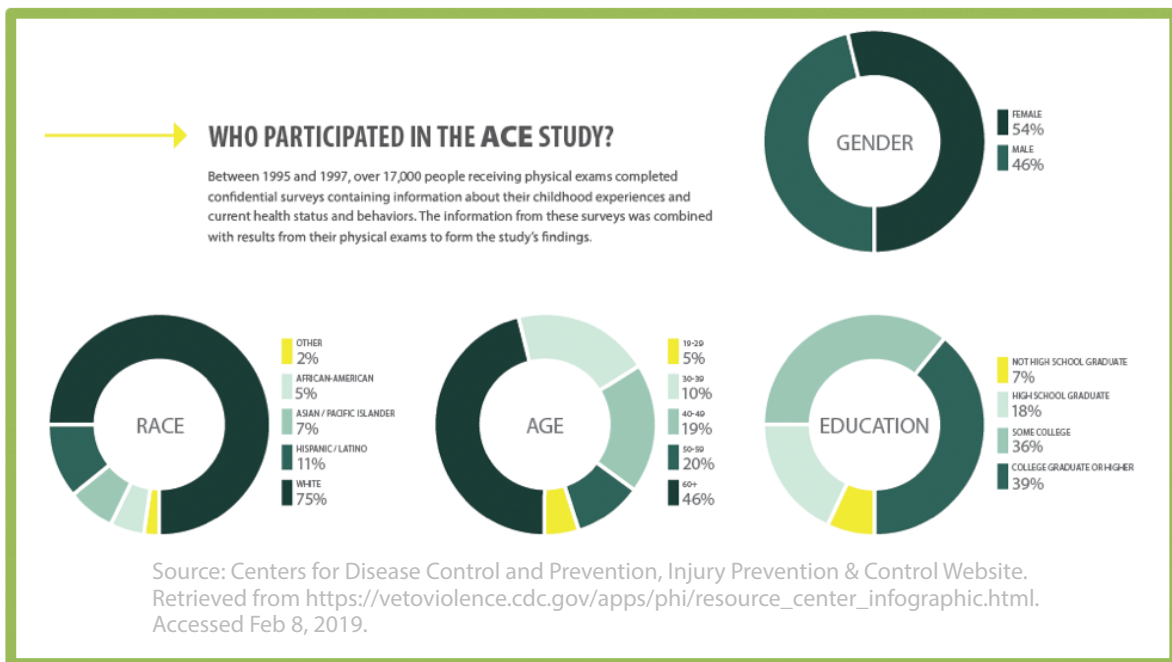


## ADVERSE CHILDHOOD EXPERIENCES (ACEs)

# Considerations for the National American Indian/Alaska Native Council of School Board Members

As with other children and youth of color, Adverse Childhood Experiences (ACEs) are one of the greatest challenges today to American Indian/Alaska Native (AI/AN) students, and they are disproportionately affected relative to white and Asian students. The need for a focus on ACEs in the AI/AN population is strongly suggested by the alignment with many of the negative outcomes identified by data collected by the Indian Health Service as specific concerns.

The original study surveyed a decidedly homogeneous, middle-class cohort. Largely representational of the middle class socioeconomically, 75 percent were white, 39 percent had a college degree or higher and 36 percent had attended some college, and only 15 percent of the study group were 39 years of age or younger.



A central challenge to AI/AN children, youth, and adults is the lack of disaggregated data, either because they are not analyzed or they are grouped, ironically, into an “Other” category. There have been limited studies in two states (Minnesota, South Dakota) and with several tribes.<sup>1</sup> Bearing this in mind, it is imperative that districts, policymakers and researchers understand the importance of using an equity lens in order to facilitate an understanding of structural, historic and systemic contexts related to the lack of data for this group of students.<sup>2</sup>

However, data can be gleaned from research that shows that ACEs are experienced by children of color at a disproportionately higher rate when compared to their white or Asian peers. Additionally, structural inequities impacting AI/AN populations play a role in placing them in other risk categories for experiencing greater amounts of ACEs. Approximately 28 percent of AI/AN children under the age of 18 live in poverty compared to 19.5 percent of children of the same age in the total U.S. population.<sup>3</sup> This same survey shows that for “Other, Non-Hispanic” children, a group that includes AI/AN children, the percentage of children with two or more ACEs is significantly higher than among “White, Non-Hispanic” children (in three regions—Mountain, West North Central, and East North Central—with large AI/AN populations).

**In relation to other children in the U.S., AI/AN children are more likely to have:**

- Lived in poverty
- Observed domestic abuse
- Been a victim of violence or a witness to violence
- Lived with a substance abuser
- Divorced parents
- Lived with a parent who died

Source: Kenny, M.K. & G.K. Singh, 2016. Retrieved from <http://ncbi.nlm.nih.gov/pmc/articles/pmc4977380> [9/12/19].

## The Response

First, boards must conduct district-level data collection and advocate for wider collection with regards to ACEs and the AI/AN population. In the U.S., an estimated 5.6 million people (1.7 percent of the total population) self-identify as AI/AN, either alone or in combination with one or more races, and there are 573 federally recognized tribes. Additionally, among AI/AN populations across the nation, approximately 23 percent are under 18 years of age.<sup>4</sup>

In addition, districts cannot ignore the links to ACEs and the impacts of multilevel, intergenerational historical trauma. School systems must be intentional about acknowledging the pain of this trauma and the healing that is needed at the community level as well as at the student and family level. Outreach to families is also critical considering the higher-level effects of ACEs in AI/AN adults’ experience compared with the rest of the population.

Caring spaces and caring adults are key to helping students deal with ACEs. Restorative practices, a trauma-informed approach, and cultural proficiency are all tools to create those resources.

Additionally, it is imperative that children and youth are surrounded by those supports when they are not in school, and districts must build strong partnerships with other entities to build and create access to external “supplemental” support systems.<sup>5</sup> These partners, in the form of nonprofit organizations, can be another source of safe spaces where children and youth can come into contact with one another, as well as with caring adults, mentors, and role models to build positive relationships and learn and reinforce important skills.

Collaboration with tribes and tribal government are the cornerstone of this approach and represent an important resource that can provide protective factors. They often have programs and services that support their cultures, traditions, values and language, which sustain their sense of identity and community. These partnerships communicate to students their value and unique strengths which will serve to foster greater resiliency—a key characteristic needed in ACEs prevention and intervention.

**Critical Tools include:**

- More robust data collection
- Cultural proficiency
- Trauma-informed approach and practices
- Restorative practices
- Integration of tribal programs and services
- Collaboration with tribes on funding issues, programs and policies
- Robust family & caregiver engagement
- Creating “supplemental” support systems and spaces



# END NOTES

<sup>1</sup> Koss, M.P., Yuan, N.P., Dightman, D., Prince, R.J., Polacca, M., Sanderson, B., Goldman, D. 2013. *Adverse childhood exposures and alcohol dependence among seven Native American tribes*. American Journal of Preventative Medicine. October; 25(3):238-244.

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<sup>5</sup> Jamieson, Kerry. Dec. 13, 2018. *ACEs and Minorities*. Center for Child Counseling website. <https://www.centerforchildcounseling.org/aces-and-minorities>. Accessed on February 13, 2019.





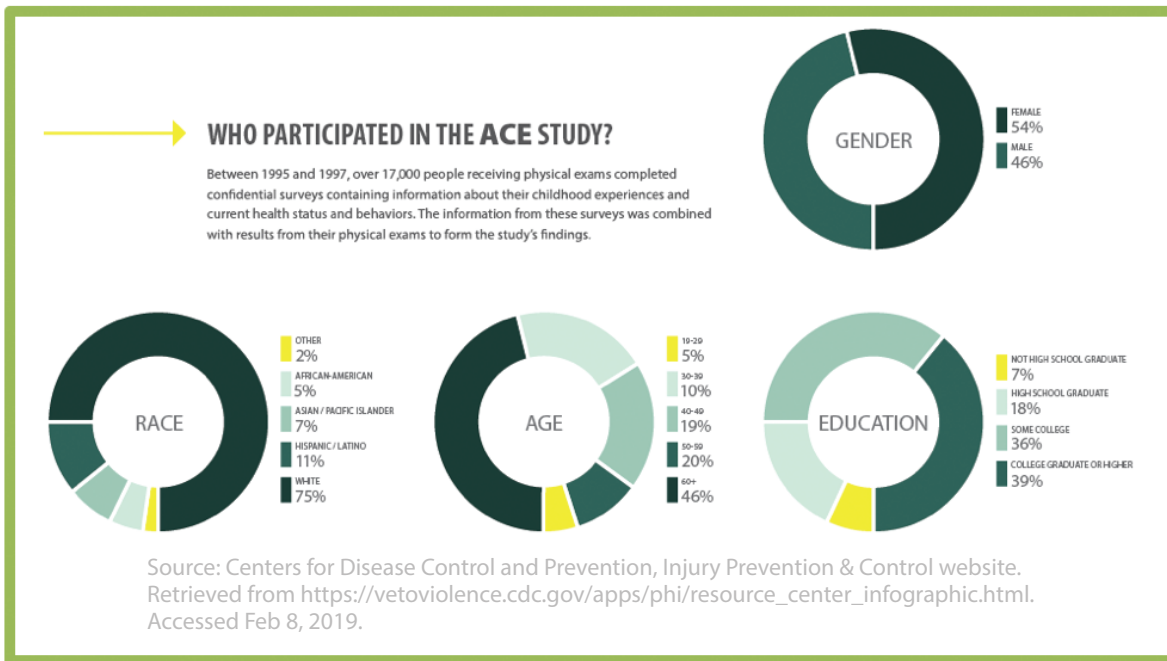


## ADVERSE CHILDHOOD EXPERIENCES (ACEs)

# Considerations for the National Black Council of School Board Members

Adverse Childhood Experiences (ACEs) are one of the greatest challenges today to providing black students equitable access to education and opportunity, particularly since data show that black and Hispanic children and youth in almost all regions of the U.S. are more likely to experience ACEs than their white or Asian peers.

The original study surveyed a decidedly homogeneous, middle-class cohort. Largely representational of the middle class socioeconomically, 75 percent were white, 39 percent had a college degree or higher and 36 percent had attended some college, and only 15 percent of the study group were 39 years of age or younger.



The original study did not survey nor did it take into consideration the impact of race or socioeconomic status with regards to ACEs, and it did not examine the intersection of and relationship of these factors with ACEs. However, more recent research has shed light on the effects of other adverse experiences and subsequent surveys have included a breadth of experiences including race and experience with discrimination.

Other studies have included factors that many black children and youth experience at disproportionately higher rates than their white peers, caused by stress rooted in structural inequities. Discriminatory housing practices, employment policies, immigration laws, bias in law enforcement and sentencing, and social bias and racism all play a role in creating trauma-producing environments, possibly also with high poverty, residential instability, high unemployment, inadequate or no access to nutritious food, and higher rates of community violence.<sup>1,2</sup>

Some researchers are focusing on racism as a specific ACE and the effects on children and youth with regards to their development and health outcomes. For example in 2010, Dr. Lee Pachter and his colleagues at St. Christopher's Hospital for Children in Philadelphia developed a questionnaire intended to look specifically at experiences of racial discrimination. More than 250 children in Hartford, Connecticut, and Providence, Rhode Island—the majority of them Latino, African-American, or Afro-Caribbean—filled out the survey which included the questions: Had they been followed by a security guard while shopping in a store? Had they been called names because of their race, ethnicity, accent or gender? Had they ever felt someone was afraid of them? Eighty-eight percent of respondents perceived racial discrimination in at least one of the 23 scenarios.<sup>3</sup>

## The Response

Certain tools are critical to respond effectively to ACEs and to gain, through their use, a meaningful and deep understanding of black students.

In addition to the importance of social-emotional learning and school-based mental health services to build coping skills and resiliency, it is important that interventions and services be provided early. Supportive factors must be put into place to help children and their families to process adversity and move beyond them. This requires robust family and caregiving engagement to enable access to resources, support, and help to build skills that allow them to help their children.

Caring spaces and caring adults are key to helping students deal with ACEs. Restorative practices, a trauma-informed approach and cultural proficiency are all tools to create those resources. Additionally, it is imperative that children and youth are surrounded by those supports when they are not in school and districts must build strong partnerships with other entities to build and create access to external “supplemental” support systems.<sup>4</sup> These partners, in the form of nonprofit organizations, can be another source of safe spaces where children and youth can come into contact with one another as well as with caring adults, mentors and role models to build positive relationships and learn and reinforce important skills.

Districts should remember that some of the systemic causes to ACEs experienced by black students are too big for schools and school systems to mitigate and deal with in isolation. They are community issues, and therefore must be met with a community response.

### Critical Tools Include

- Early interventions and social-emotional learning
- School-based mental health services
- Trauma-informed approach
- Restorative practices
- Cultural proficiency
- Robust family & caregiver engagement
- Creating “supplemental” support systems and spaces

## END NOTES

<sup>1</sup> Centers for Disease Control and Prevention, Division of Violence Prevention. *Risk and Protective Factors*. February 26, 2019. Website. <https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>. Accessed on February 8, 2019.

<sup>2</sup> Slopen, N., Shonkoff, J.P., Albert, M.A., Yoshikawa, H., Jacobs, A., Stoltz, R., Williams, D.R., 2016. *Racial Disparities in Child Adversity in the U.S.: Interactions with Family Immigration History and Income*. American Journal of Preventative Medicine. 50(1):48.

<sup>3</sup> Pachter, L.M., Bernstein, B.A., Szalacha, L.A., Garcia Coll, C., (2010) Health Social Work Journal, February; 35(1):61-69.

<sup>4</sup> Jamieson, Kerry. Dec. 13, 2018. *ACEs and Minorities*. Center for Child Counseling website. <https://www.centerforchildcounseling.org/aces-and-minorities>. Accessed on February 13, 2019.



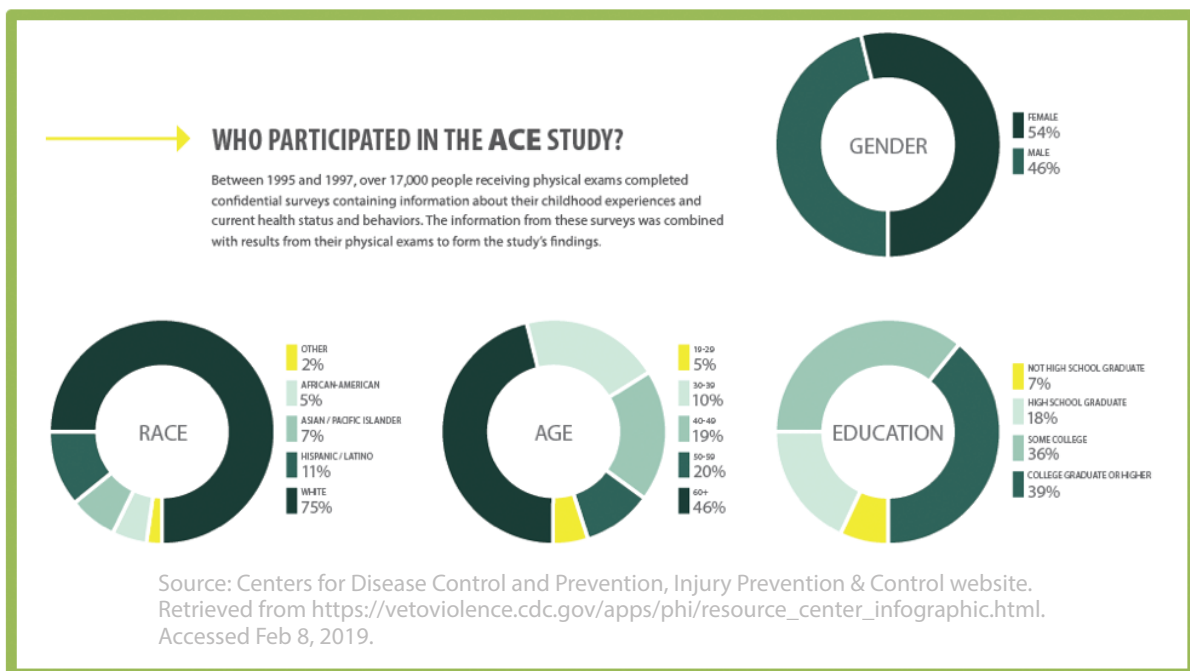




## ADVERSE CHILDHOOD EXPERIENCES (ACEs)

# Considerations for the National Hispanic Council of School Board Members

Hispanics are the largest and fastest-growing racial/ethnic group in the U.S. As of 2015, there were 56.5 million Hispanics in the U.S., which comprised approximately 17.6 percent of the total population. Nationally, 51 percent of Hispanic children have experienced one Adverse Childhood Experience (ACE), compared to 61 percent of black children and 40 percent of white children.<sup>1</sup> Important to consider with regards to the Hispanic population: 34 percent were foreign-born compared to 65.5 percent U.S.-born. In terms of ACEs, districts must attend to this group of students as a whole, as well as to the specific needs for U.S.-native students and for students in immigrant families.<sup>2</sup>



The original study surveyed a decidedly homogeneous, middle-class cohort. Largely representational of the middle class socioeconomically, 75 percent were white, 39 percent had a college degree or higher and 36 percent had attended some college, and only 15 percent of the study group were 39 years of age or younger.

The original study did not survey nor did it take into consideration the impact of race, socioeconomic or immigration status with regards to ACEs, and it did not examine the intersection of and relationship of these factors with ACEs. However, more recent research has shed light on these factors and their relationship to ACEs.



It is important to consider the proportion of Hispanic youth in the U.S. They are the youngest major racial or ethnic group in the country, and one-third (nearly 18 million) are younger than 18 years of age. In 2015, 62 percent lived in low-income families (with incomes below 200 percent of the federal poverty line), which is twice the proportion for white children. And, while important gains have been made, particularly in the areas of health coverage for children and the narrowing gap in high school graduation rates between white and Hispanic youth, academic gaps still persist.<sup>3</sup> Additionally, needs of student populations vary by region. For example, while southeastern states have had greater influxes of new immigrants over the past decade, they also have higher numbers of first-and second-generation Hispanics and Latinos.<sup>4</sup>

Other unique considerations for Hispanic students are those regarding children in immigrant families compared with Hispanic children in U.S.-native families. Research has uncovered that more children in immigrant families lived below or at 200 percent of the federal poverty level compared with children in U.S. native families (80 percent vs. 47 percent, respectively). However, 30 percent of children in U.S. native families reported high ACEs compared with only 16 percent of children in immigrant families. It is still unclear as to why children in immigrant families have significantly lower odds of exposure to ACEs despite a higher prevalence of poverty. Researchers suggest there might be protective factors, either in immigrant families or immigrant communities, which “buffer” children from exposure. It is also possible that ACE survey questions do not capture adverse experiences specific to immigrant families.<sup>5</sup>

#### **Critical tools include:**

- Interventions and social-emotional learning
- School-based mental health services
- Trauma-informed approach
- Restorative practices
- Cultural proficiency
- Robust family/caregiver engagement & connection
- Creating “supplemental” support systems and spaces
- Language, translation services

## **The Response**

Districts must be particularly sensitive to the different needs of their Hispanic students who are U.S.-born versus those who are foreign-born. Not only must school boards attend to differences in culture and unique academic and social-emotional learning needs, but maintain sensitivity to language, translation and effective communication.

In addition to the importance of social-emotional learning and school-based mental health services to build coping skills and resiliency, it is important that interventions and services be provided early. Supportive factors must be put into place to help children and their families to process adversity and move beyond them. These are particularly crucial to a growing population of immigrant students who have experienced trauma in their home countries and/or for whom formal education is a new and unfamiliar experience. Robust family engagement will enable all to access resources, support and help that builds skills necessary to help their children. Specifically for immigrant families, support in navigating the district and connecting home to school is a must.

Caring spaces and caring adults are key to helping students deal with ACEs. Restorative practices, a trauma-informed approach and cultural proficiency are all tools to create those resources. Additionally, it is imperative that children and youth are surrounded by those supports when they are not in school and districts must build strong partnerships with other entities to build and create access to external “supplemental” support systems.<sup>6</sup> These partners, in the form of nonprofit organizations, can be another source of safe spaces where children and youth can come into contact with one another as well as with caring adults, mentors and role models to build positive relationships and learn and reinforce important skills. For families new to the U.S., these partners should include organizations serving Spanish-speaking communities and immigrants.

## END NOTES

<sup>1</sup> Jamieson, Kerry. Dec. 13, 2018. *ACEs and Minorities*. Center for Child Counseling Website. Retrieved from: <https://www.centerforchildcounseling.org/aces-and-minorities>. Accessed February 13, 2019.

<sup>2</sup> Flores, A. 2017. *Facts on U.S. Latinos, 2015. Statistical portrait of Hispanics in the United States*. Pew Research Center, Hispanic Trends. (September 18, 2017) Retrieved from <http://www.pewhispanic.org/2017/09/18/facts-on-u-s-latinos>. Accessed on March 3, 2019.

<sup>3</sup> Mather, M. 2016. *Trends and Challenges Facing America's Latino Children*. Population Reference Bureau. Washington, D.C. Retrieved from <https://www.prb.org/trends-and-challenges-facing-americas-latino-children>. Accessed March 3, 2019.

<sup>4</sup> Mather, M. 2016.

<sup>5</sup> Caballero, T.M., Johnson, S.B., Buchanan, C.R.M, DeCamp, L.R., 2017. *Adverse childhood experiences among Hispanic children in immigrant families versus US-native families*. American Academy of Pediatrics. Nov:140(5).

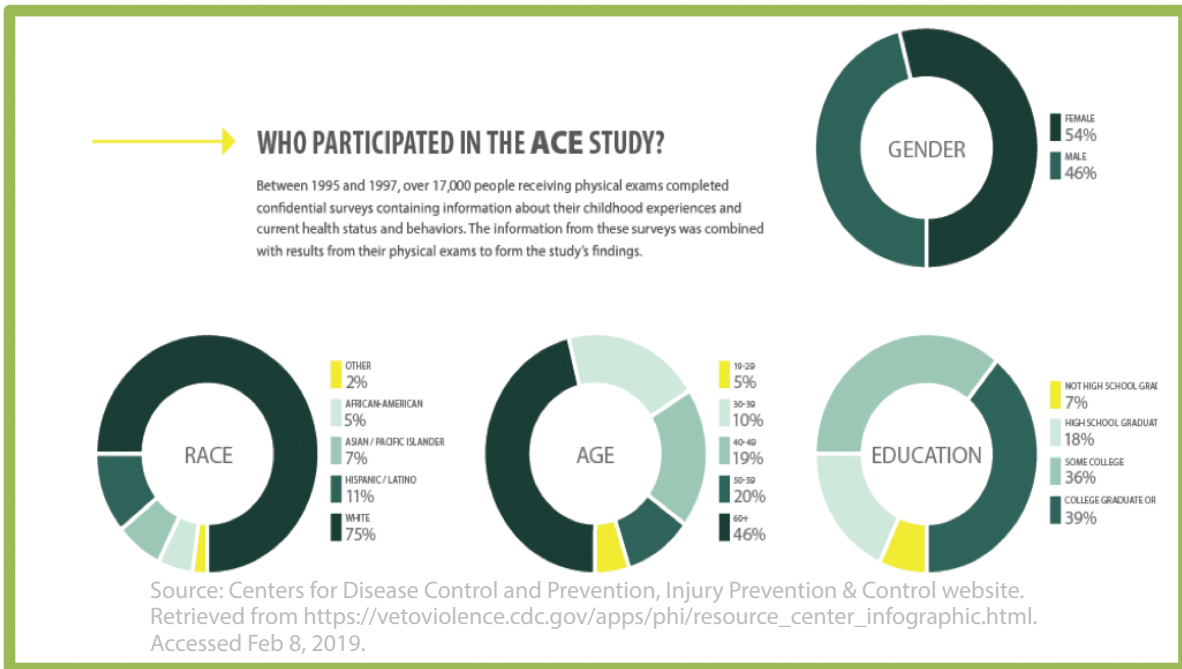
<sup>6</sup> Jamieson, Kerry. 2018.



## ADVERSE CHILDHOOD EXPERIENCES (ACEs)

# Considerations for Council of Urban Boards of Education

As with many education issues, urban school districts have unique challenges, as well as unique advantages in terms of the effects of Adverse Childhood Experiences (ACEs) on students and the appropriate response to student needs. The traditional challenges of size, concentration and intensity are constant factors. The added complexity for urban districts as it relates to ACEs is the need to expand the original 10 adverse childhood experiences identified in the 1998 CDC-Kaiser Permanente ACEs Study. However, urban districts have advantages that suburban and rural districts often do not: diversity of students, staff and community as well as more ready access to community-based resources and service providers across a variety of sectors. Both of these factors position urban boards of education to address this issue.



The original study surveyed a decidedly homogeneous, middle-class cohort. While the number, more than 17,000, was substantial, participants did not mirror the diversity of many urban communities. Largely representational of the middle to upper-middle class socioeconomically, 75 percent were white, 39 percent had a college degree or higher and 36 percent had attended some college, and only 15 percent of the study group were 39 years of age or younger.

Urban districts serve a much more socioeconomically and racially diverse community. Examining the statistics collected by the National Center for Education Statistics (NCES), there are substantially higher percentages of black and Hispanic students in urban districts, as well as a more diverse population across all socioeconomic strata, including a higher percentage of students who qualify for free

and reduced-priced meals. A large percentage of English learners (ELs) also are served by our districts in urbanized areas. In 2015, the percentage of students who were ELs was higher for school districts in more urbanized areas than for those in less urbanized areas—14 percent on average in urban districts, compared to 9.1 percent in suburban areas, 6.5 percent in towns, and 3.6 percent in rural areas.<sup>1</sup>

In terms of racial diversity, the data indicate that urban school boards must be particularly attentive to students with ACEs. A 2016 study published in the *American Journal of Preventive Medicine (AJPM)* reported that subsets of U.S. children—racial/ethnic minority children, children of parents with lower levels of education, and, for some risk factors, children of immigrant parents—have a disproportionately higher prevalence of ACEs which mirror persistent racial, ethnic and socioeconomic disparities.<sup>2</sup> The study also noted that the data regarding these disparities moves the conversation beyond discussions of whether race, ethnicity and socioeconomic status matter to how they operate together and are conditional on one another.<sup>3, 4</sup>

Additionally, the original 1998 study model did not address any structural inequities that manifest themselves in the creation of trauma-producing environments. These would include discriminatory housing practices, employment policies, immigration laws, bias in law enforcement and sentencing, and social bias and racism. This would suggest that, for some districts in some locations, childhood experiences in the context of concentrated community disadvantage (high poverty, residential instability, high unemployment, inadequate or no access to nutritious food, high unemployment) might need consideration in conjunction with childhood experiences within stressed or dysfunctional households.<sup>5</sup>

## The Response

Because of the narrative that we are accustomed to hearing when districts in urbanized areas are discussed—the focus on the deficits and challenges—coupled with the focus in ACEs studies and research on negative experiences, urban school boards have the added leadership responsibility to expand and frame the issue to focus on the strengths and factors that provide protection and resiliency to students and communities.

For example, the data in the 2016 *AJPM* study reveal that, although children of immigrant parents often have higher poverty rates, lower parent education, and less access to health care relative to U.S.-born parents, they have similar and sometimes better health-related outcomes for a variety of measures. This suggests there might be cultural, contextual or behavioral characteristics that protect immigrant children against the typical consequences expected as a function of low socioeconomic status.<sup>6</sup>

Additional considerations urban boards should give as they respond to ACEs include the elevation of student voice and robust and meaningful family involvement. Because very few assessments convey the multiple adversities to which urban students are exposed, it is imperative that the understanding of their experiences are elevated through our ability to hear their perspectives and points of view. As mentioned previously, focusing on students', families', and the community's protective factors are a necessary component of the response of urban districts to the challenges of ACEs. Programs and opportunities should build meaningful, two-way family engagement, and provide services, assistance and enhancement of skills and knowledge of parents, caregivers and guardians to support students.

Districts also should take full advantage of the diversity of their student body, community and their teaching staff to enhance efforts around cultural proficiency. Proximity to a concentration of services, providers and partners across multiple sectors are an added resource for districts in urban environments.



# END NOTES

<sup>1</sup> U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), “Local Education Agency Universe Survey,” 2015-16. See Digest of Education Statistics 2017, table 214.40. [https://nces.ed.gov/programs/coe/pdf/coe\\_cgf.pdf](https://nces.ed.gov/programs/coe/pdf/coe_cgf.pdf).

<sup>2</sup> Slopen, N., Shonkoff, J.P., Albert, M.A., Yoshikawa, H., Joacobs, A., Stoltz, R., Williams, D.R., 2016. *Racial Disparities in Child Adversity in the U.S.: Interactions with Family Immigration History and Income*. American Journal of Preventative Medicine. 50(1):48.

<sup>3</sup> Farmer, M.M., Ferrar, K.F. (2010). *Are racial disparities in health conditional on socioeconomic status?* Social Science Medicine. 60(1):191-204.

<sup>4</sup> Williams, D.R. (1999) *Socioeconomic status and health. The added effects of racism and discrimination*. Ann NY Academy of Science. 896(1):173-188.

<sup>5</sup> Centers for Disease Control and Prevention, Division of Violence Prevention. Risk and Protective Factors. February 26, 2019. Website. <https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>. Accessed on February 8, 2019.

<sup>6</sup> Slopen, et al. 2016. Am J Prev Med 50(1):48.







## ABOUT NSBA

The National School Boards Association (NSBA) is the leading advocate for public education. For almost 80 years, we have been leading the effort to support and enhance public education. We are succeeding in creating the best possible environment in which students can realize their dreams.

NSBA is a federation of 49 state associations and the U.S. territory of the Virgin Islands, representing their more than 90,000 school board officials. These local officials govern more than 13,600 local school districts serving more than 50 million public school students. Working with and through our state associations, and serving as their Washington, D.C., office, NSBA advocates for equity and excellence in public education through school board governance.

We believe public education is America's most vital institution. It is a civil right necessary to the dignity and freedom of the American people, and all children deserve equal access to an education that allows them to reach their potential.

In pursuit of these beliefs, NSBA and our members will continue to lead the national conversation about public education, advocate for public policies that ensure all students everywhere have access to a great public education where they live, create a better understanding of the importance of school boards and the benefits of local governance, and enhance the effectiveness of school boards.

NSBA and our members utilize our resources including the Council of School Attorneys (COSA), the Council of Urban Boards of Education (CUBE), the National Black Council of School Board Members (NBC), the National Hispanic Council of School Board Members (NHC), the National American Indian/Alaska Native Council of School Board Members (AIAN), the Conference of State Association Legislative Staff (CSALS), the Federal Relations Network (FRN), the Friends of Public Education Network (FPE), the National School Boards Action Center (NSBAC), the Center for Public Education (CPE), and a robust and continuous media program to fulfill our mission.

NSBA is a not-for-profit organization. The public policy agenda is determined by a 150-member Delegate Assembly made up of local school board members who represent their state associations of school boards. The Board of Directors translates this policy into action. Programs and services are administered by the NSBA Executive Director and CEO and by professional staff. NSBA is headquartered in Alexandria, Virginia, in the metropolitan Washington, D.C., area.



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