CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE
Putting Health Care Where Kids Are

Adolescent Development and Trauma: Considerations for Educators

Alicia Rozum, MSW, PPSC
Project Director, Mental Health

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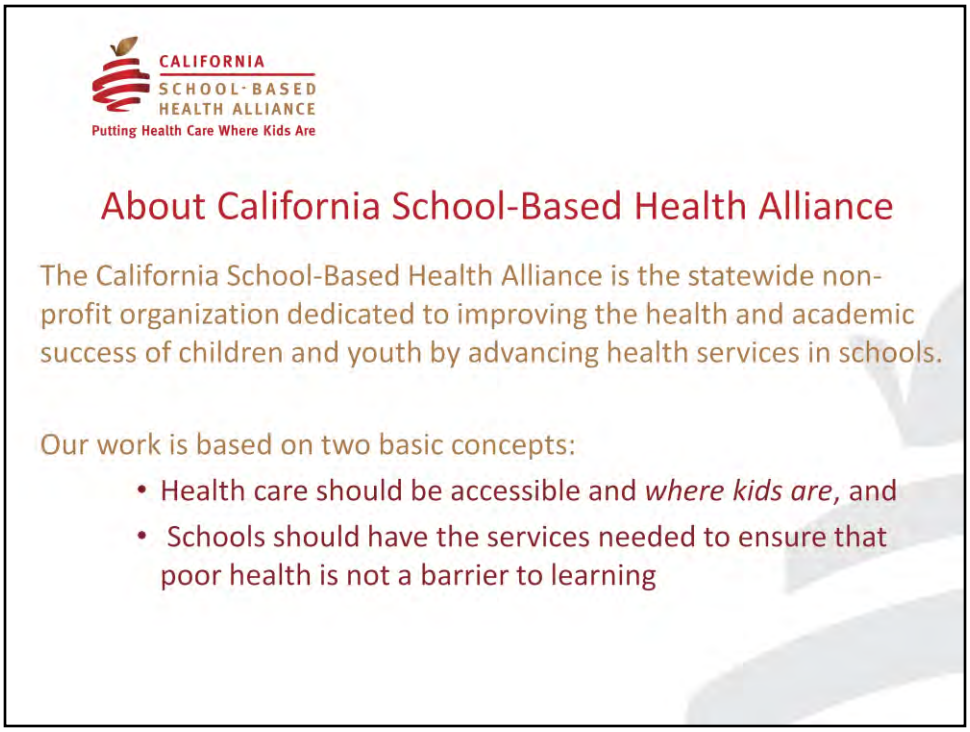
Putting Health Care Where Kids Are

Webinar Housekeeping

- Everyone is in "listen-only" mode
- Two listen options: phone or web
- Type questions in the sidebar to the right
- The powerpoint, notes, and supporting materials will be emailed to you and available on our website
- The webinar recording will be available on our website
- There will be a few polls during the webinar, which you can respond to in the right sidebar
- Contact me afterwards if you have further questions or want more technical assistance



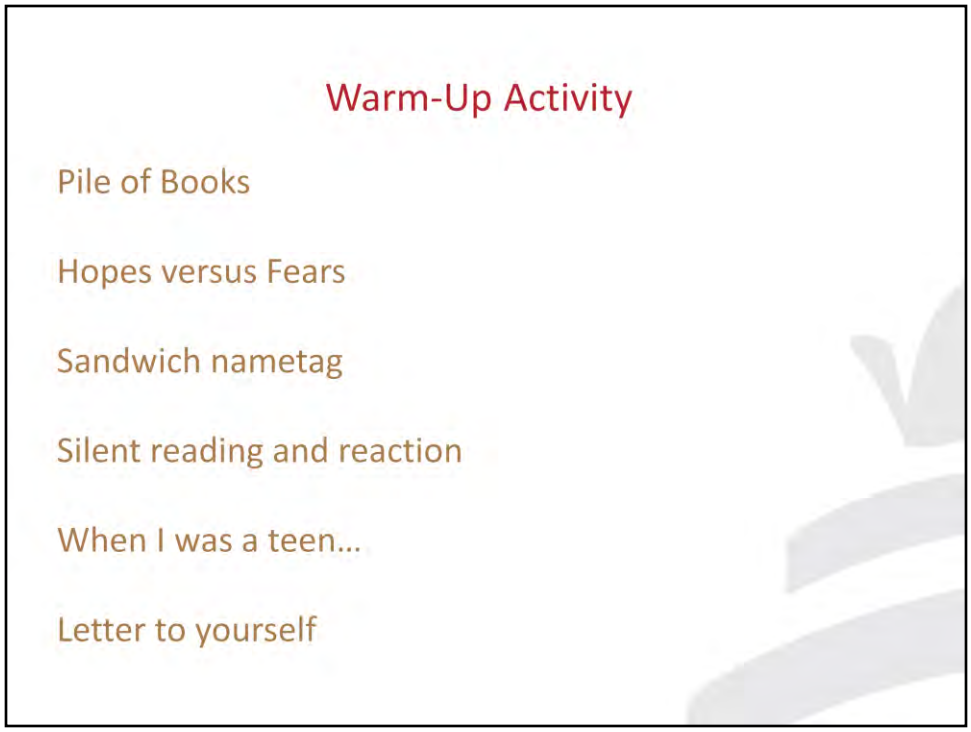
We are available to provide technical assistance and support to schools and community agencies around the integration of health services in schools. I'm focused on supporting the establishment, expansion, or enhancement of mental health services and programs in schools.

Acknowledgements: When I was working at a high school, I was fortunate to be trained by the UCSF HEARTS program in trauma-informed classrooms. It's important to note that this presentation is greatly influenced by what I learned from Dr. Dorado and Ms. Dolce, and please be sure to include the complete list of references near the end when you present this topic.

It's important to acknowledge early and often that your audience may have a lot of experience working with teens and/or traumatized youth. You are building on existing knowledge and skills, and sharing the latest research developments.

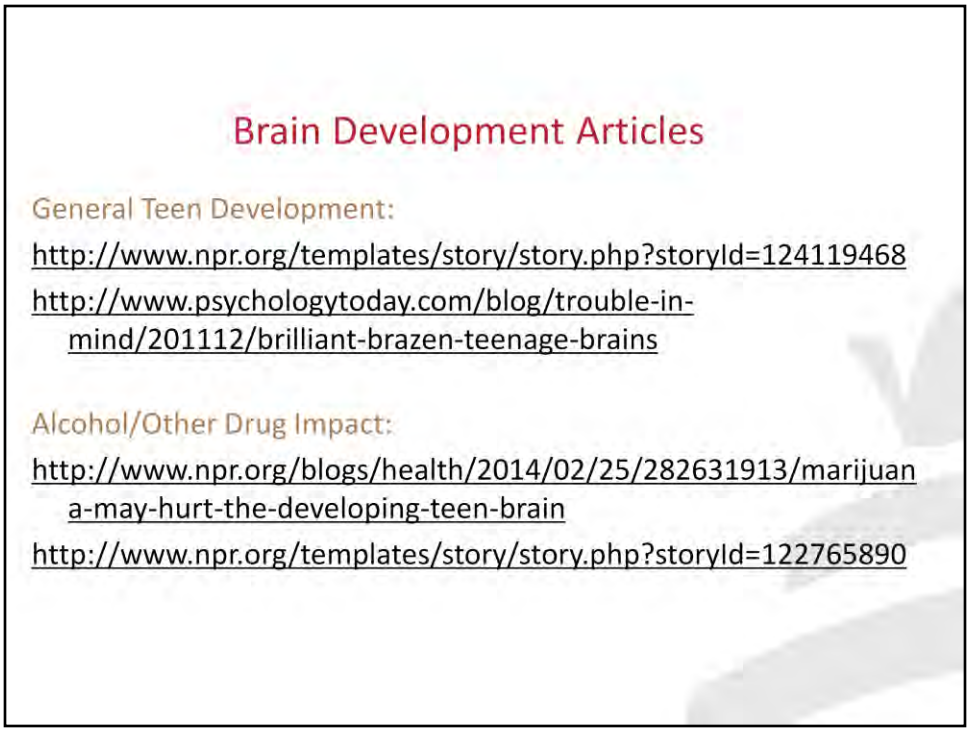
The intention of this webinar is to provide you with a template for a presentation at your middle or high school. The content runs the gamut from basic knowledge to more advanced interventions, so you will need to adapt it to the needs of your audience. I conducted similar presentations with teachers, administrators, after-school staff, security staff, and even families and students.

Note that you may decide to separate the "adolescent development" and "trauma" sections into 2 distinct but linked presentations. It's important not to gloss over the trauma content, and give it the time and attention necessary to make a meaningful difference in your school.

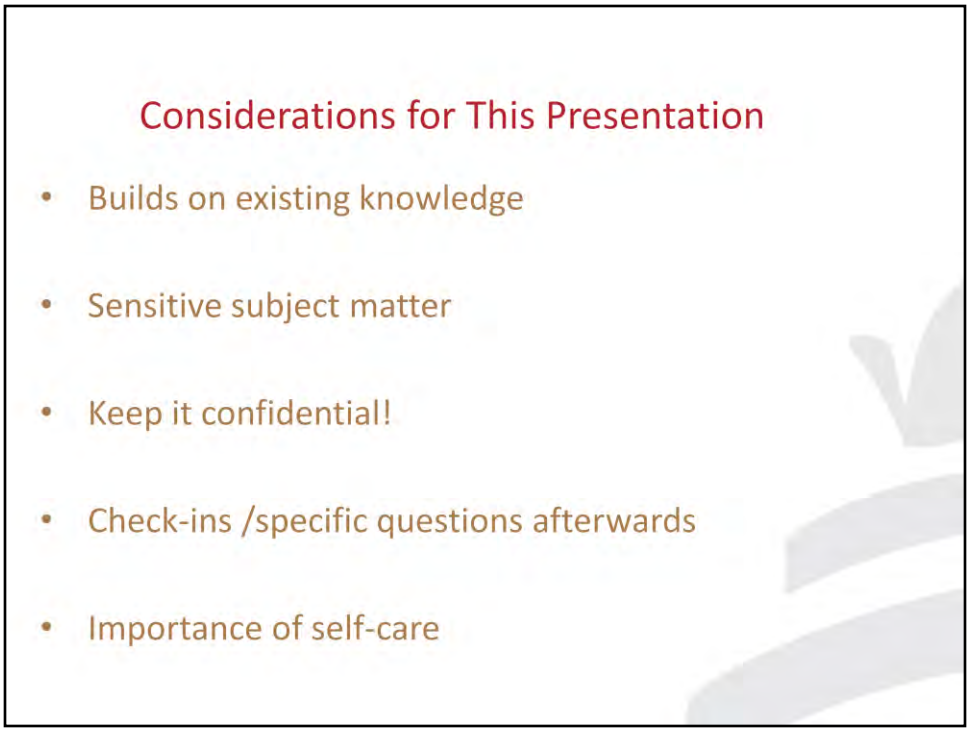


It may be helpful to begin your presentation with an interactive or visual exercise—especially if faculty meetings are conducted after a long day of teaching or your presentation is wedged in between lots of announcements or other school business:

1. Pile of books: You will need several books/magazines, binders, etc and a white board, chalk board, etc. Ask a volunteer to come up to the front. Explain that each book represents a responsibility and/or barrier in the life of a student. Start by handing the volunteer one book that represents, "all their classes". Then add additional books representing: after-school job, sports team, care for siblings, ailing parent, abusive boyfriend, etc. Ensure it's a mix of experiences that affect teens in your school community. After the volunteer is (barely) holding a large pile of books, write a math problem up on the white board and ask them to solve it.
2. Hopes versus Fears: Ask your participants to answer the following questions, but only read them one at a time: What are your hopes for your students? What are your fears for your students? Are you teaching from your hopes or your fears?
3. Sandwich nametag: Hand out large nametags. Ask the participants to write down their name in the center. Write the name of an adult that supported them when they were growing up on top; and the name of a student they support now below. Ask for a few volunteers to share.
4. Silent reading/reaction: Distribute copies of an article or reading related to teen development/trauma (several will be suggested throughout this presentation). Ask participants to silently read, and then report out what surprised them or what they learned
5. When I was a teen…: Ask participants to think about a time when they were distressed as a teen. Maybe ask them to close their eyes. What had happened? What were they thinking at the time? What did it feel like? What was hardest? How did they handle it? What would they do differently now, and why?
6. Letter to yourself as a teen—what do you know now that you wish you would've known then? What advice would you give yourself?



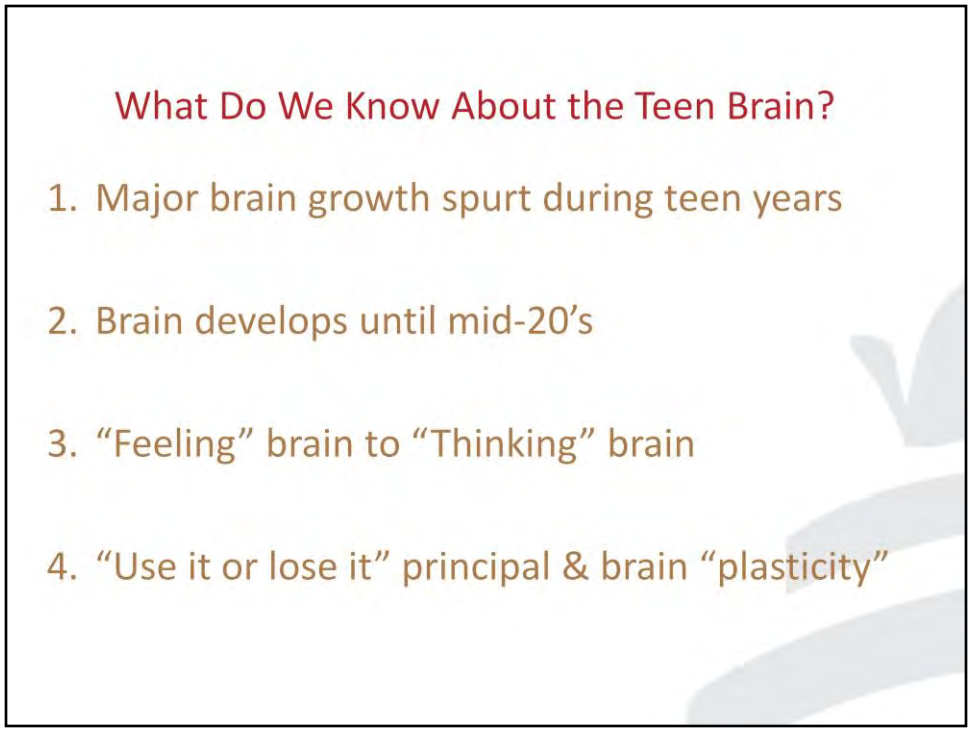
Here are a few short, easy-to-read (or listen to) media articles on teen brains.



This slide sets the tone for this presentation. You may not use this slide and just establish "group agreements" or rules that the faculty will agree to abide by during and after the presentation

Note that the goal is NOT to turn teachers into counselors—it's to increase knowledge and understanding of student behavior and offer tools for teachers to use in the classroom

- Again, acknowledge that teachers/your audience have experience working with teens
- This content might be emotional for some participants.
- Do not use student names or identifying information
- Make yourself available after the presentation for individual questions, consultation, and support
- Recognize that teaching is HARD, working in schools is HARD—especially if there are a lot of students who've experienced trauma.

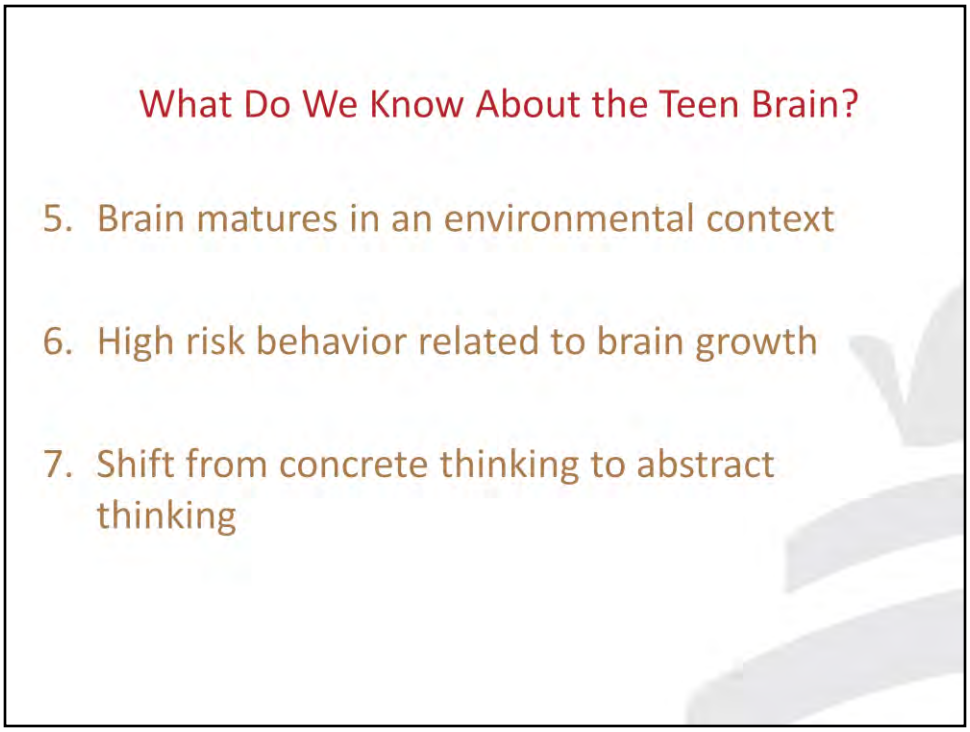


Source: Steinberg

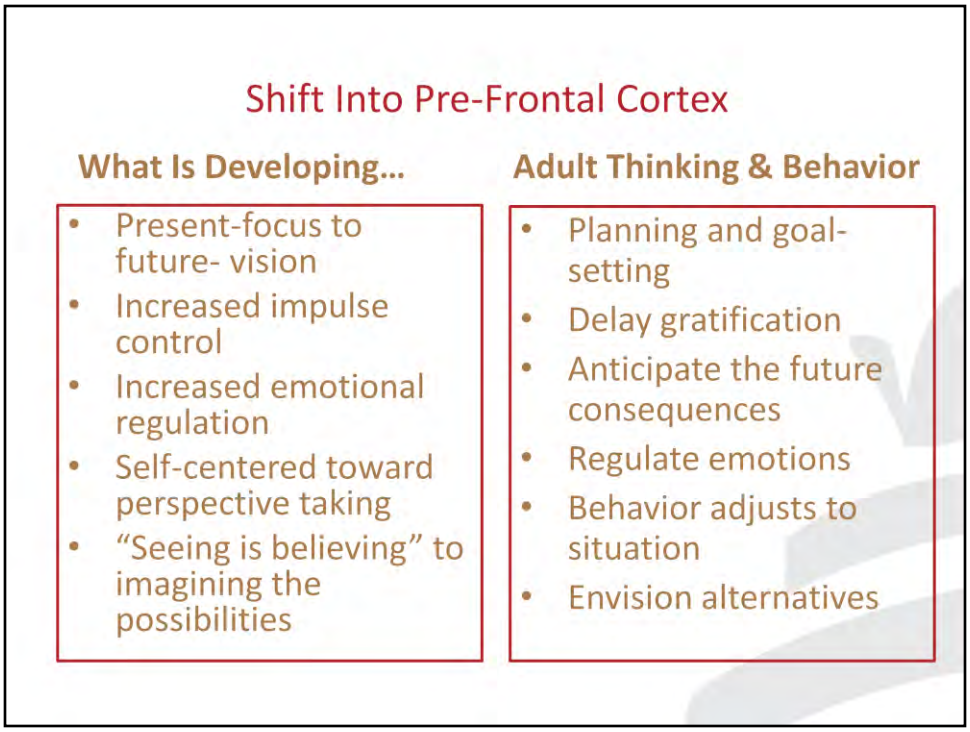
1. Teen brain is different from both child and adult brains—not mini-adults! The brain experiences major growth spurts during 2 periods—in the womb and during adolescence
2. Teens don't have an adult brain when they turn 18! In fact, brain maturation continues well into the 20's and young adulthood. The car rental companies figured it out first ☺ At 18 years old, the pre-frontal cortex is about ½ way through it's complete development!

3. Teens are learning how to *control impulses; anticipate the future, especially consequences; plan strategically; and resist peer influences* up through full adult brain development. *Sensation seeking and need for immediate rewards* peaks in middle adolescence, around ages 14-16. When explaining to students, I'd often use the "feeling" brain to "thinking" brain comparison—students are able to practice using complex reasoning and decision-making skills, with our guidance and support. Think about what's possible, instead of what's real—can envision alternatives
Think about things in multiple ways—more options, more sophisticated
Think about thinking—introspection and insight

4. Early teen years are marked by considerable "brain plasticity"—teens are growing and developing, and the brain does keep changing throughout adulthood! However, the brain "prunes" neurons that are underutilized, meaning that those connections that are used the most are reinforced, while those used the least or not at all are "pruned". Teens are very excitable and responsive to their environments, which is why they learn so quickly. After adolescence, the rate of growth slows and the connections that are most used are strongest. May also be a time when mental illness emerges. Important to identify and treat early!



5. The physical environment of a young person can influence their brain development and affect their expression of emotion, behavior, and thinking. The part of the brain involved in thinking and memory is thickest in children who have had a lot of cognitive stimulation and nurturing. This can be your nod to how trauma impacts development
6. From an evolutionary perspective, risk taking was important! Teens, especially in middle adolescence, are very sensitive to social rewards (peers) and will take risks w/o considering consequences. Important to offer teens rewards that are immediate, even if they're small, like positive feedback. The reward system is most active at the onset of puberty, and increases through middle adolescence, and then decreases in the 20's. Why teens are so responsive to their peers, and excited by unpredictable or uncertain situations. We want teens to take "healthy" risks—sports, performing arts,
7. See next slide

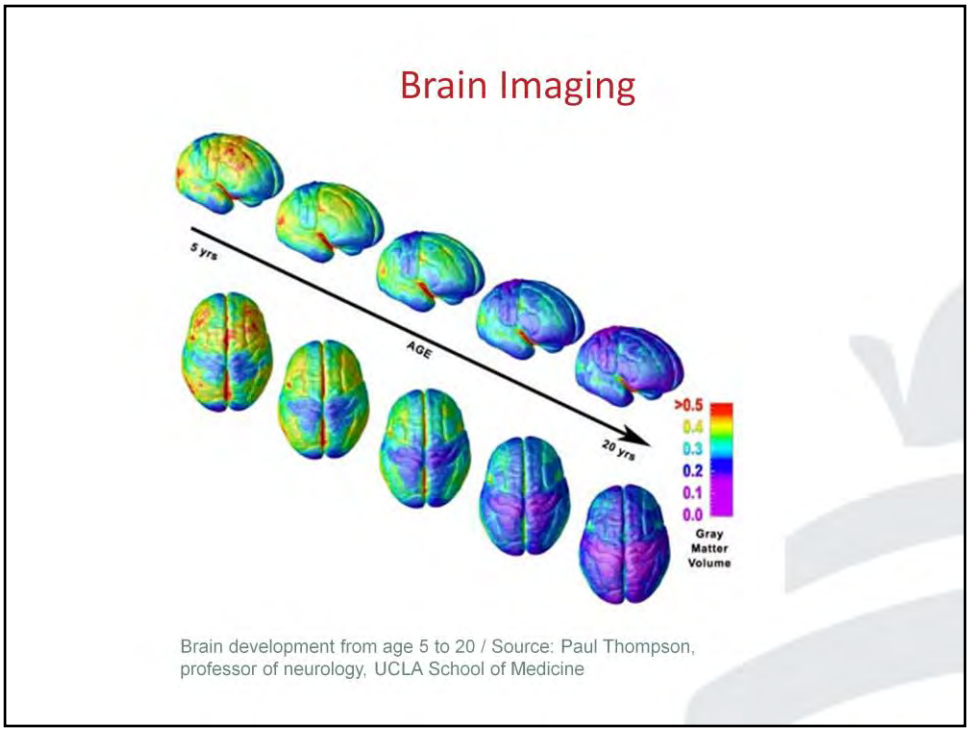


Source: Steinberg, St. Andrews
In the right box, listed is what we (hopefully!) have the ability to do as adults

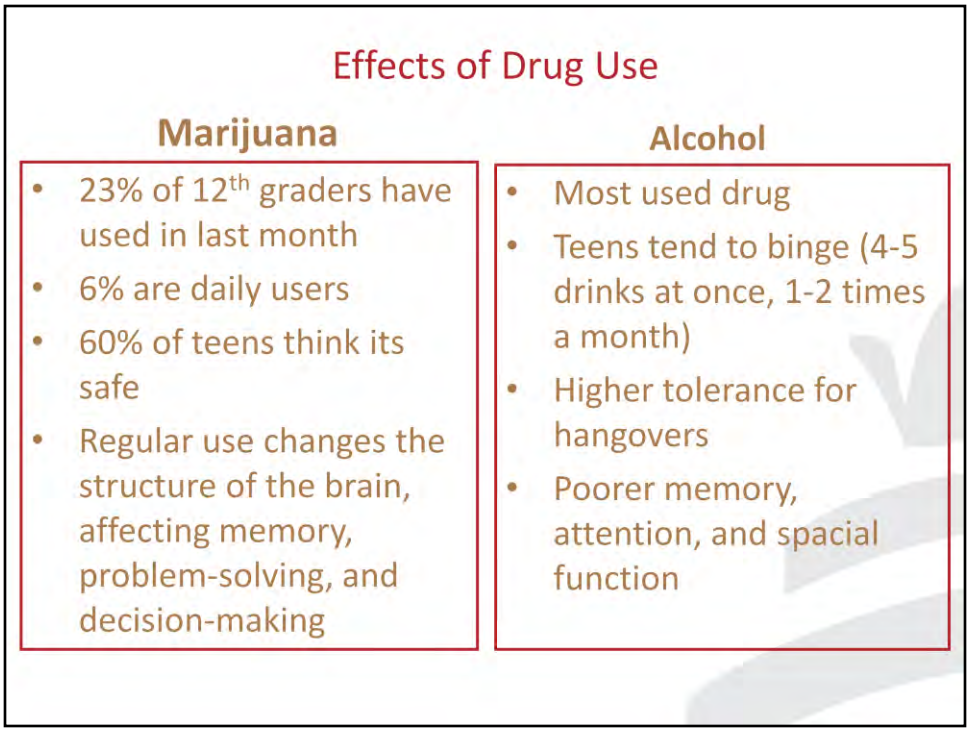
Teens are beginning to develop the frontal lobe—or pre-frontal cortex—the part of the brain responsible for higher order thinking, reasoning, impulse control, emotional regulation. Teens ARE using their frontal lobe—however, the connections between the nerve cells are slower (because of less myelin—kind of like insulation on a wire). They access the frontal lobe more slowly, which can mean delayed decision-making

Teens also have less "insight' than adults—they are more self-centered, and less capable of thinking about the "other".

All these brain changes mean that teen brains are excitable, responsive to their environment—which is why they can learn new things so quickly! Teens are primed and ready for all intensive learning! But also why trauma, and other environmental impacts (alcohol/drugs) affect can impact development.



Here is a nice visual of the brain through development. It shows the increase in white matter, which means faster connections. Really, you're just showing how much the brain actually changes from childhood to young adulthood.
Amygdala develops first—instinctual reactions, emotions, stress, fear, aggression.
Concrete thinking to abstract thinking

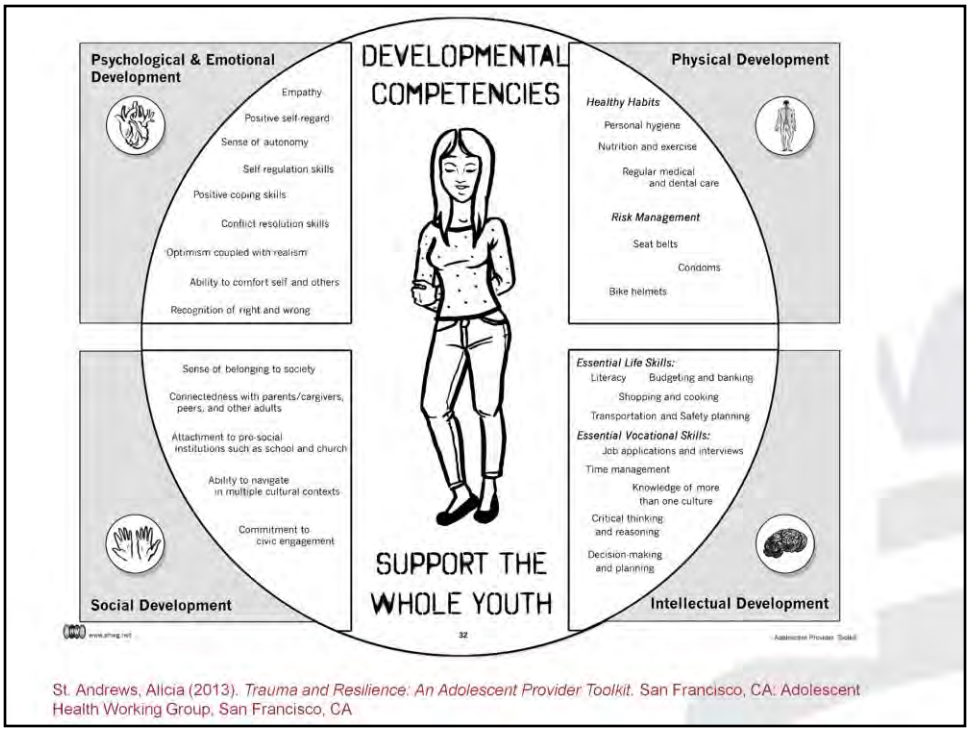


Source: NPR

I found that when I conducted these presentations, there were always questions about alcohol and other drugs. This slide is optional

Marijuana—Ironically, the teen years are the worst time to start using marijuana. The brain is actively building connections, getting smaller and faster, pruning away unused neurons. Regular marijuana use (1x/week) showed a loss of 8 IQ points from childhood to adulthood. Also important to consider that marijuana is more potent—greater THC content, greater risk for addiction

Alcohol—Teen brains are more vulnerable to the toxic effects of alcohol. Teens who binge drink have poorer quality "white matter" the composition of the brain that relays messages from one neuron to another; poorer working hippocampus, which affects memory.



St. Andrews, Alicia (2013). *Trauma and Resilience: An Adolescent Provider Toolkit.* San Francisco, CA: Adolescent Health Working Group, San Francisco, CA

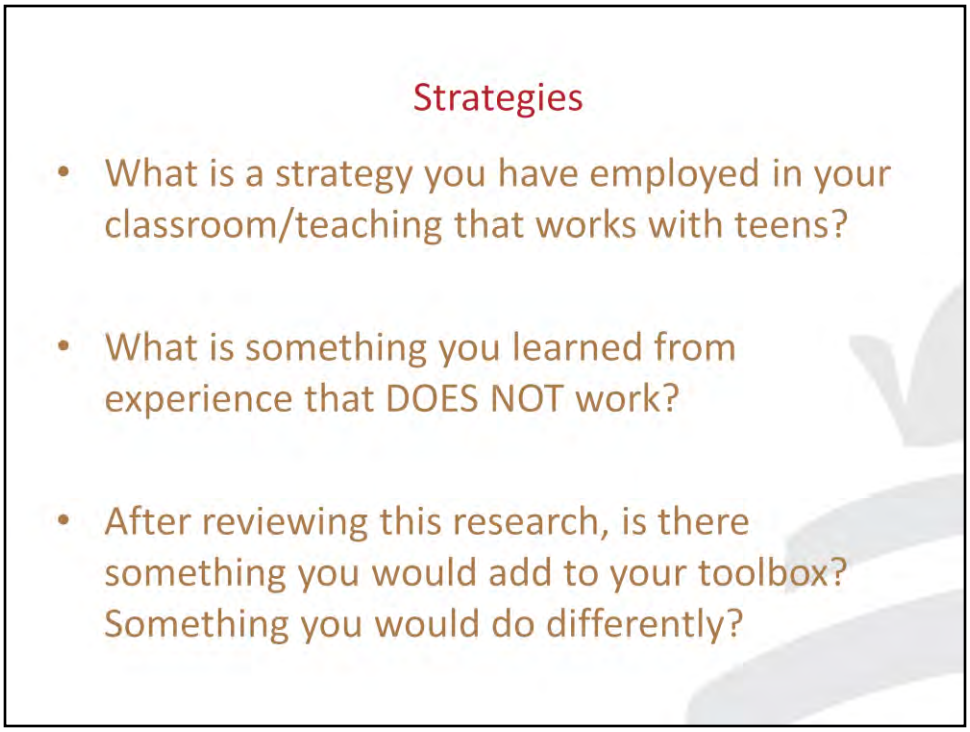
Source: St. Andrews

This is a GREAT handout—you can also make the point that this kind of developmental support IS the business of schools and educators, especially for youth who've experienced complex trauma. My mantra is that mental health services belong in schools!

Here are the developmental competencies, or tasks, of adolescence.

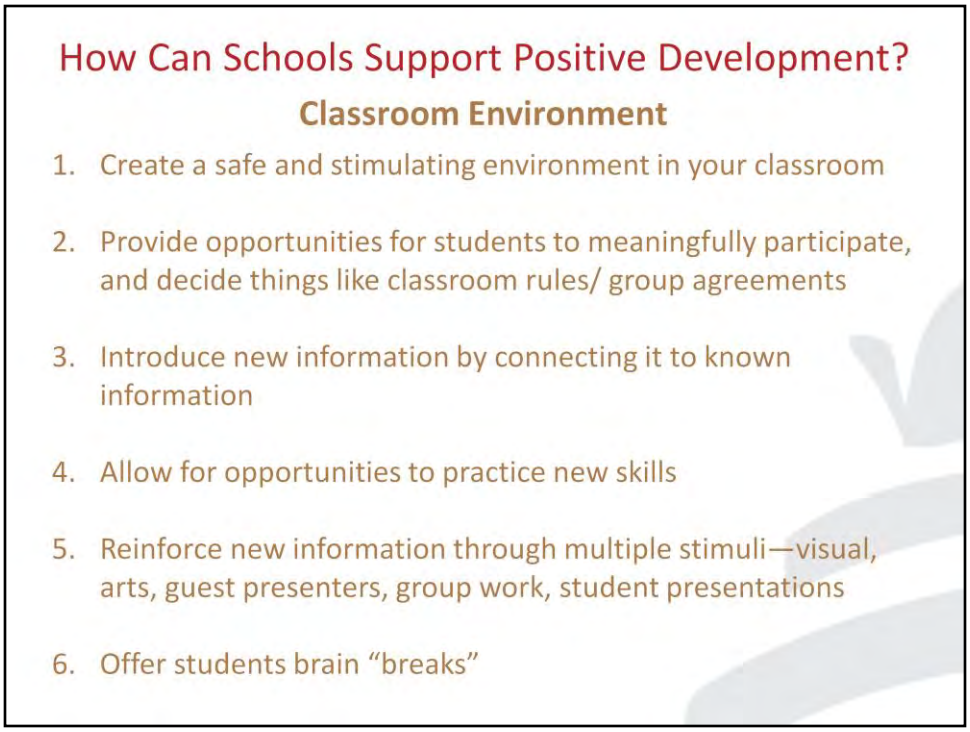
Ultimately, this is what we want our students to accomplish.

School historically focused on "intellectual development". Schools are now taking a great role in the other areas, particularly psychological/emotional development



Here is an interactive exercise, that sets up the next section. You can do this in pairs, or in small table groups. Might also be interesting to mix teachers up by experience, department—i.e. tenured, 10+ year teacher with new teacher, algebra with english OR to create affinity groups, i.e. all one department, all 9th grade teachers, all new teachers

After giving pairs/groups about 5 minutes, ask them to share out, which will lead into the next slide…

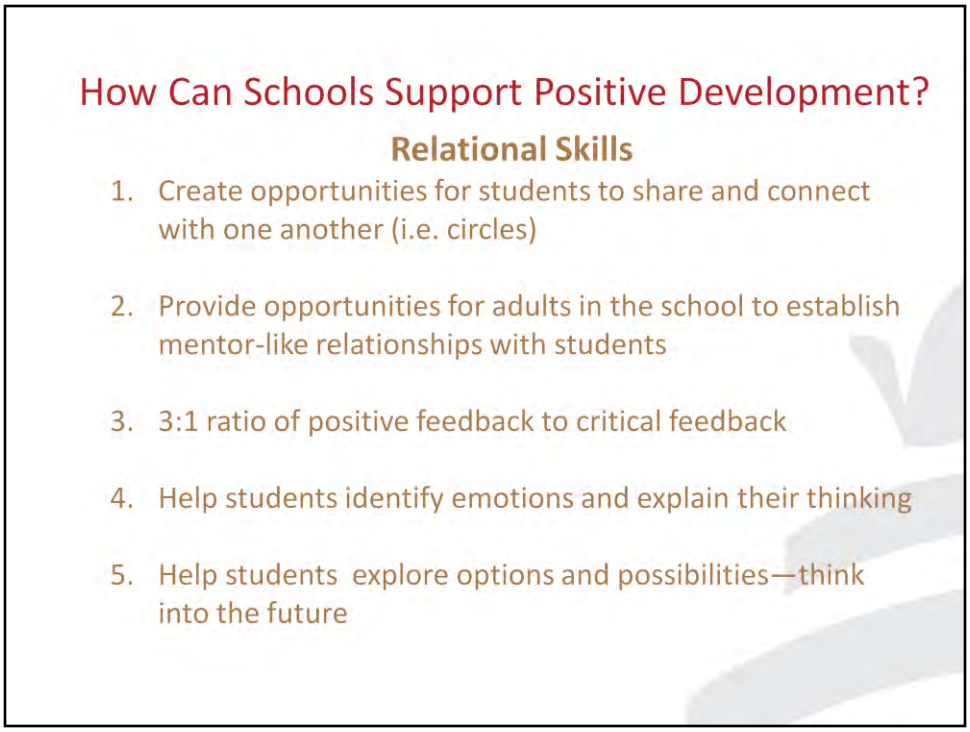


Classroom Environment: NOTE—this is not meant to be prescriptive, exhaustive, etc. Important to acknowledge and appreciate the skill and experience teachers bring to their classroom, and use this as an opportunity for teachers to share "what works".

1. Remember that teens are excitable and responsive to stimulation—multi-modal teaching (visual, hands-on, groups, role play, use of technology and media). Address issues of bullying and harassment immediately and with seriousness.
2. Consider group agreements generated by your classroom community, including a way that students hold you AND one another accountable.
3. Remember that teen brains are building connections—help them to do so by linking new stuff to old stuff. Help build abstract thinking skills by linking literal "real" things to metaphorical concepts.
4. Give students opportunities to hone their newly learned skills and practice them in a variety of stimulating ways—especially through technology, arts etc. Also a great way to build intercurricular linkages (i.e. b/t music and history; math and economics)
5. Students all learn differently, so offer them opportunities to "master" a concept in ways that builds on their strengths, and also challenges them to build new neural connections. This strategy is often what works with students who have learning differences, but remember that many students have undiagnosed learning differences, so this can benefit the whole classroom.
6. Brain Breaks: Actually do one in your presentation! See next slide

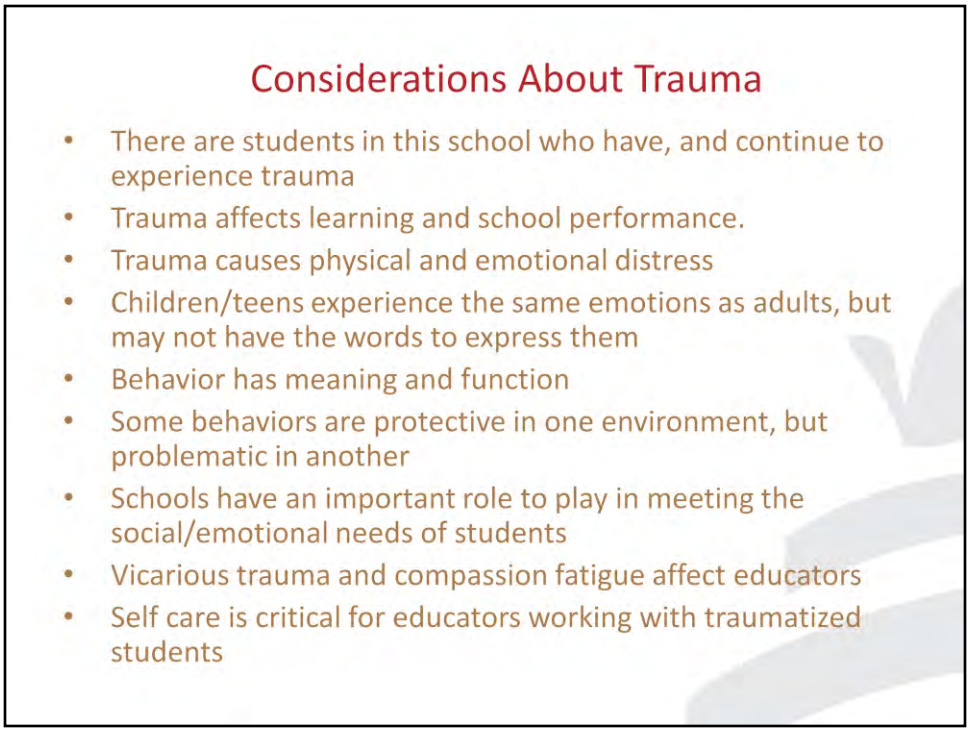
These are great to do during your presentation!

1. Inhale deeply through nose, hold for 2 counts, exhale through nose, hold for 2 counts. Do 10-15 rounds
2. Tense every muscle, including shoulders, fists, toes etc. Progressively release from toes up to head.
3. Any type of physical activity or stretching, possibly led by students!
4. For 2 minutes, toss a beach ball around the room, trying to keep it from touching the ground. Students are "out" if they drop the ball, throw it hard at anyone, talk etc—you make the rules!
5. Play a popular song and have one student lead the others in simple, replicable dance moves
6. Students start by playing "rock, paper, scissors" in pairs. After winner is decided, pair becomes a team and challenges another pair. Then pair becomes a four-some, and challenges another four-some, until 2 groups are competing. For "People Tigers Traps" you create your own movements that correspond with each.



Note: much of this is repeated in the strategy section when we discuss trauma later on

1. Could be: morning check-in circles, assignments that let students tell their "story", community building activities. Ex. Senior stress circles
2. Mentoring programs, particularly for transfer, 9th grade or other transitional students. SBHC staff, counseling staff, after-school program staff, interns, teachers. Establish a commitment to check in with the student 1x/week.
3. Even seemingly insignificant praise can help a student—Fits in with need for immediate feedback, and helps the criticism be more well received.
4. When you notice that a teen seems different, angry, sad, etc—talk with them about it! Say , "I've noticed that you seem _____". Or "What were you thinking when you said _____"? A great resource for teachers to learn how to refer students to mental health professionals is Kognito Interactive, which helps teachers/educators practice talking to a student they are concerned about
5. Talk with kids about what's next! Imagine the future with them. Not just the end result (I'm going to be a doctor) but all the steps necessary to get there. Those conversations build pre-frontal cortex thinking!

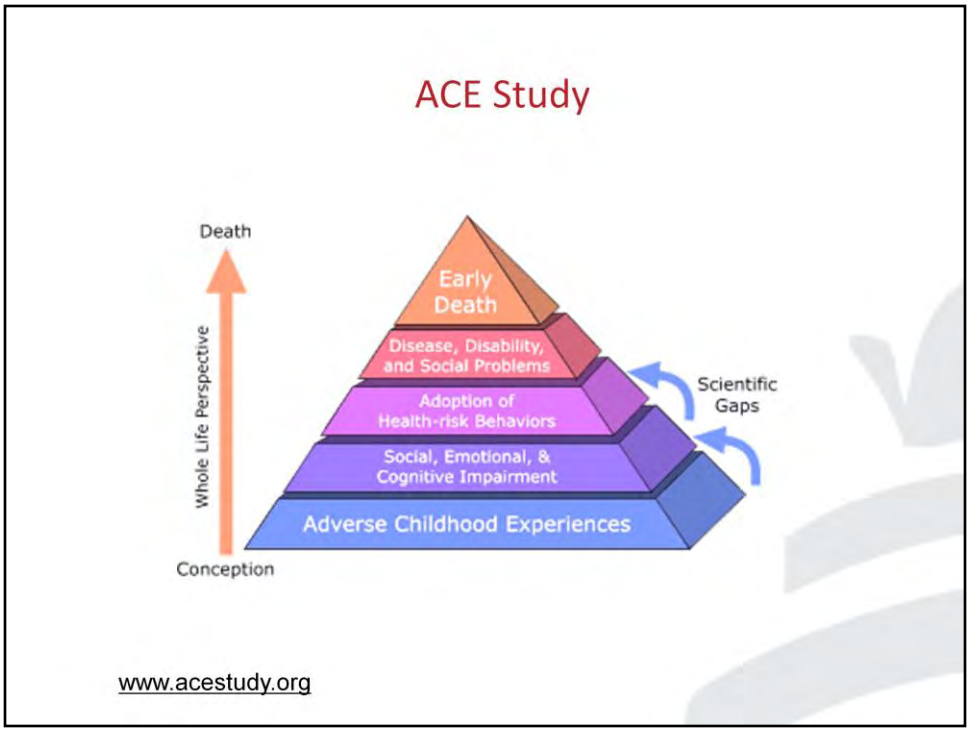


Source: UCSF HEARTS; Wright; NCTSN
These are your main points for the trauma section—don't select too many, and keep reinforcing throughout the presentation
There are a lot of BIG points on this slide. I would select 3-5 that will resonate most with your faculty and keep referring back to them throughout the presentation. Here are some additional quotes/considerations:
"School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge" (Carnegie Task Force, 1996)
"While academic curricula matter, it is the social-emotional foundation of children that primarily determines academic success" (Dr. Christopher Blogett, Washington State University, 2013)
"The primary aim of education is not to enable students to do well in school, but to help them do well in the lives they lead outside of school (SAMHSA, 2014)
"Any educator who works directly with traumatized children and adolescents is vulnerable to the effects of trauma" (The National Child Traumatic Stress Network, 2008)
"Resilience is defined as doing better than expected. We define resilience as the way we think children ought to behave; however, what is resilient in one environment may be a risk in another" (Travis Wright, Ph.D., 2014)

Source: UCSF HEARTS

Here, we are beginning to redefine trauma from something that is only experienced as a result of a BIG event, natural disaster, war, etc. to an experience that too many young people have.

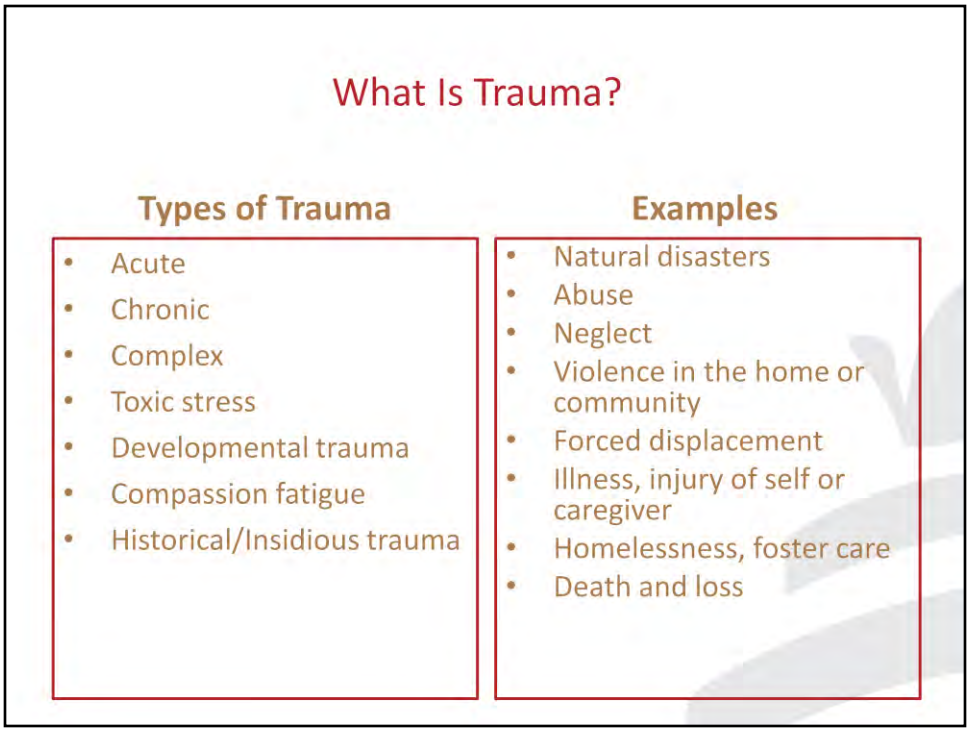
1. Different for children than adults
2. Can't escape situation
3. This can include the "abrupt, unexplained, or indefinite loss of a parent, caregiver or sibling"
4. Situation is "out of control". Child feels similarly out of control and…
5. Cannot control emotions or internal states



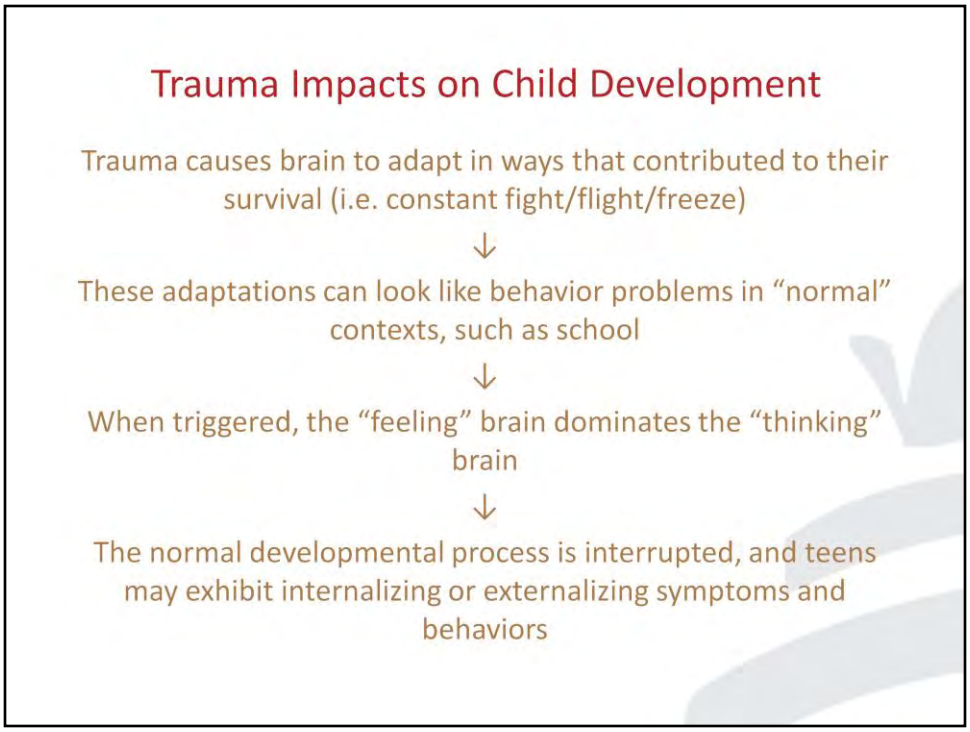
Source: www.acestudy.org
Here, we are beginning to establish a link between mental/emotional health, life experience and disease/physical health. This information was very powerful when I presented to my faculty.
Describe the ACE study:
The ACE Study is ongoing collaborative research between the Centers for Disease Control and Prevention in Atlanta, GA, and Kaiser Permanente in San Diego, CA.
The Co-principal Investigators of The Study are Robert F. Anda, MD, MS, with the CDC; and Vincent J. Felitti, MD, with Kaiser Permanente.
Over 17,000 Kaiser patients participating in routine health screening volunteered to participate in The Study. Data resulting from their participation continues to be analyzed; it reveals staggering proof of the health, social, and economic risks that result from childhood trauma.

- ACEs include abuse, neglect, mental illness/drug dependence in the home, witnessing violence, loss or death of family member, incarceration of family member
- More ACE's = poorer health
- Adults in the study with high ACE's showed increased: alcoholism/substance abuse, COPD, Heart disease, depression, fetal death, STIs, partner violence, liver disease, obesity, smoking, etc
- High ACE students often have high ACE parents
- Highlight the point that the impact of trauma extends beyond social/emotional/

mental health into physical and overall health



Source: Castro Rodriguez; UCSF HEARTS
Acute—w/in first 30 days after event, i.e. natural disaster
Chronic—trauma that repeats over and over, i.e. sexual abuse
Complex—when source of trauma is caregiver or close relationship. Often abuse, neglect, lack of nurturing caregiving relationship. Even if this occurred as an infant or young child, the body remembers. Affects attachment, and the child's sense of safety, worth, esteem.
Toxic Stress—community violence, always worried about safety
Developmental Trauma—chronic, early maltreatment in a caregiving relationship. Can result in attachment issues
Compassion fatigue—experienced by adults working with trauma-impacted students and clients
Historical/Insidious—oppression, discrimination, marginalization

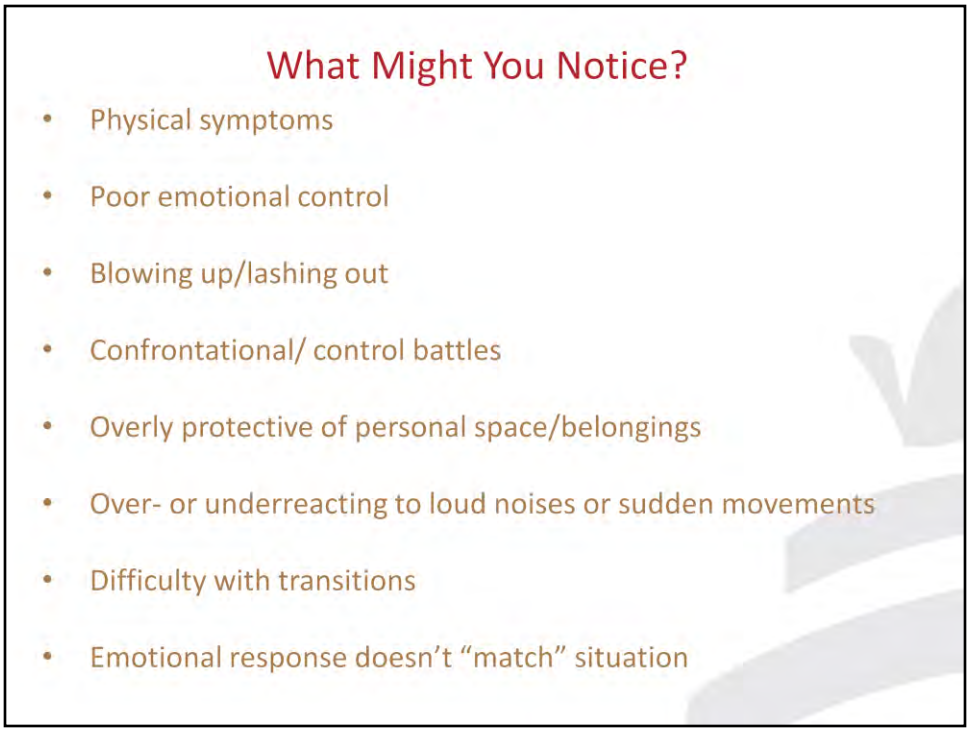


Source: Castro-Rodriguez; Hertel et.al.; UCSF HEARTS; Wright.
You might need to explain the different between "Internalizing and externalizing symptoms and behaviors" (addressed later in the presentation)
Kids who experience complex or chronic trauma may always be "activated" or in "fight/flight/freeze"
Fight or flight response is a stress response that should only be activated when in danger, and constant stress impacts brain development
Constant state of arousal can impact:

- Language and Communications Skills
- Social and Emotional Communication
- Problem-Solving and Analysis
- Organizing Narrative Material
- Cause-and-Effect Relationships

Complex trauma: Poor attachment deeply affects child development—it is one of the first developmental tasks and when disrupted effects kids ability to regulate emotions, form and sustain relationships, choose healthy relationships, and develop sense of self-worth
IMPORTANT: As stated before what is adaptive/resilient in one context may be problematic in another. I like to give an example here.
Ex.—a female 9th grader lives with mom and stepdad, who is an alcoholic. Throughout most of her mid-childhood (ages 8-12) experienced regular domestic violence. When stepdad was drunk, he would become violent toward mom. Student would step in, tried to stop stepdad and protect mom, called police. Student exhibits

explosive temper, and will not back down from teachers (especially male) when confronted.



Source: Castro-Rodriguez, UCSF HEARTS; NCTSN

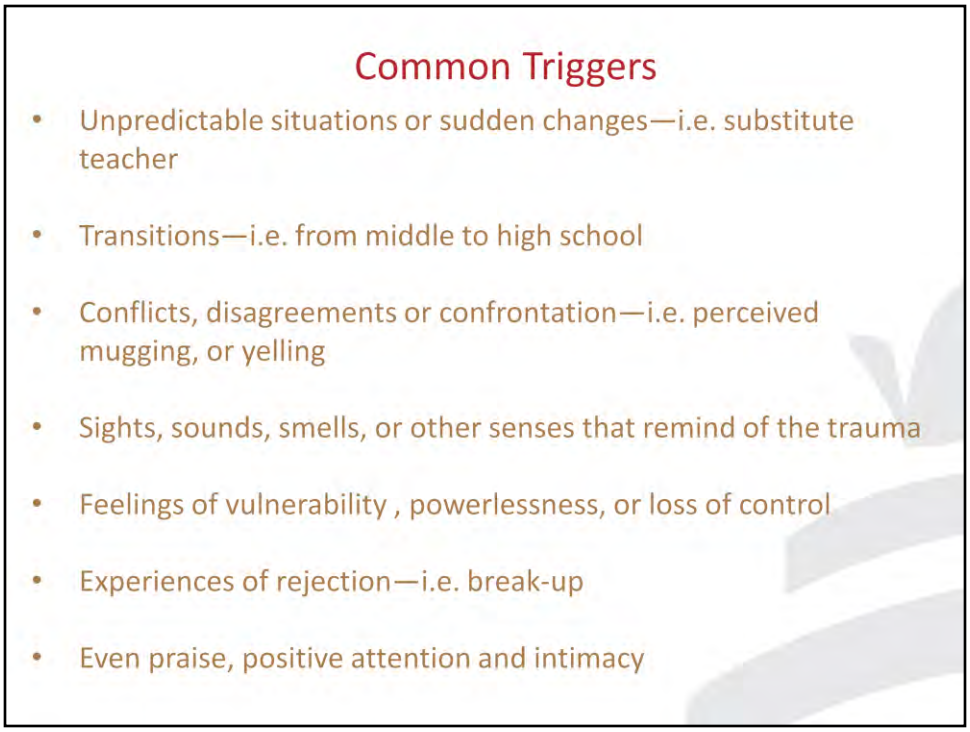
A few points:

Weave resilience through this entire section—reemphasize that many of these are appropriate reactions to a very stressful situation. Maybe relate to an experience of how a well-adjusted adult would not be expected to be happy or calm if they were in the midst of grieving the loss of a loved one or just lost their job.

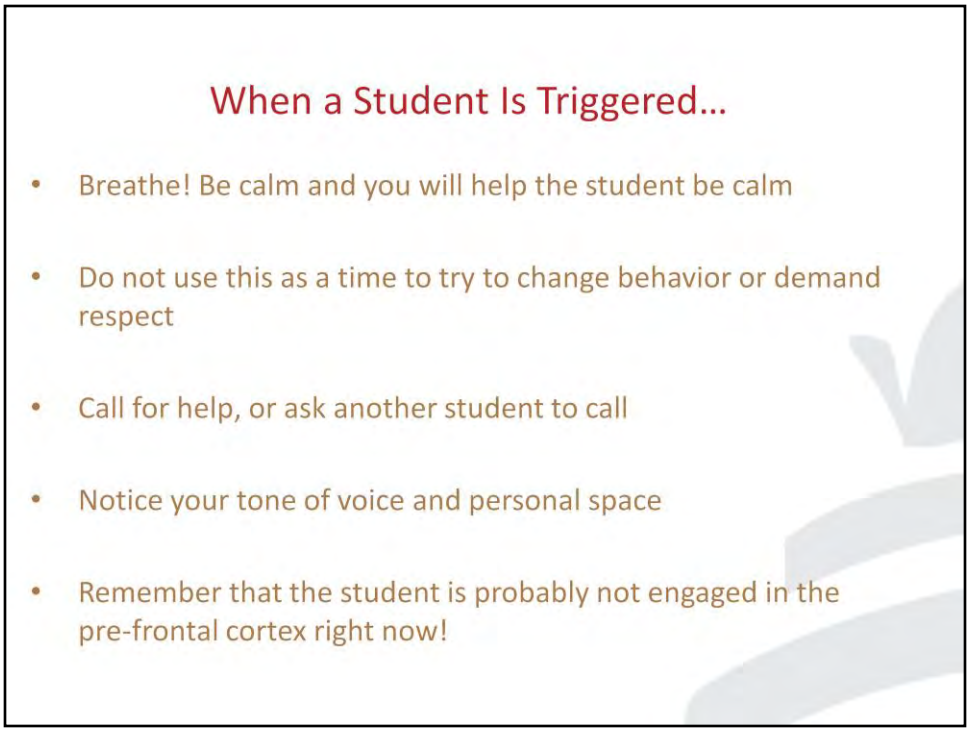
For the last two slides, you might consider telling a story or giving a case study without revealing identifying facts about the student, and/or using examples from other schools or other programs.

- Not every kid reacts to trauma in the same way.
- Grief/loss and mental illness share similar symptoms, and may also benefit from similar school interventions and classroom accommodations
- Internalizing—stop having emotions because they weren't responded to anyway
- Externalizing—have really big emotions that escalate easily and can't be controlled
- We learn emotional regulation from our caregiver
- Anger, fear, anxiety are ALL appropriate reactions to trauma
- Irritability in teens is somewhat normal—but if irritable with peers, consider a red flag

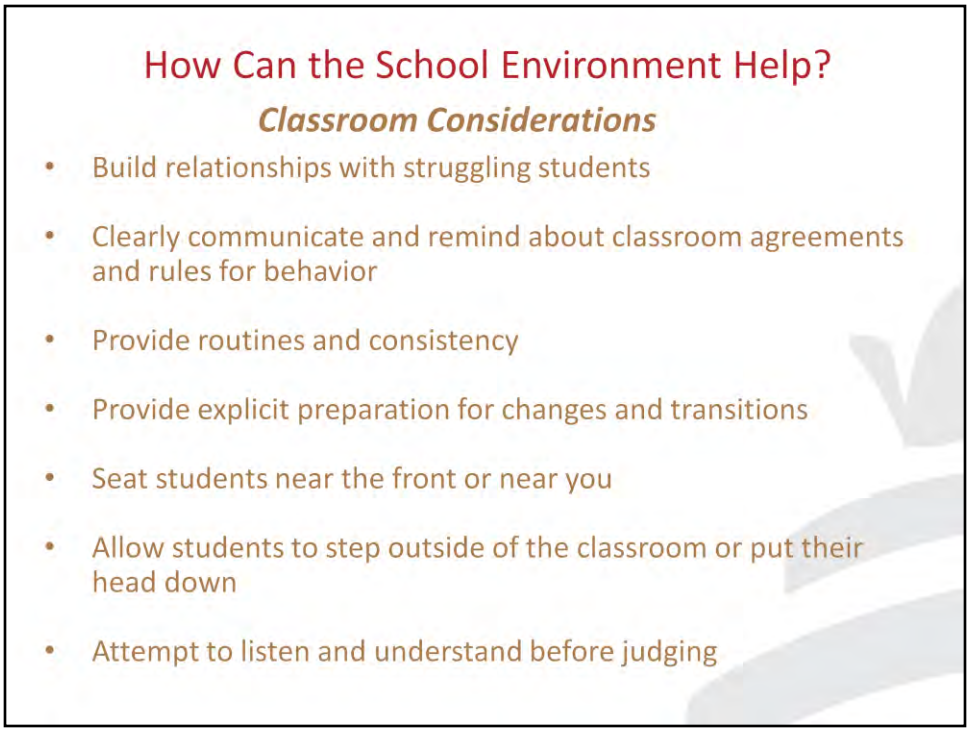
Non-age appropriate behavior—acting way too young, childish or acting like an adult and having a lot of adult or parent-like responsibilities



Source: UCSF HEARTS , St. Andrews
The next 2 slides get deeper into the stress response to trauma—what can trigger an "activation" or "fight/flight/freeze" response, that might look like a classroom blowout. Please be careful with this piece of the presentation, and remind participants of confidentiality.
Intended to help teachers intervene in the classroom when a student has been triggered. You may decide to leave these out or discuss them in a "deeper" presentation about trauma.



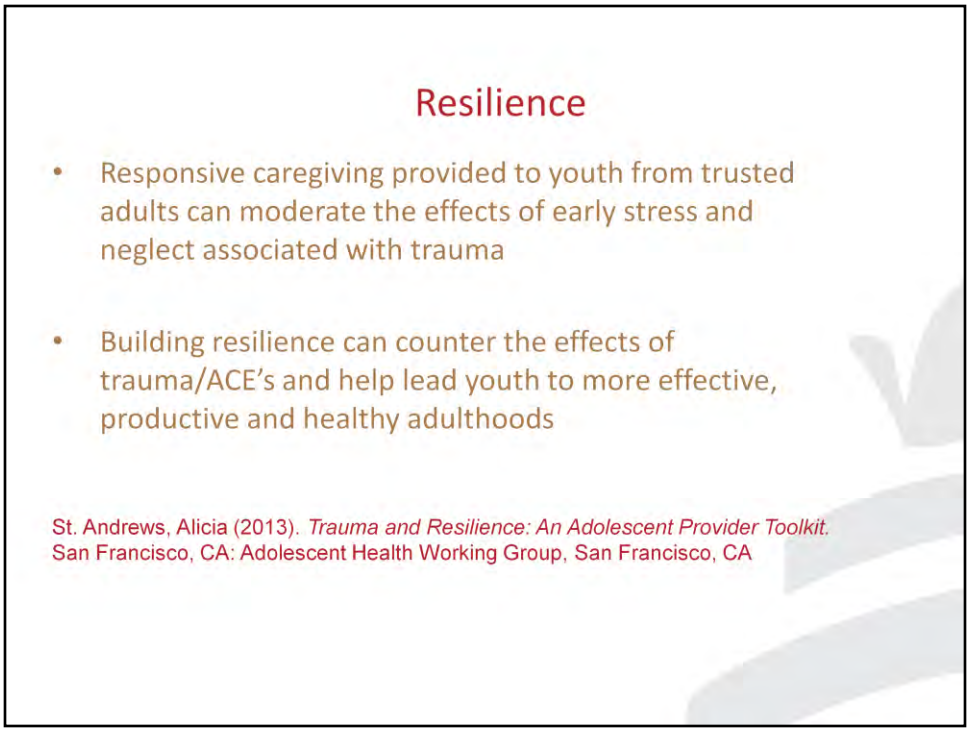
Source: UCSF HEARTS.
You might have established processes at your site for handling students in crisis, and would emphasize those here. This is also an opportunity to share how your mental health service providers can support teachers in crisis. Really, you are asking adults to use their “thinking” brain here.



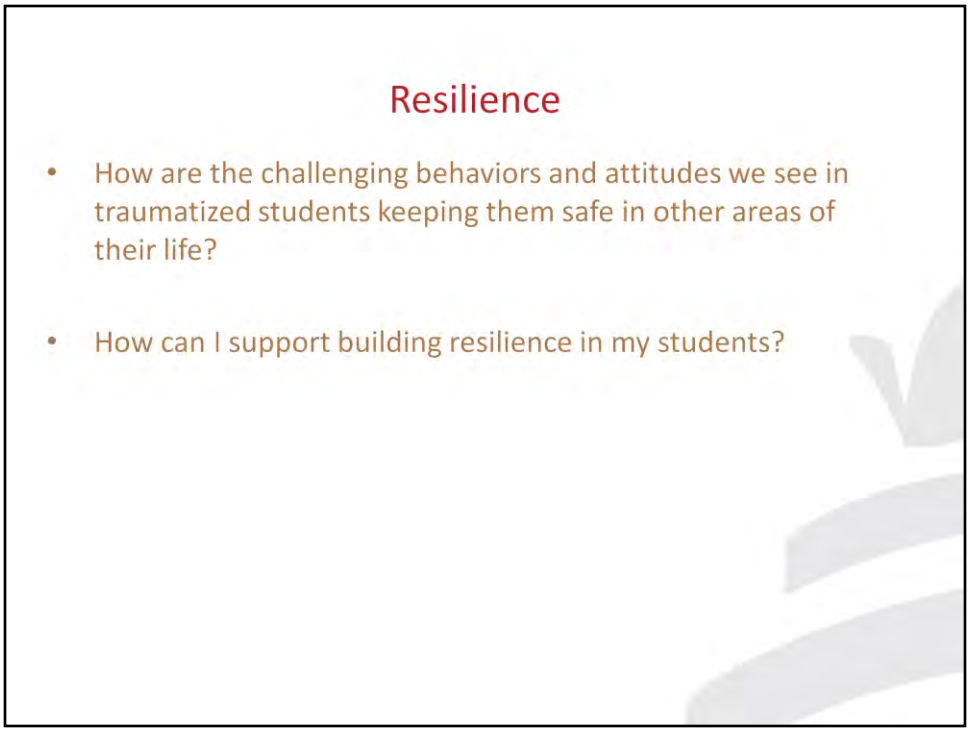
Source: UCSF HEARTS
Note that many of these strategies are similar to the adolescent development strategies. The major point is that these are not exclusive to kids who have experienced trauma. These strategies benefit ALL students

Another major point is that building relationships is CRITICAL.

This is your opportunity to talk with the staff about what you're doing in the School-Based Health Center, therapist's office, counselor's office, etc. You demystify the services, so teachers are more comfortable referring students, and are maybe more receptive to the idea of confidentiality.
Individual counseling: Identify root issue, build self-regulation skills, provide safe and confidential space for student
Safety/Crisis Planning: Identify triggers and ways to avoid or manage, identify safe/supportive people to call when in crisis
FBPs: More for SPED/IEPs, but gets very specific in identifying challenging behaviors, antecedents, and interventions.
Groups: builds developmental tasks, helps students realize they are not alone, share coping strategies
Youth Development: provide opportunity for positive youth development involvement, build skills, experience leadership, teach others about health issues
Case Mgmt: Working with families, linking services among several providers, provide "tangible" support, link to academic and academic improvement



The next few slides address RESILIENCE. You may decide to move the resilience slides up—the point is that students who've experienced trauma are not beyond hope. One of the major ways schools can help is by creating safe, supportive, trauma-informed environments and providing young people with caring adults who model healthy relationships.



Source: Wright
These questions are reframing what we consider “resilience” to be. We typically define “resilience” as doing better than expected because of one’s circumstances. We link resilience with the way we think kids ought to behave, rather than recognizing that many behaviors that seem problematic in school are exactly a kid’s expression of resiliency.
All kids are born with resilience!

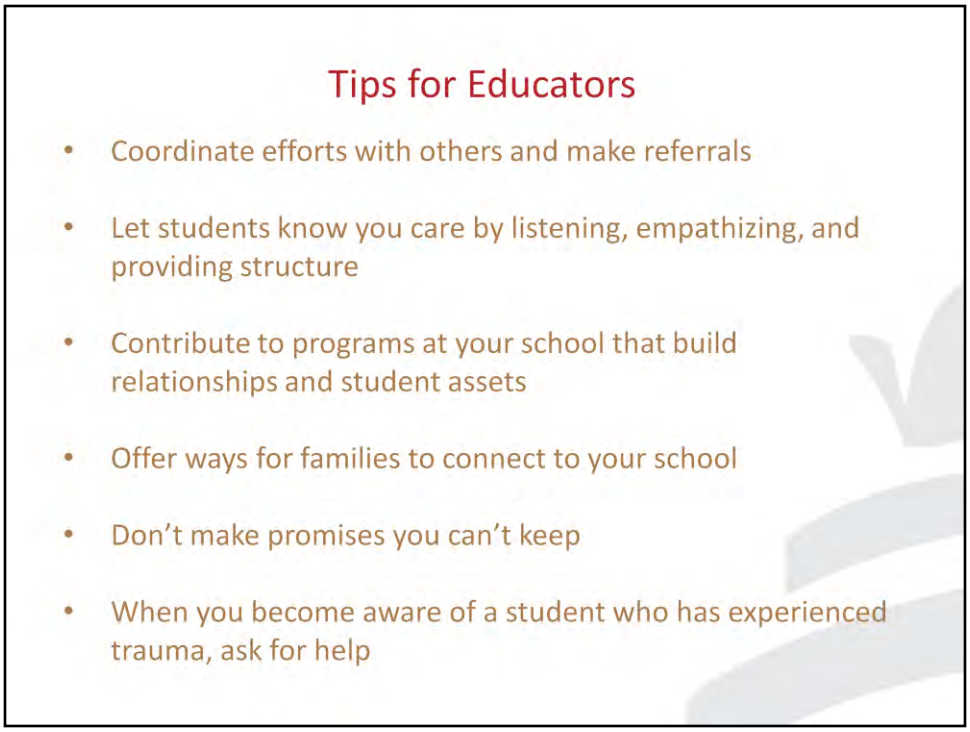
Source: St. Andrews

Again, many strategies are repeated here (building relationships!).

Main point—we all have the ability to help a young person navigate the tumultuous teen years, especially those young people who have experienced trauma

Note—if you haven't checked out the research by Dr. Carol Dweck on mindset and stereotype threat, I highly encourage it! Here is a link to a great article in the NY Times:

http://www.nytimes.com/2014/05/18/magazine/who-gets-to-graduate.html?_r=0



- It's important to recognize that supporting traumatized students cannot be done in a vacuum! Teachers and educators should reach out to student support personnel, colleagues, administrators, and community providers for resources for students.
- Remember that relationship building is one of the greatest ways to counter the effects of ACEs and trauma
- Think: mentoring, anti-bullying, youth development, alternatives-to-suspension, sports and arts programs
- Family events, workshops, trainings. Calling families when a student does something positive! Scheduling family meetings that are accessible to famiiles
- Don't say you're going to call the student every morning, spend an hour with them every day, buy them lunch, etc. if you can't follow through. While you want to build relationships with students, you also need boundaries and to prevent your own burnout
- If a student confides in you, or asks for help, or shows symptoms—reach out! Consider the Kognito Interactive training for tips on how to talk with students about your concerns and to refer them to MH professionals

Self Care is a really important piece and may be introduced earlier in the presentation depending on the needs of your audience. There is a wealth of resources online about how to address vicarious trauma in educators and mental health professionals. I will include a link to a self-care assessment that you can consider conducting with your faculty.

In this section, you may ask teachers to:

- Complete a self-care assessment
- Write down three ways they show gratitude to themselves, and three ways to show gratitude to others
- Practice a mindfulness exercise
- Utilize the handout from the AHWG toolkit on self-care and vicarious trauma, which has several tips on preventing burnout
- Solicit interest in having a teacher support group on your campus

Ex. –we held a Staff Spa Day once a semester—we converted the library into a "spa" complete with free chair massages, healthy snacks, "spa" water, soothing music, yoga mats and portable fitness equipment, etc. We had students write personal "thank you" messages to teachers, and ensured every adult in the school received one. We worked with student leaders to make custom smoothies for every adult who ordered one.

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PLEASE include all of these references in your slides. I included specific references in the notes of slides where appropriate.

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arozum@schoolhealthcenters.org