Overview of Trauma

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The goal of this three-part series is to emphasize the importance of incorporating a trauma-informed perspective into the design, implementation, and evaluation of school responder models (SRMs). Youth who have been exposed to trauma, those with mental health conditions, and those with substance use disorders are more likely to be subject to exclusionary discipline policies in school. Exclusionary discipline contributes to these youth having higher rates of juvenile court system involvement. The SRM is a school-based, behavioral health response model that seeks to disrupt unnecessary suspension, expulsion, and arrest for students, particularly those with unidentified, unmet, or undermet behavioral health needs. ***This tip sheet provides an overview of trauma to help educators understand its prevalence and how it can manifest in student behaviors.***

School personnel can better understand, contextualize, and address behaviors to understand trauma and its effects on student learning, behavior, and relationships. ***The National Child Traumatic Stress Network (NCTSN) defines a traumatic event as a "frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity."***[i] Common types of traumatic events include physical, sexual, or psychological abuse and neglect; family and community violence; the sudden or violent death of a loved one; and serious accidents or life-threatening illnesses.

In addition to these traumatic stressors, schools can also consider conditions of adversity that are linked to a higher likelihood of negative health outcomes, including those identified in the adverse childhood experiences literature.[ii] Examples of these events or conditions include emotional conflict, household dysfunction, food insecurity, parental divorce or separation, parental alcohol or drug use, and parental incarceration.

Studies indicate the following lifetime prevalences of ACEs among children: 19 percent for physical abuse, 71 percent for physical assault, 38 percent for witnessing community violence, and 9 percent for witnessing severe interpersonal violence between caregivers. Among all youth, approximately 6 percent have experienced sexual assault, but the prevalence varies significantly according to age. Roughly 16 percent of youth ages 14–17 reported experiencing sexual assault in the past year.[iii, iv]

Many, but not all, ***children exposed to traumatic events and adversities experience symptoms of traumatic stress,*** which NCTSN defines as "reactions that persist and affect their daily lives after the events have ended."[v] Children exposed to trauma may experience intense symptoms of depression or anxiety, difficulties with behavioral or emotional regulation, peer and adult relationship problems, difficulty maintaining attention, academic problems, nightmares, other sleep-related problems, and changes in eating habits. Some younger children may experience physical symptoms manifesting as stomachaches or headaches. Older children may engage in alcohol and drug use or other unsafe or unhealthy behaviors. The severity of the event, and the extent to which children have access to protective factors that offset the negative effects of trauma, can determine the overall impact of trauma on a child's well-being and functioning.[vi]

Brain research suggests that ***chronic trauma exposure can have a significant impact on brain development,*** particularly in the prefrontal cortex regions of the brain that contribute to judgment, impulsivity, and decision-making. It can also affect areas of the limbic system, such as the amygdala and hippocampus, which contribute to social and emotional development, emotional regulation, and memory. These brain areas are very much in development throughout early

childhood, adolescence, and early adulthood.[vii] The impact of trauma on judgment, decision-making, and emotional regulation processes can have significant implications for how students behave at school. The negative impact of trauma on brain structure and functioning can contribute to behaviors that may place students at risk for exclusionary discipline and juvenile court system involvement.

The prevalence of trauma, and its impact on brain structure and functioning, learning, and behavior, has prompted child-serving systems as diverse as health care, education, legal, and child welfare to examine how to create trauma-informed systems and to ensure these systems can identify affected children as early as possible—ensuring access to effective interventions.[viii] ***Among youth involved in the juvenile court system, as many as 70 percent have a diagnosable behavioral health condition.***[ix] Within an educational setting, a disproportionately high rate of children who experience exclusionary discipline (e.g., arrest, expulsion, out-of-school suspension) have diagnosable behavioral health conditions and have been exposed to trauma. Furthermore, rates of exclusionary discipline are substantially higher among students of color.[x]

Teachers, administrators, school resource officers, and other school personnel interacting daily with students will benefit from an enhanced understanding of trauma, behavioral health needs, and effective responses to student behaviors. This enhanced awareness can help ensure that the school's adults are better prepared to make decisions that set students on a pathway of accountability and support in response to challenging behaviors. Exclusionary discipline and educational disengagement increase the risk of juvenile and adult criminal legal involvement. These factors have collectively led school districts to seek out approaches such as the SRM framework to better address students' needs, help affected students avoid unnecessary entanglement in the juvenile court system, and increase participation in effective, trauma-informed behavioral health treatments.

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Trauma as a Contextual Factor in School Responder Model Implementation

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The research on trauma's impact on learning and behavior summarized in the introductory tip sheet in this series has significant implications for at least two contextual considerations that undergird the SRM approach:

1. Understanding and explaining challenging behaviors and

2. Promoting individual and community connectedness.

First, ***an understanding of trauma can provide school professionals with a new perspective for explaining the behaviors they observe***. Teachers and school personnel understand the important role they play in guiding students toward mastering reading or math. They understand students do not walk in on the first day of kindergarten with the skills they need to read or multiply. However, do school staff apply that same teaching and learning paradigm when it comes to guiding students in mastering new social, emotional, and behavioral skills?

Although the primary goal of school is academic skills development, teachers and other school personnel also play a critical role in the development of nonacademic skills and competencies. Frequently, teachers and other school personnel require training, coaching, professional development, technical assistance, and, sometimes, a fundamental change in mindset in order to fulfill that role.

A foundational underpinning of the SRM framework is that school personnel can better address student misbehavior by making different decisions before, during, and after a behavioral incident. Decades of research suggests that people make nearly automatic judgments and causal attributions in social interactions and that racial and ethnic biases influence decision-making in matters of school discipline.[i] Addressing the adult responses to youth behaviors in the SRM framework aims to ensure that students with behavioral health conditions are not met with exclusionary discipline for actions better addressed through treatment and services.

In the midst of a challenging behavioral situation, school personnel must rely on their judgment to make multiple decisions, some that are nearly automatic and some that are made more deliberately in the minutes, hours, or days that follow. Those decisions forge pathways that have real consequences for both students and schools. In some instances, preconceived notions of students' inherent "badness" or "goodness" can profoundly impact the short- and long-term decisions that are made in response to a challenging behavior.

Trauma practitioners describe a shift in mindset that occurs as individuals learn more about the impact of trauma on functioning—learning that can fundamentally change the questions they ask and how they explain student behavior.[ii,iii] For example, questions might turn from "What's wrong with this student?" to either "What happened to this student?" or even "What is right with this student?" That change in mindset can, in turn, help school personnel respond differently to challenging behaviors, as trauma-informed perspectives help shift their approach from a punitive model to a model grounded in accountability, restoration, and support.

Second, ***an understanding of trauma prompts schools to invest more intentionally in individual and community connectedness***. The human capital that is accumulated when adults invest in knowing and understanding their students at a deep, individualized level can pay significant dividends when that student later exhibits a behavioral challenge. Some school resource officers have used the SRM process to—as they have put it—emphasize the "resource" and de-emphasize the "officer" in their title, which enhances their interactions with students. A similarly inspired mindset has the potential to benefit anyone who works closely with students.

Authentic relationship building and investment in creating a positive school climate often take place well before a behavioral challenge occurs. This preexisting climate helps create a relational context in which adults responding to a student's behaviors can exhibit calming, de-escalating words and actions. This may be even more important when working with students who have experienced trauma because it may be challenging for them to form and maintain trusting connections and relationships with others, and they can have difficulties with emotional and behavioral regulation. A trauma-informed preventive approach—one in which students who have experienced trauma are provided with services and supports to address their needs—may carry the potential to help students avoid behavioral incidents and exclusionary discipline altogether. In addition, a trauma-informed school environment is one that is supportive of all students and staff through universal, targeted, and indicated strategies for acknowledging and responding to trauma school-wide.

Some students and parents feel that, despite schools being cornerstone institutions in their community, teachers and administrators may too frequently be unaware of critical events and circumstances affecting the community. For example, community violence can have profound impacts on students, particularly because witnessing or directly experiencing interpersonal or community violence are among the most common forms of trauma exposure.[iv,v] School personnel who have well-established, structural connections to community leaders are more aware of what is going on in the community and will be better prepared to support students who may be suffering from the effects of adverse community experiences and community trauma.

Furthermore, school personnel with this level of connection to the community are also more aware of the significant strengths and resources that exist in that community and can be a more informed and supportive presence in students' lives. Creating ingrained and consistent mechanisms for enhancing awareness and sensitivity to the challenges and pressures within a community is critical to an SRM.

Understanding the prevalence and impacts of trauma allows educators to deepen their understanding of the root causes of challenging in-school behaviors. By identifying potential trauma exposure, the school responder model framework provides the pathway for students to receive necessary supports and services. The framework offers a therapeutic pathway for students with behavioral health conditions to disrupt unnecessary exclusionary discipline. By connecting with students and their families and the broader community, schools implementing school responder models can enhance their understanding of the trauma-related risk and protective factors that exist to best support students.

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Implications of Trauma for the Core Components of a School Responder Model

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A trauma-informed perspective can impact each of the core components of developing, implementing, and evaluating an SRM. The four core components of the SRM framework, detailed below, are essential requirements for engaging in this work; being trauma-informed complements these required activities and is a guiding principle of the SRM framework.

FORMING THE CROSS-SYSTEM COLLABORATIVE TEAM

Teachers, administrators, school resource officers, and other school personnel frequently do not have training or experience in understanding, recognizing, and responding to trauma. The formation of the cross-system collaborative team can be the first critical opportunity for ensuring that individuals with expertise in recognizing and addressing trauma are part of the decision-making and implementation process. Community and faith-based leaders can help keep school personnel abreast of significant community developments affecting their students. Within the school and in the community, mental health professionals frequently (but not always) have training and experience in trauma-informed screening, assessment, and intervention. A hallmark of the SRM framework is providing training and professional development to all members of the cross-collaborative team, as well as those in the broader school and community. Training and professional development can be critical for ensuring that all partners in the SRM process have a common language that includes trauma and associated concepts. ***Professional development curricula implemented as part of the SRM should ensure a sufficient focus on trauma, its impacts on learning and behavior, and effective strategies for identifying and treating trauma symptoms.***

FAMILY AND YOUTH ENGAGEMENT

Parents, caregivers, family members, and community members frequently have strong opinions about disciplinary practices in their children's schools; those opinions may range from believing the school is too "soft" on misbehavior to believing that the school is too reactionary, harsh, or punitive. Engaging parents and caregivers as key partners in the SRM process is critical. Some parents are tremendously influential in communicating directly with other parents and community members and can help to either establish or hinder buy-in and support for an SRM. Many schools that have successfully designed and implemented SRMs have done so with family members at the decision-making table from day one of planning.

Similarly, youth can and should have a voice about the disciplinary policies in their school. Youth voice and engagement often provide invaluable insights and contributions to the SRM planning and implementation process. Engaging students and obtaining and valuing their input from the outset can ensure that everyone receives and benefits from the same information and develops and tests the same values and principles. Like influential parents, influential students can educate their peers and create buy-in and enthusiasm for a new approach to responding to student behaviors.

BEHAVIORAL HEALTH RESPONSE AND IMPLEMENTATION

Determining the Population of Focus

Schools implementing an SRM must determine their target population for intervention.. A subset of students at higher risk for exclusionary discipline may be identified using established criteria for assessing needs for the application of the SRM approach specifically to these students (i.e., a tier-two approach).

A school may focus SRM efforts on students with more intensive intervention needs (i.e., tier three); for example, these students may be those with a known history of exclusionary discipline, with diagnosed emotional or behavioral disturbances, or enrolled in special education. To the extent that students suffering from traumatic stress are at increased risk for exclusionary discipline, schools may consider ways to ensure that they are appropriately identified and access the SRM process.

Providing an Initial Response to Behaviors

In some instances, behavioral incidents occur suddenly, with little warning, and in the presence of any type of school personnel. When there is a sudden crisis, a key consideration for SRM practitioners is determining who makes the initial response and ensuring they have the knowledge and skills for responding in a trauma-sensitive manner. Teachers and school resource officers are most likely to be among the first on the scene to observe a behavioral incident. Administrators may not be involved in the initial response but frequently become involved soon after as part of the disciplinary decision-making process. School social workers and school psychologists are also natural fits for taking a lead role in implementing the SRM approach and may be among the first on the scene following a behavioral incident.

Some SRM approaches, such as Connecticut's School-Based Diversion Initiative, use community-based mobile response and stabilization mental health professionals to help in the immediate response to a behavioral incident in order to stabilize behavioral incidents and link and refer to ongoing services, as needed.[1] Anyone in the school building who interacts directly with students would benefit from additional training and support for responding to youth exposed to trauma in more effective ways. However, knowing who is ***most likely*** to respond to behavioral incidents, and ensuring they have knowledge and skills related to trauma, is critical to SRM implementation.

Screening and Assessment for Behavioral Health Conditions

When determining and establishing processes for identifying trauma and behavioral health conditions—which may involve the services of a behavioral health treatment provider—parental consent may be required. SRM practitioners are encouraged to ensure that their activities comply with their state's laws and regulations relating to screening, assessment, and intervention for behavioral health conditions. The use of formal screening instruments, which is part of the SRM framework, can help identify a range of presenting problems or clinical conditions, including anxiety, depression; attentional concerns, such as ADHD; or oppositional or conduct disorders. However, it is important to note that trauma is "cross-diagnostic" and may be present along with any formal diagnosis.

Furthermore, many clinicians with extensive training and experience in identifying and treating trauma believe that underlying trauma contributes to—or even causes—diagnosable behavioral health conditions. Treatment will be far more effective when that underlying trauma is addressed. It is not the expectation that school staff have this clinical training, experience, or knowledge. Instead, the SRM framework requires non-clinical screening of students who may be experiencing mental health conditions, substance use disorders, or trauma, with appropriate referrals to clinical providers for more intensive assessment and/or treatment.

1. For a description of Connecticut's School-Based Diversion Initiative, visit: https://www.ctsbdi.org/.

Given the high prevalence of trauma among youth, its profound impact on behavior, and the higher likelihood that youth impacted by trauma will experience exclusionary discipline, SRM practitioners may consider incorporating a culturally-relevant trauma screening measure into their approach. The Child Trauma Screen (CTS),[i] for example, is a 10-item, validated screening measure that examines trauma exposure and symptoms and is available for download, free of charge, in English and Spanish.[2] Students who screen positive for trauma or behavioral health conditions may then be referred for further assessment by a licensed mental health professional. Schools that are implementing SRM often must do so in close collaboration with in-school and community-based clinicians. It is important to ensure that these professionals incorporate a trauma-informed approach in their screening and assessment practices as well.

Connection to Behavioral Health Services

The SRM framework emphasizes the importance of access to behavioral health interventions for students. It is important to note, however, that not all behavioral health interventions are trauma-informed, and not all interventions have strong evidence for effectiveness. Fortunately, there are a number of interventions that are both trauma-informed and evidence-based. In the school setting, the Cognitive Behavioral Intervention for Trauma in Schools, or CBITS, is a trauma-informed, group-based intervention for children in 5th to 12th grade. CBITS is delivered in the school and has strong evidence for effectiveness.[ii] Schools may also refer students to effective trauma-informed interventions designed for delivery in community-based settings, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and the Modular Approach to Therapy for Children: Anxiety, Depression, Trauma, and Conduct (MATCH-ADTC).[iii] Finally, students who experience behavioral incidents and are diverted from exclusionary discipline through the SRM process may still need formalized interventions focused on accountability for their behavior. Although not explicitly designed as a trauma-informed approach, restorative practices offer a trauma-sensitive, relational approach for ensuring accountability that can be more effective than traditional punitive approaches.[3]

POLICIES AND FORMAL STRUCTURES

Integrating trauma-informed approaches into these core components of an SRM can help to better serve students with behavioral health conditions. An essential part of the SRM framework and the fourth core component of this approach is the codification of policies and formal structures. Institutionalizing the SRM will help ensure effectiveness and sustainability, particularly as schools experience changes in leadership and staff turnover. For example, the memoranda of agreement, or MOAs, with community-based providers offering trauma-informed interventions can be developed to codify students' pathways to receive referrals to these services. Creating a flowchart that illustrates student screening pathways and distinguishing appropriate responses to behavioral infractions can help to concretize the trauma-informed practices integrated into an SRM. Updating student and parent handbooks to describe the SRM, the collaborative team, the emphasis on trauma-informed perspectives, and other relevant details will help provide SRM knowledge to the community being served by the school, detailing the practices, expectations, and roles established as part of the SRM.

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2. To view and download the CTS, visit the Child Health and Development Institute's website at https://www.chdi.org/our-work/mental-health/trauma-informed-initiatives/ct-trauma-screen-cts/.
3. For more information about restorative practices, visit the International Institute for Restorative Practices website at https://www.iirp.edu/.

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