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

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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 distinguishes the ways in which a trauma-informed perspective can be integrated into each of the four core components of a school responder model.***

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/.

Endnotes

i. Jason M. Lang and Christian M. Connell, "Development and Validation of a Brief Trauma Screening Measure for Children: The Child Trauma Screen," Psychological Trauma: Theory, Research, Practice, and Policy 9, no. 3 (2017): 390–398. doi:10.1037/tra0000235.

ii. Lisa H. Jaycox, "Cognitive Behavioral Intervention for Trauma in Schools," ***Journal of Applied School Psychology*** 28, no. 3 (2012): 239–255.

iii. John R. Weisz, "Testing Standard and Modular Designs for Psychotherapy Treating Depression, Anxiety, and Conduct Problems in Youth," ***Archives of General Psychiatry*** 69, no. 3 (2012): 274–282.