

Trauma-informed care, schools, and mental health professionals

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The prevalence of exposure to trauma and its link to negative health outcomes has been well-documented. Beginning with the first adverse childhood experiences (ACEs) study by Felitti et al. (1998), we have learned that childhood trauma is both common and significantly related to behavioral and learning issues in school, as well as a host of other poor behavioral and physical health outcomes, and often ultimately school failure.

More recently, studies have offered an ever more nuanced approach by documenting effects of community versus household level events and recognizing that these events disproportionately affect brown and black children. Specifically, some of the events affected ability to self-regulate. In fact, racism was identified as one of the strongest negative effects (Thurston et al., 2018).

In line with these findings, some systems have sought to provide care that recognizes the impact of trauma. Guiding a system to structure these programs does not necessarily assume that all children have these experiences, but rather that most can benefit from strategies aiming to increase resilience and from a decreased reliance on punitive consequences, such as expulsion and exclusionary suspension. In schools, a particular focus has been to teach prosocial behavior rather than respond with harsh punishment.

Certainly, the addition of the pandemic to racism and police violence creates a level of risk for struggles with mental health that we probably have not seen before. As schools all over the country reopen this fall, one way to help children to readjust to classroom life may be via a trauma-informed educational lens. The National Child Traumatic Stress Network (NCTSN) defines a trauma-informed system, such as a school, as one where all parties involved recognize and respond to the impact of traumatic stress. Educators, staff, and administrators infuse trauma awareness, knowledge, and skills into their school climate, programs, and classrooms.

One example is the “compassionate schools” training, started in 2008 in Washington State and expanded to schools in 45 different states (www.compassionateschools.org). Briefly, the goal is to provide professional development focused on understanding effects of trauma on development, as well as informing policy that changes the climate of the school to focus on goals within four areas. These are:

- increasing self-regulation and management,
- improving executive functioning,
- increasing social and emotional competency, and
- helping students achieve academically.

A recent study (Parker et al., 2019) demonstrated significant attitudinal change in personnel undergoing compassionate schools training regarding:

- understanding underlying causes of problem behavior,
- responding more effectively to problem behavior,
- experiencing self-efficacy at work,
- supporting efficacy in this small training sample, and
- pointing to the need for continued research.

There are other approaches available, such as the Sanctuary model (see traumasensitiveschools.org), with similar goals and objectives. A few of these are:

- emphasizing safety,
- fostering family and student connections to the community and to the school, and
- team approach to classroom management.

At the same time, there are cautions to be considered. Some maintain that trauma-informed education is the latest trend, with little research to support its use and the potential to waste valuable time and funding in implementation. In fact, Maynard et al. (2019) note that there are no studies that use sound research methodologies that allow conclusions about effectiveness to be drawn.

The lack of proof of effectiveness, according to some, is quite concerning. Those who are not proponents of a trauma-informed approach or feel that it is not well-researched tend to support the provision of mental health services within schools in a partnership model, using evidence-based practices such as Cognitive Behavioral Intervention for Trauma in Schools (CBITS), which uses a skills-based group approach for children from ages 10–18. This model can be provided to children via a partnership model with mental health providers or by school personnel trained in the modality. In some ways, these models can be conceptualized as fitting within the tiered intervention model that is currently used within schools.

Trauma-informed care can be utilized as a tier one universal approach, while CBITS would be considered a tier two approach for targeted groups of students, and perhaps trauma-focused CBT (TF-CBT) as an individualized approach for fewer numbers of students at a tier three level.

From my perspective, the appeal of trauma-informed care is also the appeal of positive behavioral intervention and support. Rather than applying a “discipline for the masses” approach such as zero tolerance or suspensions for infractions, both emphasize reliance on support, compassion, and collaboration of staff and students. Using professional development days this summer to develop systems of support as students return is critical, and the avenue to get there necessarily varied.

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