

Trauma-Informed Care in Schools: A Necessity in the Time of COVID-19

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Abstract

With students having experienced dramatic changes to their lives and perhaps personally experiencing serious illness and death within their immediate or extended families due to the COVID-19 pandemic, schools may have to examine how to broadly implement the use of trauma-informed care in schools. This article examines why experiences related to the pandemic are considered traumas and what supportive practices have been identified in the research that educators can use to help students.

Keywords

trauma, trauma-informed care, multitiered systems of support

In December 2019, officials in China announced a cluster of unusual cases of pneumonia in Hubei province. The World Health Organization (WHO) began to investigate the illness and within a month had identified the first cases outside of China and confirmed the illness was being passed from person to person. Wuhan, the city in China that reported the first cases, went under a complete and total quarantine as the world watched.

In late January 2020, the first case of the illness, now recognized as a novel coronavirus, was identified in the United States in the state of Washington. By mid-February, the WHO officially named the virus COVID-19, and the virus had taken hold in Europe, notably Italy. Concerns over the growing spread of COVID-19 caused the U.S. stock market to plummet in late February, and the state of California announced it had a case of a person with the virus with no known exposure, indicating that COVID-19 was spreading in the community.

In early March 2020, U.S. communities began canceling large-group activities, such as the South by Southwest festival in Austin, Texas, and St. Patrick's Day parades and festivals in many large cities, to limit potential exposure to large groups of people. By mid-March, it was announced that a player in the U.S. National Basketball Association (NBA) had contracted the virus and potentially exposed players on his team and opposing players. Shortly thereafter, all NBA seasonal play ceased. At that point, what could be called the closure of the United States picked up speed quickly. Universities and K–12 schools soon closed, with many transitioning to distance instruction. College sports and eventually all professional sports were canceled.

As the death toll in Italy climbed, deaths began occurring in the United States. By the end of March, most states had

issued “stay at home” orders as deaths in just the state of New York had topped 1,000. It was a crisis the world watched unfold, with experiences unknown to anyone in our lifetimes, and to date there has been no clear conclusion (Muccari & Chow, 2020). As of spring 2021, the United States had diagnosed over 32.5 million cases resulting in more than 570,000 deaths. The U.S. suffered more deaths in the first 3 months of the pandemic than the country had experienced during the entire Vietnam War (Welna, 2020), with no estimate when the virus will be controlled (Centers for Disease Control and Prevention [CDCa], 2021).

There were approximately 56.6 million students attending U.S. public and private K–12 schools in the 2018–2019 school year (NCES Blog Editor, 2019). With the pandemic spread of COVID-19, many of those students experienced significant changes to their routines, home lives, and personal lives. Due to the widespread disruption of everyday routine, economic losses due to business closures, and the illness and potential death experienced by many families, this pandemic can be classified as a disaster. A disaster can be defined as “a serious disruption of the functioning of a community involving widespread human, material economic, or environmental losses and impacts,” usually exceeding the ability of those affected to cope using only their own resources at hand (Mahar et al., 2008, p. 5). Stafford et al. (2008) identified three criteria that can affect

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a child's reaction to a disaster situation: (a) the extent to which the child has been exposed to the specific event; (b) the amount of support the child received both during the disastrous event and in its aftermath; and (c) the amount of personal loss and social disruption the child has experienced.

Stafford et al. (2008) explained that children living through a disaster have experienced a traumatic experience. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014a) defined *trauma* as resulting

from an event, a series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's function and mental, physical, social, emotional, or spiritual well-being. (p. 7)

We also need to consider that students who had already experienced chronic trauma due to conditions such as domestic violence or childhood neglect, or had already witnessed a single traumatic event such as a violent act, are even more at risk than children exposed just to the effects of COVID-19 (SAMHSA, 2014b). Among that group of students are some with emotional and behavioral disorders (EBD).

Porche et al. (2016) determined that (a) children with repeated exposure to multiple traumas were more likely to receive a mental health diagnosis and (b) those who also lived in lower socioeconomic neighborhoods were at higher risk. Research has indicated that the best way to address the needs of individuals who have experienced trauma is through a system of trauma-informed care (TIC). A system of TIC assumes that individuals are more likely than not to have a history of trauma and utilizes practices that appropriately respond to trauma and minimize the likelihood of retraumatization. These practices can be used in a variety of settings, such as schools, mental health care settings, and social care settings, and by medical professionals, for all ages from early childhood through adults. A growing body of literature indicates that within schools, TIC can be implemented by integrating it within existing multitiered systems of support (MTSS; Herrenkohl et al., 2019; Reinbergs & Fefer, 2018; Zakszeski et al., 2017). This article will review why the COVID-19 pandemic qualifies as a traumatic event and what research- or evidence-based TIC practices schools can implement to serve the needs of all students, including those with EBD, as they work with them going forward.

COVID-19 as Trauma

The existing literature on the mental health consequences of epidemics is relatively sparse and tends to relate more to the impacts of the physical illness itself (Galea et al., 2020).

Due to the worldwide impact and quarantining that has resulted from the pandemic spread of COVID-19, it is likely that there will be research done on these impacts in the future. Holmes et al. (2020) outlined specific research questions to be answered regarding COVID-19 and mental health, suggesting that research begin immediately so that necessary interventions can be in place for any subsequent waves of infection, and addressing vulnerable groups, such as children and individuals with disabilities. However, past large-scale disasters that affected U.S. communities, such as the World Trade Center attacks, Hurricanes Ike and Katrina, and the oil spill caused by the Deepwater Horizon, all were followed by community increases in mental health issues such as depression, substance abuse, domestic violence, and other emotional and behavioral concerns (Galea et al., 2020). The CDC (2020b) explained that children may be experiencing grief over loss of typical routines and activities, such as going to school, playing with friends, or participating in typical milestone activities such as dances and graduation activities. Worldwide, education has been disrupted in 188 countries for approximately 1.5 billion children and youth. The director-general of the United Nations Educational, Scientific and Cultural Organization (UNESCO) stated, "The global scale and speed of the current educational disruption is unparalleled" (Lee, 2020, p. 1).

As the pandemic was in the early days, school employees reported anecdotal evidence that some students were struggling with the changes to their normal routines, exhibiting behaviors such as remaining inside their own rooms, refusing to shower, eat, or even get out of bed (Lee, 2020). Mental health professionals began to discuss the traumatic impacts of COVID-19 on children and youth (Bartlett et al., 2020; Jiao et al., 2020; NYU Langone Health, 2020; Pisano et al., 2020).

The signs and symptoms of trauma that children exhibit will likely vary based on the support that they receive from caregivers, and that will likely depend on how much trauma and stress that caregivers are experiencing. Children may experience nightmares or difficulty sleeping, negative feelings, behaviors that seem to be a regression to an earlier stage of development, avoidance of people or activities that serve as reminders of the ongoing trauma, and difficulty maintaining attention (Bartlett et al., 2020). Children who have parents working as health care workers are exhibiting signs of trauma, also reported anecdotally. Describing a 6-year-old forced to live with relatives because both parents are health care workers, Cox (2020) wrote,

Leah readied to leave, Tamina unraveled. She grabbed onto her mom and tried to wrap a hair tie around her wrist, imagining that it would keep her there forever. Tamina begged her to stay and screamed at her aunt when she pulled her away. "I hate you," Tamina said, weeping. (n.p.)

Horesh and Brown (2020) posited that while other mass traumas, such as war and natural disaster, have been studied extensively in the past, the global nature of this pandemic and the mass dissemination of information via smartphones and social media may make this a new type of traumatic event with impacts on every aspect of society. Considering the number of children who are already living with risk conditions, such as poverty (perhaps depending on school for regular meals), abusive parents, or neglect, the disruptive nature of the COVID-19 pandemic will likely leave schools with a large number of traumatized children (Holmes et al., 2020).

Early research from Great Britain has already illustrated the magnifying impact of poverty, compounding the trauma of the lockdown living environments of the COVID-19 pandemic (The Childhood Trust, 2020). As of September 2020, members of the U.S. Senate recognized the traumatic impact of COVID-19 on children nationwide and made a written request to the Secretary of Health and Human Services and the Secretary of Education for specific guidance and support to schools to address the mental health needs of students (Warren & Cassidy, 2020).

Generally, students who have been exposed to trauma or an extended exposure to stressful situations that can translate to trauma can demonstrate negative impacts on their school functioning (Morton & Berardi, 2018; Porche et al., 2016; Ridgard et al., 2015). These may include not only post-traumatic stress disorder (PTSD) but also separation anxiety, social anxiety, depression, suicidal ideation, and various aggressive behaviors (Cavanaugh, 2016; Ridgard et al., 2015). Students may also demonstrate difficulty completing academic tasks (Morton & Berardi, 2018; Plumb et al., 2016; Ridgard et al., 2015). Being aware of the trauma students have experienced and putting in place trauma-sensitive routines for students will allow them more opportunities for success and the ability to grow not only academically but also socially and emotionally (Paccione-Dyszlewski, 2016).

Trauma-Informed Care

Much of what we know about TIC has grown from the work of SAMHSA (2014a). There are four key components—the four “R’s” (Chafouleas et al., 2016)—to implementing recommended practices advocated by SAMHSA: (a) realizing the impacts of trauma on individuals, families, and communities; (b) recognizing the signs and symptoms of trauma; (c) responding to trauma and its effects by integrating knowledge about trauma into organizational policies, procedures, and practices; and (d) working to resist retraumatization by utilizing principles of safety, trustworthiness, transparency, peer support, collaboration, empowerment, voice, and being considerate of cultural, historical, and gender differences. In the literature, various terms are often

used for these practices, including *trauma-informed*, *trauma-focused*, or *trauma-specific* (Zakszeski et al., 2017). Much of the more recent literature has used TIC, so that will be the descriptor used throughout this discussion.

Support for the use of TIC in schools was strengthened before the current crisis by passage of the Every Student Succeeds Act (ESSA; Pub. L. 114-95, 2015), which included provisions to support schools moving toward implementing TIC approaches (National Association of School Psychologists, 2016; Reinbergs & Fefer, 2018). While the idea of the use of TIC in schools has garnered much more attention since the passing of ESSA and growing recognition of the impact of trauma of large numbers of students in our schools nationwide, that knowledge has not necessarily translated into actionable research-to-practice plans that schools can immediately implement (Reinbergs & Fefer, 2018). Reinbergs and Fefer expressed concern that while a number of TIC practices and assessments had been researched, educators in schools were being left on their own to determine how to implement them without clear direction or support. This is a significant problem not only because of the potential looming issue of trauma at unforeseen levels due to COVID-19 but because court decisions have already found that if districts do not respond appropriately to student trauma, they can be held legally liable (e.g., *P. P., et al. v. Compton Unified*, 2015). In *P. P.*, a judge declined to dismiss the case, finding that schools are responsible for not only responding to student trauma but also providing training to teachers on how to address student trauma and protect themselves from secondary trauma. Rather than pursue further litigation, all parties decided to work together to develop systems to appropriately address trauma in the California district’s schools (Sparks, 2019).

Current literature has indicated that the most likely effective way to implement TIC in schools is to utilize existing schoolwide systems, including positive behavioral interventions and supports (PBIS) frameworks. In discussing the use of TIC in schools in reference to the *P. P.* case, one researcher stated,

In doing this work, the approach we take is that this is about a shift in the practices among the adults in the building. Our argument is you will get to issues and needs of individual children more effectively and more sustainably if the intervention is really for the adults who work with the kids. (Loudenback, 2016, para. 24)

Several reviews completed in the past few years examined various TIC practices that can be implemented within existing MTSS models in schools (Herrenkohl et al., 2019; Reinbergs & Fefer, 2018; Zakszeski et al., 2017). Others have recognized the value of the existing MTSS or PBIS systems and made their own recommendations on how to implement TIC practices into those frameworks (Chafouleas et al., 2016; Plumb et al., 2016). Zakszeski

Table 1. Key Steps for Communicating With Children in a Trauma-Informed Manner.

Communication step	Detailed explanation
Let the child set the pace for communication	Do not try to force conversation about traumatic experiences; the lead-in conversation should come from the child.
Give adequate time to the child	Allow children to share experiences over a period of time; do not expect them to share a whole story regarding a traumatic experience in one conversation.
Provide emotional support and encouragement	Provide support in ways that are appropriate to the child's age, developmental level, and culture.
Show acceptance of the child's emotions	Children do not respond to trauma in the same ways; they may display various emotions, such as anger or guilt; accept all emotions, even if you find them illogical to the experience.
Do not provide false assurances	As much as educators may want to comfort children by assuring them everything will be okay, it is preferable to help children come to face the realities of their situation rather than avoiding it; however, this must be done with trust and support.
Talking may provide solutions	Being able to talk to a trusted adult may allow children, especially older children and adolescents, the ability to determine their own solutions to problems. Listening to children and being attentive and supportive may allow children to find their own methods toward emotional healing.
Allow for regression	In some children, it is possible to see regression to behavior more typical of a younger age. They may demonstrate a need for more personal care, affection, or physical contact as a way to address the emotional problems they are facing.

Note. Information summarized from Stafford et al. (2008).

et al. (2017) pointed out that due to the similarities in structure with PBIS and MTSS, TIC practices should be embedded within those frameworks lest “school practitioners and administrators alike might be discouraged by the idea of implementing ‘yet another’ multi-tiered system within their schools” (p. 316).

How Schools Can Implement TIC Practices for Students

Utilizing a tiered systems approach means that in the first tier all students should be receiving services from educational staff in such a way that staff are able to become aware of students who need more intensive mental health services and that no further psychological trauma is inflicted upon students. Stafford et al. (2008) called these nonintrusive first steps “Psychological First Aid” (PFA; p. 20). The primary goal of PFA is to create feelings of safety, connection, and self-help for those who have recently experienced trauma to begin steps toward recovery. Stafford et al. identified the key principles as look, listen, and link. The first step is to look and assess for needs and concerns. The second step is to listen to individuals without pressuring them to talk about the event or their experiences while also comforting them and helping them feel calm. The third step is to link affected students to other community supports to ensure basic needs are being met.

Training in PFA should be the first step administrators take in preparing staff to implement TIC practices. Being able to assess the needs of students safely and appropriately speaks to the need of using a full multidisciplinary team of professionals in the schools to address students’ needs. Table 1 offers key steps for communicating with students.

For Tiers 2 and 3 services, schools will need to identify appropriate TIC assessments to use with students. Assessments that could be used at each of these tiers have been discussed in several reviews (Chafouleas et al., 2016; Reinbergs & Fefer, 2018; Zakszeski et al., 2017). There are several therapeutic practices, such as cognitive behavioral therapy, dialectical behavioral therapy, and social support groups that are often components of social-emotional learning packages schools may already have implemented. These are practices that have been indicated for use with children who have more intensive trauma-related needs (Chafouleas et al., 2016; Herrenkohl et al., 2019; Reinbergs & Fefer, 2018). These practices have also been shown to be effective with students with EBD.

Utilizing resources in an MTSS design has been shown to be effective for students dealing with trauma, students at risk of EBD, and students already identified as EBD (Mitchell et al., 2019). In addition, Salle et al. (2018) found that students with EBD have lower perceptions of school climate and report higher levels of peer victimization at school. Those authors recommend the use of PBIS and other tiered interventions focused on school climate improvements to better support the needs of students with EBD. Finally, with Porche et al. (2016) indicating that higher numbers of students with adverse experiences in their backgrounds are also at risk when coming from lower socioeconomic neighborhoods, they recommended the use of schoolwide PBIS to avoid disciplinary practices that may disproportionately impact culturally and linguistically diverse students. Specific TIC programs have been designed for individual, classroom, or schoolwide use, and these are summarized in Table 2.

Table 2. Research-Based TIC Programs Available for School Use.

Program name	Description of program components	Research supporting use
Bounce Back	Delivered by school-based clinicians, combines group sessions, individual sessions, and parent education sessions	Distel et al. (2019); Langley et al. (2015); Santiago et al. (2018)
CBITS	Includes both small-group sessions and individual sessions, as well as group sessions for parents and one training session for educators. Goals are to (a) reduce symptoms related to trauma, (b) teach and build skills to manage trauma-related stress, and (c) build support among peers and caregivers	Allison and Ferriera (2017); Hoover et al. (2018); Jaycox et al. (2010); Kataoka et al. (2003); Kataoka et al. (2011); Morsette et al. (2009); Perry and Daniels (2016); Stein et al. (2003)
Grief and Trauma Intervention (GTI)	Can be conducted as group or individual sessions; if done as groups, each child receives an individual pullout session. Also includes a parent session. Combines techniques from cognitive behavioral therapy and narrative therapy to help children learn more about trauma and reactions, express their thoughts and feelings about their traumatic experiences, and reduce symptoms resulting from trauma.	Salloum and Overstreet (2008)
Healthy Environments and Response to Trauma in Schools (HEARTS)	Designed as tiered systems of support, includes professional development, allows for individualization for students with high-intensity needs	Dorado et al. (2016)
Linking Action to Unmet Needs (LAUNCH)	Designed as tiered systems of support that include teacher training on TIC, schoolwide curriculum, allowing for individualization for students with high-intensity needs or existing behavior plans	Shamblin et al. (2016)
Multimodality Trauma Treatment (MMTT)	Group sessions, with the addition of one individual pullout session, designed to deliver skills in psychoeducation, anxiety management, anger coping, narrative exposure, and relapse prevention. Originally designed for single-incident trauma, but research showed effectiveness with a wide range of trauma.	Amaya-Jackson et al. (2003); March et al. (1998)
RAP Club	Group sessions delivered by mental health counselors and young adult community members. Content includes cognitive behavioral therapy, mindfulness, and other therapeutic techniques.	Mendelson et al. (2015)
Skills Training in Affective Regulation—Adolescents (STAIR-A)	Group sessions delivered by a clinician focused on development of skills in emotional regulation, interpersonal connectedness, and social support; development of coping strategies; and then practice of those skills by applying them to trauma narratives.	Gudiño et al. (2016)
Support for Students Exposed to Trauma (SSET)	Group sessions delivered by teachers and school counselors based on elements of CBITS model (see above). All content delivered in group sessions; no individual components.	Jaycox et al. (2009)
Supportive Trauma Interventions for Educators (STRIVE)	Training for teachers to deliver a classroom-based intervention for young children designed to increase capacity to support children who have experienced trauma.	McConnico et al. (2016)
The Resilience Classroom Curriculum	Delivered by school social workers, this program includes modules focused on building skills in emotion regulation, communication, problem-solving, goal setting, and management of stress. Teacher trainings are also available.	Ijadi-Maghsoodi et al. (2017)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Designed as individual therapy sessions to meet the needs of specific students who demonstrate behaviors related to trauma-related symptoms. Also includes joint parent/child sessions.	Cary and McMillan (2012); Cohen et al. (2016); Cohen, Mannarino, and Iyengar (2011); Cohen, Mannarino, and Murray (2011); Hansel et al. (2010); Little et al. (2009)

Note. TIC = trauma-informed care; CBITS = Cognitive Behavioral Intervention for Trauma in Schools.

How Schools Can Prepare Teachers to Implement TIC

Another key consideration for schools to be able to provide universal supports for all students in a TIC approach is that all school staff will need to be trained and prepared to collaborate in an interdisciplinary manner with other school staff and even with professionals in the community to effectively meet the needs of all students. Before beginning training, administrators can first review the current practices in their school to determine what structures they may already have in place that support TIC.

Lesley University's (n.d.) Lesley Institute for Trauma Sensitivity has created and made available free of charge a checklist that schools can use. This checklist is organized around five key components in creating a trauma-informed school: (a) schoolwide policies and practices, (b) classroom strategies and techniques, (c) collaborations and linkages with mental health, (d) family partnerships, and (e) community linkages. In using the checklist, administrators are encouraged to employ a team to evaluate their school's readiness, scoring statements in each component on a 4-point scale (1–4) spanning from whether specific elements are *not at all in place* to *fully in place*. This type of checklist allows school teams to identify specific areas that should be the focus of training and preparation.

Morton and Berardi (2018) discussed the need to ensure that educators understand the nature of trauma and its effects on student learning and behaviors. Teachers may have to reframe previously held beliefs on behavior, discipline, and learning to understand that defiant behaviors or disengagement from academics may be typical stress reactions as a result of experiencing sustained trauma or extreme loss. Again, there are materials available to help administrators examine their current policies and work through this process. The Trauma and Learning Policy Initiative (2005) has two downloadable volumes, *Helping Traumatized Children Learn*, that include activities schools can do to develop schoolwide functions that are trauma-sensitive. There is also video available online to support the training in the volumes. Additional suggested resources for educator training materials can be found in Table 3.

As the COVID pandemic continues worldwide, some schools may be physically open to teachers and students in some format, whereas others may remain physically closed, requiring distance training and teaching. As the so-called waves of the pandemic wax and wane, we may also find ourselves with schools that move between physically open, completely online, or some mixture of both until there is some measure of control over the spread of the virus. That could make the use of these web resources more important than ever. Administrators can begin by reviewing materials, determining what materials are most appropriate and necessary for their teachers to read, and then sharing appropriate

materials with families. In this way, everyone working with the students will have a common language around trauma and its signs, and teachers should be encouraged to discuss these materials with the families of their students to support them in the event their child is showing signs of trauma while learning at home.

Even while working at a distance, educators should still maintain multidisciplinary teams so that appropriate staff, such as special education teachers, counselors, or school psychologists, can be called in to provide additional support when needed and be able to refer students for additional services if necessary. The Council for Exceptional Children has compiled a page of COVID-19 resources for educators that includes materials to support online education, social-emotional learning, working with families during the pandemic, and self-care for educators (<https://exceptionalchildren.org/improving-your-practice/resource-library/resources-teaching-remotely>).

Another concern related to training was discussed by Plumb et al. (2016). They suggested that one of the early steps schools must take is to review discipline policies. If the school is already utilizing best practices as outlined by PBIS research, they may be better prepared to implement TIC practices schoolwide, but Plumb et al. still recommended even those schools review disciplinary procedures. According to Plumb et al., behavioral consequences in the schools must be logical, respectful, and nonviolent. Moreover, they should never involve humiliation or focus solely on punitive consequences. All behavioral consequences should be designed within the TIC goals of PFA and ensure that even as behavioral consequences are applied for problem behaviors, they are designed to help students move toward healing from trauma while remaining connected and feeling supported by school staff (Plumb et al., 2016).

A final key consideration in developing universal supports for TIC in a school would be ensuring a system of supports for staff. Any time we have educational staff working with children who have experienced trauma, there can be a concern about vicarious traumatization, also known as compassion fatigue or secondary traumatic stress (Hydon et al., 2015), which consists of potentially harmful changes that can occur in helping professionals' views of themselves, others, and the world due to the exposure to the shared trauma of those whom they are helping (Baird & Kracen, 2006). Hydon et al. (2015) discussed the connection between secondary traumatic stress and teacher burnout, which they defined as "a prolonged response to chronic emotional and interpersonal stressors on the job" (p. 323). While secondary traumatic stress does not always lead to burnout, it can be one of the components, if not addressed.

Reinbergs and Fefer (2018) recommended several practices to ensure that teachers and other educational staff can maintain safe mental health practices while caring for

Table 3. Resources for Professional Development/Information on TIC in Schools.

Organization/source	Brief description of organization/source	Key features of available materials
ACF (https://www.acf.hhs.gov/trauma-toolkit/schools)	A division of the U.S. Department of Health & Human Services, the ACF aims to promote the social well-being of families, children, individuals, and communities.	This page provides number of resources specific to schools for TIC, along with descriptions of each resource. Resources outlined are from federal, state, and nonprofit sources. There are also suggestions on staff self-care and obtaining funding if needed.
ATN (https://creatingtraumasensitiveschools.org/resources/)	ATN has developed a trauma-sensitive schools initiative aimed at implementing TIC in schools nationwide and providing professional development for educators to prepare them to provide these services.	The page provides a handout detailing the impact of trauma on learning, a list of books on trauma and learning, additional websites and articles, as well as links to their professional development opportunities.
Healthy and Ready to Learn (https://hrl.nyc/node/hrl-trauma-educators)	This is a program from the Children's Health Fund. Healthy and Ready to Learn is an initiative developed to address issues affecting student learning and school attendance. They have been partnered with two schools in New York City since 2014 to implement a comprehensive school-based model to provide wraparound services, including TIC.	They have a specific page with COVID-19 information that addresses information not only about TIC, but a variety of COVID issues (https://hrl.nyc/node/coronavirus-alert) and has materials in both English and Spanish. The page on TIC has materials that can be used for training teachers, as well as materials that can be used to inform parents, and materials to be used in working with students; many of these are available in both English and Spanish.
NASP (https://www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-health/trauma-sensitive-schools)	NASP is a professional organization primarily representing school psychologists, but also graduate students and other related professionals, and the organization works to promote effective practices in schools that will improve students' learning, behavior, and mental health.	This page provides a brief background on TIC, the specific role of school psychologists in TIC, and policy recommendations, including specifically in regard to implementation within an MTSS model. There are additional resources to download on various components of TIC in schools.
NCSSLE (https://safesupportivelearning.ed.gov/trauma-sensitive-schools-training-package)	The NCSSLE is a grant-funded organization under the American Institutes for Research. They offer technical assistance to states with a focus on school climate and learning conditions.	This page offers training and professional development packages free of charge to schools working toward implementing a TIC model. Materials can be downloaded and include ones that are designed to educate school staff on trauma and its impact, how to build a TIC school and all its components, and training specific for school leaders.
NCTSN (https://traumaawareschools.org/traumalnSchools)	The Treatment and Services Adaptation Center is a website supported by the NCTSN. Their goal is to promote TIC systems in schools that provide prevention and early intervention for students who have experienced trauma.	The main page on TIC in schools provides resources that give background information on trauma and components of TIC in schools. This was one site that has already updated materials to include COVID-19-specific materials on another page, and it notes that they will be updating their COVID-19 materials to support the mental health needs of students.
Resilient Educator (https://resilienteducator.com/collections/trauma-informed-school-practices/)	Resilient Educator is a webpage by educators for educators primarily on how to maintain health and well-being to avoid teacher burnout and provide good education to students.	This page includes background about TIC, but has more focus on self-care for educators. There are a number of resources available for educators on how to avoid stress and anxiety themselves when working with student trauma. This site also has COVID-19-specific resources, materials on how teachers can remain resilient, relieve stress, ideas for effective teaching practices, suggestions for working with families, and suggestions for administrators.
TLPI (https://traumasensitiveschools.org)	TLPI is a collaboration among Massachusetts Advocates for Children, Lesley University, and Harvard Law School. Their goals are to help schools become trauma-sensitive and advocate for laws, policies, and funding streams that will support the development of those practices in schools.	This page contains a variety of materials on TIC in schools, including a downloadable book on creating schools with TIC policies, blogs, and videos. TLPI also has a link to their response to COVID-19 on this page and explain how they will continue to update materials on TIC and COVID-19.

Note. TIC = trauma-informed care; ACF = Administration for Children and Families; ATN = Attachment & Trauma Network, Inc.; NASP = National Association of School Psychologists; MTSS = multitiered systems of support; NCSSLE = National Center on Safe Supportive Learning Environments; NCTSN = National Child Traumatic Stress Network; TLPI = Trauma and Learning Policy Initiative.

children with trauma. They recommended equitable distribution of caseloads of students with more intensive needs and the promotion of self-care strategies. They also suggested the use of a free nondiagnostic tool that is designed to assess the well-being of helping professionals, the Professional Quality of Life measure (ProQOL). The ProQOL was developed in 2012 by Dr. Beth Stamm and was always provided at no cost to ensure provider resilience and avoid compassion fatigue in those helping professionals working with individuals dealing with trauma. Because of the current COVID-19 crisis, Stamm has also developed a “pocket card” with 10 self-care tips for helping professionals to maintain resilience (<https://www.proqol.org>). The list includes some commonsense reminders for good self-care, such as getting enough sleep and enough to eat, but also suggestions to vary the work being done, share a private joke, and learn from mistakes. The opposite side of the card has suggestions for professionals on how to focus empathy and be able to switch between work mode and off-work modes. Hydon et al. (2015) recommended the use of a training on secondary traumatic stress for educators that was developed by the U.S. Department of Education. This training informs educators about the concepts of compassion fatigue, vicarious trauma, and secondary traumatic stress and how they can lead to burnout. Facilitators then lead the training to help educators identify self-care practices for themselves. Each educator is encouraged to develop self-care strategies specific to themselves and their own needs but to also share their plans with each other to have support among their peers to all be accountable for their self-care.

Conclusion

As of this writing, scientists cannot tell us how or when we will reach a conclusion to the COVID-19 pandemic. We are not sure how delivery of educational services across the United States may look different based on school district, state, age, or services needed by individual students. Educators are hearing many phrases such as “stay nimble” or “remain flexible.” As educators, what we can safely say is that the students of this generation have experienced disruptions to their personal and educational lives unlike any other generation, perhaps since the 1918–1919 influenza pandemic. It is critical that we prepare to be there for our students, whether that be in person, via distance, or some combination of both formats.

Minahan (2020) stated that the most critical component in lessening student anxiety and trauma, even if schools remain physically closed, is maintaining connections with our students. That means sending individual messages, making phone calls (e.g., using Google Voice), emails, or even just sending old-fashioned postcards or notes to their homes to remind them that you are thinking about them.

Have “office hours” on whatever conferencing platform your district is using where students can check in and let them know they are free to just say hello or talk about their day, their pet, or what they had to eat. We hope that creating opportunities to stay connected to students, especially our students with EBD, will lessen any anxiety they are feeling and help them to begin working through the trauma of this current event. The Trauma and Learning Policy Initiative compiled some early responses from schools already using TIC practices, and they describe how practices such as those above have helped educators support students and their families, as well as maintain their own self-care, during the ongoing pandemic (<https://traumasensitiveschools.org/educators-covid-19-crisis/>).

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