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Social Justice and Trauma-Informed Care in Schools

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Abstract

Current understandings of trauma and implementations of trauma-informed care (TIC; SAMSHA, 2014) in school environments can be limited because the conceptualization, assessment, and treatment of trauma tends to focus on specific, identified histories of abuse. This reflects the impact of the Adverse Childhood Experiences (ACEs) prevalence study among the adult American population (Felitti et al., 1998). However, addressing and preventing trauma in youth populations encourages recognition of the particular and disproportionate ways trauma affects marginalized groups, especially in schools. Some advocates for TIC view TIC as a crucial partner in social justice (Crosby et al., 2018; Rigard et al., 2015). Social justice is defined as the elimination of systemic oppression and institutional barriers with the goal of ensuring equitable access to opportunities and resources for all (Graybill et al., 2018). This article aims to consider the intersections of trauma-informed care and the aims of social justice so schools might recognize trauma as both individual and systemic and make their trauma-informed frameworks inclusive of diverse experiences. This article suggests what can be done through the use of the TIC framework created by SAMHSA (2014), which will benefit from being integrated from school- and evidence-based frameworks like MTSS.

Keywords

School Mental Health Professionals, Trauma, Trauma-Informed Care, Social Justice, Prevention, Universal

Cover Page Footnote

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Social Justice and Trauma-Informed Care in Schools

A growing awareness in the public consciousness regarding the widespread nature of trauma and its significant impacts has instigated conversation regarding how the healing and prevention of trauma might occur at the individual and public level. Trauma occurs when a single, acute crisis, series of events, or set of circumstances are perceived by an individual as harmful or life-threatening and results in persistent, pervasive impacts on an individual's mental, physical, social, emotional, or spiritual well-being (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Within conversations about trauma and trauma prevention, there also has been a renewed focus on social justice. We are living through a global pandemic (i.e., a collective trauma) that has impacted us all in different ways (e.g., loss of a loved one, loss of employment, social isolation, health and mental health inequities, homelessness, food insecurity). At the same time, we have witnessed unconscionable acts of police brutality, systemic racism, and murder (Cooper et al., 2020). Social justice is a framework that has guided thought and equitable access to resources and equitable participation in decision-making (Graybill et al., 2018). Social justice, for this article, is defined as “the elimination of systemic oppression and institutional barriers with the goal of ensuring equitable access to opportunities and resources for all” (Graybill et al., 2013 pgs. 218-219). We also want to emphasize social justice is “both a process and a goal that requires action” (National Association of School Psychologists [NASP], 2017) at the individual, group, classroom, school and systems levels. We view trauma-informed care as a crucial partner of social justice which facilitates the *process* of school personnel working together to take *action* to heal and prevent trauma in school settings.

If trauma-informed care (TIC), also referred to as trauma-informed practices and trauma-informed approaches, is a crucial partner of social justice, then the interpretation and practice of trauma and TIC must continue to confront the ways in which trauma is both individual and systemic. Acknowledgement that students with specific identities, cultural backgrounds, and sociopolitical contexts can experience higher rates of exposure to individual traumatic events such as domestic or community violence should also encompass exposure to institutional abuse and inequity, hate crimes, forced migration, or intergenerational trauma. It is a social justice imperative to recognize how students' complex relationship to traumatic experiences, traumatic responses and access to resources is filtered through identity, culture, and sociopolitical contexts.

In order to adequately fulfill their mission of education, schools must acknowledge and address the social, emotional and behavioral needs of children, including those whose development, learning, and overall success at school has been disrupted by the negative impacts of trauma. Worldwide, TIC has steadily gained traction at national policy levels and has been proposed as a means to address trauma in youth populations (e.g., DeCandia & Guarino, 2015; Purtle &

Lewis, 2017). In the United States, the signing of the Every Student Succeeds Act (Public Law No: 114-95) in 2015 explicitly tied federal funding for local education agencies (LEAs) to the use of evidence-based TIC in schools through school-based mental health services and/or staff training (Purtle & Lewis, 2017). Crosby et al. (2018) and Rigard et al. (2015) have proposed the effective implementation of TIC within schools could continue to shed light on the part trauma has to play in academic and behavioral disparities among students within marginalized groups. This perspective suggests addressing trauma in schools is crucial not only to ensuring that children are educated, but students receive an education and experience within schools that reflects an on-going commitment to cultivating equity and justice for students.

This article examines definitions of trauma and Adverse Childhood Experiences, trauma among specific populations, and the impact of trauma exposure and PTSD on children and youth in educational settings. Additionally, we will discuss trauma-informed care via SAMHSA's framework and how trauma-informed care could be enacted within a Multi-Tiered Systems of Support (MTSS) framework in schools. A useful definition of MTSS can be found in bill SF 788, which was recently introduced in the Minnesota legislature. This definition brings social justice deliberately into focus and guides conceptualizations of how trauma-informed care and MTSS can work in tandem to promote social justice in school environments. MTSS is a systemic, continuous framework that seeks to provide positive social, emotional, behavioral, developmental, and academic outcomes for all students. Layered tiers ensure personnel and students have access to culturally and linguistically responsive, evidence-based practices. This framework actively engages an anti-racist approach to examining policies and practices and ensuring equitable distribution of resources and opportunity (SF 788, 2021). We advocate for the use and implementation of comprehensive, school-wide implementation of trauma-informed care through MTSS frameworks that explicitly prioritize social justice. We also highlight the importance of trauma-informed practices in schools at Tier 1 and the specific role of the school mental health practitioners.

Adverse Childhood Experiences

The CDC-Kaiser Permanente Adverse Childhood Experience (ACE) study (Felitti et al., 1998) of more than 17,000 adults in the United States galvanized public discussion regarding the pervasive, dangerous nature of childhood exposure to traumatic, or adverse, experiences. More than half of the sample reported they had experienced at least one adverse event prior to the age of 18. Approximately one quarter stated that they experienced two or more adverse events. More importantly, the ACE study (Felitti et al., 1998) and subsequent research (Anda et al., 2006) succeeded in suggesting a strong relationship between levels of exposure to childhood traumatic events and increased risk for long-term health risks and outcomes (e.g., mental illness, illicit drug use, suicide risk, risk for chronic diseases).

While the ACE study continues to function as an important point of shared access and understanding between researchers, practitioners, policymakers, and the general public regarding prevalence of trauma exposure and the long-term impact of childhood traumatic stressors, it is imperative to emphasize what was and was not considered to be a traumatic event by Felitti et al. (1998). The ACE questionnaire prompted participants to indicate if they had or had not experienced 10 different traumatic experiences in their childhood home. The 10 ACEs were: physical abuse by an adult or household member, sexual abuse by an adult at least five years older, emotional abuse or neglect by a family member, physical neglect, violence against a mother or stepmother, parental divorce, household member having problems with substances, household member having problems with mental illness, and incarceration of a household member. Anda (one of the researchers on the original ACE study) et al. (2020) described the questionnaire and its resulting ACE score as “a relatively crude measure of cumulative stress exposure” (p. 1) and asserted the questionnaire cannot account for significant factors such as frequency, intensity, or chronicity of exposure to a particular event. A resulting ACE score should not be used as a decision-making or diagnostic tool, nor is it predictive of an individual’s long-term outcomes (Anda et al., 2020; Finkelhor, 2018; Kelly-Irving & Delpierre, 2019). These assertions are supported by a recent study by Baldwin and colleagues (2021). Baldwin and colleagues (2021) examined the clinical utility of screening for ACEs for the prediction of poor health outcomes in two birth cohorts in the United Kingdom which grew up 20 years and thousands of miles apart. The results indicated the ACEs questionnaire has poor accuracy in predicting an individual’s risk of later health problems.

Researchers and institutions have sought to document prevalence of traumatic exposure in school-aged youth with a specific and wider range of potentially traumatic events and/or adverse exposure, such as war/terrorism, serious accident, natural disaster, loss of a close family member or caregiver, and serious illness. Copeland et al. (2007) determined that, by the age of 16, approximately 31% of the children surveyed had been exposed to one traumatic event and 37% had been exposed to multiple events. Copeland et al. (2007) grouped traumatic events into the broad categories of violence, sexual trauma, other injury or trauma, and witnessing trauma. Specific events that fell into these broad categories included events not addressed by the ACEs study, such as death of a loved one or sibling, diagnosis of a physical illness, serious accident, and natural disaster. McLaughlin et al. (2013) found that 61.8% of adolescents reported one lifetime potentially traumatic experience, while 18.6% reported three or more. Similar to Copeland et al. (2007), McLaughlin et al. (2013) grouped traumatic events by larger categories (interpersonal violence, accidents, and witnessing trauma) and listed all specific events that fell into those categories. Specific events of traumatic exposure that would fall outside of the scope of ACEs include being threatened with a weapon, kidnapping, experiencing stalking, death of a loved one, natural disaster, and serious accident. Finkelhor et al. (2015) found that 60.8% of children had been the victim of at least one experience of violence, crime, or abuse in the past year. Broad categories examined by Finkelhor et al. (2015) were physical assault, sexual

offense, maltreatment, property crime, and witnessing violence. Under these broad categories, the researchers included specific events such as being flashed by an adult or peer, sexual assault by a peer, dating violence, physical assault motivated by bias, internet or phone harassment, physical assault by a gang or group, threats of assault, and exposure to shooting (associated with violence and/or a crime). Many studies, including the ACEs study, count witnessing a traumatic event, referred to as indirect exposure to trauma by Finkelhor et al. (2015), as part of their overall statistics of traumatic exposure among children and adolescent populations. Finkelhor et al. (2015), however, treats indirect exposure to trauma as distinct from events where the individual is the direct recipient of a violent or harmful action. When indirect exposure to an event was combined with direct exposure, 67.5% of children had at least one exposure to a traumatic event.

Some researchers and practitioners have called for increasing the number of traumatic events included in the ACEs questionnaire. Gorski (2020), for instance, recounts a personal story told by a queer, Black transgender high school student. Shari attended a high school that was in the process of implementing a trauma-informed care framework. The school's counselor administered the ACEs questionnaire to Shari. When Shari explained that she perceived the bullying and discrimination she faced at school from students and staff to be the largest and most relentless source of trauma for her, the counselor simply responded by telling her that nothing she was describing was on the ACEs questionnaire. If screening is to be done as part of trauma-informed initiatives, it must be done in ways that seek to be inclusive and avoid re-traumatization. Researchers have taken steps to try to expand the original ACEs screener. Cronholm et al. (2015)'s Expanded ACEs added five events to the ACEs questionnaire: experiencing discrimination, witnessing violence, living in an unsafe neighborhood, experiencing bullying, and having a history of living in foster care. Cronholm et al. (2015) linked expanding the kind of traumatic events included in the ACEs questionnaire to gathering data beyond the home and to including events that would be more applicable to racially diverse populations, who may also have diverse socioeconomic and educational backgrounds.

Traumatic Exposure and Specific Populations

It is clear that trauma is not only a common experience; it is a significant, global public health and mental health concern (Magruder et al., 2017). As a consequence of the scale and complexity of issues surrounding trauma in the lives of people and communities, traumatic events, responses to trauma, and interventions meant to mitigate impacts can be described and understood in monolithic terms (Stratford et al., 2020). Thus, it is important to consider how exposure to traumatic events and responses to that trauma are influenced by individual factors and socio-political contexts (Magruder et al., 2017; Quiros & Berger, 2015).

Populations facing poverty, lack of educational opportunities, discrimination on the basis of race, ethnicity, gender, sexual orientation, disability status and other characteristics may encounter higher rates of traumatic experiences and barriers that make it challenging to cope with and overcome the repercussions of traumatic events. Forced separation from family members among immigrant populations, stressors related to chronic or generational poverty, stressors related to LGBTQ+ status, and racial stressors are only a few examples of the kinds of injustices faced by a number of students and families on a global scale (Lieberman et al., 2011; Lovato, 2019; Kuper et al., 2013). Children, youth, and families may also occupy more than one of the identities, backgrounds, and experiences discussed above.

While global socio-political contexts that may result in exposure to war or terrorism among youth populations are often unequivocally recognized as potentially traumatic, events and actions tied to systemic discrimination and institutional harm are more challenging for schools and education systems to recognize and grapple with collectively. Research exploring the intersections of trauma, racism and/or other forms of discrimination, and systemic injustice, continues to emerge in the United States (Bryant-Davis et al., 2017; Kirkinis et al., 2018) and elsewhere. However, it is important for schools and personnel to work towards understanding how these issues may impact their students and their functioning at school (Blitz et al., 2016). Schools may want to avoid constructing exposure to trauma as only that which occurs outside the school (Gaffney, 2019). School personnel reckoning with trauma in school-age populations and avoiding retraumatization requires they recognize the ways in which exposure to potentially traumatic events (e.g., disproportionate disciplinary actions, arrests, microaggressions, physical, verbal, and sexual bullying, physical assault sexism, racism, ableism, or homophobia) occur in schools (Ryan et al., 2018; Viderouk et al., 2016; Williams et al., 2018). This is an iterative and not insignificant task, however, the *recognition* of systemic inequities and injustices is an essential step that school personnel must take prior to being able to take *action* to engage in the healing and prevention of trauma.

The Impact of Trauma on Children and Youth

The psychological and physiological reactions to a traumatic event are usually referred to as toxic stress or traumatic stress symptoms (e.g., DeCandia & Guarino, 2015). Understanding what traumatic stress may look like at clinical and subclinical levels is critical when considering how to support children in schools who have been exposed to traumatic events. An immediate response to a traumatic event as it happens can include increased heart rate, increased feelings of agitation or alertness, sweating, and emotional distress (National Child Traumatic Stress Network, 2003). These are normal, protective measures bodies take in effort to keep themselves safe.

However, children who have been exposed to one or more traumatic events can develop reactions that persist or are on-going after the traumatic event has

ended (NCTSN, 2003). This level of traumatic stress can interfere with children's ability to interact with others and function in their daily lives and can manifest in a variety of responses, including emotional distress, depressive symptoms, anxiety, behavioral changes, nightmares or difficulty sleeping, and difficulty with attention (NCTSN, 2003). Some children experiencing this level of traumatic stress symptoms may go on to develop the long-term symptomatology that meets the criteria for post-traumatic stress disorder (PTSD) and other trauma-related disorders listed in the DSM-IV. Extreme stress symptoms might include persistent flashbacks or nightmares, avoidance of specific, traumatic triggers, hyperarousal, or emotional numbing that persists for more than a month after an event.

It is imperative school personnel understand not every child who experiences a traumatic event and symptoms of traumatic stress will go on to develop PTSD and other trauma-related disorders. McLaughlin et al. (2013) reported 4.7% among the 61.8% of the adolescent respondents ($N = 6,483$) in this national dual-frame household and school sample met the DSM-IV criteria for PTSD. Copeland et al. (2007) found that less than .5% of children in a representative sample of 1,420 children met the criteria for PTSD. Rates of lifetime painful recall and subclinical levels of PTSD were higher, however, at 13.4% and 3.3% respectively. Findings also suggested children who were exposed to trauma were more than twice as likely, regardless of whether they developed PTSD or not, to be diagnosed with psychiatric disorders, particularly anxiety and depression (Copeland et al., 2007).

After screening a diverse sample of 402 elementary school students for exposure to traumatic events using The Modified Traumatic Events Screening Inventory for Children – Brief Form (TESI), Gonzalez et al. (2016) assessed 138 students who reported exposure to one or more traumatic events for post-traumatic stress syndrome severity via The UCLA Posttraumatic Stress Disorder Reaction Index (RI). Approximately 75% of those students (25.9% of original sample) reported experiencing posttraumatic stress symptoms in the moderate range or above, while 36.5% (9.5% of original sample) reported experiencing posttraumatic stress symptoms in the clinical range. While schools should be concerned about the prevalence of PTSD among students, impairment from exposure to traumatic events can take a number of different relevant forms inclusive of and beyond the clinical boundaries of PTSD.

Understanding how trauma specifically affects students' ability to engage with and function in school environments over the short- and the long-term is an imperative part of the knowledge that underpins the implementation and practice of TIC. A systematic review of 83 articles by Perfect et al. (2016) provided a useful distillation of the current literature that aimed to describe school-related outcomes through specific categories (cognitive, academic, and teacher reported socio-emotional and behavioral) as they were associated with trauma exposure and traumatic stress symptoms in youth 18 years or younger. This review sheds light on the widespread nature of the impacts of trauma in school environments for students who've been exposed to trauma, regardless of whether or not they go on to develop

clinical levels of PTSD. Additionally, an analysis of this review illustrates how TIC can and must intersect with school-wide culture, context and practices including classroom management and teaching strategies, analysis of achievement data, disciplinary policy and data, the Multi-Tiered Systems of Support (MTSS) process, the special education referral and assessment process, attendance issues, as well as prevention and intervention of academic and behavioral issues. This systematic review by Perfect et al. (2016) does not analyze how impacts may have been further moderated by variables such as gender or race. The authors stressed a need for more empirical studies that explore the relationship between such variables, trauma, and its impacts on students in school environments. This view is shared by other researchers and practitioners (e.g. Rigard et al., 2015) who emphasize the intersections of TIC and social justice.

Cognitive

An analysis by Perfect et al. (2016) suggested impacts related to intelligence, memory, verbal abilities and attention. Across these studies, specific exposure to maltreatment, sexual abuse and alcohol exposure often resulted in negative impacts. Lower IQ scores were noted in youth who had witnessed or experienced violence and/or mistreatment versus comparison groups (Bücker et al., 2012; Daud et al., 2008; De Bellis et al., 2009; De Bellis et al., 2013; Kočovská et al., 2012). Although some variation between studies existed, youth with PTSD (Beers & De Bellis, 2002; Moradi et al., 1999; Schoeman et al., 2009) or more severe traumatic stress symptoms (Chae et al. 2011; Park et al., 2014) had impaired memory or more difficulty with tasks related to memory. Some studies found youth who had been exposed to trauma had lower verbal abilities (Graham-Bermann et al., 2010; Saltzman et al., 2006). Attention in youth with sexual abuse or maltreatment histories (with or without PTSD) was found to be compromised in comparison to youth who had not been exposed to trauma (Beers & De Bellis, 2002; De Bellis et al., 2003). An overlap in symptoms related to trauma and attentional difficulties, such as arousal and dissociation, was noted. This overlap also has been a source of discussion related to the reality that responses to trauma can be mistaken for ADHD (Ruiz, 2014; Szymanski et al., 2011).

Academic

Articles coded for academic functioning by Perfect et al. (2016) suggested potential negative impacts between traumatic event exposure and academic achievement. Perfect et al. (2016) noted academic functioning was primarily assessed through standardized testing, self-report, parent report and teacher report. A smaller subset of studies looked at grades, attendance and other variables like discipline reviews. A number of studies examined how PTSD and/or traumatic stress symptoms impacted children's academic performance compared to controls. Results suggested that students experiencing the impacts of trauma demonstrated lower performance in math and reading (De Bellis et al., 2009; De Bellis et al., 2013; Eckenrode et al. 1993; Eckenrode et al., 1995; Perzow et al., 2013; Saigh et al., 1997). These findings affirmed previous assertions by Crosby et al. (2018) and

Rigard et al. (2015) that TIC plays a crucial role in addressing achievement discrepancies. It is important to note the exposure to specific traumatic events (i.e., violent events, maltreatment) indicated impacts related to academic performance and/or academic difficulties related to discipline, attendance, and absences (Delaney-Black et al., 2002; Duplechain et al., 2008; Hurt et al., 2001; Mathews et al., 2009; Moradi et al., 1999; Schwartz & Gorman, 2003; Thompson & Massat, 2005).

Socio-emotional and Behavioral

The third aspect of the review focused on summarizing the current literature related to socio-emotional and behavioral functioning for children impacted by trauma. All of the studies provided data collected through teacher reports and focused on children who had been exposed to events that might be considered more severe and intense, including natural disasters, maltreatment and sexual abuse. Results indicated that, overall, exposure to trauma resulted in teacher reports of higher externalizing and internalizing symptoms. Clinically significant or elevated externalizing behaviors (e.g., aggression, hyperactivity, defiance, impulsivity) were noted (Jones et al., 2004; March et al., 1997; McLeer et al., 1998; Miller et al., 2007; Milot et al., 2010; Pears et al., 2013; Shaw et al., 1995; Shaw et al., 1996). Elevated or clinically significant internalizing symptoms (e.g., depression, anxiety, withdrawn behaviors) were reported by teachers for children who had been exposed to maltreatment, sexual abuse, or were experiencing traumatic stress syndromes (Daignault & Hebert, 2009; Daud et al., 2008; Milot et al., 2010; McLeer et al., 1998; Shaw et al., 1995).

SAMHSA: A Framework and Guidance for Trauma-Informed Care in Schools

The emphasis that social justice places on critical self-reflections about power, privilege, and inequity prompts schools to look closer at how they can provide acute and proactive support acute to students who are most in need, rather than punish or diminish them (Crosby et al., 2018). Understanding how trauma intersects with issues at every level of a school's functioning and practice is paramount to reckoning with the scope and the stakes of the issue, as well as the range of experiences within it. Additionally, looking at trauma and how it intersects with social justice reveals what trauma-informed frameworks may be appropriate for school-wide implementation of TIC, what considerations might be important for measuring and gauging effectiveness, and how TIC might be supported by tiered frameworks like MTSS.

A consistent issue for researchers, practitioners, and schools interested in TIC is the fact that research rooted in empirical evaluations of TIC's effectiveness is not yet well established (Baker et al., 2016; Chafouleas et al., 2016; Thomas et al., 2020). While schools are implementing trauma-informed supports or providing training for the use of trauma-informed practices in the classroom, it remains

difficult to examine how goals and accountability serve the long-term sustainability and success of school-wide practices related to trauma. There has yet to be a clear operationalization of terms like “trauma-informed approach,” “trauma sensitive,” “trauma-informed system,” (Hanson & Lang, 2016; Maynard et al., 2017). Additionally, a range of frameworks, essential content knowledge, and recommendations for successful implementation of trauma-informed practices exist in the current literature (Baker et al., 2016; Hanson & Lang, 2016). TIC implementation and practice is impacted by what knowledge, skills, and awareness related to trauma a school or child-serving system uses or advocates for (Ko et al., 2008) and how they are perceived by the personnel working within that system.

Conceptualizations of trauma-informed schools often emphasize a school-wide approach, which entails providing appropriate interventions or supports for students who have already experienced the impacts of trauma as well as prevention services at universal and targeted levels (Stratford et al. 2020). Advocates for the implementation of TIC in schools recognize the importance of prevention efforts and ensuring that knowledge, awareness, and support extends school-wide (Chafouleas et al., 2016; Walkley & Cox, 2013; Wiest-Stevenson & Lee, 2016), particularly in schools and/or settings where students and families may be disproportionately affected by exposure to traumatic events and a lack of access to resources (Crosby et al., 2018; Quiros & Berger, 2015). Much of the current literature (e.g., Chafouleas et al. 2016; Thomas et al., 2020; Wiest-Stevenson & Lee, 2016) recognizes and emphasizes the use of guidelines for TIC implementation put forth by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). The SAMHSA model was developed through trauma-focused research, practitioner use of interventions in applied settings, and, importantly, through information generated by survivors of trauma themselves. The SAMHSA model provides a strong example of a model and framework that allows schools to highlight the specific, diverse needs and strengths of marginalized students and families affected by trauma.

SAMHSA provides contemporary guidance for what TIC is within a system, organization, or program. A system, organization, or program that is trauma-informed (SAMHSA, 2014, p. 9):

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved in the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices;
4. Seek to actively *resist* retraumatization of both persons and staff.

These four key assumptions (the Four R's) are meant to enable systems to imagine and implement trauma-informed service delivery beyond trauma-specific interventions. While TIC is inclusive of that specific service provision, key understandings about trauma and reactions to trauma are actively and responsibly incorporated into organizational culture through the continual evaluation of policies, mission statements, training, leaderships and administration, funding, etc.

SAMHSA (2014) provides a set of six principles which suggest how TIC can be used to support trauma recovery and resilience in individuals, families, and communities. Those six principles include *safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues*. This emphasis on guidance through principles rather than a prescription of specific practices and procedures provides a necessary challenge to schools and school personnel while providing the flexibility schools and communities need to successfully implement TIC that is oriented towards social justice in their specific environments. We are reminded by Mathew Portell, an elementary school principal, that, "Trauma-informed education is a journey, not a checklist," (Vernet, 2019). Trauma-informed care, as well as social justice, thrive through the process-based cultivation of a collective mind shift and change. The importance of individual, programmatic strategies like professional development or trauma-based interventions cannot be understated, but these alone might not be all that is necessary to move a school or community towards the effective understanding or practice of trauma-informed care. Progress towards the dismantling of systemic and institutional causes of trauma will likely be achieved through concentrated, collaborative action from a number of interconnected professionals, rather than a single piece of research. At the same time, the SAMHSA model makes explicit, via the principle *cultural, historical, and gender issues*, that trauma and responses to trauma are impacted by socio-political contexts. This principle encourages schools and personnel to consider how issues of culture, history, and gender may affect students' or personnel's conceptualization of the other five principles. *Safety*, for example, may be more difficult to establish and may not be guaranteed for an undocumented student or a student with undocumented parents or caregivers. Establishing *trustworthiness and transparency* in communities with Indigenous students and families will require schools and personnel to acknowledge or understand the particular ways those communities have been historically mistreated by schools and other national institutions.

Schools who want to measure the effectiveness of trauma-informed efforts, especially diverse communities, should be encouraged by these principles to consider how seeking a reduction in symptoms associated with trauma may only be one part of measuring efficacy. Thomas et al. (2020) encourages examining effectiveness through school-level measures such as school climate, disciplinary/behavior incidents, student achievement, as well as student-level measures of attendance and belongingness. It's important to point out that disproportionality and difference are noted between White students and students of

color are often noted in many of these areas. While evidence is needed to identify what role TIC might play in reducing disproportionately and fostering improvements for student outcomes, this research can be part of the goals TIC advocates have in mind. Additionally, school-wide empirical analysis should discuss demographics and provide information regarding the specific contexts in which students receive or participate in trauma-related programs or interventions.

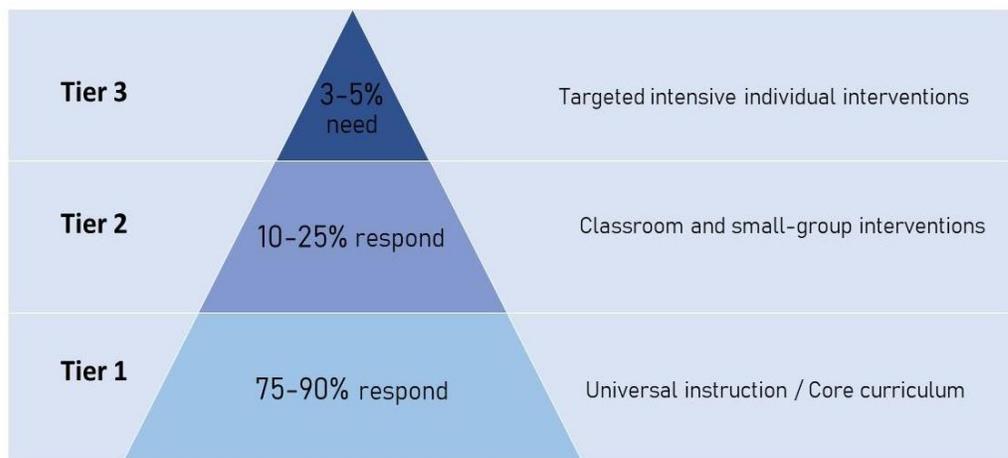
The SAMHSA model also provides useful, practical guidance for helping schools and personnel to understand and interpret what events may be traumatic for children and youth beyond the confines of the traditional ACEs, as it has been previously discussed in this article. The definition of trauma that SAMHSA provides closely aligns with common, clinical definitions of trauma used in this article and across the literature. Further, SAMHSA supplies recommendations to schools and personnel regarding what may be trauma and what is not through what SAMHSA designates as the “three E’s:” event, experience, and effect. How an individual *experiences* that event determines whether or not that event is, in fact, traumatic. The individual’s experience has an impact on the *effect* of the event, which is felt by the individual and, in the event of trauma, results in lasting impaired functioning.

Using the three E’s in tandem with clinical definitions of trauma may be useful to schools in a number of ways. For instance, it may help schools and staff better understand why exposure to traumatic events does not result in a clinical level of symptoms for every student. This might prompt schools and personnel to take a closer look at what protective factors students have access to and to examine how they might strengthen or fortify such factors. It may also help personnel or students understand how an event outside of their own personal experience or understanding of trauma, may, in fact, result in traumatic impacts for an individual. For example, a broken bone is not typically considered a traumatic event. While someone may consider this to be a frightening or painful experience in the short term, such an event is not usually experienced as life threatening or harmful to the extent that an individual develops the long-lasting symptomology and functional impairment associated with trauma. However, if the individual experienced a broken arm in tandem with a car accident or was a student-athlete now likely to lose a collegiate scholarship, such events can have a series of long-lasting, negatively impactful consequences that can be categorized as trauma. These examples transfer to ensuring that schools and personnel understand how trauma might be experienced in direct relation to a student’s or family’s identity. Cronholm et al. (2015)’s Expanded ACEs, for instance, advocates for the inclusion of bullying as a traumatic exposure. Many personnel and students would understand how bullying might be harmful through personal experience. However, they may or may not have experienced bullying or harassment rooted in degrading or dehumanizing one’s actual or perceived racial identity, gender identity, or sexual orientation. As Shari’s story demonstrated (Gorski, 2020), the intensity of threat and harm that accompanies bullying and discrimination of this nature can result in an experience and an adverse effect that would be considered trauma.

Integrating MTSS (Multi-Tiered Systems of Support) and TIC

Chafouleas et al. (2016) emphasized the merging of TIC practices with existing evidence-based frameworks in order to facilitate the provision of trauma-focused services from which an entire school community can benefit and to increase the sustainability of school programs meant to address trauma. More specifically, Chafouleas et al. (2016) suggested that TIC be integrated within multi-tiered ‘triangle’ or ‘pyramid’ frameworks, which have been used to address concerns related to academics, behavior, and school mental health. Multi-tiered frameworks of service delivery, often referred to as Multi-Tiered Systems of Support (MTSS see Figure 1), are helpful for imagining what putting trauma-informed programs or practices in place might look like and how they might effectively serve the diverse needs of students and families from a range of backgrounds and cultural experiences.

Figure 1. Multi-Tiered Systems of Support Framework



MTSS is an evidence-based model for a comprehensive, school-wide approach to prevention and intervention which emphasizes early identification of risk, varied levels of intervention meant to prevent the escalation of more serious problems and provide additional skills to students and personnel, and data-based decision making (Berger, 2019; Chafouleas et al., 2016). Again, the definition of MTSS found in bill SF 788 (2021), shows us how MTSS can be molded into a tool of social justice. This improvement framework ultimately aims to ensure positive social, emotional, behavioral, developmental outcomes for all students through anti-racist training and policies, the equitable distribution of resources, the explicit use of culturally and linguistically responsive, evidence-based practices, and through the development of collective knowledge and experience through representative partnerships with students, personnel, families, and communities. This work is conducted through the coordinated use of three tiers (Berger, 2019). Tier 1 is meant to address and support the universal needs of all students. Efforts at the Tier 1 level may focus on fostering a positive, trauma-informed environment through classroom strategies and school-wide policies, regardless of whether students, their families, or personnel have or have not been recently exposed to trauma. This would likely include providing training and awareness to personnel, as well as to the community. Tiers 2 and 3 are designated for students who need additional supports beyond Tier 1. Tier 2 would provide support to students who may have been exposed to trauma and are showing early signs of behavioral or academic issues similar to those impacts noted in the discussion of Perfect et al. (2016). These students may receive intensive academic or behavioral interventions from their teacher. Teachers/staff may receive consultative support or instruction related to trauma and trauma-informed strategies from school mental health practitioners (e.g., school social workers, school psychologists, school counselors) when administering these interventions. Tier 3 is for tertiary, intensive and individualized interventions for students that are experiencing clinical levels of impacts from trauma (e.g., PTSD). School mental health practitioners can and do provide interventions, such as Cognitive Behavioral Intervention for Trauma in Schools (CBITS), at this level. They may also facilitate connections between schools, families, and community mental health providers or may coordinate with a community mental health provider to ensure strategies to support the student's recovery are put in place in the school environment.

MTSS provides a comprehensive means to address trauma at universal and individual levels through the structured development of preventive measures and intensive intervention. The widespread and varied nature of trauma requires a multi-faceted approach so that every person, regardless of how much trauma they have been exposed to or whether or not they have developed PTSD, might benefit from having access to internal and external resources that can help reduce stressors and support coping in the midst of traumatic stress (Chafouleas et al., 2016). Chafouleas et al. (2016) also asserted that a school-wide approach to trauma-informed care imagined through MTSS would seek to provide the outcomes which align with SAMHSA (2014):

- a. Prevent adverse events and experiences from occurring,

- b. Build self-regulation capacity in individuals,
- c. Assist individuals exhibiting adverse effects in returning to prior functioning,
- d. Avoid re-traumatizing individuals who have experienced adverse events.

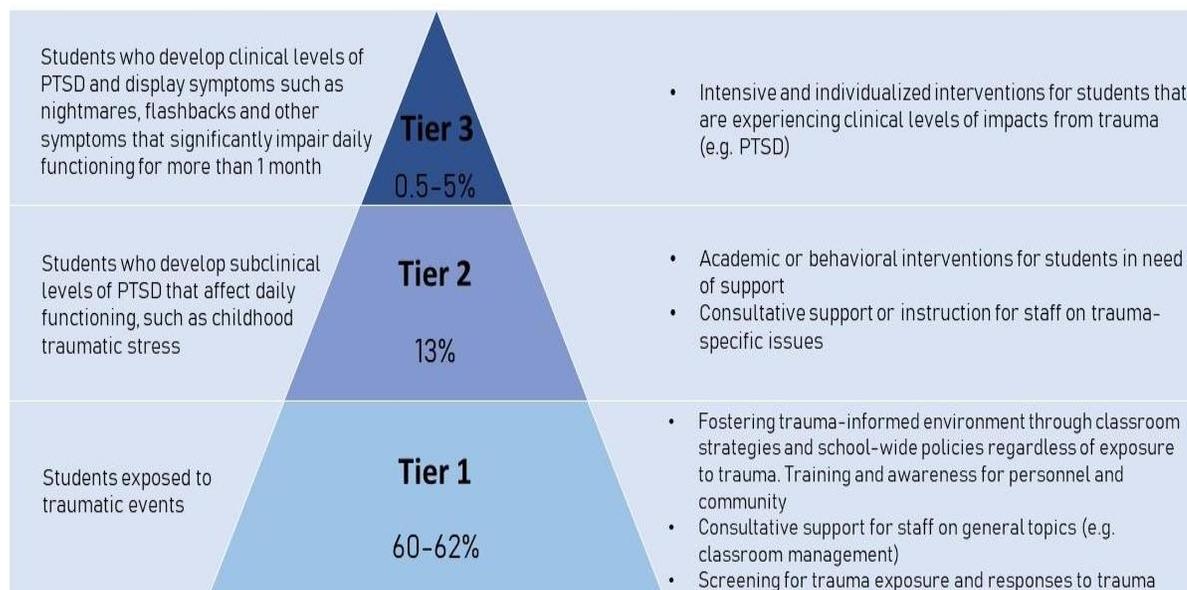
All school personnel will play an important, collaborative role in ensuring organizational structures and capacity are created and sustained to successfully achieve these four outcomes to heal and prevent trauma in schools.

While there has been much emphasis placed on ensuring TIC is not simply a reactive strategy for schools, examinations of TIC through the lens of MTSS service delivery have tended to focus on evaluating instruments for measuring trauma and trauma-related interventions, such as CBITS (Jaycox et al, 2018). These efforts are meant to support students struggling with the impacts of trauma at the Tier 2 or Tier 3 levels (Chafouleas et al., 2019; Fondren et al., 2020; Rolfnes & Idsoe, 2011; Stratford et al. 2020). Examining the efficacy and validity of such evidence-based interventions or treatments, particularly as they pertain to diverse student populations and underserved settings, is a crucial step for schools and personnel towards viewing TIC as a social justice tool. For example, Horton (2019) provided adapted CBITS resources for school mental health practitioners (a) to create a professional development training for teachers and other school personnel to recognize trauma and (b) to run group and individual counseling sessions for students who have experienced trauma. Further, Weiner and colleagues (2009) compared the retention rates and effectiveness of three different approaches to the treatment of trauma. The treatments stemmed from a variety of theoretical orientations and included Trauma-focused Cognitive Behavioral Therapy (TF-CBT) to Child-Parent Psychotherapy (CPP) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). The study was conducted with children involved in foster care programs and found that all interventions were similarly effective across racial/ethnic groups (African-American, White, Hispanic and Biracial) in improving trauma-related symptoms and outcomes as long as culturally sensitive adaptations were provided. CPP was shown to be the most universally effective across all groups represented in the study, and TF-CBT was found to work best for White and African-American populations. More importantly, the researchers emphasized the crucial role of incorporating a culturally competent approach to practice. This practice consisted of identifying barriers and making adaptations to ensure retention, feasibility and correct implementation. Examples of such culturally and needs-sensitive adaptations included aiding with access to transportation, providing off-site and at-home treatment and allowing children to choose their form of self-expression and narratives (TF-CBT) (Weiner et al., 2009). Recognizing these areas of flexibility within structured approaches instead of simply following established protocols helped ensure that resulting interventions were more sensitive to the experiences of

diverse populations. This also resulted in an increase in effectiveness and acceptability of interventions regardless of intervention type. We believe this approach exemplifies competent practice of trauma informed care in service of social justice and the SAMHSA principles.

The focus on the individual instruments or intensive tiers (Tier 2 and 3-targeted and individualized) rather than on whole school approaches (use of Tier 1 in tandem with Tier 2 and Tier 3) lends some traction to concerns outlined by Hanson and Lang (2016) and Maynard et al. (2019). These authors pointed out the lack of cohesive content knowledge and definitions within education-centered trauma-informed frameworks, while simultaneously acknowledging that pushes for TIC implementation tend to occur before strategies and points of evaluation have been fully fleshed out or considered. TIC is an urgent issue and the pressure to make TIC a part of school environments reflects that urgency. Figure 2 represents a conceptualization of the ways in which student populations exposed to and affected by trauma correspond to specific levels of intervention and lists proposed approaches to TIC at each tier. This does not eliminate the need for accountability and on-going reflection to ensure that TIC does not perpetuate the harm it seeks to ameliorate. In addition, it appears less research has focused on the Tier 1 level (Fondren et al. 2020; Stanford et al. 2020), which could provide stability and support to the process of integrating whole school approaches.

Figure 2. Integrating tiered approach into Trauma Informed Care



Practicing TIC at Tier 1

Individual screening for trauma that utilizes psychometrically sound, culturally responsive instruments can be an important part of prevention and identification efforts within TIC. However, critiques of universal screening at the

Tier 1 level for trauma are under discussed and should be examined. First, the need for appropriate inclusive assessment instruments is vividly illustrated by the example of Shari, a Black transgender student whose experiences in the school constituted the main source of trauma not listed in the ACEs questionnaire used by her counselor. In addition, confidentiality and student privacy must be appropriately prioritized and ensured. Students and personnel should have some say in what they disclose and when they disclose it. These are necessary considerations to ensure *safety, transparency, empowerment*, and to avoid retraumatization. While it can be important to understand what particular struggles or difficulties students and their communities have, the successful implementation of TIC in the school and the classroom is not dependent on knowing every student who has experienced trauma and what that trauma is. Further, like the definition of MTSS put forth in bill SF 788 (2021), TIC that is rooted in social justice aims to enact evidence-based practices and strategies which benefit everyone in a school. That said, additional support, beyond universal or individual screening, offered at the Tier 1 level is equally crucial to ensuring that personnel, as well as students and families, have access to the knowledge, resources, training, support, and relationships that TIC seeks to provide. The gap in the literature at the Tier 1 level with regard to TIC presents an opportunity for school mental health practitioners. The Tier 1 level serves the largest number of students, makes certain students (and personnel) in need of additional services or supports are identified, and often serves as the point of contact, consultation, and relationship-building between students, families, personnel, and/or community partners. School mental health practitioners can use their expertise to facilitate this distribution of resources and information while simultaneously ensuring that a collaborative network or community of relationships is fostered. The values inherent in social justice can shape a school-wide approach to TIC at Tier 1, as well as a school mental health practitioners' conception of their specific role.

If schools do choose to use individual or even universal screening at the Tier 1 level, school mental health practitioners should participate in the analysis of screening results related to trauma to ensure that students are provided services and intervention at the appropriate tier. If a student is already in Tier 2 or 3 for academics or behavior, data about the student's exposure to trauma or response to trauma acquired from screening or other sources (e.g., parent interview, teacher interview) could be used to better understand how the impacts of trauma may be affecting a student's response to those interventions. If screening reveals a particular group of students appears to be more heavily impacted by trauma or by a particular trauma, school mental health practitioners, particularly school social workers, could be active in bringing in cultural brokers from the community. This can help administration and staff understand how particular cultures interpret or respond to traumatic events, as well as what kinds of trauma may be specific to a particular group or identity.

It is important to consider how the use and distribution of content knowledge around trauma and trauma-informed classroom strategies will interact

with the various realities, values and beliefs embedded within different systems that staff are or are not part of. School mental health practitioners, who often deliver this information to teachers, administration, and/or other personnel, are encouraged to consider and tackle these challenges. Blitz et al. (2016), for example, conducted a mixed-methods study of an elementary school in an urban setting in the Northeast part of the United States. The school's student population had become increasingly diverse, while school personnel remained almost entirely White. The majority of students at this school come from low SES households and students of color were disproportionately overrepresented in discipline referrals, suspensions, and low test scores (Blitz et al., 2016). Professional development, provided by professionals from a university in partnership with the school, was integrated with trauma-informed strategies to generate more understanding among teachers regarding the historical and generational realities of poverty and race (SAMSHA principle *cultural, historical, and gender issues*). The researchers sought to convey the connection between systemic injustice and the experiences, behavior, and traumatic exposure of students and families at the school.

The teachers who were part of this study struggled to connect trauma to systemic injustice, which does reflect wider issues regarding White members of the U.S. population and their relationship to systemic inequity and racism (Blitz et al., 2016). This acknowledgement is an important step to ensure that student's *cultural, historical, and gender issues* and experiences of trauma are understood and respected by the adults in the school. It also illustrates, as discussed earlier, how adults' perceptions and experiences of trauma are an equally important part of addressing trauma in students. How can we use principles like *trustworthiness* and *safety* to address these issues like racism in ways that allow for teachers to feel supported while learning about difficult issues? How could *peer support* and *collaboration* be used to help teachers and staff learn about issues of inequity as they intersect with trauma, which may also affect them or their peers in the form of secondary traumatic stress? Addressing these questions could help shape more wide-spread school investment in learning about how historical and contemporary issues of injustice affect student populations. It could also be part of preventive efforts to reduce trauma exposure that takes place in schools or become an important avenue for addressing and preventing trauma exposure in staff.

Consultation provides school mental health practitioners with the opportunity to allow knowledge and strategies around trauma to grow through collaboration and mutual problem-solving. School mental health practitioners can enhance relationships between themselves, staff, parents, and community partners through consultation efforts rooted in *empowerment, trust* and *collaboration* that address systemic and institutional barriers. At the Tier 1 level and beyond, school mental health practitioners engage in consultation with teachers, administration, and staff regarding trauma-informed responses to behavior and the successful use of trauma-informed teaching strategies in the general education classroom. While professional development can be instrumental to ensuring that content knowledge about trauma and traumatic responses is distributed throughout a school

environment, it is crucial to continue to collaborate with staff to ensure teachers have support for implementing trauma-informed strategies in the classroom. This may be as simple as working with a teacher to determine which trauma-informed strategies they are willing to try, or which might address an academic or behavioral need they are seeing in the classroom. For example, a teacher may not be comfortable with providing students flexible due dates or assignment modalities, which is sometimes suggested as a practical trauma-informed classroom strategy that fulfills the principle of *empowerment, choice, and voice*. The teacher may, however, be open to changing the lighting and/or creating a “calm corner” in the classroom, which enacts the principle of *safety*.

The first author, in her practice, engaged in Tier 3 consultation with a second grade teacher regarding the behavior of one of her students. This student had a multi-ethnic background and lived in a dual language household. The student’s mother had disclosed to school personnel the student had witnessed significant, repeated domestic violence in the home and the student’s father was legally prohibited from contacting the student or his mother. The student was displaying behaviors at school that are consistent with trauma exposure and trauma-related disorders, such as persistent, negative self-image, hypervigilance, and difficulty regulating his emotions. The teacher had many concerns related to his behavior, but her primary or most pressing initial concern was the student’s inability to walk safely in the hallway. The student was hitting his head against walls, touching or hitting other students, blurting out, and often bounced or danced while walking in the hallway. The teacher and administration felt the student’s actions were his choice, were frustrated with the student, and had a negative view of the student and their parent. Throughout the process of consultation, the first author sought to provide the teacher and administration with opportunities to make connections between the trauma the student had been exposed to and the behaviors the student was displaying. This was necessary to prevent retraumatization and encourage participation in fostering the student’s sense of *safety*. The first author did not suggest the student was experiencing PTSD. The student was receiving outside therapeutic services, but it was not shared with the school whether or not he had any trauma-related diagnosis. The first author did note the child had been exposed to a traumatic event and that considering what the student’s body and his brain might feel are necessary or needed behaviors might be more helpful in changing his behavior than thinking about what choices the student was or wasn’t making. This was crucial in assisting the teacher and administration with making continuous connections between the student’s experiences and why the student needed additional explicit instruction and support regarding his body and what to do with it at school. The consultative process put *collaboration and mutuality* at the center of the work that the first author, the student’s teachers, and the administration did to plan and implement the intervention for this child. The student was given explicit instruction and practice regarding walking in the hall safely. In order to foster *transparency*, whoever was working with him explicitly described to the student what he would be doing and for how long. He was given positive, immediate rewards for displaying target behaviors. The first author also suggested

that, if the student achieved his goal of walking a certain number of times safely in the hallways over the course of a practice session, he then be given time in the sensory room at the elementary school. This room was rarely used by general education students. The first author volunteered to supervise the student in this room if he earned his reward in order to support the teacher and give her a break from the student. The room was quiet, was arranged in the same way each time the student visited it and gave the student an opportunity to exercise *choice and voice* regarding where he wanted to be in the room and what he wanted to play with. The student seemed to feel a sense of *safety* in the room and described it as “the best place in the world” to the first author. While this consultation was utilized to facilitate the implementation of a Tier 3 intervention and was primarily focused on one student, the process of consultation also seeks to provide indirect service and facilitate impacts at the Tier 1 level. Teachers, administration, and the first author can continue to use the trauma-related knowledge and trauma-informed strategies which were discussed and shared to understand and support other students.

Perry (2006) argued that the best intervention for trauma is what increases the strength and number of relationships in a child’s life. At the Tier 1 level, school mental health practitioners can build relationships with children and youth in their schools and/or take steps to encourage healthy relationships between students and adults. Supportive relationships with teachers are fundamental to healthy development across grade levels (Hamre & Pianta, 2001; Meehan et al., 2003), perhaps especially for children who have been exposed to trauma (Pianta et al., 2012). Dods (2015), in a qualitative review of students’ experiences of dealing with trauma in a school environment, places particular emphasis on youth-adult or student-teacher relationships in school environments. The theme that stood out across all cases was the need for more caring connections to teachers and adults. “‘Alone,’ ‘abandoned,’ ‘ignored,’ and ‘invisible’” (p. 127) were used by the students to describe their experience dealing with trauma in the classroom during their high school years. Blitz et al. (2016) argued adults in schools seeking to implement trauma-informed strategies must be given the opportunity to gain access to tools that would allow for them to have caring relationships with students and each other. Positive relationships with important adults contribute to development of promotive factors, such as emotional self-regulation, self-efficacy and positive perception of self that can ameliorate the effects of past trauma and enable youth to cope more effectively with future adversities. School mental health practitioners can enhance student-adult relationships indirectly, as well, by facilitating the development and use of community partnerships or resources. In schools where the race, experiences, or identities of students and families are not reflected in the staff, this could be helpful for building *trust* and additional avenues for *collaboration*. A system of TIC built upon the values of inclusion and equity is one that, ultimately, seeks to be a strong, expansive community where resources are shared, and relationships are given the opportunity to thrive.

Conclusion

Social justice is defined as the elimination of systemic oppression and institutional barriers with the goal of ensuring equitable access to opportunities and resources for all (Graybill et al., 2018). It is our perspective that for TIC to be an extension of social justice, the understanding and practice of trauma and TIC must confront the ways in which trauma is both individual and systemic. Acknowledgement that students within marginalized groups experience higher rates of exposure to individual traumatic events should also consider institutional abuse and inequity, police violence, hate crimes, forced migration, and/or intergenerational trauma. This approach of combating social injustices requires collaboration between all school personnel to enact change on a systems level to heal and prevent trauma. Figures 3 and 4 summarize the practical trauma-informed and social justice-oriented actions discussed throughout the article and illustrate the relationship between these suggested actions and the SAMHSA principles. Utilizing an MTSS framework explicitly rooted in anti-racist practices and goals, school personnel, including school mental health practitioners, can integrate the SAMSHA (2014) principles (safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues) to cultivate more equitable and holistic approaches to child and family support.

Figure 3

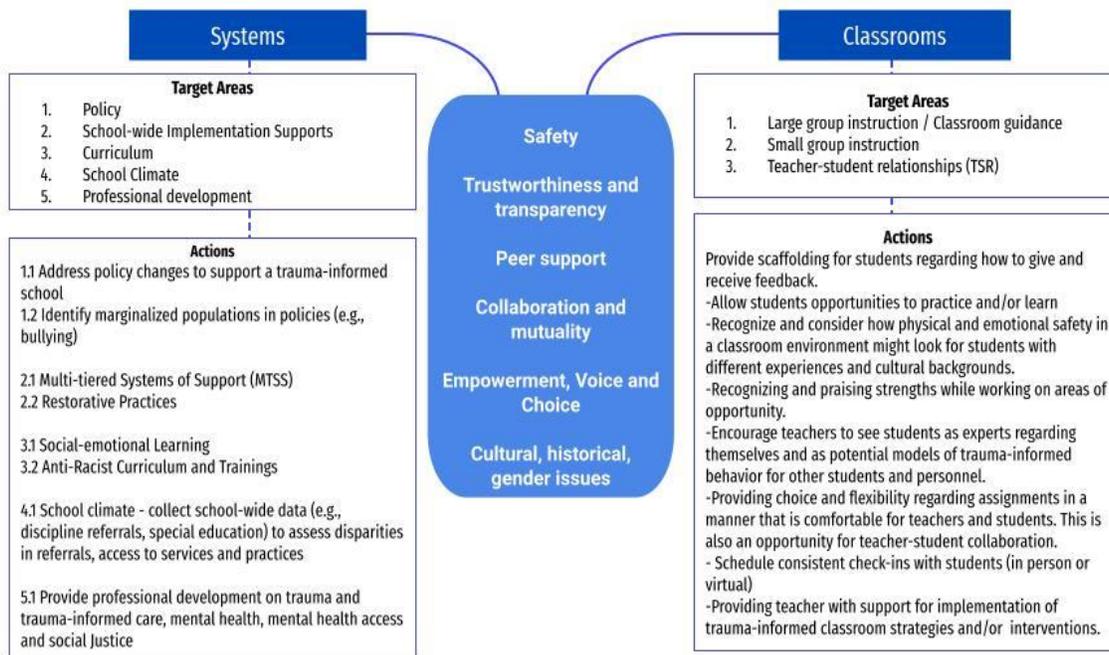
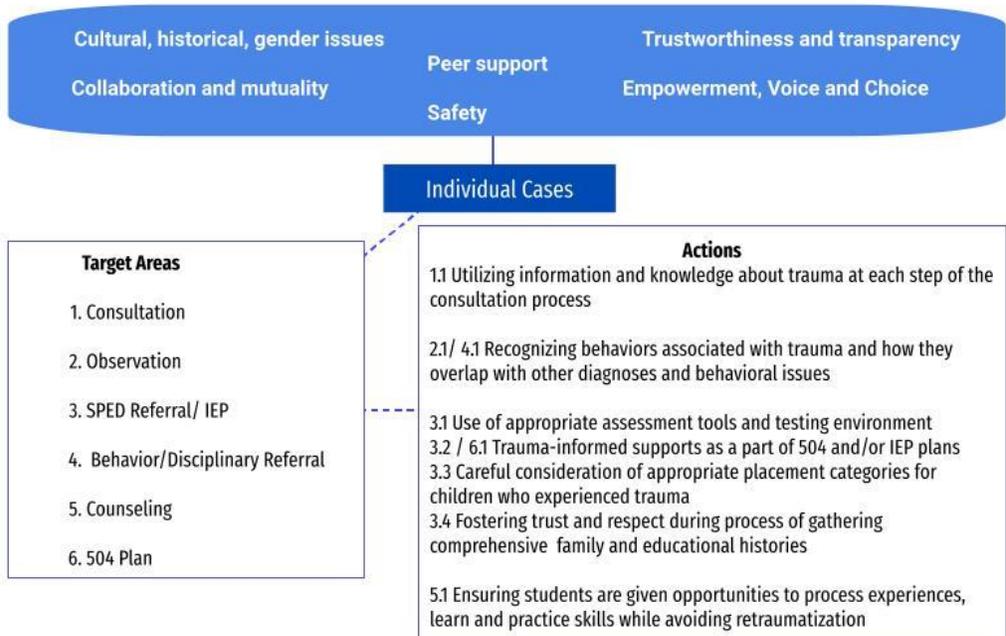


Figure 4



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