Supportive School Discipline Webinar Series

Sponsored by the U.S. Departments of Justice, Education, and Health and Human Services

Transforming School Climate Through Trauma Informed Practices

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Questions and Answers

1. **Do all people who have experienced trauma necessarily have PTSD?**
    a. Dr. Gillece: No, they do not. Some people have different symptoms, but it is not all PTSD.

2. **What are some successful treatments or interventions to assist people who have been diagnosed with PTSD?**
    a. Dr. Gillece: There is a lot of sensory modulation work that is really helpful with people with trauma-based experiences or diagnoses. There are some arts therapies that are also extremely helpful. Yoga is very helpful with individuals. The main thing is to help individuals understand what their trigger is and to establish an individualized program that helps that person find the capacity to understand that trigger. For instance, if the child is feeling that experience of trauma again, it is important that they feel safe enough to not respond in that "fight, flight, or freeze" way. It is about helping people understand how trauma affects them and helping people find that capacity to self-soothe, so that the solution that they use is one that is not going to hurt them or hurt someone else.

3. **Why aren't many administrators and staff trained in dealing with students with trauma-related issues?**
    a. Ms. Trader: This is a school by school and district by district decision. People are not as familiar as they could be. A lot of people are not informed on how to implement trauma-informed practice. Many times they are not aware that such practices exist. We need to educate people and then help them implement.

4. **How does this trauma-informed approach apply to public schools where restraints are largely not utilized?**
    a. Dr. Gillece: Using a trauma informed approach is helpful whether you are using restraints or not—being able to look at how you can assist individuals understand the meaning of their behavior is a win-win.

5. **How do you implement non-punitive and positive practices with older adolescents?**
    a. Dr. Gillece: By looking at the Positive Behavioral Intervention and Support (PBIS) framework and looking at what they are doing there. To look at the literature on strength-based approaches. (www.PBIS.org)
    b. Ms. Trader: A lot of it is being respectful of adolescents and getting to know them and listening to them. One of the things I like about a trauma-informed framework is that it starts

with respect of the individual. And that is what a lot of kids miss when they are in a school environment that has not gone through realigning their culture to be more positive.

6. **Does Ms. Trader know the background of the school and the situation regarding Sammy?**
    a. Ms. Trader: Yes. He was in the second day of his first grade year. He had never been to this school before. The cafeteria was new to him. He has a sensitivity to noise and found the cafeteria too overwhelming so he did not want to go there. The situation that got him into a restraint was that he threw a bowl of noodles.

7. **What is the outcome for these schools? How are the schools/school districts held accountable?**
    a. Ms. Trader: Many schools must face litigation. The cost of litigation is expensive. It really depends on the community, the school board, and the political mindset or nature in the community if leaders or principals are terminated or otherwise reprimanded. There is a patchwork of protections through local and state laws which is why it is necessary for federal laws to be established. The only way schools, districts, and states are going to be held accountable is with a federal law.

8. **Who oversees the use of restraints in school environments? Is there a check and balance to ensure that staff do not abuse children this way?**
    a. Ms. Trader: Unless there is a formal policy, in a lot of cases it is completely up to the school and often there is no district or state oversight. For the most part, from what we have been able to learn from our limited research, the bulk of restraints happen in special education classrooms, with no oversight by any school administrator. There is no check and balance. It is going to be different state-to-state and district-to-district. Some states are very directive and have really good policies and progressive leadership to enforce the sound policies. So if their districts are actually implementing the policy, and that is a big if, then they may be more prescriptive about oversight, the use of documentation after each incident, and the involvement of an administrator in evaluating the situation before the child is placed in restraints. Those are the things we want to see. Even if the state policy exists, it may not be enforced or implemented at the district level. Oversight is very spotty across the United States and often nonexistent.

9. **Are all K-12 schools nationally required to have a restraint and seclusion policy?**
    a. Ms. Trader: There is no national policy; there is no national legislation on restraint and seclusion. This is what is frustrating for parents. They have nothing to rely on in regards to restraint and seclusion that is going to keep their kids out of restraints and safe from the harm caused by their use.

10. **I'm feeling there is a presumption the teacher knows the student has a disability, however as a teacher I was told it would be a breach of confidentiality by telling teachers student challenges and issues. Can you give some insight to how teachers can get important student information to help in responding supportively to traumatized students?**
    a. Ms. Trader: The question of confidentiality is really a matter of whether the individual teacher or team of teachers is a member of the IEP team. The IEP team is versed in what the child's disability status is and what their needs and supports and services are according to the IEP. The other teachers and personnel in the building do not necessarily need to know that. However, in a school that has a positive culture, that should not be an issue, because if the student is having a meltdown or is upset in another part of the building, someone will know

how to respond (what supports to provide to the youth) if there has been adequate staff training, even if it is not the personnel that is on the student's IEP team.

11. **What are some specific ways that [the schools discussed in the Webinar] changed? What was done differently? How did the physical layout of the school change (if at all)?**
    a. Ms. Trader: One school changed their seclusion rooms into a different functioning room that was not punitive but supportive in nature and function. Most seclusion and restraint occurrences happen in segregated special education classrooms. Researchers have found that students with the most significant support needs can be educated more effectively in a general education classroom in their neighborhood school when their behavioral and academic support needs are met. In general education classrooms, students receiving support for behavioral needs are able to more efficiently adopt ways of managing their own behavior when modeling of other students is readily available (watch the Thaysa mini-film at http://www.whocaresaboutkelsey.com/ for a demonstration of this concept in action).

       One school for students with severe emotional and behavioral disabilities implemented a complete systems change effort related to restraint and seclusion. They engaged a university to share research so decisions could be research/data based, they taught their teachers the foundations of PBIS, and they invested a lot of time in getting teachers aligned in the vision. When they were going to do away with restraint and seclusion, they tracked each incident over the course of the first year, and every time there was an incident that required restraint and seclusion, they did a debrief, they found out what happened, they taught their staff data-based decision making—meaning they developed a paper trail so they could see what was happening and where there were problems. They also did additional staff training. That school eliminated seclusion entirely as a matter of policy and they use restraint sparingly and only when there is an emergency. But for the last two years they have not used it at all. So there was a huge change in the way staff viewed restraint and seclusion intervention. In fact, now they find it unacceptable and just do not do it.

       When schools make a concerted commitment from the leadership level down, to transform the culture of the school building, schools become schools that honor the worth of each student. They are schools that are respectful of students, communicate that respect, and are positive, supportive climates for learning and growing (www.pbis.org).

12. **Can students who witness restraint and seclusion be traumatized?**
    a. Dr. Gillece: Yes, without a doubt. The witnessing of violence is equally as traumatic as the experience of violence, because of the feeling of hopelessness. Imagine a child watching a peer being restrained or secluded. It is absolutely terrifying for them.
    b. Ms. Trader: An example of this is in Connecticut; some students in an elementary school heard children screaming in the seclusion room. They went home and told their parents about it. This got national news. They were called "Scream Rooms" by the students. The parents of the kids without disabilities created an issue about it because their kids were so impacted by it. That's what raised the use of seclusion in that school, and that school district to a national level.

13. **Are there any rights for students?**
    a. Ms. Trader: Yes, there are rights that are guaranteed by IDEA. One is that the student has the right to receive a free and appropriate education. Another is that students are supposed to receive support so that they can access academic content. Also, the IEP team, who creates the education plan for the child, is supposed to describe evidence-based practices in the IEP, and parents take that seriously. Only things proven to work in the research are supposed to be used with their children. Restraint is not an evidence-based practice. There are many ways that a child's rights are being violated in the use of restraint. Another right that students with disabilities have is that nothing should be done to them just because of their disability status. In other words, discipline in particular should not happen to them because of their disability status. It has been my experience that restraining students usually does not happen with kids without disabilities. 70% of restraints are used on kids with disabilities.

14. **Do we have some examples of what interventions that are being recommended for teachers and school personnel to use with children to pull them away from relying on punitive avenues?**
    a. Ms. Trader: The main intervention that has been widely recommended and promoted through Department of Education and other channels is PBIS. There is a national PBIS center (see http://pbis.org). There has been a lot technical assistance and training on the use of positive behavioral supports. Trauma-informed care integrates very well with PBIS. They are complimentary approaches. PBIS is the main intervention. It is appropriate for kids of any age. It applies to children no matter the extent of their disabilities.

15. **Are you familiar with the uses of art therapy to increase awareness, sensory stimulation and a sense of control in youth with verbal processing issues and trauma?**
    a. Dr. Gillece: Yes, I really believe in art therapy. I really believe in using non-verbal means to be able to help the youth self-regulate when faced with the trigger that typically invokes a response on the part of the youth who has been traumatized.

16. **Do you know what proportion of public schools or school districts use, or don't use, restraint and seclusion, or aversive practices?**
    a. Ms. Trader: We do not really know that. The Department of Education did its first data collection in 2011. Those numbers were reported to the public in 2012. We are waiting for the next set of data from the 2012 school year. But what we know is data collection that is done for the first time often has many errors and it takes time to work out all the "bugs".. The first collection did not give us enough information to go by in regards to how many schools use and how many schools don't use restraint.

17. **How do early child care centers use restraint and seclusion, e.g. Head Start**
    a. Both: We hope they don't but we have heard stories. In fact, there was a mother of a three year old child who gave testimony at a U.S. House hearing upon the first release of the restraint and seclusion bill. Her child was three years old and had been restrained at school in a preschool program.

18. **Can the presenters comment on the connection between poverty and disability status?**
    a. Ms. Trader: There is a higher incidence of disability in communities of poverty.

19. **Are there circumstances when restraint or seclusion do need to be used?**

a. Dr. Gillece: I feel no. Ms. Trader did give the example of when a child is running out into the street. I can see then if someone is holding the child. But it is on very rare occasions that I think restraint and seclusion cannot be prevented.
b. Ms. Trader: I would take the position that seclusion is never appropriate and should be eliminated. There is no reason for seclusion. Restraint should be viewed as a last resort, emergency-only technique that is used very sparingly. As I described before, a school with all kids who have really challenging behaviors has gone two years with no emergencies. That is what happens with good training.
c. Dr. Gillece: We are seeing sparing or no use of seclusion and restraint even in psychiatric hospitals, where the kids need an even higher level of care. It really is possible to eliminate these practices all together.

20. Holding leaders "accountable" carries its own sort of "trauma" doesn't it? How do we support, nurture, and care for those administrators, correction officers, and teachers that are on the front lines and carry their own stories and life experiences that may affect their behaviors in the respective settings.

a. Dr. Gillece: Trauma-informed care is really about supporting those receiving the services as well as those providing those services. It is about preventing violence and preventing any use of aversive intervention because we believe that is traumatic for the staff as well as those experiencing the intervention. It is traumatic for the staff to have to restrain or struggle with a child as well. We are really trying to look at this through providing the teachers and support staff with the additional tools to intervene at the stimulus level rather than at the response level. We want to keep situations safe both physically and psychologically for those who work in the system as well as those who are receiving the services from the system. We certainly do not want to traumatize any leaders or staff. We support, nurture, and care for them through training and reinforcing and not making this a whole new "technique of the week," but through teaching and helping staff understand that there is meaning in behavior and the behaviors that they see are not what are frequently called "attention-seeking," "manipulating," "oppositional," or "defiant," but rather solution-seeking. If the staff do not know that, then they don't know that. It is not teaching them how to intervene. I find it most successful when we teach them how to gain understanding and insight into where the behaviors come from in the first place. If you come to understand that, you will never restrain a child.
b. Ms. Trader: There is an issue about accountability and trust. Parents send their children to school and they trust that the people in that school will keep their children safe and away from harm. So from a parent's perspective, holding leaders accountable is fairly important when you are dealing with something that is as damaging and potentially dangerous as restraint and seclusion. What we advocate for is that schools need to collect data and they need to be transparent about that data, as well as how often restraint and seclusion are being used in their buildings.
c. Dr. Gillece: At the same time, I really think supporting the staff through proper education and training is important, so they understand that many interventions (like restraint and seclusion) are often times just reenacting what is causing the behavior in the first place.

21. It sounds like you are also describing youth with Fetal Alcohol Spectrum Disorders - could you comment on this?

a. Dr. Gillece: Sure, it could be a part of it, but it is not the only thing we are talking about.
b. Ms. Trader: Yes, this is not disability-specific.

22. **Is trauma-informed practice mainly about restraint and seclusion? There seems to be a lot of discussion about restraint and seclusion and I always thought it was much more than that.**
    a. Dr. Gillece: Trauma-informed practice is a way to reduce restraint and seclusion, but it is much more complex than that because it is really looking at helping people understand the causes versus just understanding the behaviors. It is about becoming strength-based versus deficit-based. It is about creating an environment that is soothing and reducing the likelihood of triggering someone. It is about helping individuals understand what are their unique triggers/traumatic reminders and helping them develop strategies to help calm themselves when they start to experience some of those triggers. So that is correct, it is much more than just seclusion and restraint but we also see preventing seclusion and restraint through trauma-informed lens, along with PBIS to be a way that we can eliminate these practices in schools.

23. **Do you know of any apps (assistive technology) that allow a non-verbal student to communicate their trauma?**
    a. Ms. Trader: There are applications that allow nonverbal students to communicate. There are no apps that are for communicating just about trauma. This is the realm of assistive technology and augmentative and alternative communication. There is a lot out there.
    b. Dr. Gillece: There are websites and listservs and places to find assistive technology.

24. **Has anyone suggested the use of cameras in the classroom with these special needs children?**
    a. Ms. Trader: Yes, a lot of parents believe that classrooms with cameras in them would solve a lot of these problems. Maybe to some degree it would, but I think it takes away from the overarching need that staff really need to be trained to manage kids that have behavioral challenges and to help students understand how to manage their own behavior. The use of cameras may help identify that something wrong is happening in the classroom, but that is just a small picture and certainly not a solution.
    b. Joyce Burrell (STTAC Project Director): Cameras can be very helpful in providing examples of good to exemplary practices that could be shared with other teachers and school staff.
25. **Are medical staff on hand to assess the types and use of restraints?**
    a. Dr. Gillece: Not usually in schools.
    b. Ms. Trader: Almost never in schools. This is one of the reasons why restraint should not be used. There are additional risk for students if you are going to use restraint, if no one is on campus to offer any emergency care if needed.

26. **Where should schools start first in making changes that reflect all of the information we now have on the effect trauma has on individuals' behavior as well as their academics? In general, what are the steps for taking our school to a TI approach?**
    a. Dr. Gillece: I think it is important to start training all staff on what trauma is, and what trauma-informed care is. Schools can go on to our website and really use whatever PowerPoint or other resources available as well as the PowerPoint for this webinar. I think the first thing starts with training and then taking a hard look at all of the different practices and then making an assessment of whether or not it is trauma-informed. It has to start with educating all the staff. I would be happy to provide schools or others with any kind of training materials they would need.

27. **I would love to hear more about the classroom learning and how we can help young people work through their trauma to develop resiliency and be more successful in school.**
    a. Dr. Gillece: We should look at developing strength-based opportunities, and at positive behavioral supports versus trying to just control the behavior that we perceive as negative. There is so much that needs to be addressed. I think it is also really important to think about those punitive interventions that take place in public. It is not just horrific for the child experiencing that kind of intervention, but it is traumatic for everyone that has to witness it as well as the staff who has to administer it.
    b. Ms. Trader: Helping young people work through their trauma is not about classroom learning. It is really a very different context. Trauma-informed care is a cultural change and a whole-school change that recognizes a certain percentage of students, as well as staff, are trauma survivors. The environment needs to address the healing of all of those people.
    c. Schools could help themselves by giving the little ten question survey from the Adverse Childhood Experience Study if children are over 11. For those younger than 11, a different age-appropriate survey tool could prove invaluable. The Kaiser Permanente lead on the study, Dr. Vincent Filletti would probably be excited to work with schools like he did with the Crittenton Foundation programs.

28. **The new school year starts in about a month. Are there any materials for use in professional development available to order?**
    a. Ms. Trader: "Who Cares About Kelsey" provides a great framework and introduction into how PBIS really works in the school and how it impacts the ability of a trauma survivor to learn. Anything on the PBIS Center website is helpful (pbis.org). There is a discretion guide attached to both "Who Cares About Kelsey" and to "Restraint and Seclusion: Hear Our Stories". Those are both meant for professional development activities. Dr. Gillece has information on the National Center for Trauma-informed Care website (http://www.samhsa.gov/nctic).
    b. Dr. Gillece: The link to the film is a great way to start (http://stophurtingkids.com/the-film). The learning questions Ms. Trader created to supplement the film are also helpful.